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GAYS IN AA: HOW DO THEY BENEFIT FROM THE PROGRAM OF ALCOHOLICS ANONYMOUS?

Madonna R. Riesenmy, Ph.D., M.A.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Art, April 1, 1998

Abstract

Objective: Recovering gay alcoholics report that, although the experience of AA is beneficial for them, they have needs different from that of heterosexuals and place dissimilar demands on the program of Alcoholics Anonymous (Ratner, 1988, Paul, Stall, & Bloomfield, 1991). Some of these needs and demands are evidenced in the ways gay alcoholics make use of sponsors, meetings, and gay meetings (Kus,1987, 1994, Hall, 1994). The present study examines the incidence of relapse and three aspects of recovery: sponsorship, meeting attendance, and attendance at gay meetings during the first year of recovery. *Method:* A group of gay recovering alcoholics (N = 32) at a gay Twelve-Step recovery clubhouse completed a 36-item questionnaire that examined the features of AA that were most useful for them during their first year of recovery. *Results:* A significantly higher proportion of Non-relapsers (NR) compared to Relapsers (R) acquired and used sponsors during the first year. This did not hold true for meeting attendance and attendance at gay meetings. Seventeen of the NR's had acquired and used a sponsor during the first year. The same was true for only nine of the R's. *Conclusions:* The findings support the idea that, for gay recovering alcoholics, the sponsor plays a significant role in the first year of sobriety. Those who work with recovering gay alcoholics or gay alcoholics interested in recovery should urge their clients to acquire and use a sponsor during the first

year. Meeting attendance and attendance at gay meetings will probably not be enough to obtain and maintain sobriety.

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Chapter 1

The purpose of this study is to examine the experience of gay recovering alcoholics in AA. Specifically, the study looks at the role of sponsorship, meeting attendance, and attendance at gay meetings in the incidence of relapse.

It is not clear what role the different aspects of AA play in warding off relapse. What is clear is that gays experience AA differently from heterosexuals (Kus, 1987, Hall 1994). Gay recovering alcoholics enter AA with the emotional damage of homophobia and often have poorly developed sexual identities (Kominars, (1995).. This results in feelings of shame, guilt, loneliness, anger, and frustration. Unfortunately, negative emotions such as these are the most common precipitants of relapse (Lieb & Young, 1994).

Relapse is part of the recovery process and is more likely to occur in the early stages of recovery (Gerwe, 1997). Alcoholics who acquire time in the program are more likely to continue abstinence from alcohol. One full year of sobriety seems to signal further long-term sobriety(Brown, Vik, Patterson, Grant, & Schuckit, 1995).

Statement of Purpose

Thus, this study seeks to examine the role sponsorship, meetings, and attendance at gay meetings play in assisting gay recovering alcoholics in staying sober, at least for the first year of recovery. Non-relapsers (NR) and Relapsers (R) are compared in the

way they make use of these features of the AA program during the first year of sobriety. It is hypothesized that there will be a relationship between the incidence of relapse and sponsorship, meetings, and attendance at gay meetings.

Chapter 2

Etiology, Development and Maintenance of Alcoholism

The etiology of alcoholism can be explained by many models. Most of these are encompassed by the American Disease Model (Chapman, 1996) which asserts that alcoholism is a primary disease that is not caused by other biopsychosocial factors or conditions such as stress, psychopathology, other drug use, or even drinking. The DSM-IV (1994) notes the presence of Alcohol Abuse as indicated when such things as school and job performance, child care, and household responsibilities suffer from the aftereffects of drinking. Individuals may experience legal difficulties from using alcohol or become intoxicated in physically hazardous circumstances (driving, operating heavy machinery). Those diagnosed with Alcohol Abuse may use alcohol even with the knowledge that continued drinking often leads to significant social and interpersonal problems such as child abuse or domestic violence.

Genetic factors may account for some portion of the incidence of alcoholism (Hall, 1990). However, women have often been omitted from major genetic studies and it may be true that, at least for them, genetic factors may not be as important as social-environmental influences. Hall adds that rape and sexual abuse are common factors in the experience of alcoholic women and may contribute to the development of alcoholism. On the other hand, Niesen and Sandall

(1990) claim that early sexual and physical victimization may be common to alcoholic men and women, heterosexual and homosexual alike.

Lieb and Young (1994) propose that the development and maintenance of alcoholism can be explained through Control Mastery Theory. This theory takes into account the development of pathogenic beliefs based on traumatic childhood experience that eventually leads to the abuse of alcohol. These beliefs regulate the behavior of alcoholics and provide them with theories of how the world works. As children, alcoholics come to believe that they are unlovable, different, and a burden to their parents. As Lieb and Young state, "However painful and disruptive such beliefs are, they are more tolerable than the truth that one's parents are neither equipped nor capable of parenting or protecting the child (p. 37)." These pathogenic beliefs are fed by unconscious guilt that the good in one's life comes at the expense of others. Thus it is wrong to have a better life than one's parents and family members or to even aspire to have one. Further, alcoholics experience childhoods during which they develop the notion that behavior directed at fulfilling normal developmental needs is inappropriate. If a child's parents are unable to tolerate the normal emotions and behavior of childhood and are unequipped to help one control and express feelings, the child comes to believe that her needs and feelings are a burden to her parents and others. These beliefs are

carried into adulthood and fuel the fire needed to maintain the prolonged misery of alcoholism.

For gay men and women the development of alcoholism may be more complex. Shernoff and Finnegan (1991) simply state that homophobia leads to chemical dependency. Most gays come from homophobic families where their sexuality is either denied or defiled. Paul, Stall, and Bloomfield (1991) support this by claiming that most gay men and women report that feelings about being gay contributed to their alcoholism. Moreover, even in the presence of acceptance of their sexuality by others, gay men and women experience internalized homophobia and have difficulty accepting their identity as homosexuals. Confusingly, the effects of this can be pervasive and therefore difficult to attach to subsequent beliefs and behaviors. As Shernoff and Finnegan state, "One manifestation of internalized homophobia is commonly exhibited when lesbian or gay clients blame all of their early painful feelings solely upon their homosexuality (p. 130)."

Other factors may come into play. Ratner (1988) claims that the self-loathing that is a part of internalized homophobia may be so overwhelming that sexual intimacy may be impossible for some gays while they are sober. Hall (1990) found that, for gay women, the development of alcoholism may be strongly related to whether or not one's significant other is an alcoholic. Paul, Stall, and Bloomfield

(1991) point out that lesbians may be more at risk than gay men for the development of alcoholism as a response to their oppression as women and lesbians. In support of this, they note the relationship between nontraditional gender roles and higher rates of drinking. Thus, gay women who assume more masculine roles and body images may be more likely than other women to abuse alcohol in order to project and protect assertive and aggressive behavior.

The Alcoholic/Addictive Experience

Alcoholism is a disease of emotions, isolation, and is in and of itself a damaging lifestyle both physically and psychologically (Heyward, 1992, Neisen & Sandall, 1990). Hopson and Beaird-Spiller (1995) identify four features of the experience that one endures as an alcoholic, "...(1) Intense feelings for which language is inadequate; (2) A disruption in the experience of time; (3) Alienation from oneself and others; and (4) A lack of a sense of agency, self-efficacy and the capacity for self regulation (p.5)." From structured interviews with volunteers from an outpatient program for chemical dependency, Hopson and Beaird-Spiller determined that these features of the addictive experience make life without alcohol intolerable for alcoholics. The inability to express one's feelings (which are intense for alcoholics and often subject to wide swings) in language results in a lack of development of self-regulatory mechanisms. As a result of learning few coping skills from parents, alcoholics tend to fear their emotions

and believe that they are self-destructive (Lieb &Young, 1994). Time seems to move very slowly or not at all. As Hopson and Beaird-Spiller point out, the combination of the lack of movement of time and intense indescribable emotions leaves the alcoholic trapped in the grip of feelings that cannot be relieved and seem impossible to endure. One's experience seems frozen and the alcoholic cannot imagine that the feelings will ever be different. Failure to experience the passage of time accents the intensity of "now". "Now" is the time to act. What may seem to an outsider to be impulsive behavior is the frantic search for immediate relief. In the absence of self-efficacy and a sense of agency, one believes that one is unable to manage emotional states. The inability to manage one's feelings and the sense therefore that one is unable to care for oneself make not only the intrapersonal relationship but interpersonal relationships problematic. Hopelessness and despair follow as one comes to terms with the fact that one is unable to connect with oneself or others.

The maintenance of the alcoholic experience is fueled by pathogenic beliefs developed in childhood (Lieb & Young, 1994). Alcoholism becomes a way of life aimed at preventing that which is good in life from occurring and as a way to "protect " one's parents and family members. Alcoholics fear that the development of autonomy will result in the abandonment and subsequent suffering of one's parents. On the other hand, dependence on alcohol allows one's parents and

others to be useful. Lieb and Young characterize the alcoholic experience as a "desperate rescue mission" to establish one's parents as needed and morally superior. One learns to avoid pleasure and induce unhappiness through alcoholism in order to punish oneself for some imagined crime. The alcoholic abuses alcohol to identify and comply with pathogenic beliefs held firmly in place by unconscious guilt. Although to an outsider the agony of the addictive experience may seem insane, the alcoholic may not be disturbed by the experience itself because it fits with her self-image as guilty and undeserving. She is often unable to connect her drinking behavior with the chaos of her life because misery "makes sense."

In an explanation of alcoholism from the epistemological approach of cybernetics, Bateson (1987) states that the alcoholic is caught in a trap in which the alcoholic's "system" requires that one be strong and exercise one's will in a struggle with the bottle. In this explanation the alcoholic has a symmetrical relationship with alcohol in which one must either defeat the urge to have alcohol or have as much as one wants. In an escalating "arms race" with alcohol, the alcoholic must consume it in an attempt to prove that the bottle cannot kill.

Some differences may exist along gender lines in the alcoholic experience. Kaskutas (1994) found in a survey of women in recovery that women are more solitary than men in their drinking, experience different effects of alcoholism during menstruation, often feel powerless

and worthless prior to drinking, and drink due to their feelings of worthlessness. Women alcoholics are more likely than men to have low self-esteem, high guilt, and suffer from depression. In addition, Kaskutas determined that women alcoholics often abuse prescription drugs along with their alcohol dependence. Women experience alcoholism later in life than men but the progression of the disease is much more rapid. Hall (1990) notes that, although women may be psychologically and physiologically vulnerable to alcoholism, they are somewhat "protected" by the constrictive expectations of their role as women. Deviation from the caretaking role is not tolerated by those around them. Women alcoholics violate "the expectation of propriety." The result of this is that women recognize their alcoholism more promptly and often seek treatment sooner than men. Despite whatever differences may exist for men and women in the alcoholic experience, Hall asserts that the evidence suggests that, although the experience may be different, the actual drinking patterns of men and women are converging.

Gays and Alcoholism

It is difficult to ascertain the prevalence of alcoholism in the gay community. Ratner (1988) contends that there has been a general lack of interest in the study of chemical dependency among gay women and men. In the body of research that does exist, often there are gaps, particularly for the study of alcoholic gay women (Paul et al, 1991).

Moreover, much of the research has been done with samples recruited from gay bars, leading to noteworthy sampling errors. Additionally, the subjects in the samples were primarily white, middle-class, and male. Nevertheless, researchers (Kus, 1989, Bickelhaupt, 1995, Holleran & Novak, 1989) typically claim that the rates of alcoholism in the gay community range from 25 to 33%. That figure translates to the prominence of the disease of alcoholism in the gay community at two to three times higher than the incidence of the disease in the general population. On the other hand, comparisons of rates of heavy drinking between gay men and women and their heterosexual counterparts are similar (Paul et al, 1991). However, gay men are much more likely than heterosexual men to report that they have drinking problems. Correspondingly, gay women report suffering from drinking problems three times more often than heterosexual women. Further, for gay men and women, alcohol is the drug of choice compared to other drugs. Fortunately, evidence (Hall, 1992, Paul et al, 1991, Remien, Goetz, Rabkin, Williams, Bradbury, Ehrhardt, & Gorman, 1995) suggests that gay men and women are in a trend away from substance abuse. There are more alcohol-free spaces for socializing at concerts, coffee houses, and sober gay celebrations. In particular, the recovering lesbian alcoholic is a growing presence in the gay community. Paul et al suggest that this may be true in part because of recent statements from several lesbian performers and musicians that they were

recovering alcoholics. Indeed it seems that gay men and women have more in common with one another in terms of the prevalence of alcoholism in their community than they have with their heterosexual counterparts. One could argue that in discussing alcoholism rates it is more sensible to refer to the sexes as either gay or straight instead of as either male or female.

Despite growing trends, gay men and women still conduct much of their socializing in bars (Paul et al, 1991, Hall, 1994, Stacy, 1997) and alcoholism rivals AIDS as the single greatest threat to the health of the gay community (Kus, 1991). Additionally, for gay men and women the bar has been the focus of political activity, public defiance, the source of collective identity, and a place to gain and act out a sense of self. Many researchers have assumed that the central position of the bar in gay life is enough of an explanation for the higher rates of alcoholism in the gay community.

From surveys of gays in treatment, Diamond-Friedman (1990) found that almost half of them see alcohol as a solution to their problems. Feelings of isolation, shame, and alienation in heterosexual society predominate in the beginning stages of alcoholism. Ratner (1988) claims that the blackouts associated with alcoholism may be comforting for gays if they eliminate the memory of acts that are still considered shameful in the minds of men and women not comfortable with their homosexuality. Hall (1990) asserts that alcoholism may be

just a part of accepting one's gay identity, albeit a tragic one. Similarly, McNally and Finnegan (1992), in interviews with gay women discovered that their was an interaction between drinking and sexual identity. They note, "...some drank to be *not* lesbian; some drank to *be* lesbian (p. 94)." Those who were in the Immersion stage of identity transformation felt the need to immerse themselves in gay culture which meant that they often experienced that culture in gay bars. Interestingly, for many of the women, the identity of Alcohol User began to take precedence over that of being a lesbian. Gay men (Kus, 1991) also report that prior to recovery they had difficulty accepting their gay identity as positive and often used alcohol to anesthetize their feelings of self-loathing. Both gay men and women with more negative affect about themselves are more likely to use alcohol as a way of easing tension and anxiety (Paul et al, 1991).

Further, in the face of the pervasive discrimination which confronts many gays, some of which is life-threatening, many develop symptoms of chronic stress. Those gays who report experiencing more discrimination in a heterosexist world were more likely to use alcohol and frequent bars for socializing. The recursive nature of chronic stress and chronic alcoholism escalates the agony for those caught in this system. More alcohol use creates more stress and so on.

Lying, denial, and projection, the ego defenses gays use to defend against the psychological toll of being gay also prevent them

from recognizing and treating their alcoholism (Ratner, 1988). Gays tend to rely on lying in order to hide a central part of themselves from their families and the rest of their world in order to survive (Shernoff & Finnegan, 1991). Keeping the secret of their alcoholism is a natural as keeping the secret of one's sexuality (Hall, 1990). As Ratner puts it, "In other words, because lying is a way of life, lying about drinking seems easy by comparison (p.31)." The denial that gay men and women express to avoid confronting their alcoholism is further employed to repress their feelings of low self-worth (Picussi, 1992). If left untreated that denial may result in self-sabotaging behavior beyond that of chemical dependency. For example, Hall states that gay women attempt suicide seven times more often than heterosexual women and that alcohol is often a part of the suicide event. Hall believes that many lesbians opt for alcoholism as a slow form of suicide. Finally, the alcoholic tendency to blame others for one's problems is exacerbated in gay men and women because, all too often, homophobic others do cause many of their problems. The defensive tactic of projection often makes it very difficult for gays to benefit from treatment or to tolerate meaningful, intimate relationships in which the "other" is the enemy.

Alcoholics Anonymous

The experience

AA defines alcoholism as a physical and psychological allergy. The alcoholic simply cannot drink in a reasonable manner. The alcoholic is powerless over her affliction and her life is unmanageable because of it. Sobriety is abstinence from alcohol marked by continued personal and spiritual growth through the application of AA's principles. (Alcoholics Anonymous World Services, 1976).

The view of AA is that alcoholism is a way of living and relating with the world of which the abuse of alcohol is only one of many features (Hopson & Beaird-Spiller, 1995). The alcoholic suffers from a disease of feelings in which she is not willing to endure the suffering which is a part of normal human existence.

According to Hall (1992), the image of recovery in AA is conversion. After a lengthy period of sin or moral decline, the alcoholic experiences a transformation and eventually recovers with a mind toward abstinence and virtuousness. This transformation (or "spiritual experience") is a singular event followed by a development of interest in helping others, trust in a Higher Power, decrease in the craving for alcohol, and the presence of a new-found serenity.

AA outlines in its widely publicized tome (Alcoholic Anonymous World Services, 1976) the activities of "working the program" in AA. These include:

1. Doing the Twelve Steps
2. Attending meetings

3. Working with a sponsor

4. Doing everyday activities along the guidelines of the program

5. Sharing oneself with other alcoholics

6. Developing one's relationship with a Higher Power

7. Reading AA literature

8. Maintaining and respecting the anonymity of AA members

According to Hall (1990) following AA's Twelve Steps and active participation, "...describe a process of surrender, acceptance, self-inventory, restitution, spiritual meditation, and helping others as a program of recovery (p. 111)." During and after meetings, members share their self-evaluations, past failures, and current successes with each other in order to give the recovering alcoholic or newcomer experience, strength, and hope. Through listening to the successes of those similar to her, the alcoholic may undergo a profound alteration of her self-esteem and experience a sense of connection to others that is entirely novel. The anonymity of AA actually enhances the feelings of membership in the group by making it clear that any individual member is no more or less important than any other member (Bateson, 1987). The spiritual component of AA offers the recovering alcoholic a limitless resource on which to draw to ensure she succeeds in her new life.

AA meetings offer alcoholics much needed lessons in expressing oneself and emotions through language (Hopson & Beaird-Spiller, 1995). Members hear "their story" as they listen to others talk

about themselves and what they are experiencing. Through this same format, new members learn phrases and slogans ("Easy Does It, "Keep It Simple", "This Too Shall Pass", "One Day At A Time") to express themselves and therefore increase their ability to endure discomfort. Meetings and fellowship provide a solution to the isolation common to alcoholics. Hopson and Beaird-Spiller claim that the identification of oneself at meetings, "My name is__________and I'm an alcoholic," strengthens one's sense of self along with reinforcing ties to others. The experience of connectedness gives alcoholics the opportunity to relax and be vulnerable and honest with others for perhaps the first time in their lives. Alcoholics desperately need to understand that their experience is similar to other alcoholics in order to combat the perception of being "different" and outcast (Johnson & Phelps, 1991).

All AA members are strongly encouraged to acquire and maintain a sponsor, someone who is available at all times for support and satisfies the need for connectedness that alcoholics just entering recovery need. Kus (1987) describes the role of sponsor as one of guide. Someone who is willing to listen and provide information on the Steps and Traditions of AA. Many alcoholics discover that, upon entering recovery, feelings that have heretofore been anesthetized by alcohol are now baffling and painful. The sponsor can reassure the newcomer that this is normal and provide support during difficult times. Sponsors often suggest that newcomers attend more meetings (90 in

90 days) and get to know other AA's. Some sponsors may choose to go so far as providing rides to meetings and participate in outside socializing with the newly recovering alcoholic. The sponsor may introduce the newcomer to AA literature and require and discuss readings with her.

AA literature principally includes the "Big Book", Alcoholics Anonymous and the Twelve Steps and Twelve Traditions of AA. Other literature that AA's commonly use are books written about AA, books, about alcoholism, daily meditations, guides to the Steps, and spiritual and religious works (Kus, 1989). Advantages to using AA literature in one's program are that most books are inexpensive, highly accessible, and can be shared with others. On the other hand, the use of literature in AA assumes literacy. Readings can be misinterpreted, and, for the newcomer, positive and negative messages in the literature may be indistinguishable.

Exposure to the spiritual component of AA can have a powerful effect on the recovery of alcoholics. Bateson (1987) states that alcoholics can change their destructive behaviors, in spite of their craving for alcohol, if they can begin to see themselves as part of a larger system, one in which God or a Higher Power exists. The omnipotence and complete and constant availability of God allows the alcoholic to assume a complementary relationship with her Higher Power, one that can be a source of power for the alcoholic who is

finally willing to admit her complete powerlessness over alcohol. The spirituality of AA, according to Chapman (1994), is a three tiered concept allowing for connections with others, self, and a Higher Power. The end result of the spiritual experience being that the alcoholic is finally able to accept her personal worth and purpose as a part of that connectedness.

For some non-alcoholics and alcoholics outside AA the activities and beliefs of AA bear too much resemblance to a cultlike organization (Galaif & Sussman (1995). Critics of AA claim that it encourages its members to be dependent on the group to the extent that AA is merely the substitution of one addiction for another and that AA strongly discourages any skepticism regarding its tenets. Those who become and remain members may lack involvement with other social groups and activities. Heavy involvement may result in outright resentment of those not involved with AA. On the other hand, unlike most cults, AA does not exploit its members financially, has no political involvement, does nothing to retain its members, does not actively recruit members, and does not claim to be the only solution to the problem of alcoholism.

AA: For whom and how does it work?

Due to such constraints as anonymity and the sampling errors inherent in using active members as participants in studies (Bradley, 1988), very little controlled research on the efficacy of AA exists. Nevertheless, Galaif and Sussman (1995) claim that the research

indicates that AA has varying effects on different groups of recovering alcoholics. AA seems to help those who:

1. Become active members
2. Are middle class, male, single, and estranged from their families
3. Are socially stable, extroverted, and have group dependency needs
4. Are comfortable with self-disclosure
5. Are less cognitively complex
6. Are more guilty about the past
7. Are more lonely
8. Have a religious orientation
9. Have had a history of more severe alcohol-related problems prior to entering AA

AA does not seem to help:

1. Those who are uncomfortable with large crowds
2. Those who do not have a religious orientation
3. Members of minority classes, women, and individuals of low socioeconomic status

Galaif and Sussman assert that the fostering of intimacy in AA and the catharsis of emotions is something that women and minorities already experience. Thus AA has little that is new along those lines to offer them. Although ethnic groups such as Blacks, Latinos, Native

Americans, and Asian/Pacific Islanders have disproportionately higher rates of alcoholism in their populations, they are underrepresented in AA. For those of lower socioeconomic status, the concept of "hitting a bottom" mentioned frequently in AA literature is not meaningful. They have never had all that much to lose.

In contrast, Bradley (1988) claims that, "...no clear profile has emerged of the alcoholic most likely to affiliate with AA (p. 196)." Sociodemographic variables such as education, socioeconomic status, or type of religion are unrelated to AA affiliation. Instead, Bradley offers that the most successful members of AA are simply those who become actively involved, adopt AA beliefs completely, and follow AA's behavioral guidelines.

The abstinence rates of active AA members compare favorably with other forms of treatment. In a review of treatment options, Bradley (1988) found that, in AA, 50% of those who are still members at three months were still sober at one year. Even those members whose meeting attendance drops off after they accumulate many years of sobriety, continue to speak at meetings, attend retreats, provide office assistance, and attend sober social events. Galaif and Sussman (1995) claim that as many as 50% of those who become long-term active members achieve several years of total abstinence. Similarly Johnson and Phelps (1991) found that alcoholics who do not attend AA

have a poor prognosis while those who get involved thoroughly in AA tend to recover much more rapidly.

AA seems to work best as aftercare (Bradley, 1988, Galaif & Sussman, 1995). Those who begin AA after an inpatient program are more likely to maintain their sobriety compared to those who participate in no aftercare. Galaif and Sussman point out that other researchers have found that AA works no better than no post treatment at all. However, they note that often the option to participate in AA is not a free choice for individuals. The courts may demand AA attendance as a condition of parole or the suspension of sentencing in vehicular misdemeanors. Further, as noted by other researchers, AA may not be appropriate and effective for individuals from minority groups.

Studies about women in AA are few. However, the research implies that women have better recovery outcomes if they attend AA meetings. Further, women often have higher abstention rates than men. Survey data from women who have or are currently attending AA (Kaskutas, 1994) indicates that it may be important to look at recovery for women as fundamentally different from that of men. Women come into AA with low self-esteem and feelings of inadequacy. Kaskutas posits that this may make it easier for women to embrace the powerlessness of AA, admit past wrongs, and ask for help. On the other hand, this same feature of women may make them less responsive to the spiritual facet of AA given that their egos are in no

need of further neutralization. They be more in need of a program that initially builds their self-esteem and confidence. Kaskutas claims that women do not need to be reminded of their failings, they are already experts at putting themselves down. Heyward (1992) states that women may find it problematic to accept the language and suggestions of AA. He says, "It is difficult for many women not only to listen to sexist religious language but moreover to be met uncritically by the program's white middle-strata, male-defined, experience of what alcoholism is and what we should do about it (p. 15)." For example, women (and other minorities) may find it difficult to accept the AA tenet that alcoholics can't handle anger and therefore should not risk being angry. Heyward submits that women may need to let out some of their anger in order to expedite their recovery.

Keeping in mind whatever gender differences may exist, Kaskutas (1994) found that what works for men often works for women in AA. She found that women give the following reasons for membership in AA:

1. AA serves as an "insurance policy" against relapse. Women believe that as long as they are going to AA meetings, they will not drink.

2. AA provides a fellowship for making and maintaining friends and opportunities for sober socializing.

3. Current AA members can be reminded by others new to recovery of the perils of alcoholism.

4. Women find that a life lived according to the Twelve Steps is more enjoyable and has a spiritual focus to which they respond favorably.

However, women also give reasons for why they find AA distasteful and membership diffifcult to maintain. They are as follows:

1. Women do not feel that they fit in AA.

2. They find the philosophy and dictates of AA too negative.

3. They are uncomfortable with some spiritual aspects of AA, particularly the idea of dependence on God or a Higher Power.

4. Many women report that AA is too male-oriented and does not address women's needs.

5. Women are uncomfortable with AA's focus on the past.

How does AA work? Any member would probably answer that question by simply stating, " Read the Big Book. Do the Steps. Go to meetings. Talk to your sponsor." Those not so acquainted with AA might require further explanation. Lieb and Young (1994), based on the propositions of Control Mastery Theory, offer further reasons for the mechanism and efficacy of AA. They note that alcoholics often experience deep loss in giving up alcohol, loss of friends, loss of family, and most importantly the loss of the logical conclusions they have drawn from their pathogenic beliefs about themselves and the world.

AA can mediate this loss by providing a support system and a different way of viewing one's place and purpose in the world. Further, AA contradicts the belief that one's feelings and needs are a burden to others. Lieb and Young state, "...this message addresses a core source of guilt by stating that it is possible to be a part of a fellowship (i.e. family) and be focused on individual development goals without negative consequences to others (p.42)." Similarly, AA passes the "denial" and "detachment" tests that alcoholics often pose to others as a way of maintaining their pathogenic beliefs. The fellowship acknowledges the presence of alcoholism and its subsequent misery in an individual's life while at the same time avoiding responsibility for any individual member's drinking. Finally, the spiritual component of AA supplies an entity (Higher Power) that is a source of continued support, nurturance, and direction. It is difficult to harbor feelings of guilt in the experience of need if one knows that all the resources one requires are available in limitless supply.

Unfortunately, as difficult as it may be to describe and measure the efficacy of AA, it is even more problematic to pin down what aspects of AA play the most important roles in acquiring and maintaining sobriety. As Bradley (1988) found in a review of treatment programs based on the AA 12-Step philosophy, tests of these components (sponsoring, being sponsored, attending meeting, etc.) give varied results. Positive outcomes seem to be associated with at

least one or more of the facets of AA taken together. However, Bradley concludes that, of all the pieces of AA, a relationship does seem to exist between AA meeting attendance and sobriety.

Gays in AA

The first "special interest" group designed for gay alcoholics in AA was founded in 1949. Unfortunately, that group had a very short lifespan and it wasn't until 1968 that another gay group came into existence. Shortly thereafter, several other groups were formed, most on the West Coast. Still, AA was reluctant to list gay meetings in its "Where and When" until 1974. Now, gay groups make up the largest set of special interest groups in the United States.

Gays in AA have recovery needs that are different from heterosexual alcoholics. As Picussi (1992) points out, recovery must include a recognition of the emotional damage gay alcoholics have experienced prior to the development of full-blown alcoholism. Consequently, their recovery must address the letting go of old pain and hurts that were a part of their lives. Similarly, Stacey (1997) avers that alcoholic recovery for gays is exacerbated by the shame, stigma, and uniqueness often associated with heterosexist views of homosexuality. Gays usually enter AA with fears of disclosure and a sense of disconnectedness from God that results from the negative religious messages they hear that promote fear, shame, and ostracism

from religious communities. In spite of this, AA can be a positive experience for gay men and women, particularly in the context of gay groups (Shernoff & Finnegan, 1991.) Gays can develop networks of supportive friends that help them attain sobriety along with a more positive gay identity, an identity that comes after some time in sobriety (Kus, 1987.) To take the place of estranged family members and communities, gays in AA can develop new "families" that include sponsors and sober friends. This may be especially important if one is attempting to distance from family members who remain chemically dependent and active. Family members, in an attempt at denial of their own alcoholism, often propose that the gay family member's homosexuality is the cause of her alcoholism and naturally a part of the gay lifestyle. Further distancing may occur as the recovering gay alcoholic begins to present her authentic self to the family and threatens the existence of old family models and roles.

Gay men and women share not-so-positive experiences in AA as well. Holleran and Novak (1989) found, as a result of a questionnaire given to gay men and women (non-traditionals) and heterosexual alcoholics (traditionals) that there were differences in the support choices for abstinence between the two groups. Gay men and women gave more similar responses to each other than to either of their heterosexual counterparts. They reported that affiliation with AA did not support their abstinence and that a significant other or a

sponsor was more important to their recovery than the group itself. As Holleran and Novak conclude:

> Positive affiliation with AA appears to have a negative effect upon the non-traditional group which shows higher than expected continued drinking. Without affiliation, however, the non-traditional experiences higher than expected abstinence. These paradoxical findings indicate a need to examine the AA approaches or values that may contribute to these results. Non-traditionals may perceive AA as a hostile or non-supportive therapeutic environment (p.82)

In a review of studies of men in gay AA groups, Kus and Latcovich (1995) found that many reported anti-gay sentiment in the regular AA groups that they had tried to attend. For example, gay men felt that, although it was appropriate for heterosexuals to talk about their opposite-sex spouses, it was not appropriate for gay men to talk about their partners. Gay men believed that they required special anonymity in regular groups. They were unsure whether heterosexuals understood that need and would therefore keep that information confidential outside of meetings. On the other hand, Kus and Latcovich point out, as long as a gay man attends gay AA groups exclusively, he misses an opportunity to "come out" in a relatively safe place in heterosexual society. Similarly, without attending regular AA

meetings, a gay man may become "ghettoized" and be unable to recognize the common experience of alcoholism and recovery for gays and straights (Kus, 1987.)

It is not uncommon for gay men to attend both gay and regular AA meetings (Kus & Latcovich, 1995.) However, many gay men believe that belonging to a gay group is important during the first stages of recovery. Membership supplies gay men with the best opportunity for reducing their internalized homophobia and the development of a positive identity. As Kus (1987) states, "...perhaps most importantly, the gay group can help the new A.A. member see how the A.A. program is applicable not only to alcoholism, but also to the gay man's sexual identity (p.272)." Kus identifies the Fourth, Fifth, Six, and Seventh Steps (see Appendix A) as important in confronting the harm gay male alcoholics have inflicted upon themselves as a result of their homophobia.

Gay men develop new support systems of sober friends in gay AA. In interviews with gay men who attended gay AA meetings regularly, Kus (1991) found that many were afraid that they would lose their friends as a consequence of sobriety. After spending much of their social life with friends in bars, many were afraid of the loneliness that would ensue if they gave up drinking. Their fears are very real and well-founded in that, as it turns out, most of them do lose their heavily

drinking friends upon entering recovery. Fortunately most of the men reported that they eventually chose to limit contact with drinking friends once they were in AA. New friends that they acquired included gay recovering alcoholics and their sponsor. Kus notes the special role of the AA sponsor in this, "The AA sponsor was seen by most men as playing a critical role in their recovery from alcoholism especially in the early days of sobriety (p. 175). The men stated that it was easier to carry on a conversation with their new friends. They had much more to talk about as their awareness of their surroundings increased due to the concurrent decline in their alcohol consumption. Further, they had a deeper trust of their new friends and believed that their sober friends were much more able to carry the responsibilities of friendship.

Kus (1989) points to the bibliotherapy of AA (Big Book, Twelve and Twelve, meditations) as appealing to gay men and helpful in the development of friendships. AA literature supplies gay men with a common language and a context in which to discuss their concerns. However, Kus cautions against too much dependence on AA literature as an avenue toward recovery. The gay men in his study reported that the single most common symptom of impending relapse was social isolation. Thus the literature of AA is, in Kus' eyes, merely an adjunct to the sharing of oneself in social relationships in recovery.

Gay men also recount that they can overcome their own anti-religious position by exposure to God in the context of a gay AA group. Addressing this point, Kus and Latcovich (1995) state, "...many gay men who have forgotten or abandoned God because of anti-gay bigotry hurled at them by traditional homonegative religious leaders come to find God in gay groups (P. 73)."

There are disadvantages to membership in gay AA groups for men, especially if membership excludes exposure to regular AA. Internalized homophobia prevalent in newly recovering gay male alcoholics may mean that gay groups appear distasteful. The homogeneity of the group could be oppressive while at the same time focusing too much attention on the uniqueness of the gay experience. Finally, romance may be a problem. Many gay men report that they found the incidence of "cruising" in gay meetings disturbing and demoralizing (Kus & Latcovich, 1995.)

Research and theory about gay women in recovery is rare (Hall, 1990.) Nevertheless, the small body of literature that exists indicates gay women raise concerns similar to and in addition to those expressed by gay men regarding their participation in mainstream and gay AA. Hall (1994), in an ethnographic study of 35 gay women in AA, found that many felt that their acceptance into AA was, at best, superficial. Gay women commonly reported instances of homophobia and noted

that membership in a regular AA group did not extend to social situations (going for coffee, dinner, etc.) outside of meetings. Lesbians noted the exclusion of topics about women's lives, the patriarchal use of language (Lord's Prayer), and the presence of a description of alcoholism that did not match the experience of women. As Hall declares, " The women in this study offered feminist criticisms of mainstream AA, pointing out oppressive ideologies and dominating practices, including an unofficial, but nevertheless operative, hierarchy of member accessibility by gender, race, class, and sexual orientation (p. 570).

Gay women struggle with what they perceive as AA's singular focus on alcohol (Hall, 1992.) Many gay alcoholic women in recovery find themselves wrestling with compulsive eating, overspending, and codependency. AA often appears insensitive to these issues or finds them not as important as alcoholism. Many gay women see it as difficult, if not absurd, to try to treat one addiction at a time.

As they remain in recovery, gay women often experience recovered memories of trauma (Hall 1992). Thus, they undergo difficulty when they encounter AA's emphasis on forgiveness. Many of the women Hall spoke to expressed that they thought it was inappropriate to forgive their abusers and could not abide by the recommendations of AA. Similarly, many of the women stated that

they were uncomfortable with AA's notions of powerlessness and the need to surrender the will. Many believed that recovery should be a time of gaining control, increasing trust in themselves and their own instincts.

McNally and Finnegan (1992) concluded from their interviews with LRA's (Lesbian Recovering Alcoholics) that a gay woman's perception of safety in meetings depends upon where she is in identity formation. If a woman is still in denial about her sexual identity, she may feel more comfortable in straight meetings. As McNally and Finnegan see it, those who drink to *act* lesbian need straight meetings because they are not comfortable with dealing with their sexuality and alcoholism at the same time. If a gay woman's internalized homophobia is too intense, attendance at lesbian meetings and having a lesbian sponsor may be too threatening for her to tolerate. Women in the Immersion stage of identity formation are even more vulnerable and need to experience the acceptance of their lesbian identity in order to initiate their recovery from alcoholism. Consequently, meetings where gay women predominate may be in order. Ideally, accepting one's alcoholic identity expands the range of ideas one holds about oneself and allows a gay woman, "...to move past the unmindful, impulsive, extremist third phase of Immersion (p. 96). Women who are past the Immersion stage still need support to counter the effects of homophobia because their identities are poorly formed. The rest of the

coming out process can be greatly ameliorated by belonging to a gay group where members voice their comfort with their sexual identity. Nevertheless, some gay woman may be confused enough about their sexuality that it may be wise for them to put their identity development aside and attend principally to their recovery from alcoholism.

Membership in exclusively gay groups can seem oppressive to lesbians (Hall,1990). Gay women enter AA, begin to come to terms with their alcoholism and experience the freedom of openly acknowledging their sexual identity only to discover that they have entered yet another culture with seemingly inflexible rules. As Hall states, "Members say proudly that they have an openly lesbian group that respects the diversity of its members, yet they often imply expectations for rigid conformity to 'good AA' tenets regarding sponsorship, meeting attendance, and methods of working the Twelve Steps (p. 115). Lesbians also note the presence of "cruising" at meetings and find it equally as disturbing as it is to gay men.

The evidence (Hall, 1994, Hall, 1992) suggests that gay women have reservations about the efficacy of AA for them. Nevertheless, they report that AA can be an environment in which they may thrive. Gay women celebrate their recovery with AA "birthdays", attend gay conferences, and create experiences to recognize the holidays in a clean and sober fashion. Many come into AA and undergo vocational

changes, often opting to pursue careers, such as nursing, counseling, and social work where they believe they can contribute to society. Hall found that the majority of women she studied valued traditional concepts of AA such as sponsorship and the Twelve Steps. However, they pointed out that there is a need for more flexibility, negotiation, and self-determinism in AA.

Relapse

Many, if not most, recovering alcoholics relapse (Hall, 1992, Lieb & Young, 1994, Hodgins & el-Guebaly, 1995, Gerwe, 1997). For the majority of alcoholics, the transition from the heavy drinking of alcoholism to complete and continued abstinence is rarely smooth. It is estimated that from one-half to two-thirds of those who enter recovery relapse and thus relapse itself can be considered a natural part of addictive behavior (Cohen, 1992). Nevertheless, a blasé' approach to the naturally occurring phenomenon of relapse is not recommended. It is a poorly explained, frustrating problem that results in the despair of those who experience it and often results in the loss of supportive friends and loved ones during the recovery process (Gerwe, 1997).

Threats

Threats to recovery that lead to relapse are numerous and omnipresent. The most common threat to relapse is the inability to

endure a negative emotional state such as guilt, depression, stress, loneliness, anger, or frustration (Lieb & Young, 1994, Hodgins, el-Guebaly, Armstrong, 1995, Gerwe, 1997).

In a study of alcoholics facing severe stress during their first year of sobriety, Brown, Vik, Patterson, Grant, and Schuckit (1995) found that life adversity that is personally threatening, chronic, and exceeds the personal coping capacity of individuals elevates the risk of relapse. Brown et al were careful to attend only to stress that was independent of alcohol and drug use in order to obtain more clear effects. Alcoholics who believed that alcohol use would alleviate stress and who were more psychologically vulnerable were more likely to relapse than abstainers. Psychosocial vulnerability was evidenced by depression and dependence on a support system that included members who were active drug and alcohol users. Abstainers experienced half as much stress as relapsers, showed reductions in their psychosocial vulnerability, and exhibited greater confidence in their ability to resist alcohol.

In a comparison of the effects of induced negative mood state and the power of alcohol cues to increase the urge to drink and the likelihood of consequent relapse, Cooney, Litt, Morse, Bauer, and Gaupp (1997) determined that only a portion of alcoholics react merely to alcohol cues. On the other hand, simply the presence of a negative

mood state triggered a relapse. Those most responsive to negative mood conditions often were more anxious and depressed and had used alcohol before in situations where their moods were unpleasant. Cooney et al submit that alcoholics who experience negative moods more often are more likely to strengthen the association between alcohol and negative emotion. They drink to self-medicate. Additionally, the researchers found that alcoholics who respond to negative mood states do not require the presence of alcohol cues in order to initiate relapse. They state, "If an individual has a learning history pairing mood and drinking, he or she may become responsive to mood states alone. Such an individual may appear to be seeking out alcohol for no reason at all (p. 249)."

Varied relapse precipitants may produce different types of relapses (Hodgins et al, 1995). Relapses that are a result of drinking pressured by social demands does not continue past the social situation. However, relapses precipitated by negative emotional states tend to be more lengthy and intense. The aftereffects of relapse, particularly depression, however, do not seem to vary based on the amount of alcohol consumed during the relapse itself (Roggia & Uhl, 1995).

Other factors may come into play. Saunders, Baily, Phillips, and Allsop (1993) in three month and follow-up interviews with men and

women in a treatment center, found that people who put themselves in higher numbers of high risk situations were more likely to relapse. The length of time alcoholics have been abusing alcohol, the amount of alcohol consumed over time, and marital conflict effect relapse probability. There may be stages in the recovery process during which different precipitants may be more influential. Some alcoholics may enter recovery with goals that are too narrow (Cohen & Levy, 1992). In not considering improvements in self-awareness, relationships, coping skills, or purpose to be a part of the recovery process, they leave themselves open to relapse.

Prevention

The prevention of relapse appears to be related to several protective factors that serve to mediate the urge to drink as prompted by environmental and emotional cues. These include time in recovery, level of commitment, the development of coping strategies, and the quality of support system.

Alcoholics who have remained abstinent for long periods of time (at least six months) are less likely to relapse (Saunders et al, 1993, Craig, Gollivelli, & Poniarski, 1997). Increases in self-efficacy, and decreases in both psychosocial vulnerability and depression are a common part of long-term sobriety (Roggia& Uhl, 1995, Brown et all, 1995). Alcoholics with six months to a year of sobriety are more skilled

than relapsers in avoiding situations that are associated with drinking (Remien, Goetz, Rabkin, Williams, Bradbury, Ehrhardt, & Gorman, 1995, Brown et al, 1995).

Saunders et al (1993) point out that alcoholics most committed to change and who intend to be abstinent for life are slower to relapse. As part of that commitment, new learning must occur. Saunders and his team found that alcoholics who had lower new learning abilities (as measured by the WAIS-R) were less likely to develop the novel strategies that could result in improved social functioning and coping skills. On the other hand, older alcoholics entering recovery who had abused alcohol for longer periods were less likely to relapse (Remien et al, 1995). Perhaps older alcoholics, although seemingly past their prime to learn but with years of alcoholism misery to reflect on, may be more willing than their younger counterparts to learn new tactics for relapse prevention.

The quality of the support system that alcoholics in recovery rely on to get them through tough times in sobriety is related to the likelihood of relapse (Brown et al, 1995). Those who depend on support systems where the number of sober members exceed the number of current alcohol abusers are less likely to relapse. Similarly, Saunders et al (1993) point out that alcoholics who can rely on their

intimate partners for assistance during recovery are less likely to relapse.

Relapse as a recursive phenomenon

As abstinence tends to lead to further abstinence, negative mood states lead to relapse, and relapse induces negative moods. The Abstinence Violation Effect noted in relapsers is evidenced by continued drinking motivated by guilt and attributions concerning lack of self-control (Saunders et al, 1993). Roggia and Uhl (1995) found that, in relapsers, alcohol use was marked by major increases in depression. They posit that, although depression may trigger relapse, relapse triggers depression. Higher rates of depression fall off if one returns to abstinence. Relapses are associated with a sense of failure and guilt (Hodgins et al, 1995). Similarly, Brown et al (1995) aver that there is a cyclical relationship between drinking and psychosocial stress. They believe that, although the stress that leads to relapse initially is important, other factors take over, such as the Abstinence Violation Effect, to determine the progression and severity of the relapse. Interestingly, Brown et al also point to the effects of abstinence induced stress and its role on potential relapse. As a result of their sobriety, some alcoholics make vocational and residence changes that are stressful and may be followed by relapse.

Relapse and gender

Not much is known about the process of relapse in women or whether noteworthy differences exist between men and women and how they experience relapse (Saunders et al, 1993). Men and women are equally vulnerable to the effects of negative mood states in relapse events. Regardless of different rates of alcohol consumption that exist for men and women, the level of their alcohol dependence is similar. There are no differences in relapse rates (both about 60%), although men return to heavy drinking sooner than women during their relapses. However, some evidence suggest that women respond to different emotional conflicts than men, are differently effected by environmental cues and supportive relationships, and are influenced in the potential for relapse by the roles they are expected to play across the lifespan.

Hodgins et al (1995) note that women alcoholics experienced more interpersonal stress (conflict) while men were more likely to undergo intrapersonal stress (negative emotional states) prior to relapse. Contrary to popular conceptions, women were not more vulnerable to emotional states such as depression. Puzzling, Saunders et al (1993) found that women who were more confident about handling situations of high risk for drinking were more likely to relapse.

Saunders et al (1993) found that, for women, the greater the number of supportive relationships they had, the less the chances were

for relapse. The alcohol use of women was more socially influenced and often occurred after a disagreement with a significant other . Women without children and who had an intimate partner were more likely to relapse. Loss of one's maternal position and changes in the configuration of marital roles may impact the onset of relapse.

Relapse and gays

Very little research exists on the experience of relapse for gay men and women. Retrospective reports of life prior to recovery and the negative mood states associated with it seem to offer the only insight into the differences that may exist between homosexuals and heterosexuals in the potential for relapse. Pre-addiction behaviors and emotions associated with homophobia, low self-esteem, and chronic depression may explain relapse rates for gays more than other factors (Stacy, 1997). Kominars (1995) claims that internalized homophobia is one of the greatest threats to long-term sobriety. In order to attain and maintain sobriety, gay alcoholics must deal with the negative thoughts and emotions associated with self-generated homophobia. Finally, Shernoff and Finnegan (1991) point to the relationship between sexual identity and relapse. Often, a relapse that occurs for no more obvious reason is a result of the fact that sexual identity remains an unresolved issue for some alcoholic gay men and women.

Demographics, hallmarks, and data collection

Surprisingly, demographics such as education, occupation, age, gender, and drinking history contribute little to an understanding of relapse (Brown et al, 1995, Remien et al, 1995, Craig et al, 1997). Further, there are few differences in the relapse experience of first-time relapsers or multiple relapsers (Hodgins et al, 1995).

A hallmark of sobriety seems to be the achievement of one full year of abstinence. The literature associated with relapse threats and prevention points to the accumulation of one year of sobriety as long-term and predictive of further sobriety (Brown et al, 1995, Hodgins et al, 1995, Roggia & Uhl, 1995, Craig et al, 1997).

In studies of threats to relapse and relapse prevention there is a heavy emphasis on the use of self-reports, questionnaires, surveys, and interviews (Holleran & Novak, 1989, Saunders et al, 1993, Kaskutas, 1994, Brown et al, 1995, Hodgins et al, 1995, Remien et al, 1995, Roggia & Uhl, 1995, Craig et al, 1997). Most of the research relies on the use of retrospective data. Participants give information about themselves that is about past events or emotional experiences. The obvious problems exist in drawing conclusions based on information that comes from potentially biased self-reports. On the other hand, there is some demonstrated consistency, at least, between

prospection and retrospection in participant reports (Hodgins et al, 1995).

A Rationale for a Study of the Efficacy of AA for Gay Men and Women

The prevalence of alcoholism in the gay community is high, perhaps much higher than that of heterosexuals. Although alcoholism rates for gays may be declining along with that of the general population, gays are more likely than heterosexuals to point to alcoholism as a source and result of deeper problems. Gay men and women share a similar etiology for the development of alcoholism. Commonly, they experience the chronic stress of homophobia, especially that which is internalized. Many struggle to attain some sense of their sexual identity while simultaneously abusing alcohol to avoid awareness of the process. The psychological defenses employed by gay men and women to survive in a heterosexist world often stand in the way of their recovery from alcohol dependence.

AA seems to work for many alcoholics who want to stop drinking and pursue continued abstinence. It is not clear for whom AA is the most viable choice for recovery. Nor is it clear that any part of AA's program (i.e. meetings, sponsors, literature, spirituality, fellowship) is more related to continued recovery than any other.

Gays in AA come into recovery with many of the same needs as heterosexuals. However, they have further needs coming out of their experience as outcasts from society and experts at self-loathing. Gay men and women need a sense of connectedness to others, a need that is often not satisfied when one lives in a hostile family and world. The longing for connectedness may be soothed by joining a group of gay, sober, supportive recovering alcoholics. In leaving the bar scene that still predominates in gay culture, newly recovering gay alcoholics must establish new social systems to ward off the feelings of isolation that accompany both homosexuality and alcoholism. Gay men and women come into recovery with well-defended egos. Their egos have served them well through lying, denial, and projection in surviving in a world where honesty and openness about who they are may get them ostracized from families, fired from their jobs, excommunicated from their churches, arrested, beaten up, or even killed. Unfortunately, those same defenses may keep them silent, alone, unrecovered, and susceptible to relapse. Thus it is imperative that gay men and women find a person and a place in which to reveal and, hence, discover their personal worth. The sponsor in gay AA may serve not only to provide the guidance found in traditional AA sponsorship, but may also supply the gay alcoholic with the first opportunity to confide and trust openly with another. "Working the Steps" as it is done in mainstream AA may need to be supplemented with action taken to get at old hurts, fears,

and self-harm inflicted under the influence of homophobia. The use of bibliotherapy in AA may be helpful for gay alcoholics, especially if a gay man or woman has a sponsor with whom to discuss readings and raise questions. Finally, for many newly recovering gay alcoholics, an image of a caring God or Higher Power is difficult to obtain. Unfortunately, the common experience of gay men and women includes many instances in which "God" and religion have been used against them. Once again, the sponsor can play a key role in assuring the gay recovering alcoholic that there are many ways to conceive of a Higher Power, ways that include acceptance, love, and caring for gays as well as heterosexuals.

The threats to relapse and the ways to prevent relapse that work for heterosexuals likely work for gay men and women. However, gay alcoholics face deeper threats from inside their own psyches that may produce the negative emotions that so often precede relapse. Internalized homophobia and unresolved sexual identity are potent producers of guilt, stress, shame, depression, frustration, and anger. Alcoholics in general face a critical time upon entering sobriety during which they need to put together some time and to develop coping strategies that will help them avoid the pitfalls of relapse. For gay alcoholics, the recovery tasks in the first year of sobriety may be overwhelming for those who do not seek the help of others, especially that of a wiser, more sober confidante in the form of a sponsor. How that experience develops may be decisive in determining whether or

not they can develop a sense of self-worth, belonging, and identity. In the absence of such recovery efforts, the picture looks grim for gay alcoholics in their struggle for abstinence and long-term sobriety.

Thus, this study seeks to examine the experience of gay men and women in their first year of sobriety. What do gay men and women do in AA during the first year? What aspects of the program most effectively address the needs of gay men and women? Perhaps most importantly, what is the role of the AA sponsor, meetings, and attendance at gay meetings in assisting gay men and women through the critical first year of sobriety by avoiding relapse?

Hypotheses

1. A significantly higher proportion of NR's will report acquiring and using a sponsor during the first year of sobriety than R's.

2. A significantly higher proportion of NR's will report that they attended at least two to three meetings a week during the first year of sobriety than R's.

3. A significantly higher proportion of NR's will report that they attended gay meetings during the first year of sobriety than R's.

Chapter 3

Participants

Participants in the study were recruited as volunteers from a sample of gay alcoholic men and women who attend meetings at a gay Twelve Step recovery club in the Midwest. Nineteen men and 13 women participated in the study; participants' mean age was 39 years (SD= 8, range = 26 to 61). All had at least one full year of sobriety with a mean of 7 years (SD= 4, range = 1 to 16). All of the participipnats were white.

Measures

A pilot study was conducted using a questionnaire that was given to 17 members of the same population. The measure was designed to ascertain what parts of AA's program gay alcoholics use and find helpful. Information obtained from the results of the questionnaire was sketchy and did not yield much beyond yes/no responses for questions dealing with relapse, meeting attendance, sponsorship, the use of AA literature, and the effects of fellowship. One interesting finding from the pilot questionnaire, however, was that there was a noticeable difference between subjects who had relapsed and those who had not. Four out of five of those who had never experienced a relapse reported that they had acquired a sponsor either

immediately upon entering recovery or at least some time during the first year of sobriety. For relapsers, only 5 out of 12 had acquired a sponsor in the first year. There were no other apparent trends or differences between relapsers and non-relapsers.

As a result of the pilot study, the questionnaire (see Appendix B) was modified in order to yield more details about how gays in AA utilized its program. Participants were asked to report their age and the number of years they had of continuous sobriety. The rest of the questions dealt with aspects of AA's program and how members had utilized AA during the first year of their sobriety. Special attention was given to the role of the sponsor during the first year of recovery.

Procedure

Three months after the pilot study, a researcher delivered the modified questionnaire to participants at the same club at three separate AA meetings. Two of the meetings (one for women only and one for men and women) were usually attended by "regulars" from the club. The third meeting (for "Newcomers") was designed to appeal not only to more regular members but to individuals new to the program. Topics at this meeting centered around issues primarily having to do with the First, Second, and Third Steps of AA.

The questionnaires were placed on a chair in the front of the meeting room and members were asked at the end of the meeting to fill one out "for a study having to do with gays in AA". Each questionnaire was accompanied by an addressed (to the researcher) and stamped envelope. A few of the members completed the questionnaire before leaving the clubhouse. They were instructed to seal their responses in the envelopes that were provided. Fifty-one questionnaires were distributed and 32 were returned for a response rate of 63%.

Results

Seventeen (53%) of the participants had never experienced a relapse during their recovery. Twenty-six (81%) reported that they had had a sponsor during the first year of sobriety. All members of the group that had abstained (Non-relapsers) reported that they had had a sponsor during their first year, Out of the group of Non-relapsers (NR), 12 (71%) had started working with a sponsor during the first three months of their recovery. Only 9 (60%) of the Relapsers (R) stated that they had used a sponsor during their first year.

Twenty-six (81%) of the participants attended AA meetings at least two to three times a week during the first year. That number was almost evenly split between NR's (14) and R's (12). Reports of attendance at gay meetings during the first year were similarly divided (NR=9, R=8). Thirty-one (97%) of the participants used AA literature

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during the first year of recovery. The only individual who did not was a Relapser.

Participants were asked to rank, in order of importance for the first year of recovery, five features of AA's program. These were meetings, fellowship, sponsor, spirituality/Higher Power, and AA literature. Results of these rankings are reported in Table 1. Notably, NR's and R's gave similar rankings. Both sets of rankings are comparable to that given by the total group.

Table 1. Rankings: "Importance of these to you during your first year"

	NR(N=17)	R(N=15)	Total (N=32)
Meetings	1.69 (1)	1.14 (1)	1.43 (1)
Fellowship	2.94 (3)	1.86 (2)	2.43 (2)
Sponsor	3.56 (5)	3.43 (4T)	3.50 (5)
Higher Power	2.88 (2)	2.86 (3)	2.87 (3)
AA Literature	3.25 (4)	3.43 (4T)	3.33 (4)

Chi-square analyses (2 x 2 design) were performed to determine whether a significantly higher proportion of NR's than R's acquired and used a sponsor, attended at least two to three meetings a week, and attended gay meetings all during the first year. No further analyses were performed with relapse and the use of AA literature

because most (97%) of the participants reported using AA literature and it was not anticipated that there would be any differences along group lines.

The proportion of NR's vs. R and sponsorship was significant, (x^2 = 7.39, 1 df, $p < .01$). No significance was found with meeting attendance, (x^2 = .16, 1 df, $p > .05$) or attendance at gay meetings, (x^2 = .01, 1 df, $p > .05$).

Table 2. Chi-Square and *p* values for Sponsorship, Meetings, and Gay Meetings

	Sponsorship		Meetings		Gay Meetings	
	x^2	*p*	x^2	*p*	x^2	*p*
Condition						
NR vs R	7.39	< .01	.16	ns	.01	ns

Chapter 4

The results demonstrate that, for gay men and women, sponsorship increases the likelihood that they will it make through the first year of recovery without relapsing. Meeting attendance and attendance at gay meetings do not seem to play as important a role in avoiding relapse.

As stated earlier, the sponsor in gay AA may assist the newly recovering gay alcoholic not only in "working the program" of AA in its traditional sense, but in soothing the disturbing and confounding experiences of homophobia and unresolved sexual identity. The early days of recovery are critical and the sponsor may be needed sooner rather than later for newly recovering gay alcoholics (Kus, 1987, 1994, Hall, 1994).

The results of the study do not indicate that meeting attendance is not important. However, meetings alone may not be enough. Plenty of alcoholics go to meeting after meeting peppering their lives with relapse after relapse. On the other hand, if one is working with a sponsor, one will be encouraged to attend meetings.

Attending gay AA meetings may not be a positive experience for newly recovering gay alcoholics. Internalized homophobia may prevent them from developing social contacts with other gays (Kominars,

1995). Unresolved sexual identity may make it difficult for newly recovering gay alcoholics to feel at home in gay AA meetings and might increase feelings of isolation. However, if one is using a sponsor it may be easier to diminish feelings of homophobia through self-examination and by experiencing the caring and acceptance of another. The gay alcoholic may discover more about herself in "working the Steps" with a sponsor, discoveries that expand her notions of identity as an alcoholic, a homosexual, and a human being connected to others.

Interestingly, participants ranked as last the importance of sponsorship to their recovery. This was true for NR's, R's, and the total group. An explanation for this may be that the group as a whole represented recovering alcoholics with long-term sobriety (Mean = 7 years). It is possible that, being past the critical phase of early sobriety, they do not think of their sponsor as very important to their recovery at present. Another explanation is that the memories of that first year are not very pleasant. Some of the tasks they might have performed in working through internalized homophobia and identity resolution with sponsors during the first year, once completed, may be left to rest. Perhaps they themselves are sponsoring gay alcoholics and this may take the place of being sponsored as a source of continued healing and growth. The questionnaire did not appraise the role of this in their recovery.

Limitations

Conclusions that one draws from the results of this study must take into account that the sample size was small. The measures, although similar to those used in other studies of AA and relapse, consisted of self-report questionnaires. The participants were volunteers. It is not clear how volunteerism could have affected the results. However, it may have been true that participants who had never relapsed were less intimidated and were therefore more willing to answer questions regarding their recovery. Hence that may have resulted in more NR's returning their questionnaires.

However, it seems sensible that the special situation of newly recovering gay alcoholics requires a special response from gay AA. The sponsor plays an important role in that response. Passive attendance at meetings and the mixed experience of gay AA meetings may not be enough of a response during the first year of sobriety.

Chapter 5

AA has been around longer than any other treatment option and is an "essential element" in recovery (Johnson & Phelps, 1992, 1991, Hopson & Beaird-Spiller, 1995). Referral to AA is the most common therapeutic step for clinicians (Galaif & Sussman, 1995). Although studies of AA do not support causality between AA and sobriety, many believe it to be the most effective treatment for alcoholism. On the other hand, if clients are not religiously oriented (Craig et al, 1997) AA may not be helpful. Women and minorities often feel that they have a difficult time fitting in AA and find that the language of AA is not useful for them (Hall, 1994). Counselors need to know that this occurs and provide anticipatory guidance and a place to vent concerns while newly recovering alcoholics begin to explore AA. The counseling session may be employed as a place to uncover how obstacles to recovery in AA may be overcome.

Counselors should encourage clients to take action in their recovery in order to begin to disconfirm pathogenic beliefs about themselves, to challenge the propensity for denial, and to develop their ability to contain affect. (Lieb & Young, 1994). Alcoholic clients will test therapists on their views of the client as unworthy, their willingness to minimize their alcoholics problems, and their tendency to be

emotionally overreactive. The first relapse may be a critical time for these tests to occur.

In addition to the physical and emotional components of recovery, counselors must treat the epistemological (Bateson, 1987) and spiritual (Chapman, 1996) issues of alcoholism. In developing spirituality and a changing epistemology, clients shift their explanation of alcoholism from the external to the internal. This allows the client to see recovery as an ongoing process rather than a finite one, something alcoholics need in order to pursue recovery as a life task.

In preventing relapse, counselors should work with clients to prepare them to cope with mood and alcoholic stimuli (Cooney et al, 1997). Alcoholics who are more responsive to negative moods may need extensive help with this in order to undo the learned association between negative moods and relief from alcohol. Counselors can also help clients plan for high risk situations where alcohol may be present (Hodgins et al, 1995). Information about previous relapses may offer insight into the development of these plans.

Counselors need to be aware of the fact that mainstream treatment programs are often hostile environments for gay men and women. They have often been told to avoid discussing their sexuality or were discharged from treatment once their sexuality became known (Ratner, 1988, Hall, 1990). In risking disclosure, gay alcoholics often

find that their sexuality becomes the focus of treatment instead of their alcoholism. Further, the topic of homosexuality becomes the source of voyeuristic intrigue for other alcoholics in treatment and staff.

Most gay alcoholics enter recovery with some measure of homophobia. In the absence of alcohol previously used to anesthetize emotions, the experience of homophobia is likely to intensify (Shernoff &. Finnegan, 1991). Many gay alcoholics are ambivalent, if not depressed, about their sexual identity entering treatment. Participation in gay AA may alleviate some of these difficulties. It can supply the gay alcoholic with alternative means of socializing and sober role models in order to generate positive images of being gay (Ratner, 1988). However, counselors are cautioned that the interplay between unresolved sexual identity and recovery within a gay group can be tricky.

Finally, counselors are urged to encourage their clients to get and use a sponsor in gay AA. The traditional guide role that sponsors play in AA is an important one. However, for newly recovering gay alcoholics the mediating role sponsors play in alleviating homophobia and exploring identity may be paramount in avoiding relapse. It is strongly recommended that counselors be aware of this when working with newly recovering gay alcoholics and "check in" often with clients during therapy to ensure that this is happening.

Appendix A

Twelve Steps of AA

1. We admitted we were powerless over alcohol and that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God *as we understood him*.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God and another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all person we had harmed and became willing to make amends to them.

9. Made direct amends to such people wherever possible except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong, promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for the knowledge of His Will for us and the power to carry that out.

12. Having had a spiritual awakening as a result of these Steps we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Appendix B

Copy of Questionnaire

Dear Participant:

I am doing research on some of the factors that contribute to sobriety. The following questionnaire is part of a study designed to clarify the effects of some of those factors on sobriety. Your participation is appreciated. All information I obtain from participants will remain confidential, no names will be used and data will be coded in order to avoid revealing the identity of participants. Please mail the questionnaire back to me once you have completed it.

Age________ Sex________

1. What year did you enter recovery?

2. For how long have you maintained continuous sobriety?________________

3. Have you ever had a relapse?__________

   How many have you had?__________

   In what year of your sobriety did your relapse occur?_________

ALL OF THE FOLLOWING QUESTIONS REFER TO THE FIRST YEAR OF YOUR RECOVERY

4. Did you relapse during your first year of recovery?_________

   In what month of your first year did your relapse occur?

   1-3________ 4-6_________ 7-9__________ 10-12_________

5. Did you acquire a sponsor during your first year of recovery?___________

   In what month of your first year of recovery did you get a sponsor?

   1-3________ 4-6_________ 7-9___________ 10-12_________

Did you relapse during your first year while you were working with
a sponsor?______________

6. During your first year of recovery did you and your sponsor:

Work through the Steps___________

Do a 4th and 5th Step_____________

Talk frequently about your recovery_________________

I didn't use my sponsor very much___________________

Other (please describe)

____

____
___.

7. Did you use AA literature during your first year of recovery?_________

Used the Big Book___________

Used the 12 and 12__________

Used meditations____________

Other (please describe)

____

8. How often did you attend meetings during your first year of recovery?

Almost everyday__________

Four or five times a week____________

Two to three times a week___________

About once a week_____________

Less than once a week_____________

9. Did you usually attend meetings that were:

Men only_________

Women only______

Mixed___________

Gay____________

Please rank the following features of recovery (from 1-5 with 1 being the most important) according to their relative importance for you in your recovery during your first year.

Meetings__________

Fellowship_________

Sponsor___________

Spirituality, Higher Power____________

AA literature________________

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