White, W. & Chaney, R. (1992). *Metaphors of Transformation: Feminine and Masculine*. Bloomington, IL: Chestnut Health Systems.

**Introductory Note:** From 1986 through the early 1990s I was deeply involved in evaluating a gender-specific treatment program (Project SAFE) that was being replicated in 24 Illinois' communities. That experience stirred a sustained meditation about how women recovered from addiction in ways that were qualitatively different than men achieving such recovery. My plan was to do two studies, one of women who recovered from addiction outside the framework of 12 step programs and a second of women who achieved recovery within 12 step programs. The paper, Metaphors of Transformation: Feminine and Masculine, constitutes the first of these exercises. In the months and years following its completion, I became enmeshed in work on the book *Slaying the Dragon* and was never able to return the second phase of this project. Large numbers of women have achieved sustained recovery through AA, NA and other 12 step programs. With this paper as a backdrop, studies are still needed to understand how these women have applied, reframed or altered the core ideas and language of the 12 step recovery program to fit there experience as women and as recovering women.

William White, 2010

## Metaphors of Transformation: Feminine and Masculine

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> "...the risk of ignoring differences is greater than the danger of naming them." Deborah Tannen *You Just Don't Understand*[1]

This paper is an exploration of the differences in the experience of addicted men and women and how such men and women experience or fail to experience a recovery process. It is a study of how models based on the experience of culturally empowered men have been indiscriminately and systematically misapplied to culturally disempowered women (and other disempowered persons). Our inquiry focuses in particular on differences in the key ideas addicted men and women use to initiate, organize and sustain their recovery. We seek through our critique of current clinical practices not to demean or undermine the current models of treatment and recovery. We have more than 35 years of combined experience working within and with these models. We seek only to expand those models so they are broad enough to embrace

the other half of humanity not considered in their design or evolution.

There are dangers in discussing special needs of men and women as there are in discussing any special population of people--dangers in the very categorization of "special." Benign efforts to define and respond to this specialness and to sketch with a broad brush what has been learned through such efforts always risks ignoring the enormous diversity found in any so-called special population and in replacing old stereotypes for more modern and politically palatable stereotypes. Sweeping generalizations about men and women ignore the range of differences produced by age, ethnicity, sexual orientation, occupation, religion, region of the country, and thousands of other idiosyncratic elements of experience that would deny any classification effort.

While attempting to abstract the essence of collective group experience poses risks, the failure to venture such an investigation raises the specter of misapplied technology. While there are benefits to be gained and potential harms to be prevented, we will walk gently into this discussion guiding ourselves carefully between the dual dangers of denying or overstating the differences between the addiction and recovery experiences of men and women. In the space below we will try to sift out some of the most salient differences in the constructs and experiences that become points of transformation for addicted men and women. While reality is much more complex than the models and metaphors we use to elucidate it, these tools may help us enhance our ability to conceptualize and enhance the helping and recovery process. While these constructs do not fully reflect the complexity and uniqueness within and across gender, we do believe they capture the mainstream experience of many addicted and recovering women and men in this culture.

This study was begun with some trepidation. There were concerns about exposing our sometimes painful self-examinations of these issues amid the sense that our work on these ideas was not complete and could never be irrevocably finished. As such, this paper is more a snapshot in time of a thinking process than a set of definitive conclusions. Any paper exploring gender differences within a historically patriarchal, but rapidly changing, culture and professional field of endeavor typically incites debate and criticism, and this paper is not likely to be an exception. If the ideas contained here stir dialogue that deepens our understanding of the different recovery pathways available to addicted men and women, then the risks and any resulting bruises will have been worth it.

### *The Male Treatment and Recovery Paradigm*

There is no question that mainstream assessment, treatment and recovery technology in the addictions field was developed based on experience with men. Most of the basic paradigms, principles and practices of the field had been hardened and set before women arrived in great numbers as clients, volunteers or professional staff.

The experiential foundation of Alcoholics Anonymous (the years from 1935-1939) that produced the 12 steps which would come to so influence our current understandings of addiction and recovery was a foundation based almost exclusively on the experience of alcoholic men. When the "Big Book" (*Alcoholics Anonymous)* of AA states, "Here are the steps we took" in introducing the 12 steps, the "we" reflected the experience of culturally empowered, alcoholic men. At the time these words were first written only two women had made short-lived contact with AA. In fact, the inscription, "The story of How More than One Hundred Men Have Recovered From Alcoholism," appeared on the title page of the 1939 first edition, and was proposed as the book's title until Florence R., who would later leave AA and return to drinking, argued it down.[2] Marty Mann, who would become the first woman to achieve sustained sobriety within AA, threw a draft of the Big Book on the floor when she first read it because of its frequent references to God and lack of references to women.[3] Charlotte Davis Kasl and others have cogently documented how the 12 step prescriptions were defined to fit the character armor of the culturally empowered male alcoholic.[4]

Professional research and clinical models of intervention with alcoholics were similarly based on experience with men. We are talking about the experience of men whether we talk of the physiological effects of alcohol, the progression of alcoholism, the major alcoholism assessment instruments, or the heart and soul of the 28-day "Minnesota model" of alcoholism treatment. While estimates of alcoholic women in the United States range as high as 5 million, only 8 percent of the subjects in studies on alcoholism and chemical dependency conducted between 1970 and 1984 were women and many of these studies did not isolate and contrast data for men and women.[5] Vanicelli's 1987 review of alcoholism research studies could only find 3,278 women who had been included in alcoholism studies in the past 29 years![6] Women were rarely included among those designing and conducting addiction research and were not included as research subjects. The experience of women has until recently been excluded from the field's theory-building. The field has openly practiced a phenomenon sometimes referred to as the "Adam's Rib Syndrome"--the assumption that women are identical to men, that research conclusions based on experience with half of the population can be extended to include the whole. What technology exists is clearly based on the experience of men.

Women's needs and experiences have also not been reflected in our mainstream programmatic and clinical practices. When women first began to enter self help structures (the 1940s) and treatment structures (the 1970s) in large numbers, the primary concern was not with their special needs but the extent to which their presence would serve as a distraction to men. These women entered helping systems in which their alcoholism was defined based on experience with men and their treatment and recovery was proscribed within a model defined by men, for men, in helping relationships between men. As newer and alternative models of treatment (therapeutic communities, methadone maintenance) and new specialty areas (employee assistance programs, criminal justice diversion, intervention programs for drinking drivers) these also would be crystallized primarily based on experience with men.

A large number of women have utilized these traditional male-based frameworks of intervention, treatment and recovery to support their recovery from addiction. Of the 9,394 persons who responded to AA's 1989 membership survey, for example, 35% were women.[7] Traditional frameworks of treatment and recovery have slowly evolved as more women have entered them. Many recovering women sought supplemental services (concurrent therapy) and may have gotten sober in spite of, rather than because of, such male-based frameworks of recovery. It is a testament to women's strength and resilience that they could interpret and reframe these male-based models to fit their experience and needs. Within the framework of women's meetings, women's mentoring and sponsorship of women, and shared encounters across tables in living rooms and coffee shops, this male-based recovery architecture was feminized, filtered and reinterpreted to fit the experience of women. Like oversized clothes, the traditional models had to be cut up and reassembled before they fit comfortably and yet many women would be criticized for such personalization--shamed to the point they were often silent about the interpretations and changes they were creating to make this "simple" program fit the complexity of their experience and needs.

A number of events have set the stage for the reassessment of our mainstream treatment philosophies and techniques.

- **Treatment outcome studies** confirm our clinical observation that a significant portion of alcoholics and addicts do not respond to our best treatment and recovery paradigms. A review of treatment outcome studies of the past decade reveals that from 50% to 65% of clients leaving treatment will not be abstaining from alcohol and/or other drug use two years following their discharge from treatment.[8] In the most recent (1989) survey Alcoholics

Anonymous conducted of its membership, it was found that approximately 50% of persons who come to AA will leave within three months, with progressively slower attrition rates continuing beyond this period.[9] If such programs are to be measured by their ability to generate sustained patterns of sobriety, there are many subpopulations of clients for whom this treatment and recovery technology quite simply is not working.

- **Challenges to the single pathway model of addiction** occur daily. The tenants of this model (1. Substance abuse springs from a single etiological source. 2. It presents itself in consistently homogenous characteristics. 3. The disease responds to a very narrow approach of philosophy and technique. 4. There is a single pathway of long-term recovery that all must follow.) are being challenged by a view of multiple etiological sources of substance use disorders, multiple subpopulations who present diverse patterns and needs and respond to very different treatment approaches and who may utilize a wide diversity of long-term recovery pathways. From these challenges have come new treatment approaches and self-help structures for adolescents, women, people of color, gays and lesbians, persons with physical/psychiatric disabilities. Advocates concerned over the misapplication of interventions defined to work for men to women raise two concerns: the first, that the male-based treatment technology simply fails to produce the desired results when applied to women, and second, that the male-based treatment technology when misapplied to women can actually have an iatrogenic (treatment-caused harm) effect.

- **The women's movement** forced a reassessment of the exclusion of women from professional and leadership roles within the addiction treatment field and the special needs of those women who were being served as well as those women who needed services but weren't being reached by our traditional service models.

- **The movement of women into research, clinical and administrative roles** within the addiction treatment field has provided forums from which to raise the special needs of women. These voices posit that it is not enough to bring women into the field and have them do to women clients what men have done to men clients--to practice the "state of the art" as women inherited it. It is not enough to force women into the mold of the male counselor and to mold the bodies and psyches of women clients to fit the masculine mold of addiction recovery.

- **Federal and state funding** for research on substance use disorders among women and funding for programs specializing in treating addicted women were crucial in supporting the work out of which would come much of our current knowledge about the treatment and recovery process for addicted women.

### *The Emergence of Women's Ways of Healing*

As each month passes, a growing body of research and clinical experience accumulates to underscore the differences between patterns of addiction and recovery in men and women. Researchers have found differences in drinking and other drug consumption patterns between women and men that include:

- Alcohol consumption patterns (Women are less likely to drink, with 40% abstaining from drinking.)
- Licit drug consumption (Women are more likely to be using/abusing licit psychoactive drugs alone and in combination with alcohol.)[10]
- Alcohol metabolism (Women reach higher peak blood alcohol levels; women on oral contraceptives metabolize alcohol more slowly.)[11]
- Morbidity and mortality (Women have more severe medical problems than men with less alcohol consumed.)[12]
- Genetic risk of alcoholism (Males have higher genetic risk.)[13]
- Etiology of alcoholism (Addicted women bring other life experiences, e.g., parental alcoholism, sexual victimization in childhood/ adolescence/ adulthood that can serve as etiological forces in addiction or obstacles to their recovery.)
- Onset of excessive alcohol/drug use (Onset in women tends to be tied to identifiable events.)[14]
- Speed of progression (Progression is faster in women.)
- Stages and symptoms (Stages are less distinct for women; some early stage symptoms for men are late stage symptoms for women.)[15]
- Stage of intervention (Women, primarily because of social/family enabling and stigma, enter treatment at later stages than men.)
- Barriers to treatment (Women may have special barriers such as increased stigma, lack of child care, and concern for physical/psychological safety in male dominated treatment environment.) [16]

As clinical experience with women increases in the addiction treatment field, so has the concern about the pressure on addicted women to comply and experience treatment whose essence has been defined and whose success is measured based on

the physical, psychological, social and spiritual architecture of men. The more experience we have with women experiencing alcohol/drug-related problems, the louder is the growing voice that defines and calls for a more effective response to their special needs.

This paper is a single note within a more extended composition being written within the field which posits that we need to look anew at the needs of addicted women and our response to those needs. It is part of a broader movement that says our treatment models must emerge out of the needs and experiences of our clients as opposed to programming these needs within a pre-set and perhaps alien architecture. It is the premise of this paper that treatment and recovery principles within the addictions field were designed for culturally empowered men and require significant modification to respond to the needs of women.

### *Masculine and Feminine Metaphors of Change*

> "How can women create stories of women's lives if they have only male language with which to do it?" Carolyn G. Heilbrun, *Writing a Woman's Life* [17]

Addicted men and women both exhibit chronic self-defeating styles that serve to sustain addiction. These patterns become compulsive and progressively self-accelerating. They become individually specialized, fixated and cognitively self-perpetuating. These culturally encoded styles must be unlocked through the treatment and/or self-help process. The treatment process is a discovery of those metaphors--words, phrases, ideas, stories--that like keys to locks and ciphers to codes can open avenues of change.

Change, whether social or personal, requires a special fire-like chemistry. There must be the required fuel and oxygen and that special igniting spark. Lacking any of these ingredients, change fails to occur or is prematurely extinguished. Ideas have long served as organizing axes that, at the right time and place, drive the process of change. Ideas can be so galvanizing in their implications that they force breakthroughs in perception--breakthroughs that create a redefinition of self and the self-world relationship. This paper focuses on particular kinds of ideas called metaphors that in their subtlety, complexity and power strike deep emotional cords that incite a process of self-assessment, self-restoration and self-creation.

Metaphors are terms or phrases--crystallizations of ideas or constructs--that through analogy and comparison label and elucidate complex experience. Metaphors can

enhance understanding of one's experience and open up a vision of the course of action one must take. There are many such examples in the chemical dependency field. The construct of "allergy" has been an important notion around which many persons within AA have cognitively framed their sobriety decision. The more dominant "disease concept" is a construct whose utility far transcends its eventual disposition in scientific debate. Such constructs are "true" in the sense that they validate and make sense of otherwise incomprehensible and sanity-challenging experiences for many persons. They are metaphorically true to the extent that they provide a cognitive cornerstone through which untold numbers of addicts organize their movement from addiction to recovery.

Treatment interventions must reflect an understanding of the styles through which men and women are culturally programmed to respond to decreasing competence in their role performance. The metaphors for culturally empowered white men are so dominant within the addictions field that they have defined the field. They constitute the cognitive and emotional axis points through which all persons are expected to initiate and chart THE pathway (notice the use of the singular here) from addiction to recovery. What has been designed as a universal paradigm is actually a reflection of a narrowly prescribed band of human experience. We are not proposing that the metaphors within this paradigm be discarded; they can be life-transforming when matched to the persons for whom they were designed. There are, however, a whole range of persons--women, culturally disempowered men, people of color, youth, and others--who may not experience these metaphors as empowering. While there are many persons disempowered persons who have been aided by these mainstream metaphors, there may be a whole world of emerging and yet untapped metaphors that will prove to be much more effective and central to the liberation of disempowered persons because these alternative metaphors speak more powerfully to their needs and experiences. It is our belief that there are contrasting metaphors for men and women that can serve as the catalysts for personal transformation. Words, symbols, and constructs which men may use to free themselves may provide no such liberating influence on women and may inadvertently drive them into the darker shadows of their chemical and social imprisonment.

The character Bathsheba in Thomas Hardy's *Far From the Maddening Crowd* could have been speaking for past and current generations of addicted women entering male-based treatment and recovery programs when she said: "It is difficult for a woman to define her feelings in language which is chiefly made by men to express theirs."[18] How frustrating and demeaning it has been for recovering women to define their experience in language and metaphors developed by, and through the experience of, recovering men. Until recently, women have been forced to forge their recovery

out of men's language, men's metaphors, men's models of meaning and change. More recently, women have begun to break free by telling the truth to one another--breaking silence about both their individual and collective experience. This phenomenon can be seen within women's groups within traditional 12 step programs, in the emergence of alternative recovery models such as Women for Sobriety, in the spread of adult survivor groups, and in the growth and sophistication of groups organized to counter violence against women and children. A parallel process is reflected in the growth of women's research, the increase in specialized treatment services for women and the growth of women writing and training within the field. Through these personal and professional rituals of breaking silence have risen women's language, women's stories and women's metaphors of healing.

In the remaining pages of this discourse, we will explore the nature of the differences in feminine and masculine metaphors of transformation. Our approach to this exploration is a form of inductive anthropology through which we will compare the language, myths and metaphors that characterize the literature and oral folklore of men's and women's addiction, treatment and recovery experiences. The sources used to construct these comparisons include highlights from substance abuse research and research on gender psychology/socialization, a semantic analysis and comparison of recovery programs that have emerged based on the separate experiences of men and women, the identification of issues being consistently raised by programs specializing in the treatment of addicted women, and observations from the authors' combined clinical experiences. The comparison of recovery models contrasts Alcoholics Anonymous (male-based) with Women for Sobriety and a number of adult survivors of sexual abuse recovery frameworks (women-based). Given the exceptionally high prevalence of sexual abuse among addicted women, we feel the inclusion of adult survivor frameworks is particularly elucidating and reveals dimensions of healing excluded from male-based treatment and recovery designs.

### *Powerlessness versus Empowerment*

> "We admitted we were powerless over alcohol--that our lives had become unmanageable." First Step, Alcoholics Anonymous[19]
>
> "I have a drinking problem that once had me." First Statement of Acceptance, Women for Sobriety[20]

Recovery within 12 Step programs begins in the first step with two metaphors: *powerlessness* and *unmanageability*. The action evoked by these two metaphors is

the action of acceptance, of surrender, of giving up. What makes this ritual of acknowledged defeat such a clinical milestone, the axis upon which the initiation of recovery begins? While such acceptance is the obvious antidote and unfreezing o f the alcoholic's cognitive defense structure--the denial, minimization, projection of blame, etc. that sustain drinking and protect self-esteem--there may be even more profound magic in this ritual for the men from whose experience it was framed.

The admission of powerlessness over anything for culturally empowered white men would constitute a major clinical milestone. The first step of AA marks a deep intuited understanding of how culturally empowered men are culturally programmed to respond to alcohol-induced deteriorations in personal competence: grandiosity, aggression, increased preoccupation with power and control, and/or flight. Juxtaposed against this pattern of defense, this proclamation of powerlessness and unmanageability of one's life marks a deep emotional break from the Sysiphisian effort to control one's drinking and maintain self-worth.

Cultural empowerment imbues not just a legitimacy to one's existence but a sense of entitlement, privilege and superiority. It is the inherent belief in one's power to control the fate of oneself and others. It is dominance based on differences between the superior or inferior character of one's age, gender, sexual orientation, race, religion, profession or class. Cultural empowerment bestows a mantle of superiority; cultural disempowerment creates an unending succession of wounds to one's legitimacy and value. Power is to culturally embraced white men what water is to fish--an ever-present but invisible life support system taken for granted until its esteem-feeding oxygen is withdrawn or lost. Powerlessness for men is to experience themselves outside these cultural waters--to lose the experience that they have authority and control over their personal destiny. Thrust outside these waters, there is often a breakthrough in self-perception of such remarkable and terrifying clarity as to evoke what may be later framed a spiritual crisis. Such crises have often been noted for their ability to ignite the movement from addiction to recovery. If this breach in the male ego--this crumbling of the narcissistic illusion of power--constitutes such an emotional breakthrough for culturally empowered men, how do women (and disempowered men) respond to these metaphors of powerlessness and unmanageability? The confrontation technology that has been so commonly used to precipitate a crisis of transformation by deflating the alcoholic male's ego can re-victimize women and cultural minorities whose egos, whose senses of self-value, have been weakened under the crushing pressure of sexism and racism.

The first step of AA and the first statement of acceptance of WFS have some parallels. There is in both a breakdown or breakthrough in the denial of alcohol's

debilitating effects. But the manner in which this denial is countered shows significant differences between AA and WFS. Where AA focuses on this emotional surrender and the admission of powerlessness and unmanageability, WFS focuses on an assumption of power and control. The first statement of WFS brilliantly intuits and counters how women have been programmed culturally to respond to decreasing competence via passivity, helplessness, hopelessness and dependency. In the face of such cultural assault, neither the admission of powerlessness and unmanageability nor the experience of surrender would constitute an emotional breakthrough. As one of our clients put it: "Powerless and unmanageable? So what else is new!" Acceptance and surrender can hardly be considered as clinical milestones for persons whose physical and psychological safety has been contingent upon obedience and submission. In contrast, the experience of assuming power and control may be a breakthrough. Jean Kirkpatrick, founder of WFS, illustrates this experience of assuming power when she discusses this first statement of WFS.

> "I have a drinking problem but it no longer has me. I am the master of it and I am the master of myself."[21]

The forth and fifth WFS statements reinforce these themes of self-control, power and mastery.

> "Problems bother me only to the degree I permit them."[22]

> "I am what I think."[23]

This theme of control is further illustrated by Gannon's first step of recovery for adult survivors of childhood sexual abuse, a program like WFS based almost exclusively on the experience of women: "I have resolved the breakthrough crisis, regaining some control of my life."[24]

For culturally empowered men, recovery begins with the experience of surrender to one's powerlessness and loss of control. For culturally disempowered women, recovery begins with the experience of empowerment--recognizing and embracing the power to shape one's own destiny.

### *"Hitting Bottom" (Pain) Versus Seeing the Top (Hope); Enabling Versus Empowering*

The addictions field has through its dominant experience with men evolved a folklore about the nature of the motivational crisis that propels one from active addiction to active and sustainable recovery. Experience with middle and upper-class men provided several evolutions in this folklore beginning with the notion that recovery springs from the experience of hitting bottom. This folklore posited that alcoholics stop drinking when the pain of drinking gets greater than the pain of quitting and not drinking. This view suggested that when sufficient pain and loss accumulate to a kindling point, there will be a crisis out of which the recovery process is ignited. Then came the breakthrough in intervention technology based on the discovery that outsiders could raise the bottom--speed up this crisis point--by pulling out all of the enabling relationships and behaviors that help sustain drinking and by staging a loving confrontation with the alcoholic to bring home the full effect of drinking on those the alcoholic loved. And the intervention technology worked wonderfully in precipitating this crisis for culturally empowered white men. Both the old and new versions of "bottom" technology assumed the presence of some remnant of hope which culturally empowered men brought in great abundance because they had experienced their own ability to make decisions that could influence their personal destiny. But what happens when such intervention technology is applied to persons who have no such experience of hope? How does such technology fit poor addicted women of color? Is there an insufficient quantity of pain and consequences that prevent them from moving into recovery?

The focus on addiction-related pain and consequences for the culturally disempowered is impotent to effect change if it is not accompanied by an infusion of hope. In more and more programs this hope occurs in the context of a relationship--often with one or more other women who share similarly life-shaping experiences (sexual victimization) or characteristics (color, poverty, loss of children) and who are in active addiction recovery. Metaphors of hope may be more change-inciting to culturally disempowered women (and men) than the metaphors of pain to which culturally empowered men have so consistently responded.

Traditionally, any activity that prevented the addict from experiencing the pain and consequences of drinking was viewed as an enemy of the recovery process. Family members and addiction therapists alike closely guarded themselves against the shameful charge of ENABLING. Does the over-application of this concept pose risks of abandoning addicted women (and other culturally disempowered persons) for whom alternative strategies might prove more effective in achieving the goal of

initiating a recovery process? In the program manual of a project which has intervened with more than 1,000 women since 1986 can be found the following words:

> Service interventions that might be viewed as "rescuing" or "enabling" for chemically dependent men, may be essential ingredients to initiate and sustain early recovery for a significant portion of chemically dependent women. The issues of treatment is not whether these women have experienced enough pain and consequences related to their alcohol and drug use. Such pain exists in high magnitude. It is the absence of hope and opportunity, not pain, that must be the focus of the intervention process.[25]

There is a consistent message emerging from programs serving addicted clients with culturally-driven and deeply imbedded characteristics of passivity, dependence and learned helplessness and hopelessness. That message is that many such clients, in spite of their strengths and survival competencies, have a marked incapacity to spontaneously initiate their own recovery solely as a response to pain. It is our energy, our caring, our hope, our belief in them--the existence of an empowering relationship--that must initiate the leap of faith into recovery. If we wait for them to hit bottom, they will die.

### *We (Connectedness) Versus I (Individuation)*

Self-help structures for recovering men and women by definition provide a vehicle for mutual support and sharing, and yet there seem to be differences in the recovery maps that emerge from such groups depending on whether the recovery structure was shaped on the experience of men or the experience of women. These recovery maps provided contrasting metaphors that provide men an increased experience of intimacy and attachment and women an increased experience of self.

In the 12 steps of AA, for example, the word "I" does not appear. The 17 pronouns found in the 12 steps convey the experience of connectedness: we, our, ourselves, us. There is little doubt that this emphasis on group connectedness was the intuited antidote used to transcend the narcissism, alienation and haunting experience of aloneness alcoholic men brought to AA from its earliest days. The emphasis on pronouns of inclusion and connectedness to others also serves to counter the cultural attribution of value to men based on individual achievement and the dwarfing of men's ability to experience intimacy and connectedness to others. The "We-ness" of AA opens a desperately needed pathway to sharing and belonging. "We" and "our"

are metaphors that touch deep emotional needs in addicted and recovering men--metaphors that hold out hope of escape from the growing agony of their isolation.

In contrast to AA, there are 14 first person pronouns (I, my, me, myself) that appear in the 13 statements of acceptance of WFS. There are 49 first person pronouns in Poston and Lison's 14 steps of growth for incest survivors; "I" appears 30 times.[26] There are 43 first person pronouns in Gannon's 21 step recovery program for adult survivors of childhood sexual abuse; "I" appears 25 times.[27] The words "we" and "our" do not appear in any of the statements/steps of these programs. One of the few rules for communication set forth by feminist therapist Toni Laidlow, in her groups for women with compulsive disorders, is the requirement that each participant must speak for herself--must speak as the "I," and not in terms of "we," "you," "they" or other abstractions.[28] Just as the "We-ness" of AA responds to needs for connectedness, the "I-ness" of WFS and other recovery frameworks which emerged in response to the needs and experience of women responds to the need for individual identity. The "I-ness" of WFS allows women to experience themselves separate and distinct from the roles and relationships within which their personal identities have been fused and sacrificed. The repeated use of "I" within women's -based recovery models holds out hope for the discovery of self to the addicted woman.

If we construct a continuum of relatedness, we might hypothesize that men and women are culturally programmed for placement at very different points along this continuum. We could further hypothesize that the addictive experience exaggerates the forces that serve to propel individuals to the poles of this continuum. Addicted men and women may be seeking the same thing--balance and harmony--but their search begins from two very different existential positions. Each pronoun--the I and we--from our different recovery models is itself a metaphor of the experience sought and needed.

Where male identity has been structured within the framework of individual achievement (autonomy, competition, isolation), feminine identity springs from one's identification with, relationship to, and caring for others--through roles of child, spouse, or mother. Each of these gender-shaped molds within which men and women are programmed to seek their destiny is unidimensional--one restricting connectedness to others, the other limiting the experience of self. Such distortions of character become even more extreme and exaggerated through the experience of addiction. Addiction pushes men and women to the extremes of this continuum and then through its debilitating effects engenders deteriorating competence and the experience of failure within these restricted roles. Addicted men seek exaggerated efforts at independence and autonomy, e.g., preoccupations with power and control,

geographical flight, etc., only to escalate dependency. Addicted women seeking exaggerated efforts to achieve connectedness become progressively isolated and alone. While each needs the discovery of more balanced experience, men must achieve this balance through discovery of connectedness to others while women achieve this balance through the discovery of connectedness to self. He must open himself to the influence of others; she must open herself to self-definition. He must extend caring beyond the self; she must incorporate self into her value of caring and service. The metaphors of treatment and recovery must speak to these two very different pathways. Carol Gilligan describes the point of balance and harmony--the goal to which these recovery experiences are directed when she notes:

> These disparate visions in their tension reflect the paradoxical truths of human experience--that we know ourselves as separate only insofar as we live in connection with others, and that we experience relationship only insofar as we differentiate other from self.[29]

### *Power Greater Than (Outside) the Self Versus Power within the Self*

2. Came to Believe that a Power greater than ourselves could restore us to sanity.[30]
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.[31]

The second and third steps of AA reach into the heart of the pain-induced crisis and use that crisis to propel a major shift in the characterological anchorages of the male alcoholic. Step two, first of all, taps the often unspoken theme of the alcoholic's hitting bottom crisis (fear of complete loss of sanity): fears fueled by the repeated episodes of loss of control, radical personality changes while drinking, and repeated sanity-challenging failure of promises and resolutions to others that characterize the predominantly male pattern of alcoholism that E.M. Jellinek referred to as gamma species.[32] The steps further provide the antidote for the alcoholic's escalating narcissism and failing struggle to maintain control over alcohol. The steps extend the surrender of will that began in step one and unequivocally posit that the source of hope for recovery relies on resources outside of and greater than the self. The culturally empowered male has experienced a broad range of power and control in his life but in steps one and two confronts the reality that he is impotent to control his relationship with alcohol. Steps two and three place the alcoholic within the traditions of the great religious and spiritual disciplines which call for the submergence of individual will and ego to a higher power. Spirituality--this connectedness beyond the self--is used as a further antidote to narcissism, isolation

and alienation.

In contrast to AA, the program of WFS focuses not on powers beyond the self, but powers within the self. There are no references to God or higher powers in the three women's recovery programs. Although there are references to spirituality found within the affirmations of WFS and in Gannon's 21 step recovery program for adult survivors, all three recovery programs reinforce the power within each woman to think, feel and act in ways that shape her own destiny.

Anne Wilson Schaef attributes the focus on power outside the self for women to the concept of original sin--the idea that one can only be saved through the aid of some more valuable and superior force. She suggests that women have been programmed to define themselves and their value through attachment to such an outside force, usually a man.[33] Where turning their will and their life over to something outside the self might be a new experience for men, it would be business as usual for many women.

***Focused Attention versus Divided Attention***

When the traditional addiction treatment and recovery technology demands a singular, obsessive focus on sobriety, it asks for a form of focused attention very familiar to men. The male alcoholic is asked to apply to his alcoholism the same singularity of focus to which they have historically excelled. Men are programmed to set aside diversions and other personal needs and sacrifice everything for the pursuit of their singular area of accomplishment. When counselors and sponsors consistently frame "secondary" obligations as "distractions" or propose the formula of "90 meetings in 90 days," they are asking for a focusing of attention that men have long been socialized to display in their professions, pastimes and pathologies. Men have been afforded such focused attention quite often because of the "little woman behind the great man." He can go to 90 meetings in 90 days because he is alone without caretaking responsibilities or because his partner continues her over-functioning as homemaker and parent, holding in check her own unmet needs as she has through the progression of his addiction. He can focus because she continues to assume a great share of his duties or responsibilities. Not only are men provided supportive roles that allow their singular focus, they are also given more financial resources which can be utilized to resolve any environmental obstacles to their recovery.

Women's lives are rarely free to pursue such a singular purpose. Women are instead challenged with what Mary Catherine Bateson calls a "sustained divided attention"--a balancing of multiple roles, responsibilities and activities.[34] Under such

bombardment, response to one's own needs must be sandwiched between responses to demands springing from many other sources--demands that provoke the phrase "juggling act" anytime women are asked to describe their lives. When she is challenged to do "90 in 90," she is much more likely than her male counterpart to be confronted with insurmountable obstacles. An androcentric model of assessment might view a addicted women in this context as follows:

> During the assessment interview, this client persistently minimized her substance-related problems and instead focused on all of the other secondary problems that would prevent her from entering treatment at this time. Her use of distractions to defocus attention from her addiction appears to be a chronic pattern of self-sabotage. The client's intense resistance makes her prognosis for entering or successfully completing treatment very poor until some more intense crisis forces her to address her addiction.

There is great danger that androcentric models will interpret as attitudinal and as resistance what for many women is environmental and overwhelmingly real. To demand a singular focus on sobriety defies the reality that sobriety must be integrated into the total fabric of women's lives. While addiction recovery can be both the center of her life mosaic and the thread that ties other remnants of experience into a meaningful whole, this focus on sobriety must be integrated within rather than displace the multiple role demands placed on women. The multiplicity of women's needs must be addressed simultaneously and integrated into a meaningful whole. Where men are taught to exclude demands outside the singular focus of recovery ("Let it Go"); women must discover a way to mesh together their response to such demands. Where men are taught to exclude complexity ("Keep it simple"); role demands within women's recovery pathways inevitably involve great complexity. Within the broader problem of the "feminization of poverty" in the United States can be found addicted women for whom environmental obstacles to initiating treatment and recovery seem insurmountable.

There seems to be a greater inter-connectedness of problems--what Marilyn French has called "circularity"--for addicted women.[35] Each discrete problem interacts with all other concurrent problems intensifying each and creating a synergism of multiple problems, each of which cannot be addressed in isolation from the others. Mechanisms that decrease or help manage these demands such as the provision of outreach and case management systems, advocacy services, homemaker services, day care services, and transportation services are more effective than a cultural double-bind that overloads the substance-abusing woman, shames her for not handling this

load and then defines her as pathological if she refuses to let go of these responsibilities through a singular focus on recovery. Asking her to let go of such responsibilities, in essence, means she must let go of her entire being and meaning for existence. One single mother, when advised to enter inpatient treatment, desperately and emphatically stated, "I'll do anything you say, but I won't leave my babies or my job."

This singular focus is particularly problematic for poor women with children for whom sobriety must be placed within the competing demand for physical and emotional survival. How does a poor single parent woman with four children under age five attend meetings? How many self-help meetings offer day care or transportation? We would do well to listen to the experience of these women. What other community institution provides a supportive framework for sobriety, will welcome this woman's children and will transport her and her children? Should we be surprised by a study indicating the church was the primary sobriety-based support structure being utilized by poor, African-American women following their treatment for addiction? It is essential that we acknowledge and concretely address the environmental--social, political, economic--realities within which each client must construct her recovery and seek her personal destiny. What works is not a single fixation on sobriety, but the forging of a pattern, a process of living, a whole life that is meaningful. Such lives for women are a mosaic constructed not by plan or recipe but out of the raw material of daily experience.

Behind the oft-verbalized metaphor of the "juggling act" lies another experiential metaphor for addicted women--the metaphor of being "trapped." Trapped may reflect their specific addiction experience, but it also describes a kind of cultural imprisonment--an enslavement of one's time and emotional energy through multiple role responsibilities over which one has lost all choice and all sense of self. From this experience of entrapment come the fantasies and hunger for personal freedom. While the concept of "freedom" may galvanize action to confront addiction, the broader implications of this term make it a particularly powerful and liberating metaphor for recovering women.

Men's recovery is described in a language that is hierarchical, linear and obsessively focused. The hierarchical and linear qualities of male recovery paradigms are apparent in the focus on numbered steps and moving from point A to point B. Even positing that women may have different recovery pathways than men still uses a metaphor—pathway--that suggests movement through a predetermined course of action and experiential territory. Metaphors that appear in women's oral folklore and in women's literature--metaphors such as the circle, the mandala, the web, the mosaic,

the net, the collage or the patchwork quilt--may more realistically capture the real life realities and complexity of experience of recovering women.

Men's models of recovery which focus on doing one thing at a time and in sequence miss another reality of recovering women. The men's model implies that one thing is done and then you go on to the next recovery task. Many women's problems are dimensions of living that don't get permanently fixed at a particular point in recovery. Such dimensions ebb and flow into her attention, first calling for time and effort and then ebbing into the background, lying dormant but likely to re-emerge later with a slightly altered appearance. Many developmental tasks for recovering women are addressed not through a singular episode of focused attention but rather through intermittent bursts of attention separated by periods of neglect scattered over years or a lifetime. Some of the physical healing and corrective emotional experiences that mark women's recovery unfold internally within predictable time frames while other movements backward and forward spring from serendipitous events in each woman's life. Such a healing process defies neat depiction in a treatment plan whose duration is four to six weeks.

The traditional male paradigm dictates a single pathway for long- term addiction recovery--continued affiliation and active participation in a 12 step program. While women may indeed need support structures to sustain their recovery, a close examination of their long-term recovery experiences reveals a much broader spectrum and variety of support structures than this traditional paradigm. Male recovery paradigms emphasize recovery as the single organizing principle of one's life and taking on the focused (almost obsessive) identity of recovering alcoholic or addict. Women's recovery metaphors do not convey sobriety as a goal to be achieved through such focused obsession. The goal is "composing a life" that is whole and meaningful.

### *Guilt versus Shame*

The aphorism, "you're only as sick as your secrets," that has been long imbedded within the folk culture of AA bears testament to the need for alcoholics and addicts to give up such secrets. When we compare, however, the content of the experiences revealed through these rituals of self-disclosure, we discover some significant differences between recovering men and women, differences that can be illuminated by exploring the distinction between guilt and shame.

If there is a dominant emotion around which AA's 12-step recovery is organized it is unquestionably that of human guilt. Anyone who has worked with persons with

primary addictive diseases will not be surprised by this statement. The alcoholic and addict are caught in an escalating spiral of "I'm sorry, it will never happen again," "I promise it will be different this time," and "all I'm asking for is one more chance." Dr. Jekyll promises and the drinking Mr. Hyde violates the most sincere of commitments and intentions. For sins of omission and commission that preceded and grew geometrically through the progression of alcoholism, AA provided a framework for healing to expiate guilt over what one had done. Pulling from its spiritual predecessors, AA developed a technology to address such guilt that included self-inventory, confession, self-forgiveness, restitution, and service.

4. Made a searching and fearless moral inventory of ourselves.[36]
5. Admitted to God, ourselves and to another human being the exact nature of our wrongs.[37]
8. Made a list of all persons we had harmed, and became willing to make amends to them all.[38]
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.[39]

AA's founders instinctively knew that alcoholic men would drink themselves into oblivion or even more abruptly shorten their lives if this threat to sobriety was not contained. More positively, it provided a straightforward technology by which esteem could be salvaged--a system for personal redemption that, if not wiping the slate completely clean, at least cleaned enough toxic emotion off the slate to abate the ability of guilt to fuel self-punishing and self-destructive acts.

Where AA evolved a recovery technology to address guilt; WFS and other women-based recovery programs evolved a technology that focused on shame. Where guilt is a self-indictment for doing; shame is an internalized indictment of being. Lenora Fulani understood such self-indictment when she once observed: "Women of color who comer to us for therapy see themselves not as having problems but *as the problem*."[40] Guilt is self-blame of behavior; shame is self-blame of one's character--one's very essence. Shame says, "You have no right to exist, you deserve no better, it was your fault, and you are not worthy of recovery!" The logic of shame is self-annihilation. The antidotes that work so well to dissipate guilt cannot remove from the self the more indelible stain of shame.

Shame comes from collective as well as personal experience. It comes from the full knowledge that to be born female in this culture is to carry a culturally ascribed mantle of inferiority. Sexism, racism, homophobia and all the other self-obliterating "isms" drive this shame-based self-hatred--this growing sentiment throughout one's

development that one has no value--no right to be. WFS and the other women-based recovery programs seek to initiate a radical cognitive restructuring of how each woman perceives herself and her relationship with the world.

12. I am a competent woman and I have much to give life. (WFS)[41]

16. I am entitled to take the initiative to share in life's riches. (Gannon's 21 step program for Adult Survivors)[42]

20: I see myself not only as a survivor but as a thriver in all aspects of life: love, work, parenting, and play. (Gannon's 21 step program for Adult Survivors)[43]

This individual restructuring of self-perception--how I perceive my age, race, or those who share my sex and/or sexual orientation and how I see myself within the context of my own personal history--is the essence of the transformative movement into sustained sobriety and health. It is a restructuring of both collective history and personal history. A heightening of collective consciousness of gender or race or sexual identity may provide the foundation out of which comes individual consciousness and personal transformation. Seeing one's own history as a thread in a broader community history--seeing her own victimization mirrored backward in the lives of so many women in other times and places, seeing a link between her personal destiny and the destiny of all women--can be the beginning of the awakening that unfolds into recovery.

Where the fourth step inventory of AA often involves the assumption of self-blame, women's-based recovery frameworks often involve casting off self-blame and the appropriate assignment of blame to others. Where the fifth, eight and ninth steps of AA involve confession and restitution; women's recovery steps often involve breaking silence about victimization and conducting real or symbolic confrontations. Where recovery for men focuses on resolving guilt of what they have done to others; recovery for women often focuses on expiating the shame induced by what others have done to them. Where men seek to make restitution to those they have injured; many women seek real or symbolic confrontations with those who have injured them.

There are also distinctions in how male-based and women's based recovery programs restructure identity as part of the healing process. The ritual of introduction of WFS ("Hello, my name is Mary and I'm a competent women") is quite different from the ritual of introduction ("Hello, I'm Joe and I'm an alcoholic") within AA. AA's ritual of introduction is an antidote to denial and the closing of the meeting with the Lord's

Prayer, seeking forgiveness for transgressions, is consistent with this focus on diminishing guilt. WFS' ritual of introduction is a self-affirming antidote to shame, as is its ritual of closing: "We are capable and competent, caring and compassionate, always willing to help another, bonded together, in overcoming addictions."[44]

These are significant differences in the core activities and experiences that are at the heart of the healing and recovery process depending on whether we are healing perpetration, healing victimization or both. Perpetration--experienced as sins of omission and commission--has long been addressed within the 12 step framework. Victimization--experienced as an irrevocable tainting of the self--requires different processes. As we bring guilt and shame technologies into the addiction treatment field, our next step will be to transcend the gender-based application of this technology. As we move forward, we will need to be open to hearing the victimization issues of men and the perpetration issues of women.

### *Self-effacement (humility) versus Self-affirmation*

Tradition 12 of AA declares the spiritual significance of anonymity.[45] By placing "principles before personalities" and calling on each alcoholic "to practice a genuine humility," this framework reigns in grandiosity and suppresses the "I" of the male alcoholic ego. The achievement of humility is an antidote to the culturally programmed (and alcoholism-amplified) male pattern of adaptation to decreased competence: increased preoccupation with power and control and increased propensity for aggression, projection of blame, grandiosity, and geographical flight. The culture of the 12 step program is profuse with self-effacement and self-deprecating humor: the neutralizing agent for narcissistic and grandiose temperament of the actively drinking and recently sober alcoholic. The language of AA (embedded in the 12 steps and 12 traditions) was designed to break the narcissistic bubble of the male alcoholic. It did this through a language of ego-confrontation and submission: words like powerless, unmanageable, wrongs, defects of character, and shortcomings.

The culture of WFS and the milieu of most women's-centered addiction programs is distinctly different. Jean Kirkpatrick commented on this difference in a 1987 interview: "I've never met a single alcoholic woman who needed more humility. I believe that women need exactly the opposite--the self-confidence to stay sober." [46] Rather than self-effacing, women's-centered programs are infused with self-affirmation. The language of WFS (imbedded in the 13 statements) was designed to empower the will of the alcoholic woman. It did this through a language of ego-affirmation: words like happiness, life, love, emotional and spiritual growth,

enthusiasm, competent, responsible. Nearly all women-based models of transformation focus on self-esteem as both the primary obstacle and primary medium of change. Mary Catherine Bateson once noted, "It is not easy to cherish oneself when one's whole life has been organized around cherishing others."[47] Women's-centered treatment programs balance this love of others with a focus on acceptance and love of self. The work of Maureen McEvoy embodies this power of self-affirmation in her work with survivors of sexual abuse. She has built into her groups regular rituals of affirmations whereby group members express compliments and appreciations to each other. To counter women's conditioning to resist and discount such acknowledgements, McEvoy and her co-facilitators have created a "rule" which asks each woman receiving an appreciation to respond with "Thank you." Later in the group process the rule is amended so each group member is to respond with "Thank you, I agree," a shift in the ritual that is greeted with "howls of protest and laughter" when it is first introduced.[48]

### *Softening Judgment versus Learning to Judge*

As the self-esteem of the male alcoholic deteriorates, a cognitive defense structure emerges to sustain drinking and maintain his sense of personal power. Elements of this defense structure include grandiosity, hypercriticalness, black-white thinking and heightened irritability and resentfulness. For recovering men, the achievement of humility and tolerance, the management of resentments, the "easy does its" and "let it gos", are all antidotes designed to soften this defense structure. The traditional recovery technology is also designed to fit two other primary defense mechanisms of male alcoholics: projection of blame and intellectualization. . There is an assumption not only that the alcoholic can think--but that he thinks too much. e.g., "Your best thinking got you here." Slogans (designed to reprogram self-talk) like "Keep it simple, stupid!" constitute antidotes to such defense mechanisms.

In contrast to alcoholic men, the defense structure of alcohol and drug dependent women is more likely to involve passivity and self-blame. The shame-based indictment of the alcoholic woman creates an existential position within which she has no right to judge others, in which she is incapable of thinking and judging, in which she is not worthy of judging others. Where the focus for the recovering alcoholic male has been one of faith and acceptance--a distinctly anti-intellectual tradition, the focus for recovering women may be more appropriately focused on the development of critical thinking skills, developing confidence in those skills and in the verbal assertion of those beliefs and judgments. For her, to think, to know, to judge and to give voice to that judgment is to acquire power and visibility.

### *Achieving Silence versus Breaking Silence*

> *"We've only just begun to fashion a vocabulary to deal with the 'silences' of our lives."* Toni Cade Bambara[49]

We live in a culture where "women cultivate their capacities for listening while encouraging men to speak."[50] Culturally empowered men have inherited a language developed by men and the power to speak in ways that define the world in their own image and experience. When the power to perform major role functions deteriorates in addicted men, language skills become an important tool to ward off environmental confrontations. Language becomes the primary defensive weapon used to sustain addiction. It is through language that the addict's denial, projection of blame and intellectualization are actualized in interaction with others. It is in this manner that the culturally empowered addict's voice becomes an obstacle to his own recovery. This elaborately constructed and oft-activated linguistic defense structure must be silenced and reformulated for addicted men to enter into a recovery process. For addicted men, silence is something to be achieved.

Addicted men achieve transcendence over their ego-centrism by discovering silence and then opening themselves to the act of listening. Constructing and telling their own story while an important developmental stage in recovery is an extension of their historical narcissism. It is in listening to and actually hearing and experiencing the stories of others through which the male addict's existential position is fundamentally shifted. It is the act of listening--achieving self-silence--that is the precursor to empathic identification and connectedness to others. It is the medium through which the addicted man breaks out of isolation. It is the beginning of self-inventory and self-renewal.

Metaphors of silence and voice have a central place in feminist thought and writings. Silence can be the act of homage and surrender to external authority. Silence can be the obedience that says women, like children, should be seen and not heard. Silence can be the systematic devaluation that occurs in a world in which men are taught to speak and women are taught to listen--a world that convinces her she has nothing of value to say. Silence can be the seal that hides victimization. There are numerous circumstances that intensify silence for chemically dependent women--familial histories of alcoholism, physical and sexual victimization, the special stigma and shame attached to substance abuse and women--and addicted mothers, in particular, in this culture. This silence can be literal--verbal passivity in a woman who has become increasingly word phobic out of the experience that words have been weapons used against her and that her own words can provoke violations of safety.[51]

This silence can also be symbolic--a kind of noisy silence in which one's true feelings and self are hidden behind a screen of safe and shallow chatter, evasion, or tears. She may gain voice through the experience of intoxication, and yet it is a false and distorted voice--one that is diminished from the culturally-induced shame of intoxication. Silence is the existential position from which most addicted women begin.

"Breaking silence" is a powerful metaphor for recovering women. Liberation for chemically dependent women involves the act of telling the truth to one another--breaking silence about their individual and collective experience. This discovery of voice is not just the discovery of words and speech, is not just the act of speaking. It is the experience of being heard. To be heard, to be believed and to be understood are the beginnings of her empowerment.

Consciousness generated from this truth-telling incites the commitment to break free from such collective and personal history. The act of breaking silence is liberating. Out of her own voice comes the discovery of personal power. Breaking silence is a screaming declaration of one's existence--a refutation of invisibility. Breaking silence is a shift from obedience to external voices to respect for and obedience to her internal voice. Breaking silence is rebirth.

When silence is first broken, the newly discovered voice--this reborn self--is very fragile and must be nurtured until it gains strength. It is often in the chemistry of mutual support between recovering women that this rebirth of self occurs. Discovering and externalizing these inner voices is generating women's language, women's metaphors and women's stories. It is feminizing the culture of recovery throughout the United States.

These distinctions suggest that the experiential pathways of recovery for addicted men and women can be quite divergent. Her silence and his grandiose and aggressive speech both anchor addiction. Where he must learn to walk softly on the earth without scarring it, she must learn to leave a footprint. Where he must discover silence, she must break silence.

### *Service to Others versus Acts of Self-Care*

Brought forward from AA's spiritual godparents (the Oxford and Emmanuel movements), service plays a central role in the 12-step recovery program. AA's beginning is crystallized in an act of service--the meeting of Bill W. and Dr. Bob.

Service is the antidote for the cultural suppression of empathy and caring in men. For the male alcoholic--narcissistic, alone and lonely, adrift in a chemical autism-- service is a medium for getting outside his own ego and a means to connect emotionally with other human beings. It provides a way for him to escape the roar of his own pain and own needs and experience connectedness. As a further antidote to guilt, acts of service functions as a kind of generic restitution for past wrongs--a balancing of the karmic bank account. In a type of poetic paradox of justice, service provides the medium through which the narcissist becomes the servant, the predator becomes the rescuer.

What life experience or existential position of addicted women would alter the role of service in the recovery process? Women have been culturally scripted for service. They have been charged with what Gomberg has called "the keepers of personal relationships," programmed for service roles within families (wife, mother, homemaker) and, until recently, provided only service roles as the primary occupational pathway out of the family (nursing, teaching, clerical). Where empathy and caring have been culturally suppressed in men, these same traits have been culturally imbedded to excess in women. At the same time, women have been made to feel "selfish" for such "masculine" traits as self-assertiveness, competitiveness, decisiveness, and risk-taking. Such characteristics in women were viewed as a betrayal of what sociologist Jessie Bernard, in her wonderful book *The Female World,* called the "female ethos of love/duty."[52] Such programming is even more intensified for women who spring from generations of male alcoholism. Women born into such families experience from their earliest breath the message that other people's (particularly men's, and, even more specifically, addicted men's) needs are more important than their own. Service for women in early recovery, particularly service directed to men and children, provides not a new and transformative experience but a return to her most basic psychosocial position. Programs that emphasize service as an early stage recovery task reinforce the culturally programmed value of self-sacrifice for women.

If recovery requires experiencing oneself differently--a break from one's existential position--then acts of self care and the discovery of relationships based on mutual self-interest rather than sacrifice provide the foundation of recovery for addicted women. Discovering mutuality and reciprocity in relationships with other women--a growing consciousness of womanness as a component of individual identity--may be the equivalent of service for women. Service within women's recovery frameworks focus, not on sacrifice, but on the value and capabilities each woman has to offer others and on a mutuality of support between women. This difference in focus can be seen within the WFS program and its evolution since the early years of its

development (1973-1975). The original 12th and 13th statements of WFS read as follows:

> "I Am a Competent Woman and Have Much to Give Others"
> "I Am Responsible for Myself and My Sisters."[53]

Jean Kirkpatrick, the founder of Women for Sobriety, says that her first formulation of these steps was influenced by her own "gender conditioning," creating the caretaking mother as the model for women's recovery. As a result of this realization, statements 12 and 13 of the WFS program were changed in 1987 to read as follows:

> "I Am a Competent Woman and Have Much to Give Life"
> "I am Responsible for Myself and for My Actions."[54]

For an alcohol and drug dependent woman to experience service as a sacrificial flight from self is not progress, but regression into the self-refutation of the legitimacy of her own needs, and ultimately her own existence. Learning to reward oneself, to feel one deserves one's share of life's riches, to feel some innate and earned entitlement to opportunity is the foundation of self-care. On the continuum from narcissistic preoccupation with self to self-flight through sacrificial fusion with another, recovering men and women each need to find balance and harmony in the middle although each, like in the earlier continua we described, must travel this pathway toward moderation from very different beginning points and may require different metaphors to mark and speed their journey.

***Dependency versus Autonomy: Codependency--A Cultural Double Bind for Women***

While many persons have noted men's zeal for autonomy and individual achievement and women's zeal for attachment and affiliation, there are at least three divergent paradigms from which to view and judge these differences.

The most recently emerging paradigm is one which posits that these female traits, while culturally devalued, are superior and should become the guiding values of the future. The writings of Riane Eisler[55] and Jean Shinoda Bolen[56] are illustrative of this paradigm.

A second paradigm (reflected in the basic framework of this paper) holds that women's propensity for affiliation and attachment are noble virtues but that such virtues have been achieved at a high price--sacrifice and suppression of self. This

view calls for a balancing of accounts whereby women are freed to explore personal achievement and men are freed to explore intimacy and attachment.

The third paradigm posits that women's zeal for affiliation and caretaking is pathological. The first group of proponents of this paradigm includes the mainstream proponents of developmental psychology. From writings on development spanning Freud and Erikson through Vaillant and Levinson [57], the model of healthy human development has been judged on markers of separation, individuation and autonomy. Works by Miller[58], Gilligan[59] and others have emerged to challenge this androcentric view of development and to challenge the process by which women are socialized for affiliation and connectedness and then defined as inferior for their absence of male-defined virtues. Some of the most visible proponents of the pathology paradigm include the leaders of the codependency movement within the United States. The remainder of this section will critique the utility of "codependency" as a metaphor in the recovery of addicted men and women.

The 1980s saw the emergence of a new industry in the United States organized around lectures, books, tapes and new self-help groups and treatments for a newly conceptualized disease: codependency. That this concept of codependency touched a deep emotional chord within the culture and within women in particular is evident from the success of this industry. That a large number of individuals have found this movement a source of emotional healing is also unquestionable. And yet as we move into the 1990s, a growing number of voices are emerging challenging both the basic premises and the over-extension of this concept. From the full-scale indictment of Katz and Liu in *The Codependency Conspiracy*[60] to the feminist critique of Carol Tavris in *The Mismeasure of Woman*[61], critics are challenging the theoretical and practice applications of this concept. Major points of criticisms include the following points.

- The definitions of codependency are so broadly inclusive that the term has lost its clarity and utility.
- The alleged symptoms of codependency (Beattie[62] lists 254) while all encompassing, inordinately target those characteristics that most women have been raised to cultivate and possess.
- The characteristics the codependent is encouraged to develop through recovery--detachment, independence, self-reliance, ability to say no to other's demands--constitute the characteristics of the stereotypical male in this culture.
- "Codependency" turns problems of environment--particularly, social oppression--into problems of psychopathology. By internalizing pain,

women's energy and anger are channeled into personal recovery rather than environmental change.

- By defining the condition of women ("who love too much") in medical (disease) rather than political (oppression) language, we fail to hold abusive men responsible for their neglectful, demeaning and violent behavior. Critics contend that if codependency is a disease, then it is a social disease--a disease of culture through which half the population are taught to deny the legitimacy of their own individual needs while the other half are taught that the world revolves around their needs.
- The codependency movement encourages women to "bond in pain instead of power."[63]
- The codependency movement infantalizes its members by calling them "adult children" and encourages their self-centeredness and self-indulgence--an infusion of the cultural values of the 1980s out of which the movement was born.
- Self-help groups within the codependency movement "promote dependency under the guise of recovery," leaving members "trapped at an immature stage of development."[64]

What is to be made of such criticisms and to what extent does the concept of codependency serve as a metaphor around which change can be initiated and sustained in addicted women? Our critique can be summarized as follows.

1. A significant portion of addicted women present themselves to treatment with familial histories of addiction and past and current intimate relationships with addicts.
2. Continued contact with addicted family members, intimate partners and friends constitutes a major source of sabotage of recovery for addicted women.
3. Any concepts--including the concept of codependency--which help heal emotional pain from one's family of origin and enhance the physical and emotional disengagement of the addict from such relationships will diminish the risk of relapse and support the early recovery process.
4. Concepts which help label a problem and which help energize the initial change process may not have the power to sustain a long term process of transformation. Because the codependency movement has utilized an adaptation of the 12-step male-based recovery model, we would anticipate that many women will find this framework inadequate for their long term developmental needs and that alternative recovery models will emerge that flow directly out of the needs and experiences of women.

5. The future of the codependency movement hinges on its ability to evolve dynamically in response to the above criticisms. Achieving or failing to make such evolution will determine whether codependency becomes a viable and sustainable recovery concept or an historical artifact, a developmental stage on the way to concepts and structures not yet visible.

### *Blindness to Safety versus Sensitivity to Physical/Psychological Safety*

Male-based treatment and recovery paradigms show a marked absence of concern related to physical safety perhaps springing from the assumption that men must either take responsibility for their own safety issues or deny with exaggerated bravado that any such threats to safety exist. The most cursory review of the institutionalized violence against women in this culture underscores why safety is a central issue for women. One in six women has been raped. Three out of every four women in the U.S. will experience at least one violent crime during her lifetime. Half of all women seeking emergency medical services are battered. More than 20% of married women report physical abuse by their partners. A man beats a woman every 12 seconds in the United States and four women each day die from such beatings.[65] Surveys of employed women reveal that at least two thirds have experienced some form of sexual harassment in the workplace. All women live their daily lives in this culture awash in violent sexual imagery reminding them of the tentativeness and uncertainty of their personal and psychological safety.

For the addicted woman entering the recovery process, the issue of personal safety is likely to be even more intense. She is much more likely than a non-addicted woman to have been sexually abused and her sexual abuse is more likely to have involved multiple traumagenic factors: early age of onset, multiple rather than single episodes of abuse, multiple versus single perpetrators, and violence or threat of violence as a component of the abuse experience.[66] Her addiction quite frequently brings her into deep involvement with a culture of addiction in the United States that is increasingly predatory and violent. Her substance abuse is often bound up in toxic intimate relationships. Her addiction cannot be unraveled without unraveling the threads of exploitation and violence within which it is bound. As she begins to disengage her life (and the lives of her children) from such toxic intimate relationships, her co-addicted partner will often seek to squelch such sparks of independence through verbal intimidation or physical brutality. In short, the addicted woman's survival has been conditioned within a world where trust is violated and safety is an illusion.

Women's programs are instinctively aware that issues of safety and trust are paramount in the treatment of addicted women. They are particularly aware that the

de-stabilization of toxic intimate relationships produced by a woman's sobriety poses risks of psychological sabotage and physical retaliation. Women's-based treatment addresses such issues through gender-exclusive residence and service modalities, special attention to the physical security of the treatment environment (locked doors, close screening of visitors), close links with domestic violence and sexual assault counseling services, and encouragement and advocacy related to orders of protection and use of shelters.

Effective treatment of addicted women is also extremely sensitive to how women's psychological safety has often been violated within traditional treatment models. When women fail to respond to treatment in the male-defined vision of progress, they are often defined as resistant and further shamed and stigmatized through labeling or intensified verbal confrontation. In this clinical double-bind, women are confronted as compliant people pleasers when they agree and are confronted as resistant or as being in denial when they assert their will through disagreement. The often intrusive and confrontational methods designed to penetrate and deflate the puffed up ego of the male alcoholic can be very violating to women. Such techniques can damage already fragile esteem, escalating shame and fueling continued self-destructive behavior. In contrast, women's treatment programs lean toward more supportive, less intrusive, less manipulative and less coercive treatment techniques. This style of treatment demonstrates respect and acceptance of her as an individual. Belenky, Clinchy, Goldberger and Tarule, speaking of how women learn, make the point that it is not enough for women to be told of their *capacity* or potential to become wise and good, they need to have the goodness that is already within them validated.[67] Women's recovery programs seek to reinforce this goodness within and avoid interventions that could potentially damage this sense of self-value.

The issue of physical and psychological safety is particularly paramount for the high percentage of addicted women who bring developmental histories of physical and sexual abuse. These violations could more aptly be described as processes rather than events, meaning that an act such as incest or an act of complete abandonment were often the last steps in a progressive process of over-involvement or disengagement. There are dangers that poor boundary management in male-dominated treatment programs may recapitulate such progressive violations, triggering flight or heightened defensiveness against what the client perceives to be impending seduction or impending abandonment. Sensitivity to psychological safety requires sensitivity to such boundary issues and the establishment of trust as a precursor to psychological healing. Where men's groups may struggle at times to get any level of affective disclosure, facilitators of women's groups tend to be very cognizant of the dangers of premature disclosure and build in high levels of structure and safety within which

self-disclosure and self-healing can occur. Staff members of women's programs are also aware of how a too aggressive desire to help and heal can trigger panic and flight. Commenting on the need for gentleness and time as essential components of trust-building, therapist Naida Hyde, once remarked that she had "momentarily forgotten that safety for the incest survivor resides in aloneness, not relationship." Respect for the client's choice of the content of therapy and her control of the pace of the therapeutic process is the essence of psychological safety.

Another safety issue involves concern with the potential re-victimization of women within the very environments from which they seek help. A growing number of individuals and organizations are breaking silence and beginning to confront the historical sexual exploitation of women in predominantly male treatment and self-help environments. Sensitivity to the ways in which women can be re-victimized within treatment environments is paramount. Mainstream treatment settings can address these issues by defining, monitoring and enforcing clear standards designed to promote the highest levels of professional and ethical conduct in our service relationships. While 12 step and other self-help programs have historically relied on the "group conscience" to inhibit or address such exploitation, a growing number of groups are beginning to confront much more directly the practices of seduction and exploitation referred to euphemistically as "thirteenth stepping."

### *Blindness to Image versus Sensitivity to Body Image*

When active addiction is removed as the centerpiece of one's life, men and women begin to experience issues and problems they share in common with other non-addicted persons in the culture. Body image and its role in the self esteem of women is one such issue that is arising with increasing frequency in the treatment of addicted women. While many women may face crises of self-esteem, the potential capacity of such crises in recovering women to trigger relapse makes this issue potentially life-threatening. How the recovering woman perceives her own body, how the culture perceives her body and how these perceptions influence her sense of self-value is critical to the foundation of self-acceptance and self-love upon which women's recovery is based.

All media--movies, television, magazines and newspapers--bombard us with visual images of beauty which women are expected to emulate, images against which each woman assesses her own value. Where do these images come from and what is there cumulative effect? Naomi Wolf in *The Beauty Myth*[68] has explored how anorexic fashion models have emerged as this culture's icons of beauty and the standard by which women judge their own physical adequacy. She believes:

- The systematic effort to medicalize and pathologize that which is biologically normal for women has long been a tool of oppression--a tool that encourages women to focus their attention and define their discomfort on personal flaws rather than the external conditions that starve them economically, politically and socially.
- The construction and enforcement of arbitrary standards of beauty which are unobtainable for most women is also spawned by multi-billion dollar diet, cosmetics, exercise and surgery industries whose profits hinge on "warping female self-perception and multiplying female self-hatred." After all, "...a woman who does not feel damaged cannot be relied upon to spend money for her 'repair'."
- The beauty myth places all women in a double-bind. Women who approach the standard become fetishes and devalued in the knowledge that the source of their value is superficial and non-sustainable. Women who fail to meet the standard are set up for daily self-indictment and endless attempts at self-correction.
- The power of such enculturation is evident everywhere.
  - More than 70% of women over age 13 believe they are fat while only 25% are medically overweight; up to 45% of medically underweight women believe they are too fat.
  - Eighty-seven (87) percent of cosmetic surgery is performed on women.
  - Over 90% of anorexics and bulimics are women; the prevalence of anorexia is consistently estimated to include 5-10% of all American girls and women.
- The consequence of such socialized devaluation and assured personal failure is a weakening of women's self-esteem, a decreased sense of personal power and efficacy and increased passivity, helplessness and hopelessness.[69]

There are also connections between the "beauty myth" and the addiction of women in this culture. Studies of young women smokers consistently report a desire to keep their weight down as a motivator for smoking and fear of gaining weight as the major fear associated with quitting.[70] Eighty percent of amphetamines prescribed in the United States go to women presumably as an aid to weight loss.[71] Eating disorders among addicted and recovering women are common. Perhaps an even broader issue is how the beauty myth affects the esteem of recovering women. Where self-esteem for adult men is based on achievement of money, power or status, self-esteem for women in this culture is heavily influenced by our visual images of beauty and

femininity.[72] Because self-esteem is such a critical issue within women's recovery, the related issue of self-image of one's body is an important one to integrate within the fabric of addiction treatment.

Women-based treatment programs are beginning to address these issues through such mediums as:

- Consciousness raising education that seeks to reverse the socialization that has taught women to be hypercritical of and reject their own bodies
- Assessment for and concurrent treatment of eating disorders
- Assessment, education and treatment strategies that focus on healthy nutrition, and
- Creation of new standards of beauty that in Wolf's words are "non-competitive, non-hierarchical and non-violent."[73]

The most sweeping intervention available to treatment programs is complete abandonment of the beauty myth by defining women's normal bodies as beautiful rather than ugly. Perhaps a day will come when the following Virginia Wolf dictum will be embraced by treatment centers and the women who occupy them: "One cannot think well, sleep well, love well if one has not dined well."[74]

### *The Metaphors of Time and Timing*

What addiction recovery frameworks for men and women share is a focus on living in the present--a recognition that the alternatives of dwelling on the past and the anticipatory fear and anxiety of the future pose risks to sobriety, sanity and life. The focus on today--working a 24 hour program of recovery--is proving itself a cornerstone of recovery for both men and women. There are, however, two differences related to temporal issues that can be noted in these recovery frameworks. One involves the preferred timing or sequence of recovery activities; the other involves the duration of support activities required for successful recovery.

There has been intense interest the past few years, stimulated most notably by the work of Stephanie Brown[75], in conceptualizing a developmental model of addiction recovery. Such a model would describe predictable stages in the recovery process and the developmental task and milestones that characterize each stage. Some conceptions of a developmental model have already been incorporated within the folk wisdom of addiction treatment and recovery circles. A major tenant of this folk wisdom has been that the defense structure of the newly recovering addict is much too fragile to address emotionally volatile family of origin issues. The alcoholic or addict

wishing to raise such issues has been told firmly and politely to not drink and keep going to meetings, that now was not the time to deal with such concerns, and that there was a place down the road where such issues would be addressed. There is at least one subpopulation of women for whom this folk wisdom has created problems and that is the significant portion of addicted women who were sexually abused in childhood. For many of these women, there is growing evidence that their adult substance abuse is part of a broader pattern of post traumatic stress disorder. In short, these women have developed patterns of excessive alcohol and drug consumption to self-medicate the emotional consequences of sexual violation. When this pattern of self-medication is removed via the crisis of entry into treatment, these clients begin to emotionally thaw with a resulting intensification of emotional experience. When they seek to discharge this intensity through disclosure of their victimization, they are often met with the above folk wisdom. Finding no vehicle for drug-free catharsis, many such clients respond with flight from treatment and a return to self-medication. It is quite clear that developmental models of recovery constructed on the emotional architecture of alcoholic men will need to be redesigned to fit the experience and needs of many recovering women. Within women's programs such redesign is already occurring by defining issues of sexual victimization as legitimate and necessary early stage recovery work. An important research agenda for the next decade is the construction of a developmental model (or, more likely, models) of recovery based on the experience of recovering women.

Another difference in temporal orientation in men's and women's recovery programs involves the proscribed and expected duration of support activities. The folklore of AA calls for continued life-long involvement in the rituals and activities of AA. The implicit message is that failure to continue one's involvement in meetings and other recovery rituals will result in deteriorating emotional health ("stinkin' thinkin'", "dry drunk") or resumption of the addictive career via relapse. Anything short of such continuing involvement is viewed as risky and stupid. In contrast to the AA forever dictate, WFS expects its members to participate for only as long as they need such group support. AA forever provides a conduit for continued male connectedness via dependency on the AA group; WFS provides a pathway for female individuation via movement out of WFS into other frameworks of personal growth and development. AA takes the alienated male and provides a healthy medium through which dependency needs can be met; WFS opens pathways for women into decreased dependency and increased individuation. Where AA frames disengagement as pathological, WFS speaks proudly of the women who have "moved onward and upward" after getting what they needed from the WFS program. "Forever" and "as long as you need" may represent different temporal metaphors for recovering men and women.

### *Recovery versus Discovery*

We have used certain words in this paper because such language is the medium of discourse within the field and yet much of this language inadequately reflects or misrepresents women's experience. The label used to describe the movement from addiction to sobriety and sanity—recovery--implies that one can get back what one has lost, a fact challenged by a woman client who in a discussion about the relationship between her drinking and her self-esteem, once retorted, "I didn't lose it; I never had it!" Recovery is the reacquisition of that which one had but lost. It is a *re*habilitation technology. It presupposes prior levels of achievement and functioning. What is this thing that has been lost? Power and control over one's life, self-respect, sanity, mutually respectful relationships, material possessions or social status achieved through one's own competence? However we define what has been lost, for many women, the phrase "I am discovering" may be a more apt depiction of their experience of movement into health than the traditional, "I am recovering." For many women, they are not getting it back; they are moving into the future experiencing it for the first time--moving forward into discovering and becoming rather than backward into recovering. Moving out of addiction for many women is more self-creation than self-retrieval, a fact clearly evident in WFS' self-description of itself as the "New Life Program." Kasl, in her remarkable book, *Many Roads, One Journey*, also makes the observation that "recover" connotes covering something up--hiding again that which has been hidden before. She recommends an expanded vocabulary that includes "un-covery"--a getting out from under addiction--and "dis-covery," meaning an opening up to growth and moving forward.[76]

### *The Helping Relationship: "Dominator Model" Versus "Partnership Model"*

This paper has described different metaphors and experiential axes through which men and women experience the transformation from active addiction to sustained recovery. Just as the experience of male alcoholics formed the basis of our understanding of alcoholism and recovery, it was male helpers in their relationships with male alcoholics that defined the structure and process of the addiction counseling relationship. In this section, we will explore a fundamentally different reconstruction of the helper-helpee relationship that is occurring in women's treatment programs.

Riane Eisler in her remarkable work *The Chalice and the Blade*[77] describes two basic models--the dominator model and the partnership model--for the structuring of human relationships throughout history. These models will be adapted here to describe two very different approaches to the structuring of treatment relationships with men and

women in chemical dependency treatment settings.

The dominator model of helping relationships is hierarchical, emphasizing the disparity in power between the helper and helpee. In this model, the client seeks and passively accepts the consultation of the dominator's special expertise. The dominator's advice is to be passively, appreciatively and obediently followed. The dominator model is arrogant in the extent to which it places knowledge and value on only one side of the helper-helpee relationship. The dominator model says, "Listen to me, be like me, I am the model of what you must become. Wellness is to think like me, feel like me, act like me, be me." The dominator sees the client as an object--a piece of clay to be molded in their own image. In the dominator model, the helper has ascribed power and his or her weaknesses are denied or hidden while client weaknesses are magnified.

The dominator model of structuring helper-client relationships in addiction treatment is based exclusively on experience with culturally empowered alcoholic men. In this model, the puffed up alcoholic ego is punctured by the skillful confrontations of the counselor. The alcoholic male's surrender to a higher power is thus played out symbolically in the counselor-client relationship. In the dominator model, recovery begins when the client gives up the power struggle with the counselor and abandons the defense structure that has supported his drinking.

In the partnership model, both the helper and the client are perceived as entering the relationship with strengths and weaknesses. Where the dominator model focuses on the identification of client pathology, partnership models focus on the identification of client strengths. Where the dominator model emphasizes the competence of the therapist; the partnership model emphasizes the competence of the client. Partnership models view the etiology of individual problems within an ecological perspective, noting the ability of oppressive social structures to distort individual development. Client behaviors that have become problems are viewed in the context of resilience and survival. In partnership models, control of treatment--its content and pace--remains with the client. The partnership model seeks to minimize the power differential in the helper-helpee relationship. Where the dominator model is information transmission, the partnership model is one of mutual discovery--the emergence of mutual knowledge and understanding that comes out of the relationship. Partnership models are models of *doing with* rather than doing to or doing for.

Many women's treatment programs, having become disillusioned with the utility of the male-based assumptions and approaches they had inherited, moved toward a

partnership model. Project SAFE, a treatment program for addicted mothers and their children that has treated more than 1,000 women in 14 Illinois communities, illustrates the emergence of this partnership concept. Since 1986, speakers at Project SAFE Annual Symposia have consistently intoned that:

> Project SAFE is not a model; it is a commitment! It is a commitment to assess the needs of these women and their children and let these needs define the scope and intensity of our service model. The service model at any site at any particular time flows out of this dialogue and partnership.[78]

Many women's program's evolved into the partnership model when the staff began to trust their own instincts more than the mainstream philosophies and technologies they had professionally inherited. Bonnie Brendel, Director of the Recovery Home within The Women's Treatment Center in Chicago wonderfully illustrates this transition through the following vignette.

> When the Recovery Home was opened in 1992, one of the early tasks completed was the development of a 75 page program manual that outlined basic information about the Recovery Home's philosophy, procedures and rules. Most of the content of this manual was borrowed from other residential programs whose designs were based primarily on experience of male staff worked with addicted men. As more and more women came through the Recovery Home staff became increasingly aware that the imposed structure was not working. When this awareness ripened, staff responded in the following manner. All residents of the Recovery Home were instructed to bring their program manuals to community meeting where along with all the staff, they tore up the program manuals. As of that moment, the Recovery Home's philosophy and procedures and rules grew out of a dialogue and partnership between staff and residents. This ritual affirmed that what occurred within this program was a process rather than something imposed within a hierarchical structure.[79]

This story reveals how one program's philosophy and procedures moved from something static to what Bonnie Brendel describes as a "living, breathing, dynamic process." With the ritual destruction of their original program manuals, the Recovery Center shifted from a dominator model to a partnership model of structuring relationships between the women providing and receiving services there. Such experiences tell us that the voices of the women seeking our assistance will guide us if we will listen carefully and let them become our teachers.

Stories like the above have been replicated many times within the partnership models of women's service organizations. Such organizations tend to be organized more horizontally than vertically, reflecting a more egalitarian view of staff/volunteer-client relationships. Addiction treatment programs organized by and for women tend to cultivate the personal over the "professional." They are less title-fixated. They have fewer obstacles between the helper and the client--secretaries, tape machines, desks, waiting lists. They are less procedure-obsessed. They see themselves more as a family or community than an agency. They are warm and welcoming. They recognize the existence of and utilize indigenous healers that exist within every oppressed community.

The different ways in which service relationships are structured in men's-based treatment and women's-based treatment reflect differences in the needs of addicted men and women and how such needs can best be met.

### *An Escape From Dualism*

Through intense gender-based socialization, men and women have been forced to suppress parts of their character while exaggerating other parts, all in the name of desirable traits of manhood and womanhood. Given any core trait that could be represented on a continuum, we have tended to push men and women to the poles of such characterological definition. Men have historically sacrificed their emotional life, their capacity for empathy and intimacy, and their roles inside the family. Women have sacrificed their self-interests, their rationality, and their roles outside the family. Both men and women become fictive personalities through this process, having parts of their essential character suppressed and other dimensions elicited to excess. That men and women adapt and go forward in the midst of such cultural assault on wholeness is a testament to the resilience of the human spirit. Survival under such circumstances comes at a high cost--parts of the self must be offered in sacrifice in exchange for physical and psychological safety.

Not all women and men respond the same to gender socialization. Not all women and men are clustered at the ends of these continua. There have always been men and women who escaped or defiantly transcended such socialization, but until recently such defiance came at a high personal and social cost. Such costs made escape from the influence of gender socialization an exception. Addicted men and women have been especially susceptible to these forces of enculturation. The erosion of self-esteem that accompanies substance abuse sparks exaggerated efforts to perform, to be o.k., to get it right in the eyes of one's non-addicted peers. Such efforts at over-compensation push men and women to the extreme ends of the continua of

experience upon which they must seek their daily destiny. Addiction escalates this desire to get it right at the same time drug-related impairment diminishes one's capacity for performance. Addicted men and women become caricatures of that which we idealize until the quest for this esteem is abandoned as hopeless in the later stages of addiction.

The human potential of both women and men have been shackled through unidimensional enculturation. Such potential may be discovered by accessing those specific dimensions of character that have been suppressed. The reason men and women's treatment needs to be different is that the parts of the self each must reclaim are fundamentally different. The goal of this reclamation is wholeness. It is not to turn men into women or women into men. It is to break the socially contrived, unidimensional character of each. It is to break down a system that defines by gender the limits of what one can think, feel, do and be. This reclaiming of lost parts of the self is not a peripheral growth activity but the very heart of the recovery process. Addicted men and women must struggle out of these cultural and psychological prisons toward balance and integration but must, we believe, travel different experiential journeys--journeys that will be guided by distinctly different metaphors.

In her evocative work, *A Room of One's Own*, Virginia Woolf wrote in 1929 of two sides of the self--feminine and masculine--and the inclination to suppress half of this whole:

> "It is fatal to be man or woman pure and simple; one must be woman-manly or man-womanly....Some marriage of opposites has to be consummated." [80]

The goal of women's treatment is not to destroy those dimensions of character that have been culturally defined and programmed as "feminine," in short, to ask addicted women to take on the characteristics of men in the name of recovery. The goal is to allow the cultivation of those dimensions of character which have been denied access to her. Alcoholic men and women must find balance by wandering out of the emotional and social territory that has been defined as gender appropriate. For addicted women and men who find themselves at the extreme poles of dimensions of character and experience, salvation lies in the middle, in the consummation of Virginia Woolf's "marriage of opposites."

The distinctions made in this paper between men's and women's recovery experiences are gender-related but not necessarily gender-exclusive. The fact that more women than men share a particular characteristic may be critical in our formulation of

treatment interventions but must also be based on the recognition that some women will not share this characteristic and some men will. Many of the dichotomies described here are becoming outdated today as cultural transformations affect how men and women see themselves and each other. But as long as power and value are differentially ascribed to men and women in this culture, each is likely to bring a different experiential foundation from which both addiction and recovery must be understood. As rigid patterns of gender-based enculturation weaken, the differences between men and women will dissipate, bringing closer feminine and masculine pathways of addiction and recovery. We welcome the day when changes in this culture make this paper a curious artifact of history. Until then, responsiveness to gender differences in the addiction treatment setting is essential. This responsiveness begins with the acts of listening and believing. It begins with the premise that models need to be defined and evolve out of the needs and experiences of women rather than have women's needs and experiences defined by such models. Such responsiveness must recognize, as this paper has sought to illustrate, differences in the language, ideas, metaphors, and stories around which men's and women's recovery from addiction can be inspired and sustained.

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