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'Making Whoopee'? : An exploration of understandings and responses around women's alcohol use

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**'MAKING WHOOPEE'? AN EXPLORATION OF
UNDERSTANDINGS AND RESPONSES AROUND
WOMEN'S ALCOHOL USE.**

by

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in partial fulfilment for the degree of

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‘Making Whoopee’? An exploration of understandings and responses around women’s alcohol use.

Patricia Staddon

ABSTRACT

In this thesis, I explore the different meanings women’s drinking may have for them, and the ways in which these may differ from those of the public, the medical profession, and alcohol treatment providers. I consider the sociological factors involved, such as marginalisation by medical diagnosis as a method of social control, involving particularly the disempowerment of women (Ettorre 1997).

I challenge conventional views of ‘alcoholism’ as a ‘relapsing condition’ (Szumlinski et al. 2008 p.24) and present an alternative, competing discourse. This recognises how women’s social dissonance may be both response and resistance to gendered constraints, drawing upon understandings of the roles of carnival and the grotesque, as ‘safety-valves’ which may either undermine or support established authority (Presdee 2000; Bakhtin 1984). Such a discourse sees it as unethical to impose majority behavioural expectations upon less powerful groups, such as the poor, the female and the lesbian, when no harm is being done to others by different approaches to, for example, alcohol use.

Finally I consider ways in which a better understanding and acceptance might be achieved as to the nature of ‘health’ and the importance of authenticity and acceptance. When I began this research, I still saw myself as ‘an alcoholic’, although I had long ago stopped using alcohol, and the thesis reflects my journey as a lesbian, a mother and finally as a sociologist, applying this perspective to my life experience and that of other women.

‘Making Whoopee’? An exploration of understandings and responses around women’s alcohol use.

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‘Making Whoopee’? An exploration of understandings and responses around women’s alcohol use.

Patricia Staddon

AUTHOR’S DECLARATION

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Graduate Committee.

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‘Making Whoopee’? An exploration of understandings and responses around women’s alcohol use.

Chapter 1: INTRODUCTION

Alcohol use may be seen as representing ‘morality or immorality and power and weakness’ (Morgan 1987, cited by Ettorre 1992 p.42).

Consequently, assumptions of immorality and worthlessness may be made by more powerful groups about its use by less powerful ones. On a personal level, such disapproval may be a serious obstacle to a recovery of self-worth. On a political level, it impedes a critical analysis of how and why people use alcohol, and how use which is seen as ‘improper’ is ‘treated’. It particularly affects the ‘treatment’ of marginalised groups such as women, Black/minority ethnic people and lesbian/gay/bisexual people. Such treatment, while presenting as an agency for ‘health’, is also an implicit mechanism for the social control of weaker groups by more powerful ones.

I have a personal interest in this issue. My own drinking began as a teenager, attempting revolution, going out drinking ‘with the lads’. This activity involved competitive social drinking and wild, sky-larking behaviour. But I was not a lad. At 20, I became a young mother, grimly completing my first degree and then suffering: ‘a sense of dissatisfaction...that women suffered in the middle of the twentieth century...Each suburban wife... was afraid to ask even of herself the

silent question: "is this all?" ' (Friedan 1976, cited by Coote and Campbell 1987 p.4-5).

I tried to be a 'good woman' (Hughes 2002 p.72, cited by Jackson and Tinkler 2007 p.263), caring for a husband and, before long, two daughters. However, I could not abandon alcohol, which gave me glimpses of some amazingly beautiful reality which I could not bear to live without: '...alcohol can be perceived, like food, as an essential substance in our lives...linked with either body hunger...or heart hunger...and that women experience both hungers in relationship to alcohol' (Ettorre 1997 p.43).

In the end, what I had to live without was my family. I found it impossible to manage my life without alcohol, and finally they asked me to leave. I drifted round the country for several years, unable to sustain my heterosexual or my lesbian relationships, and constantly in and out of hospital with accidental injuries.

Recovery from alcohol dependence began when, while living in a derelict basement, I was befriended by two women who took me and my guinea pig to live in their flat, disregarded my drinking, and took me around with them to pubs and discussion groups, to meet other lesbians. I felt accepted, just as I was (Aaronson 2006 p.810). This has been called 'unconditional positive regard' (Rogers 1975, cited by Nelson-Jones 1982 p.211). I still drank more than most people, and

got drunk more often, but no one seemed bothered. Some of these women liked to drink and some drank little or nothing, but being drunk was not shameful, and did not destroy perceptions of worth. In the end, I stopped drinking altogether, in November 1988. I was 44.

I went as a patient to an NHS day treatment centre in January 1989 because a GP told me I would certainly drink again if I did not. It provided group counselling and some activities, but we were also expected to accept that we were life-long 'alcoholics', to follow the Alcoholics Anonymous (AA) 12 Step programme¹ for recovery, and to attend its meetings. I had found these demoralising in the past, so concealed my non-attendance, in order to remain at the centre for the counselling and art-work, which I found therapeutic.

The widespread influence of AA on how alcohol misuse is understood dominates 'addiction' discourse, affecting popular understanding, research funding, policy and treatment. Its theory and practice support a system which denies the influence of social factors, including gender, abuse and inequality, and is resistant to change. Its data are patchy, unreliable and subject to misrepresentation (Hammersley and Reid 2002, Walters 2002, Ragge 1998, Bufe, 1997, Peele 1995). It is 'systematically organised around the processes of sacrifice, investment, renunciation, communion, mortification and transcendence' (Donovan 1993 cited by Plant 1997 p.190). The fact that its views still

¹ The 12 Step Programme is to be found in Appendix 1

inform considerable numbers of academic publications, and many areas of public policy, makes this a fascinating area of sociological research.

While the importance of self-help groups is well established (Wells and Wright 2003), their suitability is greatest for middle class, heterosexual family units, since they perpetuate the status quo (Eber 2000 p.9). Poor women, lesbian women and old women often feel powerless to start with, and the AA programme was designed for relatively powerful groups (male, heterosexual and professional) who did perhaps need to 'surrender' their belief that they could fix all their problems unaided. Marginalized women (Swallow 1983) find traditional AA programmes to be less effective than those designed specifically for women: 'Many participants were uncomfortable with AA's tendency to individualize problems, clothe recovery in the language of Christian spirituality, and encourage "surrender" and "powerlessness" ' (Hall 1994 p.572). I avoid the use of the nouns 'alcoholic' or 'alcoholism' wherever possible, since they define individuals by a medical condition, supposedly involving particular sets of characteristics and behaviours. 'Alcoholics' are forever 'in recovery'. This understanding has often been disputed (Hall et al. 2001, Ragge 1998, Cameron 1995, Prochaska et al., 1994, Peele 1984).

Alcohol treatment frequently presents women with ideals such as those of 'la Sufrida': '...the long-suffering, self-effacing, ever-present, self-

sacrificing mother-image...'(Segura and Torre 1999 p.156). Women may be told they are 'hopeless cases', and/or 'neglecting their families', and/or are 'unfeminine' (Ettorre 1997 p.118). These are attempts to re-orientate women into behaviour approved by a masculinist social structure (Campbell 2000). They reveal underlying moral panic (Cohen 2002), fear of diversity (Branfield and Beresford et al. 2006), and a disregard both for the role of the emotions (James and Gabe 2000), and for the effects of domestic violence on health (Williamson 2000). Such an approach seems unlikely to illuminate the use of intoxication or to lead to appropriate ways of helping those who seek treatment for it. I consider these issues further in Chapter 4 and elsewhere (Staddon 2005).

Recollections of my own alcohol treatment made me want to apply a sociological perspective to this situation, perhaps making my painful experiences meaningful. My very existence, as a woman who was dependent on alcohol for nearly three decades, and has been 'recovered' for a further two decades, asserts the impermanence of the 'alcoholic condition', placing that condition within a social framework rather than a medical one:

...the focus, in the alcohol field, on psychological and physical addiction as well as moral failure has been limited to a search for causes within individuals, with 'individuals' viewed primarily as men or male alcoholics. Alcoholics and alcoholism have been studied mainly from the perspective of treaters and experts....(Ettorre 1997 p.20)

It was only gradually that I came to realise the extent to which my own history would influence what I found, how I understood it, how it would affect me, and how I would be able to interpret it (Letherby 2003).

I swiftly lost any residual shame about my own 'alcoholism'. I was still, and always will be, grieved at the distress caused to my family, but I did come to see women's alcohol 'abuse' as a completely logical response to social structures which are disabling and unjust (Ettorre 2007, Raine 2001, Hendry 1997, Jacobson 1988, Smart 1976) and perhaps a taking back of power (Mendoza 2003). One way that I signalled this to myself and to the world was to stop calling myself 'an alcoholic' and to call myself (when asked, as opposed to offering it as a self-definition) an ex-alcoholic, or as someone who used to be addicted to alcohol. I also discarded the word 'abuse' in this context, since it seemed inaccurate; the alcohol might have been 'misused', but it had certainly not been harmed.

I set out to challenge this situation by developing my own 'service user research', applying a feminist sociological perspective to women's alcohol use and society's responses to it. Long before beginning this thesis, I had been interested in feminist methodologies (Letherby 2002, Reinharz 1992), gender (De Beauvoir 1997, Dinnerstein 1987), sexuality (Foucault 1987, Weeks 1985) and dis-ablement (Oliver 1998, Beresford and Campbell 1994). Ironically, I had not applied sociological

perspectives to my own past 'alcoholism'. When the local NHS Trust gave me the opportunity to research women's alcohol use and its treatment, as an ex-service user², it was challenging. It required the inclusion and acknowledgement of an auto/biographical strand, despite the fear lest subjectivity 'discredit the work in some quarters' (Rose 1983 cited by Scott 1998 para.4.6).

Adopting an auto/biographical approach and calling myself a 'recovered alcoholic' may engender personal as well as academic criticism. This definition is unacceptable and deeply offensive to established views on 'alcoholism': 'This is a problem that "traditional" researchers don't face because they reveal less about themselves, and respondents don't face because they're protected by anonymity.' (Cotterill and Letherby 1993 p.76).

Alcohol use has been studied in various disciplines, and in Chapter 2, I describe how differently it is viewed in the fields of medicine, anthropology and sociology. A medical perspective would view the consumption of alcohol which exceeded currently acceptable 'safe limits' as an illness, or even a disease. Anthropological interest would focus on what functions were served by different alcohol use in different groups. Sociologically, alcohol use might be seen as a way of distancing oneself from a situation, or of feeling more at home in it; as protest or as celebration. Chapter 3 outlines my methodology. I explain

² 'Service user research' implies it was done by people who are, or have been, users of mental health and/or substance use services. The degree of involvement varies.

how I constructed a complex network of perspectives, including the auto/biographical, and involving a Research Advisory Group of other 'ex-alcoholic' women. I also conducted in-depth interviews and focus groups with 23 other women with alcohol issues, 10 GPs and 11 treatment providers. This enabled women's experience to stand alongside that of the medical establishment, and subsequently for each perspective to inform the analysis of the research. I consider the ways in which emotional involvement and power were factors, both for my respondents and for me.

The empirical research itself is described in Chapters 4, 5 and 6, where the experiences of women, GPs and treatment professionals are placed in a social context. I look at the contradictions whereby a social lubricant such as alcohol is fiscally encouraged and promoted, while a repressive treatment approach towards 'women who drink' is frequently legitimised. I consider the extent to which people may take or lose power over their own lives and those of others, and look particularly at the way that alcohol use, whatever its extent, may be empowering, as well as a possible threat to social order and to physical health.

Finally, in Chapter 7, I suggest further research to develop alternative ways of seeing the alcohol use of disadvantaged groups, avoiding a disablist approach (Oliver 1998, Beresford and Campbell 1994), and employing social models. I include some reflections on the way that the research process affected me personally.

Chapter 2: A REVIEW OF THE LITERATURE

Introduction

This chapter considers three ways of looking at alcohol use, from a medical perspective, an anthropological perspective, and a sociological perspective. As I explained in Chapter 1, I began my research from the perspective of a 'service user' (Beresford 2005), i.e. someone who has suffered, or is suffering, from a permanent condition which may need ongoing treatment. I came to view myself more as a 'survivor' (Wells and Wright 2003), but initially I accepted the medical view of my past alcohol problems, as an illness or a disease. However, when I began concentrating on medical perspectives of women's alcohol use, I found that 'addictology', in particular, described a reality which was far from my own experience. This perspective saw 'addiction' as a biological entity, muddling 'social discourse, moral dilemmas, psychological states and pharmacology...' (Hammersley and Reid 2002 p.8). Alcohol use was seen as the cause of social problems, rather than developing as a result of them. In 2.1, 'Medical and moral approaches to alcohol issues', I give an account of some of the literature which supports these beliefs.

There are differences between current Western understandings of how alcohol should be used, and the understandings of some other cultures and societies (Bowie 2000, Heath 1987, MacAndrew and Edgerton

1965). I describe literature offering such different perspectives in section 2.2, 'Cultural understandings of alcohol use.'

Finally, in 2.3, 'Sociological approaches to women's alcohol use', I examine the ways that women's alcohol use in particular has been perceived (Plant 1997, Gusfield 1996). I consider the ways that a process of labelling may be used (Becker 1963, Becker 1991) which emphasises deviance (Merton 1968), facilitating the use of stigma and attempting social control (Goffman 1990). I show how such processes may instead result in alienation (Ettorre 2007, Staddon 2005) and social dissonance (Wearing et al. 1994). I mention the anomalies present in the way in which substances are prohibited and allowed (Kushlick 2007) and in the disapproval and penalties incurred and by whom (Mandelbaum 1965). Most of these sanctions fall more heavily on women (Waterson 2000, Ettorre 1997, Ettorre 1992).

Anthropology, sociology and women's studies are all areas of knowledge which have contributed to an understanding of alcohol use. The weaving together of information from these disciplines is both controversial and challenging, as this chapter shows.

2.1 Medical and moral approaches to alcohol issues

The current classification of substances has been demonstrated to be illogical, with: 'Alcohol, ketamine, tobacco, and solvents (all unclassified at the time of assessment) ... ranked as more harmful than

LSD, ecstasy, and its variant 4-MTA (all class A drugs)' (Nutt et al. 2007 p.1050). In this respect, the scientific paradigm, which perceives knowledge as value-free, is seen to have failed effectively to have informed government policy, since it did not take into account emotional reactions, as well as social and economic factors, which affect how and why people react to substance use. This situation illustrates the muddled state of thinking and lack of coherent policy affecting substance use in general and alcohol use in particular.

Despite the lack of evidence that alcohol problems constitute a physiological, medically treatable disease, and despite increasing information that their causes are complex and at least partly social, there is still a kind of mystic belief in medical treatment among many addictologists. It has been suggested that our understanding of alcohol issues is undergoing a kind of Kuhnian paradigm shift (Kuhn 1970). The anomalies of such statements as, for example, '12 Step Treatment Works!' may be disregarded and minimally challenged for many years, before a general shift in opinion is effected, due in part to the considerable investment of scholars and business people alike (Bride and Nackerud 2002).

Some have defended the use of the term 'disease', perhaps cynically. For example, funding is more likely to be obtained for neurological research into 'disease' than into 'abuse' (Midanik 2008). Such research has located specific areas of the brain which are more likely to respond

to alcohol in some people than in others; these are supposedly the people who could become 'alcoholics'. This supports a view of alcohol problems as a disease, which it is inappropriate to term 'abuse'. It is not the patient's fault:

The change in societal images has been slow and gradual. Alcohol and drug addictions were perceived as social blights, rather than diseases ...it is now admitted that the brain of an addicted patient no longer functions like a normal brain: it has lost the freedom to decide when confronted with the object of its addiction...(Reynaud 2007 p.1513).

Other researchers support the theory of 'loss of freedom to choose', describing the way that addiction can 'hijack' the brain (McDowell and Spitz 1999 p.14). However, they agree that such effects will have been affected by a combination of genetics and environment, with people tending to decrease consumption as they get older. They also confirm that there is no such thing as an 'alcoholic personality' (McDowell and Spitz 1999 p.30).

These findings co-exist with continuing and vigorous discussion, as to whether a condition which was traditionally seen as a sign of immorality or insanity (Plant 1997) could be seen, as many doctors, and many members of the Alcoholics Anonymous (AA) movement have claimed, as a disease. Jellinek's *The Disease Concept of Alcoholism* (1960) is the classic text, seeing abstinence as the only solution for 'alcoholics', even while relapse is considered inevitable.

Medicine itself, while theoretically committed to the highest standards of evidence-based diagnosis and treatment, suffers from being saturated with lay approaches and moral values (Bauer 1982). Many doctors still speak of drinking a lot of alcohol as an 'abuse', even if they also see it as a 'disease'. Some responsibility may lie with the early association of AA and the Temperance Movement, whereby 'temperance' was a moral virtue:

Although...the word itself was carefully avoided, the concept embracing the root virtue that proclaims and seeks to inculcate is *temperance*... 'emotional sobriety' and 'serenity'. What these and their other synonyms suggested and prescribed was, however, in more classic terms, 'temperance' (Kurtz 1991 p.228, original emphasis).

The disease concept is commercially advantageous, since breweries and the government profit from an understanding that although a few 'diseased' people are unable to control their drinking, most people have nothing to worry about (Plant and Plant 2006). Some see the naming of a failure of the will as an illness as scientifically invalid: 'unlike a mental illness such as schizophrenia, which is indicated by disordered thinking and feelings, addictive disorders are known by the behaviours they describe' (Peele 1995 p.6).

In any case, not all academics have been convinced by the disease concept:

...all versions...propose that alcohol misuse is a chronic disorder, progressive in nature, which if not arrested will inevitably lead to death. Research...by contrast indicate[s] that alcohol abuse can be... situational, variable and subject to moderation...(Walters 2002 p. 55).

The simplest reason the myth [of AA and NA] is believed is because it provides a clear, if impractical, answer to drugs problems. If drugs cause addiction with minimal contribution from the person, or the setting, then the only moral approach to reducing supply is eradication, the only moral approach to treatment is abstinence and the only moral approach to prevention is to insist that drug use should never be initiated (Hammersley and Reid. 2002 p.12).

The medical profession appears to have felt able to support both the disease concept, and AA, which was started by an American doctor, from early on. There is disagreement as to whether AA philosophy and the disease concept are effectively one and the same, but both involve an antithetical belief in a life-long character flaw (Kurtz 2003) which is nevertheless a 'disease' (Fromberg 1994).

Relatively sophisticated versions of the 12 Step treatment method have been developed, but AA itself remains essentially unchanged. As Leighton admits, it is difficult to allow the diverse methods which recovery from addiction clearly requires to be integrated into a single model, and even harder to stop AA members saying whatever they wish (Leighton 2007 p.436). This would appear to make it futile to

suggest that there is hope of the traditional beliefs of the 12 Step system being updated within that system. Individual groups do, on a day to day basis, consistently oppose change in their system. New ideas need to develop outside the organisation (Walters 2002).

Other experts puzzle over the fact that to date: 'treatments fail to cure most addicts...[A]lthough rehabilitative treatments, such as the 12-step programs, help many people grapple with their addictions, participants still relapse at a high rate' (Nestler and Malenka 2004). Vaillant (1995 p.389) suggests that the answer is 'a redoubling of effort'.

Some doubt the long-term effectiveness of intensive approaches. Cameron led one of the first community based alcohol treatment programmes in the UK and found that: 'High-cost intensive treatment programmes did not seem to produce better results than minimal interventions' (Cameron 1995 p.45). 'Harm reduction' has been the aim of many treatment programmes for illegal drugs, and to a lesser extent of some alcohol programmes. The term is so vague as to be applicable to almost any approach (Heather 2006) but its aim is to reduce the risks of the behaviour rather than attempt to prevent the behaviour itself. It may involve the use of legal, substitute drugs, such as methadone. There remains much disagreement about this approach, and about the evidence that some people who have been addicted to alcohol can learn to drink in a non-alcoholic way (Heather and Robertson 1992). This research was partly inspired by the works of

Davies (1962) and Edwards et al. (1977). Such work on 'controlled drinking' has been commended by Orford (2001) and Peele (1984), opening up important debates about much current treatment.

Ritson (2005) describes the variety of alcohol treatment resources available, reflecting different philosophies of approach. He particularly notes Brief Interventions and Motivational Interviewing, whereby more individually based, non-confrontational methods are used. Similarly, Raistrick advocates a psycho-social model, combining: 'behavioural self-control training, motivational enhancement therapy, marital or family therapy and coping or social skills training' (Raistrick 2005 p.1212).

These approaches are largely community-based, and are both much cheaper and less socially disruptive than residential rehabilitation centres, especially for women with children. As regards effectiveness, the United Kingdom Alcohol Treatment Trials (UKATT 2005) confirm the findings of Project Match (1997) that whatever type of treatment is employed, people's addiction tends to decrease when they are provided with some form of attention. There is also evidence that continuing contact with support of some description---family, friends, counselling, AA---is of assistance in people maintaining control over their drinking (Raistrick et al. 2006). No one treatment method has been shown to be more successful than any other, although some treatment programmes and their supporters have claimed differently.

Research shows that an approach's success depends on its being suitable for the right person, at the right time. These findings have been replicated when the drug being researched was nicotine. The importance of a large toolkit of available help, including a phone-line, written materials, strategies, and ongoing counselling, has been stressed (Coleman 2004 p.397). It is also known that most people who develop addictions recover without being treated (Hall et al. 2001, Ragge 1998, Peele 1989) and there is recent confirmation that:

Self-healing or spontaneous recovery from problem drinking is extremely common – up to three-quarters of those who have had a drinking problem take this route and, of these, up to two-thirds achieve moderation (Raistrick et al. 2006 p.173, referring to Klingemann 2001).

These writers have confirmed the efficacy and likelihood of self-change, as a result of maturity, and the isolation and other costs of 'alcoholism'. Such a development has been demonstrated elsewhere, for example in young people's growing out of criminal behaviour (Rutherford 1992).

For most of the history of medical treatment for alcohol problems, gender was not seen as a relevant factor in either causes or treatment (Raine 2001, Waterson 2000, Ettorre 1997). This omission may have been partially due to women's having been reluctant to admit that they had a problem, for fear of disgrace. One of the earliest texts about

women's drinking is the collection of essays *Alcohol Problems in Women* (Wilsnack and Beckman 1984) where attention is drawn to such gendered variations as women's iconic role (Fillmore 1984) and the difficulties experienced (though not always acknowledged) by early researchers in the field, in finding enough women who drank enough to be included in their configurations. The history of women's alcohol use is well documented by Plant (1997), showing important differences in the way that women use and have used alcohol, the different consequences for them physically and psychologically, the different construction put upon that use by the rest of society, and their different experiences in treatment and in AA. Plant's book is of relevance also to the sociology of alcohol use.

There has been much written about the possible impairment of a woman's role in reproduction by her alcohol use. Literature which describes the impact of alcohol on the foetus has a much longer history than literature which examines the effect on the woman herself:

The term 'Fetal Alcohol Syndrome' was first used in 1973...In a paper published in 1981, the United States Surgeon General issued the following statement: 'Even if she does not bear a child with full FAS, a woman who drinks heavily is more likely to bear a child with one or more of the birth defects included in the syndrome...(United States Surgeon General 1981, p.1)'(Plant 1987 p.161).

The debate tends to move between whether a moderate amount of alcohol in pregnancy promotes good health or whether alcohol should

be avoided altogether, at least in early pregnancy (Pirie et al. 2000). Similar concerns have been expressed around smoking. Recently there has been acknowledgement of the beneficial function of smoking, as stress relief for young mothers, despite damage to their physical well-being and that of any children (McDermott 2006). In both cases, the needs of the child are automatically perceived as paramount. Alcohol use has also been reported as causing breast cancer (Fish 2006), a further threat to a woman's sexuality, and perhaps to the extent to which doctors take her other health problems seriously.

Single sex facilities might benefit many areas of medicine but are particularly likely to do so in respect of alcohol problems (Thom 1986). Here the lay knowledge of the general public is likely to affect the understanding and response of the medical professional (Reilly 2007, Campbell et al. 2007, Roberts 1985), over-riding or bypassing clinical training. There is a slightly unsavoury aroma to the 'illness', 'disease' or 'condition', particularly where it affects women. Women who drink in a way which is seen negatively, putting 'their femininity and female roles in society at risk... "Nice girls don't drink too much"... women who do drink too much are saying a big "no" to society. They do that unacceptable thing: lose control' (Ettorre 1997 p.15).

There is now ample literature offering evidence that, if in treatment, women benefit most from work with someone of the same sex. They are less likely to benefit from the mixed sex group approach usually

employed by the many treatment centres employing AA's sister programme, the Minnesota Model (Women's Resource Centre 2007, Niv and Hser 2007, Barron 2005, Angove and Fothergill 2003, Ettorre 1997, Thom 1997, Plant 1997). Reasons given for a preference for single sex work include the feeling of greater safety to disclose intimate information, an absence of a need to facilitate the emotional disclosures of male patients, safety from sexual harassment, better understanding of the dangers of domestic violence, and more likelihood of a shared understanding of the highs and the lows of alcohol use.

If minimal attention was until recently given to women's particular issues, attention to different causes and treatments for lesbian and bisexual women's alcohol problems has been even slower to appear outside the pathologising of sexual identity described by Hall (1993):

Medical writings in the first three quarters of this century were frequently disparaging of lesbians (Stevens and Hall 1991)...Drinking was thought to cause covert homosexual tendencies to appear overtly (Hall 1993 p. 111).

Hall further affirms that cultural interpretations affect the understanding of alcohol issues so that:

...medicalization of addictive problems, beliefs about alcohol use are still framed in moralistic terms...concepts like codependency have special implications for a stigmatized subculture in which family structure and social support differs

greatly from that in mainstream society... (Hall 1993 pp.109-110).

There is continuing disagreement as to whether lesbian and bisexual women have more problems with alcohol than heterosexual women (Fish 2006, Hunt and Fish 2008). There is some evidence that lesbian and bisexual women believe themselves to be more aware of their health in general, which might be expected to make them more likely to address their alcohol issues than heterosexual women. In practice, academic evidence for these beliefs is a little scarce:

What does seem to be the case is that the lesbian who needs treatment for a mental health and/or substance use problem is less likely than a heterosexual woman to have a positive experience: 'Substance use counsellors have negative or ambivalent attitudes towards LGBT clients, in particular towards transgendered people, and lacked knowledge of their needs.' (Eliason 2000 quoted in Fish 2006 p.45).

Doctors and treatment specialists have been prone to looking at the sexual deviance as the root of the problem (King et al. 2004). The challenge to this way of looking at mental health issues, based on a heteronormative construction of health, is still inadequately addressed in the literature about substance use (Ettorre 2005, Staddon 2005).

2.2 Cultural understandings of alcohol use

While addictology has focused on the increasingly deviant drinking of someone who has developed 'an alcohol problem' (Barrows and Room 1991, Bacon 1958), anthropology has focused traditionally on the meaning of 'drinking', and how it illustrates other aspects of the society in which it occurs (Winlow 2007). Bacon (1958) identified the importance of the meaning of 'drinking', and of placing both 'normal' and 'abnormal' drinking in a social and anthropological context, rather than a medical one. Addictologists have focused on his research in their view of 'alcohol as problem', but what is most interesting is his demonstration that the particular social function of drinking alcohol will vary from culture to culture. In some societies, it may include drunkenness; other societies may see this as bad etiquette. However, its use is always understood locally in very precise ways, deviance from which causes discomfort, and finally alienation from the majority. Once this occurs, the person concerned is no longer 'drinking' in the sense whereby the word implies the social reciprocity and interaction specific to that culture.

There is a considerable area of agreement among anthropologists that the effects of using alcohol may be governed largely by expectation, and that these expectations, being based on local mores, are culturally determined: 'the capacities officially attributed to a substance stem, in priority, from moral and political preoccupations' (McDonald 1997 p.7). Such cultural effects include disinhibition (Mandelbaum 1965). The

cultural origin of disinhibition following substance use was also noted by Becker (1969), in respect of marijuana. Not only the substance was required but also a recognition by the user of what symptoms to expect, in order to experience them. More recent research, using placebo trials, has confirmed that the effects of alcohol on a variety of social, affective, cognitive, and motor behaviours are heavily influenced by expectation (Testa et al. 2006). Alcohol, as Mandelbaum (1965 p.281) said, is a 'cultural artefact', expectations of which tell us about the society within which its use occurs. It may be seen as holy and blessed or dangerous and damaging, and:

Cultural expectations regulate the emotional consequences of drink...demonstrations of affection...hostility...pleasant physical sensation...devoid of guilt or ambivalence. Conversely [it can be] accompanied by a flow of guilt feeling (Mandelbaum 1965 p.282).

Mandelbaum's worldwide examples, of the different cultural rules around alcohol use, include drunkenness, which can be seen as a social activity just as much as more moderate use. Like Bacon (1958), he distinguishes clearly between alcohol problems (which he perceives as drinking which is abnormal in the context of the culture in which it occurs) and drunkenness: 'which can be quite normal culturally, and should not be confused with the standard drinking practices of any society' (Mandelbaum 1965 p.287). This is particularly interesting when considering current preoccupation with young women's binge drinking

and how it is viewed by different social groups (Van Wersch and Walker 2009).

Frequent and heavy drinking does not appear necessarily to lead to problem addiction, even when drunkenness is 'explicitly sought' (Mandelbaum 1965 p.285). He cites Heath (1958) who suggests that one reason for some groups, such as the Camba of South America, choosing to enjoy bouts of 'gross inebriation' is that their life involves a good deal of moving around, and little ongoing friendship: 'all people in the world value association with others and the Camba choose to get such association in drinking parties rather than in other ways' (Heath 1965, cited by Mandelbaum 1965 p.285).

Mandelbaum considers it very likely that, like other similar social groups of the Andean foothills, the Camba may be shy and reserved, wary of strangers, and generally distrustful of others:

Normal Camba drunkenness thus seems to arise from a fear of one's fellows and a desire not to interact much with them even in their presence. This is quite different from the attitudes of Jews or Italians, whose childhood training teaches them to need social interchange and to fear social isolation. Among these people, convivial drinking is condoned, but isolated and isolating drinking is strongly disapproved (Mandelbaum 1965 p.286).

These reports also have interesting implications for alcohol use in fragmented societies and among different social groups, such as young professional women enjoying leisure.

All the societies described by Mandelbaum are patriarchal, with most stringent laws around women's drinking, and he states that it is unknown for women to be expected to drink more than men, or for the upholders of priesthood or politics to be expected to drink more than others. This observation is not supported by the work of feminist historians and anthropologists such as Eber (1995), Harvey (1997) and McDonald (1997) which I mentioned earlier. However, there are certainly precise and differing rules for particular groups in all societies (Goffman 1990).

MacAndrew and Edgerton(1969), writing soon after Mandelbaum (1965), confirm and discuss the way that behaviour is not dependent on the amount of alcohol consumed so much as on the expectations of the consumer, whether it is limited disinhibition or a way of taking 'time out'. Marshall (1983) and Room (2001) have confirmed these conclusions, adding examples of the use of feigned, ostentatious drunkenness, in order to excuse conduct not normally seen as acceptable. Room (2001) notes the variability of this understanding cross-culturally and ponders the extent to which bad behaviour can and should be attributable to being in a special state. He does confirm the great importance of the anthropological perspective to understanding

alcohol use, and challenging 'a crude pharmacological interpretation of drunken comportment' (Room 1981 p.190). Levine has observed that bad behaviour was only attributed to drunkenness in the 19th century and was not necessarily a permanent feature of the activity (Levine 1983, cited by Room 2001 p.190).

Room's interest does shift from an interest in different ways of behaving and their rationales, to a consideration of how these behaviours may be improved (Room 2006). This is a tendency within the alcohol studies field which has been noted by a number of anthropologists, including Heath (1987) and Gusfield (1996). That is to say, it is easy to move, in alcohol research, to seeing its use as a 'social problem' rather than 'an area in which to explore aspects of...life and processes of political and legal change, which are concerns of sociologists...' (Gusfield 1996 pp.5-6).

Hunt and Barker (2001) have recently addressed the way that the public health model has become the dominant way of looking at alcohol issues, following more in the traditions of the Temperance Movement in that it concerns itself principally with the consequences of young people's binge drinking, drunken violence, etc. They consider accusations of the anthropologists' enacting 'problem deflation', but their main anxiety is that the powerful public health model: 'will continue to dominate and subvert anthropology's unique ability to

describe and analyze the place of ingested substances in social life' (Hunt and Barker 2001p.184).

They see anthropology's role as assisting society to reconceptualise and thus understand the nature and role of 'drug' use, rather than seeing it as a 'public health' issue. Hope has been expressed by Marshall et al. (2001) that a more multi-disciplinary approach between alcohol and drugs studies, medical anthropology, and public policy may lead to an increased awareness of the diversity and complexity of alcohol use, although he notes the problems of having such research funded.

Most recent anthropological literature concerns drug addicts, such as Bourgois' account of social marginalisation in the drug culture of Harlem (2003), and there has been less interest in the culture of 'alcoholics', with Spradley's description of 'down and out' males being a notable exception (Spradley 1970). However, it is at this point that it becomes difficult to decide where lie the boundaries between anthropology, ethnology and sociology, and I mention both Bourgois' and Spradley's work in the context of sociology in section 2.3.

An anthropological perspective may be applied to the ways in which women's alcohol use is seen differently from men's. McDonald (1997 p.20) describes how women are 'overwhelmingly' more likely to be prescribed tranquillizers than men because these drugs have enabled

them to continue to support the rest of society, often at the expense of the activities they would have preferred to pursue. She points out that drugs such as benzodiazepines and Prozac are seen as culturally acceptable for women (McDonald 1997 p.20) since they are medically prescribed, are not seen as recreational, and do not 'count' socially as 'drugs'. They have even been referred to as 'mother's little helper' (song by Marianne Faithfull). Alcohol use, however, is perceived as recreation, to the liberal use of which which women may be seen, or may see themselves, to have less right than men (Strang 2001).

McDonald (1997) has also drawn attention to the different position of female drinkers in non-patriarchal cultures. Feminist historians such as Stone have pointed to earlier cultures, mentioned in the Old Testament and the Koran, where social structures appear to have been devised by women who were seen as wise and who were often deified---these societies were not viewed with approval by Hebrews, Christians or Muslims, and were wiped out as thoroughly as possible (Stone 1976). Archaeological finds all over the world have testified to the existence of these remnants of matriarchal society (Gimbutas 1982).

Whether or not they were great alcohol users, their ways of using alcohol will have been different from those of male-centred cultures. There is firm evidence that drugs, including alcohol, were used by priestesses to assist in reaching a high state of psychic awareness (Eber 1995, Shuttle and Redgrove 1978) and by many women to abort

the inter-uterine lining as a way of controlling reproduction (Shuttle and Redgrove 1978). Substances were also used as part of rituals for 'inducing special states' in ceremonies to celebrate physical and transitional states, such as that between puberty and womanhood (Goodison p.164). They also had a function as the enabler of poetic creation (Hall 1980).

In parts of Peru, and some other societies which remain agrarian, women may drink to intoxication, together with men, at the festivals, which is believed to encourage collaboration with the spirits and to improve the prospects of harvest. The process is viewed as sacred, with the drunken person often seen as acting as a conduit for supernatural powers (Harvey 1997 p.213). In this instance, the gender of the drunken person is not mentioned as being of importance.

Harvey describes how the Spanish conquerors of the 14th century brought Catholicism and a mistrust of the traditional belief in the link between drunkenness and the sacred. Such a link had previously been seen as central to life: 'In keeping with European ideas about the nature of pagan belief and the influence of the Devil, drunken behaviour was also thought to be indicative of moral inferiority, particularly laziness and sexual promiscuity (see Saignes 1989)' (Harvey 1997 p.212).

However, much of the population retained a belief in the connection of drunkenness and the spiritual, whether they drank or not. The disapproval of the Protestant Evangelist churches, reported by Harvey as a recent phenomenon, endorses the Northern European focus on drunkenness as problem, as mentioned above (Harvey 1997 p.213). She emphasises the range of drinking practices which exist side by side among the Andean people. There is also the opportunity drunkenness offers to women and men to behave in differently gendered ways; to experiment with different roles without fear of giving offence and to eschew behaviours which in their everyday lives are seen as their responsibility:

When drunk...people frequently refuse to abide by the limits of these sometimes contradictory ideas of masculinity and femininity...drunken men often adopt a gendered identity that pushes beyond the limits of their own, normally accepted, cultural biology....Women...fight and joke better when they are drunk...they do adopt attitudes beyond the limits of normative social relations. They stop looking after the household...[they] talk openly when drunk about the limitations and hardships of their lives...challenging the values on which their daily lives are based...(Harvey 1997 p.223).

Later in this chapter I refer to the role of substances in assisting with the spirit of carnival, and its function as an opportunity to express dissent and grotesquerie within a designated social space.

The contradictions in Andean society between indigenous values and those of the conquering Europeans are particularly well illustrated by the roles of women:

[D]runkenness in women is thought to be particularly indicative of an indigenous identity, an image associated with indigenous dependence on the supernatural powers of the landscape... The greater the cultural orientation towards the city, the less a woman is likely to drink and thus the richer, more powerful women in the village are very rarely drunk in public... Richer women are thus used, and indeed use themselves, to create concrete images of class distinction within the village (Harvey 1997 p.220).

Eber (2000) has also illustrated the complex relationship of women with alcohol in rural Mexico, where the local people tend to see themselves as one of three groups. Traditionalists 'maintain an intimate relationship with Maya deities and Catholic saints, which they have worshipped side by side in their communities since the Spanish invasion' (Eber 2000 p.11). Alcohol is seen as central to that tradition, giving happiness to the people and pleasure to the gods, even while they recognise that it can bring problems. These problems will be addressed through prayer and dreams. Those who are not Traditionalists may be Protestants who 'promote abstinence and private capital accumulation, and reject shamanistic cures...' (Eber 2000 p.11).

This group is likely to see drinking as sinful. Alternatively, local people belong exclusively to neither culture, respecting traditional fiestas and

drunkenness (although they will not necessarily drink themselves) but committing themselves to Bible Study groups and moderation. There is a strong desire to hold on to cultural traditions, while attempting to avoid the pitfalls of problematic drinking, and the women appear to be most active in analysing and attempting to focus on the dichotomy (Eber 2000 p.13).

Despite women's often important role as producers and sellers of alcohol, their drinking has been seen frequently as unacceptable, although some countries see it as part of modernisation, of becoming more like the West. Gender differences around drinking alcohol are 'universally evident' (Plant 1997 p.14) and women were, in Greek history, excluded from the many rituals which involved wine drinking:

It is possible that this was because of the belief that women had magical powers and that if wine was imbibed by these already powerful and mysterious people then the spiritual/religious link between women and the gods would make men powerless (Plant 1997 p.34).

However, she maintains that women did drink in Greek and Roman cultures, as well as being, in the case of the Roman women, the keepers of taverns and brothels. This could imply that at least in latter days it was only the sacred drinking from which they were excluded; it could also mean that their position had deteriorated even further, being seen as so lowly that drunk or sober they were unimportant.

There is little literature to be found which documents the use of alcohol by lesbian and bisexual women in other cultures. Given that until recently there was little to be found about lesbians and alcohol at all this is not really surprising. Research has typically been based on opportunistic sampling in bars, which in itself is a method impossible to apply cross-culturally. Bridget (2003) documents research from Australia, Sweden, Norway and the United States of America.

However, the drinking cultures of lesbians in these areas are similar to our own and these are the populations upon which research about lesbians and alcohol appear solely to be based (see section 2.3).

There are a few respects in which the alcohol use of lesbian women of different ethnicities has been thought to differ (Parks and Hughes 2005) but not significantly so. It is therefore not possible to comment upon how the alcohol use of women who are lesbian or bisexual is viewed in 'non-Western' cultures.

2.3: Sociological approaches to women's alcohol use.

Sociologists have tended to approach alcohol from the perspective of problematic drinking. This is a more obvious field of enquiry, given Western perceptions of what constitutes health and illness (Ettorre and Riska 1995). The belief that problematic use of alcohol and other drugs is an area of deviance which can be treated also makes this an area for which it is easier to locate funding. Furthermore, the effects of alcohol consumption may be viewed across the cities, particularly at weekends, and is seen as an infringement of 'women's proper

behaviour'. Consequently, most interest has been generated by what are seen as women's 'problems' as opposed to their legitimate enjoyment of leisure and perhaps of their embodied resistance to 'traditional femininity' (Wearing et al. 1994 cited by Ettorre 2007 p.48).

Considering the extent to which women's alcohol use has been seen as a problem, Ettorre (1992) refers to Ahlstrom (1983) who:

suggests that the women and alcohol issue has become important for three reasons: (1) the strong growth of alcohol consumption in western industrialised societies; (2) women's special role as an instrument of reproduction and an agent of socialisation; and (3) the rise of feminist research (Ettorre 1992 p.32).

Alcohol issues have taken a hold on the public imagination, with the vocabulary of the treatment centre, such as 'recovery', 'denial', 'co-dependent', 'keep it simple', becoming that of common speech. One reason may be a search for meaning; for quick answers in a society which is becoming mistrustful both of religious beliefs and more recently of mainstream medicine. Beck (1999) has described this new 'risk society', which includes a discontinuity of family and neighbourhood support. Reasons might include the need for employment mobility and increasing isolation within private vehicles. Individualisation may be stressful rather than satisfying, and might create a need either for the comfort of substances, or for alternative 'family' and community support networks such as those provided by

AA. Whatever its success or otherwise in dealing with 'alcoholism', it is agreed by many to provide the sense of continuity, reliability and goodness once to be found in the family or the church (Atkins and Hawdon 2007). This sense of continuity is certainly of value to some people for some of the time, with AA, like the Church, providing its own kind of insurance policy for the future.

McDonald (1994) has pointed out that concern about the moral and political dangers of behaviour, in this case, 'alcoholism', depends for its impetus on the perception by established society that groups identifiable as different from them, such as Irish immigrants, Blacks, the working classes, are doing it (McDonald 1997 p.4). Once compelled to admit that people otherwise like themselves could end up with alcohol problems, theories of disease and compulsion begin to replace those of immorality and irresponsibility. However, these theories still focus on the individual and his/her relationship with the world. This has created a complex situation whereby: 'there is a degree of interplay... in that both biomedicine and spiritual healing engage in discounting social determinants, and can thereby lead to "victim-blaming" '(McClellan 2005 p.644).

Plant (1997) charts the history of women's drinking and beliefs about it over time, mainly from the perspective of its being a problem. She shows how, when they are visibly enjoying drinking large amounts, women are pictured as whores and/or as down-and-outs, to an extent

depending on their social class, and frequently being seen in both ways.

Wilsnack and Beckman (1984) record for posterity the description in 1975, by researchers of 'alcohol abuse in women', as being a 'non-field' (Kalant 1980, cited by Wilsnack and Beckman 1984 p. ix).

However, despite this observation, the book is able to include such work as that by Fillmore (1984), looking at the truth and the popularity of the convergence hypothesis (the theory that as women's circumstances, such as being employed, become more like those of men, their alcohol consumption will also become the same as men's) and that by Gomberg and Lisansky (1984), which considers the many different ways that a woman's drinking may become a problem.

Acknowledgement that women drink for different reasons than men has not necessarily led to the realisation that: 'Alcohol problems... are frequently a rational response' to oppression (Waterson 2000 pp.6-7).

Waterson (2000) refers to the high level of attention given to how alcohol may affect women's care of children, whether born or unborn, as a reflection of the way that society still sees women primarily as mothers, selfishly drinking at the expense of un-nurtured children. She notes that concern about the effect of alcohol upon men's reproductive functions has not attracted comparable interest.

Thom (1994) describes waves of interest in women's drinking, from Victorian concern over women's drinking and possible risks to children both unborn and living, to the 1960s' renewed interest in women's health (Thom 1994). Changes occurred whereby 'alcoholism' was seen to be a less appropriate concept than 'problem drinking'; a social problem rather than a disease. As I observed earlier in this chapter, and mention later in chapter 5, such changes have not necessarily affected practice.

Raine (2001) does consider women's need to escape from oppression and depression, and most research into binge drinking, such as that of Stewart et al. (2006) and Measham and Brain (2005), also sees the drinking as the unfortunate result of social pressures. Women's binge eating and drinking have been considered by a number of sociologists, as evidence of attempts at problem-solving. Such problems are frequently seen as a product of inequality when: 'the level of analysis tends to be on the collective and social rather than the individual...developing cultural and social awareness is viewed as crucial' (Ettorre 2007 p.10).

Other studies have attributed such behaviour to abuse (Cernovich et al. 2008) and to lack of social bonding and family involvement (Hirschi 1969). The extent to which discriminatory behaviour, based on gender, has produced 'problem behaviour', such as alcohol 'misuse' in women, has been estimated by Eitle (2002). Thom (1997b) has linked women's

alcohol problems with outsider status and notes that their different treatment needs were only taken seriously when it became clear that the same 'preventive approach [needed to be] directed towards the population as a whole' (Thom 1997b, p.62).

Literature on social marginalisation (Becker 1966) is relevant to this approach. This has been seen as a major factor in the drug culture of Harlem, where social status may be acquired by deviant behaviour by disaffected groups (Bourgois 2003, Cohen 2002). Such delinquency may illustrate one aspect of the new version of strain theory (GST, or General Strain Theory) suggested by Agnew (1992) whereby undesirable behaviour becomes attractive as a response to actual or anticipated negative life experiences. Other sources of strain include emotional and material factors (Agnew 2006) and are experiences common to large numbers of women, particularly lesbian/bisexual women and BME women. Cohen's version of strain theory (2002) might have placed lesbians in a 'delinquent boy' group. They might feel stress and anger at finding themselves in an outsider position in society, and might choose to deal with this by behaving aggressively and dressing distinctively. These tactics might reinforce their sense of self-worth, while irritating and angering others. However, like the Mods and Rockers (Cohen 2002), they could easily discard such outward proofs of cultural identity, and melt away into social invisibility, or 'the day job'.

Anxiety at the erosion of social norms focuses most readily on the 'binge drinking' of young women (Plant and Plant 2006) with little being said about the fun and excitement, only about the dangers, deviance and stigma (Room 2006). Such drinking may be seen as a cultural challenge, allied with feminism (Thom 1997b).

Alcohol often has a role in the construction of gender. Suggs (1996) describes how, in capitalist Botswana, men continue to drink publicly as of right, while women need to earn that right by economic success. Moore (2008) examines women's beginning to take control of their own health in the 1960s, in defiance of the professional medical hegemony, and the feminist response to more recent health initiatives which confirm their position of responsibility for family health. This paper is relevant because alcohol is included in the health promotion package which is aimed at women as care-givers. It confirms the importance of women's, as opposed to men's, 'sensible' behaviour in modern society. Other research has noted how public attention has been moved from the mainly male, unskilled 'lager louts' in the 1980's to: 'media portrayal of "binge drinkers" [as]... young female professionals socializing in city centre café bars drinking bottles of alcopops' (Measham and Brain. 2005 p.266).

What is relatively new is the focus on drinking to get drunk as a leisure pursuit in itself. Measham and Brain (2005) refer to it as a 'culture of intoxication' including both legal and illegal drugs, which created

profound public anxiety over fast-moving social change and increased materialism under the Thatcher government (1979-1990). They describe how the alcohol industry recaptured the attention of young people from the illegal drugs and the dance scene, making money by developing a citified, smarter image of drinking, to appeal to a wider range of consumer. The authors call this 'recommodification' (Measham and Brain 2005 p.268) and one result may have been the greater acceptability, at least among those under forty, of public drunkenness. This is one reason for current anxiety about the visibility of women out drinking, challenging stereotypes of 'proper behaviour' (Rolfe et al. 2009, Van Wersch and Walker 2009).

Heavy drinking is also reportedly occurring in the extended work space. The popularity of such events as Awaydays, to improve team solidarity, and the increase in women's holding significant posts, has made it far more likely that women will be joining the (often considerable) drinking that occurs outside working hours, but in the company of work-mates. Hendry (1997) describes the way that Japanese companies often expect the women working there to join the men in the after-work drinking: 'the event is not entirely social...many men claim that they feel obliged to attend...the "relaxed" behaviour is fully expected to bring out underlying tensions...' (Hendry 1997 pp. 180-181).

Binge drinking has been reconsidered as 'calculated hedonism' (Szmigin et al. 2007p.39), with emphasis on the enjoyment of the

feelings of drunkenness, and of careful planning. There has been exploration of the concept of alcohol as an aid to sexual and other physical pleasure (Ettorre 1997); as an enhancer of awareness and meaning--- a shaman on a journey into the unknown (Eber 1995).

Ettorre's 'post-modern paradigm' of substance use stresses the way that women taking drugs in a group may experience a positive pleasure in the ritual of the process, even while they also experience distress and negative emotions. Their drug use remains an exercise of their human rights (Ettorre 2007 p.10). Such an approach shares common ground with perspectives such as those of Fenton and Sadiq Sangster (1996), in the context of mental and physical health in general. These imply that there may be as many categories of ways of drinking as there are languages and cultures in which they are described.

Traditionally, women have been expected to to keep their bodies under control---their menstruation secret, their food consumption neat and modest, their degrees of being clothed and unclothed strictly defined, even when modified by fashion (Holland 2004). Getting drunk outside the home, as a 'top-of-the-range experience', may provide women with what is lacking for them as similarly wonderful in the rest of their lives (Ettorre 1992). It may also allow them:

to access their own raw materials of emotion and awareness of risk; to consume actively but carefully and to create a particular life-style that has traditionally remained undeveloped in drug-

using environments...women are able to use drugs for pleasure... Drug-using women do not necessarily need to view their actions as deviant (Ettorre 2007 pp.43-44).

Ettorre (2007) also sees signs of what Hutton (2004 p.236) calls a 'positive femininity' emerging in the club scene, where women engage with each other in a relaxed and friendly atmosphere, challenging 'traditional modes of femininity...clubbing female bodies take pleasure in avoiding risk' (Ettorre 2007 p.47). The centrality of pleasure and ecstasy in women's substance use is also mentioned by Henderson (1996) and Hinchcliff (2001), acknowledging too that danger may enhance these experiences. Ettorre (1997) develops the concept of 'positive drinking', which is not necessarily moderate drinking, but does entail learning what for you is the amount which gives you pleasure. Other writers, such as Davenport-Hines (2001), do not necessarily accept that 'sobriety' exists; while Goodison (1990) links all forms of altered consciousness, whether drug induced or not, with a reaching out to other psychic realities; and Roth (1989) describes how dance may be effective as a way of escaping fear and despair and sadness.

Alcohol use can be viewed as problematic or as positive, but these ways of looking are complementary and need to be considered together (Ettorre 1997). A post-modern paradigm of drug and alcohol use 'paves the way for an anti-oppressive approach...developing cultural and social awareness is viewed as crucial' (Ettorre 2007 p.10).

For example, alcohol has been seen as being the key to various spheres of adulthood and competence (Sulkunen 2007). Its use has been explained as often facilitating the virtual negation of social mores, while remaining firmly tied to the society and individuals in question (Stein 1985). Used in this way it could be said to occupy the space previously occupied by the carnival, the place of transgression on the borders of society (Presdee 2000). The locale of the drinking, i.e. its public nature, has also been seen as significant, and the way that this has been understood by the public and by academics (Valentine et al. 2008).

Carnival and excess have been linked to a rejection of increasing rationalisation of everyday life, and a way of coping with community fragmentation (South 1999). He notes a disregard of the legal and illegal status of drugs and cites Lenson (1995 p.4) as stating that 'The difference between Prozac and Ecstasy is mostly a matter of marketing' (South 1999 p.3). He also refers to society's needing to construct deviants, whereby substances make ideal social enemies for 'societies uncertain about their moral and constitutional strengths in other areas of life' (South 1999 p.10).

Hendry (1997) points out the principle function of drinking procedures as social cues. Other cultures may allow time-out without necessarily involving alcoholic effects as understood in the West; i.e. the entering of alcohol, into the bloodstream. This may be achieved by tiny sips

being taken, but by allowing behaviour to develop as if the alcoholic content consumed were much greater. People who use alcohol in this way may be able to 'snap out of it' almost instantly, perform complex tasks, and then return to the previous and apparently very drunken condition (Hendry 1997 p.181). This confirms the observations of previous sociologists and anthropologists about the context of drinking being of crucial importance in any society: 'The use of alcohol symbolizes a temporal lifestyle and accentuates the transformation out of the posture of social controls and self-imprisonment' (Gusfield 1996 p.72).

Lesbians figured little in the sociology of substance use before 2005. Hall (1993) confirms the often punitive approaches and prejudiced attitudes of the treatment agencies, the popular but unconfirmed belief that lesbians are more likely to develop alcohol problems, the different peer support available to stigmatised groups who are often not acknowledged by their families, and the stress caused by leading a deviant life-style (Goffman 1990). Hall (1994) also acknowledges the tension involved for lesbians' engaging with AA and with formal treatment, particularly citing a patriarchal ideology and individualisation of issues.

Ettorre's (2005) compilation of essays on lesbian substance use filled an important gap, offering a lesbian-sensitive perspective across a variety of approaches. Much of the book considers alcohol problems

relating to depression (Bostwick et al. 2005) and treatment (Matthews and Selvidge 2005) but some sections consider the importance of gaining a positive identity as a lesbian as a way of escaping alcohol dependence (Matthews et al. 2005, Staddon 2005). There is disagreement in the field as regards lesbian/bisexual women's greater or lesser use of tobacco and alcohol (Burgard et al. 2005, Hughes 2003), partly due to the difficulty of sampling. Lesbian/bisexual women can choose whether they come out, and take part in surveys. However, a recent national report on lesbian/bisexual women's health claimed that: 'Nine in ten lesbian and bisexual women drink and 40 per cent drink three times a week compared to a quarter of women in general [and that] lesbian and bisexual women are five times more likely to have taken drugs' (Hunt and Fish 2008 p.04). To what extent such data are accurate over all, and whether or not these findings evidence a health problem, should provide material for interesting future research.

Neville and Henrickson (2006) note that more women than men reported that their doctors presumed they were heterosexual, and that homophobia continues effectively to operate in this area. The difficulties encountered by lesbians in alcohol treatment have been mentioned by Ettorre (2007), Cochran (2006), Fish (2006) and Staddon (2005). For example:

As lesbians, we may be suspicious about the motivation behind current mental health treatments on offer...When lesbians seek help for alcohol issues and are open about their sexuality, the

labels, 'lesbian' and 'alcoholic', indicate to clinical staff that they are socially dysfunctional...lesbians 'are much less likely to present to these services for a variety of reasons ... (including) ... fear of their sexuality being pathologised if they do present' (Malley, 2001). (Staddon 2005, pp.73-74).

Authenticity has also been confirmed as a crucial part of modern identity, perhaps experienced with particular acuteness in gay and lesbian bars. My own experiences indicate that rebellion may be crucial for women growing up in a social straitjacket and may well involve:

finding lesbian friends who were neither drinkers nor judgemental about my drinking...[I met] women who were interested in feminist issues, and made me feel welcome... In lesbian bars, we are not outsiders and can take pleasure in our differences... For the first time in twenty-eighty years, I could manage without alcohol. (Staddon 2005 p.70-71).

There are connections between this recognition of women's alcohol use as a road to self-understanding and expression, and the service user/survivor approach to mental health experiences. Service user criticisms of conventional mental health approaches in general (Rose 2002, Beresford 2005) seldom consider the relevance of such perspectives to alcohol use. However, approaches which challenge the 'top-down' certainties of psychiatry are relevant to the way that I have approached women's alcohol issues, addressing the politics of mental health, as I address the politics of alcohol treatment. Such ideas were:

...first brought into view by the 'anti-psychiatrists' who gained prominence in the 1960s---Laing, Cooper, Basaglia, Szasz... Each of these figures stood for a different approach, and all have therefore disowned the umbrella label of 'anti-psychiatry' ... [but] all... were united in seeing the scientific image of psychiatry as a smokescreen...whose side is the psychiatrist on? what kind of society does he serve, and do we want it? (Ingleby 2004 p.8).

Others have linked the 'survivor movement' with loss of faith in science and technology 'to resolve human and social problems' (Bracken and Thomas 2001 p. 724). The alcohol survivors' movement is not yet at a stage for its research to be cited here.

Reflections

Sociological approaches to women's alcohol use have focused predominantly on the problems it can cause and the problems from which it may stem. However, studies have also centred on the role of alcohol in enabling women to take time out, achieve ecstasy and increase their potential. There appears to be an increase in the latter kind of study in the last eight years, and although research into illegal drugs still predominates, its findings are often relevant to alcohol use. Lesbian and bisexual women have particular issues with treatment, but more social support available, ironically often by way of bar-centred networks.

Medical understandings of 'alcoholism' are probably the most significant factor affecting not only a woman's recovery, or otherwise, from 'alcoholism' but also her whole existence, given the position of medicine in the Western world. It could be seen as an important disabling characteristic of that world. Medical research seems focused on a biomedical understanding of the 'disease' and an insecurely based reliance and understanding of AA.

Anthropological research provides a much-needed antidote to medical theories of 'disease'. The variety of its approaches and its discoveries underline the emerging acknowledgement that there is no one 'answer' to what we call 'alcohol problems' and it provides evidence of different ways of knowing and understanding which are very helpful when attempting a sociological analysis of what has been seen as a medical field.

There is a significant amount of sociological research into women's problematic use of alcohol. However there seems to be an increasing awareness that there are other reasons for women to use mind-altering materials as well as distress and damage, and that these may link with concepts of leisure, of risk, and of independence. This may well indicate a more dynamic and pro-active field of feminist alcohol research in the future. Useful links could also be made with the more developed sociology of women's illegal drug use, and its implications for understanding changes in women's approaches to substances.

CHAPTER 3: METHODOLOGY AND METHODS

Introduction

As I mentioned in Chapter 1, the local NHS Mental Health Trust had agreed to fund me to carry out 'service user led' research projects into women's alcohol use and its treatment. I was not paid, but it was agreed that I was free to use my findings as the basis for my PhD. My aims in these projects were, to discover how women with alcohol issues had fared when they looked for help, and how those whose role it was to offer such help perceived the women, the treatment process, and their own position. The Trust expected a report at the end of each of three years, and I was also expected to talk about my research to staff and 'service user' groups. The Trust also wanted me to aim at academic publication as I went along¹. While undertaking research in their name, I was provided with an NHS line manager, the Clinical Manager of a local NHS alcohol treatment unit, and we met monthly to discuss progress. The unit concerned also held the research funds for me, and I went every month with my receipts to be reimbursed. At the end of the three years that I spent on the empirical research, I was free to concentrate on developing a more sociological perspective on my findings, with a view to attaining a PhD.

¹ I produced one peer-reviewed publication in 2005 and another, by invitation, to a second academic journal in the same year.

These factors had some affect on the way the empirical research was organised and on how I initially understood my role. I had to work within a medical context, following NHS research guidelines, and attempting to reconcile my lowly status as a 'service user' with my responsible public persona of 'NHS researcher'. In practice, as I explain in 3.1, 'My approach and its effect on the research process', these multiple perspectives were of value in achieving reflexivity. I explain how I planned the research in 3.2, 'Examination of the field and recruitment of RAG'².

In 3.3, 'The first research project: "Making a Start" (2004)', I describe and consider the experiences of women who had or had had alcohol issues, most of whom had approached Alcoholics Anonymous (AA), a GP, or the treatment services. This section is subdivided, firstly, in 3.3.1, describing 'Recruitment to "Making a Start" '. Information about respondents is to be found in Appendix 5. In 3.3.2, 'Interviews with women who had had alcohol issues', I detail how the interview process was carried out, continuing in 3.3.3 by describing 'Focus groups for "Making a Start" '.

The following section, 3.4, 'The second research project: "Treatment Approaches" (2005-2006)' is also subdivided. It describes and considers interviews with GPs and alcohol treatment professionals. It first describes, in 3.4.1, 'Recruitment to "Treatment Approaches" '. I do

² Research Advisory Group for the projects

not include a subsection of details of these respondents, because they gave me minimal personal details. However, some basic information about them is to be found in Appendix 9. In 3.4.2, ‘Interviews with GPs and treatment professionals’”, I detail how the interview process was carried out. There were no focus groups for this group of respondents.

‘Analysing the data’ is explained in 3.5, and finally, in 3.6, I address ‘Power and powerlessness in research’, considering how and where power and emotional involvement are factors, and the ways that my own understanding of ‘women’s alcohol issues’ developed sociologically as a result of the projects. This development occurred less because I asked the ‘right’ questions than because the respondents volunteered information which helped me develop the theoretical base of my PhD thesis.

3.1: My approach and its effect on the research process

I employed a qualitative methodology which is feminist, reflexive and auto/biographical (Stanley 1993; Reinharz 1992; Cook and Fonow 1990). Its many perspectives include that of the ex-‘alcoholic’ (Staddon 2005), lesbian (Staddon 2005, Ettore 1997), the woman outsider (Jackson and Tinkler 2007) and the ‘service user’ (Faulkner and Thomas 2002). Auto/biography encourages a reflexive consideration of the relationship between the self and the other in the research process. I aimed: ‘...to ensure that the research design explicitly incorporates a

wide range of different perspectives so that the viewpoint of one group is never presented as if it represents the sole truth about any situation' (Mays and Pope 2000 p.51). These perspectives were enhanced by the role played by the continuing and empathic input of my Research Advisory Group (RAG), including the way that interviews and focus groups were devised and organised.

This part of the methodology is based principally on the work of Letherby (2003), Reinharz (2002), Stanley (1990) and Greed (1990). I wanted to ensure that I focused on women's experiences of social rejection, blame and clinical management when trying to deal with alcohol issues (Angove and Fothergill 2003.) There were many difficulties in employing these approaches within the framework of NHS-sponsored 'service user' research³. I kept the research 'grounded' (Strauss and Corbin 1994, Glaser and Strauss 1967) in the experience of other women who, like me, perceived themselves as having had alcohol problems. Some might consider themselves to be 'service users'. Theory would be developed as the research progressed and would reflect the women's subjective experiences (Wuest 1995, Strauss and Corbin 1994). The object was better understanding and political change (Radford 1994). I hoped that the NHS Trust would act on my findings, and that how women were 'treated' might improve.

³ See Chapter 1, footnote 2

The use of a grounded theory approach was particularly appropriate to a feminist appraisal. Such an approach, while recognising the importance of focusing on respondent meanings, also acknowledges that researchers don't have 'empty heads' (Stanley and Wise 1990). Hence it may 'reject abstract theory' (Letherby 2003 p.67) and begin the research process with as open a mind as possible. This may allow for reflexivity: awareness of the effect of the researcher on the situation and on the data collection and interpretation. 'Scientific' rules about, for example, the tools of data collection, have meant that the respondent has often felt used and uninformed, the researcher did not find out so much about the respondent, and that the process tended to be dehumanising. Feminist methodologies are designed to avoid such a situation. The personal involvement of the researcher leads to far higher quality data (Nielsen 1990). Reinharz states that: 'utilizing the researcher's personal experience is a distinguishing feature of feminist research' (Reinharz 1992 p.258). It was also exhilarating to realise that experiences I had thought of as 'only' personal, 'counted' as lay knowledge, and could be accepted as having value (Popay et al.1998). All my identities (mother, divorced woman, lesbian, 'ex-alcoholic', patient, academic) were often relevant in that it was easy to find common ground with different women. I have therefore included observations about how different situations made me feel, admitting that these feelings sometimes led me to interview in a less effective way than I should have liked.

In addition, much alcohol research I had read (see Chapter 2) seemed to rely too heavily for its evidence on: ‘...women already in the treatment system or those seeking official ‘help’...the experiences of women overdrinkers who *don't* seek help might be very different...’ (Ettorre 1997 p.113, original emphasis). Many social factors affect admission to the treatment system, so that research based solely within it is grounded not in the experience of women drinkers as a whole, but of those who have come forward for treatment.

Using a feminist methodology where: ‘I am studying a world of which I am myself a part, with all the emotional involvement and accusations of subjectivity that this creates’ (Greed 1990 p. 145) made me more aware of the role of my own experiences. This included empathy with the women I met who had or had had alcohol issues, providing me with rich and detailed data. It allowed the women who were involved to off-load in a safe environment; to talk about the dangers and disadvantages of our alcohol use; to share a joke about something otherwise seen as unacceptable; to find unexpected similarities in our experiences. This is an example of the reflexivity which characterised this part of the research, and which I had sought when considering the design: ‘Feminist scholarship reveals... that the knower and the known are of the same universe, that they are *not* separable.’ (Du Bois 1983 p.11, original emphasis).

I had had positive experiences of women's discussion groups, where each of us would bring her own experience to whatever topic was 'on the agenda' and support and encourage each other in sharing it. The object was better understanding and political change (Radford 1994). These discussions were characterised by this encouragement and by a belief that we could build a better world: 'Though sharing experience was important...it was never an aim in itself...[it] included the sharing of lived experience, but as a part of a broader feminist process.' (Radford 1994 p.46).

Becker (1963) and Bourgois (1996) have emphasised the great importance of living and identifying with the group to be researched. It helped being a woman, it helped greatly to be an ex-'alcoholic' woman, and for the lesbian and bisexual women it mattered enormously that I was one of them. Those who had spoken to a GP or had alcohol treatment had not usually disclosed their sexual orientation there. If women chose to share this information with me, I always acknowledged my own orientation immediately, and they relaxed far more (Fish 2006). This information exchange definitely facilitated a positive interview. It usually occurred following an open-ended question which made such a disclosure easy; however, sometimes the information would be offered spontaneously.

The PhD process was an emotional experience and a journey of 'recovery' for me (Ettorre 1997). Auto/biography was an essential part

of my methodological approach, acknowledging the relationship between 'my story', that of the research respondents, and its possible effect on my conclusions. As an approach, it enabled me to include my own experiences of alcohol use and treatment, as a counterpoint to the stories of my respondents, and in doing so, offering an 'experiential analysis' (Wise 1990 p. 143, in Stanley (ed.) (1990)). I dealt with the difficulties of negotiating issues of 'independent perspectives' by introducing multiplicity, involving a variety of other women with alcohol issues, as well as people employed in the health and treatment fields.

3.2: Examination of the field and recruitment of RAG

I began by visiting a number of different alcohol treatment centres and AA meetings, acting as a 'service user' representative for the Trust, reading background literature about 'alcoholism', and recruiting RAG. Both the AA meetings and the NHS Trust work updated me with current medical approaches to addiction and its treatment, since it was 15 years since I had been in treatment myself. My attendance at the AA meetings caused some surprise to the few members there who knew me, since I had not attended throughout that time. The meetings did not seem to have changed.

RAG was to be central to all stages of the empirical research. Its members were not to be respondents, only advisors. I already knew that there were many different ways of experiencing alcohol addiction and of recovering from it (Raistrick et al. 2006, Heather and Robertson

1997) and I wanted my research to be grounded in such multiple understandings. The RAG women's skills included understanding the issues from first-hand experience, and being open to new ideas and a variety of solutions. This seemed to me to be essential if the research was to claim a feminist perspective (Corbett 2007, Cotterill and Letherby 1993, Anderson et al.1990, Oakley 1981).

I advertised⁴ for members of what was to be effectively a support and ideas group of women who, like me, had once experienced alcohol problems themselves. These women, who were no longer addicted to alcohol, would share in the management of the research projects. They would provide emotional and moral support, as well as peer knowledge in the designing of the advertisements and the interviews, in discussing research issues, as they came up, and helping me to develop solutions.

I placed fliers in libraries, health food shops, pubs, cafes, and anywhere I could find a free notice-board. I could not afford the notice-boards in newsagents' shops. Although I did not realise this at the time, I think that in doing so I privileged middle-class women, who were perhaps more likely to frequent the sort of venue to offer such a facility. These were places where it was safe to stop, read a notice, and make a note of the phone number.

⁴ See Appendix 3

I could not leave fliers at AA, as only AA's own material may be advertised. Fortunately, many AA members go to meetings at the NHS treatment centre where my Clinical Manager was based, and where I had once been a patient, so were able to see my notice on their board. Friends were also able to distribute fliers to AA members on a personal basis, outside the meetings.

The advertisement described me as a 'recovered alcoholic'. I hoped that the phrase might interest both women who saw 'alcoholism' as a life-long condition, and those who did not. This worked, and a good range of 'recovery positions' were represented⁵. Everyone joining RAG had been free of alcohol problems for over two years. The majority no longer used alcohol but two now drank in a way that they did not consider to be problematic.

Reasons for volunteering included a belief that women needed different sorts of help than were available and delight that someone like themselves would be investigating. Most were strangers but I had known one for several years and had met another at an art group I set up when I came out of treatment. 'Service user led research'⁶ sounded like a wonderful opportunity to challenge traditional assumptions about what sort of treatment, or other help, women like us might need (Rose 2001).

⁵ See Appendix 4

⁶ See Chapter 1

No Black or minority ethnic (BME) women came forward. The reluctance of these women to discuss intimate matters with women of different ethnic origins has been written about elsewhere (Johnson et al. 2006, Leland 1984). The group did, however, include a variety of sexual orientations, and ages ranged from early thirties to late fifties. Initially we had twelve members including myself, but our numbers went up and down between 'recruitment year' (September 2002—August 2003) and May 2006. A core group of six remained engaged for three years, of whom three remained involved for four years. Other women would join us from time to time, perhaps staying for six months and then taking up another interest. Our initial twelve included two women who felt unhappy when they found that not all women who had recovered believed in the 12 Steps recovery plan⁷ of AA, and these women only came twice. Others, themselves AA members, did not feel threatened in discussions with women who had different philosophies. The six 'core members' I have mentioned included one AA member and one woman who had found NA (Narcotics Anonymous) helpful. Some had recovered spontaneously from feeling addicted. None of us had chosen a conventionally religious path out of addiction, although one had become a Priestess at one of the Goddess Temples. Most of the group, including me, had felt safer, or at least more relaxed, if we remained abstinent, but still used pubs and/or restaurants with friends who did drink alcohol. Two women now found it easy to drink in

⁷ See Appendix 1

moderation. Several of us found physical activities like dance and aerobics gave us new ways of feeling good.

Only one RAG member felt positive about her experiences in alcohol treatment, and she had been able to access an alternative approach, based on counselling, meditation and art therapy, in another part of the country. Most of the alcohol and treatment issues we were looking at had affected us all, whatever our sexual orientation. We felt that as women with alcohol issues we had been being treated as lesser beings, unclean, and untrustworthy and unpredictable by definition. Even the women who had been able to make use of AA felt angry and upset about the thinking behind the 'disease concept'⁸; the idea that they had been born with a flaw. As women we had grown up being told we had to do many things to be acceptable human beings, and to be told we were in addition diseased and/or flawed was unacceptable. This was especially true of the lesbian members of RAG, who had already had to deal with the common perception that a lesbian woman was 'a social misfit' (Staddon 2005 p.71).

The group met monthly from November 2002, to plan and discuss the research. Often meetings would only have a few members present, with the rest phoning or emailing comments and suggestions. Respect for difference of opinion and lifestyle was seen as essential for us to be able to work together, and I think that our differences were enriching.

⁸ See Chapters 4 and 5

Personal details were disclosed or not as people chose. After each meeting I circulated an account of it, but without mentioning any names except my own, to all the women who had come forward to join, whether they had made it to the meeting or not.

I was able to discuss with them the visits I had made to a variety of treatment centres, both residential and day, and this helped me to decide what were likely to be areas of importance to discuss with respondents, once the research projects began. This has been shown to be a desirable way of initiating research projects in the area of social research (Stalker 1998 p.6). The discussions with RAG members helped me to deal with the feelings the interviews would often promote in me, such as despair and rage, and also helped me see the information in different lights. They were very supportive, and of course had views of their own, which enriched my interpretations.

In my inexperience of funding applications, I had not thought to ask for money to pay these women's expenses in the first year, so their involvement did indicate serious interest on their behalf. One member worked extremely long hours and in the end was usually most often available on the end of a telephone only, but remained involved. A second had to make two bus journeys to get to each meeting. One was made homeless during the year, but still kept attending our meetings. Another had three children and had to arrange childcare before she could make the journey in from the country for the RAG meetings.

We had an emancipatory philosophy, seeking change (Stanley 1990), but I was also driven by a need to understand the processes which made women the victims of their own needs. On a personal basis, I hoped for a better understanding of what had happened in my life.

3.3 The first research project: 'Making a Start' (2004)

'Making a Start' was designed to find out, from women who had or had had alcohol problems, whether and in what ways they had sought help and with what result. Women are less likely to enter the residential treatment centres, which have been the basis for much 'scientific data' about alcohol problems (Greenfield et al. 2007, Plant 1997, Ettorre 1997, Thom 1994, Fillmore 1984). Other research has made similar errors. Fish (2006) points out that early twentieth century researchers into homosexuality shared the common concept of it as deviant or abnormal, so saw no problems in recruiting respondents from prisons. In the same way, recruiting alcohol respondents from clinical settings will inevitably produce skewed results. Ettorre (1997 p.113) agrees that very different experiences might be heard from women who have not entered treatment.

For this reason, I planned to advertise across the community as a whole, for women who had, or had had, alcohol issues. I also planned to 'come out' publicly about my own background. Women were more likely to want to talk in confidence to someone like me, since peer

group experience tends to inspire trust (Soyez et al. 2004). At the same time, the fact that the research was being carried out under the auspices of the NHS would make them feel more certain that everything would be done in a professional manner and that the project was worthwhile.

Interviews were usually to take place in the woman's own home: 'The interview location plays a role in constructing reality, serving simultaneously, as both cultural product and producer' (Herzog 2005 p.25). I also planned follow-on focus groups, to provide a safe and welcoming environment to discuss what respondents saw as the most important issues; probably a first-time experience (Crossley 2003). The project was to be completed within a year, and a report sent to the Trust.

3.3.1 Recruitment to 'Making a Start'

When advertising for respondents for this first project, I described myself as 'a woman who has had alcohol problems but is now well'. This was to avoid unnecessary alienation of AA members by calling myself a 'recovered alcoholic'⁹.

I wanted my fliers¹⁰ to reach a wide audience, including treatment centres. It did not occur to me to consider the possible influence of key-

⁹ The AA 'Bible', known as The Big Book, states that 'Over any considerable period we get worse, never better.' (AA Big Book Online p.3)

¹⁰ See Appendix 5

workers. I realised this might have raised an ethical issue, as well as a methodological one, when a respondent, Elsa¹¹, told me in interview that one of the reasons she had contacted me was that her key-worker thought it was a good idea. This vulnerability and anxiety for approval is very likely for stigmatised women in treatment (Faulkner and Layzell 1999, Gearhart et al. 1991).

It would have been very interesting also to have advertised for women who enjoyed or had enjoyed getting drunk and did not see it as a problem at all. I did in fact come across evidence of this phenomenon, but an advertisement which did not make use of the word 'problem' would probably have obtained more. However, I understood myself to be funded in order to try to improve the alcohol treatment experience for women who were 'ill', and at the time it did not occur to me that such information might have provided valuable insights.

The fliers were placed in a wide variety of media and venues, in January 2004. They invited women who had ever had issues with alcohol to speak to me pseudonymously, to discuss their experiences. I included local radio and newspapers, libraries, advice centres, health centres, the Equality Unit, Council Houses, University Unions, homelessness and domestic abuse agencies, and a variety of other voluntary organisations. I also included alcohol treatment centres and those few AA meetings where RAG was successful in leaving fliers.

¹¹ All the names of respondents have been changed

The large area covered included four urban areas and their surrounding countryside. With a bigger budget I could have placed small advertisements in local shops across the area, to reach women who could not afford to buy a paper and did not visit any of these public spaces. The most effective medium turned out to be the local evening paper, which ran two full-page articles, featuring my photograph and a 'gutter-to-success' story.

Research such as mine falls into the category of 'sensitive topics' (Lee 1993) which may throw light in unexpected places but which may also present very particular challenges. It was one thing to interest a range of women who were prepared to disclose highly personal information. It was another to deal with the expectation of some callers that I must have answers about 'how to stop drinking.' I did my best to ensure that the separate phone-line I had put into my home was not seen as a help-line and that respondents did not see me as a recovery expert. However, the publicity, while effective in gaining the number of responses I required, was also effective in turning me temporarily into a local 'success story' and I think some people may well have hoped to get answers rather than just talk over their experiences.

The special 'research project' phone was only plugged in at specified times, and when I was alone. Over 60 calls were received; none from anyone I knew. Twenty-four were from women who saw themselves as having or having had alcohol problems. The other calls were from

relatives, friends and workers who would have liked to arrange interviews for other people, or from men. I explained to third parties that a woman who wanted to talk about her drinking had to phone herself. The men were told that the research was focusing on women only; nonetheless many talked to me for a long time, as did the friends and relatives. I found this stressful, as I did not feel qualified to advise them, but I think that our conversations did often help these callers to an extent.

All but one of the 24 women mentioned were willing to be interviewed. The exception was one woman who left a message when drunk and who denied having made such a call when I phoned her back. We would chat briefly about the research, and I would say something about my background and what I hoped the research would achieve. I also warned the women that although I would not use their real names at any point, I would need them to sign a Consent Form for the benefit of the NHS Trust. I promised that they would be given opportunities to view and correct their own transcripts. They would also be able to view and make additions to the final reports before they were sent off to the Trust.

The focus groups which I explained would be run later, for interested respondents, were definitely a factor in being able to arrange some of the interviews. Most of the women wanted me to visit them in their homes, but three (Bella, Helen and Fran) chose instead to meet me in

treatment centres which were near to them or which they attended anyway.

Some women were glad to be able to talk to someone who was not 'official', such as their GP, and was not trying to sell them a 'product', as the AA helpline was described as doing. They were excited to hear that another woman had had their problems but *had recovered*. In addition, for some women, enlisting for such a research project might have offered a chance to 'do something to help', as well as a chance to discuss their issues for their own benefit. They had been made aware, by seeing the advertisement, that their experiences were suddenly of value to someone, as opposed to being something entirely shaming.

The 23 respondents¹² ranged in age from 25 to 57. Two of them, Renee and Lucy, had never mentioned their alcohol problems to anyone before, and Sherie had only approached AA. Queenie had spoken to AA on the phone and seen a homeopath and an acupuncturist. Margaret and Jane had only spoken to their GPs although Jane had also been to AA. Seventeen women had approached treatment centres at some point, and of these women two (Nen and Helen) were currently receiving treatment, while a few others remained in touch with treatment counsellors.

¹² See Appendix 5 and Chapter 3.3.2

All the women were of White British or Irish origin. A later study of EACH (Ethnic Alcohol Counselling in Hounslow) publications indicated that effective Asian outreach work would probably be necessary to attract a response, rather than a generalised approach such as I had used (Shaikh and Reading 1999). One respondent had read about the research in the local Racial Equality Council newsletter, because her partner reads it, but she is White British. Six respondents (Elsa, Fran, Jane, Karen, Pat and Wendy) described themselves, during their interviews, as lesbian or bisexual, and most of these six women had been influenced by knowing that the project was run specifically by and for women.

I kept up-to-date information about current treatment projects, for women who asked for them when they phoned me. Many people said that they had been unable to find out information other than an AA number, even from their doctors. Fortunately too I had also worked for several years on a telephone help-line for lesbian/gay/bisexual people, and had trained in telephone counselling skills, and, on another occasion, in alcohol counselling, although I was not qualified.

However, dealing with these 60 calls was still very stressful. This was partly because, although I did not have the phone plugged in all the time, when it was plugged in I was on edge, and after the calls I was often quite shaken up. I had not considered that people interpret what they read in certain ways. This could be perceived as the use of

'emotional intelligence' whereby there is an appreciation of what is felt by the writer even when this is not precisely stated (Goleman 1995, Schutte et al. 1996). In this case, my advertisement did not hold out any suggestion that I had 'answers', but as I mentioned, many people believed I must have them. Fortunately I was able to phone people in RAG for support, although of course information which might lead to the identification of the caller was never shared. I had not realised how lonely and distressing this could be in practice. There was no safe way to share how very bad some of the calls made me feel, or how inadequately I felt I had dealt with them. Research of this sort has been termed 'emotion work' (Letherby 2003, Hochschild 1979). The researcher has to 'manage' how she feels and how she shows, or does not show, her feelings. At the same time, she must be attentive to the feelings of her respondents, and mindful that she does not inflict distress by appearing to offer more intimacy and support than she can ethically and practically maintain. This can be a very difficult balance to maintain, especially in such lengthy and relaxed interviews as some of those in 'Making a Start'.

3.3.2: Interviews with women who had had alcohol issues

The taped interviews, and later the focus groups, at which a RAG member took notes, aimed at discovering how the women had felt about their drinking, how it had affected their lives, how others had reacted to it, what it had been like looking for help, and how things were now. The interviews were planned to last for about an hour and a

half. I had never been formally trained in interviewing techniques, although the empirical work for my Sociology MSc. had involved carrying out several interviews and conducting several focus groups. This research had elicited good detail from semi-structured or unstructured interviews with other women, particularly one sharing some similarities of background. This phenomenon has of course been observed by many writers, such as Kelly-Weeder (2008), Letherby (2003), Cook and Fonow (1990). I had also found that material gathered in small groups of women (taped, in note form, or both) was often very rich, with one woman's experiences reminding another of something she had forgotten, and so on (Ettorre 1980). Hence, I hoped that some of the women I interviewed on a one-to-one basis would be taking part in one of several small focus groups later on.

Most interviews took place at the respondent's home, and we were almost invariably alone together. Deirdre's interview was accompanied by the sound of her husband, to whom I had been introduced, moving around upstairs, but Deirdre seemed completely undisturbed by his proximity. When I interviewed Lucy, her boyfriend, a heavy social drinker, was expected to arrive soon. It was only in this case that the respondent seemed concerned, becoming increasingly anxious, so that we cut the interview short by mutual consent.

All the RAG women had suggested questions for the in-depth interviews. This was of great help since we all thought of different

aspects of the interview procedure which might be encouraging, demeaning, etc..I only took a single sheet of open-ended questions to the interviews, based on our shared ideas, and designed to get respondents talking. Many of these questions were never used, as enough material was being brought up without them, but having them with me gave me confidence.

I had given no thought to my own safety, only to that of my respondents, so was surprised to find that the treatment centre, which was my link with the NHS, wanted me to telephone them before I entered a house and when I had left it. This was a formal requirement, for my own safety. Sometimes, if it was a deprived area, I should have preferred not to do this, as a middle-aged woman on a mobile in such an area may spell 'social worker', and this is not always the safest way to be perceived. I think I was imagined to lock myself into a car on leaving, whereas I often had a good walk, followed by a wait at a bus stop. It was also a Trust requirement that at the start of each interview I read through a Consent Form and got respondents to sign it. Some found this alarming, although I had explained in advance that it would be necessary. In the end I told women that they could call themselves by a different name, and many did. Others were unconcerned, either identifying me with officialdom, which had a right to their personal details, or perhaps trusting me because of my background (McIntosh 2003).

I exercised the utmost care with these personal details, using a pseudonym for each woman from the moment I got home and labelled her tape. This was the only name which ever went onto the computer. Addresses were kept in a shabby book which was kept separate from my work, and did not appear to be connected with it. This was partly because the Trust took confidentiality very seriously but also because I felt responsible for protecting the privacy of the women concerned. I felt almost ashamed that I knew who they were, perhaps a 'hangover' from the fear I remembered of people knowing about me when I used to drink.

I thought carefully about what I would wear. I had 'been', and dressed as, a variety of versions of myself in my life, including 'professional woman' and 'drop-out'. At this time, I looked like a lesbian woman, usually wearing her hair very short and spiked, which was fashionable for such women in my area at the time. I also tended to the baggy trousers and sweat-shirt style of dress, with running shoes. I had already made considerable adaptations to this style for some occasions connected with my work for the NHS Trust. For example, when visiting treatment centres, before beginning my research projects, I had worn earrings, smart trousers and a jacket, to try to look professional (King and Wincup 2007, McCarty 2007) and to be accepted on my own terms first. I would introduce the subject of my sexual orientation if and as I chose. Not all lesbians might agree that this is good practice (Crane 1999). On the other hand, when I attended

Clinical Governance meetings as a service user representative, I dressed as usual, to remind them that not all 'service users' were bound by conventional dress regulations and that diversity needed to be recognised. Describing these practices makes me sound rather a play-actor, an 'actor-up' (Fuss 1991) but there is some necessity for people who are 'other than the norm' to learn to play different roles, if they want to be universally acceptable (Hadfield 2006, Cannon 1989).

I knew that it was important to all the women I was to meet that I was one of them, at least as far as the alcohol experience was concerned. I now had to consider to what extent I should present them with other aspects of myself. Conventional wisdom suggested that I should dress quietly and blend in with whatever their situation seemed to require, so that they would feel comfortable. This was what I decided to do, brushing out my spikes, putting in my earrings, etc., and then let more controversial aspects of myself emerge as seemed comfortable and appropriate. In practice this seemed to work out well (Ramsay 1993 cited by Letherby 2003 p.110).

I did not take as many notes as I had planned until I got home, because I found that it spoilt the comfortable feeling between the respondent and myself. Sometimes I was shown round the house; sometimes I was asked to put my feet up. On the whole, I felt I was taking away too much in return for the little I was giving:

The long interview is a highly unusual speech event, one that makes for a most peculiar social relationship. ...[but it must] take care to observe the rights (formal and informal) of the respondent. [We must] take advantage of the qualitative opportunity without taking advantage of the respondent. (McCracken 1988 p.12).

Talking freely was not usually a problem, due perhaps to the knowledge they already had about my background as a recovered 'alcoholic' and my reassurances as to their pseudonymity. I was in their homes by invitation, and I felt, and was, privileged by this. I was not necessarily privileged to receive all the sorts of information I might have liked:

even trusted individuals are shielded from certain kinds of information. While developing trusting and even intimate relationships with participants will grant the researcher access to certain kinds of data, it will also systematically exclude him or her from other kinds of information (Murphy et al. 1998 p. 128, citing Emerson 1981).

On the whole, I talk too much when I feel anxious, at difficult points in an interview for example, and when I was transcribing the interviews, I would sit and listen in dismay to myself chattering on. Was I invalidating the data? When I consider or refer back to information gained in these interviews, I check the context, to see to what extent this might have affected what respondents said. For example, the respondent might have seemed to me to be shy about saying

something and I might try to be helpful but find I had been mistaken, and should have kept silent. As far as I can tell, this just resulted in the woman correcting me, without anger or upset. There were also respondents, like Alex and Nen, who seemed just to repeat chunks of AA's Big Book in response to a question. However, Nen was one of the respondents I interviewed who later came to the focus groups so we must have connected in some ways.

I have mentioned 'research clothing' but not research roles. I explained earlier how likely it was that people reading my advertisement for respondents would tend to see me as some sort of recovery expert. In the interviews, as opposed to on the phone, this unwelcome perception tended to wax and wane. For example, respondents with a commitment to AA often saw themselves as the experts, when they learnt on enquiry that I did not belong to it, and tried to recruit me. Others would be disappointed at my lack of instant solutions and look bored when I explained that many small things (I called them my 'toolkit') had added up to being of help for me. This seems a similar reaction to that of the respondents mentioned by Letherby (2003), who withdrew when she was firm that she was not a medical expert, had not necessarily felt the same about her experiences, and might not share their opinions.

It has also been noted that how well the interviewer and the interviewees interact will make crucial differences to what information is

exchanged, and that a non-hierarchical relationship between women cannot be assumed: 'Other social attributes, such as race and class, can influence the balance of the power relationship in interview' (Tang 2002 p.704). Carol, for example, seemed to see herself as being of a superior social class, and to be doing a great favour in seeing me. However, Deirdre, comfortably off but undeniably working class, accepted me at face value, and we laughed a lot together.

On the whole, I think it would be true to say that the respondents and I enjoyed the interviews, even though sometimes distressing subjects were mentioned, leading to tears. It felt as if we had cleared a special, safe place to share these issues: 'it may be easier to talk to a researcher than to a "significant other"' (Letherby 2003 p.111). It was also a further example of the 'emotion work' referred to above. All respondents were also offered transcripts of their interviews, but only two wanted to receive them. I promised that I would get back to them about meeting up again for focus groups. Most seemed keen on the idea of meeting other women with similar problems, but in practice only a few were to do so.

I had promised to make contact again in May, but began to feel that this was a long time ahead for women who had just entrusted me with so much intimate information about their lives. Consequently, between March 10th and March 14th 2004, I ran a telephone check to reassure the 18 women already interviewed, which was fortunate, as more than

one had hoped to hear from me sooner. In addition, 13 days and 48 days respectively since each of their interviews, two of the women, Carol and Margaret, had disappeared. This naturally distressed me very much. A number of phone calls had failed to get a response, and I was not allowed for ethical reasons to enquire about them in any other way. I had to hope that something good had happened in their lives rather than something bad. Two years later I met Carol, in another context. She acknowledged me but gave no explanation as to why she had disappeared without making contact, and it seemed inappropriate to do more than say I hoped everything was going well for her. She did not seem to want to talk further.

3.3.3 Focus groups for 'Making a Start'

The focus groups were to give the women the opportunity to concentrate on discussing those aspects of their addiction and recovery, or otherwise, which were of most interest to them. Women in RAG had all felt that discussion with other women was often very helpful. Minimal structure was planned, like that of consciousness-raising groups, concentrating on achieving a pleasant and relaxed atmosphere and 'enabling women to discuss and understand their experiences from their own viewpoints' (Reinharz 1992 p.220). I also felt that because 'alcoholism' is a shaming experience for women, an opportunity to chat in a safe environment and a non-judgmental arena would be beneficial to respondents as well as informative for my research.

As the area was a large one geographically, including cities and countryside, I planned five groups, to happen at different times of day and in different locations, to ensure that all the respondents who wanted to come could do so. Bella, Renee, Sherie, Alex, Olly and Deirdre had always said they did not want to attend the focus groups: Bella had too much to do and was too depressed; Renee had a job and in any case did not want anyone to recognise her; Sherie had a job and went to AA meetings most evenings; Alex had a job and was getting ready to go on holiday. Olly did not want to meet up with other women who might still be drinking; Deirdre did not like to go anywhere without her husband, and did not think he would like having to wait for her while she attended a focus group. Carol and Margaret had disappeared. The other 15 women said at first that they would like to come.

They did not usually want to attend a group near them, and one or two were glad to hear they could have a taxi if they wanted. However, very many women changed their minds about coming. In the end, only eight of the 23 women who had been interviewed did manage to attend one of the two focus groups (Anne, Fran, Helen, Gill, Jane, Karen, Nen and Ursula). Each group was augmented by a RAG group volunteer, to help me facilitate and to take notes. In practice this meant that each focus group had at least six members, and provided very good forums for debate and shared experience. I was disappointed that attendance

was not better, but in retrospect it is unsurprising; it takes immense courage for a woman to meet strangers who will know that she has a stigmatising condition (Angove and Fothergill 2003). It has also occurred to me since that eight out of 23 was a very good turn-out, when all the difficulties and anxieties are taken into account (Ussher et al. 2006). Two women who had been very keen on coming right up to the last minute, Pat and Elsa, backed out without warning---Pat was not there when the taxi arrived for her, and did not reply when I rang and left a message for her and Elsa did not turn up at the meeting as she had arranged to do. The difficulties mentioned by women for not being able to come to a focus group after all included unexpected family commitments and holidays (Vi, Lucy, Queenie and Alex). In Teresa's case, she had just been beaten up yet again by her husband and did not want to see anyone.

Despite some initial anxiety, all the attendees said they had really enjoyed meeting each other. There was a lot of laughter and a very positive atmosphere. Women hoped that by doing this they would help improve the lives and treatment of others in future but were enjoying themselves too. For some, meeting up in a women-only group was a novel experience in itself. It was good to see peoples' delighted surprise when they heard someone else describe an experience they had had themselves, such as unfriendly and sometimes insulting behaviour from doctors' receptionists and at treatment centres:

The value of this type of work is that women substance abusers, viewed traditionally as a stigmatised, polluted social group, are able within a woman-oriented environment to look at the ambiguities, confusion, ambivalence and complexities that underscore their overall human experience and their specific dependence on substances. The sense of isolation experienced previously in private breaks down as women learn to share a renewed sense of vitality and vigour with other women similar to themselves (Ettorre 1992 p.136).

All respondents were asked whether they would like to see the final report but most did not want to; some seemed to feel they had achieved their goals in taking part. Others became involved in the group, Women's Independent Alcohol Support (WIAS), which developed as a result of these 'Making a Start' focus groups. Later, the national 'service user' group, Shaping Our Lives, financed a further meeting, not only for my respondents, but also for women who had joined WIAS subsequently. This gave me further insights into how women felt about their alcohol use and how the health professionals treated them.

3.4 The second research project: 'Treatment Approaches' (2005-2006)

The main focuses of the women respondents' discontent had been GPs, treatment centre assessors¹³, and AA groups, so these were the people whom I wanted to meet next, to hear their views about what

¹³ Before treatment at a treatment centre people are first 'assessed' as to what their drinking problems are like, and whether the centre is likely to be of use to them

alcohol treatment did and should provide and how they felt about it. However, the NHS Trust funding my research felt that attempting to interview AA groups might make the research project unwieldy, so the project focused on GPs and treatment assessors. Again, the project was to be completed within a year, and a report sent to the Trust.

There were several differences between the organisation of this project and that of 'Making a Start'. The planning of 'Making a Start' had been left to me to decide and to put into operation, with the help of RAG, and according to the NHS protocols agreed. However, the Trust wanted me this time to involve an additional Steering Group of professional 'health people'. The reason was not explained. I discussed this with RAG, and we wondered if it might be because I would now be questioning staff as opposed to patients. Might the Trust be feeling alarm at the extent of our findings in 'Making a Start'? Perhaps the Trust simply thought we would be more likely to get our interviews with more 'heavy-weight support'? Anxious to retain our feminist approach, without waiting for Trust approval, I invited a number of prominent local women onto the Steering Group, together with two representatives of RAG as well as myself. I wanted a variety of representation, but particularly from the groups to be studied (GPs and alcohol treatment providers). Thirteen professional women agreed to take part in the Steering Group for one year.

All the new Steering Group members were giving their skills and advice on a voluntary basis. Their details are to be found in Appendix 7. One of the group's roles was to ensure that treatment providers and GPs were approached effectively; another was to advise as to the way that the data might best be circulated and noted. I was also able to use them, as I still did RAG, as a sounding board for ideas. They were very busy, and we did not meet often, but they were always available by telephone and email, and their expertise was of great help in their different areas. Their involvement also lent weight to the project and may have satisfied GPs and treatment agencies that the interviews were worthy of their time. Perhaps the only drawback was that some of them knew so much about their own fields, which did include alcohol use, that it was sometimes necessary to remind myself privately that there was a level at which RAG and I were also experts (Faulkner and Thomas 2002). We possessed experiential knowledge (Beresford and Campbell 1994) but our difficulty was that we were people who had 'transgressed', our transgression had convinced us that our value was less, and we feared that they must 'know' more than we 'knew' (Oakley 1981 p.31).

The second research project was designed to achieve reflexivity, with the comments of the different groups of people ('service users', GPs and treatment assessors) reflecting back on each other. Only 30 minute semi-structured interviews were planned since I had been warned by the Trust's Director of Research that these professionals

would be extremely unlikely to agree to longer sessions and that they might not respond at all.

3.4.1 Recruitment to ‘Treatment Approaches’

‘Making a Start’ respondents came from a very large area. Directly approaching all the GPs and treatment assessors across such a zone would have been an enormous task, requiring numerous requests for permission from a large number of Primary Care Trusts (PCTs). The Trust felt unable to finance this. We made a compromise; I would concentrate on the major city involved in the ‘Making a Start’ research. For the recruitment of GPs, I would select a PCT in that city which had an ethnically, socio-economically and culturally mixed population. I would approach all GP practices in that PCT, with a view to interviewing one from each of ten practices. This figure was decided by the fact that the city happened to have ten day care alcohol treatment centres, most also dealing with ‘drugs’. I would interview an assessor from each one, and an equivalent number of GPs.¹⁴

To engage the GPs, I had first to obtain written permission from their PCT’s Director of Research. Next I had to approach all the 38 GP practices in that PCT simultaneously, by a letter to each Practice

¹⁴ I did not include residential treatment centres as most were not within the city. Also, only 4 of the 23 ‘Making a Start’ women had used them, as opposed to day centres.

Manager¹⁵. The intention was to interview one GP from each of the first ten GP surgeries to respond positively. I then waited for two weeks before following up with a series of telephone calls and emails, keeping strictly to order of rotation. Each practice seemed to handle correspondence differently, and not always consistently. I might be told different things on different days by different receptionists, in relation to whether the Practice Manager had received my letter and whether an interview with one of the GPs would be a possibility. I was often told that they had not received my letter. Sometimes, the Practice Manager had been away when it arrived and no trace of the letter could now be found. Alternatively, the Practice Manager might be absent when I rang, for example on maternity leave or on holiday. Some Practice Managers were part-time, but when I called back at the time recommended, they had changed their rotas. More often than not, duplicate letters were requested. Fortunately, they would often accept these by email, thus reducing costs and time.

Reception staff and Practice Managers acted as effective 'gatekeepers' in what seemed like attempts to deter me from interviewing any of their GPs. They were protective of their employers' time, and they were very wary of people calling themselves researchers. A report on receptionists' training in part of Newcastle, in 1988, reported it to be poor, with only 27% of respondents' feeling that it had been adequate (Copeman and Zwanenberg 1988) and a study in Leeds confirmed it to

¹⁵ See Appendix 8

be a highly stressful job (Eisner and Britten 1999). Apparently multi-tasking is central to receptionist skills, but not always personal communication (Hewitt 2006). I found it quite difficult to persuade many staff that I was a bona fide researcher, accredited by their PCT's Director of Research, and that one of their GPs might have time to see me. I had already been warned that these difficulties might arise, so persisted. Practice staff told me their GPs were extremely busy, and some took it upon themselves to say that all their GPs were too busy. Others seemed to give in and become friendly after several telephone calls, putting me through to a GP after I had hung on for a long time. Some Practice Managers were friendly but unable to commit a GP at that point. When I called back, the Practice Manager was not necessarily working that day, or (in one case) had actually left, so that I had to start again, as far as that practice was concerned.

However, on one occasion, following up my letter by telephone, I was put straight through to a GP who agreed an interview date on the spot. On another occasion, a practice arranged an interview for me within a month of the initial letter and after only one telephone call and two emails. A third sent me a personal letter asking for more information but making it clear that an interview would probably be agreed, and in a fourth practice I was recognised by the receptionist, who arranged me a slot after a brief consultation with one of the GPs, who turned out to be my own. I had some concern about this, but felt unable to express it. I have a good relationship with my GP, who had been supportive about

my doing the research, and who wanted to be helpful. However, it is possible that our having a professional relationship as well as a research relationship could have affected what we said to each other, since we wanted to keep each other's good opinion (Klitzman 2007). In practice, what was to occur was that my GP, who is always chronically busy, felt sufficiently 'at home' to continue to sort her papers during our interview,

Once I spoke to a GP over the phone, or exchanged emails directly, there were few problems about arranging a day and a time. They did appear to be very pressed for time, so perhaps I was interviewing the ten who had the greatest interest in women and alcohol. If the latter is true, perhaps they were also the least likely to be the GPs complained of in the 'Making a Start' interviews. I continued to pursue the thirty-eight practices in rotation until ten interviews had been arranged.

The ten GPs who agreed to be interviewed¹⁶ ranged in age from forty-two to fifty-five, and all were white. Eight were women. All were told that there would be a semi-structured interview, with the object of obtaining further information as a result of the 'Making a Start' study and that it would not take more than half an hour. They did not ask what the women in that study had reported and I did not mention it. Publication of 'Making a Start' findings was withheld until the

¹⁶ See Appendix 9

'Treatment Approaches' interviews had been completed, in order not to prejudice its findings.

Of the ten treatment centres in the city,¹⁷ the 'Making a Start' women had only had experience of three, probably because fewer treatment centres were saying at that point in time that they would deal with alcohol as well as illegal drugs, but also because no-one had told them about the others. I hoped to interview one person from each centre who 'did assessments'. This group of staff was my focus because being assessed as to suitability for treatment had been a procedure causing great distress to many 'Making a Start' respondents. I refer to these senior treatment professionals as 'assessors'.

Nine of the ten centres were in the voluntary sector so could be approached directly. The tenth was the statutory treatment centre, and permission was obtained from the NHS Mental Health Trust funding my research. I approached the centres by letters very similar to those I had sent out to the GP practices¹⁸. Several telephone follow-up calls needed to be made before all ten interviews were in place. There were often problems when trying to explain what was required over the telephone, since my initial letter had frequently disappeared.

Sometimes the people I spoke to on reception at treatment centres seemed unable to disentangle my status as a recovered 'alcoholic' from my status as an NHS researcher. On one occasion it was

¹⁷ See Appendix 9

¹⁸ See Appendix 8

assumed I must be seeking counselling in a roundabout way. However, these interviews were much easier to obtain than those with the GPs. This greater accessibility could have been a result of the nine voluntary sector centres' seeing themselves more as businesses in need of clientele, rather than strictly professional bodies. The statutory centre was the one where I was based, so was in any case accessible to me for this reason.

All the treatment centre staff responding were told there would be a semi-structured interview, with the object of obtaining further information as a result of the 'Making a Start' study and that it would not take more than half an hour. Like the GPs, they were not told what the women in that study had reported. There was a little more curiosity about what the 'Making a Start' study had found but my impression was that many treatment centres felt sufficiently confident to deal with any criticisms which might have been made, while those which were less confident were even more anxious to learn.

Eleven interviews actually took place, since one centre unexpectedly provided me both with an interview with the Director and an interview with a female assessor. Another centre informed me, early on in our interview, that I was speaking with the Chief Executive (who does not do assessments at all) and that I would not be allowed to see an assessor: 'Anything like this, it's always me that it comes to' (Purple Centre assessor).

The eleven day treatment centre staff whom I met ranged in age from thirty-one to fifty-eight, a larger age range than that of the GPs who had agreed to be interviewed. Nine out of the eleven were women. Ten out of the eleven were white.

3.4.2 Interviews with GPs and treatment professionals

The interviews were semi-structured and tape-recorded. All but one took place at the respondent's place of work, the exception being that of Dr. Fisher, which I carried out at her home. This meant that, compared with 'Making a Start', there was less informality, cups of coffee, etc., and therefore a less relaxed atmosphere. Minimal personal information was provided. There was also the time limitation; these interviews were approximately one third of the length of the 'Making a Start' ones, so there was not the opportunity to 'unwind', even if the respondents had felt it appropriate to do so. In fact, the two respondents with whom I was acquainted---one my own GP, the other a treatment assessor, did provide more relaxed interviews, and the treatment assessor also produced coffee and biscuits. One GP was desperately short of time and was simultaneously organising her desk, with many apologies, which had the effect of making me feel I should hurry. Consequently her interview was less informative. On the other hand, the treatment assessor who told me not to worry about the time produced all sorts of informal information about treatment in the area which I would not otherwise have been able to access.

I was again required to obtain signatures on Consent forms—the GPs scribbled signatures without reading them but one or two treatment assessors looked over the forms carefully. I explained that all data would be pseudonymised and that all that anyone would know was that the person interviewed was a GP working for a local PCT or a treatment assessor working at one of the local treatment centres. There was no ethical requirement for me to contact my NHS base before and after the interviews as they were deemed to be occurring in a safe environment. In fact, the majority of the interviews with treatment assessors took place in run-down areas where I was less ‘safe’ than when interviewing many ‘Making a Start’ women.

I offered transcripts and a report but all seemed too busy to be interested. However, some doctors made recommendations for better liaison between themselves and the centres, and I sent these out to PCTs and ‘Treatment Approaches’ respondents when the project was completed. Some of these recommendations have been implemented in some places. I was also able to publish some of the results of ‘Making a Start’ in academic journals¹⁹. However, it is difficult to know to what extent the ‘political change’ I sought has occurred, since such change is a very slow process and sometimes occurs as part of a general paradigm shift.

¹⁹ ‘Labelling Out’ was published in 2005 as was ‘Women’s Alcohol Treatment as Social Control’.

3.5: Analysing the data

Being alive to the way respondents and I engaged with each other was an important factor in analysing the data, since the data may have meant different things according to how we felt about each other at the time (Katz Rothman 2007). It could also have been affected by how I felt when I was writing up the interviews. I made notes, as well as taping, also adding to them on reaching home, but the notes were often scrappy, the more so if I was deeply engaged with the respondent, or just tired. It was impossible not to be reminded continually of my own life, when I was drinking, and one way I dealt with this distress was to keep a diary; another was to make frequent telephone calls to my family, who were not happy about this. This further emotional work did affect how I dealt with my data, and could perhaps be seen as analytic reflexivity (Mauthner and Doucet 2003).

Initially I sorted data into categories, and later into themes. I drew not only on the interviews and focus groups but also on my personal experience (Stanley and Wise 1983) and that of RAG. This was important, as I was using a grounded approach (Glaser and Strauss 1967, Cutliffe 2000, Pope and Mays 2000) rather than beginning with a hypothesis as to what I believed, and then seeking to disprove it.

Later, I searched back again through the data for themes suggested by these categories, a task I eventually did manually. Although laborious and demanding of large amounts of floor space, this process gave me

a great familiarity with the text, and served to keep me feeling closely involved with the research respondents: 'Immersion is the time-honored strategy...By cutting oneself off from other interests and concerns, by listening to informants hour on end...by allowing one's mental life to be taken over...themes often emerge' (Spradley 1980 p.145). It was also an easier way to remember, and take into account, the context of the data; how respondents had looked or behaved at a given moment.

I found there were many ways to define the respondents and to match them, thus cutting the data in a number of ways. For example, often I would say 'the women' for the respondents in 'Making a Start' and 'the GPs' or 'the treatment providers' for those in 'Treatment Approaches', yet most of these were women too. Some of the GPs (both male and female) were also distressed by the poor treatment of women, and some of the 'Making a Start' respondents did not see the GPs and treaters as real people at all.

I looked at the range of causes the women in 'Making a Start' had seen as being related to their need for alcohol, finding that there were a number in common, such as sexual abuse, domestic abuse, loneliness, depression and rage. Treatment provided another set of themes; avoiding any 'help' outside the family; trying AA; entering day or residential treatment. Sexual orientation was another way of grouping the women, as was being a mother, holding down a job, being a

student. The GPs could be subdivided into men and women, although only two were men; they could also be divided into those who were convinced they knew the answers to 'alcoholism' and those who were unsure; into those who saw women's issues as different and those who did not; into those who admitted it was a complex area and those who saw it as a simple problem needing abstinence. All but two of the treatment providers were also women; otherwise they could be grouped according to how they responded (apologetically, brusquely, eagerly), what they believed (e.g. 'chronic, relapsing condition'), how much of themselves they were prepared to reveal, and how they felt about the treatment system.

In both research projects it was helpful to study the feelings of the respondents: how they felt about their alcohol use, and about themselves; how they felt about the responses they had got to their drinking or their attempts to help. GPs would feel angry and frustrated but also miserable at their lack of effectiveness; they would sometimes feel helpless in the same way that the 'Making a Start' women did:

I find it worrying and I also don't find [treatment and AA] particularly effective...my impression is that you get them over that hump and then they go back to it and then they come back again, 6 months down the line...and I also have this fear that they will do both, drink and take the drugs....it can be quite hard... (Dr. Ilford, 'Treatment Approaches').

However, as I describe later, they did often seem interested and open to new ideas. I felt that they would not make changes quickly but that their minds were far from closed: 'For doctors to believe other than that their current practices are soundly evidence-based would compromise their capacity to practise with confidence...' (Hader et al. 2007 p.605). Some of the treatment providers also showed their feelings, which included despair, over-confidence, and genuine involvement; at worst they had perhaps come unquestioningly to believe in dogma.

Other similarities between patients and professionals included bewilderment at administrative processes which did not comply with needs, misunderstanding and inaccurate information, leading to biased decisions, and a wish to be acceptable to each other. Unfortunately, in writing up, it was necessary for me to be selective and only to focus on some of these aspects.

There was also a need to study my own feelings in such contexts. It is possible that my sympathy with the problems of 'the oppressors' could have been a result of my own conditioning as a female: '...women and other exploited groups are forced, out of self-preservation, to know the motives of their oppressors as well as how oppression and exploitation feel to the victims...' (Cook and Fonow 1990 p.74).

Analysing data while work is in progress has both advantages and disadvantages as others have pointed out (Pope 2000, Cutcliffe 2000).

It enabled me to find out better ways as I went along to refine and improve how I conducted interviews and focus groups. It also meant that once an interview had taken place, I could not go back and ask the same respondent a question which had occurred to me in a later interview. Pilot studies are essential for ensuring that the responses offered as possible answers actually do exhaust all the possibilities (Shipman 1988 p.80). Although I did run pilot interviews with RAG, and with my daughter (a GP in another part of the country), more extensive piloting would have made for more effective interviews. When examining the interview content I wished I could have gone back and asked for more information about the pleasure women experienced in using alcohol, and the GPs' own ideas about the nature of expertise, which I had not pursued sufficiently, or even thought of, at the time.

It was also the case that theories I began to form in the first research project, such as that concerning the victimisation of women patients by GPs and treatment workers, needed modification once I had encountered some of the responses in the second project. An example was acknowledgement of the lack of skills and good information available to GPs. This modified my vision of alcohol 'treatment' as a body to be challenged, and made it seem more like a fragmented entity with strands including the anxieties and agendas of many sets of people (Mennell 1974, in Crow and Pope 2008).

I became aware at this time of the extent to which I was influencing the research just by being myself (Katz Rothman 2007). One example is my use of the first and third person (Stanley 1993). When I wrote up 'Making a Start' and 'Treatment Approaches' for the NHS Trust, I used the third person because that was what they expected; they saw such a format as objective and value-free (Faulkner and Thomas 2002). However, when I began writing up my thesis, I used the first person, because this made it easier to acknowledge my own role in the research process and consider the extent to which my personality entered the exchanges, and the effect they had on me. This acknowledged my place within the production of the knowledge. When I have compared my two different styles, to see to what extent the different style of presentation affects one's understanding of it, I find that although the original research reports sounded authoritative, they omitted much valuable information, partly because I was afraid that including my own perceptions would make me look unprofessional and partly because at that stage I had not realised how important my own perceptions were. I did not 'write myself in' at all at that stage, whereas had I done so the reports would have had more meaning and a wider perspective.

3.6: Power and powerlessness in research

The penalties and the benefits of 'doing in-depth research' have been noted elsewhere, being described as a 'roller-coaster ride' (Beale et al. 2004 p.146). There is no doubt about the value and qualifications of

'experts by experience' (Faulkner and Layzell 1999) although emotional risks for us can be high (Lowe and Gill 2006). I lived in a state of multiple consciousness for at least two years, finding myself holding several positions (academic, 'service user', interviewer) simultaneously. This was intensified while I was transcribing the interview tapes. I found myself re-living with the women their experiences, which were so very close to many of mine. This could be seen as taking on the lives of the respondents (Tillman-Healy et al. 2000).

'Service user research' does not seem to be taken seriously in the NHS, and qualitative research scarcely more so. The former was thought unlikely to be published in peer-reviewed journals and the latter to be dismissed as 'grey' if the findings could not also be 'proved' in a two-dimensional way (Rose et al. 2003). As a 'service user researcher' within the NHS, I was completely outside the culture of other researchers and administrators, who spoke a language of acronyms I had to struggle to understand. It was impossible to form friendships or even genuine work acquaintanceships since they shared no personal information with me. I was many sorts of 'outsider' (for example, being unsalaried and only having the other researchers' work phone numbers) and 'insider' (for example, my personal experience of being a lesbian and of being a 'service user'). Naples (1996) refers to such a position as contributing to numerous positions of 'knower', but it was lonely and frightening. 'Service user involvement... can easily be

degraded, diluted and devalued... (Branfield et al. 2006, p. ix). Even my first-hand knowledge of the field of alcohol treatment could be disempowering as well as enriching (Cotterill and Letherby 1993).

I felt as if I was not worth much anyway; that I was 'only' a 'service user' (Beresford and Campbell 1994); my research would not 'count'; I did not 'really' know much. My history as 'a woman who drank' also made me slow to accept that my own observations had validity (Raine 2001, Rowbotham 1973). For example, as soon as I realised that GPs thought it inappropriate to question patients about sexual orientation, I lost my conviction that I had a right to ask them this. Such difficulties were not only in my own mind. While initially visiting treatment centres for background knowledge, I had found that if I disclosed that I had once been in treatment myself, staff attitudes usually changed at once. Usually they became friendlier, but condescendingly so, so that I wondered if they saw me as having less worth.

When I began looking for respondents, I felt a great sense of responsibility towards them. I was aware that if I were not meticulous in describing the nature of the research and their possible roles in it, and in protecting their identity, I might cause harm. However, I did not see this as having power. I thought that the respondents were the ones with the power, because they could choose not to take part. Nor had I thought that the respondents would see me as someone with expertise,

simply because I was stating in my advertisements that I had recovered from alcoholism.

Those with less power over their lives in general are usually more vulnerable to research exploitation (Wiles et al. 2007). The 'Making a Start' respondents were infinitely more prepared to give me information, without much concern about what I did with it, whereas the 'Treatment Approaches' respondents were more cautious and circumspect about what they said and interested in what I would be doing with their comments later. Additionally, they were almost always talking to me in the work-place, which would be likely to make them more careful (Goffman 1971). This could also be seen as the difference between 'researching down' and 'researching up', since at least some of the 'Making a Start' women saw someone doing research as having a higher social position than themselves, while I certainly felt that some of the 'Treatment Approaches' respondents were of a higher social status than I was (Wiles et al. 2007).

I eventually became aware of my own power in the research process after I had carried out my interviews. I realised that both researcher and researched hold power in different ways (Fish 2006, D'Cruz, 2000, Roberts 1985). The area of the consent process is a good example. Although mental health is considered as a factor, the fluctuation of awareness which may occur in the use of substances (or of epilepsy) is not addressed (Wiles et al. 2007). There could have been such an

issue around the 'Making a Start' data. Everyone signed Consent forms, and I was not aware that any respondents had been drinking beforehand. If I had thought they had, I might have been uncertain about the validity of their 'consent' to giving me information. However, when, like Gill, they either drank alcohol while I was there, or, like Anne, were continually swigging co-codamol and water, should I have deemed their signed Consent forms to have become invalid, and left? Should I have used the data? This is a delicate area. Had I withdrawn, I should certainly have caused distress.

In both cases, I continued the interview. When it came to transcribing these interviews, it was clear that Anne was completely lucid, and in full possession of her faculties as far as it was possible to tell. I therefore used Anne's transcript as it was. Gill, however, began to ramble incoherently after an hour, and it was extremely difficult to make sense of what she was saying for a while. This part of the interview I was unable to transcribe, or to use, so my belief is that no harm was done by continuing either interview. However, this is an area which needs thoughtful and sensitive handling, if the power of the non-drinking interviewer is not to be abused.

Sometimes my roles seemed in conflict. In each interview I had been honest about such potentially difficult issues as my not using AA, but I had been careful not to give offence to anyone who was using it or had a high opinion of it. At the same time I would sympathise with those

who had disliked it. In a focus group it was harder to sit on the fence, feeling I was somehow conniving with those who disliked AA; a 'discrepant role' (Goffman 1971).

Similarly, in the focus groups of 'Making a Start', I had interviewed all the women, and unless they chose to disclose any of the content themselves, that person and I were the only ones who knew those private things. Everyone present knew that I knew them but that it would have been an infringement of my promises to them to reveal these 'entrusted secrets' (Goffman 1971 p.143). I worried that the respondents might be concerned about what I might say about them; or at least whether I would be mentally checking up on them in case they said something which contradicted what they had said in their interviews.

In the 'Treatment Approaches' interviews I felt controlled. I was aware that respondents were being selective about what they said and that they had their own agendas. The GPs wanted the PCT and the Trust to provide better resources and made me feel as if we were all on the same side. The treatment assessors were more likely to try to 'sell me their product', i.e. persuade me that their treatment programme was the best. It only occurred to me later that the power I possessed with both groups was the report I was to be sending to the Trust and the PCTs, which might have affected their funding.

Power was a complex factor in RAG's involvement. It was a new and co-operative approach to alcohol research, but I decided how much power the others might have. Although the group's ideas and opinions were always listened to and usually acted upon, when it came to the interviews and the writing up, the extent to which I followed them was up to me. Once I had made the transcripts, it was my view and my understanding of the data which shaped its interpretations; I was the one who chose the most important (to me) themes, and decided what construction to place upon them. I had 'ultimate control' (Letherby 2003 p.117). At the same time, their good opinion had become important to me, and I felt, and tried to be, accountable to them.

My attempts to share power with the respondents were fruitless since none wanted to see the reports of 'Making a Start' or 'Treatment Approaches' before I submitted them. Perhaps they felt that they had done enough already. However some did signify limited approval by joining the support group, WIAS, mentioned above.

The process of obtaining the interviews with GPs and treatment professionals raises different issues about power; for example, the effective control of the practice staff over what information reaches the GP, and that of the treatment professionals about who gets treatment and of what sort. This is an area well worth researching on its own account (Tidmarsh et al. 2003).

Reflections

During the considerable period of time which elapsed between deciding I wanted to research women's alcohol 'misuse' from a sociological perspective, and completing my analysis of the data, my focus had shifted from: 'what is wrong with women's alcohol services and what should be done about it?', to: 'what are the factors in society which might explain the way that many women need to drink and why most treatment appears to be ineffective for them?' My aim became a fuller understanding of these processes, although still with a faint hope that I might discover some possibility of a solution to the unhappiness and confusion I had seen among patients and treaters. My respondents frequently supplied me with rich data, the full relevance and significance of which I would only discover at a later stage. This may be an example of: 'unanticipated consequences of purposive action' (Crowe and Pope 2008 p.219).

Chapter 4: WOMEN'S PERSPECTIVES OF THEIR ALCOHOL USE

Introduction

This is the first of three chapters which draw heavily on data from 'Making a Start' ('MaS') and from 'Treatment Approaches' ('TA'). In it I look at the experiences of women who saw themselves as having issues with alcohol, and affirm that the experience of such issues is affected at all levels by gender. The very existence of women who have alcohol issues is a challenge to social stereotypes, yet as this chapter shows, the issues themselves may also be caused by such stereotypes. Pen portraits of the women respondents are presented in Appendix 6, and of the GPs and treatment professionals in Appendix 9.

In this chapter I look first, in 4.1, at 'The effects on women of social restrictions and abuse'. These include a lack of opportunity to experience authenticity, and domestic and sexual abuse. These may in turn lead to distress, depression and illness, and in 4.2, 'Embodying distress in alcohol consumption' I show how women who have alcohol issues may be deemed 'morally sub-standard', misunderstood by GPs, and acquire an increased sense of worthlessness. I look in 4.3, 'Women and social dissonance' at the way that women may survive social dissonance by adopting labels such as 'mentally ill' and 'alcoholic', achieving acceptance and fulfilment by living 'beyond the

pale', 'an outcast' . Finally, in 4.4, 'The experience of alcohol treatment' I describe how treatment may be damaging, ineffectual and degrading.

4.1: The effects of social restrictions and abuse

One analysis of women's less powerful position in society proposes that, having succeeded, as adult women, in breaking free of our mothers' control, we do not continue our journey into independence:

Few of us ever outgrow the yearning to be guided...we do try hard to outgrow...our subjugation to female power...we do not really want to be our own bosses...Patriarchy remains a refuge we are afraid to dismantle (Dinnerstein 1987 p.188-189).

Such subjugation has been described by feminist writers for over a century (de Beauvoir 1997, Coward 1993), as have ways to defy and reverse it. A wealth of knowledge and experience is available to women who do successfully break with patriarchal power and 'run with the wolves' (Estes 1992), and substance use may well be used as a tool in this process (Ettorre 1992). In some cultures, ritual drinking has also provided an accepted arena to express spiritual power and cultural dissent, otherwise perceived as dysfunctional, and I consider such possible benefits later in this chapter and, at greater length, in Chapter 6.

One way that a gendered power imbalance is maintained is by dominant and limiting views of what constitutes being a socially

acceptable and 'feminine' woman. Women may find it as difficult to be themselves today as they did as a result of eighteenth century perceptions of women's 'sensibility':

Prevented from exercising their intellects and energies in the public world outside the home, women...are reared to place inordinate emphasis on their senses; confined 'in cages...they have nothing to do but to plume themselves...'. In exchange for their keep, they yield up their liberty, health and virtue... (Oakley 1981 p.4 citing Wollstonecraft 1929 p.62).

More recently, attention has been drawn to the way that eating disorders may result from the traits women feel obliged to adopt in order to be 'feminine' (Green et al. 2008).

These dominant views are now most likely to be imparted by women's magazines and other media. Magazine pictures of slender, attractive young women, with expertly made-up faces and glamorous clothing, embody the 'beauty myth' to 'checkmate power at every level in individual women's lives' (Wolf 1991 p.19). More recently, the significance of the role of the fairy princess, as helpless and lovely, has been noted, in stories told to little girls (Holland 2004). Such images influence what is seen as normal appearance and behaviour, so that where a woman is seen to be situated on a fashion continuum will affect how she is treated. At the same time, maintaining that position consumes her time, energy and money, all 'checkmating' her freedom to develop authenticity. Women who do not fit such an established

model of femininity are vulnerable to being labelled as failures, even unfit mothers. They may also feel they should have more control over their less than satisfactory bodies: '...negative implications can also result from viewing the body as being under the control of the individual and perceiving deviations from the 'proper' body as being due to personal transgressions' (Johnston et al. 2004 p.407).

Such established patterns of femininity can be experienced as stifling and demoralising from an early age. My own life experience had certainly been one of being trapped and restricted by what was available and allowable to a girl growing up in England during the 1950s (Oakley 1981). Inspired by stories of the war, I wanted above all things to fly. My first warning that this might be problematic was the frustration, by the boys in the infant school playground, of my attempts to join them in the never-ending games of 'Spitfires'. You raced around with your arms out, 'being a Spitfire', while other boys crouched on the ground firing at you. My Spitfire was never allowed off the ground. Teachers intervened in the indignant arguments that ensued and I was sent off to play with a skipping rope, an occupation for which I acquired a lifetime's loathing. Later, I was told that the RAF did not accept women as pilots any more now that The War was over.

Like the young women smokers Jacobson (1988) describes in *Beating the Ladykillers*, I still attempted to associate myself with the glamour and freedom I believed that the young men I knew possessed. I

smoked and drank like them, but since I was female, the behaviour induced by the alcohol brought me ignominy rather than glamour. Later, when I attempted to pursue my second choice of career (training for a Foreign Office job involving travel and ability in foreign languages) I learnt that despite my otherwise suitable qualifications, the fact that I had become pregnant and married disqualified me from government employment. Additionally, the many requirements of femininity (wearing make-up, not answering back, letting men make the decisions, and being discreetly seductive) were a handicap in the pursuit of self-sufficiency and personal effectiveness (Coote and Campbell 1987). My attempts at equality of opportunity were foiled by the gender expectations and prohibitions of that time.

My impression is that as a child and a young woman, I was attempting to adopt the male rites of passage rather than the female, having noted that they were more fun but not that their availability was gendered (Roger and Duffield 2000). Feminist anthropologists have observed the differences in rites of passage from childhood to adulthood in other societies. These rites are designed to prepare youngsters for the roles they are to occupy. Bowie (2006) describes examples of initiation for females which involve its being done in private, away from other young women, so: 'there is no opportunity for bonding...[unlike that which is] characteristic of the shared experience of male initiation' (Bowie 2006 p.158).

The male initiation is designed to facilitate independent status; the female counterpart is designed to teach a young woman the correct attitude to adopt towards her tasks. She is consequently kept close to her family, whereas a young man is encouraged to bond with his peer group. Bowie (2006) also notes that whereas contemporary Western societies provide space for many different life-scripts for men, those available to women remain more problematic. Whatever 'free choices' women may make, they lay themselves open to criticism in a way that men do not, since 'most discourses construct femininity in negative terms relative to masculinity' (Bowie 2006 p.100). In the end it remains the case that women usually do have the children, do most of the domestic work, have less autonomy and may be disadvantaged nutritionally.

There is, of course, ample evidence available in the writings of Western feminists as to the restriction of women's activity by expectation and, at least until recently, by legal prohibitions such as those I have mentioned in connection with government employment (Walby 1990). I wanted to find out to what extent respondents felt that their lives had been affected by the impressions they received in growing up as to how they should look and behave (Wolf 1991). I wondered if they had felt they were expected to mediate their own and others' behaviour, act as a stabilising force; be 'good girls' (Lees 1993, Oakley 1981). I wanted to know to what extent these expectations had run counter to their own needs (Ettorre 1992) and whether the experience of being

female was alienating and indicative of outsider status in itself (Cotterill 1992).

By the time I was interviewing the respondents on which this research is based I was 60 years old. Their ages ranged from 25 to 55, and I was aware that the experiences, of the younger ones at least, might differ from mine for generational reasons if for no other. However, it was to transpire that essentially similar factors had inhibited their lives as had inhibited mine. For example, social expectations had trapped several women, such as Helen and Deirdre, into early motherhood and other caring roles; controlling family members had tried to restrict Margaret's career so that she could help more in the home; Anne and Deirdre spoke of being taunted on the street for having been drunk. Men would have been less likely to suffer in these ways, since their rites of passage to adulthood include normalisation of such behaviour (Harnett et al. 2000).

I did not feel, after considering the accounts of the 'Making a Start' women, that social class, in the conventional sense, had been a major factor in their experiences of oppression. This was not because I felt that class was no longer relevant; that it had been overtaken by individualization and 'liquid modernity', as critiqued by Atkinson (2008). Neither was it because I thought that women could be lumped together, with generalised oppression making class differences insignificant (Skeggs 2005). Certainly gender was one of two unifying factors, but

the other was the way that their alcohol use had particularly isolated and stigmatised them in a way which destroyed their identity (Goffman 1968) and became their master status (Becker 1966). These women were talking to me because they had shared the experience of having alcohol issues, and this experience had tended to over-ride differences such as education or field of employment. For example, Gill had a good middle-class job with a supportive union, and was given time off to seek counselling for her drinking. She had no dependents. She fetched her bottles of vodka by car and still received some emotional support from an ex-husband. At the other end of the spectrum, Bella was jobless, living on benefits, travelling to the supermarket by bus, had four children and was being regularly attacked by neighbours on her run-down council estate. Both women were desperately unhappy and felt unable to improve their situations.

Class of origin was far less of a factor than economic circumstances. Both Gill and Bella came from middle-class backgrounds, but Bella had lived in poverty and chaos for many years, as a result of abuse and disability. Both women were equally unhappy and desperate, but Gill retained more options and resources; more social capital (Bourdieu 1984), and if/when she recovered, her options for moving on from this bad time were infinitely greater than Bella's. Bella did not seem to have retained the confidence exhibited by Queenie, Gill, or Wendy, whose initial class backgrounds had been similar to hers, but who had not

been equally exposed to the social services and to domestic and sexual abuse.

It is also the case that among those women who engaged with treatment services, those who would still see themselves as middle class, such as Carol, found it easier to 'handle' their GPs, seeing them less as powerful figures to be challenged than as professional colleagues. However, women without such advantages had developed coping strategies of their own, such as Nen's planned and successful 'assault' on her doctor's reluctance to refer her to specialist alcohol treatment: '... So when I couldn't cope with work I went to the doctor and had hysterics because I couldn't get them to listen any other way. I said I've been here before, and I want you to refer me... And she said no, you don't need [the Pink treatment centre]' (Nen, MaS).

Carol was strikingly unsuccessful with her treatment centre, where she offended a nurse by her knowledge and confidence, and Gill also recoiled from the same centre, seeing its methods as simplistic and irrelevant: 'I thought I'm not going to do that, sit around making models!' (Gill, 'MaS'). These are just a few illustrations of how the complexity of class, position and gender intersect with alcohol treatment. More research is needed in this area.

There could be no doubt, from the 'Making a Start' interviews, that most women I interviewed had low self-worth. Even a respondent who

had been alcohol-free for as long as fifteen years remembered her feelings and behaviour with contempt and retained a low opinion of herself. She only kept going by self-medicating with valium and cocodamol:

I had such daft feelings. Didn't want a drink but I was going to be a social drinker. So I bounced out of the Royal Gwent Hospital...and I come to the first pub and I think, 'I think I'll just go in and have one half. Then I'll go home.' Went in, I had one half, came out, went along the road, and there was a pub by the bus stop. Went in there and had one half.... happy-go-lucky me, everything's okay. I ended up back in Intensive Care. It was like a suicide mission....Valium. I go nowhere [since I stopped drinking] without my Valium. It's like cocodamol. There's no cocodamol in here [she's sipping cloudy water throughout interview]...but I take cocodamol. [Fishes in bag.] Let's see if I've got a couple...I take more than eight a day...(Anne, 'MaS').

Such a lack of self-esteem was common, sometimes developing early on:

I wasn't able to mix very easily. I was very shy as a child and my mother would try to make me join in things and I always hung back...I was bullied at school and very shy...never did any work, never...I don't think I ever fulfilled my potential, academically, because I wasn't a stupid person but I was crippled by shyness and inhibition and we had a very violent home life (Ursula, 'MaS').

And I think what happened to me was a lack of self-esteem, d'you know what I mean, like I stayed [at boarding school] for 18 years and when I came out I had no friends because all my friends were boarders (Vi, 'MaS').

Teresa's husband had told her she was ugly and in an episode of self-disgust she had cut off all her hair. She self-wounded frequently and considered herself to be ugly and unlovable: 'I know it's rotten of me but...he makes me miserable and...his cough's really bad and he's really sick....but at least he's there' (Teresa, 'MaS').

Deirdre also had doubts about her self-worth. She had married, while young, a widower with three children:

I...wouldn't say I had a hard life really...like I say, got these three kids [of his]...course I had an abortion...he didn't want no more kids...so of course I had to...I had one in [local city] and one in Birmingham... I thought a lot of him and...I still do now...besides twenty-nine years of marriage...but...did he want me as a person, or did he just want to get a mother?...I mean, the first time [I had an abortion] wasn't *too* bad... that was in [local city]...but then I had to go to Birmingham on me own. That was three days. And I was on me own 'aving it and on me own 'aving to get the train back... (Deirdre, 'MaS').

In our interview, Deirdre did not dwell on these experiences, but they are likely to have had a role to play in her periodic alcohol binges (Thom1994).

Margaret's lack of self-worth had placed her in a relationship with her boss for many years, although he had not wanted to marry her, and used her as a housekeeper. When he died she became homeless:

I shared his house...it wasn't a case of living with him. I was like a lodger. It was almost like he was ashamed of me....his daughters didn't really approve but they liked it when I cooked for them because it saved them the bother and I tried to take them everywhere they wanted. I was in that relationship about 12 years and I resent that now... Then...he *died*. *Died* on me...he'd had a triple bypass because he was older than me and then he had another heart operation and then....Well I stayed a few more weeks and then I got sacked (Margaret, 'MaS', original emphasis).

Sometimes, even when the marital partnership had been a relatively harmonious one, the male partner had expected to be able to control the way that the female took part in socialising, so that she became lonely and depressed: 'and he didn't like me going out...that I fancied dressing up and getting out on my own...not meeting people, just to get out...'(Anne, 'MaS').

Such experiences as those of Deirdre, Margaret and Anne, show how some women have been led to subordinate their own needs, often at great cost, in order to feel loved and wanted (Doyal 1995). The extent to which women may feel that their most important role is the facilitation of the lives of others, at the expense of their own, was painfully illustrated by several respondents. It could be seen as a

natural outcome in a society where female status is that of the 'other' (De Beauvoir 1997). Primary experience is perceived as being male, and identification with supplying need is perceived as female (Bowie 2000).

The sense of being responsible for the welfare of others often extended into feeling responsible for any problems in their own lives, even when these were due to having a disability:

I had quite a lot of hearing problems myself and to have grommets in my ears and that made me feel quite isolated. It was difficult having friends as well, partly my hearing problems...my Mum being quite protective...what with [the] main road and not being able to hear properly...I felt quite isolated (Bella, 'Making a Start'['MaS']).

Conditions which are not immediately apparent, such as deafness, dyslexia and anorexia, were referred to by other respondents as often leading to greater loneliness and isolation:

I can remember [being] about eight, starving myself....I don't remember an awful lot. I especially remember eight because I got sent to boarding school and I hated it. ...I hated school, didn't fit in, always on my own.....I never really understood what was going on, I just used to sit there (Wendy, 'MaS').

Wendy only recently received evidence of her dyslexia and says that finding she had a physical problem all along has made her feel better

about herself and her failure to achieve as much as she had hoped. This is a response to being labelled which echoes the relief some women feel at being told they are 'an alcoholic' (Hayward and Bright 1997).

This feeling that illness and misfortune must be one's own fault might even extend to feeling responsible for having been sexually abused. Ursula had been frightened, isolated and shamed:

And then when I was 14...and I was stood at the mirror brushing my hair and my father came up behind me and put his hands inside my vest, where I was just starting to develop, and started to fondle my breasts and I felt absolutely terrified and I could hear heavy breathing and I was just so terrified of him anyway and I just pushed him away from me and...luckily that's as far as it went. But he always used to spy on me, I never had any privacy and he was always there when I was getting changed for bed, and from that moment on not only was I scared of him because he was a physical bully, I felt I could never be on my own with him...I've never forgotten it and I've got deep shame over that. You do...I don't know why, but you do feel responsible, because I was a pretty little girl and I thought that was why it was. That I'd kind of invited it because people said, oh she's very pretty, and it was my fault... (Ursula, 'MaS').

Bella also suffered abuse, which in her case led directly to her regularly drinking herself into oblivion as a very young girl:

My brother from about when I was 4 or 5...was sexually abusing me...when the abuse started...heightening in intensity, and his explorations of my body were getting...um...more than I could actually bear to think about...I was always helpful in the kitchen so I could get more wine!...and then I'd do the washing up, and have more wine, like, my Mum wouldn't know...at about 11, I was regularly getting drunk (Bella, 'MaS').

Other forms of violence and physical abuse were also common to my respondents, and are likely to have contributed to their feelings of low self-worth. Of the twenty-three women I interviewed, 12 had suffered some form of domestic abuse in their lives. Childhood abuse had been inflicted on nine women. Bella, Elsa, Nen, Ollie, Teresa, and Ursula had suffered childhood sexual abuse and Carol, Elsa, Helen, Pat, Teresa and Ursula suffered childhood cruelty and violence.

Others confirm that the effect of such experiences in childhood can lead to feelings of guilt, low self-worth, and difficulty in forming adult relationships, and that the prevalence of such abuse may be as high as over 50% among girl children (Peckover 2003; Burton et al.1991).

Additionally, eleven 'Making a Start' respondents (Anne, Bella, Elsa, Fran, Nen, Ollie, Pat, Queenie, Sherie, Teresa, and Ursula) had been in cruel and violent relationships as adults, with Elsa also being sexually assaulted by a non-family member, outside the home.

Between 50% and 90% of women attending substance misuse services may have experienced abuse, either in childhood or adult life, or both (Barron 2005, Ouimette 2000).

These experiences seem to relate to the idea that females are the property of patriarchal family units (Friedman and Alicea 1995). This may involve even more than their being the sexual property of the family males. High expectations of support and loyalty from female offspring are common (Broadbridge 2008, Walby 1990). After describing her parents as: 'okay; they had their ups and downs' Margaret admitted that she had left home because 'they gave me an ultimatum: I had to cut the hours I worked and do more at home or leave...so I left' (Margaret, 'MaS').

Girl children and adolescents are often expected to be a credit to their families and not to expose the family to criticism from outside (Ussher 2003, Coote and Campbell 1987). This appeared sometimes to amount to emotional abuse: 'We weren't allowed to have problems; not nice; everything had to be perfect, and just glaze over the top of these things' (Bella, 'MaS').

The majority of the women respondents who had been abused as children had also ended up with abusive partners, perhaps due to low self-esteem and/ or to being desperate to get away from home (Taket et al. 2003):

He's abusive...although he prides himself on saying he's never hit me...he's left bruises on me, from his pushing, and pulling,

and verbal abuse, it really does my head in. But he's been a lot better lately...I don't know if that sounds crap... (Bella, 'MaS').

He wasn't that bad...not when I first met him. He was very, very miserable.... And he used to hit me, quite a lot. And then I had to leave him (Pat, 'MaS').

Even when there was no mention of violence, most 'Making a Start' women thought little of themselves. It has been noted that cultural domination and oppression, which is not recognised as violence, is still 'symbolic violence', and may be internalised by oppressed groups (Lewis 2009). As well as feeling worthless, many women were convinced that they had no right to feel other than happy and well. If they did not, but took comfort in some way which was deemed inappropriate, such as drinking, they saw themselves as being at fault:

A lot of my problems I bring on myself...because I'm lazy and I'll go to work and when I come home, the idea of people coming round, I really can't be bothered... Somebody at work has pointed that out...you feel too sorry for yourself... [but]...I'm talking 20 years ago; I used to do quite a lot of embroidery and fine stitching, I covered two chairs for here, and did all the curtains, and now I've got no...well you can see the state of the place. I'll just sit here, I don't care if the washing builds up, or the vacuuming (Gill, 'MaS').

Loneliness was frequently mentioned, with existing social structures again proving themselves unable to provide the support and comfort the woman had needed:

I was wed at 18 and...well I'd have a glass of wine but me husband didn't like me getting drunk...Anyway then I met a bloke...I split up from him...everything was going wrong...then I started drinking again...you go through a grieving process anyway...loneliness, failure...in the things that are important to me; I'm not very good at handling that (Helen, 'MaS').

Sometimes such loneliness would lead to a whole series of emotional and other disasters, early in adult life. These included homelessness and accidental pregnancy. Unable to get on with her stepmother, Karen:

...offered to go into care because I could only keep hold of myself in care and my sister was in care already and I wanted to go with my sister but she was in a Special Needs school so it sort of backfired...but I couldn't have stayed home either...: occasionally I used to go drinking with my friends but I always used to get, like, emotional...(Karen, 'MaS').

[I was] with my foster parents till I was 17 and then I got pregnant...it was in those days when unmarried mothers were unheard of!...I got put into the unmarried mothers' home then and told I couldn't keep the baby so 'ad the baby adopted and after that I went to live in a hospital and trained to be a nurse 'cos it gave me somewhere to live....[I was] 18,19....and I was drinking secretly in my room (Jane, 'MaS').

[My depression] started when I...I was married at 18 and I got pregnant straight away and that wasn't on the agenda; that

wasn't planned. So I had a termination. That was the turning point in my life (Renee, 'MaS').

Renee's mother, perhaps anxious to ensure her own daughter's sexual caution, had made a habit of commenting, when she heard that girls had got pregnant early on and had abortions, that they were sure to have nervous breakdowns as a result. This had stuck in Renee's mind and:

When I came out of hospital [after an abortion] I just went downhill. I got really depressed and I thought, Mum's right, Mum's right...and then, you know, got low....and [from] that day I became absolutely terrified of mental health [problems]...has followed me right through till now... I've had about six pregnancies in all. And each time I lost a baby I thought...oh well, I'm inadequate...and then we had two children and always I'm terrified of schizophrenia, hearing voices in my head...probably now at 46 I realise how silly I was but...I've had this fear of mental illness (Renee, 'MaS').

The use of the word 'lost' in this context is particularly painful; Renee felt inadequate because of her childbearing 'failures'. Saying she 'lost' the baby somehow places the responsibility, as well as the pain and fear, with her, causing her acute anxiety and loss of self-esteem (Cummings et al. 2007). It is another example of how women are 'meant to' take care of others, and keep children safe, even before they are born (Frost et al. 2008).

The two other major factors women described as a background to their unhappiness were stress and a sense of emptiness. There were graphic descriptions of the strains and stresses of coping with everyday life as the mother of a child with a borderline personality disorder. Bella's emotional distress, and poor social services, had left her inadequately supported in trying to keep her family:

Lucy...when she was really small...I had to put her in a buggy, otherwise she'd be...like a whirling dervish, all over the shops, and I'd be chasing after her...but if you put her in the buggy she'd scream...make her body go absolutely rigid and she'd hold her breath until her eyes rolled backward and she'd pass out in a heap!...I'd be pulling my hair out, drinking, when I got home! ...Nightmare...it was like being on an express train and never being able to get off! I found myself shopping at the all-night Tesco's and... 12 o'clock at night...I looked and...I'm not the only Mum tagging around with a small child, some of them are even smaller, sat in the trolleys in their babygrows, while their Mum's still in her work clothes and they'll be stuck in a trolley (Bella, 'MaS').

Other women experienced a sense of emptiness and pointlessness (Ettorre 1992) for which they had no name, but which sound like a need for greater fulfilment and meaning in their lives:

I've noticed throughout my life that it's not just that people are happy, sad, whatever...regardless-----I just drink myself to oblivion, or eat, regardless...I do know it does depend on how I feel about my life...it is connected (Wendy, 'MaS').

It's not when I'm upset, it's when I've got something to celebrate. I'll have *real* problems then....if something good happens, that's it; that's my biggest trigger...not knowing how to be happy without something to go with it (Vi, 'MaS'; original emphasis).

I have actually noticed that if I don't have a drink...for a day or two...my body's telling me, like, I know it sounds stupid like, 'got to have a drink'; I get like a butterfly inside my stomach (Pat, 'MaS').

In these instances, women sound afraid and panicked by their feelings that something is missing. Alcohol would be the quick fix that kept them going a little longer.

Depression often occurred following abuse, perhaps as a coping mechanism like over-eating, self-harm, and risk-taking (Boushel et al. 2000). It figured largely among respondents in 'Making a Start', with all the women having been affected by it in some way.

I was spending most of my time sort of gazing out of the window...I spent most of my school time wondering...if I should be telling someone and I'd always be picking up stories of how children had had to go to court and they'd be ripped apart...and how it would ruin families and how often the child would be thought to be lying or telling tales...'children are such liars aren't they?'...so I didn't ever tell anybody. For fear...could I cope with me being the person that would split up the family...and how I would be blamed for opening my mouth; because I knew the family liked tokeep family secrets... (Bella, 'MaS').

For some women, depression formed the backdrop to their entire lives. Fran described her childhood home life as very good. She was adopted as a baby, but she seemed to lose heart in her teens when she had to change schools: 'I got kind of fed up with it... It was a completely different part of the country.... I think most people'd made their friends by then' (Fran, 'MaS'). She started and dropped out of various courses, mainly picking up on the social life, which centred on drinking:

It was easier with my friends from college...[we drank] just in groups... Well I didn't finish that course... I went back to [home town] and got a job there, as a secretary...[It was a] load of crap! Very boring. Soon as you got out, you'd think, 'God!!' I'd go out and get pissed.....all the people were round about my age, or younger, and we used to go out like and take a few drugs and go round the pubs...whatever, you know (Fran, 'MaS').

However, despite this backdrop of depression, Fran enjoyed her drinking and socialising, and might have suffered far less in a society providing greater variation in the expected comportment of females.

The prevalence of women's experiences of depression, oppression, and illness have been described by many writers (Ettorre and Laitinen 2004, Orbach 1982). As long ago as 1976, Smart attributed the high incidence in women's mental breakdown to the impossibility of combining self-respect and self-acknowledgement within the traditional female role (Smart 1976). Some writers have postulated that 'mental

illness' (which might include 'alcoholism') is an expression of unhappiness and social dysfunction (Szasz 1961, Foucault 1961, Laing 1960). It should also be remembered that: 'severe mental health problems may themselves result from the infringement of human rights...' (Busfield 2006 p 223). Others have indicated the way that this is a cross-cultural phenomenon (Fenton and Sadiq Sangster 1996). It seems likely that a woman who is unhappy is likely to be attracted to anything which dulls the unhappiness. Some women did see a connection between their depression and their drinking:

I suppose mainly it was depression...which nobody understands either...I'd got my natural depression...I'd lost my previous job because of drinking...it was just a habit. I wanted to come home to a glass of wine; but it didn't stop at one glass and in the end all I was getting was drunk and.....[I lost] my last job (Margaret, 'MaS').

Among lesbian and bisexual women, depression and anxiety is believed to be common, as is suicidal behaviour, as a result of homophobia (King and McKeown 2003, Alcohol Concern 2002). There is also evidence that such depression is likely to result from feeling different, fearing the consequences of sexual orientation becoming known, either while a child or as an adult in the workplace, and feeling unable to share personal details such as loss of a partner (Bent and McGilvy 2006). Karen had been in the armed forces, had needed to have clandestine relationships there and had developed a reluctance to mix subsequently with 'out' lesbians. She saw that as: 'one of my

problems. When I was in the Forces we had to keep it secret...I mean it was there, but if we talked to each other about it we had to be careful...and when I came out, I kept that up, I never told anybody' (Karen, 'MaS').

Other lesbian/bisexual women's depression did not seem linked to their sexual orientation. Pat's childhood experiences of abandonment might equally well have happened to someone of any sexual orientation:

Well I was in care for practically half my life, you know, like boarding school, care homes...you know...then that was it...I went home...and I couldn't get on with my Dad...he had the same problem, cos he was alcoholic as well. Maybe that's why I got it, from my dad. Cos I'm sometimes like him (Pat, 'MaS').

Similarly, Jane did not link her long depressions with her sexual identity, but with her loss of her family:

My Dad died when I was two so I don't remember him. But my Mum was left with three children and there weren't any benefits then, that came years later; she went on the game; the NSPCC came along and said she was neglecting us so [they] took us away.... when I was ten...and my brother and sister, we were split up and put into different homes... I think I did [think it was my fault]... I was used to looking after the other two...well like kids do, you do blame yourself don't you, when things go wrong...they found us different foster homes cos they said they couldn't find anyone to take the three of us...I never got on in any of the other places really 'cos well they didn't care for

us...and ...we never went home again. It was totally puzzling when you were a child really...[I saw my Mum] twice a year maybe...but she died when I was 16 anyway so...I was still angry with her a lot of the time, I used to wish her dead!...you know what I mean?...and then somebody could adopt me or something...but then when she did die I did feel bad. [Crying] (Jane, 'MaS').

As I have argued previously, whether or not lesbian and bisexual women have more problems with alcohol is more complex and there are many factors to consider:

Being a member of a minority is stressful and lesbians more than heterosexual women tend to feel the ill effects of a value system based on a heteronormativity. This is especially true for those who have felt unable to live open lives. Homophobia creates depression, a major factor among women who misuse alcohol (Kendler et al. 1993). Lesbians can become unhappy and depressed because of their families' incomprehension of their lesbianism, their inability to share in the lives of heterosexual workmates and their being ignored by the health providers and educators. If the lesbian scene is not for them, they may experience loneliness. For them, alcohol can be exciting and pleasurable: 'You get what you need from drugs,' (respondent quoted in Raine, 2001 p.23). It would not be surprising if some lesbians abuse alcohol and feel unable to control their alcohol intake. Some research indicates that stigma, alienation, discrimination, and the cultural importance of bars place lesbians more at risk of developing problems with alcohol than heterosexual women (Rule 2003). Other research supports the idea that lesbian drinking is more problematic than

that of heterosexual women (Jaffe et. al. 2000). (Staddon 2005 pp.72-73)

In 'Making a Start' I discovered that a relatively high proportion of the respondents who volunteered to take part were lesbian or bisexual (six out of 23) and all had suffered depression as well as alcohol addiction. This may have been because it was a women's research project. However, there were some important differences between the lesbian/bisexual women and the heterosexual women, and these seemed to cluster around the extent to which respondents experienced themselves as being morally sub-standard. I have written elsewhere of how, for many lesbians, the experience of having alcohol problems lacks the shame factor which so damages self-worth in many women. It can even be a style, part of who we are, social renegades and deviants:

Some lesbians may be scornful of traditionally feminine behaviour such as looking smart and tidy, not being noisy in public and not being seen to be affected by alcohol. This attitude is likely to make it easier to admit to yourself and your friends that you have a problem with alcohol, since you are not perceived as being socially disgraced in the same way (Staddon 2005 p.73).

This might well indicate that no matter how damaging past experiences of heteronormative society may have been, lesbian women have a better chance of survival from alcohol dependence and alcohol treatment, especially if they have the support of other lesbians.

Lesbian culture itself tends to denigrate and perceive as worthless the traditional ways in which women have been able to attain self-worth in a patriarchal society, and these include sobriety. Lesbians without such support are more likely to kill themselves than those lucky enough to find it, due to depression and isolation (Rivers and Carragher 2003).

Whatever the sexual orientation of my respondents, they had reached adulthood in a society which denied them sufficient opportunity to develop as people in their own right, which had frequently led to depression and loneliness. Emotional and material factors, such as an unhappy relationship, a low income, a lack of choice, prejudice and discrimination, may all be sources of strain (Agnew 2006). An aim of worldly perfection is fostered by a capitalist society, beyond what is achievable, and even leading to the creation of 'illnesses', such as boredom, requiring medication (Elliott 2003). It may also lead to new ways of manipulating women via their 'health' (Moore 2008). This could sometimes include unnecessary concern about their drinking, in the same way as they might become unnecessarily concerned about their weight:

But I think, is it him or me?---some of the things he's said---like, I'm living and working in his house, and living the life of Riley, and I think...am I really?...he wants me to up sticks...he says I've had that life now...he seems to be getting harder and harder...When I met him I put him on a pedestal, I never thought he'd leave his children. But then somebody else comes along.... I don't know the real me any more. 'Cos when I've had a

drink I am quite witty and...but without a drink, could I be satisfied sitting in here without a bottle of wine? (Renee, 'MaS').

Women had usually internalised the feeling that they were worth less than male relatives and their children. Sometimes specific issues of cruelty and abuse were cited. Nen's family treated her very badly, including rape and incest, and making her feel she had no right to be there:

...all the time we were growing up it was 'soon as you're 16 you're going'...and I had no idea about life at all...been brought up totally isolated in this village...so I end up going to college in lodgings. And I was really miserable; didn't go to any classes...It was a miserable, horrible system; I just felt really dreadful (Nen, 'MaS').

It is not surprising that such internalised pain might lead to the subsequent use of alcohol for comfort.

4.2: Embodying distress in alcohol consumption

The women's feelings of loneliness and depression may have caused, or contributed to, their feelings of worthlessness, their reliance on alcohol, and the extent to which they experienced denigration and contempt. However, in 2004, when the 'Making a Start' interviews took place, in many parts of the UK, mental health conditions, including 'alcoholism', were still perceived by many as illnesses, even diseases, which existed in their own right, independently of social and gendered

factors (Fingarette 1988). Earlier medical research had tended to link depression and anxiety to the withdrawal effects of alcohol and such assumptions remain common in addictology.

Other research has acknowledged 'Dual Diagnosis', i.e. the presence of depression and other mental health problems which have preceded the addiction (McDowell and Spitz 1999). As many as two thirds of women with substance misuse issues may be suffering from additional mental health disorders (Zilberman et al. 2003) and might be considered to be using the alcohol for purposes of self-medication.

Evidence also exists that social factors could lead women, not only into depression, but also into a condition of mental isolation often termed madness (Kitzinger and Perkins 1993, Chesler 1972) and certainly into dependence on substances (Ettorre 2007).

It was not always easy to confirm or contradict such causes in many of the 'Making a Start' interviews, since a number of respondents would often use the 'disease' terminology of Alcoholics Anonymous (AA) to explain what had happened to them: 'I stopped drinking a year ago and I had three relapses...I mean I didn't go on benders but dry drunk syndrome...but I had all the insanity' (Nen, 'MaS').

'Dry drunk syndrome' is a phrase used in AA to describe someone like myself who no longer drinks alcohol but does not attend AA meetings. Attending these meetings is seen as the only way of changing your life.

The belief is that unless you attend meetings you will continue to think in the same way as you did when you were drinking, and will ultimately drink again. 'The insanity' is also an AA phrase to describe such thinking.

A benefit of the 'disease' terminology was that it did help some women to feel less frightened and isolated, since it appeared to be the same as what had happened to other 'alcoholics'. It was no longer a problem unique to them, and this was obviously comforting to some of them, such as Nen, Carol and Helen. On the other hand, it could make it difficult to discuss their lives from other perspectives; the special AA vocabulary would block attempts to look in any way but its own. Special words, loaded with significance, are routinely used by such groups, to facilitate inter-communication and exchange of ideas, but sometimes making it more difficult for members to think 'outside the box' (Hausman et al. 2008). An example would be the use of phrases like 'alcoholic thinking' and 'reacting wrong', meaning that the speaker behaved in a way contrary to AA's beliefs, but not necessarily in an 'alcohol' context at all (Ragge 1998 p.84). They might behave, or think, in a way which acknowledged feelings of grief and despondency. Such thinking would be seen as self-pity, and someone seeking an excuse to drink. This is because AA believes that people who 'are alcoholics' all think in similar ways about life as a whole, and are forever falling into the same traps of 'alcoholic thinking'.

Bella confirmed the way that this terminology implied not only that 'having a disease' was not your fault, but also: 'That gave me licence to drink! Look! You've got to accept! I'm an alcoholic! I've been given the label!' (Bella, 'MaS'). This is a graphic example of the power of the labelling process.

At the same time, adopting an AA identity is of some protection against the moral stigma of being a woman 'drunk'. I explain in 4.3 that women are more vulnerable to this stigma, since they are seen as holding a special iconic role in society. Damage to such a role is understood to place everyone at risk (Ettorre 1997). They are also seen as the family anchor, central to the upholding of moral beliefs and the maintaining of social control, powerfully conjoining affection and responsibility (Coleman 1988). There is ample evidence in academic literature about the harm done to families by the alcohol use of partners and parents (Velleman and Templeton 2007, Velleman, Templeton et al. 2003). The families concerned are, typically, white, male-led, heterosexual and nuclear. Although there is also ample evidence that such family structures can be harmful to women and children (Itzin 2000, Dobash and Dobash 1980), there is little approval for mothers and daughters who reject them, particularly if they are using alcohol (Plant 1997, Wilsnack 1984,). A woman who acknowledges her 'fault', and promises 'good behaviour' by joining AA, could be seen to be doing all she could to re-establish her position of trust within the family. A woman who cannot be trusted to behave as the family anchor and support is not

seen as a proper woman at all (De Beauvoir 1997). Her fear of losing this position is of advantage to society as a whole, since it confirms the expectation that women will be there when required. At the same time, public fears that such support might not be reliable adds to perceptions of risk, convincing the public that there is an increase in women's 'alcoholism' and that this is connected to women's greater freedom to drink a lot in public (Measham and Brain 2005). Such a freedom is seen not to be consonant with women's role as carer (Currie et al. 2006).

Given this philosophy, it is ironic but not surprising that a common cause of low self-esteem and a need for oblivion was domestic and sexual abuse, as I mentioned in 4.1. Even as children, women had often been expected to provide a facility for others. Six out of twenty-three 'Making a Start' respondents were sexually abused as children, and sometimes the links between this kind of oppression and the women's alcohol use were stated directly by the respondents:

The abuse...I mean, some people freeze over, and other people go on sexual rampages, and I just had no respect for my body at all, and didn't have any boundaries, no way to say 'no', because I hadn't been allowed to say no...no wasn't the answer and there was nothing I could do about it. But I was always out of my head... (Bella, 'MaS').

I lost my sister when she was three and I was six and I couldn't understand why my Mum was upset...I was abused when I was

nine and I still see the guy walking around today... I told the social worker and she said, oh well, there's nothing you can do about it now... This particular social worker, she told me I had to cry for a week... but it's basically when I've been unhappy [that] I've had the drink as a comfort. And then when I've had a few drinks I've thought, sod it, what's the point, and I've took tablets and that (Teresa, 'MaS').

As I mentioned in 4.1, other sorts of abuse within the family were also common among the 'Making a Start' women. Alcohol would often be used for comfort in such situations. Pat was 14 when she began to hitch around the country, with a bottle for company, staying where and with whom she could. She described her brief, patchy periods of time living at home as being marred by her father's violence and his drinking. At least two respondents attempted to escape their domestic abuse by getting married, but in both cases with dire consequences:

I ended up getting married, thinking that would make everything all right... he was a *major* alcoholic, so we'd end up [having] huge great drunken rows, and smashing everything up... I had two children with him... I'd moved into this grotty council estate in Frome after being made homeless and living in a hostel---'cos I was escaping violence from this drunken ex-husband... (Bella, 'MaS', original emphasis).

I was forced really into an early marriage because it was... you know, in the sixties, and my parents were very strict with me and I was never allowed to go off and share a flat and I met this fellow and he probably wasn't right for me, but I was so desperate to get away from my family 'cos they totally ruled me.

My father's physical violence and my mother's emotional bullying...so I went off and I married this fellow and it was a complete disaster...(Ursula, 'MaS')

For Teresa, the violence remained the material of her life. Her distress was palpable, for she still cared for the man who:

...always plays up on Tuesday nights after he's had to go down probation...hasn't paid the rent for three weeks...and he had another go at me and the police were called again...The police came, didn't seem very interested and off they went. Anyway, later on, because he was having a go at me, he ripped up the rent and the poll tax cheques in my face *and kicked the stairs till they cracked* and my daughter actually phoned the police again and I was in the kitchen...I'd actually got the wine out again 'cos he'd told me to take a load of pills and do away with myself (Teresa, 'MaS', original emphasis).

None of these women presented, or perceived, their abuse as the sole cause of their drinking. On the other hand, the alcohol did provide some sort of a refuge, or coping mechanism.

Usually such experiences were only mentioned to a GP with reluctance, if at all. Admitting to having an abusive partner, especially if it is one you love, is experienced as at least as shaming as admitting to an alcohol problem (Ellsberg et al. 2003). Women's experiences of seeing doctors about alcohol has been described as being exposed to the inequitable experience of 'the (male) medical gaze' (Bowie 2000 p.98). They suffer a dual disadvantage as women, when coping with

male medical professionals, since their female and lay statuses combine to place the doctor in a doubly superior position (Armstrong and Ogden 2006, Shaw 2004, Broom and Stevens 1991, Roberts 1985). GPs are also hampered and embarrassed by ideals of women's behaviour. These include the perceived inappropriateness of a woman presenting with symptoms which reflect upon her moral worth. Some 'Treatment Approaches' respondents had frankly admitted themselves to be at a loss when it came to treating 'alcoholism'. The history of Anne was a chaotic one, with a history of broken relationships, some domestic abuse, and being in and out of clinics and mental hospitals, and one doctor displayed his feelings of helplessness and frustration to her father, demanding: 'What am I expected to do?'

'Making a Start' women had felt anxious about 'coming out' about their alcohol use to their GP. The GP's consulting room is supposedly a safe place to discuss sensitive issues and the GP's response was agreed by RAG and by the 'Making a Start' respondents to be crucial.

Nineteen of the twenty-three 'Making a Start' respondents had spoken to a GP about their alcohol problems. Although these accounts sometimes referred to events which had occurred several years previously, the reactions described by RAG, and in the GPs' own words in 'Treatment Approaches' are all recent. RAG members had mixed experiences of taking their alcohol issues to GPs, as do the women who contact the WIAS helpline. The GPs generally had poor

information and attitudes were very variable, as I demonstrate in Chapter 5.

In my own case, I first saw a GP in November 1988 to ask for advice. Although I had stopped drinking, I had done this before but without being able to keep it up. Like most patients, I assumed he would know what I should do (Allsop 2008, Delgado 2008; Roberts 1985). He had never met me before and suggested that I went to AA. I explained that I had been often, sometimes for extended periods of time. I had felt depressed at the meetings and always drank again. He sighed: 'Well, there's the Pink centre...' I agreed at once. I did not know that the Pink was known locally as a last resort for the chronic 'alcoholic', populated with people, mainly men, who would be admitted time and time again. They were what most of society considers to be bums and drop-outs. The Pink, being a statutory day treatment centre¹, was accessible to anyone if referred by a GP. However, the GP was kind and gentle, which I appreciated. He also seemed tired and resigned. With hindsight, I think he was probably wondering how soon I would be back, since GPs I later interviewed in my research certainly did perceive alcohol treatment as part of a 'revolving door syndrome' (Dimeff and Marlatt 1995). This may help to explain why the interviews for 'Making a Start' found that not all women who took their alcohol issues to a GP were treated so well.

¹ This is a treatment centre which is provided by the NHS, so is free to use, but is only accessible through a GP or an NHS hospital doctor.

Women patients and GPs may not share an understanding about the meaning of the alcohol use or what it was they were seeking when they came to talk, ostensibly, about their drinking. There was no evidence that the GPs mentioned by the 'Making a Start' respondents, or those in 'Treatment Approaches', had thought beyond a simple definition of 'good health' and their role in its maintenance. In this respect, the 'Making a Start' women had often thought more laterally about issues such as the taking back of personal power, in a social context which disallows it (Bostwick et al. 2005). For example, Karen saw alcohol as providing time out, doing something just for yourself: "spose it's a place of my own' (Karen, 'MaS'). This is an issue I discuss further in Chapter 6. These were not ideas which would have been easy to explain to a GP.

Most respondents wanted more time with a GP to discuss a range of personal problems. They might have preferred a doctor like Dr. Andrews, who was very vague about what help was available for women with alcohol issues, but believed in letting them talk:

A high proportion...have suffered sexual abuse... This can lead to all sorts of problems of dependence... women often find themselves in abusive or not very supportive relationships with young children ...[there is a] need for more one to one counselling (Dr.Andrews, 'TA').

Some women preferred GPs who were very decided in their opinions to those whose caution may have been perceived as uncertainty and

disinterest. Nen, for example, would have been delighted with the approach of Dr. Halford, who did not believe in 'pussyfooting around':

my trainer in Belfast...was very tough with alcoholics... 'Stop drinking or you're dead! Or you've got a wet brain! It's your choice! The best way of stopping drinking is to go to AA'....and I very much picked up that as my philosophy (Dr. Halford, 'TA').

It seems that what women had hoped was that the GP would have good information, but would also be able to pick up magically on what their real, emotional needs were. Sadly, this was seldom to occur.

Like me, Carol and Deirdre ('Making a Start') did meet kindly responses from GPs and were sent to the same statutory treatment centre, the Pink. Carol's GP 'hadn't thought she was the type' but acted quickly to get her an assessment there, as did Deirdre's. These well-intentioned responses were to fail for Carol and Deirdre, since the approach and ambience of that centre were unsuitable for them. Both women presented as respectable and conventional, and this centre, with its often aggressive assessors, and its slightly disreputable clientele, was to come as an unpleasant shock. I had found it very difficult to remain there myself, as I mentioned in Chapter 1, but the external support I had from the women who had 'rescued' me made a great deal of difference, since they were offering me an alternative view, while encouraging me to complete my time at the treatment centre.

One of the other nine centres, had their GPs known about them, and provided they were in existence at that time, might well have been more suitable. They were certainly in existence when Helen's GP sent her for assessment at the Pink, because 'that's all there is'. Fran's GP only suggested the Pink as a last resort, when three residential rehabilitation treatment centres (Rehabs) had failed to help her stop drinking. Doctors' apparent ignorance of the difference between different centres, even if they knew they existed, was largely confirmed when I interviewed them in 'Treatment Approaches', as I mention in Chapter 5.

The doctors my respondents had seen had also seemed to be unaware of the desirability of single sex treatment or the relevance of sexual and domestic abuse to the advice which should be proffered. For example, specialists in the field of alcohol and domestic abuse have warned of the dangers to a woman of encouraging her to stop drinking, without first finding out about her domestic situation. Sometimes the partner may continue to use her drinking as a way of controlling her, or may want her to drink to keep him company. In either case, stopping her drinking without first making her situation safe can be extremely dangerous (Galvani and Humphreys 2007).

GPs may also fail their patients by revealing negative attitudes and using inappropriate language (Deehan et al. 1998). Margaret had been very depressed after a long-term and unhappy relationship with a

married man. When he died, she had lost her home as well as her relationship. Her comfort drinking escalated to the point where she lost her job and went to see a doctor who 'said she was a naughty girl.' The comment was probably intended kindly, but made Margaret feel she had lost the doctor's respect. The response of Jane's doctor was not merely inappropriate, but cruel and unprofessional. Jane had a history of self-harm and attempted suicides, for which she had been sectioned more than once, and the GP seems to have found her irritating: 'The GP wrote me off---said he didn't want anything to do with me any more 'cos I was too much trouble!...calling him out and stuff...'cos I was suicidal...he got fed up. He said I'd have to find another GP' (Jane, 'MaS').

Doctors were said often to show such low tolerance and to possess preconceived ideas as to 'women's problems'. For example, many 'Making a Start' women complained about being given anti-depressants. Bella and Nen both mentioned the GPs' fondness for offering prescription drugs:

...[C]ouple of the male doctors...they come over to me as having a prejudiced belief that...here's a single parent on a council estate; let's get the anti-depressants out. You know? I get the female doctor.....actually trying to help me work at this problem and to sort things by writing letters to the council, really asking about my alcohol needs and what they can do to help, and stuff like that, whereas the male doctors, it's all...cocktails of benzos and anti-depressants... (Bella, 'MaS').

When Ursula and Teresa went to talk to GPs about their drinking they too were offered anti-depressants but this might have been because they did not emphasise how much they were drinking so much as their unhappiness. It can become a habit for professionals to 'work from a script' in a job, asking questions to which they have the answers and being confused or simply not hearing when the answers actually made do not complement the assumptions behind the questions (Hodges 2007). It is also true that doctors may consider their view of what is in the patient's best interests as possessing most validity (Ettorre 2004). Offering prescribed medication did appear to be a frequent response to depression and alcohol use. Gill was given Prozac, HRT, and Librium, on presenting with alcohol issues, and each time felt that the GP simply hadn't wanted to listen to her story of unhappiness. Helen's son had died recently as a result of solvent misuse. Her doctor had been kind and sympathetic around this, without seeming to want to address her long-standing alcohol problems:

'E gave me anti-depressants....of course drink, like, is a depressant isn't it, so pointless exercise giving me anti-depressants when I was drinking! I mean I kept on asking for counselling...He gave me numbers and that but I wasn't capable of meeting strangers and having to go through the whole process again...(Helen, 'MaS').

There seems little doubt that despite academic papers emphasising their risks (Holbrook et al. 2000) and campaigns by organisations like

BAT (Battle Against Tranquillisers) doctors still do prescribe such medication to a considerable extent, particularly to women (Swartz et al. 1991), and it seems likely that this is connected with depression being twice as common among women as among men (Soares 2008). If doctors felt irritated or helpless, this might seem to them like an obvious solution.

Several women in 'Making a Start' did mention the way that their doctors seemed bored or irritated by them, and let them see it: 'She made me feel...as if, well, as if I was getting on her nerves, as if I was wasting her time, and she used to look at her watch all the time. She actually used to make me feel terrible and I used to come out of there feeling worse' (Nen, 'MaS').

Nen finally took matters into her own hands. Believing that the GP saw her as a hypochondriac and was reluctant to refer her to the local statutory treatment centre:

I went to the doctor and had hysterics because I couldn't get them to listen any other way. I said I've been here before, and I want you to refer me...and she said no, you don't need [that]... Yes, I really chanced it, because I hate going to the doctor's and my friend said to me, you've got to feel you deserve help, and of course I didn't have the courage to go in there and be myself 'cos I was so used to going in there and putting on an act... (Nen, 'MaS').

On the whole, GPs mentioned in 'Making a Start' were ill-informed and usually offered advice which was little better than what the women might have obtained by asking anyone they knew. I look at the reasons for this poor information and inadequate response in Chapter 5. The result could be an intense feeling of betrayal. There are similarities between the way a woman may approach her GP, about her drinking, today and the way she might have approached her priest or vicar a hundred years ago. In both cases she feels guilty. In both cases, the person approached is believed to have answers and advice, which it is her moral duty to follow (Davies 2008). Perhaps doctors sometimes offer medication as a 'quick fix', much as the priest might have offered a quick prayer.

4.3: Women and social dissonance

'Social dissonance' (Shaw et al. 1999) is a theory which would explain the use of substances by women and by other disadvantaged groups as endemic to modern society and an example of protest, or as the construction of a more satisfactory reality. Women 'making whoopee', insisting on their freedom to get drunk, may be taking that extra step of active dissent, mentioned in 4.1 with reference to Dinnerstein's (1987) analysis. Their intellectual freedom to behave independently, despite social disapproval, has progressed to the actuality of doing so.

In our culture, young women in particular are not seen to have earned privileges such as the right to be drunk. This is in contrast to what is seen as acceptable for women such as those in Botswana who are economically successful (Suggs 1996) and whom I mentioned in Chapter 2. Women behaving like men in the same situation threaten the status quo, by exercising rights they do not have. These are male liberties as surely as once was the right to vote. Like the suffragettes, they are likely to face imprisonment, in the form of a Rehab, and social and financial disgrace (Weedon 1997). Binge drinking remains less likely to be seen as a rite of passage for young women than it is for young men.

Alarm at this situation is demonstrated by such headlines as: 'Teenage girls are "out of control!" ' (Doughty, *Daily Mail*, 2006). 'Out of control' expresses both fear and outrage; future generations are at risk, and also power is being exercised by a group (both female and young) which doubly lacks the right to it (Estes 1992, Coote and Campbell 1982). 'Outsiders' (Becker 1966) are taking liberties which are 'meant for' privileged people, the male and/or the rich. Such drinking may well be a protest against the constraints of femininity; of having to be 'good', of holding a special iconic role; of 'knowing when to stop' (Dutchman-Smith 2004). 'Being drunk ... it's a brazen refusal to be quiet, well-behaved and ladylike ... Femininity ... relies on, is defined by, inhibition' (Lawson 2000).

Fear about women's drinking may be a focus for a more general fear of social change, uncertainties about right and wrong, gender roles and expectations, the security of employment. Lupton (1999, citing Douglas, 1985) explains how a sense of unsafeness leads easily to a moral perspective, seeking ways to blame and explain perceived hazards. This echoes the observation of Mills (2000 p.90) that when people see something as a problem they are making an evaluation; it may simply be something which is alien and distasteful to them. For example, there is a public discourse of unease and insecurity around 'non-traditional' families. With a quarter of families in Britain being headed by lone parents, and cohabitation being more common than marriage among lower income groups (Marsh and Vegeris 2004) fury is often directed at 'young women binge drinkers' and 'single parents', particularly 'teenage mothers', groups often confused in public moral outrage. There has even been a suggestion that young drunken women are responsible for sexual assaults carried out on them (Amnesty 2005). The fear is focusing on a group it is easy to criticise (female, young, 'presumptuous') but is part of a broader feeling that not only young women, but society, and the world itself, is running out of control (Cottle 1998).

I mentioned, in Chapter 2, Thom's (1997) observation that women's needs were only recognised and attended to when it was realised that the rest of the population would also benefit. Her drinking does not service the needs of others unless she is sexually promiscuous, in

which case she may be castigated and shamed. It endangers her perceived role of carer and icon; it is not decorative; it may endanger children. This latter may even be seen to be the case when a woman's children are grown up or when she has none. An assumption is also made that women who are drunk might be less careful about being made pregnant by someone who was not a regular partner, and are therefore more likely to become a 'burden on the tax payer' and a threat to social stability.

The fear and the anger generated transmit powerful messages to women from the established patriarchal order that they must play by the rules, rather than try to dissent. They are the mothers (and nurturers and life-long unpaid carers) of the next generation. These lay messages are underlined by the views and behaviours of the judiciary, of GPs, and of alcohol treatment personnel. Wanton behaviour is seen as a threat to the established order and perhaps to its view of morality (Becker 1966). An earlier example might be the sanctions against witches in the seventeenth century, as severe or more so than those exerted against 'drug dealers' today, which served to drive much herbal medicine underground for three hundred years, while helping to establish the ascendancy of the medical profession (Hester 1992).

Much concern is expressed about 'young people's' health and safety when drinking (Plant 2008) but the photographs and headlines are more likely to emphasise the dangers for young women, depicting girls

vomiting, girls with their clothes in disarray, and girls who have been sexually assaulted. In this way, the media are able to emphasise the deviance of such behaviour; the extent to which these young women have spoilt their identities as iconic models of health and modesty and become figures of fun and contempt. They may be pictured sprawled helplessly across park benches, an empty bottle alongside; or scantily clad young girls may be shown, leaning drunkenly against each other in discos. The headlines and pictures titillate and attract, despite their avowed intent of expressing moral outrage.

Adopting behaviour, such as drunkenness, challenges expectations as to women's expected and rational behaviour, is culturally unacceptable and can result in her being labelled as a slut and a whore:

She has become a 'non-woman'...Her drunken visibility is a direct challenge to the established social order---she should be looking after `her home and family...how can she do this if she is a drunk? She is 'prostituting' her identity...polluted (Ettorre 1997 p.38).

Young girls are meant to be icons of public morality in a way that young men are not, to stand in for the cleanliness, beauty and sexual purity (Allen 2003), which are valued but not much practised by everyone else. If a young woman is perceived as putting her body at risk in this way she is thought to be committing a crime against nature, which has apparently ordained that she should keep her body safe for the

purposes of reproduction (Ettorre 1992). It is not hers, to do with as she wishes.

The predominant media coverage, including academic papers, books and conferences (Plant and Plant 2006) demonstrate the expectation that women will take care of their bodies and look after society as a whole. Their use of time is seen to be the business of society as a whole to monitor. A woman has a moral responsibility, which men do not, of retaining all her faculties at all times, *in case she should be needed* as a carer (Ettorre 1997; my emphasis).

The role of the media is important here. It effects censorship, designed to keep sub-groups in their place, on behalf of those with more power. At the same time it provides the population as a whole with stimulation and gossip (Eldridge et al. 1997). Additionally, the masses are 'whipped up' (Chomsky 2002) to express disapproval of the abrogation of male rights to public drunkenness, and to intimidate young women into behaving more discreetly. The media are expressing and generating moral panic (Cohen 2002) on behalf of the powerful (such as men, the Criminal Justice System, owners of property).

Women have not always been so controlled, or expected to refrain from intoxication, or to behave in a sexually exclusive way. Pre-Christian goddesses were not sexually inhibited or exclusive, and agrarian cultures retain strong links between celebrating the seasons

by imbibing substances and the removal of sexual inhibition between humans:

...These seasonal festivals usually include a ritual and spiritual ingredient... drunkenness is not only for pleasure but also...to communicate with the spirit world. Children born of sexual unions at such times may be seen as having special attributes, even as being gods themselves... [as] may be identified in the story of Jesus Christ. Such heavy drinking, to the point of hallucination, may itself be seen as sacred (Harvey in McDonald, 1997 pp.213-214).

In such cultures, paternity may be uncertain and is likely to be the shared responsibility of the matriarchal, polytheistic group. When patriarchal cultures and monotheistic religions do develop, a woman's liberty becomes limited, since she becomes someone's property (Stone 1976).

Christianity colonised aspects of the old goddess religions it could not destroy, renaming goddess worship sites, especially springs, after female saints, for example. The effective deification of the mother of Jesus ensured that the continuing awe of women's fertility might be safely channelled away from worshipping heathen goddesses and acknowledged female power (Sjoo and Mor 1987). The role of alcohol in Christian ritual is reduced to a tokenistic sip, following Confession. The woman has metamorphosed from bounteous pagan goddess to modest and monogamous mother.

Traditionally, even Christian societies have provided, or at least have tolerated, arenas for enacting behaviour which is not approved or which does not fit conveniently into day-to-day living; for example murder may be enacted on a stage, performing a cathartic function for all present (Bowie 2006, Presdee 2000). Drunkenness has been a normal feature of seasonal celebrations, allowing and even encouraging behaviour which is seen as outside everyday social boundaries. In Chapter 6 I look in more detail into the ways that women's 'problematic' alcohol use can play positive roles in their lives. These may include celebration, communion and communication (Presdee 2000, South 1999). Such a way of viewing alcohol and drug use allows for multiple understandings (Ettorre 2007). It may also point to alternative solutions, since alcohol may facilitate women's self-acceptance, and, while defying social mores, affirm their identity (Staddon 2005, Wilsnack 1984). I refer to these alternative solutions again in Chapter 6.

Denying women the right to such legitimate self-expression is likely to lead to illness, just as surely as large amounts of alcohol. Meanwhile, women who do use alcohol extensively are likely to be marginalised, both in their everyday lives and in their experiences of treatment (Broom and Stevens 1991). I have shown in 4.1 and 4.2 that one consequence of such marginalisation is likely to be that their needs go unrecognised or misunderstood, leading to further alienation and distress (Ettorre 2007). Alcohol has, nevertheless, enabled many

women to break social codes of modesty and selflessness, and to challenge their secondary status. It is believed to decrease inhibition, allowing greater freedom of action (Gillet, Polard et al. 2001). In such cases its use can be empowering. It can additionally be used to draw attention to what the woman feels is wrong in her situation, yet otherwise feels unable to change:

...He didn't come back, and I knew he wasn't going to, and I just thought bugger it, and I found a bottle of whisky I'd been given from work, and I drank the whole bottle in one go! It was like revenge. I'd never drunk so much in my life, and when he came back from the pub I was unconscious on the floor (Ursula, 'MaS').

This is an example of how women's drinking may be a powerful means of expressing dissent, whether as an expression of dissatisfaction with a secondary position, frustration at the importance ascribed to physical appearance, a demand for independence, or a need to find different answers from those of a consumerist society. They might be answering their dissonant needs in the face of considerable social and medical opposition, based on the belief that they should look after their 'health' and that of their families. This illustrates the crucial difference between conventional and feminist views of women's use of alcohol. The latter does not support:

...the prevailing disease model of 'family dysfunction' [which] obscures unequal power relations within families and attributes

a range of emotional and social problems to a family disease treatable through a path of prescriptive behaviours [Haaken 1993] (Eber 2000 p.9).

The 'Making a Start' respondents often used alcohol in order to suppress anger, express anger, make a point, or effectively change a situation they disliked. They might feel anger at being poor, having too many demands on their time, having been abused, and being strictly controlled (Kitzinger and Perkins 1993). Alcohol certainly helped Helen to release her anger about her son's death, 'I was angry at everything, everybody. Angry at myself mainly. Once I got drunk it came out and I lashed out at everybody' (Helen, 'MaS').

Others have confirmed that using alcohol for purposes of dissent may be a gendered phenomenon (Ettorre 2007) and may be related to a form of General Strain Theory, whereby problem behaviour and delinquency may result from unfairness and abuse (Eitle 2002, Cernkovich et al. 2008). Similar theories have been advanced in relation to other mood altering behaviours and substances, such as getting kicks from shop-lifting, eating quantities of chocolate and sugary foods, and smoking (Warner 2009, Horvath 1998).

Dissent by use of intoxication may cause unhappiness as well as physical harm. However, my research indicates that this may be balanced by benefits so substantial that women who have lost one precious part of their lives after another may still not wish totally to

abandon their use of alcohol. This is an alternative way of looking at what may otherwise be seen, as I mentioned earlier, as 'a chronic, relapsing disorder, characterized by an uncontrollable motivation to seek and use drugs' (Szumlinski et al. 2008 p.1).

This may be a lonely form of dissent, or 'outsider culture', without providing the benefits enjoyed by, for example, Becker's (1966) musicians, who achieved a special, protected status by largely isolating from the audience. However, lesbian/bisexual women often share a supportive alternative culture similar to that of the extended heteronormative family (Staddon 2005), even though women as a whole are more likely to be poor (World Bank 1990). Counter-cultures, or 'dissenters' forums' often emerge as a result of being seen as deviant, both challenging the social order and sometimes indirectly reinforcing it.

The extent to which women who drink are seen as deviant may be often based on films about them as sexy but ruined (Room 1989). This perception is less likely to affect lesbian/bisexual women, who are already perceived as 'deviant', although they do appear to suffer higher levels of mental disorder (Hunt and Fish 2008, King et al. 2003). This group has traditionally been thought to make more use of bars and clubs than heterosexual women, but research has often been bar-centred, as this is the easiest way for non-lesbians to locate

respondents (Hall 1993). It cannot therefore be relied upon as representative of the lesbian/bisexual population as a whole.

A further reason to question such research might be that some lesbian/bisexual women who are isolated may use drinking in pubs in the same way as the Camba men mentioned in Chapter 2: to facilitate socialising, to which they may be relatively unaccustomed (Mandelbaum 1965). The Camba had an isolated existence and were mistrustful of strangers. This need not imply that their drinking is problematic. Many lesbian/bisexual women I know are not 'out' at work, or to their neighbours, and often feel extremely isolated, particularly when relationships break up or close family members die. Alcohol use, to whatever extent, is one way of redefining oneself as a member of a fringe group (Ettorre 1997).

Lesbian women are likely to feel confident that they have a *right* to drink; it can be seen as proof of their independence and sexual status. They are also defying the expectation that they must be 'good' and on hand to help others (Moore 2008). In 'Making a Start', some heterosexual women also found their morale and self-image was enhanced by the competent handling of large amounts of alcohol, and by the enjoyment of socialising without needing to obey feminine strictures as to 'appropriate' behaviour. They liked to revolt against gendered expectations. However, some also referred to feeling an outcast because of their drinking. The 'outcast experience' might even

be comforting, to an extent (Camp et al. 2002), but did not usually extend to the development of a positive identity as a heavy drinker. Some respondents gave vivid descriptions of how they were treated like pariahs and jokes:

I said I don't want to meet anyone from this area, 'cos they all knew. Alkie Annie, you know; oh yes, people are so cruel. (Anne, 'MaS').

The situations I got myself in...and ...I was embarrassed...and people having to walk me home and that shows me up. Well I won't be seen out on the street for three or four days...I'll stay home...and then me husband tells me exactly what I've done...said you come home, and yer tits was hanging out. (Deirdre, 'MaS').

These accounts mirror the reactions often experienced by women who drink heavily, and their feelings of shame and self-contempt (Ettorre 1997). They are less likely to be experienced by women from alternative cultures which do not greatly value women's decorum.

There can be both advantages and disadvantages to holding the position of 'outsider' (Becker 1966) or to belonging to a group of people seen as outsiders. I have mentioned the advantages experienced, in some circumstances, by lesbian/bisexual women, such as feeling less shame in failing to meet the criteria of femininity. However, disempowerment also occurs, outside mainstream cultures, and may take many forms. For example, considering heroin use among middle

and upper class women, Friedman and Alicea (1995) acknowledge the connections between resisting patriarchal power and the use of substances. They note, however, that a number of the women they studied felt disempowered both in the drugs world and in the medical treatment world:

Despite their socialization by a patriarchal culture, fellow heroin users, and the medical therapeutic culture, these women sustained a critical perspective and refused to be fully controlled...[maintaining] multiple interpretive frameworks for constructing their identities and resisting class and gender domination (Friedman and Alicea 1995 p. 433).

Another 'outsider' identity, 'lesbian', was of comfort to all the lesbian respondents, although it was not always that identity which they experienced as rendering them outsiders. Fran ('Making a Start') enjoyed her outsider status and might have been seen as belonging to Cohen's (2002) 'delinquent boy' group. She had adopted, and even celebrated, negative aspects of her alcohol use and low income, embodying them in a way which alleviated her difficult circumstances (Agnew and White 1992) and enabled her to experience authenticity in a way which her conventional education did not. How she lived, for her, expressed who she was, and this was also true for Wendy. She too had dropped out of a series of chances at further education but loved to dance, to drink, and to dream. She also had a very laid back approach to life. She did not seem to feel a need to conform in any way, including the pursuit of conventional career paths, or the

completion of her various degrees. She had worked out ways to manage her alcohol intake so it did less damage:

I do try [to look after my health]...I don't allow myself to drink at home...I only drink socially, with other people...I try to drink no more than twice a week but I do tend to, on the whole, binge drink. And I know I used to drink on an empty stomach (Wendy, 'MaS').

Fran had suffered depression, but was proud of being a bit different. Although her life was restricted by poverty and agoraphobia, and centred on being able to acquire enough money for her daily alcohol intake, she did not seem to be particularly unhappy about the fact that many people on her run-down council estate laughed at her, because they sometimes saw her drunk. She had a few friends, but was finding drinking was less fun than it had been:

I can't say it makes me feel different...I mean it makes me feel grim, whereas before it didn't. I dunno...I can't really think...unless...dunno. It's like, it's fun to go out and have a few drinks but ...lately I've been drinking on my own, and I start thinking it'll make me feel better but it makes me feel worse, you know? And then I can't be bothered to do anything (Fran, 'MaS').

Fran subsequently became a member of WIAS (Women's Independent Alcohol Support), the group which developed out of the 'Making a Start' focus groups. Her alcohol use never appeared to lessen, and she often had pain in her liver, but she was a strong supporter of anything 'a bit

different'. She was greatly disgusted by AA: 'I didn't hold with it!' Although she paid lip service to acceptance that her alcohol use was bad for her health, she showed no other signs of concern and met the many ups and downs of her life philosophically. Her identity as a lesbian and a nonconformist sat well with her acknowledgement of herself as being someone whose behaviour around alcohol was unconventional and a source of anger to some other people. It was as if she had achieved the difference she wanted by being and looking like a drop-out and a drunk; for her it seemed a positive identity, even with its drawbacks. My impression of both Fran and Wendy was that they were comfortable, and often happy, with being different, with being outsiders, even when it might mean depression and loneliness. Neither had particularly strong links with the lesbian community but both felt confident about their identity, despite some depression and a degree of isolation (Camp et al. 2002).

Typically, it was the lesbian respondents who found it possible to celebrate being an outsider and to develop a positive identity, either regardless of their drinking or at least partially on account of it. This was presumably because their sense of self had already experienced rejection in a heteronormative world, and developed a variety of ways to develop a sense of self worth (Bostwick et al. 2005). These were likely to include locating similar women and forming strong friendship networks.

My own experiences of being an outsider began early in life, attempting to be acceptable by the standards of those with whom I mixed most. Once I discovered it, alcohol was useful to dull the pain of rebuttal and disgrace, and to give me the courage to go on. I described in Chapter 1 how I escaped from dependence on alcohol, and met lesbian and feminist women who helped me to make changes in my life. Along with a reevaluation of who and what I was, came a sense of pride and happiness in my identity. It was liberating to find that there were more ways to live than those I had previously encountered. For many years, I not only associated this awareness with having found a group of 'outsiders' I could identify with, but I also failed to see that there were similarities between my 'rescue' from hetero-politicised society and that of some other women who joined AA. My great dislike of the rigidity, masculinism and very many other features of the organisation, prevented me from acknowledging that, with all its faults, it did provide a few women with a similar sense of rightness to the one I had experienced in coming out as a lesbian: 'So then I went to an AA meeting; and I instantly felt at home' (Carol, 'MaS').

There is an extent to which being already a fringe person, a deviant of some description, may actually be an advantage when dealing with social institutions designed to effect social control. It has traditionally been seen as stress-making to be different (Cohen 2002), for stress to cause disease, and for stress factors to multiply for individuals, but it seems possible that the positive experiences of being 'other', for

example, in making it easier to find common ground with a new group of people, may often outweigh such disadvantages (Meyers and Miller 2001). Such an explanation would account for my survival at the Pink treatment centre.

Normal processes of assimilation of outsiders (Waters and Jimenez 2005) can, in any case, take place over time, with gradual acceptance and change occurring as people cease to seem 'foreign' or 'other'. The process may be a two-way one. For example, greater public acceptance of lesbian and gay people may allow them to interpret themselves less rigidly, perhaps involving re-interpretations of what 'being a lesbian' means. Styles may become less polarised, so that fewer people present themselves definitively as 'butch' or 'femme'. In the same way, the term 'bisexual' no longer attracts the criticism from lesbians and gays that it once did.

There is greater mainstream acceptability of deviant behaviour by people who are wealthy, people of the upper classes, and some celebrities. This is partly because they have more freedom than others, having more money, and less need to be in regular daily employment. It may also be that they are part of a show, an entertainment for the rest of us (Veblen 1994, Mills 1967). The behaviour is still, however, perceived as deviant; merely acceptably deviant for certain people at certain times. There are connections with the functions of carnival and of ritual (Stein 1985, Presdee 2000). This special acceptance does not

include a general view that drunkenness, or madness, are valid ways of experiencing the world most of the time, and only exceptionally includes women's drunkenness at all. Fury is expressed, as I mentioned earlier, when women take these liberties as 'binge drinkers' and are seen to be 'out of control'.

In a different way, AA offers a form of acceptability for deviants. It has seemed very resistant to change, perhaps feeling anxious about retaining its special status. Greater reliance on it by the treatment services could lead to some assimilation by AA of different perspectives, such as women needing different treatment styles. Plant (1997) hoped this was already happening. If it did, it might even include an acceptance that most so-called 'alcoholics' recover completely, and unaided (Zimmerman and Zeller 1992). In the past, both lesbian and 'alcoholic' social groups could be seen as half-worlds, where the deviant identity could become the most important, the defining, factor (Goffman 1968). It could even enable a member of a deviant group to believe in a 'rise above society which he [sic] is normally thought to be below' (Pearson 1975 p.11). Such a belief is frequently propounded in these worlds, but it is possible that some sort of continuum is developing, along which 'alcoholic identities' may exist, as sexual identities already do (Leighton 2007).

Sometimes heterosexual respondents did report a kind of pleasure in accepting the new outsider status of being 'alcoholics'. This was a new

identity and offered possibilities for offering new versions of their lives, or 'performances', to themselves and to others (Goffman 1971) with the hope of acquiring better personal understanding:

Yes, [the doctor] told me there was nothing wrong with me, that I was basically very healthy. I'm not basically healthy at all!...[she thought I was] pretending, putting it on... 'you're a hypochondriac'... I got this a lot... I *knew* something was really wrong. I didn't understand that I was an alcoholic. I really realised it... oh, a few months ago I suppose (Nen, 'MaS').

Nen 'knew' she was 'an alcoholic' and for her the continuity that AA sometimes appears to offer was important (Atkins and Hawdon 2007). She dealt savagely with the male oppression which can characterise their meetings. She was heterosexual, but an outsider in many other ways, classified informally, she believed, as 'a nutter'.

Some kinds of outsiders can be supported within AA, which offers an identity carrying at least conditional respectability and acceptance. AA's methods have something in common with Christianity, embracing confession, atonement, and life-long commitment. In AA meetings, catharsis is sought by the public re-living of drinking behaviour; endless 'shares' describe the guilt and folly which alcohol caused speakers to inflict and experience. There may be some psychological benefit to be derived from this (Valverde and White-Mair 1999), but different expectations of gendered behaviour, described above, can make such a public process humiliating and even dangerous for women.

The AA meeting may provide outlets, sin-bins and boundary-markers, but sometimes demonstrates behaviour remarkably similar to that of the conventional cultures it replaces or augments (Matza 1990).

Women in 'Making a Start' were able to testify that there could be back-biting and unpleasantness in what was meant to be the supportive AA network, and the same is probably true of lesbian 'scenes'². The irritation is perhaps the result of people seeing rather too much of each other rather too often, and also depending on each other for mutual support (Goffman 1968 p.149).

Of the 23 women I interviewed, only three had never contacted AA.

Renee was terrified of speaking to anyone, in case someone recognised her and she lost residence (custody) of her children. Lucy did not see herself as being addicted so had not thought of contacting AA. She went out chiefly at weekends, and drank heavily in the company of others. She was concerned about her increasing tolerance, but did not want to stop going out and 'having a laugh'. Anne was still abstinent after 15 years, having become convinced by a hospital doctor that he would make her well. She believed him and recovered, with the support of family and friends. She said she had never thought of going to AA.

² 'Scene' describes the social activities, such as clubs, groups and events, organised and attended by those who are 'out' about their sexuality.

However, most women in 'Making a Start' had had telephone or group experience of AA, which is particularly well represented in the part of the country I was researching, with over 70 meetings a week, at different times of day. It is in any case a cornerstone of mainstream alcohol treatment, with its philosophy sometimes described as 'the medical model' (Moncrieff 1997). It was very helpful for me that the Research Advisory Group (RAG) had one or two members who had continued to attend AA meetings, so their input was of particular value.

What had attracted 'Making a Start' women to AA initially was its high profile. It is effectively advertised by GPs, and by enthusiastic members who are told that their own sobriety depends on recruitment. Its claims are difficult to refute, since: 'Witnesses encounter acute problems of credibility...unless their testimony accords with what policy-makers want to hear...' (Campbell 2000 p.47).

Those that had found it suited them, like Carol, were women who felt better with a defined structure. They were also women who were able either to accept that they were 'guilty', like Carol, or, like Olly, were able to disregard the aspects of the organisation they did not care for. Other women, such as Queenie, Gill, Pat, Fran and Wendy, felt it put their freedom to be who they were at risk. Respondents confirmed my own impression and the research of others that AA attenders are normally White (Schmidt 2007). AA belongs to the tradition of 'mutual aid' organisations, developing in the nineteenth century among the working

classes: 'to cope with the disruptive effects of the market economy' (Makela 1996 p.13). Long-term members also tend to be male³ and over 30⁴; women were originally forbidden to join, and are still expected to adapt to what is provided. This is harder for women who seek, or have achieved, economic and professional independence, but they may feel they have no choice: 'It's all we've got' (Ursula, 'MaS').

Two respondents still using AA, Olly and Sherie, gave the organisation 'full marks'. Olly had been to a private residential Rehab where the importance of AA attendance had been stressed. She had been using it for a year, including her time in residential treatment. She reported sexual harassment, but 'that's normal with men, isn't it?' Olly described herself as a very conventional person: 'I got involved with the police, which was so unlike me, you know...[I like to feel] comfortable and safe' (Olly, 'MaS').

Like Olly, Sherie was young, while most respondents were a decade or so older⁵. Both women had started to be aware that they liked to drink more than other people when they were in their teens, whereas most other respondents had not seen themselves as having a problem at that age. Sherie had not liked the AA meetings at first because:

³ The percentage varies from 60% to 90% in different countries (Makela 1996 p.102)

⁴ The percentage varies from 70% to 90% (Ibid.)

⁵ Three were in their twenties, six in their thirties, ten in their forties and four in their fifties

I still had this feeling of superiority... 'I'm not as bad as you!'... But I carried on going to meetings... I think I was hoping for friendship and all that stuff... and I'm thinking, is this a life-time commitment? Am I going to have to do it forever... And I think people found me hard to approach because I was so angry (Sherie, 'MaS').

Perhaps what had been common to both Sherie and to me was our feeling that life, as it was, was not enough. I did not crave alcohol in itself, while looking after my young family, but a kind of personal freedom I only dreamed of, and had seldom experienced. When I did use alcohol at that time, it was to dull the feelings of restlessness and loss.

Sherie's mother was also in AA and she had found that once she started to go too, it brought them closer together after years of disliking each other. She said the meetings gave her 'grounding, support, reassurance', which sounds similar to my own feelings when I go to lesbian events; I feel as if I have found somewhere where I belong. There are other similarities, between lesbian and AA affiliations, which I consider later in this section. Sherie had stopped drinking completely for a few years, after having her son, but had gone back to it:

I think I can say I was completely barking mad at that stage in my life. I mean, I wasn't drinking but I thought about drink every day. I was trying to control everything in my life... I ended up with an eating disorder... Everything else became completely out of control but I wasn't drinking so that was okay!!...but I was still

quite upset about it; every morning I'd think, oh I wish I could have a drink (Sherie, 'MaS').

Six women (Nen, Helen, Olly, Carol, Sherie and Ursula) were still using AA when I interviewed them. Nen and Helen were still in 12 Step treatment at the Pink, where AA attendance was expected, and Olly had only recently left a residential 12 Step Rehab. The positive aspects of AA membership that were mentioned included a sense of security and rightness, support, friendship and structure, and despite Sherie's past fear of 'a life-time commitment', all seemed content to remain with it, at least for the moment.

Both Olly and Sherie preferred to restrict their socialising to other AA members, following the advice frequently displayed on the wall at AA meetings: 'Stick with the Winners.' (The 'winners' are believed to be the AA members.) In this respect too there are similarities between the AA world and the lesbian world. As I said elsewhere:

The sense of being in your own secure environment, experienced in lesbian bars, may be felt when mingling in AA 'Rooms', where people with similar life experiences drop their guard. In lesbian bars, lesbians do not need to apologise for who they are. In the same way, people in AA meetings do not need to explain who they are. However, frequently they apologise for their behaviour. In my experience, there is an uneasy relationship between being lesbian, celebrating difference from heteronormativity, and being alcoholic, which sees alcoholism as a 'disease'....For me, AA is like an open

asylum for people who accept that they can't be cured but do their best to behave in ways society requires alcoholics to behave. In one sense this is the opposite of the lesbian and gay world - out and proud. On the other hand, the AA world is similar to our own. Both worlds have obtained a measure of respectability, if not acceptance. Both enrich social diversity and are somewhat visible. But, both are named, owned and controlled by heteronormative society (Staddon 2005 p.74).

A problem encountered in AA by Nen was the men's behaviour. She and I had both found this sexually abusive:

...The abuse issues, you can't talk about those when you're in a mixed group, and it's very difficult if you try and share⁶ it at an ordinary AA meeting. There was one woman the other day, I so admired her; at an AA meeting...she said, I feel really vulnerable around the men. And it's what everybody says and nobody ever shares it (Nen, 'MaS').

Unlike me, Nen felt able to cope with this, and still to gain from the meetings.

Respondents reported a variety of other problems with AA. Jane had some positive comments, but they were qualified. She had initially found it helpful, providing a group of people with similar experiences to whom she could relate. However, she was troubled by its philosophy, which is sometimes presented as rejecting prescription drugs, which she has to take for a different mental health condition. Dogmatic

⁶ A 'share' is a confidence about your drinking experiences which you 'share' with your AA group.

insistence on such an interpretation by other AA members made her decide she could do better alone (as she has, for 15 years). She also disliked the 'masculine style' and being told that she 'must not get angry'. After a while she left. Injunctions against anger are very common in AA, and perhaps another example of its being both designed for men and out of date. A more gendered approach might suggest that women needed to express their anger, while men needed to consider alternatives to anger (Niv and Hser 2007). Bella did not find the philosophy helpful either and did not go for long: 'then [this counsellor] was an AA person, wanted me to go into AA ... which actually made me quite a lot worse... I thought, yes, that's me, I'm an alcoholic, so that gave me licence to drink!' (Bella, 'MaS').

Ursula was not happy with AA but was resigned to it. She disliked how it dwelt on shame and guilt, but she was continuing with the same determination she was putting into running a business. By contrast, Carol 'felt at home at once'. She had a background of childhood domestic abuse and a Catholic boarding school so perhaps there were connections with her feeling comfortable with strict discipline and a quasi-religious atmosphere⁷:

...The Newcomers Group⁸...it was tough to begin with...run by somebody who was a real control freak....did provide a fantastic structure for people without any boundaries...whatever it was

⁷ AA has always stated that it is not a religious group. Its roots are Protestant, although its language reflects its anxiety not to offend the religious doctrines of anyone else (Kurtz 1979).

⁸ Rumoured to be the most rigidly disciplined AA group in the area.

there was something attractive to me and I began to go there on a regular basis (Carol, 'MaS').

Unfortunately she was still very depressed and, like Jane, suffered from being ostracised at AA because she was using medication:

... I'm not sure where the alcoholism ends and the depression begins ...It's a very controversial area in AA because a lot of people feel you shouldn't be taking medication because it's mood altering. In fact I had a very distressing conversation with a very close friend who doesn't want to spend time with me because of my being on medication....Now if you go by the Big Book⁹, it says AA offers some things and the medical profession offers other things (Carol, 'MaS').

Carol felt that if she had been 'working the programme' (i.e. following the Twelve Steps of AA carefully) she would not have been depressed, yet its basis was being directly challenged by her therapy. This is a good example of how someone who otherwise has no problems with the AA ethos can still suffer from the inflexibility which some members impose, in a drive to remake sinners into useful citizens (Freidson 1983). It has supported Carol's critical view of herself: 'I'm an extremely self-centred person' (Carol, 'MaS').

Of the 20 'Making a Start' women who made contact with the organisation, 14 shied away quickly. Helen left both AA and Women's

⁹ AA has a Big Book which looks like The Bible, and which is treated reverently. It is read from at meetings in much the same way as The Bible is used in Christian churches.

Independent Alcohol Support (VIAS) a few months after taking part in the 'Making a Start' focus groups. She had made friends with two RAG group members, who helped look after her dog when she lost her flat. She began drinking again, her home life became increasingly complicated, and in the end she disappeared. A friend of the RAG group adopted the dog, but Helen has never reappeared.

Queenie made her decision not to go to AA after a lengthy phone call to their number:

...she said...the fact you picked up the phone and rang us suggests to me strongly that [you're an alcoholic]...I was thinking, well, if I'm saying to her, 'I don't think this is right' then I'm an alcoholic in denial!...automatically...so I felt uncomfortable about that... I thought well, maybe I don't want to do that and maybe it's a whole host of things anyway (Queenie, 'MaS').

She was repelled, despite the person's enthusiastic encouragement to come to a meeting, by the 'weird, twisted logic'. Gill said that 'as soon as I got in the door, I thought, no way!' Pat covered her face to say 'I didn't like it' and did not want to talk further about her experiences there. Pat was often homeless and disliked a settled existence so could have been alarmed at the number of rules and prohibitions. Fran didn't like the idea that one was 'powerless over alcohol', 'I didn't hold with it'. Margaret described the meetings as 'judgmental and cult-like' and Alex considered them to be very old-fashioned. Karen found it unwelcoming

and sat alone at several meetings, hoping in vain that someone would speak to her. Although able to make some use of it for a time, Vi too had found it cliquy: 'I'm afraid AA and I are not [suited]... people who've been there a while... [are funny about] who makes the tea...' (Vi, 'MaS').

Wendy's comments were similar: 'I couldn't get on with the philosophy...whatever it was. It was *not me at all*, I'm afraid! ...not going back there...no point' (Wendy, 'MaS'; original emphasis). Elsa had also found it old-fashioned and prescriptive but in any case had decided against abstinence, wanting to be a social drinker. Teresa had frequent binges, usually connected with the domestic abuse she still suffered, and, like Bella, found it impossible to organise her life around abstinence goals or regular meetings.

Deirdre described the whole AA set-up as 'hilarious'. Her husband had taken her to an AA meeting and when he had come to collect her there was no-one there:

You come out of the AA meetings, there's a pub next door, and you all go into the pub! So my husband, he'd come to pick me up and we were all in the pub. So I said to him, what's the point going to a AA meeting and then going in a pub? Pattersley¹⁰ meeting, that was. I tell you, I seen it. (Deirdre, 'MaS').

¹⁰ Pseudonym for a local AA meeting

One possibility here is that some people who attended the meeting that day had been sent there by a treatment centre (a common practice, though not one which AA encourages officially) and were not really ready to stop drinking at all, so seeing a pub next door went in, taking Deirdre with them!

For these 14 women it seems that the factors which make some people find AA of use (accepting they are 'ill' and adopting a fairly rigid routine in the company of others, while distancing themselves from the substance and people using it) drove them away. However, as I noted earlier, the narratives about AA success are impossible to refute, as long as 'witnesses' may be found to stand forth and insist that it works if you want it to do so. This places the organisation in a powerful position, making women's issues and viable alternatives all but invisible.

Most of the 'Making a Start' respondents had retreated from AA with speed, not always giving it the time to 'work' which the organisation recommends: '90 meetings for 90 days'¹¹. However, a few women did find the organisation helpful, particularly in the short term. The benefits described included an opportunity to hear other people's stories, and having a safe structure within which to live. The drawbacks experienced included the atmosphere, the philosophy, the sexism and machismo, and the difficulties encountered when complex issues

¹¹ This slogan is one of many which may be displayed at AA meetings.

needed to be addressed. Its protective environment could be perceived as disempowering, which conflicts with a feminist perspective (Ettorre 1997). Such drawbacks were, after all, what they had been used to as women, at least when they were younger; AA's atmosphere has been described as 'belonging to the 1950s' (anecdotal). Loneliness had been a frequent issue, and here was medically approved socialising, even if members were not always quick to make them feel at home. My impression was that those, the majority, who did not remain long with the organisation, were meeting in it the very same factors, mentioned above, which made them want to drink to begin with.

There is ample literature available about the way that AA facilitates self-acceptance, although rather less on the way that for many it makes it more difficult (Staddon 2005, Ragge 1998, Peele 1995). It is possible that women may be dissatisfied with the stressing of guilt in the meetings, feeling they have enough guilt to contend with already (Plant 1997). Having made that great break with being 'good girls' which led them into being addicted to alcohol, they may not be prepared as yet to accept further restrictions (Ettorre 1997). Another possibility is the lesser suitability of a didactic model of behaviour for twentieth century women who have been brought up to believe they have a right to determine their own lives. However, it is possible that in AA some people may be able to achieve greater self-acceptance, and an opportunity for friendship.

4.4: The experience of alcohol treatment

Alcohol treatment, with its common moral component, may be oppressive for women (Ettorre and Riska 1995). This may not only be for the many reasons cited above but also because they are the 'wrong' sex to have such a problem. Their life experiences, and expectations as to their behaviour, will be different from men's, as I explained earlier, and in the past these have seldom been taken into account in conventional alcohol treatment (Grant 2007, Women's Resource Centre 2007).

Treatment had been received by 17 of the 23 'Making a Start' women. This included Anne, Carol, Ollie and Ursula, who were still abstinent. Ursula however had found the treatment unhelpful and harmful, as I describe later; she had stopped drinking later on. Nen and Helen were still in treatment and were abstinent initially, but Helen began drinking again during the research project. Eleven women, Bella, Deirdre, Elsa, Fran, Gill, Karen, Pat, Teresa, Vi, Wendy and Alex, had received treatment but were not abstinent at interview. A few remained in touch with treatment centre counsellors.

I describe the treatment centres themselves more fully in Chapter 5. The treatment experienced by most respondents, and by me, was at the statutory Pink centre, and involved a commitment to abstinence and principally mixed sex group-work. People introduced themselves,

described what their drinking was like, and the problems they were still experiencing. They were similar to AA meetings, and usually people were also required to attend these frequently, as well as having more intensive one-to-one sessions with alcohol counsellors, and perhaps having some form of occupational therapy. This sort of group-work might continue for several weeks before a woman was allowed to attend a women-only group. The reason I was given for this arrangement, while I was interviewing for 'Treatment Approaches', was the greater expense of running single-sex groups, and not wanting to 'waste' them.

There was general agreement from 'Making a Start' respondents that one-to-one sessions were better than group-work, especially at the start. Helen, for example, had found attending the Pink to be of help, but had been dismayed by its method of making people begin treatment by attending the mixed sex, confrontational groups:

I think when I first started coming here it would've been better to have a couple of sessions with a one-to-one...then with a keyworker who asked me what I feel would be better...if I wanted to go into a group of people in the same situation or still continue with a one to one a little while longer. I needed to be prepared for that. 'Cos you're in this group of drinkers, all talking about the same thing, and then somebody going in there saying they've relapsed...(Helen, 'MaS').

As well as the mixed sex groups being cheap, it has also been noticed that men do better in mixed sex groups (Hodgkins et al. 2006). It has traditionally been men's needs which have been considered, both in AA and in alcohol treatment, even though the Pink acknowledged that they sometimes had as many female patients as male.

Respondents also mentioned the lack of single sex counselling; a failure by treaters to understand or be aware of predominantly female issues such as sexual and domestic abuse; and a need for flexible treatment times. Despite these drawbacks, some innate stubbornness sometimes developed:

There was about 30 of us in a big circle...different people because different ones would relapse... I've always been a hugely competitive person, and...everyone had abandoned me or turned against me. But the only thing I had was, I'm not going to relapse. I won't. And I used to crawl out of that place after an hour of all that turgid nonsense going round the room, of people's sagas, and they wouldn't come back, and there was two suicides while I was there, and I began to feel worse and worse and worse...but I thought, no, I won't relapse (Ursula, 'MaS').

Perhaps the stubbornness was there all along. Women who drink in a deviant way are already putting their personal needs before conventionally acceptable behaviour and could be said to be acting politically, in that they are claiming the right to self-determination

(Pearson 1975, Bransen 1998). I explore this idea further in Chapters 5 and 6.

I found my treatment at the Pink, back in 1990, very demanding. Its model remains much the same now, but offering fewer sessions, so that the experience nowadays is more dependent on attendance at AA meetings between group and one-to-one sessions. Explanations were, and are, few and far between, and most information was obtained from other patients. These were all White, and mostly male, and had usually attended the treatment centre before, 'knew the ropes', and came from both working class and middle class backgrounds. Such factors continue to be the case today. It was stressful in that you had constantly to be on your guard to say the right kind of thing in the treatment groups, or you would be sharply criticised for your 'crazy thinking'.

Acceptance of AA and the 12 Step programme was taken for granted but not always explained. The mixed sex groups might have forty people in them, some of whom could be very frightening. The thinking behind the treatment was that you had become a dishonest person by becoming 'an alcoholic' and your aim was now total honesty with yourself and everyone else, at all times. This could theoretically be a healthy experience, but what felt unhealthy was feeling controlled and distrusted. The Pink seemed based on the premise that, as you were an 'alcoholic', you were by definition dishonest and that you must never

trust yourself; what Peele (1989) calls the Catch-22 of Denial. For me, this confirmed my low opinion of myself, and others have agreed that such perspectives can be demoralising for women, as others have discussed (Campbell 2000; Ettore 1997).

The Pink followed the 'disease' model of alcohol treatment, also known as the 'medical model' (see Chapter 2). The 12 Steps of its recovery plan (the same 12 Steps as those used at AA) were central to this¹². The first Steps were easy: I had to accept that I was 'an alcoholic' and needed help. I was less sure about giving up my power to God as I understood him (Step 3), but put this to one side. As part of my treatment, I listened, in large mixed sex groups, to deeply shaming stories from other women and (mainly) men, of how they had experienced social disgrace. It did not occur to me that there was anything illogical about treatment which encouraged one to feel shame and yet which claimed equally that what one had was a disease. I did feel shame and I was relieved to hear I had a disease. Neither did it occur to me to question why people who had been abstinent for a quarter of a century were still describing themselves as being 'in recovery' or 'recovering alcoholics'.

There was plenty of time to sit and talk to the other 'alcoholics' and to smoke. Everyone smoked. Smoking did help me with tensions such as those I have mentioned, and I am glad I did not give it up till a year

¹² See Appendix 1

later, on my first 'alcohol anniversary'¹³. I gave it up then because I had noticed that I was having a cigarette when I would otherwise have reached for a drink (Hughes et al. 2000). It occurred to me that if I stopped smoking I would always have a fall-back position if life got too tough without alcohol. The sitting and talking were also part of the treatment, and were both positive and negative. One did become indoctrinated into the repetitions and assumptions of the 12 Step programme, but one did also achieve a sense of belonging, which could be valuable, at least in the short term.

Some studies have attributed similarly positive outcomes for women using AA for extended periods (Moos et al. 2006). Yet residential treatment provided the most powerful indoctrination process and seemed ineffectual. Fran had been to three Rehabs but without lasting effect upon her alcohol use:

I was quite young...23, 24...They arranged for me to go to a [residential] treatment centre....frightened the life out of me...It was basically a 12 Step Method. ...I hated it! It was pretty rough...I went straight back out and on it again! ...Every time I came out I used to be mad at something so I ended up in the pub! (Fran, 'MaS').

Pat's experience was similar in that residential treatment seemed simply to have prevented her from accessing alcohol for a time:

¹³ People who decide they will abstain from alcohol usually remember, and celebrate, their 'alcohol anniversary' for many years if not for life.

I was in a rehab down in Devon; I was there for 6 months without a drink...I was pretty bad when I...like shaking and sweating.....[they] gave me...I can't remember the name of the tablets butand then they'd look after my pocket money so if I wanted to go down the shops I had to ask a member of staff to come with me to make sure I didn't buy alcohol...[then] I think I come back into a bed and breakfast for about maybe 3 weeks. I just can't remember what happened....(Pat, 'MaS').

Some women did not seem to object to being humiliated in treatment, perhaps feeling that they deserved it. In my own case, I turned my shame and despair in onto myself, and had I not had the support of my friends outside the treatment unit, I think I might have killed myself at this time. It is difficult to imagine how women might be expected to be shamed into conformity while being denied their self-respect. Low self-esteem often leads women to drink, as does childhood abuse, etc., and this 'sharing' may be the last thing they need. This is one of many examples of the unsuitability of this sort of treatment (Seddon 2008).

The most positive comment about treatment came from Bella. Although it had not been effective in helping her to stop drinking, as a frantic, poverty stricken mother of four children, one of whom had dyspraxia¹⁴, residential treatment did at least give her space and some proper nutrition:

¹⁴ 'A developmental disorder of the brain in childhood causing difficulty in activities requiring co-ordination and movement' (Oxford Dictionary of English 2005).

There was a 12 Step programme. I just tried to make the most of the time, knowing that I was one of the really lucky ones... I still had my children and I was able to go to a treatment centre; and I really didn't think I would ever, ever get that opportunity again... [then]... everybody else was going off to Secondary¹⁵...but the Social Services insisted that I came home...And then I get drunk again...just to say, look, I haven't had enough treatment....it was so far away from anywhere, you couldn't get anything to drink. They kept to the usual routine, kept you busy, kept you fed...if you're home you literally run out of money---if you're on benefit...yesterday I was starving---and we'd run out of electric [*crying but pulls herself together*]...it just gets...and I mean, sort of trying not to drink, on top of that....(Bella, 'MaS').

Nen was still in treatment and described it as:

...really good, yes; I was in a really bad state and I felt really helpless and I felt I'm never going to get out of this depression bit. They give you all these ways of thinking...ways to change your thinking...all this sort of thing...and I did AA, I did AA religiously as well (Nen, 'MaS').

These women certainly benefited briefly from the unusual experience of being looked after and given attention.

'Being a lesbian' was not of interest to the treatment staff when I was at the Pink, since it would not have been seen as relevant to 'the

¹⁵ 'Secondary' here means second stage of rehabilitation; usually a residential centre but with some access to the outside world, support and supervision; sometimes called a 'dry house'.

disease'. Perhaps I was fortunate that being lesbian was not, as far as I am aware, seen as the cause of my drinking, as has been suggested to others in the past. As I mentioned in Chapter 2, it is not that many years ago that a homosexual identity was sufficient to justify the administration of electric shock treatment (King and Bartlett 1999). Few of the 'Making a Start' lesbian/bisexual women who had gone for alcohol treatment had revealed their sexual orientation, and this cannot have helped their recovery. Similar silences have been noted by others, and it is suspected that covert heterosexism may be at work in treatment (Neville and Henrickson 2006). Rigid expectations about sex-roles may be in place (Hall 1994) and this is reinforced in the AA literature and approach which individualises issues in a way which is inimical to a feminist perspective. As I have written elsewhere:

When lesbians seek help for alcohol issues and are open about their sexuality, the labels, 'lesbian' and 'alcoholic', indicate to clinical staff that they are socially dysfunctional... Perceived as doubly deviant in their substance use and their sexuality (Roberts, 1985; Bridget, 2001) lesbians 'are much less likely to present to these services for a variety of reasons ... (including) ... fear of their sexuality being pathologised if they do present' (Malley, 2001) (Staddon 2005 p.73-74).

Marginalised women, such as black women and lesbians, are more likely to approach 12 Step treatment from a critical perspective and to object in particular to its language (Swallow, 1983). For me, this feminist awareness developed as treatment went on, as did my

indignation at the centre's refusal to take an interest in wider issues such as causes of drinking. Most people said nothing or left.

The benefits I was receiving from treatment began seriously to disintegrate when I was instructed to undertake 'Step 4' of AA's 12 Steps: '... a searching and fearless moral inventory of ourselves.' I had to tell the whole group, of around 20 men and women, my 'drinking history'. I was told to be completely open about my life, which in my case included selling sex for drinks and being a lesbian. To my astonishment, some men in the group perceived both revelations as invitations to offer me uniquely satisfying sexual experiences themselves. The other women had all been to the Pink before and knew not to reveal sexual information of any description. The staff seemed unaware of such behaviour. Staff I spoke to years later, while doing my research, stated that as a patient I should, and indeed would, have been warned not to speak of intimate things in front of the men. This was not the case for me, or for my respondents, or for RAG members. Furthermore, had such a warning been given, it would have been contrary to the injunction to be completely honest and straightforward. Such different 'Making a Start' respondents as Nen, Ollie and Ursula, confirmed that this form of sexual harassment remains usual in mixed sex treatment, and there is further confirmation from other research of sexist attitudes and behaviour by staff in such units (Raine 2001 p.78).

Some respondents did seem to have coped better than I did; Nen, with a far more abusive background than mine, dealt briskly with the sexual harassment situation at the Pink:

When I went [there]...I shaved all my hair off! ...I'd wear really scruffy [clothes]...cos normally I've always dressed quite nicely and worn make-up and stuff, but it worked like a charm!
...they're so dumb. They said, 'we thought you were a lesbian' and I said, 'well you can think what you bloody like, can't you!'
One day [I'd like to] make sure they know...how vulnerable I feel...(Nen, 'MaS').

Another serious problem I encountered in treatment was the expectation that I would also attend daily AA groups. In the past these had depressed me and made me crave alcohol. I eventually decided to conceal my non-attendance, which was frightening, as I was still emotionally dependent on the centre's approval. No-one seemed to notice, but I learnt a valuable lesson: that every person's journey will be different. I look at possible alternative journeys in Chapter 6. The two friends I have mentioned helped very much. I had never dared mention at the treatment centre that we all went out together, with others, to pubs and clubs. I only drank Coke, but such behaviour would have been seen as foolhardy, and I began to realise that just as important as the days at the treatment centre were the evenings and weekends of endless discussions with other women. These offered affirmation while my self-worth was otherwise being battered daily in the treatment groups.

The rigorous and critical therapeutic groups may benefit patients who are totally self-confident and unwilling to listen to criticism. Probably 'treatment' of this sort was designed for just such people; people who suffered from a 'ballooning ego' (AA 1957 p.4). However, all the women I interviewed felt, as I did, that their self-esteem was fragile, as is likely for women in alcohol treatment (Raine 2000, Ettorre 1997). Jane's description is of an AA meeting, but the 12 Step treatment centre group sessions follow the same model:

... You start to feel horrible about who you are. If you're angry, it's 'oh it's not good to be angry'... I mean part of recovery is feeling that anger and expressing it. They'd say, if you get angry, you'll drink. I think that's really awful... You do hear that in AA and they spout the stuff and they say 'I'm not angry' and you think, 'well you are really.' I see angry people trying not to be angry and that is so disempowering... telling yourself not to be real (Jane, 'MaS').

It might have worked] in a little group... [just] sit down and share experiences... Nobody says oh it's your fault, you shouldn't have done this, you shouldn't have done that, where you can just talk and say what you want to say... And you could get to make friends, get to know people (Elsa, 'MaS').

Many of us in RAG agreed that the treatment groups' mission seemed to be the destruction and the rewriting of our personalities (Ragge 1998). If they saw us as being diseased, this would be a logical thing to

do, and some treatment centres would have seen it as part of the job (Raine 2001).

The shame which frequently accompanies women into such situations makes staff behaviour difficult to challenge (Women's Resource Centre 2007). Such methods may consequently appear to be effective in the short term, as agents of conformity (Ragge 1998). However, they particularly damage women, whose roles as icons of respectability have been destroyed by the loss of dignity and self-possession (Raine 2000; Ettore 1997). It is also apparent that the stigma and shame is often exploited in treatment by community psychiatric nurses (CPNs) and psychiatrists. One CPN at the Pink was named frequently by different women as delighting in making them feel worthless: 'He thinks it's his role in life', (Nen, 'MaS').

Humiliation seems sometimes to be a conscious technique of treaters, being seen as therapeutic. Carol's experience of the statutory treatment centre, the Pink, had been of this sort. She was a competent professional woman, committed to abstinence, who had had a positive interview with her GP before attending the Pink for assessment. Carol was told after her first treatment session that she had 'the wrong attitude': 'one of the nurses took me to one side and said, you realise you're an alcoholic as well, you're not one of the therapists' (Carol, 'MaS').

Deirdre was unworldly, by turns timid and aggressive, and mainly looking for help because of her family's concern; her GP had also been kind and helpful. Yet Carol walked away from her first treatment session, and Deirdre her assessment interview, both full of disgust.

It was at the assessment interview that many 'Making a Start' women first glimpsed the controlling purpose of treatment. Assessment is a procedure designed by staff to assess the patient's suitability for the treatment centre programme, and needs to be handled delicately, so that clients feel safe to talk about their alcohol problems. It is also the essential gateway between being referred by a GP for treatment, and accessing that treatment. Deirdre saw a notorious assessor at the Pink, who confided to some patients that he was an AA member, and one of whose lines is reported to be: 'You haven't drunk enough! You have to gulp it!' (Carol, 'MaS').

I have no recollection of my own assessment, but complaints made by respondents, and by RAG, included the unsuitability of having to talk about very personal things, at such an early stage, usually with a male assessor. They also complained about cynicism and bullying, principally in connection with the Pink, and mostly by two male assessors. Ursula had overdosed:

And the psychiatrist said, 'I recommend you go to the Pink'--- and I didn't know what he was talking about...he said it's the Pink for you, and I know someone and I can get you in early, so

off I trailed. My daughter came in and looked at me as if I was a terrible person. And I had an appointment [with the assessor referred to above]...He made me feel like a piece of shit (Ursula, 'MaS').

Assessors sometimes seem to have been devastatingly critical and didactic. Deirdre felt it was hopeless trying to make this same assessor understand her periodic binges, which he said were not 'alcoholism' so could not be treated. There appears to be a link between the moralistic slant of the medical model of alcohol treatment, and the behaviour of certain assessors. Certainly the assessments done in centres with a different model seem to have been conducted more sympathetically: 'I went to [the Turquoise] and they were brilliant---just listening and no matter what you said, not fazed' (Gill, 'MaS') It is easy to see how people holding a gate-keeping role may be impatient, critical and over-hasty, as I note in Chapter 5, but perhaps it was as well for potential patients to get a fore-taste of what 'treatment' at places like the Pink could be like. I discuss this further in Chapter 5.

Gill and Fran had had positive experiences of the Turquoise, which deals with both alcohol and other drugs. Fran lives nearby so had heard of it herself. Gill heard of it by chance. They both experienced it as healing and respectful and both had had one-to-one counselling with a woman. Gill had stayed away from drinking for some time, and felt much more positive. Unfortunately, that centre is funded for local people, and only saw Gill as a favour. Consequently, when other

circumstances in her life changed and she had gone back to drinking heavily she had not felt able to return there. Fran had not stopped drinking while having counselling at this same centre, but continued there because it made her feel happier in herself. The less didactic approach at these centres is discussed in Chapter 5.

Six respondents had gone to another voluntary sector centre, the Green. I describe it more fully in Chapter 5, but despite its self-referral system, and its description of itself as offering 'person-centred counselling' (Rogers 1978) and a 'harm reduction'¹⁶ approach, women were disappointed by it for various reasons, perhaps chiefly because the counselling was short-term, and because many counsellors attempted to persuade them to go to AA, which supports abstinence.

These three, the Pink, the Green and the Turquoise, were the only local day treatment centres the 'Making a Start' respondents had been able to access. I look further into the nature of treatment, into what else was available, and into the approaches of professionals, in Chapter 5.

Reflections

The position of the 'Making a Start' women had come about principally through an imbalance of power. Convinced by the media, and often by their family and friends, that they must keep up certain standards of

¹⁶ 'Harm reduction' and 'abstinence based' treatment models are described more fully in Chapter 5

femininity, such as a caring role, at the expense of what they wanted to say and do, they had become lonely and depressed. Some, like Renee, suffered a perpetual sense of loss. A lack of opportunity to develop as people was experienced by the majority, and those like Carol, who did not lack opportunity, were obsessed with guilt. All had suffered from controlling and/or abusive family members and/or partners, and had often come to blame themselves for this.

Given these factors, self-medication with alcohol was an obvious and comforting solution, but one which soon brought unhappiness as they struggled to cope with the consequences of being seen as femininity failures. The most usual suggestion made to them, membership of AA, brought more problems than blessings, principally because the organisation offered an even more stringent interpretation of the very social expectations which had precipitated their problems.

With the next step in attempting to obtain help, speaking to a GP about their alcohol use, women typically faced lack of understanding of their unhappiness, which by this time might include numerous elements, from homelessness to suicidal depression. Usually they were not sure of what they wanted by way of help. GPs were often ill informed, and biased in favour of returning the patient to what they themselves understood as 'normality'. What resources did exist were often not known to doctors, and those that were, usually had an agenda of conformity and compliance.

Much of their doctors' lack of knowledge and empathy was rooted in lay perceptions of how women should behave, what was good for their health, and what was good for their families. They may have been influenced by the media, or by the academic addictology publications, whose view of health is not typically multi-faceted. They were far from being alone in these perceptions. On the contrary, the disgust engendered by women being seen drunk had translated into a general fear that women, especially young women, were out of control, risking the future of civilisation. Certainly alcohol was enabling many women to enjoy at least brief freedom from constraint, to experiment with being an outsider, and to show their contempt for established behaviour norms, in the same way as young men have typically done.

Once caught in the treatment net, these women found that humility and proper acknowledgement of their mistaken behaviour were normally the required attitudes. Even those who tried what appeared to be more liberally minded treatment centres might find themselves being re-directed to the ubiquitous AA. Their self-respect, which had sometimes been briefly improved with alcohol, underwent new attacks. The most valuable aspect of 'treatment', one to one counselling with someone of the same sex, was short-term, and frequently possessing a moral focus. The reasons were that the centres, like the GPs, were there to re-direct these women to a proper appreciation of their roles and responsibilities. These required them to be sober.

This chapter demonstrates the lengths to which society will go in pursuit of its perceived needs---in this case, a kind of underclass, which will receive certain benefits, in return for adequate performance (VanEvery 1995, Malos 1995, Delamont 1980). For a range of reasons, these women had turned in a poor performance. Renee had 'lost' babies; Teresa had refused passively to submit to abuse; Anne was dissatisfied at never being allowed out in the evening; Deirdre had wanted to have her own children, not have them aborted; Nen had declined to continue with being domestically abused. When they used alcohol for comfort, they were criticised for not using it in moderation, in the way that more privileged citizens seemed able to do. Their behaviour was deemed unsuitable, and they were punished by social stigma and, too often, by treatment and its 'support groups'.

Many women had still managed to move forward in different ways, regardless of whether they had stopped drinking or not. Sometimes, like Deirdre, what they had got principally from just approaching treatment was the chance to take another look at what they were doing with their lives. Bella got a rest at a treatment centre and someone to talk to. Deirdre felt justified in her feeling that treatment could do nothing for her, and got a dog instead. Elsa and Alex had enjoyed the discussions and counselling at different centres and had plans for their futures which included dramatic dance and motorbikes. Fran liked to

joke about treatment but still appreciated knowing she could drop in at her local centre for a cup of coffee and a chat.

When I examined the negative and positive experiences which women had described as being connected with their alcohol use, I was struck by the importance to them of feeling able to be free to be themselves, whether alone or in groups. There are not many opportunities for this in Western culture. Women enjoying ritual dance, art, myths and magic are likely to find it hard to fit this in with being an income-generator, a home-maker, a mother, a wife, and unless they are reasonably well off and live in a city they are unlikely to have access to such possibilities in any case (Artazcoz et al. 2004, Bristol Women's Studies Group 1979).

If we accept that there are important links between being able to find out who you are and to express it, we also have to accept that this takes time and is not friendly to capitalist enterprise. Given the great pressure many women of most classes are already under to find any 'time out' for themselves at all, women's 'alcoholism' could be seen as resistance to imposed social order, and a determination to take that time, whatever the cost (Sherman et al. 2008). As I show in Chapter 5, it appears that a considerable range of forces are ranged against them.

Chapter 5: PROFESSIONAL PERSPECTIVES OF WOMEN'S ALCOHOL USE

Introduction

This chapter also draws on data from 'Making a Start' ('MaS') and from 'Treatment Approaches' ('TA'). It considers the experience, views and approaches of GPs and treatment providers, both from their own accounts in 'Treatment Approaches', and as they were reported by the 'Making a Start' respondents. It then sets these responses in the context of how women's behaviour around alcohol is perceived and governed. Pen portraits of the women respondents are presented in 3.3.2 and in Appendix 5, and of the GPs and treatment professionals in Appendix 9.

I look first, in 5.1, at 'GPs' different understandings of alcohol use'. I begin, in 5.1.1, by describing 'The knowledge and training of the GPs I interviewed', before continuing in 5.1.2 to consider 'How these factors affected GPs' dealings with their patients'. I use a similar approach in 5.2, 'Treatment professionals' different understandings and practice, related to women's alcohol use'. The alcohol treatment system in the city I studied was complicated, which might help to explain why GPs knew little about it. I therefore begin, in 5.2.1 with 'A general description of the alcohol treatment available locally', before describing, in 5.2.2, 'The individual treatment centres and their assessors.' I move then into

5.2.3, a consideration of 'The effects of different approaches on the treatment offered'. In this section, I look first, in 5.2.3.1, at 'Aspects of abstinence based treatment centres', then make a comparison, in 5.2.3.2, with 'Aspects of harm reduction based treatment centres'. Finally, in 5.2.3.3, I consider 'Practical and emotional issues' relevant to these two main approaches.

These two sections are followed by an analysis, in 5.3, of 'The role and effect of alcohol legislation, governance and treatment'. I have already indicated the way women's alcohol use, in particular, is frequently criticised, and its treatment mismanaged. In this section, I consider the reasons for this. I begin by looking, in 5.3.1, at 'The mismatch between evidence and practice'. I consider, in 5.3.2, 'The role of social control'. I then look, in 5.3.3, 'Moral and political ambiguity', at the contradictions within medical, social, individualist and consumerist approaches. This leads me, in 5.3.4, to look more closely at how 'Consumerism in health' may aim at impossible goals of perfection. Finally, in 5.3.5, 'Paradox', I draw attention to the way that greater attempts to order, control and medicate are likely to be self-defeating.

5.1: GPs' different understandings of women's alcohol use

The Primary Care Trust (PCT) in which the GP practices were situated was a large one, including a very mixed population, and most of the doctors seemed rather over-worked and anxious. Dr. Danvers had to continue with essential paperwork as we talked, and Dr. Ellis worried

about time factors as a whole: 'alcohol is just a factor among many of their problems and often it's mentioned right at the end of the consultation and you've run out of time...you only have 10 minutes'. Unlike the treatment centres, some of which felt very different from each other, particularly, the rather grim Pink and the warmly welcoming Yellow, the doctors' surgeries were much like each other, regardless of whether they housed a single practice, such as that of Dr. Halford, or a multiple one such as that of Dr. Danvers. All had brisk receptionists and an official atmosphere.

5.1.1: The knowledge and training of the GPs I interviewed

Training in alcohol issues had typically been scanty. Most GPs said they had not learnt much about 'alcoholism' at medical school, or subsequently. This left them rather at a loss:

There were courses in the training then...Study days, or whatever....It was recognised that it's difficult to treat...and the time I learnt most about it was when faced myself as a GP with a real big problem and realising how completely inadequate my help was! That's where I learnt the most; the reality...(Dr. Jacobs, 'TA').

When alcohol had featured significantly in GPs' training, it had affected them strongly. Drs. Ilford and Halford had qualified in Eire and Northern Ireland respectively, and had been taught more about 'alcoholism' than those trained in England. This training presented 'alcoholism' as moral

weakness, and Dr. Halford had acquired decided views, based on this philosophy. Her practice was an inner-city one, with many male patients she termed 'alcoholics':

We had a really very good psychiatrist... very tough with alcoholics... 'Stop drinking or you're dead!The best way of stopping drinking is to go to AA.', he'd say....and I very much picked up that as my philosophy because of the effectiveness---I mean there's no point in pussyfooting around, in my experience, patients will often come back and say 'thank you for sticking to the point' ...maybe their problem is due to alcohol rather than being solved by it (Dr. Halford, 'Treatment Approaches' ['TA']).

Historically, AA has been part of an unofficial medical lexicon, and advice from 'Treatment Approaches' GPs invariably included AA attendance.

Dr. Ilford felt that abstinence was the easier way rather than the only way:

I had 6 months psychiatry...It was very interesting because there were three consultants there and they worked in very different ways. One rewarded the alcoholics by giving them plenty of time when they weren't drinking but gave them short shrift when they were! Another looked very much to see whether there was underlying depression and that was the one I was most impressed with, although I did see some merits in the other, giving the attention, rewarding good behaviour (Dr. Ilford, 'TA').

In the approach she describes, the phrase 'good behaviour' carries paternalistic and controlling connotations, of which she seemed unaware.

No GPs had first-hand experience of what AA meetings were like, despite their recommendation of it, or much evidence of their success. Some admitted that they knew of few women finding AA helpful, and added:

...[it] doesn't suit everybody (Dr.Ellis, 'TA').

Sometimes people find it helps and sometimes they just hate it (Dr.Danvers, 'TA').

I'd suggest it; it doesn't suit everybody (Dr. Cooper, 'TA').

It can be very successful and supportive but...I can't recall anybody...who's become a recovered alcoholic just through AA (Dr. Branscombe, 'TA').

The GPs were certainly influenced by the general public acceptance of the progressive nature, and 'incurability', of alcohol dependence (Jellinek 1960). However, as Dr. Goodge admitted, while generally believing it to be a relapsing condition, they were not in a position to know this, since those who recovered might not come back to report their success. This was the case for me, and for most of the Research Advisory Group (RAG). People often moved to a different area, and not

everyone chose to discuss past alcohol issues with a new GP. Others have written about the invisible majority who recover completely but do not publicise it, for example Fletcher (2001), Hall et. al. (2001), Peele and Bufe (2000), Ragge (1998), Sobell and Sobell 1995, Prochaska et al. (1983), Davis 1962). This will remain an area of debate as long as research into treatment effectiveness is based on respondents who remain in touch with the treatment services, as opposed to individuals who either chose not to engage with services at all, or, having engaged with them, chose not to remain in touch with them. Other GPs did recognise the uncertainty of their information as to outcomes, an uncertainty supported by other research (Walters 2002, Nestler and Malenka 2004).

The comments below are typical of the GP respondents in this respect:

it's not curable...I don't think people can go back to social drinking...that's what people would like...to be able to rid themselves of the problem of the alcohol dependenceBut I do know people who have successfully stopped...I would never say to them, well you'll be OK now....I just wouldn't risk it....largely it's incurable but arrestable (Dr. Jacobs, 'TA').

I don't think it's curable but I think it is probably treatable ...but people are prone, like AA say, for the rest of their lives to be...you can talk to people in their seventies who've been abstinent for ages and they never quite get over the feeling that they might go back to it, in which case they're not cured, are

they?...they recognise it as being different to people who don't feel that way about alcohol (Dr. Cooper, 'TA').

This was despite prominent, conflicting information, such as that of Raistrick et al. (2006) for the National Agency for the Treatment of Substance Use (NTA), and is further evidence of GPs' 'working to a script', rather than keeping up to date with new research. They may also have been influenced by awareness of the 'revolving door' syndrome, whereby alcohol patients are seen as people who keep coming back for help whatever treatment they are given (Shaw 2004).

Dr. Goodge also felt that GPs were not sent enough updated information about treating alcohol issues. However, what arrived at the surgery did not always reach the GP's desk. Dr. Andrews, who said she had only heard of the Green and the Pink Centres, actually had a flier up for the Blue Centre in the waiting room. Dr. Cooper worked almost next door to the Turquoise centre, which made use of harm reduction and social learning approaches, but had never heard of it, or of anywhere except the Pink and Green centres. Dr. Fisher was also anxious about lacking information: 'I'm...aware that it's very difficult to keep up with all the voluntary and statutory service that might be around and there are probably things I don't know about and I'm not using.' (Dr. Fisher, 'TA').

Dr. Fisher was obviously sincere, but she had not always managed to keep up, since despite her professed interest in gender issues, she did

not know that AA and the 12 Step philosophy had been found to be less suitable for women than some other methods (Campbell 2000, Plant 1997, Wilke 1994). Again, although all the GPs agreed that 'alcoholism' could, and did, often result from social trauma, this did not appear to affect the majority view about a patient's 'being an alcoholic', as if it were an intrinsic part of their genetic make-up, nor did it alter the recommendation from them all that women should go to AA, where such a view would certainly be confirmed.

This approach to 'the disease' was able to over-ride their own observations as to social causes and their largely humanitarian views. Perhaps this anomaly revealed a fear of reaching conclusions which conflicted with early training. This may be part of a far-reaching effect on GP attitudes of 'the moral perspective' I have described. As I noted above, medical training is inadequate in preparing doctors to be the moral arbiters that both doctors and patients frequently expect (International Centre for Drug Policy 2007, Abbasi 2004, Crome 1999, Crome 1987). Doctors face a dilemma of training versus experience; enculturation in a sexist and pejorative ethos, versus lived experience of human distress and injustice.

Training in the field of substance use remains a postgraduate option in most medical schools, and where it exists it has been greatly criticised. Attempts to assess this training met with a poor response (20.5% over-

all) from medical schools (Crome 1999). Of the clinical staff responsible for this teaching:

Under 50% felt confident in the identification of substance problems; in the ability to diagnose and classify these problems, and to detoxify patients.....*Deans did not regard poor outcome and the lack of scientific credibility with reference to substance misuse as factors limiting training in the speciality...* (Crome 1999 p.116-117; my emphasis).

Not long after this report, in 2003, 'profound changes in medical training' were being announced (Wass et al. 2003) but they would not have been adopted in time to have affected many of the doctors who saw the 'Making a Start' respondents, or those I interviewed. This would also have been the case with the development of the new Foundation Programme for medical students, which was praised in an Editorial in the *Lancet* (2005 p. 607).

In any case, not everyone sees such changes as have occurred since then as being beneficial. Concern about doctors' training continues to be expressed by a group very likely to be aware of its weaknesses, the teachers:

[C]linical teaching today...is less effective than it used to be and needs to be... due to digital information systems, clinical trainees inevitably review patients' laboratory data and diagnostic images before they do a history or physical examination. This [not only devalues] bedside skills; it is nothing less than complete

inversion of the conventional diagnostic process. The good news is that innovation in medical education eventually catches up with advances in science and technology. The bad news is that the pace of change is glacial (Reilly 2007 p.705).

In the same year, the great difficulties of training doctors to be ethical, empathic, trustworthy and able to deal with complexity and uncertainty, were acknowledged by Campbell et al. (2007). Doctors who train are predominantly young, and may not be mature enough to deal with what is often harrowing as well as difficult work.

It is thus unsurprising that an American national survey reported in 2001 that, following a response rate of 57%, most of their GPs did ask about alcohol problems, but frequently lacked the knowledge or the expertise to deal with the response (Friedmann et al. 2001). A UK study two years later found similarly that:

[T]he perceptions of GPs themselves would suggest that, in order for primary health care to fulfil its potential, both education and training and the creation of a supportive work environment... need to be provided... This study did not address the elements of effective education, although analyses reported elsewhere indicated that education was not only related to the number of patients managed, but also to the practitioners' diagnostic and clinical management skills... (Anderson et al. 2003 p. 600).

They were also affected by the low status of alcohol issues in mental health, a fact which has fostered anomalies and inconsistencies in the

system. For example, it was very difficult to get alcohol patients more specialised psychiatric help. There appears to be considerable prejudice 'at the top' as to how unimportant is the issue of women and alcohol dependence. Dr. Branscombe told me: 'I can't refer alcoholics to our normal psychiatric services, because they get the whiff of alcohol, it's an alcohol problem, that's not their problem. So they won't accept referrals from anyone with an alcohol problem' ('TA' 2005). This observation was confirmed by Dr. Cooper: 'If you send people to secondary care, to the psychiatric service...then they're unavailable' ('TA' 2005). This awareness that they are dealing with issues not seen as important by senior medical staff is likely to have a 'knock-on' effect on how patients are treated by their GPs.

Reportedly moralistic and unkind behaviour by some GPs to alcohol patients is confirmed by a national survey in 1998 of GPs in England and Wales which showed evidence of negative attitudes in so far as alcohol patients were seen as a difficult group to work with (Deehan et al. 1998). This may be connected with doctors' training: '...we know so little about medicine's informal curriculum (clinical training) that it's hard to know where to start' (Reilly 2007 p.705). The *BMJ* has referred to the 'enculturation' of trainee doctors; a 'hidden curriculum' of neutralising the emotions, promoting professional identity by ritual and hierarchy, and an unofficial prospectus including humiliation and haphazard tuition (Lempp and Seele 2004). Certainly, psychiatrists and GPs try to avoid treating patients for whom they have some sort of

distaste based on 'moral grounds' and whom they experience as 'difficult' or 'dirty work', i.e. work doctors have to do, but find unpleasant and demeaning (Shaw 2004). Another term in use is 'heart-sink patients' (Anecdotal).

Most GPs I interviewed were concerned, but knew little, about alcohol problems, or the available help for them, and this seemed to apply whether they were in a multi-cultural, over-crowded practice, like Dr. Danvers, or in a quiet, wealthy zone, like Dr. Ilford. All admitted there were limitations to their knowledge, and expressed a wish to know more and a desire to be more effective. They did not seem to know about different approaches to dealing with alcohol problems, such as 'harm reduction'¹ but were familiar with the concepts of 'alcoholism' and abstinence, learnt in training or as lay people.

5.1.2: How these factors affected GPs' dealings with their patients

Doctors such as Dr. Ilford and Dr. Halford, who had received training in 'alcoholism', were more confident about dealing with alcohol issues than the others, although they were not as up to date as they might have been about new research and treatment. Patients like Carol ('MaS') might have found their confidence reassuring, and felt supported by it, at least initially, when they were trying AA or a traditional 12 Step treatment programme. However, while peer support

¹ See Chapter 2 and Chapter 5.2.1

from others with a similar condition can be valuable, it should not be didactic, and sometimes it seemed as if the GP was too relieved, that s/he had something to offer, properly to investigate the extent to which such treatment might be suitable.

The inadequate training meant that 'Treatment Approaches' GPs were inevitably thrown back on lay information and responses, and this lay advice was what was offered to the patient, who had sought medical expertise. Nearly all the 'Making a Start' women had noticed that their GPs were short on information about alcohol dependence and its treatment, and often displayed lay prejudice about women drinkers. Their complaints about GPs' lacking professional knowledge were supported by evidence supplied by the doctors themselves in 'Treatment Approaches' (e.g. Dr. Fisher's comments above) and have also been confirmed elsewhere (McAvoy 1999). Most GPs were ignorant, not only of the causes and the nature of the condition, but also of the varieties of treatment available, how to access them, and how effective they were.

Most blamed this on a lack of time; but it perhaps has most to do with the relatively low profile of mental health problems in general (Wykes 2004). This is probably historical, resulting from and perpetuating stigma and a lack of resources. Bad practice is compounded by lay and medical doubts of the worth of putting time into people with alcohol issues (Harvey 2007), and the influence of the media. Doctors were

affected negatively by the low status of alcohol issues, as I mentioned in 5.1.1, and this, together with frustration at not feeling able to effect a total alcohol cure, may have influenced the advice they gave (Armstrong and Ogden 2006). Sometimes frustration may have resulted in impatience, which could explain the case of Jane ('Making a Start'), whose doctor said she was too much trouble. This may be an extreme example of how practitioners, feeling they have no solutions to the patient's problems, may react, but other 'Making a Start' respondents reported similarly:

I got really bad, I was shaking, and the doctor came out and he said 'You're an alcoholic!' and I just looked at him, and I didn't know what to say really. He just banged the door and left me! ...and he looked at me with such disgust. I'll never forget it (Ursula, 'MaS').

Many other writers have also observed such revulsion (Armstrong and Ogden 2006, Shaw 2004, Armstrong 1998). Moral perspectives are applied when there is insufficient understanding of social factors which affect people's ability to work, or to stop drinking (Rogers 2007). This may include moral and political ambiguity in the way that alcohol consumption is viewed, enabled, legislated, taxed, policed and treated (Measham and Brain 2005). A farcical situation may result, whereby: 'Far more civil servants are employed in relation to the production, distribution and sale of alcohol than in relation to its health effects' (Plant and Plant 2006 p.150). I consider this situation further in 5.3.

It may be easier to blame the patients than the treatment, when they fail to respond. Their condition may be seen as deliberately acquired, or a form of self-harm (Fish 2006). While some doctors may feel impatient about such illnesses, including bulimia and anorexia, others are often aware that they may conceal or express unhappiness, by taking it into the body, and providing a physical demonstration, such as drunkenness, of the emotional distress.

Moral judgements are particularly likely to be made when cultural norms are violated (Reiner 2000). GPs do often have difficulties in separating their personal beliefs and practices from their medical knowledge, for example, in respect of smoking guidance (Vogt et al. 2006). S/he is part of the same community, which has reacted furiously to the concept of women drinking, perhaps at the risk of damaging both born and unborn children (Waterson 2000). In that community, women are not seen as having the same right to damage their health as men have (Smart 1992). They are meant to be concerned about childcare and successful reproduction in a way that men are not (Eagly and Carli 2007, Bernstein 2004, Waterhouse 1993). Consequently, it is unlikely that doctors will be immune from the prevailing sense that women who get drunk are behaving selfishly and irresponsibly. Neither do GPs appear to be immune from imagining that 'women who drink' cannot be 'people like us'. As I have mentioned, when the well-educated and middle class Carol told her GP about her drinking, he exclaimed that

she 'didn't present as your typical alcoholic' (Carol, MaS). This is another factor I consider in 5.3.

GPs also seemed unaware that the medical language they used imposed moral values. Comments like, 'the people I can think of who are the...*chronic offenders*...' (Dr. Cooper, 'TA', my italics) automatically impute blame, and include moral judgements, as do 'tough with alcoholics'; 'good behaviour' (Dr. Halford, 'TA'). Dr. Cooper was in many respects a doctor able to think 'outside the box', but was still using words which implied a moral stance, so that moral judgements were being made, but perceived as medical. However, since morality is not an area in which the doctor has qualified, s/he is acting in a lay capacity while apparently acting in a professional one.

I mentioned in Chapter 4 how women's experiences of telling doctors about their drinking had been shaming on a number of counts, for example, being a woman with a stigmatising condition she must describe to a man. In this case, both GP and patient may feel that her moral worth has been damaged; this is likely when there is a lack of understanding of social factors (Rogers 2007). Sometimes GPs could be sensitive to social factors such as sexual abuse, and their frequency as a contributory cause of alcohol problems. However, they might still offer advice based on a medical understanding of the alcohol use. For example, Dr. Halford agreed that:

...there are some people, especially very exact people who ...like to do everything well, and high moral standards...that type of woman I think is more liable to actually have alcohol problems, and also, sexual abuse in the past. It makes the woman have problems to do with sense around control of a situation...suddenly something happens to make them fail their own standards, and they feel the only solace in life is alcohol... (Dr. Halford, 'TA').

Yet the 'treatment' Dr. Halford would have strongly advised would have been the particularly controlling 'medical model' of Alcoholics Anonymous, which emphasises personal responsibility for 'failure'.

GPs may also feel a need to protect their status as expert (Smith 2004). The 'Treatment Approaches' GPs had usually seen many people attempt unsuccessfully to deal with alcohol issues, and sometimes felt desperately helpless. This may have influenced the way that they often allowed lay prejudice and common sense knowledge to affect, and even stand in for, professional judgment. However, all the GP respondents appeared to have shown an interest and engaged with women who wanted to discuss their drinking, although not all would have probed to uncover it (Smith 2004). I felt that they probably operated on more than one level: genuinely hoping to offer good and effective advice, but also possessing the dreary knowledge that patients were likely to return again and again for help they could not give. Some GPs may even have used the diagnosis of 'alcoholism' as a coping mechanism, because they did not want to look for causes: 'I

deal with what comes up...except generally asking people their level of alcohol... we don't go out looking for the problem. We've got enough to do with everything else!' (Dr. Goodge, 'TA').

Although medical training would have been likely to incline them initially to favour the 'disease model' which sees 'alcoholism' as an obsessive illness (Jellinek 1960), and hence to feel positively about AA and 12 Step treatment models, GPs I interviewed would have been dismayed if they had realised how badly many women fared in AA meetings. Given that they knew so little about them, and were uncertain as to their effectiveness, invariably advising patients to go might indicate incompetence or a blurring of professional boundaries (Maxwell 2005).

However, looking for causes of alcohol issues could, ironically, lead to other problems. Sometimes 'Making a Start' respondents had felt that their alcohol dependence was being shuffled aside. For example, Nen's doctor's reluctance over making too hasty a diagnosis of 'alcoholism' could have been connected with a reluctance to label her with a shaming condition, and perhaps a knowledge of her domestic abuse. A GP who was unwilling to state that a woman was suffering primarily from 'alcoholism', rather than, say, depression, might be criticised as not taking the woman seriously enough. Doctors who were very alive to women's problems, and who were avoiding placing the blame on alcohol use, might well have appeared to be 'fudging the issue'. Sometimes women patients had previously had contact with AA

members or the AA helpline, whereupon they could, like Nen, have come to the doctor already certain as to what was wrong, and thus saw the doctors' more cautious and professional approach as reluctance to confirm their 'alcoholism' (Rogers et al 2000).

This is a dilemma which might account in part for the problems in communication between doctor and patient. Should an apparently confident and definite response be relayed to the patient (Smith 2004) or should any uncertainty in a scientific diagnosis be shared? Patients may attribute great wisdom to their doctors (Williams et al. 1998) so their anger and pain are likely to be great if they feel their trust was misplaced:

[I told her] I've got a problem with drinking...it's getting me into trouble at work and I feel very distressed...and she put me on Prozac. I think she suggested [the Green] and I have been there a couple of times and maybe it was the mood I was in at the times I went there, I just didn't find it at all helpful. But then this friend of mine told me about [the Turquoise] and I went there for a few more occasions... (Gill, 'MaS').

Gill's doctor may have believed that she was protecting her from the harsh realities of the Pink, and in any case her other physical problems probably did need attention. However, Gill had wanted help of a different sort, as our lengthy interview, and subsequent session in a focus group, made clear. Perhaps long-term counselling, without an alcohol focus, might have helped, giving her time, but without her

having to accept labels like 'alcoholic'. However, such counselling is not readily available on the NHS (Cass 2005), another problem for GPs.

Most GP respondents would try to provide a space where the woman would feel safe to talk about issues of sexual abuse in childhood, and domestic violence. These were issues which had been very prevalent in 'Making a Start', although they had not always been revealed to the women's GPs. They are also mentioned in other research, such as Galvani and Humphreys (2007), Niv and Hser (2007), Raine (2001). All the 'Treatment Approaches' GPs considered such issues to be both relevant and prevalent:

...[Q]uite self-destructive....there is a link to abuse there...and maybe quite serious sexual abuses, maybe in their younger days...sort of complicity from the grandparents and so on...it's a sort of self-abusive thing....whereas men are more externally violent, women...turn it in on themselves...(Dr. Cooper, 'TA').

The eight female and two male GP respondents seemed equally aware of gender issues in general, including the fact that seeing a woman doctor might be more beneficial for women than seeing a man. As I have observed earlier, this self-selected sample of doctors would have been unlikely to include the more reactionary elements of the profession. These doctors all perceived themselves as caring professionals with a responsibility, and were interested in me and in my

research: 'There is a huge lack of sympathy for it; these women are treated very badly I think' (Dr. Branscombe, 'TA').

These comments from doctors in 'Treatment Approaches' conflict to an extent with the rather negative impressions of talking to a GP, conveyed by the 'Making a Start' respondents. A possibility here is that the 'Making a Start' respondents (of whom 12, just over half, had been abused sexually and/ or violently) may not have mentioned such issues to their GPs. None said they had done so, and perhaps their GPs had not probed. This is a respect in which change may have occurred, at least in the medical journals (Ellsberg et al. 2008). The combination I observed of pessimism and uncertainty could also have given a rather negative impression to patients. Similar behaviour might have contributed to the general feeling of the 'Making a Start' women that doctors were not really bothered. Depression and frustration in doctors could easily be interpreted by women patients in a negative way:

Some people really feel they've got nothing to lose but to keep drinking...and when they've got no dependents it makes it harder...you know, they lose their jobs, they lose their homes, and the only thing that keeps them comfortable is alcohol even though they know that it will kill them....sometimes...it's as if they've lost the will to live (Dr. Ellis, 'TA').

We have a counselling service, but they don't really want to see people with alcohol problems...if you send people to ...the psychiatric service...they're unavailable...if there's any alcohol

involved, whether it's cause or effect, then it's got to be [dealt with first] (Dr. Cooper, 'TA').

Well I think that sometimes people think we can solve their problems for them...we can't... I think sometimes the expectation is there that we can give them some tablets and take it all away (Dr. Cooper, 'TA').

In practice, doctors may find it particularly hard to communicate information which is painful to them or to the patient (Arams 2002); telling a woman she 'is an alcoholic' would have been difficult for several GP respondents .

Some doctors I spoke to were relatively optimistic about the future of patients with alcohol issues. Dr. Goodge confirmed that they did not get an effective over-all vision:

I think that... it seems to be a chronic relapsing [condition]...well, the ones I see, I tend to see fairly often, then there are the others that...well have killed themselves or whatever...that applies to a lot of what we see here [but there must be cases where] things do get better [and] people don't feel the need to get back to us (Dr. Goodge, 'TA').

Dr. Fisher also believed full recovery to be a possibility; asked if he thought people could get over alcohol dependence, he said:

Yes, I think people do have phases in their lives...and I think there is a spectrum...probably some 10 or 20 % of people who

have alcohol problems really cannot drink... I think there are different life phases, when they have matured ... I think they can drink...I think they may still be vulnerable to turn to drink when they have problems...yes, I don't think it's an incurable disease! (Dr. Fisher, 'TA').

These responses indicated a breadth of vision which was not equally apparent at all stages of the GPs' interviews, or in the reports from 'Making a Start'. They were usually made later in the interview, after some reflection, and perhaps when greater trust had been established.

5.2: Treatment professionals' understandings and practice, related to women's alcohol use

As I mentioned at the beginning of this chapter, there were a number of complexities in the system of alcohol treatment in the city, and I begin this section with some background information.

5.2.1: A general description of the alcohol treatment available locally

When I came to do my first piece of research, 'Making a Start', in 2004, there were one statutory and nine voluntary sector day treatment centres for alcohol and other drugs. Some had a harm reduction policy, as opposed to the abstinence model followed by the statutory centre, most residential rehabilitation centres, and some voluntary centres.

Abstinence based treatment centres aim to eradicate, and harm reduction centres to regulate, the use of mind-altering substances. A simple comparison of the two approaches might be that abstinence treatment models tend to assume that the patient belongs to a group of people who have a form of allergy, and are unlikely to be able to use alcohol at all, without becoming addicted to it; they are 'alcoholics' and always will be (Silkworth 1976). Knowing this, they are seen as having a moral responsibility to abstain. A social learning approach, applied in the 'harm reduction' school of thinking, would propose that what has been learnt may be unlearnt, and such an approach would consider it possible that the so-called 'alcoholic' might be able to return to non-problematic drinking (Heather and Robertson 1997). However, harm reduction frequently involves using prescribed medication to assist abstinence from illegal substances. Such medication may effectively be prescribed for lengthy, even indefinite periods, while alcohol is not usually forbidden. This is reported to cause some dissent among treatment groups at these centres, where some patients, whose presenting problem was illegal drugs, are 'allowed' to drink and others, whose problem was alcohol, are not (anecdotal). There are also issues for some AA and NA members as to whether certain prescribed medication is in line with their philosophies. This criticism is usually levelled at drugs affecting mood, such as anti-depression and anxiety relief drugs.

Even more of an issue is mutual prejudice, with some 'drug users' and 'alcoholics' not wanting to mix with each other. Women who have only been addicted to alcohol often look down on women who use 'street drugs' ('at least I don't do that') and women who use street drugs are likely to see themselves as more intelligent and fashionable (RAG feedback). This perception is a social construction without medical foundation (RSA 2007). It is not the potential physiological harm of the substance which is being used for comparative status purposes by the users but how acceptable it is, within that population group. In this respect the phenomenon could be seen as an enactment of social roles, by exercising exclusion and/or moralising techniques to imply power and enhanced self-value (Bell and Hugh-Jones 2008).

The harm reduction centres offer women a less authoritarian approach, featuring the use of techniques based on 'social learning' and 'motivational enhancement therapy' (Heather 2006, Heather and Robertson 1985). These methods aim to encourage a number of positive life changes, including improved housing, work and relationships, and counselling. This counselling will aim to assist the client in understanding her drinking, and learning different ways to solve problems and manage her life. Such centres are much better off financially than alcohol treatment centres, as I have explained above. This probably makes it easier for them to achieve a higher staff ratio and be more flexible and up to date in other respects, such as

providing single sex groups, childcare, one-to-one same sex counselling, etc.

Some treatment centres could be accessed simply by walking in; some were free to people from a particular area; others required a number of forms to be filled in, and funding to be applied for. However, most were not known to the 'Making a Start' respondents, sometimes because their GPs had not told them, sometimes because they were not in existence when they originally sought advice, and sometimes because, although already in existence, those treatment centres were only treating illegal drug use at that time. Many had been set up to deal with illegal drug use, and only started to deal with alcohol as well when clients began to present with 'cross-addiction' (i.e. using alcohol as well as, or instead of, these drugs.) Only the Pink, Green and Turquoise centres had been used by the 'Making a Start' respondents.

This was unfortunate as a far wider range of help than GPs or their patients realised was actually available. Part of the explanation is certainly lack of information; as I have mentioned, the GPs were not at all up to date with what was available. However there might also have been the complicating factor that most treatment centres were designed (and funded) principally for the treatment of illegal drug use, and probably did not always welcome referrals of clients whose main problem was with alcohol.

The complexity of alcohol treatment in the city reflected the muddle and confusion over how substance use should be viewed, treated and controlled (Ewick 2000):

Medical professionals work alongside (and often in collaboration with) spiritual self-help organizations such as AA, the tax collector, licensing board, schools and culturally specific habits and customs practised by individuals over their own behaviours and desires. All of this activity produces what Valverde calls 'regulatory chaos' (Ewick 2000 p. 308).

There is also confusion about who pays for what, and why. Alcohol Concern (2008) has called alcohol treatment 'the poor relation', with most decisions about how much is spent on it, as opposed to being spent on other drugs, decided at local level, by the Primary Care Trusts (PCTs). The Department of Health has advised, but 'has been powerless to insist that local alcohol treatment is either considered or provided, even where the need has been most transparent' (Soodean and Shenker, for Alcohol Concern, 2008 p.2).

This Alcohol Concern report notes that PCTs in many areas have not followed statutory guidance on providing alcohol treatment, and fears that money which is needed to treat severe 'alcoholism' will be spent on preventing future problems, such as the government's 10 year campaign, SSS (Safe, Sensible, Social), which is designed to effect cultural change in the way that people drink alcohol. It also shifts

responsibility, so that the 'alcoholism' can be seen to be the fault of the individual, and less money needs to be provided.

Treatment for illegal drugs is funded both by the Department of Health and the Home Office. The money is allocated to the Drug Action Teams (DATS) across the country, who use it, sometimes together with money from other sources, to buy treatment from the NHS, the voluntary and the private sectors. Only the treatment of illegal drugs is currently funded officially in many areas, although alcohol and tobacco do most physiological damage (Raven and Wodak 1994).

5.2.2: The individual treatment centres and their assessors.

Treatment assessors at the ten treatment centres had a very varied assortment of qualifications. One was a qualified psychiatrist; another had only a single counselling qualification but a lot of experience; some had one or two counselling or motivational interviewing training qualifications. Most assessors were very confident, compared with the GPs. Unlike the GPs, they saw 'alcoholism' as a problem they should know everything about, and most believed that they did, although this knowledge was often limited to particular treatment models. Like the GPs, they seemed not always to distinguish between lay and professional knowledge. However, over-confidence was not universal, and some treatment assessors were open to the possibility that they still had things to learn, particularly if they were operating a harm

reduction, or social model, of treatment. This model seemed to make assessors more open to different interpretations of alcohol use, such as emotional and economic deprivation.

I found it harder to talk to the treatment assessors than to the GPs. Perhaps this had something to do with my own past experiences, since I had not met with severity from GPs, only from treatment professionals. GPs seemed less defensive and more willing to share problems with me, without obviously viewing me as 'an alcoholic' myself. They were also, of course, effectively self-selected, while the treatment assessors had been assigned by their centres to speak on their behalf. Both professional groups had their professional identities well in place, so that obtaining a full picture of what they were like as individuals was difficult. Our time together was also limited, with the professionals giving me no more than a third of the time typically given me by the women patients in 'Making a Start'. I did find some of the treatment assessors lacking in empathy for their clients, and this seemed to apply whether they had experienced addiction themselves or not. Treatment assessors definitely perceived a need for there to be professional distancing from clients, and perhaps found it difficult to achieve without very strict ground rules (Linton 2008). However, although the GPs had often seemed anxious and uncertain, they did not usually seem consciously to distance themselves from distress.

The Pink was the statutory NHS centre, that all the GPs had known about. I had heard considerable criticism of its assessors while speaking to 'Making a Start' respondents. However, the assessor who was put forward for me to interview was a fairly new, female assessor, rather than one of the two males at whom most of the complaints had been directed. Of course, even if I had been able to interview one of the assessors who had been criticised, they would have been unlikely to speak to a researcher as they were reported to have spoken to some women patients in private; I had a tape recorder. They would also have been too experienced to make disparaging comments 'for the record'.

The Pink assessor had a medical degree and postgraduate qualifications, including psychiatry. She saw her work at the Pink as a more collaborative treatment process than was the case in much psychiatry:

I like the model of care that is used... I like the fact that it's more collaborative....that it's not coercive...that it's essentially voluntary for clients whether they go in treatment or not ...[alcohol is] part the responsibility of the clients, making their own treatment plans really (Pink centre assessor, 'TA').

This did not sound much like my own experiences at the Pink, but in my case, many years had passed. However, the Pink's treatment had also been experienced as morally coercive by some women in 'Making a Start' and by women in RAG, and is still so experienced by women

contacting Women's Independent Alcohol Support (WIAS). They seldom feel much choice is involved. On the contrary, most seem to feel they have none, and may even be so told, as I was myself. They are consequently likely to feel coerced, even though, at present, their treatment, unlike that of 'mentally ill' patients, is not legally compulsory, as opposed to morally coerced.

The cumbersome machinery of the NHS compounds conservative attitudes like those of the Pink, particularly since this is where the 'worst cases', the ones who have 'failed to recover' again and again, do get sent, because it is part of the statutory obligation to provide care. The atmosphere is not conducive to new ideas and lateral thinking, but seems impregnated with shame and unhappiness. It was also a cultural shock to hear that the treatment I had undergone myself was called 'terminal care'. I had not realised that many of my co-attendees would die of 'alcoholism', so I was startled when the Pink assessor acknowledged:

I ...have had quite a few deaths...in some respects it is terminal care...that's what we acknowledge...some people are going to die of alcohol related diseases...we do have a reasonably high mortality here. It's the nature of the disorder that it does kill people (Pink centre assessor, 'TA').

This is a possible explanation for the tough line taken by staff at the Pink; they believe that their methods are the patient's only chance of staying alive. They are also continually in contact with dedicated AA

members, who come to speak at events, help with training sessions for trainee doctors from the local medical school, and assist in maintaining the high AA profile in the statutory sector. Such representatives are likely to reassure the staff that gender, family issues, abuse, are all secondary to the essential message of 'abstinence first'.

The Indigo was a voluntary sector centre which also required abstinence. It possessed optional residential facilities, and had acquired expensive central premises. These would be easier for women to access than those of the Pink, and it lacked the grim atmosphere projected by the Pink's reception area. However, it was still abstinence based, and strongly centred around the pejorative 12 step model. I found the assessor's description of the centre's remit confusing:

...it's not that I judge people who are still drinking but we're not the right place; if you want to carry on drinking that's fine; go to the Green centre...and they'll help you look after yourself while you're drinking...I'd say it's 12 Step influenced but it's not totally 12 Step....I'm into Cognitive Behaviour Therapy...it is definitely 12 Step but I don't like saying it's a 12 Step project because it's not; a 12 Step project has such a myth...I wouldn't say the 12 Steps are no good...but we can pick the bits we want from the different philosophies (Indigo centre assessor, 'TA').

My feeling was that something more modish and upmarket was being presented ('we do acupuncture') but that no new thinking about alcohol use, or about gender, appeared to be influencing treatment.

The Indigo centre had not been suggested to any of the 'Making a Start' respondents, and had only recently acquired its high profile. It was soon to open a sort of preparatory section for people who 'were not ready' for abstinence, and some staff from the Green, which closed, were to go there. This was interesting, since the Green, while advertising itself as being based on a harm reduction model, had been seen by so many of my respondents as unofficially promoting goals of ultimate abstinence and AA attendance.

I had not known about this prospective change when I interviewed the Green assessor, who was, a few months later, to reappear as a manager at the Indigo centre, when the Green closed down. Her response, when I asked what treatment methods they favoured, is an example of the way that both the Green and Indigo centres were able to mix and match in ways that were not always convincing:

I have some knowledge of the 12 Step programme; I worked while I was training at the Rehabilitations Centre...I know people who use the 12 Step programme and I work with people in group here...we don't advocate any one particular system, if we get someone who uses the 12 Step programme we can work with that....so as regards the 12 Steps if you asked me to recite them I couldn't do it. I have them written down and I keep them...we work with harm reduction here, and we're client centred...We work with what they bring (Green centre assessor, 'TA').

The client-centred approach is one where the therapist reflects back at the client what she has presented; it is supposedly non-directive (Rogers 1978). It has been criticised as being too vague, and therefore open to too many interpretations to be a reliable method, which could explain the fact that 'Making a Start' women had not had particularly good experiences at the Green. However, it did provide a valuable resource by providing self-referral and one-to-one counselling, even if: '...they couldn't offer me anything because I didn't feel I was going to relapse...' (Carol, 'MaS').

The only other local centre 'Making a Start' women had used was the Turquoise, which operates a drop-in as well as one-to-one sessions. Unlike the Green and the Indigo, it was one of the 'neighbourhood centres', set up in poorer parts of the city, to tackle addiction. Its friendly atmosphere was what respondents valued. Its assessor had come from London:

I think previous to that I was more ignorant about the 12 Step approach because although it exists where I was working... I just thought that was one option. Till I came [to this city], and it really was quite a shock... very AA based... but I don't feel that there are enough options for women specifically... there's such an influence outside to use 12 Step and AA and a lot of them felt coerced into doing that... it's ended up being quite damaging.... I've spoken to a lot of them in here and it had made them feel very vulnerable..... and then very difficult to get out of-- being seen to be failing if they don't stick with the AA, with following the 12 Steps.... and feeling they have failed in their

recovery...they are very, very pressurised (Turquoise centre assessor, 'TA').

It seemed to be the case that the 'social model' of treatment, where what was considered most urgent was the client's general well-being and safety, as opposed to her substance use, almost inevitably generated this kind of understanding rapport. Perhaps this was because staff and clients were starting from a basis of getting to know each other personally, rather than solely as treater and treated.

This social model was also used at the Blue. This centre was relatively new, and slightly off the beaten track, although not far from the city centre. It specialised in alcohol treatment, employing harm reduction and social learning methods, with an emphasis on personal empowerment (Rogers 1978). It had an unusually holistic approach, including in its programme gardening, walks and going out for meals and coffee as well as one to one sessions and single sex group-work. The Blue Treatment Assessor was a fully qualified therapist with a special interest in alcohol dependence. Although her centre had a harm reduction approach she did not wholly disapprove of the 12 Step model:

I consider that a lot of the Steps are...valuable...my only concern is...the way in which they can be delivered...[Harm Reduction philosophy is] the school I was brought up in, and that seems to

work...so I have a lot of faith in that. I'm not saying 12 Steps don't work, but I am saying that harm reduction works best in my experience (Blue centre assessor, 'TA').

I felt that the Blue centre had evolved a way of working which was similar to what had 'worked' for me, i.e. acceptance, friendship and a variety of things to do, but without alcohol being actively forbidden. No 'Making a Start' respondents had heard of it, but it might well have suited many of them. It is often difficult for new voluntary sector treatment centres to acquire the necessary funding, and the Blue was at a disadvantage in that it specialised in alcohol, which carried minimal funding priority at the time.

The Red centre had not been accessed by any 'Making a Start' women either. Its social model was very well suited to the deprived inner city area, which had a high proportion of Black/Minority Ethnic (BME) people, but GPs in the rest of the city did not seem to know about it, or the considerable support it received from the local residents. In practice, it saw most of the city's BME drug and alcohol clients, whichever part of the city they came from. The Red Treatment Assessor was a qualified counsellor to Diploma level with personal experience of domestic abuse:

...there tends to be...a significant correlation...we work with one to one counselling and are culturally sensitive and that's based on the low numbers of people from BME communities who access other services...however...other communities can access us...and do; we can honestly say that we work cross-culturally...(Red centre assessor, 'TA').

This was a centre at the heart of its local community, and a similar approach had been used in the planning for the other five centres, the Grey, Turquoise, Purple, Yellow and Orange, which had been set up to deal with illegal drug use in the 'neighbourhoods', the large council-built housing estates ringing the city: 'High rates of addiction among socially subordinated groups raise questions about the social effects of structures of exclusion, disenfranchisement and marginalisation' (Campbell 2000 p.16).

With the increased attention to cross-addiction, these centres had begun to deal with alcohol as well, although they were not usually funded to do so. These 'neighbourhood' treatment centres using a social model of treatment were also very likely to provide other support, such as childcare, same sex groups and key-workers, and a friendly atmosphere. Most were cautious around recommending AA, although all would have supported a client who wanted to give it a try. The AA image, for them, was a white, middle-aged, middle-class, masculinist one, so not very appealing to young BME women, or to women on a low income out on a housing estate.

The 'neighbourhood' centres often had a higher proportion of women clients. Many were young mothers. The Orange and Yellow centres had many teenage clients, as well as several men, newly released from prison. The Purple, Grey, Orange, Yellow and Turquoise centres were situated in very poor districts, with (reputedly) 90% unemployment. Much housing was in tower blocks. The boarded up shops made me wonder how anyone survived out there at all, with or without substances. There were no shops except an off-licence, a newsagent, a mini-market and a couple of pubs. Treatment centres, often precariously housed themselves, were perhaps as near to community centres as these areas had. What was very noticeable was the welcoming atmosphere in the centres, and usually the great awareness that the substance was a problem but that the problem of poverty, violence or social exclusion was as great or greater. Most of these assessors were eager to share their experiences and to be looking out for new solutions.

The principle remit of the 'neighbourhood' centres was moving people from illegal substances to prescribed drugs, such as methadone, in what was designed to be a short-term intervention. Sometimes they saw abstinence from mind-altering substances as an ideal, but more typical was the approach of the multi-cultural Red centre: 'We come from a harm minimisation approach...more to the social model because I believe things that have been learnt can be unlearnt...I don't

know if it's helpful for people to see their suffering as a disease...it can be a label to hide behind...' (Red centre assessor, 'TA').

The Orange centre was situated in a Portakabin, on an estate, and the coffee mug was in your hand as you entered. This centre had many young people with drug and alcohol issues:

We will take anybody on, at any stage...I suppose we are trying to think of people in their social context..... Connecting the substance use with whatever else is happening in their lives... how they're influenced by their family and their different social settings...I mean we are working specifically in really quite deprived wards; where alcohol misuse is a feature of the landscape (Orange centre, 'TA').

The assessor I spoke to had experience of alcohol misuse within his family but his background was mainly in teaching, and he felt comfortable relating to youngsters.

The Grey was unusual for a 'neighbourhood' centre, in that its Assessor, perhaps influenced by her own background of recovery within a 12 Step Residential Rehabilitation Centre (Rehab), seemed to see abstinence as being on a higher plane:

I think most staff would encourage abstinence...so use of the 12 Step programme is there, but we also use the person-centred and really it's down to any counsellor's style and they do a harm reduction service...so if people wanted to try harm reduction or maybe controlled drinking first they could (Grey centre, 'TA').

She had a lifetime's experience, of recovering herself, and then of training in professional counselling, so perhaps this had influenced her belief that abstinence was the most worthy goal (Jarvinen 2008). She had also experienced alcohol and drug misuse in her family. The Grey centre had excellent child-care facilities and women-only groups, in a city where these are a recent innovation and not usually seen as viable at centres such as the Pink or the Indigo, whose focus on a medical understanding of addiction seemed to limit awareness of social factors.

The Yellow Treatment Assessor I spoke to was a retired police officer who had done a course in Motivational Interviewing. His area, too, was poor and had a high crime rate. He had had a lot of experience, while a policeman, of youngsters with drug and alcohol issues. His opinions about treatment were that whatever sort it was, it worked if you wanted it to; more or less the conclusions drawn in most research, at considerably more expense: 'Well those that want help it'll work for, and those that are only playing with it, it don't work for...' (Yellow centre, 'TA').

The Purple centre only allowed me to meet its manager: 'Anything like this it's me it comes to' (Purple Centre manager, 'TA'). Interviewing her was an uncomfortable experience, since she was unusually protective of her centre. She was incredulous that any women might have criticised their assessments, wherever they had taken place, and suggested that this was caused by: 'transference of [their shame] into the process, as opposed to the actual process itself' (Purple centre, 'TA'). This is possible, but her refusal to let me speak to her Assessors, and then her vigorous denial of possible error by any treatment centre staff, anywhere in the city was odd. It was not possible to tell how clients would have felt when they went for assessment there, but this was a very poor and desperate part of the city, and she presented as middle-class and authoritarian. It was difficult to know what the centre itself was really like.

5.2.3: The effects of the different approaches on the treatment offered

I describe in turn the approaches of the abstinence based centres, and the harm reduction based centres, before considering practical and emotional issues within treatment.

5.2.3.1 Aspects of abstinence based treatment centres

I have mentioned that all the doctors knew about (but none had visited) the Pink statutory centre, which was only accessible via a GP's referral. When I went for treatment there in 1989 it was the only one mentioned by my GP. It attempted as far as possible to operate like a residential Rehab, by heavily emphasising the importance of AA attendance, whenever patients were not at the centre. By approximating as nearly as possible to a 'total institution' (Goffman 1968), it made it difficult for the 'recovering alcoholic' to receive any conflicting information about alcohol use, or, of course, to drink. This pattern continues. Although the Pink offers less 'treatment time' than it once did, it still expects patients to attend as many AA meetings as they possibly can, to fill the gaps.

In addition, some patients, myself included when I was in treatment, may be given 'dry house' accommodation nearby, so meeting up even more frequently and living even more in an enclosed world. I was told by everyone there that I was ill; that I had a disease; and that I could, by abstaining permanently from alcohol, and following certain rules, become someone whom people would not despise as 'just a drunk'. Treatment in most residential Rehabs is also based on 12 Step, abstinence based group-work, like that of the Pink. It is cheaper to administer, since group-work uses less staff, and some of the 'treatment' is provided by interaction within the group, as I described in

4.4. The Indigo, which was in receipt of both public and private funding, actually ran its own live-in accommodation.

The effect of these centres may not be dissimilar to the effect on people of entering a psychiatric unit:

One enters as a human being in distress but emerges as a psychiatric patient, often looking medicated, with a diagnosis that tends to imply a lifetime of disability. Loved ones may shrink away or act warily; to obtain employment and respect can be impossible; and patients are at substantially increased risk of assault. Psychiatric institutions must counteract stigma, and ostracism, by forever reinforcing their patients' humanity, and by encouraging employment, education, and meaningful relationships (Yawar 2008 p.285).

A system of treatment which has been described as masculinist and punitive (Wilke 1994) is likely to be mirrored by the behaviour of those implementing it (Goffman 1968). These people in turn influence each other and read the same treatment literature, while the careful assessments of possible patients by current staff is likely to exclude dissident voices. The Pink felt as if it were still, after nearly 16 years, a very boundaried place, with fixed ideas and minimal awareness of complex issues, such as gender and sexual orientation. There was also Ursula's terrible experience of assessment at the Pink: 'I told him about getting involved with [a younger person at the treatment centre]...and he said, "You're a sugar mummy" ' (Ursula, 'MaS').

Many women leave such alcohol treatment units believing that AA meetings will be a necessary part of the rest of their lives, and a 'safe' place for them. Yet, on the contrary, much harm may be inflicted there. The helpline for Women's Independent Alcohol Support (WIAS)² continues to receive distressed calls from women who have spoken on the phone to AA, or had an assessment interview with one of the more traditional treatment centres, such as the Pink. They speak of feeling denigrated and hopeless, feeling that their emotional difficulties went unheard, while professional 'treatment experts' spoke authoritatively about the way they should live their lives. Often they had only sought advice about cutting down on the amount they used, but were frightened at hearing about the damage they were apparently doing to their bodies, and the supposedly inevitable ruin ahead. Some rebelled; Queenie ('MaS'), for example, was so annoyed by the response to her call to AA that she never attended a meeting.

Traditional 12 Step, abstinence based treatment focuses on victim-blaming and is particularly harmful for women. If they are 'serious about recovery', they are likely to be expected to achieve abstinence first, before other serious and dangerous issues, such as domestic abuse, are dealt with, if they are dealt with at all. Such a course of action may put at risk the life of the woman who is using alcohol, if her partner in turn is using her drinking to control her (Galvani and Humphreys 2007, Swan et al. 2000).

² The group which developed out of my first research project, 'Making a Start'

Additionally, families are increasingly involved in alcohol treatment (Velleman and Templeton 2007, Meyers and Miller 2001). Women who, as I mentioned in 4.1, may already feel responsible for 'failing' their families, may be subjected to shaming and reproach in family group sessions (Velleman and Templeton 2007, Meyers and Miller 2001). Women who suffer from this treatment may lose a sense of personal dignity and worth. Such experiences are common to women of most social classes and sexual orientations (Moon 2002). The use of the family in this way, as a resource, has been termed the Family Systems model: 'One of the strongest motivations for eliminating drug use may be...desires to maintain his or her love and family relationships' (Senate Subcommittee on *Adolescent Substance Abuse* (1993), cited in Campbell 2000 p.41). Such use has long been a policy of Alcoholics Anonymous, by way of their sister-organisation, Al-Anon, and as a treatment technique, family involvement is on the increase (Velleman and Templeton 2007).

5.2.3.2 Aspects of harm reduction based treatment centres

As I have mentioned, these centres are frequently situated out on the big 'neighbourhood' housing estates, with considerable poverty and high crime figures, and with greater reported illegal drug use (Sherman et al. 2008). They provide a valuable social space for numbers of women and other disadvantaged groups. Only two 'Making a Start' women had been able to access one of these centres, the Turquoise,

as it was intended to be for the use of people in its immediate vicinity. The one-to-one counselling and easy-going atmosphere had been very much appreciated by them. It meant a lot to Fran, who did live locally; she could drop in for a coffee; and this sort of casual support was what she wanted. The Turquoise felt a cheerful place, where it was hard to tell staff from clients, and the substance use issue seemed less important than the socialising.

A different perspective on such centres would suggest that they could also be seen as part of a system of control, involving both medicine and the law, with the aim of 'normalising' and controlling drug users (Sherman et al. 2008). Thus, their political function could be seen as no less authoritarian than that of the abstinence centres, but less of an attack on dignity and personal worth (Warner 2009). They are still actors in the social control of women (Ettorre 2004). 'The roots of harm reduction...show that harm reduction is in part a regulatory construct...closely implicated in "regulating womanhood" (Smart 1992)' (Seddon 2008 p.103). However, whatever their ideology and political purpose, these centres did provide social support, and a better understanding, than was available in the abstinence-based treatment centres. I will be considering the implications of what treatment is offered in 5.3.

5.2.3.3: Practical and emotional issues within treatment

Many practical and emotional issues had affected women seeking treatment at the Pink and the Green. I mentioned to the Pink assessor that attending the centre had been a problem for some women, in that they might need to catch two buses each way, and it could be difficult to fit all this in with meeting children from school and so on. More flexible treatment times had been high on the wish-list of the 'Making a Start' focus groups. I wondered if childcare money or facilities were a possibility:

No...a lot of women are very frightened about what will happen to their children if they go into treatment...and usually what happens is that women can manage childcare... we can't offer childcare...I've never heard of that being offered...I mean I haven't had that as a barrier to a woman coming for treatment and I would be interested if that was the case...There are cases when they won't come to group in school holidays...(Pink centre assessor, 'TA').

This was a depressing response, showing little awareness of what life was like for women with children and no transport, and reflecting an approach based on the requirements of male patients and of staff. For professional/ employed women, paid childcare for under-5s, and acceptable hours, are seen as a normal part of life. For example, the Pink assessor did think of her own child-care difficulties. She first used the professional language of 'boundary-setting' to explain why the Pink did not offer treatment at less conventional times:

...there's also an element of boundary-setting about it, in that if people are committed to coming into treatment they will come into treatment....often if they don't come back they're voting with their feet, and they're probably saying, well, I'm not ready at this stage (Pink centre assessor, 'TA').

She then continued: 'I mean, I personally have my own family commitments so I couldn't stay late.' She was obviously unaware that she was operating a dual standard in this respect. Even an acknowledgement of the importance of womens' childcare would have gone a long way towards both practical help and a recognition of their needs being different from those of most men (Women's Resource Centre 2007; Grant 2007). It reflected a disappointing failure to look at a woman's alcohol issues as part of her life rather than as the centre of it. A solution here might have been for the treatment centre to have run a free crèche for under-5s belonging to either patients or staff, and extended to after school care and older children in the school holidays. However, such a solution would have required an approach which saw patients as 'people like us' as opposed to 'alcoholics', from whom a professional distance must be kept. This may be part of the dehumanising effect of medical treatment models, whereby the patient is defined by the illness, rather than being seen in the context of their lives. Day-to-day concerns of 'patients', such as childcare and catching a series of buses, may simply not register with those offering treatment.

Equally disappointing was the information that the Pink centre still could not run same sex groups when women entered treatment, one reason given being cost, and the other, which I mentioned in Chapter 4, being that the men did better when groups were mixed sex. Similar arguments have been used in support of mixed sex schools (Jackson 2002). Unlike Dr. Branscombe, some treatment centre assessors did not in any case see any particular reason for women being offered same sex counselling: 'they're trained, they're professional, they know what they're doing, they're advised. So it shouldn't matter which member of staff you have' (Purple centre assessor, 'TA'). The evidence that women do best with single sex treatment is now overwhelming (Women's Resource Centre 2007, DH 2003, DH 2002), but it is also true that alcohol services are greatly under-funded. However, at that time, both women-only sessions and evening sessions were being provided by the Blue, the voluntary sector treatment centre which only dealt with alcohol issues, and whose funding would have been very much smaller, and more uncertain, than that of the Pink statutory centre. This suggests that the issue is a failure by the PCTs to recognise the importance of social factors such as gender in successful treatment.

It would be inaccurate to imply that offering one-to-one counselling was, in itself, a guarantee of a good service. The Green centre had a good reputation locally, and might have been expected to be the most popular with the 'Making a Start' women. Certainly its self-referral

system was seen as a great advantage, avoiding the need of telling their GP about a stigmatising condition. GPs themselves usually knew about the Green, which they believed to be a softer option for women than the Pink, so it was often suggested. It was also situated in a pleasant part of the city centre, offering further discretion, if women did not want local people knowing where they were going. It was seen as having a middle-class client group, and supporting a policy of harm reduction. It offered only one-to-one sessions, again giving women a greater sense of safety and privacy.

Surprisingly, the best recommendation it got was from Pat, who said 'the talking helped a bit'. The complaint made most often was that, while describing itself as not being abstinence-based, it used counsellors who were themselves AA members, and who encouraged clients to attend. It was also accused of being too middle class. The valuable one to one counselling was unfortunately short-term. This last factor might have been a reason for the Green's encouraging women to go to AA, but it seemed as if a quick, unsatisfactory fix was being offered, and women were disappointed. The centre was also said to have had numerous management problems, and not to have applied for funding once the Indigo (which took some of its staff) acquired its high profile locally. Perhaps its high reputation had been acquired by a combination of enthusiastic praise from its successes, and by its being believed to be an alternative to the Pink and/or AA.

5.3: The role and effect of alcohol legislation, governance and treatment

This section makes links between the state of alcohol knowledge, legislation, and treatment practices. It draws conclusions about the paradoxical situation whereby attempts at social control may have the opposite effect to that intended.

5.3.1: The mismatch between evidence and practice

In 5.2, I described to some extent the way that harm reduction treatment centres had developed, but other political issues have affected the kind of treatment which is available. Drug control has been described as moving, in the twentieth century, into a 'welfarist' approach which is more interventionist and prefers drugs to be under regulatory control, preferably through a doctor or pharmacist (Seddon 2008). This has involved risk-based strategies, which are particularly aimed at women. Harm reduction has become, in the last few years, less of a public health initiative, and an improvement on the traditional 12 Step approach, than an initiative focused on crime and punishment.

This political background may explain the greater number of 'harm reduction' treatment centres in poorer areas, where the dangers of crime, and ill-tended babies, are perceived to be greater. Control of women's use of substances, on behalf of a society focused on the

importance of women as carers and breeders, is an important aim. Jarvinen (2008) notes that while harm reduction centres are often critical of abstinence centres for writing their own agendas, rather than the client's, they are frequently paternalistic in their own way, risking trapping users into life-long and stigmatic dependence on legal substitutes such as methadone.

Use of such sanctioned drugs has the public's confidence and may make it feel safer. Objectivist research into the effects of such drugs is more readily funded and published (Wilson 2000). Statutory treatment strongly supports neurological and pharmacological research, which may provide drugs such as Naltrexone, which block the pleasure centres of the brain which are affected by alcohol (Dalley et al. 2007). Surgery and plastic implants, performing similar functions, are also under consideration (Hall 2006). However, Moncrieff (2008) has seriously questioned both the evidence for chemical imbalances in the brain, a very popular concept with addictologists, and the advisability of allowing the pharmaceutical industry to promote the massive use of prescribed drugs, to control mental health and substance use problems.

All the 'neighbourhood' centres operated a harm reduction policy, based on a social learning approach, as opposed to an abstinence based approach, to problem drinking. Some centres had a greater

appreciation of what women presenting for assessment were being asked to give up; that something of value was at stake, something connected with outsider status and self-worth (Holt 2003). At that stage in my research, I had not developed an adequate awareness of the 'positives' of alcohol and drug use myself, so I did not ask questions which would have given clearer information on this. I merely received the impression, from odd comments made around the 'Treatment Approaches' interviews, and recorded briefly in my notebook, that in at least some of the 'neighbourhood' projects there did exist a respect for different ways of relating to substances. I have also been able to talk to two more counsellors from these projects since. This respect might effect 'treatment outcomes' more in tune with those sought by individuals using the centre, engaging with poverty and alternative cultures (Bourgois 2003); the use of transgression as an access to glamour and enhanced self-value (Bell and Hugh-Jones 2008). It often extended to offering what the patient seeking 'treatment' might want as well as, or instead of, substances, such as a special place to be, or a special person to talk to. This is discussed further in Chapter 6.

The government has been described as:

lacking in integrity when it comes to ideologies surrounding substance use and misuse...It is not so much the 'problems' women face which lead to substance misuse, but the quality of their social life and the way their emotional lives are shaped through the social structures surrounding them. When this is recognized then perhaps Government policies will begin to

reflect the reality these women face and begin to value the way women are expected to manage the emotions of a troubled society (Moon 2002 p.94).

This approach now appears to be affecting approaches to alcohol treatment. Since the marketplace continues to offer cheaper and more easily available alcohol, a rich source of revenue, the treatment priorities are now seen to be 'vulnerable groups', such as young people and women, particularly pregnant women. Their bodies, as Ettorre (2004) has observed, are not really theirs to treat as they wish. A recent poster, designed for publication by the Department of Health, pictured a hugely pregnant woman, with a big red cross over her belly, with a picture beside her of a glass of red wine. This emotive embargo on pregnant women's drinking at all (DH 2006) is based on information which is constantly changing, and additionally:

There is a mismatch in the United Kingdom between the available evidence and the evidence selected to inform policy. The health-care agenda has been largely replaced by a public order agenda as has happened for illicit drugs. The current preoccupation with binge drinking and its companion responsible drinking release the government and the industry from imposing limits on the availability of alcohol: treatment will be directed at binge drinking individuals (Raistrick 2005 p.1213).

Treatment funded by Primary Care Trusts (PCTs) is meant to be based on good practice and satisfactory outcomes, but there is disagreement about the nature of both. Treatment effectiveness is hard to measure,

since, as I have mentioned earlier, patients and clients often do not return to report 'success' or 'failure'. Unfortunately, these patients are deemed 'lost to follow-up' and are commonly assumed still to be using the substance (Yudkin 2003). Women who have survived alcohol addiction and treatment, recovered completely, and gone on to develop their lives in different ways, are seen by places such as my old NHS treatment unit as amazing aberrations. Yet, had the treaters read it, data have been out for many years about most people with alcohol problems recovering completely and unaided (Fletcher 2001, Hall et al. 2001, Peele and Bufe 2000, Ragge 1998, Zimmerman and Zeller 1992, Ludwig 1985, Prochaska et al. 1983). Even in 'Making a Start', four respondents had been alcohol free for a considerable time, following severe alcohol dependence, and there would have been no official record of this. Ursula had stopped long after attending treatment; Jane, Sherie and Margaret had received no alcohol treatment at all.

It is also difficult to judge effectiveness, due to the moving of unsatisfactory outcomes into different financial years (Hope 2004) and the ability or otherwise to communicate between agencies of treatment, housing, and extended social support. Alcohol treatment, as well as being underfunded, is patchy, and policies inconsistent, across the country (Plant 2004). Some areas have very much higher numbers of AA groups; one had 73 in 2008 (telephone information from AA Head Office, Nov. 2008). This particular area also has a medical school, with

a particular focus on a neurobiological approach to 'alcoholism', a nearby university with a special interest in alcohol, and a town with a very high number of residential (principally 12 Step) treatment centres. Together, such factors may greatly influence a local PCT's policy on what alcohol treatment it feels it should fund.

Recent research into heroin addiction found that the provision of an alternative substance, such as methadone, provided the best 'cost-consequence' results (Moore et al. 2007). However, the very different social factors, such as risk of imprisonment, affecting users of illegal substances, make this finding of only limited use in the alcohol field. Outpatient care is reported to be equally effective (Mattick and Jarvis 1994), and much cheaper, than Residential Rehabs, which are popularly believed to be most effective. As I have mentioned above, most people who develop addictions recover without being treated at all (Raistrick et al. 2006 p. 173, Hall et al. 2001, Ragge 1998, Peele 1995, Fingarette 1988).

Despite the difficulty, if not impossibility, of obtaining reliable information about treatment effectiveness, claims to the contrary are still made (Greenfield et al. 2007, Christo 2004, Gossop 2004). This enables the continuing application of the medical view of 'relapsing conditions' and 'revolving doors', which may account for the difficulties encountered by 'Making a Start' women and others like them. This view was at least partly responsible for their mental health being made

worse, by judgements as to their worth as women. In this respect, as I suggest later in this section, the real function of such philosophies may be more realistically seen as attempted social control, but without any real understanding of the issues, or a clear implementation strategy.

Longer-term treatment effectiveness has not been shown to be greater for any one kind of alcohol treatment than another, including data from Project MATCH, the largest alcohol treatment trials ever carried out (Peele and Bufe 2000). Similarly, the more recent UKATT trials (2005) found that residential Rehabs were dearer and no more effective than day patients' receiving either Motivational Enhancement Therapy or Social Behaviour and Network Therapy, both of which treatments were reported in the *BMJ* (2005) as being highly effective. Both therapies saved about five times as much in expenditure on health, social, and criminal justice services as they cost (UKATT Research Team 2005 p.544).

Instead, what is funded may well be what the public and the media have asked for, short-term, morally driven 'treatment programmes' which get nowhere near the sources of the patient's pain and rage (Campbell 2000), supplemented by life-long attendance at AA meetings. These methods successfully place the 'guilt' with the individuals, rather than with society as a whole. Consequently, the abstinence based, 12 Step model of treatment is the most likely to be

funded (Gastfriend 2007) and is seen by many as appropriate to 'criminals' (Rutherford 1992).

5.3.2: The role of social control

GPs and psychiatrists are seen, and see themselves, as an important part of maintaining social order. One consequence is that they may understand their job as the returning of the 'sick' individual to normality, acting as gatekeepers to various medical services (Parsons 1951, in Timmerman and Haas 2008 p.659) and as moral arbiters. Disease is seen as an external phenomenon which can be examined in Randomised Controlled Trials. However, in practice, GPs typically discover the significance of the doctor-patient relationship and the importance (and difficulty) of understanding what the patient is actually seeking (Wilson 2004). As I pointed out in 5.1, GPs I spoke to could often look holistically at a patient's alcohol problems, and see that there were few successes visible in conventional treatment. Yet their training inclined them to feel what is effectively a responsibility for their patients' 'moral souls' (Sweanor et al. 2007 p.74), and for this the remedy of which all had heard was the morally focused, abstinence based approach of AA and 12 Step treatment.

The focus on a morally based approach is understandable, given the shame and stigma attaching to the condition. It is seen to affect and even destroy personal identity; it is seen to interfere with productivity in

a capitalist society. 'Alcoholics' are often seen as having become ill unnecessarily and as a result of greed; they have no right to expect treatment (Lincoln 2006). Political thrusts like that attributed to David Cameron underline the culture of blaming the victim:

We talk about people being 'at risk of obesity' instead of talking about people who eat too much and take too little exercise...people being at risk of poverty, or social exclusion: it's as if ...obesity, alcohol abuse, drug addiction — are purely external events like a plague or bad weather (Oliver and Oakeshott 2008)

Such observations make it harder for those giving care to feel adequately rewarded by experiencing the social status they may feel they are due (Tew 2002). GPs' and others' failures to 'cure alcoholics' may make them feel less competent, more irritated, and more likely to be attracted to theories which absolve them of blame, even when these are ill founded.

It may also make it harder for those receiving care for mental health conditions, particularly those involving substance use, to make complaints heard. It is currently much easier to draw attention to your needs and obtain sympathy and cutting edge treatment if you have a physiological illness than if you need help with a mental health condition (Thorncroft 2006).

The medical approach to alcohol treatment tends to perceive the social factors affecting the patient as secondary to diagnosis and treatment (Straus 1968). In additionally defining social factors as 'inadmissible evidence' it becomes trapped in a system of care which does not work. I noted in 5.1 the way that GPs in 'Treatment Approaches' had been caught in this mind-set. At the heart of this entrapment lies the similarly inadmissible fact that scientific conclusions are influenced by personal opinion and other factors; they are not value-free (Faulkner and Thomas 2002).

Medical judgement is particularly trusted when the status of the illness itself, such as that of 'alcoholism', is questionable, and what is truly sought is a moral perspective. Yet, it is in just such situations that the ethics of treatment are most open to question, and most scrutiny is required, on an ongoing basis. Medical doctors may not be in a position to decide whether, at what point, and to what extent, treatment for a 'moral illness' should be carried out. Notorious medical errors of judgement in this respect include its conduct in the area of homosexuality. It was only in 1992 that homosexuality was removed from the list of psychiatric disorders, due to lack of replicable evidence. Homosexuality, like 'alcoholism', was historically defined in medical terms, pathologised, and anathematised (Forstein 2004). It was also 'treated', physiologically and psychologically (King et al. 2004).

It also seems to be the case, that in alcohol treatment at least, there is now more power in the hands of specialist nurses (CPNs) than in the hands of doctors. The CPNs were usually the 'treatment assessors', and their control over what happened to women in assessment, and later in treatment, was seen by all parties as very great. While in theory the movement towards specialist nursing care might be seen as a positive one (Luzio 2008) this might not be the case if the area concerned, such as alcohol treatment, or other 'rehabilitation' might attract individuals with fixed agendas and a moralistic focus (Goffman 1968).

Once we consider alcohol treatment as an aspect of social control, justifiable within a moral framework, other anomalies begin to make sense. The role of medicine in social control was discussed by Parsons (1951) when he stressed the crucial role played in illness and treatment by social factors. Many writers have suggested that violations of human rights occur when 'behavioural problems and social deviance' are defined as illnesses (Conrad 2004 p.102, Szasz 1985) and when such illnesses are 'treated' by inducements to conform. For example, although addiction has been regarded, medically, as a disease, the acknowledged failure of medicine to cure it is blamed not on the profession but on the patient, who is said to be suffering from moral weakness. This is an apparently illogical conclusion (Fromberg 1994), unless the perception *by medicine itself* is that the treatment is not medical but moral. Given such a perspective, it is also its duty to 'cure'

deviance, as a threat to modernity, productivity and 'moral worth' (Campbell 2000 p.75).

Compulsory mental health treatment already exists, whereby those who have been sectioned lose normal rights, such as suffrage, or freedom of movement. They undergo 'civil death' (Davidson 2004 p.1). This involves a loss of authenticity which is arguably unjust, since those ordering it are not in a position to judge the over-all social and civil contribution of those sectioned. This contribution may be variable and may not be of a sort which is measurable by those exercising a diagnosis of 'insanity'. Sectioning involves the removal of human rights to be oneself. For survivors of alcohol treatment, similar destruction may have been effectively managed by the moral coercion and disempowerment inherent in traditional 'treatment' and the 12 Step philosophy.

Even when third parties are endangered, compulsory treatment offers a slippery path (Thomas and Cahill 2004) with uncertainties about the extent to which treatment is for the benefit of the patient or for the smoother running of society, and to what extent such interference is legitimate. In addition, only limited choices will be possible in a social context, with privileged groups tending to be able to make more choices than others (Veblen 1994, Bourdieu 1984). Furthermore, what is seen as a right at one point in history will be seen as an abuse at another (Marshall and Bottomore 1992). In the treatment of mental

health and substance use, the human rights of the patient may be removed by the 'expertise' of professionals: 'The ethic of consent has been subjugated by the imperative of treatment' (Bracken and Thomas 1999 para.2).

Women (like other under-privileged groups such as BME people and LGB people) have a greater chance of having a mental illness (Tew 2002), so are more likely to receive compulsory treatment for mental health problems as a whole. In the USA, coerced treatment for addiction is also enforceable if the patient's health is at risk (Sullivan et al. 2008). In the UK, Alcohol Concern stated in 2004 that:

In our view, there should be powers to detain *for assessment* people who are intoxicated or alcohol dependent, when they pose an acute risk to themselves or others. There should be powers to detain *for treatment* people who have co-existing mental health and alcohol problems, where appropriate (Alcohol Concern 2004 p.2, original emphasis).

This second condition, known medically as Dual Diagnosis, is both common and increasingly recognised, with one third of patients with a severe mental illness having a substance use problem (usually alcohol) and half of the clients in substance use treatment also having another mental health problem (The Royal College of Psychiatrists 2002, Marsden et al. 2000).

Women's use of alcohol and drugs which is not considered to be connected with mental health issues may also be seen in this way (Ettorre 2007 p.10). In Sweden, 'alcoholics' may be detained compulsorily, in their own interests. A Swedish court ruled in 2002 that the compulsory detention of 'an alcoholic' in an institution did not infringe upon his human rights, although he had been forcibly retained in a rehabilitation unit. The justification given was that he was risking his possibilities of employment by his continued drinking, thereby ruining his life, according to the opinion of the Court (English 2003).

Women are particularly likely to suffer such a loss of rights, and to take advantage of alcohol being cheap. They have lower incomes than men, earning on average 17% less if they are in full-time employment and 38% less if they are in part-time employment (Bellamy and Rake 2005).

'High rates of addiction among socially subordinated groups raise questions about the social effects of structures of exclusion, disenfranchisement and marginalisation' (Campbell 2000 p.16).

Brewers have been quick to exploit a group with less money but the potential to attract bigger spenders of the opposite sex, with offers of lower prices on 'feminine' drinks like 'champagne'. Reports about the alcohol use of women and young people, in particular, has led to a state of moral panic (Cohen 2002). This has been partly caused by: 'the moral directives of journalists [making] 'problems' out of some drugs and not others' (Davenport-Hines 2001 p.236). The panic has affected government ministers to such an extent that they have ignored

the advice of the Advisory Council on the Misuse of Drugs as to the best way to categorise, for example, Ecstasy (Travis, *Guardian* online Feb.11, 2009).

Compulsory treatment of addiction is frequently recommended: 'Coerced or involuntary treatment comprises an integral, often positive component of treatment for addictive disorders' (Sullivan et al. 2008 p.3). Residential alcohol treatment is already offered as an alternative to prison for persons who have broken the law under its influence. However, there is evidence that treatment is not effective if it is not voluntary, and it could certainly be challenged as unethical (Fennel 1996, MacAvoy and Flaherty 1990).

The role of the media in social control has been discussed in Chapter 4, including that of reminding the public as to how they should behave. Women are expected to take care first and foremost of family responsibilities and domestic continuity, putting the happiness of men and children (i.e. 'the family') first. Most importantly of all, they must never bring shame on their families by looking ridiculous. A woman's body is the home of reproduction and for her to 'abuse' her body is seen as a crime against nature in a way that it is not if a man behaves similarly (Ettorre, 1992 p.10). In a post-Industrialist and heteronormative society, a preoccupation with women's sexual monogamy and their iconic role may be economic and may even be religious.

Compliance will be encouraged by the use of fear within the treatment system, where patients' experiences may be pathologised, and personal acceptance may depend on the good opinion of the staff. In the short term, this may mean a negation of personal identity, an 'adaptation' (Letherby 2002 p.285), which is frequently too insubstantial to support them once they leave. Developing the crucial 'sense of self' is a slow process, taking years rather than weeks, and it is a negation of that sense, rather than its development, which is encouraged by the 'dominant discourse' of conventional alcohol treatment. Too often, the latter carries a hidden agenda of punishment, of retribution, similar to that of a penal institution (Hannah-Moffat 2001). Too often, the underlying purpose is social control.

5.3.3: Moral and political ambiguity

Less obviously an agent of social control is individual responsibility, which co-exists with public faith in 'the doctor' and 'medical knowledge'. This enables damage to health to be located in problems of individual biology (Moncrieff 1997), obscuring the social processes that produce and define deviance and illness. This perspective is inconsistent with a social model of mental health and substance use, consonant with the disability framework of health, whereby people with impairments are disabled by social structures (Beresford 2002). It re-introduces a moral framework, a powerful weapon of social control. It also encourages self-help philosophies, which often pay little attention to social

components such as gender, shame and marginalisation (Ettorre 2007, Raine 2000, Ettorre 1997). This is particularly pertinent to women, whose crucial role, as takers of responsibility for everyone, is continually emphasised by magazines aimed at them (Roy 2008).

People are increasingly being encouraged to take responsibility for their health, by eating better, exercising, not smoking, drinking less (Castledine 1998). It is seen to be a personal responsibility, and as such to possess a moral ingredient. The public health approach could be illustrated by reports such as the Wanless Report (2004), which demands action on obesity; Government papers such as *Choosing Health* (2004). A climate which produces such documents as the Department of Health's *Safe, Sensible, Social* [drinking] (DH2007b) suggests that the future for those *who do not look after their health properly* (my emphasis) is bleak.

At the same time, legislation, such as that between 2007 and 2008, banning smoking in enclosed public places (Hempel 2008), takes away from personal responsibility. Neither approach takes account of such social factors as the lesser opportunities for achieving good health of poorer people, or their shorter lives and their greater likelihood of being smokers and drinkers (Commission on Social Determinants of Health 2008).

Such conflicting policies enable 'moral and political ambiguity in relation to alcohol and "health" ' (Measham and Brain 2005). For example, Plant and Plant (2006) note that more civil servants are employed in relation to the production, distribution and sale of alcohol than in relation to its health effects (Plant and Plant 2006 p.150). They also point out that the relaxing of legislation to allow cheaper liquor to be available more readily, particularly in supermarkets, makes it easier for lower income groups like women to buy it.

There may also be links to the politics of commerce. I have mentioned a city with 73 AA groups, and this same city has an impressive guild of wine importers dating back centuries, who have been involved in funding some local alcohol treatment centres for many years. They could be expected to have some interest in making alcohol problems look like personal issues rather than having connections with price and marketing image. In this way, the dangers of alcohol to some people are acknowledged, while its risk to (by implication) the sensible majority is minimalised. Treatment can thus be funded, produced and commodified for an 'incurable but arrestable condition' from which 'most people' are immune. Such a condition is frequently ascribed to deviance or criminality, and carries connotations of pathology and of blame (McClellan 2005).

To counteract this unwanted result of a free market economy, special health drives and moral panics develop, attempting to deter women

from 'over-drinking' (Valentine et al. 2008). These panics exert control by implying social disapproval, risk to others, and the destabilising of society. Women's emotional identification with people who might be hurt by their actions will be used (Hirschi 1969). This informal exercise of power controls their space and appearance, affecting their reputations and the degree of respect which people grant them (Mendoza 2003). In this way, commerce is able to proceed, with ill effects seen as the responsibility of the individual.

5.3.4: Consumerism in health

The importance now placed on health has the potential to be as restrictive and autocratic as religious beliefs have often been. A pursuit of longevity and perfect health is situated within a context where only this current life is one of which we can be certain (Frank 2002). It has replaced more holistic views whereby all kinds of life have relevance and importance for their own sake (Gimbutas 1982) and of all life being inter-connected and thus everlasting (Eckel 2002). Such a 'medically fundamentalist' position (Szasz 1985 p.xvi) is less likely to include the need and the right of women and of men to be free to pursue their lives in ways which others see as 'unhealthy', and liable to cost the community money for unnecessary 'treatment'.

Recent developments in medical practice, such as the 'pay for performance' contract for GPs, introduced in 2004, have increased the likelihood of a more biomedical approach to patient care, rather than

the more holistic approach GPs are said to have favoured but which took more of their time (Checkland et al. 2008). The concept of surgical 'treatment' for 'alcoholism' may be more compatible with traditional understandings of 'alcoholism'. The belief that there is a neurological explanation for their 'alcoholism' is acceptable to 'recovering alcoholics', and such an operation would be on a level with being 'born again', without their 'disease'. It could also be seen as an example of the consumerism of health (Henderson and Peterson 2002), involving a stereotyped concept of health which is infinitely and indefinitely improving (Blaxter 2004, Elliott 2004). A degree of standardisation may be involved as to its constitution as, historically, has been a controlling function. It implies that there is an elite which knows best how everyone should eat, drink, smoke, etc., and whose superior knowledge may be legitimately imposed on others (Davies 2008). It is unlikely to look favourably on lifestyles and conditions which, being different, may be feared to be 'un'-healthy, such as using a lot of alcohol or other drugs, or even being lesbian or gay.

Lesbian women with alcohol issues could be perceived as not only doubly deviant as women and as 'alcoholic' but triply deviant in that they are not heterosexual (Staddon 2005, Broom and Stevens 1991). Such life choices or orientations are often perceived to be less amenable to quantification, legislation and mainstream patterns, than the heterosexual family unit. They may therefore be suspected of being 'unhealthy' and to lack authenticity (Holt and Griffin 2003).

It has been claimed that the 21st century will be the era of the incorporation of the patient's perspective into treatment (Roter 2000). It is easy to see how such an idea might have been conceived, considering the involvement of service users in research, the marketing of drugs on the internet, and the greater ability of some patients to make free choices (Conrad and Leiter 2008). Yet, it is most likely that this incorporation will be limited. Medical training still leaves much to be desired, particularly in the area of patient interaction (Crome 1999) and service user involvement is minimally under the control of service users. Despite competition from other medical health workers, doctors are still very much the dominant and authoritative voice in a practice (Luzio 2008).

One result of the current, predominantly fundamentalist approach of statutory medicine to 'alcoholism' has been the development in the voluntary sector of Rehabs (Henderson and Peterson 2002). Rehabs have been quick to seize a marketing opportunity, preying on people's fears of becoming 'an alcoholic': '...we believe we can be perfect and that intoxication and bad behaviour should and can be eliminated' (Peele 1995 p.257-258). A consumerist view of illness, including addiction and madness, has adopted phrases such as 'a relapsing condition' and 'in recovery', to imply that such conditions (to quote Dr. Jacobs, 'Treatment Approaches') are 'incurable but arrestable' and are thus worthy of being treated repeatedly, even without evidence of success, as in the case of Fran ('Making a Start').

Meanwhile, the 'normal' public's enjoyment of substances implies competence and taste, and a dislike of controls by a 'nanny state': 'Consumers are seen as managers of themselves, making choices and accumulating their social and cultural capital' (Sulkunen 2002 p.67). Consumerism may also provide 'an identity label and language for (re)claiming rights for disadvantaged groups.' (Henderson and Petersen (2002) p.4). However it may be an irritant for doctors; already, the commodification of health in the USA is said to have had a bad effect on their relationships with their patients (Veatch 2006, Pellegrino 1987).

Consumerism may be a factor in more people's wishing to make use of mood-altering drugs, for 'escapades of the mind' as well as comfort and healing. On the other hand, while use of such substances is as old as recorded time, evidence of its extent is not so recorded. Should it be on the increase, as opposed to increasingly visible and reported, this could be connected with an increase in consumerism, as well as social fragmentation and oppression of minorities. 'Recovery' may mean a displacing of the substance from its position as 'primary other' into part of an integrated and satisfactory life-style (Aaslid 2006). Such a possibility is considered in Chapter 6.

5.3.5: Paradox

A one-dimensional view of what constitutes health, and its applicability to all, was endorsed by most treatment assessors. They concluded that provided a person drank less, and ideally acquired paid work and a family life, treatment had been successful. There was no perception that mental health may involve different ways of seeing and feeling, and certainly not that such ways might involve the use of alcohol or other non-prescribed drugs (Critcher 2000). These are possibilities I consider further in Chapter 6.

Paradoxically, attempting social control over the use of alcohol, particularly by under-privileged groups, on the basis of concepts of 'health' and of 'order', is likely to increase rather than decrease its use. Categorisation as 'an alcoholic' or 'an addict' has an effect on all parties: 'the classification and diagnosis is constructed, and this very construction...helps to produce...behaviour, which in turn confirms the diagnosis...' (Hacking 2001 p.10). In addition, beliefs underpinning concepts such as 'alcoholism' and 'treatment' are transient; i.e. what is seen as a useful categorisation at one stage in history may be perceived as no more than a fashion at a later date.

Reflections

The GPs and treatment assessors were often guilty of allowing a moral perspective to affect what they would certainly have believed to be

value-free decisions and behaviour. This could be expressed in a forthright manner, or more subtly, and often it occurred without their being aware of it. GPs particularly felt under-informed about 'alcoholism', and did not appear to have kept up to date with relevant research. When they had had a more thorough training, it had left them rather blinkered, and unwilling to question the approaches learnt at medical school. They were occasionally defensive about their practice, for example in the area of sexual orientation.

This alcohol training, when it occurred, was in any case moralistic in its focus, so that whether the doctor was relying on such training, or on lay knowledge of what 'alcoholics' were like and what they needed, recommended 'treatment' was much the same. A moral perspective prevailed, even when the doctor was sympathetic. Ironically, a doctor who tried to probe for causes was likely to be seen by the women patient as not being able to spot the 'real' problem, 'alcoholism', straight away. For this situation, some responsibility may be awarded to the high public profile of AA, and the familiarity of many people with the Web, where it is possible to self-diagnose before meeting the doctor, while being at the mercy of advertisements by commercial residential rehabilitation centres.

Treatment assessors frequently saw the view of alcohol issues they held, themselves as the one which was obviously correct. However, some did offer friendly, supportive services to people with very few

other places to go. Those which operated within the community offered numerous services, and were often regarded with affection. It was not possible to say which treatments were more or less effective than each other, and recent research has found similarly. The nature of that effectiveness, the length of time involved, and other imponderables, make this a difficult, even impossible, exercise.

What all forms of treatment possessed, to a degree, was the desire to increase the acceptability and accountability of the woman concerned to the rest of society, and in this respect they functioned as agents of social control and delineators of deviance. Few treaters, and no doctors, appeared to have considered concepts such as the freedom and the right to use substances, or the difference in options available to women.

The over-all effect of government directives has been to increase public interest in the drinking of certain groups, such as young people and women, while allowing the more extensive, but less obvious, drinking of the majority, profitably to continue. It is more popular, and cheaper, to fund Brief Interventions, principally targeted at young people and others with less severe alcohol issues. They may be 'out there', visibly defying convention, the parents of future generations. They are also a more attractive cause than the depressed and untidy old man with the bottle, most people's picture of 'an alcoholic'.

Less money is therefore provided for treatment for severe alcohol dependence (Soodean and Shenker, for Alcohol Concern, 2008); commerce suffers as little as possible, the PCTs spend less, and the less powerful sections of society (the young, the poor and the women) are hopefully controlled by media and other public disapproval. It could also be argued that by targeting younger people, the government is putting 'prevention' into practice, by making 'old men with bottles' less likely in the future.

However, I have shown that there is excellent evidence that there are inexpensive and more effective ways for people to recover from addiction. It seems that muddle, moral ambiguity and commercial interests have led to a failure to action unprejudiced research, such as that of the Advisory Council on the Misuse of Drugs (ACMD) (Sample 2009).

This does not augur well for the wishes of the 'Making a Start' women, who had asked for more talking time, less didactic treatment options, and most of all to have an improved quality of life. In this chapter it has become clear that not only does this seldom occur in treatment, even in the GP surgery, but also, that there are certain respects in which it is against the interests of a capitalist society for it to occur. In such a society, women need to take a full part in producing wealth, consuming services, and providing a stable basis for the family. If they dissent, at least they may still contribute as life-long consumers of treatment

services, or be involved in years of 'family therapy', in which such issues as domestic abuse may go unmentioned.

In the following chapter, I consider ways in which such a situation might be avoided, amended, or seen differently.

Chapter 6: ALTERNATIVE RESPONSES TO WOMEN'S ALCOHOL USE

Introduction

I stated in Chapter 3 that theory was to be developed as the research progressed, based on the respondents' experiences, and that I had hopes of contributing to political change. I have shown in previous chapters the difficulties many women experience when they seek help and understanding with their alcohol use, and some of the reasons why these difficulties may occur. I have also shown how their use may have been seen as a chronic illness, or as an escape from social restrictions, distress and abuse. I have indicated the many social factors which make this a likely 'solution', and have also fully acknowledged that using alcohol in this way may lead to further health problems. In Chapter 5, I also showed that treatment appears to be inconsistent, dogmatic, and politically oriented.

In this chapter, I address a contentious issue, problematising the problematisation of women's intoxication. I begin in 6.1, 'Emancipatory alcohol use', by describing the ways in which 'Making a Start' women experienced their alcohol use as empowering, even though it might cause other problems, both physical and social.

I first describe, in 6.1.1, 'Pleasure', the way that enjoyment featured in the drinking of the 'Making a Start' women. Their experience of alcohol use as 'Time out' is explained in 6.1.2, and as 'Embodiment' in 6.1.3. In 6.1.4, 'Spirituality', I discuss how some of the women used alcohol to facilitate ritual and alternative understandings of their lives. I then note, in 6.1.5, 'Authenticity and competence', the ways in which women often found alcohol of use in achieving these areas, and the extent to which their alcohol use may be perceived as 'choice'.

I next look, in 6.2, at the 'Politics of empowerment', considering how far health is the responsibility of the woman herself, and how far it is the business of society as a whole. In 6.3, 'Blaming women', I examine how women may feature as moral scapegoats, and how the allocation of blame demonstrates where power lies (Plant 1997). Finally, in 6.4, 'A better model of health', I consider ways in which empowerment and health might come together.

6.1: Emancipatory alcohol use

As I mentioned in Chapter 2, using alcohol 'symbolizes a temporal lifestyle and accentuates the transformation out of the posture of social controls and self-imprisonment' (Gusfield 1996 p.72). It may function as a social cue, permitting the user to act in specific ways (Hendry 1997). This is not always recognised in alcohol research, which is dominated by a hegemonic model of health which excludes such options as choosing intoxication and alternative perceptions of reality; what I have

already referred to as 'escapades of the mind' (Aaslid 2007 p. vii). Such escapades may be used as a way of challenging the status quo.

I explained in Chapter 3 that my initial research, on behalf of the NHS Trust, was carried out as a 'service user', interviewing other women who had self-defined as having alcohol problems. There was a pervasive, medical understanding of alcohol consumption as a problem, so that what I was doing might more accurately have been called 'alcohol research' than 'sociological research' (Gusfield 1996). I was influenced by being surrounded by professionals and others who saw my ceasing to use alcohol as success, and my drinking years as damaging and wasted. I had not been looking for evidence of fun when I talked with respondents as much as at the causes of their problems, and their experiences of seeking help. I had barely considered the positive use of 'problematic' alcohol consumption, such as celebration, communion and communication (Presdee 2000, South 1999). Such a way of viewing alcohol and drug use allows for multiple understandings (Ettorre 2007). I had forgotten that, although my attempts to be a part of male cultural drinking as a young woman had had some disastrous consequences, I had often been better able to recognise and express who I was, with alcohol, than I could without it.

I decided to look at the 'wasted drinking years' again, in the context of the stories of the 'Making a Start' respondents and the experiences of the Research Advisory Group (RAG) women. Unfortunately it was too

late to affect the direction in which the 'Making a Start' interviews and focus groups might have gone, but they still revealed a good deal of information about women's positive use of intoxication, as I will be explaining in this section. I describe several ways in which women, even those with alcohol problems, were still often able to experience their alcohol use as empowering. I consider the extent to which difficulties encountered are politically based, stemming from a hegemonic model of femininity, and describe a model of care and self-management which might answer some current concerns.

6.1.1 Pleasure

Glamour and excitement (Szmigin 2007, Stein 1985) are frequently attached to night-time socialising. Women who go to a Rave, or an all-night party, may be seen as behaving in a risky way but also as being sporty and desirable (Chatterton and Hollands 2002, Critcher 2000, Lupton 1999):

Well I don't drink loads but if I'm home of an evening I might have 2 or 3 drinks...and sometimes if I go out I think people will binge drink, like on a weekend, people, not just myself, they'll drink till the sun comes up! (Lucy, 'MaS').

[The job was] a load of crap! Very boring. Soon as you got out, you'd think, 'God!!' I did go out and get pissed...-then I got a better job in another factory and I worked shifts, I worked double day shifts; all the people were round about my age, or younger, and we used to go out like and take a few drugs and go round

the pubs...whatever, you know...it was...[quite fun] at the time (Fran, 'MaS').

nothing [else] is going to get me that fix, that quick ...I absolutely love feeling.....well, drunk! (Gill, 'MaS').

It is not so much the substance in itself which is sought as much as the experience and the drama. The latter can extend to the dramatic rites which are important elements in all cultures (South 1999). In Chapter 4, I described how women's power has been expressed in celebrating the vital connections between womanhood, menstrual rites, the passing seasons, and the cycles of the planets. Substance use was frequently a part of the ceremonies, holding a ritual position, as it does in Christian Communion services today. It has been suggested that illnesses such as the premenstrual syndrome are a result of the loss of women's substance-centred ceremonies (Harding 1973 in Sjo and Mor 1991 p.186). Perhaps: 'using substances is a very fundamental but as yet unrecognised part of women's lives and experiences.' (Ettorre 1997 p.36).

...I've got friends who do exactly that [so I] just go out and let my hair down and get drunk and dance around for hours...yeah they don't see it as a problem....I think I do sometimes see it as allowing me to access something that's not necessarily accessible otherwise...I don't think I really know how to use it...(Wendy, 'MaS').

Others have noted how much of the drama and excitement are enjoyed in the preparation for going out drinking, and in talking about it

afterwards; but also how solitary or secret drinking is seen quite differently, as something rather pathetic and contemptible (Lyons 2006, Measham and Brain 2005). This did not prevent respondents' solitary drinking from providing a sense of excitement, of fulfilment and of joy which was hard to find elsewhere. It also enhanced their awareness of hidden aspects of themselves: 'The depression used to stop me thinking...the alcohol used to slow me down and relax me and then I could think again' (Research Advisory Group [RAG] member).

In this respect it may be compared with the use both of illegal substances, such as heroin and mescaline, and substances which are generally approved, such as coffee, chocolate, etc. Recent research has shown important associations between binge eating and alcohol consumption, purging and dieting, in young women (Piran and Robinson 2006). Unfortunately that study did not mention the pleasure, excitement or relaxation provided by the different substances to the women concerned, or the sense of power they won when restraining their needs, using instead such terms as: 'severity of engagement'. Consequently, the meaning behind the behaviours was inadequately explained.

Wendy, Jane, Lucy, Fran and others had all experienced their substance use as empowering, despite the many problems it also caused, and perhaps for women, substances are necessary to play the role of 'hero', even if only in imagination:

While heroes can in theory be of either sex and of any age they are predominantly young males...Adult men may also feature as heroes, or share this role with a younger protagonist...Where the hero is female she is almost always pre-pubescent...It is as if the hero role is inimical to mature femininity (Bowie 2006 p.288).

Women remembered exciting aspects of their drinking sprees, which could be described as 'heroic', i.e. enabling them to cast themselves in dramatic roles not normally accessible to them as respectable women:

[My drinking] was also combined with shoplifting; I was shoplifting at a very young age really..[It was] excitement...the thrill of it...something about challenging the law (Carol, 'MaS').

well it just kind of gave me a buzz really. I used to like...getting out of it. All the feelings that I had...just kept looking for some kind of high really...at the time it seemed like a good idea to me (Jane, 'MaS').

[When I've] had a few to drink...I can be...a bit reckless. [Laughter]....the people you sleep with...or you can do something stupid and when you have the alcohol you think oh it could be fun but it ain't a lot, and then crazy things end up happening and you wonder why it's happened and then you look back on it and you were really drunk! [Laughter] (Lucy, 'MaS').

Drunkenness might have felt emancipatory, permitting them to behave 'inappropriately' (MacAndrew and Edgerton 1969) but in a way that they associated with intense pleasure, and a sensation of feeling in control of their lives (Ettorre 2007). This is a further example of the

extent to which the story-teller, in such heroic tales, enjoys both the memory of the event and the telling of it (Lyons 2006, Measham and Brain 2005). This may be enjoyable, and may substitute for consumption (Lyons 2006).

6.1.2 Time out

Anthropologists have noted the role of alcohol, across all cultures, in the attaining of time out and leisure (Eber 2000). Anthropological research can often: 'undercut a crude pharmacological interpretation of drunken comportment [favouring] an interpretation in terms of cultural construction' (Room 2001 p.190).

It may be that women are more likely to need 'time out', since they do more work over longer periods for less reward and their needs are likely to be spiritual and emotional as well as mental and physical (Ettorre and Riska 1995). It is also easier for many women, in a society that prefers them, publicly at least, to demonstrate decorum, to express their sexuality when drunk (Traeen and Kvalem 1996, Wilsnack 1984). I knew that many women, myself included, liked sometimes to enhance their sexual pleasure with alcohol and other substances (Ettorre 1992, McDonald 1994). Perhaps because of my age, or perhaps because I did not ask them directly, respondents did not mention the increased freedom to enjoy their sexuality which has been mentioned in some research (Ettorre 1997). This is an area of self-care and acknowledgement which is easily lost by less powerful groups, such

as women, who have less money and time and less confidence in their right to sexual expression (Rosenblatt and Blake 2003).

Relaxing of concern for 'good behaviour' is often demonstrated in drunkenness. Both South (1999) and Presdee (2000) have mentioned the role of substances in enabling behaviour 'out of role'. Both authors acknowledge the function of carnival in this regard. Presdee explains that: 'It is the fact that culture continually challenges, disrupts and carnivalises the serious business of 'order' that in itself becomes a threat to law and order' (Presdee 2000 p.19).

South (1999) sees transgression as a necessary flip side to order; carnival is one of community's functions. Without alcohol, it is harder for more constrained groups to take part, and groups with an essential caring function are least likely to be allowed to do so. The increased popularity of the 'hen party', or the 'girls' night out' is seen by some as a sign of women's greater freedom, but others have pointed out the way that:

...the hen party is a celebration of 'empowerment' that rests almost exclusively on heterosexual tropes...[however] ...This is a space where different practices of drinking and belonging within late-night culture are being developed, and which should transform how we perceive women's role in engaging with alcohol and public space at night... The hen party deserves examination as a newly emergent rite of passage (Eldridge and Roberts 2008 p.326).

At the same time, these nights out are watched by the rest of the world with a variety of emotions, which for some will be vicarious pleasure and voyeurism, since these are not freedoms which have traditionally been approved for women. This is particularly marked when the activities border on the grotesque, challenging and over-turning everyday notions of what is appropriate behaviour. Unexpected reversals of expected appearance may offer a symbolic challenge to established order and at least briefly alter perspectives, whatever the moral position of the onlooker. Such familiarity may be achieved by the use of more profane and noisy language than usual (Bakhtin 1984), or by spectacles such as women urinating in the street.

The present day lesbian/bisexual/gay 'scene' offers other groups ways of enjoying time out of role. It exists, alongside and sometimes intermingled with, hetero-normative society, and participants are indistinguishable from others, unless they choose to be identifiable (Valentine and Skelton 2003). This makes it an attractive place for those who seek more than one way of being, perhaps as a transgendered female at night and a heterosexual man by day. The essential secrecy of earlier times is lessened, due to changes in law and public perception (Fish 2006), but the alternative nature of the cultures retains an atmosphere of 'otherness' and subversion. This may explain the attractiveness of LGBT venues to heterosexual couples on a night out. It is a trip to another way of being and of seeing yourself.

Drinking, both moderately and to excess, remains important in urban lesbian/bisexual culture. The advice given at the Pink centre, to cross the road rather than go past a pub, would be as unsuitable for many lesbian and bisexual women as warning them against watching television. It is particularly unfortunate, since friendship and support is available in lesbian/bisexual venues, while pressure to consume alcohol, in my experience and that of RAG, is rare. My own experience, and that of Elsa, Fran and Wendy, was that the environment may feel 'risky' but exciting and fun, with a sense of belonging to a group. These are factors often lacking in the lives many women, particularly as they become older. Of course, support and friendship and shared interests are also available to lesbian and bisexual women in other ways, although the variety of groups and venues is often very limited, especially for women in less urban areas.

Women may often invoke 'carnival' with the help of alcohol, accessing different behaviours as an essential 'other side' to their workaday selves:

Having a laugh...fun...I liked it...and...I worked double day shifts; all the people were round about my age, or younger, and we used to go out like and take a few drugs and go round the pubs...it was fun...[then later] there used to be a club opposite where I lived. I got to know quite a lot of people in there...these people in the club, we had laughs together (Fran, 'MaS').

[My dead husband] loved his drink, loved his drugs, loved his wacky baccy, and the people that live there tend all to be into the same thing, and about five or six times a year we all used to go out on a big bender, me included. I thought it was useful to sort of keep my hand in! [My kids] would know when it was going to happen and they'd have a bucket ready for when I came in! They got quite practised at this!' (Ursula, 'MaS').

It didn't occur to me that there might be any problems at all at that time. It's just how I'd been growing up; it was the *norm* in life. You get drunk, you don't know what's happening, you wake up with some strange face in the bedroom... 'oh! What happened?' (Bella, 'MaS', original emphasis).

Sometimes these recollections were tinged with regret that life is no longer so much fun and no longer seems to offer so much friendship:

At no point then did I think it was drink that was the problem. I mean I had loads of friends up until...you know, I was still having great fun drinking up till I came into AA (Olly, 'MaS').

I look back, and I laugh at it and...a lot of it was fun...and a good social life...and I haven't got any social life now!I do feel very lonely sometimes....I feel I'm too young to be on my own... So—that really is my life story up to today (Anne, 'MaS').

Come off shift, start drinking...go to the pub straight from work, come home, have something to drink...they were drinkers, all of them....[I had more friends when I was drinking] (Elsa, 'MaS').

Both hearsay evidence and advertisements¹ for alcohol make women feel they will have even more fun if they consume it, so it is difficult to know whether it was the experience or the expectation which was being recalled for these respondents. Perhaps it was unimportant, since either interpretation would allow for the essential experience of transgression: 'It is here that we see writ large Nietzsche's remark that "the secret for harvesting from existence the greatest fruitfulness and the greatest enjoyment is . . . to live dangerously" ' (Nietzsche 1974 in Presdee 2004 p.268).

There can be no doubt that the 'Making a Start' women were able to make such positive use of alcohol, against all the odds. The youngest respondent, Lucy, was probably the one who mentioned most pleasure in her substantial use of it. Although sufficiently anxious, at 25, about her alcohol intake to volunteer to take part in my research, she still enjoyed her drinking, even the topping up in secret, because she had built up such a high tolerance to the alcohol. All her friends drank a lot and she drank most days, including when she was getting ready to go out. I asked her what happened when she went out and whether she ever got into trouble but she said that she and her friends looked out for each other, similarly to the 'calculated hedonism' I mentioned earlier in this chapter in connection with the glamour and excitement of night-time socialising (Szmigin 2000).

¹ 'Grand Marnier: it changes everything'; 'Real friends. Real Bourbon.' ('55 advertisements for alcohol': www.stanford.edu/class/linguist34/advertisements/alcohol%20ads/index.htm - 10k [Accessed Dec 10 2005]

This could be seen as evidence of a successful meshing of cults of consumerism and intoxication, whatever the chaotic state of British regulation and de-regulation (Plant and Plant 2006, Measham and Brain 2005). Some women found that a lot of alcohol helped them relax and enjoy their social lives, ‘ ’cos when I’ve had a drink I am quite witty...but without a drink, could I be satisfied sitting in here without a bottle of wine?’ (Renee, ‘MaS’). Some said that it helped them to make friends: ‘I wasn’t exactly making friends at work...friendly hellos, you know...[but] these people in the club, we had laughs together’ (Fran, ‘MaS’).

Drinking could also be strongly associated with acquiring or confirming the existence of a safe place. Drinking alone at home reinforced Karen’s feeling that it *was* home, and private. Deirdre had experienced safety and comfort at home as a young girl, with a lot of alcohol around, and had tried to recreate such a situation in her own home, at first with cups of tea rather than alcohol.

In my own experience, it takes a while before women are able to transfer the feelings of safety, relaxation and fun they previously associated with socialising and alcohol to socialising without alcohol. I learnt to do it myself in a series of lesbian bars and discussion groups. As I have mentioned, for me the importance I had assigned to alcohol when I was out was gradually (over about a year) assigned to having a

glass of Diet Coke in my hand. This change was helped by a reduction in anxiety, perhaps facilitated by a lot of physical exercise (aerobic classes most days) as well as a development of political awareness. Other women in RAG had also succeeded in moving their feelings of comfort and safety from alcohol use to a variety of other activities, usually including physical elements such as dance, boxing or weights. Those of us (the majority) who continued to share social activities with alcohol users, or even re-established some form of non-problematic alcohol use, had also encountered an interesting phenomenon whereby we found that over a period of time we might, without using any mood-altering substances at all, come to share the mood of relaxation and 'time out' of the alcohol users we were with (Hendry 1997). This might have been because we had in the past learnt what to expect in that situation, and now, given the situation but not the substances, we could still experience it. I found it rather frightening at first, as did some of Becker's (1963) respondents, since it reminded me of times when I had been out of control, and when bad things had happened to me.

6.1.3 Embodiment

'Making a Start' confirmed the extent to which minds and bodies are interdependent. Some women might be using significant amounts of substances such as alcohol (or for that matter chocolate, tobacco or ice cream) in order to embody happiness and a sense of being complete and full (Ettorre 1997). Given that they are also taught that their bodies

are not their own to 'abuse' and that they should be thinner, browner, paler, taller and sexier, it is remarkable and significant that women still do find the courage to 'use substances to reclaim their bodies' (Ettorre, 1997 p36). Women seemed determined to extend themselves beyond the paradigms constructed by a male hegemony, and affirm their right to do so, by whatever means they found they required (Ettorre 2007).

The connections between our bodies, our health, our feelings, and what we ate, drank or smoked, was invariably a popular subject among the RAG women and in the 'Making a Start' focus groups. We had all made the connections, usually independently, between what we put in our mouths and what was happening in our lives. This even applied to the few of us who remained AA members, who tended to place the alcohol drug in a special category. Women had often perceived the links between quantity consumed and resulting emotional satisfaction: 'It makes me feel good inside—like when I have too much to drink I sleep much better' (Pat, 'MaS').

Pat's use of the words 'too much' is interesting. It is common to describe drinking enough alcohol to make you feel intoxicated as having 'too much', implying that there is something morally and culturally unsound in the activity. Here, 'too much' could be seen as indicating a crossing of some line of acceptability, and perhaps the

access of transgression, excitement , and the unexpected. 'Too much' to do, or to be, what?

These experiences were of assistance to women in escaping from an iconic role, where they feel obliged to behave with dignity and elegance. Instead they could feel powerful, and, at least briefly, to feel independent of public opinion as to their correct behaviour.

I drank cider and the sense of omnipotence was just fantastic!
(Carol, 'MaS').

It's not when I'm upset, it's when I've got something to celebrate!
(Vi, 'MaS').

There seems to be acknowledgement of the function of substances in replicating those of food, sex and perhaps pregnancy; the references by respondents to 'fullness', and 'feeling good', and 'complete' complement Ettorre's analysis (Ettorre 1997).

6.1.4 Spirituality

I mentioned earlier in this chapter that some women feel a lack of meaningful ritual in their lives which once might have been met by awareness of physical, emotional and psychic connections with the universe and with each other. Alcohol can both facilitate and imitate such connections. Some women, while using alcohol, had reached psychic worlds they did not want to relinquish: 'I feel I've travelled a lot

more than I really have....I used to feel like I could fly, miles away, and now...well, sometimes I can do it' (RAG group member).

There is evidence of women's psychic powers in many cultures (Toren 1997, Gimbutas 1974). These are often associated with cycles of the moon, which have been shown to influence women's mental and physical well-being, from menstruation to schizophrenia (Goodison 1992). Religious and spiritual occasions for intoxication still exist in agrarian societies, to celebrate the changing seasons and to propitiate the gods. These pagan beliefs were firmly put down, or driven underground, by Jewish, Christian and other monotheistic, male-centred religions (Stone 1976). Women were usually deprived of their public participation in (and perhaps control of) the conduits between day to day existence and spiritual awareness (Sjoo and Mor 1991). This repression was almost certainly based on fear by men of women's psychic and other abilities when allowed to conjoin with spiritual forces and with each other (Goodison 1990).

Only two members of RAG, and three 'Making a Start' respondents (Carol, Nen and Wendy) were able and willing to talk about connections between their alcohol use and their spirituality. Carol had been able to find her spirituality in AA, Nen in Buddhism, and Wendy in dancing while intoxicated; the two RAG members used dance and music, but without substances. Research suggests that the use of alcohol to enable ritual transformation and enactment is fundamental to

human culture (Bowie 2006). If alcohol had enabled other respondents to enter spiritual worlds, perhaps on 'recovery' they would not have wanted to mention their experiences. Their drinking had been associated by others with greed, unfemininity, and a failure to observe 'normal' social boundaries. Whereas illicit drugs possess glamour and excitement (Presdee 2000, South 1999), alcohol is seen as an everyday substance. Consequently women who seem unable to use it 'normally' carry the additional slur of incompetence and foolishness. Owing to having attained spiritual heights while 'misusing' it might have felt too risky.

One of the RAG members, who spoke of making connections with her spiritual side, was also very attuned to her natural rhythms, enjoyed ecstatic dance, and had become a priestess of a Goddess religion. She had not had a problem with her alcohol use for many years but was not abstinent. She now found it easy to drink in moderation and to access her spiritual energies through dance rather than alcohol. I had also found that the kind of physical 'high' I got from squash and aerobics was very similar in kind to the sort of feelings I had once accessed with alcohol (Brown 2003). The other RAG member who saw her life without alcohol as having a spiritual connection had gone to live in the country, had a very strong affinity for wild life of all sorts, and was developing a holistic view of life which included spiritual awareness.

These reachings out for alternative ways of seeing, whether facilitated by substances or not, could be a response to over-rigid definitions of what constitutes 'sanity' and 'normality' in post-industrialist society.

This rigidity is likely to be caused by fear (Allan 2006 p.4). What we see as rationality and sanity is culturally defined, even though: 'the hegemony which natural-scientific ideas have enjoyed over the last hundred years [has led us to believe] that there *are* no other valid forms of knowledge' (Ingleby 2004 p. 46).

For example, behaviours which we see as 'mad' have sometimes been valued by other cultures as evidence of special abilities of various kinds, such as communion with higher powers, and ability to foretell the future: 'Neurological research indicates that we only use one tenth of our brain's capacity consciously. Schizophrenia feels like the other nine tenths...becoming fiercely alive' (Shingler 2008 in Jackson 2008 p.23). Intoxication may offer us an exciting glimpse of that nine tenths. I still find it very much harder to connect with that far-out, part-spiritual, part-sexual, aspect of myself which I first reached with alcohol. Others have noted the way that use of substances may feed inspiration and enhance vulnerability (Ginsberg 1956).

6.1.5: Authenticity and competence

As I mentioned in Chapter 4, no-one in 'Making a Start' ['MaS'] or the Research Advisory Group [RAG] understood their alcohol use as something over which they had 'no choice'. The biomedical model was

of no help to them in making sense of their experiences (Tew 2003). Whatever the level and frequency of their drinking, they saw themselves as choosing to drink, or choosing not to do so. They were quite clear about this. This is important because these women were often victims, feeling they had no choice, in other respects, such as domestic abuse and abandonment. Not seeing themselves as helpless victims of 'alcoholism' indicates an awareness that they were making choices, at least in this one area of their lives, and even at (often) great cost. I return to this point in 6.2.

Being, or not being, a 'victim' is an important strand of this thesis. The word may challenge, as may the term 'survivor', conventional perceptions whereby blame may be attributed to those with alcohol issues or even mental health problems. The implication may be that the person has been damaged by external events and/or systems, as opposed to being personally and directly responsible for what has happened to them. It is intended to remove stigma and to challenge stereotypes, and often does so. However 'victim' is less empowering than 'survivor' since it emphasises past and/or current helplessness, rather than past and/or current triumph over adversity. It also fails, as I noted in Chapter 3, to take account of the way that people's identities vary according to many factors, so that they might, for example, be victims in one context while being oppressors in another (Mennell 1974). At the same time, using a label such as 'victim' or 'survivor' could help towards establishing an identity or in discarding another.

Of particular importance to the 'Making a Start' respondents was their sense of self. Alcohol had frequently helped them to realise this, within a social structure which demands nurturing, not wildness, from women (Waterhouse 1993). Women who engage in 'binge drinking culture' may be asserting their rights to adulthood and to authenticity:

The female participants in this study did not drink as much as the males overall, but did engage in heavy drinking nevertheless. This was encouraged within the group, and was normalised...binge drinking and drunkenness was part of having fun with friends and enjoying a night out, and having shared experiences and stories to tell later...many of the 'night out' stories were jointly told by participants in the group (Lyons 2006 p.4).

Perhaps there is a need in both sexes, seldom fulfilled, to outgrow the feeling of needing protection (Dinnerstein 1987, p.189) and perhaps, when women decide to drink alcohol to a point at which their vision of themselves and their circumstances has altered, they may, among other things, be attempting to bridge that gap, to free themselves of authority and to become truly themselves.

For young women in particular, binge drinking may well be a case of experimenting with areas of competence and the use of 'secret knowledge', such as how to order drinks, how to pay, how to stand or sit, how to behave with the drink itself. Learning to behave

appropriately in special situations was also described with respect to marijuana use (Becker 1966). These are part of drinking cultures, usually seen as ways in which (principally) males may learn how to be masculine and assertive, cool and competent, serving the functions of play, transgression, ritual, and adulthood. The focus is usually the experience, rather than the substance, since sociability, and the capacity for shared pleasure, are key components (Sulkunen 2007). A comparison could be made with online dating or gaming, using multiple identities, sometimes of another gender. Zaheer (2008) draws attention to the freedom experienced by exchanging everyday identities for cyberspace personalities. These activities could have complex effects, being seen as healthy and harmless outlets for aspects of the self not compatible with the 'main' life being lived, or as threats to the security of others. In either case, the person's freedom to self-expression is being facilitated, whether by alcohol or by cyberspace, without necessarily having regard for their usual proprieties.

Enjoying play, and experiencing competence, are especially difficult for women whose lives are particularly restricted, for example mothers on a low income and women with mental health problems. A similar challenge to preconceptions about 'feminine behaviour' is provided by women's smoking. This activity has become increasingly moralised, as a threat to 'health', and now has the extra appeal of being perverse, a fringe activity, appreciated as respite, or time-out, by prisoners, mental health patients and other women (Warner 2009, Jacobson 1988).

Drinking and smoking can help establish and maintain your image of yourself, lending you a little style and glamour. For example, poorer and less privileged groups are more likely to smoke, and women combining running a home and a job are most likely to smoke (Warner 2009, Graham 1993). Smoking relieves stress, as does alcohol, but it is particularly interesting that 47% women in the UK smoked by the end of World War II, following successful marketing of brands like Marlboro which suggest: 'power, status, success and confidence...Marlboro is [particularly] successful in poor countries' (Jacobson 1988 p.51). The cigarette (or the glass) can symbolise independence and choice, as I noted earlier.

Substances are only one of the ways in which women may defy pressures to conform to a particular model of femininity. In dress, for example, a degree of dissent, of difference, is socially acceptable, even sexy. Many women like to be seen as following alternative models from the crowd, for numerous reasons (Orford 2001, Holland 2004), and for them this may be an adequate expression of their individuality and even their anger. Holland describes: 'adult women who ...negotiate a path between being "alternative" and being feminine' (Holland 2004 p.1).

They avoid being 'fluffy', which they correlate with being controlled, developing a sense of style which is unconventional but not 'scruffy'; strategies include tattoos, piercings, and wearing garments in

unconventional ways: 'Compromising their appearance presented a threat to "the woman I wish to remain" although several participants said they were prepared to "tone it down" temporarilyHowever this was not willingly done' (Holland 2004 p. 150).

Another way of challenging hegemonic expectations is by being fat. The media bombard us with visual images of thin, young women, whose looks we are meant to emulate, low calorie recipes, and 'tips to lose a stone'. These messages are reinforced by the drive for public health, whereby 'fatness' is seen as something undesirable, unhealthy and for which we are to blame, even though the evidence for this belief is seriously flawed (Aphramor 2009). It has been pointed out that medicalising women's 'fatness' as a 'problem' is an infringement of their civil rights (Cooper 1997). Like being seen drunk, being seen as fat is increasingly likely to invite criticism and abuse, even from strangers. Both responses are a form of embodiment, and can supply a means of regaining of the self from social and other pressures (Moore 2008). As Karen ('Making a Start') said, "s'pose it's a place of my own'. In that virtual space, which she accessed with alcohol, she felt safe and comfortable.

Substances such as alcohol and food may be another way of enabling women to escape temporarily from concerns as to public opinion about their correct behaviour and appearance. Sometimes the control exerted by social conditioning has prevented their experiencing inappropriate

feelings, such as anger, joy, sexuality, in any other way. Eating or drinking more than you 'should' may sometimes be part of a strategy to express who you are, as opposed to who you are supposed to be (Wheeler et al. 2001). Alternatively, it may be a way of hiding, to cope with stress (Henderson and Huon 2002). Such stress may then be made worse by prejudice against being overweight.

Excitement, time out, answering our own needs, spirituality, authenticity, competence: this is a formidable range of reasons for women either to choose to continue to drink or to suffer sadness and depression if they do not do so. Some try with varying degrees of success to adapt their needs to the conventional solutions on offer, which are arguably safer. Others may, as I did myself, move away from alcohol, at least in part, as a political act, wanting to address the social injustices which I believed had placed me where I was, 'an alcoholic'. The majority of women 'with alcohol issues', as I have shown in previous chapters, appear likely to continue to blame themselves for being unable to fulfil the behavioural roles which are assigned to them, and to suffer depression and unhappiness, whether they continue to drink or not.

6.2: Politics of empowerment

In an equal society, there would have been no need to use alcohol to achieve, for example, authenticity and competence. Women's access to equal status has long been subject to factors which alternately force

them to work outside as well as inside the home, for example in time of war, and to surrender external workplace jobs when, for example, the soldiers return (Bradley 1989). However, their status has not always relied on work outside the home, nor on the work status of male kin. Before industrialisation, women's and men's roles were 'mutually dependent and together supported their children' (Clark 1968, in Bird et al. 1979 p.196). The woman's work might include work outside the home, such as being a shoemaker, or her work within the home might include brewing, fieldwork and the organisation of numerous staff.

Bird et al. (1979) describe industrialisation as one factor in the narrowing of women's roles, although some heavier female work was replaced by jobs in the retail industries. They also cite evidence that a great amount of women's work, such as voluntary work, cleaning other people's houses, and caring for other people's children, has gone unrecorded. Much of this work is compatible with the ongoing perceived responsibility of women for childcare, which has long made it difficult for them to access the better paid, higher status, full-time, 'career work' which is still more accessible to men. Women's empowerment has long been subject to numerous factors connected with the insecurity of such employment and lower rates of remuneration (Pearson 2004). Changes such as the kind of work that is done, the use of information technology, and the greater availability of self-employment and home working, for both sexes, have the potential to give women greater freedom to work and to earn on their own account.

However, they have not yet made a great impression on how men's and women's work responsibilities are seen (Kuhn 1970).

This background was influential in the social situations of the 'Making a Start' women often being unequal and unjust, factors I consider in 6.3. It might be the case that they had a right to take whatever action seemed to them to improve their situation, even in the short term. This may have involved their 'choice' to make use of alcohol, to whatever extent. There is an inescapable tension between human rights and the gendered pattern of contemporary social organisation. This must be recognised, to escape the slur of moral degeneracy, and a psychiatric discourse which personalises blame and denies equal moral worth (Lewis 2009). This observation about mental health issues as a whole may also be applied to women who 'abuse' alcohol. To change such a situation involves addressing institutionalised power, and adopting a social model of understanding distress, involving citizens as a whole (Lewis 2009).

I believe that women's bodies are their own, as are those of young men, and while full information should be available about the long-term effects of alcohol, the choice of whether, where, and to what extent, to use it is theirs. If, as a society, we should prefer people to find different, 'healthier' ways of enjoying themselves, perhaps more attractive suggestions should be on offer (Van Wersch and Walker 2009). If it is the case that many adults need to use alcohol heavily in the long-term,

not for enjoyment but from need, there are serious questions to be asked of a consumerist culture of unequal opportunity and reward.

I have emphasised that none of the 'Making a Start' respondents perceived their alcohol use as something in which they had no choice; i.e. they did not see themselves as helpless victims of a substance. This was not the case with their other circumstances, such as poverty, domestic violence, loneliness and depression, where they did often feel powerless. They had all become aware that their drinking had been, and often still was, problematic, and that it might lead to further problems still. Yet, with no encouragement from me, some were still able to recall the importance of the alcohol experiences most graphically. Perhaps their drinking might be likened to Huxley's (1932) 'soma holidays', and like them, it could provide inspiration and ability to continue with a less than satisfactory life experience, even while it was likely to shorten it.

I have already mentioned, in 6.1, the correlations between 'being fat' and 'being alcoholic'. Both conditions may result from social inequality; both are likely to lead to even greater inequality as a result of stigma and 'public health' campaigns; both may none the less provide comfort and serve to demonstrate defiance (Wheeler et al. 2001). In both cases, the evidence for the effects on 'health' are open to dispute (Aphramor 2009, Ettorre 2007, Thakker 2006, Peele and Brodsky 1999). What is seldom disputed is the effect of such 'personal choices',

or perhaps 'responses to social pressures', on the rest of society, particularly on 'significant others'.

Like the right to commit suicide, the right to consume substances, including food, at will, is a contentious area. While it is true that no one is an island, and that there are emotional and practical consequences to others in circumstances such as these, to take an opposing position is perilous. I have mentioned the position in Sweden, where compulsory treatment may be inflicted; within my lifetime in the UK, it has been illegal to commit suicide, and I have myself been sectioned for attempted suicide. There are real issues of human rights here, for all concerned (Szasz1990). Should we seek to prevent people from living on junk food, climbing mountains in poor visibility, and taking other health risks? At what point does the rescue team refuse to turn out, or the police intervene to prevent the expedition starting?

These are valid concerns, even when they are backed by medical understandings of 'health' and 'ethics' which are not so much multi-faceted as utilitarian. Such approaches focus sharply on the physiological and other damage being done by, for example, ingesting alcohol, rather than an approach which sought reasons for unhappiness and dissatisfaction and made provision for dealing with them holistically. Deprived of the opportunity to live their lives as they might want to, rather than in a way which is 'good for them', women are

only considered to have 'rights' if they stop drinking (Ettorre and Laitinen 2004).

6.3: Issues of Blame and Shame

It is not new to blame people's illnesses upon defects of personality, whether the illness in question is obesity, venereal disease, AIDS or hysteria (Thorncroft 2006, Chesler 1997). In each of these cases, popular (and frequently medical) opinion has placed responsibility with the guilty patient—they have been greedy; they have practised homosexuality; they have been women who did not behave as they were expected to do. Typically, these supposedly causal factors have been applied to those with less power by those with more (Plant 1997). I have shown that 'alcoholics' and 'drug addicts' are not seen as having the same human rights to differ as the majority of the population, and that women are not seen as having the same freedom to enjoy pleasure and leisure, including intoxication, as young men. As I noted in Chapter 4, women's drinking could be seen as resistance to imposed social order, and a determination to take time out, at all costs. At the same time, they are featuring as society's moral scapegoats, serving another despised but necessary function, their deviance and revolt as much a part of social organisation as conformity and convention (Merton 1968).

It is impossible to escape the conclusion, amply demonstrated in both 'Making a Start' and 'Treatment Approaches', and detailed in Chapter

5, that women suffer an almost overwhelming burden of social control and psychological abuse. This not only contributes to a need for alcohol, but is also illustrated by traditional responses to women's drinking, including treatment. This control is achieved principally by the adoption of moral strictures as to what is, and is not, appropriate for women to do (Warner 2009). It may work by encouraging feelings of guilt and shame and even be reinforced by domestic abuse. Poverty and malnutrition, often caused by factors other than, or additional to, alcohol, may serve as apparent evidence of wilful self-harm. These factors assist in keeping women in a secondary position, since women who drink, or use other substances, are likely to represent a threat to order and to 'civilisation itself' (Campbell 2000 p. 57). Our society's expectations of women, as I have explained, is that they take responsibility for moral order, while being denied full human rights (Lewis 2009). This involves their being denied the right to behave as irresponsibly as full citizens, i.e. men. Their socially acceptable use of alcohol is far more limited.

I have already described the way that the development of an industrialist and a capitalist society has placed women in an anomalous position with regard to how their worth is ascribed. They are likely to be under pressure to be a wife, to care for a family, to do paid work, to look slim and youthful, and to control any feelings which are not consistent with the 'feminine role' (Lemish 2003). Substances, of which alcohol is one of the most accessible, are one way of coping with

a position which others have agreed to be untenable (Smart 1992). The approach of the media, the direction of doctors' training, and the organisation of alcohol treatment, all appear largely to confirm the roles of women as described above. The position of the women still drinking, and even, to a lesser extent, those who have stopped, remains that of risk factors to be controlled, boundary-markers. As Campbell (2000 p.4) says: 'Women embody a collision between normative expectations of how citizens should conduct themselves as citizens, and how women should behave as women'.

Such shame as may be experienced by women who have taken pleasure in alcohol at the expense of the well-being of their family, or even by those whose family issues have led to their alcohol use, may perhaps be seen as therapeutic as opposed to damaging (Morgan 2008). For example, it may lead to a re-examination of one's own conduct, in the light of its effects on others. Since women, like men, live in a social environment, an awareness of these effects is desirable if we are to be full citizens.

However, I would argue that since we are not full citizens at present, we may choose to acknowledge our shame, without necessarily choosing to adapt our behaviour. The paranoia and pain of a homosexual man may place him in 'an "other place" full of historical truths' (Munt 2007 p. 168) where he must navigate creatively between different ways of understanding and seeing himself, in search of

authenticity. Such navigation may also be required of women who feel their lack of authenticity and continue, or return to, alcohol use as they attempt to explore and acknowledge different selves, and different social reactions to those selves.

The evidence suggests that women feel a need for greater empowerment in their lives (Women's Resource Centre 2007, Niv and Hser 2007, Eliason 2006, Women's Health Council of Ireland 2005, Barron 2005, Neville and Hendrickson 2005, Laitinen and Ettore 2004). Such empowerment may include opportunities for friendship and leisure, as well as those offered by suffrage. It is nearly 50 years since Heath (1962) was suggesting that bouts of intoxication may be used as a substitute for reliable and ongoing friendship (Heath 1962 in Mandelbaum 1965 p.285). More recently, others have indicated that such a substitute is frequently used by isolated and unhappy women (Raine 2000, Ettore 1997). Women from 'Making a Start' who started the WIAS group spoke of the importance and empowerment they experienced by meeting other women in an environment unconnected with home, work or treatment. Such social bonding is seen as natural and healthy for men and for children, but is more difficult for women to achieve. For women, access to pleasure needs to be justified, and is frequently feared and contained (Ettore 2007). The best treatment centres have already incorporated such elements; one example is the Blue, mentioned in 'Treatment Approaches', where women are offered friendship and non-judgmental support, enjoying discussions,

gardening, outings for coffee and cakes, and walks in small groups. Often this is the first time that these women have enjoyed substance-free leisure. Providing it is not just about 'treatment' but a political act.

6.4: A better model of health

Whatever the legitimacy of self-pleasure and the civil right to drink alcohol, it can, like many foods and behaviours, cause harm, both directly and indirectly, particularly in the long term. This harm is likely to continue to be seen, at least in the immediate future, as a 'personal problem' rather than a problem caused by a society which places women in an impossible position, a situation I considered above.

Should a woman ask for help with alcohol issues, she will have recognised either that her real needs are not being met by the substance or that the cost to her life of meeting her needs in that way is too high. Many cease their alcohol use of their own accord, perhaps as their social role changes; what has been referred to as 'drift theory' (Matza 1990). Others, despite having had serious alcohol problems, become able to return to non-problematic drinking (Heather and Robertson 1997, Cameron 1995, Davies 1962). To assume that women who have been seen as having 'problems' will always have such 'problems' is to negate the role of social learning (Heather 2006) whereby, to cite the Red Centre assessor, 'things that have been learnt can be unlearnt.'

Whatever her situation, when she decides to change how she uses alcohol, a woman may well need several kinds of support. The 'Making a Start' research showed, and Hodges (2007) has confirmed, that women who have had alcohol issues often need help with a multitude of issues, such as social dissonance, loneliness, depression, abuse and fear. Their alcohol use may be the least of these problems yet this is the issue on which attention is likely to focus. As 'Treatment Approaches' showed, their issues do not seem to fit the models of help with which alcohol professionals come armed.

A model of women's health needs to acknowledge that substance use may be a passionate need to identify with the self, which may not be possible for women whose lives limit: 'their ability to make informed choices and to act upon them...over sustained periods of time...'
(Doyal 1995 p.8). Doyal is here referring to women with mental health problems which may or may not include substance use, but the same comment might be applied to the lives of many of the 'Making a Start' women. Loss of this support can be experienced as bereavement, like losing a friend. Traditional sources of support, such as Alcoholics Anonymous (AA) tend to perceive the alcohol use as entirely negative, which makes it difficult to mourn what is seen as illness, weakness or misfortune.

For the reasons I gave in 6.2, there seem few chances of the necessary and major changes to governmental, judicial and medical

attitudes to treatment policy which would provide women with the kind of support this would require. However, this research has indicated that there could be better ways of not only helping women to find alternative survival strategies, but also, ways of living with their alcohol use, with society as a whole benefiting as a result.

In complex areas such as women's alcohol issues, I feel it is asking *too much* of alcohol services to provide the emotional insight, the complex political understanding and the solid practical support that women may need. Such provision needs to derive from an infrastructure involving a number of different kinds of resources, of which medicine may play only a very small part; for example, in the cases where supervised withdrawal from the substance is needed:

giving up alcohol completely is not a necessary prerequisite for overcoming all drinking problems...If this were more commonly known, it is likely that more people would seek help...associated with an abandonment of the 'psychiatric' associations of such clinics...it is possible to envisage a snowball effect of improved public image, increased referrals, and reduced stigma (Heather and Robertson 1998 p.181).

A different kind of treatment centre could provide information for women about opportunities for self-care, socialising in safe spaces and finding sources of sympathetic and woman-centred support. Such opportunities need to be easily and continuingly accessible. Needs change over time, and it may be many months before a woman who

has presented herself as 'having an alcohol problem' is able to step back and see that a range of problems are affecting her and that a range of social and alternative care might be of help (Women's Resource Centre 2007). Even with the 'alcohol problem' itself, people trying to change long-established patterns of behaviour are likely to take a long time before their final 'success', and need a wide range of long-term support (Aaronson 2006).

To do this the treatment centres would themselves need to be better informed, to be differently staffed, and to have less of a medical focus. The relative absence from treatment centres of women, BME, LGBT, disabled, Gypsy/Traveller groups and people over 60 is an illustration of the current failure to achieve goals of inclusivity:

It is important to accept and embrace the fact that even a gold standard treatment might be effective for some but ineffective or even harmful for others...we need to gain a much broader understanding of why a particular treatment is effective and for whom (Witkiewitz and Marlatt 2008 p.650)

In any case, the training of GPs and treatment centre workers requires an increased emphasis on social issues and on how to engage a variety of people with a variety of needs. Their information, unlike that of some of my GP interviewees, needs to be up to date, and their personal style responsive and friendly (McAvoy 1997). It would be of great value to run a pilot study for perhaps one year, to assess what

information is being provided, and in what way, and how such information impacts, or fails to impact, on GPs.

As with other areas involved with mental health, single sex provision is essential for safety reasons and for over-all effectiveness (Women's Resource Centre 2007, Niv and Hser 2007, Eliason 2006, Women's Health Council of Ireland 2005, Barron 2005, Neville and Henrickson 2005). For women who still need or want to drink, at least on an occasional basis (Currie et al. 2006, Measham 2005, Broom and Stevens 1991), a constructive way of offering support would be the provision of women-only safe spaces which could be made use of for a few days at a time by women in need of them. A useful term might be 'Women's Support Centres'. There would be no attempt to deter women from drinking, and they could be pleasant, relaxing venues. Activities could be available, as could counselling and advice about housing, domestic violence and job training; but the focus would be on women enjoying a brief escape from the unequal responsibilities with which they have been burdened. Social support would be required for women with family responsibilities, but this would cost the community far less than the consequences of day to day 'alcohol problems'. A certainty of the availability of such escapes might enable some women to make use of them less often, or even stop completely; others might want to use them for many years. Potential advantages could be the absence of blame, of sexual hazard, and domestic risk, and the presence of a happy and positive environment which encouraged the

performance of dance, poetry and drama, provided opportunities of consultation on domestic, work and personal health issues, and offered a detox service and medical advice if required. Space would also exist for adventures in 'escapades of the mind,' the increased need for which may be related to consumerism (Aaslid 2007) and a lack of meaningful women's ritual:

By making discoveries about themselves in a supportive environment women are able to transform their identities...prescribed drug use by women in the form of Prozac may be seen to reinforce gender boundaries [whereas] drug consumption such as smoking...can be experienced as an embodied form of female resistance to traditional femininity (Ettorre 2007 p.48)

Again, a pilot study could be run, to assess the kinds of need and the kinds of solution, that women would value in such an environment, and to estimate the costs of launching such a service.

Cost would certainly be a concern. Utopias are not cheap but can save money in the long term. Lost and unhappy people cost money too, and giving them opportunities to identify with themselves is in the interests of all members of society. These pilot studies would do well to include information about current costs of alcohol misuse. For example:

The Prime Minister's Cabinet Office (2004) reported that alcohol misuse cost the National Health Service £1.7 billion, and that 360,000 incidents of domestic violence were alcohol-related.

[The Office also mentioned that] '1.2 million violent incidents (around half of all violent crimes)... up to 22,000 premature deaths per annum; at peak times, up to 79% of all admissions to accident and emergency departments; up to 1,000 suicides; up to 17 m. working days lost through alcohol-related absence; between 78,000 and 1.3 m. children affected by parental alcohol problems..' (Plant and Plant 2006 pp. 67-68)

However, the positive results of such a scheme will not be quickly visible, for example within the lifetime of a government's term of office. There will also be arguments about who is to pay; the Department of Health may feel it is being asked to fund a leisure activity and the Department of Communities and Local Government may see it as the responsibility of the Department of Health. Locally, the PCTs are currently responsible for commissioning alcohol services, but their vision of what is a worthwhile service can vary and tends towards the conservative. A pilot scheme might be floated in which the private Sector, such as Virgin, might be interested in funding one of the Women's Support Centres I have mentioned, in line with its interest in hyper-clinics. I suggest one way in which this might be effected in Chapter 7. Such schemes might assist by putting into effect Lavack's suggestions about de-stigmatization and social marketing (Lavack 2006). There would also be possibilities within the Voluntary sector, funded by charitable donations. However, in the longer term, since it is principally the government which currently pays the cost of alcohol misuse, it would be the government which would ultimately need to fund the Support Centres, rather than spending 'alcohol treatment

money' as it does at present. Again, a pilot study would need to demonstrate the effectiveness and economic advantages of such a Centre, showing that the policy implementation would save money in the longer term.

It is true that the policies I have outlined, for Women's Support Centres, would face many criticisms. Threats of danger which might be cited could include women's own health and the right to health of unborn children; the dangers to, and other effects on, children already in existence; the possible increase in public disorder and crime and increased costs of policing; the largely unseen emotional costs to families and carers. However, I would maintain that they had the potential to address the real causes of unhappiness, by offering non-judgemental support to all concerned, and providing a platform for political change. In these circumstances, personal choices made might be very different.

Reflections

This chapter has illustrated the legitimacy of women's pleasure in alcohol use, and has problematized gendered ways of judging such use. It confirms the need for many women to drink, in an unequal society, but also defends their right to do so in any society. The issue appears to be, that choice is integral to self-worth and to authenticity, but that the choices people can make will depend on conditions which already exist, and which are seldom of their making.

The sadness and loneliness frequently expressed in 'Making a Start' was the result of these women's having less freedom of choice in their lives as a whole, and far greater penalties for making the 'wrong' choices. Until children may be reared without fear of sexual and domestic abuse, and women's lives may offer the same freedoms as those of men, drinking, or using other substances, to escape unhappiness is likely to continue. In the meantime, some women have achieved freedom to enjoy alcohol for pleasure, on their own terms. I see such alcohol use, like that of enjoying high calorie food, as a political issue, rather than one of health.

Chapter 7: FINAL REFLECTIONS

Introduction

The research on which this thesis has been based has been exciting and challenging. I benefited personally because my past 'alcoholism' had originally been too shaming a part of my 'personal' for me to be able to see the illness or its treatment as 'political'. I have experienced the PhD process as a period of intense personal growth. The continual reappraisal of myself, my beliefs and my experience formed a powerful counterpoint to the certainties which continue to be expressed in the field of alcohol research and treatment. It has enabled me to develop a kind of ongoing and multi-faceted awareness which is neither comfortable nor certain but which affects almost everything I do. This is a kind of awareness I had previously associated principally with alcohol use. It is this awareness which has led me to a realisation that what is needed in the area of women's alcohol use is cultural change, which would include a less materialistic focus, and an acceptance of the validity of different experiences of reality.

In this final chapter, I begin, in 7.1, 'A unique contribution', by outlining the principle findings of this research, and their value to the sociology of women's alcohol use. I continue, in 7.2, 'Implications', by discussing the extent to which my findings develop understanding of women's feelings about alcohol use and alcohol treatment, of the thoughts and

behaviours of doctors and treatment professionals, and of treatment policy. In 7.3, 'The research process, its effects, and how it might have been done differently', I look particularly at how the interaction, intrinsic to the methodology, has affected both respondents and me, and the possible consequences of a different approach. Finally, in 7.4, 'Future directions', I consider ways in which this research might be taken forward.

7.1 A unique contribution

My perspective, as a woman and a sociologist, who had herself recovered from 'alcoholism', enabled me to relate closely and easily with the 'Making a Start' respondents, two of whom had never previously discussed their alcohol issues with anyone at all. Later discussion with the 'Treatment Approaches' respondents assisted me in a better understanding as to why the misunderstandings, distress and ineffectiveness had occurred and continued to occur. The interchanges were also informed by the experiences of my Research Advisory Group (RAG), so that I was able to set the different perspectives of 'the treated' against those of 'the treaters'. My findings link, within a sociological framework, the continuing failure of alcohol 'services' to 'serve' women, by their failure to recognise the importance of authenticity and of difference. This enabled me authoritatively to problematise the problematising of women's alcohol use.

The research confirmed my initial impression that how women experience their alcohol use is seldom understood by doctors and treatment professionals. I have shown that women often use alcohol for reasons other than those they feel able to explain in a medical context, and that those whose job it is to help them often have fixed understandings of what constitutes health, and are unaware of this discrepancy. They are often unconscious of the 'treatment' function as an exercise in social control.

As I showed in Chapter 4, there are ample reasons for women to drink alcohol and often to become dependent on it. My respondents described social restrictions, domestic abuse, lack of opportunity to develop as independent people, depression and loneliness, conditions which had affected most of them at some point. The alcohol would give them comfort, at least in the short term, with the disadvantage most frequently mentioned being shame and guilt about subsequent behaviour. However, there was also mention of excitement, fun, joy and a feeling of safety, positive experiences which were often hard to find elsewhere. The lesbian/bisexual respondents seemed to suffer less from the stigma of 'alcoholism', sometimes taking some pleasure in being 'delinquent' (Cohen 2002). As I explained in Chapter 5, this group perhaps suffered more in 'treatment', usually concealing their sexual identity for fear of its being pathologised. A few women drew comfort from Alcoholics Anonymous (AA), finding there an opportunity to express regret at their behaviour, while also being offered continuity

and even a second chance at acceptability. However, the majority drew away from the organisation quickly, recognising the same kind of restrictive culture and moral opprobrium which had been an ingredient in their need to drink (Sweanor et al. 2007, Moncrieff 1997).

Most respondents sought advice from GPs, but usually felt rejected, misunderstood and abused by them. They had expected the doctors to know best, and to tell them what to do, but had usually been disappointed. Their GP had seemed in a hurry, or had spoken rudely, or had not really listened. I kept these reports in my mind as I interviewed GPs. These respondents would have had an interest in women's alcohol issues, so might not have been representative, but even so they revealed anxiety over how little they knew about women and alcohol and how little was available in 'treatment' (McAvoy 1997). They often expressed compassion for their patients. However, they also expressed ignorance, irritation and impatience; they did not seem to understand what it was their patients wanted from them. The medical 'solutions' they mentioned to me were few, usually consisting of a recommendation to attend an AA meeting and a mention of one or two of the local treatment centres. None had visited any of the ten local treatment centres and they knew little of what they were like or what they advised.

Respondents currently receiving treatment for their alcohol use were usually positive about it, but the majority had found it unhelpful and

destructive. Some accounts were horrifying. When I interviewed treatment providers I found great variation between those whose centres offered a flexible approach based on harm reduction and social learning, and those whose centre followed the 'medical model' of abstinence and a lifelong commitment to AA. The latter seemed more likely to see their 'service users' as products, whose worth depended on whether or not they were abstinent, and for how long. The GPs were more likely to blame themselves for 'failures' than the treatment centres, who were more likely to see 'unsuccessful' clients as being 'not ready'.

Doctors and treatment professionals alike seemed unaware that their interpretation of 'health' might preclude authenticity, particularly for marginalised groups such as lesbian/bisexual women and, very often, for women as a whole. In promoting goals of abstinence, rather than those of social learning theory (Heather and Robertson 1997), they had adopted a moral stance (Warner 2009). They might additionally be infringing human rights; what Cresswell (2009) terms 'experiential rights', whereby people suffering from a condition may be made to suffer further by their experience of treatment. They presented themselves as being unaware of their important positions as agents of social control within a medicalised society (White 2002).

7.2 Implications

Alcohol use is both legally and socially acceptable, although it is ranked the fifth most toxic drug (Nutt et al. 2007). Restrictions on its use and price have been reduced in recent years, making it more accessible to people who are poorer and have a lower social status, a group which includes women and those with mental health issues (Marsh and Vegeris 2004). At the same time as it has become part of most people's leisure, it has become a vehicle for demonstrations of social defiance and the overturn of traditional behaviour (Plant and Plant 2006). The consequent moral panic has resulted in recommendations of 'safe limits' of consumption, 'education' of young people, and media contempt for women who are seen drunk in public (Plant 2008). The possibility of compulsory treatment may mean that 'public health' becomes an area which encroaches considerably on the area of human rights.

Medical authority is generally expected to operate in a way which is accountable and reliable. However, as this research has shown, and others have noted (Rogers 2007, Vogt et al. 2006, Reiner 2000, Roberts 1985) doctors and others in positions of power are likely to be affected by lay prejudice and may not understand women's emotional and political issues. Yet the GP has become a moral arbiter of almost every sphere of human experience (Armstrong and Ogden 2006, Shaw 2004, Broom and Stevens 1991).

A medical approach to health is largely incompatible with a social one, unlikely to diagnose disenfranchisement and poverty as contributory causes of physical and psychological conditions. It is even less likely to see the presenting 'illness' as a way of acting out, recreation, and a form of selfhood to which one has a right (Cresswell 2009, Aaslid 2007). Instead, it operates as an agent of social control, perceiving lack of conformity as illness which it may be able to 'treat' (Gusfield 1996) and basing its 'expertise' on majority opinion. It also subscribes, at least in principle, to the understanding of 'alcoholism' as a physiological condition, for which the patient may not be responsible (Renault 2007, McDowell and Spitz 1999, Jellinek 1960), even while sharing the popular belief that patients could stop if they wished, so are also 'guilty' (Walters 2002, Peele 1995).

Even social approaches to drunkenness frequently perceive it as solely problematic, sometimes explaining it as one consequence of a free-market economy. People who are uprooted from their established patterns of living are typically deprived of traditional sources of physical and spiritual support and are vulnerable to addiction (Alexander 2000). However, as I showed in Chapter 2, societies which existed and exist outside that economy do not necessarily eschew drunkenness. What is consistent is the strict regulation around how, when, how much, and by whom, alcohol may be consumed (MacAndrew and Edgerton 1969, Mandelbaum 1965). People who drink in ways which are inconsistent with such regulations are stigmatised. These are local and social

understandings. Our society's expectations of women, as I explained in Chapter 6, is that they take responsibility for moral order, while being denied full human rights (Lewis 2009, Coward 1983). Different behaviours are seen as socially problematic, but they are also indicative of ways in which current structures may be, or have become, unfit for the purpose (Kuhn 1962).

These structures may not only have resulted in inequality and oppression, leading women to use alcohol in ways which they may acknowledge to be harmful. For many women intoxication may be a need, and some would say, a right, encompassing leisure, risk, and independence (Eber 2000, Lupton 1999). Such a need may be caused by a capitalist society which effectively places them under pressure to be a wife or domestic 'partner', to care for a family, to do paid work, to look slim and youthful, and to control any feelings which are not consistent with the feminine role. Substances, of which alcohol is one of the most accessible, are one way of coping with a position which others have agreed to be untenable (Busfield 2006). As I noted in Chapter 4, women's drinking could be seen as resistance to imposed social order, and a determination to take time out, at all costs. At the same time, they are featuring as society's moral scapegoats, serving another despised but necessary function, their deviance and revolt as much a part of social organisation as conformity and convention (Merton 1968).

However, it is a mistake to see women solely as victims of what is certainly an unjust system, as I have noted earlier. Many of those interviewed might, like Ursula, Teresa and Bella, sometimes be expressing defiance and demanding recognition. Many others, like Fran, Lucy and Vi, were using alcohol to help them achieve greater enjoyment of leisure, often in the face of considerable opposition. In this respect, it would be true to say that most, if not all, of the 'Making a Start' respondents were active agents in their alcohol use, as opposed to being merely victims of oppression.

Such a conclusion has major implications for future alcohol 'treatment'. While we must always be aware of the role of cruelty, poverty and abuse with regard to substance use and self-harm, and have available ways to prevent and ameliorate these factors, we must also accept that substance use may be an important part of achieving self-knowledge and fulfilment, even when such use may be physically damaging to the drinker and embarrassing to others.

What I now see as necessary, although very distant, is a cultural change, whereby women's holistic well-being, and their control over their own bodies, is respected, so that they do not need to use alcohol to make their everyday life-experience bearable. This respect would include an acknowledgement of their equal rights to pleasure, relaxation, sexuality and spirituality, achieved in whatever ways the women concerned felt to be appropriate, including the use of alcohol

and/or other substances. The right to experience alternative ways of being and of living is one for which people have fought and died throughout history, often influenced by a particular religious ethos. As I mentioned in Chapter 6, the achievement of such an acceptance would involve a considerable shift in popular, medical and judicial views as to the appropriate behaviour and responsibilities of women.

It is difficult to be optimistic as to the immediate possibility of change in social policies affecting women's alcohol use and its 'treatment'.

Although some alternative treatment does exist, as I noted in Chapter 6, it remains rooted in a society which sees women's freedom to use substances as problematic, for the many reasons described above.

Three things are needed:

- (i) a culture change, drawing upon what other communities understand to be the meaning of 'drinking' (Bacon 1958) and 'addiction' (Reinarman 2005, Hammersley and Reid 2002);
- (ii) an acceptance of alternative ways of experiencing and defining reality (Ettorre 2007, Lyons 2006);
- (iii) more diverse and accessible support for women who use alcohol and for medical staff who may find themselves working with them.

It is the third of these changes which for which I suggest relevant research options in 7.3.

7.3: Future research

I have explained how the first research project, 'Making a Start', led to the development of WIAS, for women who needed some sort of support and friendship, as a result of society's reactions to their drinking. This was an incidental, not a planned, outcome of the research, illustrating 'unanticipated consequences of purposive action' (Crowe and Pope 2008 p.219). However, it is only a very small proportion of women who hear that there are alternatives to 12 Step programmes, are able regularly to keep in touch with each other and have money and transport to meet up. There are also the financial and emotional demands of families and significant others. Although large numbers of women contact WIAS for advice and (most often) reassurance, only a few manage to attend meetings.

I mentioned in Chapter 6 my concept of Women's Support Centres, but perhaps the future may be virtual rather than physical. There are a number of research possibilities.

- (i) Women could be invited to join a special social networking site, with the aim of sharing experiences of alcohol issues by using a Message-board. Reactions could then be assessed, for example, by a researcher talking to them on the phone, or by

emailing a questionnaire, about how helpful they were finding the scheme. Such a methodology could avoid the difficulties of time, transport and nervousness which may have affected attendance at the 'Making a Start' focus groups. It might be particularly valuable for stigmatised and isolated groups.

- (ii) A pilot study could first be run, to see what kind of site would be most likely to appeal, and the best ways of providing back-up and support for women taking part. In applying for funding, it would be sensible to point to the extremely high current costs to the government of alcohol misuse and associated problem behaviour.

Such action research as these two projects is likely to exclude a significant proportion of the population at whom it is aimed, since women's access to private use of computers is likely to remain limited for the foreseeable future, for the same cultural and economic reasons which affect their ability to socialise freely. However, if shown to be effective for the women who took part, further research could be undertaken:

- (iii) to identify the groups of women who had not taken part, such as women with no access to a computer. Consultation could demonstrate what their needs were, and it would then be possible to make a case for funding, for example, women's

internet cafes, or free mobile phone accounts. Such a piece of research would be inexpensive to run, and would assist women's empowerment. In doing so it could make more radical changes to the distribution of power in our society. It would certainly be likely to interest those responsible for public health (Letherby and Bywaters 2007);

- (iv) to compile and publish a 'toolkit' of survival skills, using the telephone and the internet, whereby women could anonymously record strategies which had been of help to them and to their families, while they were still using alcohol, and their effects on its use;
- (v) to monitor, as mentioned in Chapter 6, the information about women and alcohol which reaches a sample of GP practices, perhaps over a year, and also to monitor its impact. To what extent does it support a broader perspective of treatment approaches? This would make it easier to make recommendations as to what information they should receive, what they fail to receive, what is noted, what is acted upon, etc. GPs with an interest in women's issues, or in substance use, might well want to take part.
- (vi) Finally, as recent research places the blame for social ills squarely with inequality, calling it 'structural violence' (Wilkinson

and Pickett 2009 p. 134) a piece of new research with such an approach might explore the effects on health of the different ways that women still feel their lives are controlled, such as by destructive relationships, lower income, poorer diet, the demands of fashion, less time in education, and greater family commitments. It might address the cultural changes whereby women's alcohol use may come to be seen less as misfortune and more as a demand for equality. Again, this could be economically achieved by way of web and telephone-based social networking.

7.4 The research process, its effects, and how it might have been done differently

This research did not start from a particular theoretical perspective. Rather, it adopted a pluralistic approach, combining an auto/biographical strand with a variety of techniques which involved a maximum of perspectives. 'Coming out' publicly as a woman 'ex-alcoholic' made it possible to make contact with seldom-researched groups, whose experiences appear not to be recorded elsewhere.

Working with a group of other women 'ex-alcoholics' as my Research Advisory Group not only enriched the process but also helped with running the focus groups. Attending these groups was a big step for the 'Making a Start' women, who were often unused to socialising without alcohol. Later,

some of them developed Women's Independent Alcohol Support (WIAS), as I mention in Chapter 3.

It was also a big step for someone who had continued to see herself as 'an alcoholic' before doing this research, to be interviewing GPs and treatment providers, on a (more or less) equal footing. The treatment providers in particular sometimes found it a little strange themselves. A 'service user' was questioning *them*, about their work, and it was not a position to which they were accustomed.

As the research for this thesis progressed, my initial focus, on what was wrong with women's alcohol treatment, and how it might be improved, changed. I am confident that the data on which this thesis is based are of high quality and are unusual in the way they have been gathered.

However, my personal experiences of the stigma of 'alcoholism', and the moral opprobrium I experienced in 'treatment', initially got in the way of a more sociological approach; namely, why women needed to drink in the first place, why treatment was largely ineffective, and why society as a whole saw women's drinking as problematic. What helped me to develop a more sociological focus was a greater awareness of the similarities between how many 'Making a Start' respondents, like the Camba described by Heath (1958) and Mandelbaum (1965), chose to use drunkenness as a way of associating with others or of discovering themselves. Women's alcohol use was not just about need and desperation, but also about defiance, a taking back of power, a reclaiming

of authenticity and a social activity. Alcohol made them feel that they could do so (Testa et al. 2006).

What if I had realised this earlier? Would I have done the research differently? I feel happy with the methodology and would make one significant change only: I would make sure that the 'Making a Start' respondents felt safe to discuss further the fun they had had or still had with alcohol, what made it worth the risks, and what insights about their lives they had gained by using it.

In conclusion

I first wanted to do this PhD because I had become aware that my first-hand experience of recovery from alcohol addiction and alcohol treatment might be interesting, but that it was of limited value when challenging the medical 'expertise' of the addictologists. It was 'only' my personal experience. I hoped that improving my knowledge, and developing a sociological perspective, would enable me to step outside and around medical interpretations. I am particularly glad to have done it in the way that I have, involving consultation and networking, enabling numerous groups to agree and implement strategies for equality (Dawn Ontario 2009). I hope that the findings of my research may be of some help in the development of better public health strategies for women.

On a personal level, I feel very much more than the seven years older that I am since I started the PhD. This is partly through having to 'live through'

some terrible experiences in the lives of many respondents, to re-live many of my own experiences, and also through having had carefully to consider the validity of my beliefs about, for example, AA. It is very difficult to come through personal trauma without bias, but I have tried to be fair and to acknowledge good practice when I have seen it. It has been very valuable to learn how to apply a number of different perspectives, and to compare the different views obtained. I think that is probably what I have valued most as a personal outcome; the ability to look at phenomena in more ways than one, and, hopefully, to reach a balanced conclusion.

I hope very much that I will be able to find ways to take forward at least some of my ideas for further research, as I believe they might lead to a better understanding of women's alcohol use and its treatment.

THE 12 SUGGESTED STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

From:

Alcoholics Anonymous: The Story of How many Thousands of Men and Women Have Recovered from Alcoholism' Alcoholics Anonymous Publishing, Inc. New York City 1955 pp. 59-60.

Research Advisory Group

12 women who had once had alcohol problems but considered themselves to have recovered.

They advised and supported me during both 'Making a Start' and 'Treatment Approaches'.

Recruited by notices in shops and libraries and by word of mouth.

Steering Group

16 women, mostly professionals, with expertise in the areas of alcoholism, sociology, domestic abuse, racial abuse, medicine and feminism.

They gave additional advice and support during 'Treatment Approaches'.

Recruited by personal contacts.

'Making a Start'

In depth face to face interviews with 23 women who had or had had alcohol issues.

Interviews were taped.

Focus groups involving 10 of these women. Notes were taken.

Recruitment by extensive advertising in media.

'Treatment Approaches'

Face to face interviews of half an hour each with 10 GPs and 11 Treatment Assessors.

Interviews were taped.

Recruitment by letter, email and telephone.

WOMEN WANTED!!!!!!!

I am a sociologist and a recovered alcoholic. In October 2002 I am starting a piece of academic User-led sociological research into Women's Alcohol Dependency. This research is based at the Robert Smith Unit, and is funded by the Avon and Wiltshire Mental Health Partnership Trust.

In the future, I expect to involve a wide cross-section of women in the practical research itself; but for the time being my main task is to review what has been written about the issue already, and feed back this information in a series of Workshops. These Workshops will be open to anyone who is interested, and will be advertised later.

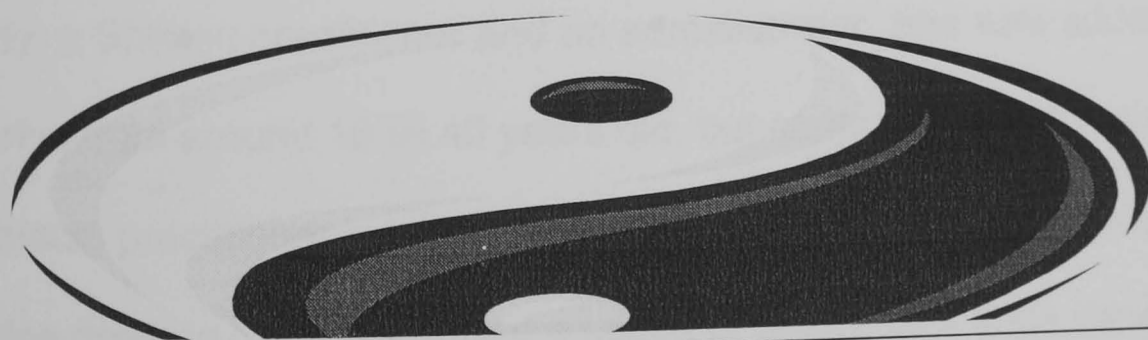
At this stage, I am looking for another **2 or 3 women** to join the **Research Advisory Group**. This Group will be meeting once a month, at times and in places to suit members, and its task will be to provide critical and imaginative input to the project, with every opportunity to influence the way the research is thought out, designed and managed.

Women joining the Advisory Group should ideally:

- have had, or have, a **problem with their drinking**;
- have achieved a **good measure of control** over their own drinking;
- have given **considerable thought** to women's alcohol issues;
- have an **interest (not necessarily experience) in research** into women's alcohol use;
- be **open to different ways** of resolving the different problems.

If you would like to take this **opportunity to make a real difference** to the lives of other women with problems like the ones you have struggled with, please send some details to me: Patsy Staddon at the Robert Smith Unit, 12, Mortimer Road, Clifton, Bristol BS8 4EX.

Or **phone me on 0117-942-3634 for more info.**



RESEARCH ADVISORY GROUP MEMBERS

(The group was asked to tell me what they wanted said about themselves.)

Linda: a mother and an artist, she had recovered from alcohol addiction with the help of alternative therapy and counselling. She said 'I joined RAG as I feel strongly that women should be offered choices in the help they receive. For many years the only thing on offer to me was AA. After a good many years of going to AA, and on and off abusive drinking, it should have been obvious that perhaps AA wasn't right for me. Instead I was told that I wasn't working hard enough at the AA program! I am so lucky that I eventually did get the help that WAS right for me (which was counselling and being given the tools to manage my depression and my life), but it is such a waste that I didn't get that help years ago, and, indeed many women I know, never get the help that is right for them.'

Jo: a shop manager who had recovered with the help of Alcoholics Anonymous(AA). She had liked the look of the advertisement for RAG group members.

Sally: a Shiatsu practitioner and an administrator. She was addicted to alcohol from around 18 till 40 years old, but controlled it. Her training as a shiatsu practitioner initiated the change from controlled drinking to choice drinking. She developed a space of safety; emotions trapped in the body were able to be released and expressed, rather than suppressed by her coping strategy. She still drank socially and

RESEARCH ADVISORY GROUP MEMBERS

celebrated the fact that alcohol no longer controls her. She joined RAG as she believed AA was not the only way to heal alcohol dependency, and questioned why it is rarely challenged or openly evaluated. There should be more innovative approaches to dealing with alcohol addiction and appreciation that women may benefit from single sex work.

Sue: In her thirties, and very well educated and travelled, she did not want any other details recorded. She found Narcotics Anonymous (NA) useful but seldom went now. Keen on meeting new people and on world travel, she thought RAG looked interesting.

Mary: a mother and an NHS employee, she no longer drank problematically, but wanted to help because she had seen that women needed something different.

Kay: Mother and musician, she no longer drank at all. She spent time in a residential rehabilitation unit but found AA very off-putting. 'This is very important work.'

Betty: Carer for her mother and did voluntary work with the NHS. Once a keen AA member but found 'the conversation limited' and preferred a stable group of non- and light-drinking friends. She joined RAG because she'd seen AA *not* working for many women, and was interested in a different approach.

RESEARCH ADVISORY GROUP MEMBERS

Nora: Described herself as a high flying student and career woman in Chicago in her twenties, all the while doing a lot of alcohol and sex.

She felt AA groups in Chicago had saved her life, literally from the gutter. She believed passionately in women's groups.

Kit: Suffering from mental health issues so not working. She had tried AA but isn't happy with it. She came to RAG 'to give it a try'.

Bea: She was diagnosed as being bipolar and having low self-esteem. She only stayed in the group briefly. Like Kit, she wanted to give RAG 'a try'.

Vanessa: Retired university teacher. She belonged to Women for Sobriety and only came twice.

WANTED!!!

**WOMEN WHO HAVE OR HAVE HAD
ISSUES WITH ALCOHOL**

TO BE INTERVIEWED in strict confidentiality by a woman researcher who **has had alcohol problems but is now well** and is doing research for the NHS on a project called **'making a start: women seeking help with their alcohol dependence'** *

WHAT FOR?

TO FIND OUT WHAT WAS HELPFUL OR UNHELPFUL IN ACCESSING TREATMENT

OR

WHY YOU DECIDED AGAINST TREATMENT

AND

HOW THINGS ARE FOR YOU NOW

WHAT'S THE POINT?

TO HELP MAKE LIFE BETTER FOR OTHER WOMEN IN FUTURE by contributing to a local piece of **NHS sponsored** research which is **run by and for women service users**.

TO FIND OUT MORE OR TO TAKE PART

Phone this number, using any name you like, and speak with

Patsy at Women's Alcohol Dependency Project

0117-373-8797

We will arrange to meet you---you choose where and when.

Help may be available with transport and childcare

ANYTHING ELSE?

ONLY IF YOU CHOOSE TO, you will get a chance to meet up with other women in a similar situation, and talk in complete confidence with them about all the problems and possible solutions, perhaps making new friends and getting new ideas.

THIS IS A NON PROFIT-MAKING PROJECT, which has been reviewed by Bath NHS Ethics Committee, and is **RUN BY AND FOR LOCAL SERVICE USERS**. YOU CAN **CHECK ITS VALIDITY BY PHONING BRISTOL'S ROBERT SMITH UNIT----**0117-973-5004

Anne, aged 55, heterosexual

Anne had been 'dry' as long as me; 15 years. She had had a very eventful life, with a variety of male partners, some of whom were abusive and some of whom were heavy drinkers, but she had a good word to say about them all. She had been sectioned following attempted suicide, but had never had alcohol treatment although she had been 'dried out' more than once. She had been inspired to stop drinking by a particular hospital doctor and with her family's support had pulled her life back together. She worked as a nurse, and had several grandchildren. Her home was clean and tidy and situated in a working class part of the city. She described herself as 'happy go lucky' but cheerfully admitted to consuming startling quantities of Co-codamol and Valium throughout the day.

Bella, aged 39, heterosexual

Bella was a binge drinker at the time of interview. She had been sexually abused as a child and had also had to wear hearing aids which had made it harder for her to make friends. She had gone on the road as a young woman, enjoying a hippy sort of life. 'I didn't have any boundaries.' A series of abusive relationships, all involving partners who drank heavily, had left her stuck on a violent housing estate on the outskirts of the city, with four children, one of whom had dyspraxia¹. She had had several tries at alcohol treatment, including residential. However she would come out and everything was the

¹ Dyspraxia is 'a developmental disorder of the brain in childhood causing difficulties in activities requiring co-ordination and movement.' (*Oxford Dictionary of English*.)

same for her. She was desperately unhappy and felt completely hopeless about the future, financially and in every other way.

Carol, aged 55, heterosexual

Carol felt that her Catholic upbringing may have accounted for why she 'instantly felt at home' in AA. She had joined 7 years previously and had found it effective. She had also attended boarding school and liked to have a defined routine to deal with what she described as her 'addictive personality'. She had never been out of work or short of money, and had a comfortable house in an expensive area, but her drinking had been making her ill, and she had eventually decided she needed to give it up. She had visited a day treatment centre but did not care for the people she met there. It was at this point that she joined AA, which had become a central part of her life. She was one of two respondents to disappear after her interview, although I was to see her again by chance three years later.

Deirdre, aged 49, heterosexual

Deirdre lived in a comfortable house in a very respectable working class part of the city. She used alcohol as an escape, but was not sure from what. Her husband was considerably older, and she had brought up his children from his first marriage. She had been pregnant herself twice and had two abortions, because her husband had not wanted more children. It was an extended family, with everyone seeming very attached to her, but she had no work or social life outside her home. Every so often the need to drink would come over her 'and that's it'; she would go off on a binge. Her social life seemed to

be limited to the confines of home and family and she did not like to meet new people without her husband.

Elsa, aged 33, lesbian

Elsa was brought up by her grandparents and suffered physical abuse from her grandfather. She was also raped by her father at the age of 12. She became a nurse to get away from home, where she had coped by drinking in bus shelters. She married at 18 and she and her husband had both been heavy social drinkers. They had split up 3 years before and she was now in a lesbian relationship. She was living in supported accommodation with three other people and enjoyed the companionship. She had had some counselling for her alcohol use and was now practising social drinking. However she had decided that if this didn't 'work for her' she would go for abstinence. She had suffered depression and had a breakdown but felt hopeful about the future, which included a new motorbike.

Fran, aged 41, lesbian

Fran had been adopted as a baby. She described a safe, uneventful middle class childhood, but had always loved to drink and socialise more than doing her college work. She had managed to jump quite a few career hurdles but became bored with jobs and much preferred socialising. She had had partners of both sexes but identified as lesbian. She had been to three different residential treatment centres for her alcohol use as well as various day centres. Her view of AA and the 12 Step programme was succinct: 'I didn't hold with it.' She was now 'on the sick' and living on a run-down council

estate and struggling to manage her debts and buy tobacco, but did not want to feel controlled by other people's rules about her drinking. She often financed this by sexual liaisons with men, a method she disliked but felt unable to escape.

Gill, aged 47, heterosexual

Gill was very depressed when we met, and spent most of the time drinking alone in her home overlooking the countryside. She loved her long garden and its birds and badgers. Her employers were being supportive of her efforts to get her life under control, but she was very unhappy and used alcohol as an escape route. She was deeply shamed by her behaviour when she had been drinking but felt unable to stop for long. She had only seen herself as having a problem in the last 10 years and had been prescribed a variety of medications including Prozac and HRT. Her difficulties seemed to have started when she tried to make contact with her father, who had left when she was a child, and around the same time broke up with her husband. She had tried different treatment centres and AA but disliked most of them, feeling exposed in groups and misunderstood in counselling.

Helen, aged 42, heterosexual

Helen had recently suffered the accidental death of her teenage son, but had been in a lot of trouble with her drinking before that. Both parents had been violent and also heavy drinkers, and at school she had bullied other children so that they would leave her alone. Her doctor had given her anti-depressants and been sympathetic but she was sure that alcohol lay at the root of all her

problems and was currently attending 12 Step treatment; 'I've learnt a lot from AA about drinking and alcoholism.' This was her second 'try' at treatment. She was particularly grieved that her family had turned its back on her and felt violently angry sometimes. Her flat was a long way from the treatment centre, which was a problem—the journey took nearly two hours each way---but she had a dog which she was attached to and it was hard to find accommodation which would take him.

Jane, aged 57, bisexual

Jane had been taken into care as a child, and split up from her siblings. She was the eldest and felt she should have taken better care of them. She got pregnant at 17 and was put in a home for unmarried mothers, and her baby was adopted. She then trained as a nurse because it 'gave her somewhere to live.' She used alcohol secretly from teenage, as a comfort. She was in and out of hospital with depression and other mental health issues, and someone she met there encouraged her to go to an AA meeting. She enjoyed the friendships she made there and went for 25 years, never drinking again. However in the end she decided the meetings might be causing her depression so started seeing a psychotherapist instead. Jane thought of herself as bisexual but thought that men were too much trouble. Her small flat was in a pleasant part of the city and she worked part-time for a national charity.

Karen, aged 42, lesbian

Karen had enjoyed her time in the Forces and now found it hard to make friends. She had always liked drinking and got into trouble often because of it. She had spent most of her childhood in care, and liked to be able to come home and have a drink because it made her feel safe. However she was getting panic attacks and agoraphobia, and finding life hard to deal with. She had approached alcohol treatment a number of times but felt unable to make a commitment to it. She was using Antabuse some of the time but coming off for a few days when she felt like going drinking. Drinking helped her feel less lonely and more relaxed. She had bought a small house on the outskirts of the city, was holding down a full-time job despite her regular binges, and enjoyed being at home.

Lucy, aged 25, heterosexual

Lucy was not sure whether her drinking was a problem or not. She had met some AA people and having listened to them she thought that it might be. She had noticed that she drank more than her friends, but they all liked going out drinking so she thought perhaps she had acquired a high tolerance level. She drank most days and had done so since she was 14, but not in the day when she had to work. She was part scared and part amused at some of things she had got up to. Her partner also drank a lot socially and she was afraid he might have alcohol problems. They shared a cottage by the river and she seemed afraid of him.

Margaret, aged 45, heterosexual

Margaret agreed with the doctors that she had had an alcohol problem, which had started when she had lost her partner and her home. She had been living in his house and acting as housekeeper for him and for his daughters but when he died she had to leave and began drinking to help with her depression. She had been about to go into a residential alcohol treatment centre when she was taken ill with centrifugal myelitis. She also had a tracheotomy. She was in hospital for five weeks, and when she came home she found she no longer needed to drink. She was extremely lonely, partly because although the area was pleasant it was isolated and she could not talk easily or drive a car. Margaret was one of the two respondents to disappear after I had met with her.

Nen, aged 42, heterosexual

Nen was in treatment when I interviewed her, and enthusiastic about her AA involvement and the 12 Step programme. She had had to argue with her doctor and finally pretend to have hysterics to get alcohol treatment. The GP concerned considered that her real problem was depression and had wanted to keep her on anti-depressants. She had also become a Buddhist, which she found to be of enormous help in dealing with life---she had suffered sexual abuse as a child, and domestic violence in adulthood from partners and grown-up sons. She had just succeeded in evicting them from her house. Her vocabulary was entirely that of AA---'I had all the insanity'---but she did seem

positive about the future. She had been a nurse before her life had become too chaotic to hold a job down.

Olly, aged 29, heterosexual

Olly parted with less information about herself than anyone else. She was living in a 'dry house' in a pleasant part of the city and had come from another part of the country, where she had been in a residential rehabilitation centre. She described herself as always having stayed off benefits and held down jobs and relationships, but always enjoying drinking a lot, usually in the evenings with friends. She saw her anger as the first evidence of her alcoholism; she would become violent and abusive at some of her boyfriend's behaviour once she was drunk. She described her life with her parents as happy and unproblematic. Her life centred on AA meetings and AA contacts which she considered to be 'safe'.

Pat, aged 36, lesbian

Pat was in a sheltered housing project when I met her but preferred to be on the road. She had learning issues and did not read easily. She had been in residential rehabs but always drank as soon as she came out. She suffered panic attacks without alcohol. She had been in care most of her life, care homes and boarding schools, and her father had been a heavy drinker. She had also married a big drinker who was violent, but they had split up. She had had interviews for some voluntary work but had not yet been accepted anywhere. She seemed bored and lonely, but described herself as making friends easily.

Queenie, aged 36, heterosexual

Queenie was happily married and living in a pretty house with no sign of any problems. She had got completely drunk one night at a hen party, and this had made her feel that she was no longer in control of her drinking. She enjoyed relaxing with alcohol as did her husband and friends. At work she was a very conscientious nurse, if a rather anxious one. She was interested in various sorts of alternative healing, and had not liked the sound of AA when she rang them for advice. Both Queenie's parents had been heavy drinkers, with alcohol and Gold Spot² being seen as staples of life. She was cheerful and positive about the future.

Renee, aged 46, heterosexual

Renee was one of the saddest respondents, lonely and isolated despite her comfortable and incredibly clean home and car. She described herself as being very fussy. She lived in terror of anyone finding out about her drinking, in case she lost residence of her two children. She drank alone in the evenings, for comfort, and held down a job in the day. She had a very unhappy relationship with her ex-husband, who had remarried and started a new family. She had very few friends and loathed the idea of AA, although she had never been or phoned them. She was also very frightened of having a mental health problem, which her mother had told her she would, because she had once had a termination and six miscarriages.

² A breath freshener very popular with drinkers as it is supposed to mask the smell---however it has a very distinctive smell of its own!

Sherie, aged 32, heterosexual

Sherie was a keen AA member, as was her mother; Sherie believed that it was AA which had brought them closer after not really liking each other. She had decided she was an alcoholic after years of carefree drinking, when a friend of hers wanted to go to AA but wanted someone to go with her. The friend went back to drinking but Sherie stuck with AA, which she found gave her 'grounding and reassurance'. Previously her relationships had been with drinkers. Her mother and her father had both been violent but only towards each other. Now she felt secure with her son, yoga, meditation, and AA.

Teresa, aged 44, heterosexual

Teresa's life was chaotic in the way that Bella's was. She lived in a pleasant part of a small city, but amidst violence and terror; she had to cope with her own drinking and that of her violent partner, and had set the house on fire recently while attempting to kill herself with painkillers. She did have some treatment for her drinking, and a counsellor she liked and trusted, but, again like Bella, her other problems were overwhelming.

Ursula, aged 52, heterosexual

Ursula was something of a survivor. She no longer drank and grimly used AA, which she disliked, because 'it's all we've got'. She had suffered sexual abuse as a child, and her adult relationships had often led to disaster, but she had built a series of successful lives, some being extremely rewarding financially. She had suffered some terrible experiences in residential rehabs and had

been pronounced a hopeless case, but had now been happy with the same partner and without alcohol for five years.

Vi, aged 46, heterosexual

Vi was a married accountant with one child. She described herself as a heavy social drinker who binged occasionally. She had had one to one counselling which she found helpful and had tried AA which she thought was too rigid. Vi had a high standard of living, with plenty of travel and possessions but had just lost her driving licence for a drink/driving offence. She was concerned at the impact this would have on her life. She felt that her drinking became problematic following a particularly difficult and stressful period at work, but the main reason she did not want to give up completely was the way that alcohol helped her when she wanted to enjoy herself and celebrate something.

Wendy, aged 38, lesbian

Wendy enjoyed bingeing for a few days at a time; usually with friends. She suffered from depression and was not very interested in sustained career development but had enjoyed a number of courses such as Fine Art and Music. She had had a lot of counselling and therapy but felt that her depression was part of her and that alcohol took away some of the pain by numbing it. She came from a wealthy family, had been to boarding school because 'it's what you did' and had a small flat with a wonderful view. She did not really see her drinking as a serious problem so much as part of her life.

Alex, aged 28, heterosexual

Alex had been in and out of 12 Step rehabs for several years and said she was now doing controlled drinking. She was still living in supported housing, in a very pleasant area and was hoping to get her own place soon. She had hated school, feeling she didn't fit in, and never really understood what was going on. Recently she was diagnosed as having dyslexia which made her feel better about it all. She had gone back to college, where she was studying Dance: 'My college means ever so much to me. I love it, I put my heart and soul into it, and I will not let alcohol get in the way of that.'

Appendix 7

MEMBERSHIP OF ADDITIONAL STEERING GROUP FOR 'TREATMENT APPROACHES' (pseudonyms used)

1. Dr. Mandy Cann, Professor of Alcohol Studies, local University.
2. Dr. Josie Stuart, sociologist and Research Consultant.
3. Dr. Debbie Green, Department of Politics, local University.
4. Dr. Linda Pratt, Clinical Lecturer in Primary Care at the
University Medical School and GP.
5. Dr. Peta Wright, GP.
6. Jane Grey, Client Services Manager, The Turquoise Project.
7. Paola Simpson, Clinical Manager, The Pink Project.
8. Cheryl Napp, Senior Nurse, R.G.N. R.M.N., BA(Hons), MA.
9. Anne Cooper, Co-ordinator, Battle Against Tranquillisers.
10. Barbara Keen, local Domestic Abuse Forum.
11. Penny Scott, Advisor for local Women's Forum and psychotherapist.
12. Sue Golding, semi-retired accountant.
13. Joy Frost, City Council, Legal Secretary, UNISON- Steward, Regional
Women's Committee Regional Black Members Committee also
National representative of both committees.
14. Linda, Research Advisory Group.
15. Jo, Research Advisory Group.

LETTER SEEKING RESPONDENTS FOR 'TREATMENT APPROACHES'

The Practice Manager
Dr. A. and Partners,
X Health Centre,
Y Road,
City.
Postcode.

The Treatment Unit
Road
District
City
Postcode

**Women's Alcohol Dependency:
sociological factors**

Direct line for project :XXXX-373-8797
Email:patsy.staddon@blueyonder.co.uk

April 2005

TREATMENT APPROACHES: March 2005---February 2006

You are invited to take part in a unique local research project which it is hoped will help to improve alcohol services for women in Bristol. It is designed and led by an ex-service user, Patsy Staddon, financed by The Mental Health Partnership Trust, supervised by Professor Elizabeth Ettorre of the University of Plymouth, and governed by a Steering Group whose names appear below.

The research is also supported by the Senior Programme Manager (Social Inclusion) Local Primary Care Trusts of the North City PCT Alcohol Service Improvement Network .

The project follows on from the 2004 research project, *Making a Start*, which interviewed women in the area who have had alcohol issues, in order to discover what they had found most and least useful when seeking help and to hear what they would have liked to have happen. This project seeks to discover what improvements medical practitioners and treatment staff themselves would like to see, what are their views on best practice around women's alcohol issues, and to what extent they see research such as this being worthwhile.

Interviews will be brief, lasting less than half an hour, and may be held at a location of the participant's choosing. Pseudonyms will be used from first contact and the strictest confidentiality observed. They will be only semi-structured, giving maximum freedom for interviewees to speak freely about individual concerns. Tape-recordings will only be made with permission, and transcripts made available to participants. Copies of the research report will be circulated to all participants, with their permission.

Academic papers will be offered and presented at the conclusion of the research. The project will pave the way for analogies to be drawn between the needs of service users, as expressed in *Making a Start*, and the perspectives of doctors and other treatment staff. It offers the medical and clinical

LETTER SEEKING RESPONDENTS FOR 'TREATMENT APPROACHES'

professions a unique opportunity to express their thoughts about alcohol treatment processes in confidence. As it is planned and researched by a Service User, and supported by a widely qualified and experienced Steering Group, important new data should be made available to the NHS and other treatment bodies.

Only one GP from each medical practice in North City PCT and one assessor from each day treatment centre in the city is invited to interview. Should too many GP applications be received, a randomised selection process will be employed.

Your participation would be of immense benefit to patients and staff, and would be greatly appreciated. Please write to the above address or telephone XXXX-373-8797.

Yours sincerely,

Patsy Staddon, B.A.(Hons), M.Sc..

At this point, I appended a list of the members of the Steering Group of 'Treatment Approaches'. (See Appendix 7).

(i) The GPs

Dr. Andrews, aged 40, female: Qualified 1997. Low opinion Rehab effectiveness. Aware of stigma of AA and loss of social life if no alcohol.

Dr. Branscombe, aged 55, female: Qualified 1974. Aware importance child abuse as causal factor; also social pressures to drink.

Dr. Cooper, aged 52, male: Qualified 1976. Notes family often complicit in naming someone as 'the problem'. More women turn pain in on selves.

Dr. Danvers, aged 52, female: Qualified 1977. AA helps some but unsure about it in general—coping mechanism can be learnt when growing up.

Dr. Ellis, aged 42, male: Qualified 1992. Mainly male patients he sees with alcohol problems. Women do better once they decide to go for it.

Dr. Fisher, aged 42, female: Qualified 1985. Psycho-social causes; stress factor important. Recommends Womankind.

Dr. Goodge, aged 47, female Qualified 1981. Huge practice in white working class area. Resigned to relapse, conscientious, prefers not to look for extra problems.

Dr. Halford, aged 47, female Qualified 1984 in Belfast. Tiny practice in very tough area. Dedicated AA enthusiast but 'it is very male.'

Dr. Ilford, aged 50, female Qualified 1977 in Eire. Not a mental illness; get shorter shrift generally than drug addicts but hard to know what's best.

Dr. Jacobs, aged 46, female Qualified 1982. Sympathetic, anxious; feels impotent. She would tell them they were going to die if they didn't stop.

(ii) The treatment centres (only the first three were used by 'Making a Start' respondents)

Pink centre: statutory sector; referrals only; 12 Step medical model (abstinence based); strongly advocates AA. Assessor well qualified but not very experienced; nervous and apologetic.

Green centre: voluntary sector; harm reduction but reputation for advocating AA as best policy; one to one counselling only; person-centred model. Assessor very experienced and confident but did not inspire confidence. Seemed shifty.

Turquoise centre: voluntary sector; neighbourhood project; innovative ideas and open door policy; social model. Assessor very experienced and sympathetic; not very hopeful about future of many clients.

Red centre: voluntary sector; set up by and on behalf of BME community; culturally sensitive but anyone welcome; social model. Assessor very experienced and sympathetic; hopeful and dynamic with strong belief in community involvement.

Blue centre: voluntary sector; new small project based on 'unconditional positive self-regard'; holistic but underfunded; person-centred model.

Assessor very experienced and sympathetic; open-minded about treatment approaches and considerable personal financial and emotional investment in an holistic model.

Orange centre: voluntary sector; neighbourhood project based in Portakabin; mainly drugs and young people; social model. Assessor very experienced and sympathetic Ex-teacher who got on well with teenagers; I also saw a second Assessor there, female, who was also very motivated.

Purple centre: voluntary sector; heavily under control of its Chief Executive; one-to-one counselling and groups; social model but also refers on to Pink centre. Not allowed to meet any assessors; this person no training except in management; very assertive and controlling.

Grey centre: voluntary sector; voluntary sector; neighbourhood project; mainly drugs and young people; social model but also refers on to Pink centre. Assessor very experienced but less sympathetic than most following social model---saw abstinence as ideal.

Indigo centre: voluntary sector; huge new project; person-centred but advocates abstinence and picks and mixes from 12 Step model. Assessor fairly experienced but seemed slightly unsure of what she was doing.

Yellow centre: voluntary sector; very small neighbourhood project with good networking; practical help and advice; social model. Assessor ex-policeman; not a lot of training but fond of youngsters and warm. Friendly approach.

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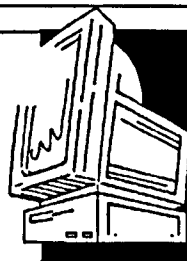
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Labelling Out: The Personal Account of an Ex-Alcoholic Lesbian Feminist

Patsy Staddon

SUMMARY. In this paper, I look at my past alcohol dependency from a political as well as personal perspective. I consider the problems caused in my life and that of other lesbians by alcohol abuse, outdated treatment methods and self-help organizations such as AA, which misrepresent social factors leading to alcohol abuse. I focus on a series of themes: the personal and political; lesbian bar styles; alternative realities; lesbian problem drinking; problems facing lesbians in treatment and engaging with Alcoholics Anonymous; treatment as it often is and treatment as it should be. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]

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KEYWORDS. Alcohol abuse, 'feminist' treatment, lesbian survival

Being drunk . . . it's a brazen refusal to be quiet, well-behaved and ladylike . . . femininity . . . relies on, is defined by, inhibition. (Lawson, 2000)

THE PERSONAL AND THE POLITICAL

I left alcohol abuse behind when I saw my individual distress in the light of wider cultural phenomena. My personal history is also a political one. I am a 60-year-old British lesbian and ex-alcoholic. Without the feminist movement and lesbian and gay civil rights in the 1970s, I would not be alive today. Being out as a lesbian and recovered alcoholic is my declaration of independence as a living human being. Wearing these labels has given me courage, but these labels also limit the ways in which other people perceive me.

When I first discovered alcohol, I found it liberating. There was a new person inside myself—witty, confident and capable. Without alcohol, I felt a nonentity. Before alcohol, I wanted to fly airplanes, explore jungles, express new ideas and change the world. But, those possibilities were closed for a girl in 1950s Britain. During my twenty-eight years of drinking, I could only get glimpses of my real self. I came to believe what I was told: that my drinking problem was a personal, moral weakness. No one, not even myself, thought it could be related to being a woman. When I was admitted to a Twelve Step specialist day treatment center 16 years ago, patients and staff told me I had a disease for which I was not at fault, but that I was responsible for its consequences. By that time, I had been drinking chaotically for many years. My life was out of control. The one simple explanation was that I was an alcoholic. Grateful for the new label, I would have liked to have believed everything they told me.

At the time, I didn't know many people who had given up destructive drinking on their own, although I knew they existed (Hall, Bolsted & Hamblett, 2001; Ragge, 1998; Prochaska et al., 1983). I too had managed to stop drinking on my own. This was during the six weeks before I entered the Twelve Step day center. This was a result of my finding lesbian friends who were neither drinkers nor judgmental about my drinking. They introduced me to women who were interested in feminist issues, and made me feel welcome. For the first time in twenty-eight

years, I could manage without alcohol. I chose to go into treatment because I thought it would help me to stay sober. It was not totally negative, given that I learned some useful techniques for relating to others and understanding myself. The personal space gained by attending such a treatment center was valuable for me. But, the Twelve Step philosophy embedded in the treatment program was difficult for me to accept because I was beginning to question the values of a patriarchal, heterosexist society. In my view, this philosophy upheld such a society and although I was frightened, I was determined to reject it. How could I accept a philosophy which in my view devalued what I loved most in myself, for example, my independence of thought and openness to new ideas?

Gradually, I was able to build a new life without alcohol and wear a different label besides alcoholic. I was a lesbian feminist—a label I embraced. Still, I was desperate to make sense of my life. Why had I become an alcoholic? Could my experiences be explained sociologically through a perspective that focuses on the group as the basic unit of analysis and asks the observer to take a concentrated look at social phenomena (Gusfield, 1996)? Perhaps, I thought. Through a sociological lens and as a lesbian feminist, I saw that I was damaged by growing up with heterosexist expectations about how I should look, act and feel. But, I still found it hard to connect my earlier need to drink to oblivion with my having felt a social misfit for most of my life. Drinking had been a coping mechanism when I felt that I didn't fit in the heterosexist world. Coming out gave me the opportunity to fit into my newly discovered lesbian world.

LESBIAN BARS: LOOKING HEALTHY "BEING COOL"

As lesbians, we have had to build our own environments in a world that is structured by and for heterosexuals, and the gay bar is "where you can meet your friends . . . be who you really are" (Jo, aged 34).¹ In a heterosexist world, with its talk of husbands and families, we may never feel that we fit in. We need places where we can grumble to friends, show off a bit and relax. In lesbian bars, we are not outsiders and can take pleasure in our differences. Style is an expression of this pleasure, as we create new lesbian attire and ways of behaving with fascinating results. Lesbian style is being at home in your body, your clothes and knowing who you are. "It's about being at ease, in your element, knowing what's expected. The ultimate cool is when everyone knows you. If

it's a new place, it's important to know the etiquette . . . how things are done" (Caro, aged 46).

I've noticed that drinking a lot of alcohol in lesbian bars is less common than earlier when I had drinking problems. It's the idea that nowadays we can look good with a soft drink—"It's not so much of a sex symbol thing. It's looking healthy that looks cool" (Caro, aged 46). Where I come from lesbians have to travel a bit to find a lesbian bar—probably further than heterosexuals do to find a straight one. So the car and driving license are precious. "It's the het (sic) girls who go out in gangs getting plastered now. It's sort of respectable for them. But not many of us would have more than a pint . . . during a night out" (Jen, aged 29). Once you know the crowd and local etiquette, you fit in whatever you drink. In a new setting, you may feel a stranger, but less so than you would in a straight bar.

ALTERNATIVE REALITIES (OR, WHOSE BODY IS IT ANYWAY?)

Heavy consumption of alcohol may have a particular relevance for some lesbians, although they may not drink in bars. Drunkenness may be a gateway to sexual and spiritual freedom rather than an unhealthy and deplorable activity. Women, encouraged to be sedate, at least in public, often lack a suitable physical and psychic arena for expressing difference and sheer pleasure (Ettorre, 1992). Other cultures, in particular agrarian ones, often have a different attitude to drunkenness in women (Harvey, 1994). Additionally, a substantial number of women perceive alcohol as an aphrodisiac (Wilsnack, 1984) in a patriarchal society that fears women's power over their own pleasure, and this can also apply to lesbians (Sjoo and Mor, 1987). Western societies lack rituals of spiritual expression which remain a normal part of life in the developing societies (Harvey, 1994). It could be said that exploring the self is a common need, whether this is achieved by prayer, meditation, shooting up, or drumming in the moonlight. Perhaps, we're wrong to assume that drunkenness in women always requires medical attention and control through deviant labels such as "slut" or "whore." It may be an appropriate expression of one's current spiritual and emotional needs (Ettorre, 1997).

LESBIAN PROBLEM DRINKING

Being a member of a minority is stressful and lesbians more than heterosexual women tend to feel the ill effects of a value system based on

heteronormativity. This is especially true for those who have felt unable to live open lives. Homophobia creates depression, a major factor among women who misuse alcohol (Kendler et al., 1993). Lesbians can become unhappy and depressed because of their families' incomprehension of their lesbianism, their inability to share in the lives of heterosexual workmates and their being ignored by health providers and educators. If the lesbian scene is not for them, they may experience loneliness. For them, alcohol can be exciting and pleasurable: "You get what you need from drugs" (respondent quoted in Raine, 2001 p. 23). It would not be surprising if some lesbians abuse alcohol and feel unable to control their alcohol intake. Some research indicates that stigma, alienation, discrimination, and the cultural importance of bars place lesbians more at risk of developing problems with alcohol than heterosexual women (Rule, 2003). Other research supports the idea that lesbian drinking is more problematic than that of heterosexual women. (Jaffe, Clance, Nichols, & Ernschoff, 2000)

PROBLEMS FACING LESBIANS IN ALCOHOL TREATMENT

Chaotic drinking occurs for all women, lesbian or straight, but being a lesbian and drunk may be a less shameful experience. Some lesbians may be scornful of traditionally feminine behaviour such as looking smart and tidy, not being noisy in public and not being seen to be affected by alcohol. This attitude is likely to make it easier to admit to yourself and your friends that you have a problem with alcohol, since you are not perceived as being socially disgraced in the same way. Unfortunately, this advantage is soon cancelled out when you go for treatment. As lesbians, we may be suspicious about the motivation behind what current mental health treatments offer. Where women are concerned, "the clinician . . . will find little in the way of sound empirical guidance" (Braiker, 1984, p. 349). Yet lack of "sound empirical guidance" has not prevented the medical profession from putting its ideas about lesbians into practice. It is less than fifty years since it was considered appropriate in the U.K. to administer electric shock treatment to homosexual patients to "cure" them. The *BMJ* recently, and belatedly, published an apology for this on behalf of the medical profession (MacDonald, 2004).

Lesbians are right to still be concerned about a mental health service that does not make adequate provision for women patients, let alone those of sexual, racial or ethnic minorities. When lesbians seek help for

alcohol issues and are open about their sexuality, the labels “lesbian” and “alcoholic” indicate to clinical staff that they are socially dysfunctional: “Conformity rather than being viewed as a social accomplishment is elevated to the status of ‘health’” (Pearson, 1975, quoted by Kitzinger 1987, p. 33). Perceived as doubly deviant in their substance use and their sexuality (Roberts, 1985; Bridget, 2001), lesbians “are much less likely to present to these services for a variety of reasons . . . [including] . . . fear of their sexuality being pathologized if they do present” (Malley, 2001).

AA: YET ANOTHER ALTERNATIVE REALITY

In my view, these difficulties explain why some lesbians make use of the Alcoholics Anonymous (AA) network. The sense of being in your own secure environment, experienced in lesbian bars, may be felt when mingling in AA “Rooms,” where people with similar life experiences drop their guard. In lesbian bars, lesbians do not need to apologize for who they are. In the same way, people in AA meetings do not need to explain who they are. However, frequently they apologize for their behaviour. In my experience, there is an uneasy relationship between being lesbian, celebrating difference from heteronormativity, and being alcoholic, which sees alcoholism as a “disease.” Possibly, this is easier for lesbians who see themselves as “alcoholics” first and lesbians second. The AA world of acceptance and perpetual dependence may feel strange to lesbians who have already had to fight society in order to accept their sexuality. AA newcomers are termed “babies”: one never grows up and recovers. Instead, one is forever “in recovery.” Members are warned: you will drink if you leave AA. Frequent suicides are often passed off with explanations like “the alcohol got ‘em,” and these serve as warnings to others to be humble, obedient, selfless (Ragge 1998, p. 138). Aware of it or not, AA members buy into a limited respectability and acceptance for themselves by being tagged “alcoholic.” If they embrace AA membership they are able to avoid a sizeable proportion of blame for drinking. Going to AA meetings implies that they are following the AA Twelve Step program. They accept that they have an incurable, lifelong disease, and are doing their best to deal with it by admitting they are powerless over alcohol. They give up their power to “God as we understand him” (Alcoholics Anonymous, 2002) and follow the Steps while remaining abstinent. If they drink, and confess this in AA, this lapse is described as a “slip.” Members are encouraged to “work the Steps” (i.e., to follow the program) rigorously and not to look at specific causes for any slips.

For me, AA is like an open asylum for people who accept that they can't be cured but do their best to behave in ways society requires alcoholics to behave. In one sense this is the opposite of the lesbian and gay world—out and proud. On the other hand, the AA world is similar to our own. Both worlds have obtained a measure of respectability, if not acceptance. Both enrich social diversity and are somewhat visible. But, both are named, owned and controlled by heteronormative society.

TREATMENT AS IT OFTEN IS

In my experience of treatment, I found fear of disapproval to be an important mechanism of social control. Both this fear of disapproval and the additional one of not being understood can affect lesbians in treatment. For example, recently, I interviewed lesbians and bisexual women about their experience of alcohol treatment. With one exception, all reported that because of these fears, they concealed their sexuality throughout treatment. Could this have helped their "recovery"? Are their fears well founded? Perhaps they are, given that staff belittlement of females occurs often in the masculinist environment of alcohol treatment centers (Ettorre, 1997). I found that ridicule, coercion, verbal abuse and contempt were used by psychiatrists, doctors and community psychiatric nurses. In my current research, one lesbian reported that a medical practitioner walked out on a lesbian who admitted her symptoms were linked to heavy alcohol consumption. In another incident, a male psychiatric nurse scorned an important lover relationship for his lesbian patient and reduced her to tears. "I'd never go back there," she said.

The methods employed by AA tend to be used in a number of treatment centers. Overall, the medical model of mental disorder, of which the AA ideology is a part, obscures the social processes that produce and define deviance by locating problems in individual biology (Moncrieff, 1997). A patient's partner may be abusing her or she may have many other problems. However, these problems may be perceived as irrelevant by treatment staff who lack the will to implement change (Bridget, 2001) or consider wider social issues.

TREATMENT AS IT SHOULD BE

In the U.K., some treatment centers have adopted more eclectic and holistic methods, including acupuncture and non-directive counseling,

such as the Community Action Against Alcohol and Drugs (CAAAD) project in Bristol and the Gloucestershire Drugs and Alcohol Services (GDAS) project in Cinderford. In a few areas, such as London's Tower Hamlets, substance misuse and domestic abuse agencies work closely with one another. There is provision of specialist services for lesbians with alcohol problems such as the Drug and Alcohol Service for London and the Calderdale service.

Current treatment recommendations for women seeking help with alcohol issues (Staddon, 2003) show that women do best in women-only groups (Raine, 2001; Thom, 1994) with one-to-one counseling and choice of gender of worker (Cameron, 1995); flexible opening hours (Swan, Farber & Campbell, 2004); when their responsibilities as family caretakers are recognized (Raine, 2001; Plant, 1997); and they are allowed to take their children with them into residential treatment (McCaul, 1998). Of course, these issues apply to all women, lesbian, bisexual or heterosexual.

But, in my experience, lesbians have different treatment needs, although the general belief in the treatment world is that lesbians are the same as everyone else and should be treated the same (Bridget, 1994). Bridget (2001) recommends the establishment of a Lesbian/Gay/Bisexual/Transsexual Addictions Task Group, which would conduct assessment of needs and then establish services which are friendly to Lesbian/Gay/Bisexual/Transsexual people. It would involve a dedicated person to work with members of this group with alcohol/drugs problems. She envisaged "coming off addictions" groups for Lesbian/Gay/Bisexual/Transsexual people.

In conclusion, while endorsing the above recommendations, I should like to see a greater awareness of the positive contribution use of alcohol may have in the lives of lesbians. Those who would like to help in the treatment field should free themselves of outdated methods which seek to control rather than empower lesbians. If "getting well" implies adopting a set of prohibitive instructions for day-to-day living then "getting well" may be an unwanted disablement. We must have a wider view on lesbians' alcohol use and abuse if we want to effect changes. Otherwise, for many lesbian alcoholics the bottom of a bottle might still be the safest place to be.

NOTE

1. The quotations used in this section come from a small pilot study that I ran in April 2004, to obtain the views of lesbians in bars in a large city in the southwest of England.

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