# How lesbians recognize and respond to alcohol problems: A theoretical model of problematization

To determine how one specific at-risk population problematizes alcohol use and responds to alcohol-related difficulties, findings from an ethnographic interview study of lesbians recovering from alcohol problems were used to develop a theoretical model of problematization. Problematization consists of two phases: recognition and response. Recognition involves problem indicators varying by type (cumulative vs immediate) and source (personal vs environmental). Movement from recognition to response is hindered by perceptual and environmental constraints. Response consists of interrelated processes of construction, interaction, action, and validation. On the basis of validation, problems are reconstructed and new problems are recognized as the cycle continues. Key words: alcohol, alcohol problem, ethnography, help-seeking, lesbian, recovery, theory

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ALCOHOL PROBLEMS are estimated to be three times more prevalent for lesbians than for women in general.[1-5] Lesbians themselves identify alcohol problems as a major health risk for their communities.[6-11] Alcohol use patterns and alcohol problems are manifested and interpreted differently in various subcultural groups.[12-15] Therefore, an adequate understanding of lesbians' alcohol problems requires culturally specific information about how members of this particular group view alcohol use, recognize problem drinking, and seek help. In other words, clinical interventions need to reflect some comprehension of the process by

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which at-risk populations, such as lesbians, "problematize" their use of alcohol.

Assisting people with alcohol problems has been difficult for health care providers for several reasons. Those outside the substance abuse field generally hold negative and fatalistic attitudes toward "alcoholics," making them reluctant to identify alcohol problems in their clients, even when symptoms are glaring.[16-18] At the other extreme, providers in the substance abuse field have developed confrontational techniques for pressuring individuals into alcohol treatment, whether or not these individuals acknowledge having such problems.[19-22] Neither of these approaches is based on knowledge about how individuals from specific high-risk groups come to recognize that their use of alcohol is a problem for them and that it warrants help-seeking.

The purposes of this article are to offer a theoretical model depicting how lesbians problematize their alcohol use, provide empirical evidence about lesbians' alcohol recovery to support concepts and propositions in the model, and discuss implications of the model for nursing theory, practice, and research. The problematization model was developed from findings of a critical ethnographic interview study of lesbians' alcohol recovery experiences, using a research-to-theory process as outlined by Meleis.[23] *Problematization* refers to the processes through which individuals discover that something is seriously wrong, link this awareness to their use of alcohol, and attempt to address their concern through some responsive action.

## BACKGROUND

Alcohol problems are not confined to the concept of "alcoholism," but encompass myriad physiologic, psychosocial, cultural, and political concerns related to alcohol use and its effects on personal, relational, and community health.[24-26] There are a number of gaps in the current knowledgebase about women's recognition and response to alcohol problems. Although there is evidence that subjective indicators of alcohol problems are different for women as compared to men,[27,28] extant research on women's alcohol problems does not generally explore women's perceptions of their difficulties with alcohol. Rather, investigators focus on the effects of excessive drinking on women's biological and functional roles as mothers and caretakers.[29]

There are barriers to help-seeking for women. Providers and significant others are less likely to recognize alcohol problems in women as compared to men.[17,18,30] Because alcohol problems are especially stigmatizing for women,[18,31-33] they often "masquerade" as other health and social concerns. This contributes to "inappropriate" referrals[34,35] and cross addiction to prescription drugs.[36] When women face additional stigmatizing factors related to race, sexual orientation, and class, recognizing alcohol problems may become an overwhelming proposition.[8]

Lesbians have a unique historicocultural relationship to alcohol.[37] The alcohol-centered urban lesbian subculture that flourished from the 1950s through the 1970s[38-41] has in the past two decades moved away from substance use to become more recovery-oriented.[9,37,42-44] Many lesbians have become abstainers and lesbian events in urban areas are often "clean and sober," that is, alcohol- and drug-free. This change has raised interpersonal and political tensions among lesbians and serves as an example of how the definition of alcohol problems reflects gender, race, class, and sexual orientational

conflicts in society.[25,42,45,46] The current mainstream trend is away from alcohol use,[47] and lesbians seem to be at the cutting edge of this trend. Learning from this at-risk population how alcohol use is problematized may therefore provide insight about prevention, early detection, and recovery in other at-risk populations.

The study as a whole explored experiences of lesbians recovering from alcohol problems, including how they came to recognize these problems, what actions they took in response, and their views of recovery over time. Reported elsewhere are findings about images of recovery,[25] interactions with health care providers,[16] and experiences in Alcoholics Anonymous (AA).[48] The model offered here was derived from findings about problematization in the transition to recovery. Transition to recovery was conceptualized as the sequence of events each woman identified as the turning point, the beginning of her healing from alcohol problems. Problematization is of greater clinical significance at the transition to recovery than at later periods in the recovery process, because at this crucial turning point women at risk have less awareness of and access to resources and may be struggling in isolation.

The specific research questions through which problematization was explored were: How do lesbians whose use of alcohol is a problem come to recognize this? What criteria shape their definitions of alcohol problems? What are the barriers to problem recognition? What are the help-seeking strategies undertaken by lesbian problem drinkers in the initial recovery transition? How do these women's views of their alcohol problems change over time as recovery proceeds?

## METHODOLOGY

### Setting and sample

Thirty-five lesbians in the San Francisco Bay area participated in the ethnographic interview study[49] during 1990 and 1991. They were recruited through community-based purposive sampling.[50–52] Initial participants who responded to flyers posted at lesbian gathering places and mailed to lesbian organizations referred others through snowball sampling. Inclusion criteria required participants to be at least 21 years old, self-identified as lesbian, self-identified as having an alcohol problem, and abstinent from alcohol and other drugs for at least 1 year. There was no requirement that they identify as "alcoholic" or "addicted," nor as AA members.

The sample was multiethnic, as follows: 24 (68%) Euro-American, 6 (17%) African American, 3 (9%) Latina, 1 (3%) Asian Pacific, and 1 (3%) Native American. Ages of participants ranged from 24 to 54; the mean was 37. All participants had completed high school; 60% held college degrees. Incomes were low relative to educational levels; the mean of $27,000 fell below the 1990 average annual pay of $30,325 for the San Francisco area.[53] Thirty-four percent were employed in health-related occupations; the others were employed in a variety of occupations. About half were in committed partnerships with other women, and 8 (23%) had children.

All of the women reported problems with alcohol. Thirty-two (91%) were polydrug abusers, having additional problems with cocaine, marijuana, amphetamines, LSD, heroin, or laxatives. Sixteen (46%) reported that they had three or more addictive problems, including difficulties with drugs, food,

"codependency," sexual compulsivity, and/or compulsive spending. Twenty-six (74%) reported having had a problem-drinking parent. Twenty-two (63%) reported having experienced some form of childhood abuse; 16 (46%) specifically reported a history of childhood sexual abuse. Generally, the women in this study had maintained long-term abstinence from alcohol and drugs. The mean length of recovery from alcohol problems was 6 years, ranging from 1 to 25. Twenty-six (74%) were actively involved in AA.

## Procedure

Potential participants contacted the investigator by telephone, the study was explained in detail, and interview times were negotiated. Informed verbal consent was given by each participant. Confidentiality and anonymity were strictly observed throughout the study. Researcher-conducted interviews took place in participants' homes or lesbian-frequented settings such as women's coffeehouses. Each interview lasted about 2 hours and was audiotaped. In the interviews, open-ended questions[54] were used, followed by occasional probes to ascertain chronologic order of events and clarification of details. Examples of interview questions were: How did you come to recognize that alcohol was a problem for you? What did you do when you saw that something was wrong? What influenced you in your decisions about the problem? Were there people in your life who were urging you to seek help? What happened when you sought help? Did your view of the problem change over time? All procedures were approved by the Committee on Human Research, University of California, San Francisco.

## Data analysis

The interview data comprised lesbians' accounts of their problematization of and recovery from difficulties with alcohol. Given the storied nature of the accounts, narrative analysis[55,56] techniques were used. Narrative (ie, the telling of stories) is a common form of everyday communication, and thus provides naturalistic data about human conditions.[57-60] In this study, narrative was defined as the stories a woman told about her difficulties related to alcohol and how she made the transition to recovery.

Each woman's narrative of her transition to recovery was identified and abbreviated into a summary by the use of adequate paraphrasing, a technique for isolating the operative action and essential elements of narratives.[61,62] Verbatim quotations were preserved to articulate in each woman's words what specific difficulties brought her into recovery. The chronologic order of events was ascertained and a visual diagram of relevant events was then made for each participant account. Contextual cues in women's stories were used to temporally locate elements of the problematization process. A concerted effort was made to separate a participant's contemporaneous awareness and definitions of problems from her retrospective interpretations. In a few instances, it was not possible to distinguish the two perspectives.

Participants' strategies in response to identified problems were documented, including communicating with friends and partners, contacting health care providers, entering substance abuse treatment, seeking individual and group psychotherapy, and attending AA or other 12-Step programs. Identification and naming of problems,

help-seeking, and periods of abstinence were thus differentiated in the summaries and diagrams, providing a complex picture of the recovery transition for each woman.

The problematization summaries and diagrams were compared and contrasted across participants, generating a model of problematization. Dominant themes and common patterns uncovered in the narrative analysis were translated into concepts and propositions, and related in a provisional theoretical model of problematization. Criteria of rigor for feminist qualitative research[63] were used to verify the scientific adequacy of analytic processes and theory generation.

## FINDINGS

An introductory overview and visual representation of the model (refer to Fig 1) are provided to orient the reader to the basic concepts and processes of problematization. Detailed descriptions and excerpts from the data are presented in subsequent sections to support the concepts and propositions of the model.

### Overview of the model

Problematization is an ongoing process in which persons recognize and respond to difficulties they associate with their alcohol use. There are two major phases of problematization in the transition to recovery: *recognition* and *response*. Recognition is the process by which individuals consciously acknowledge and name alcohol-related difficulties, based on their awareness of indicators of these difficulties. Indicators of problems are distinguishable according to two major *parameters*: the *type*, cumulative vs immediate, and their *source*, person

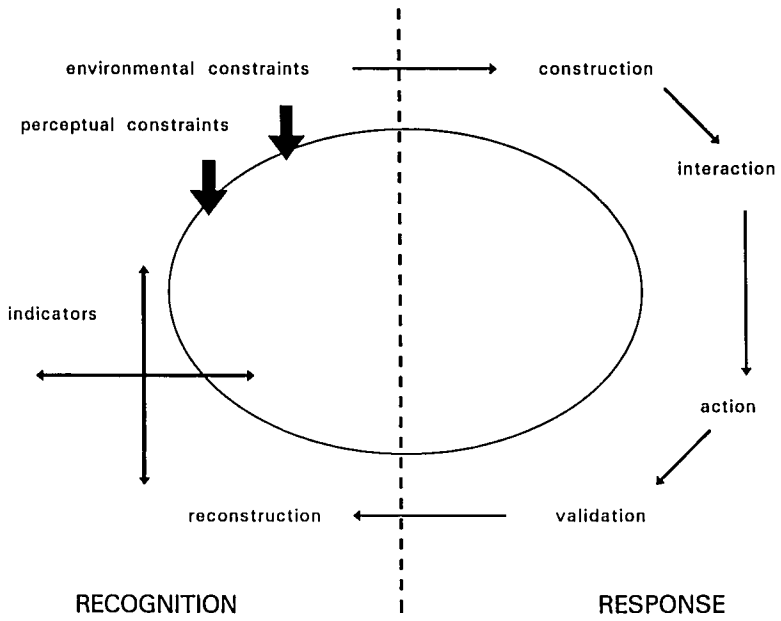


**Fig 1.** Problemization model: Addressing alcohol-related difficulties.

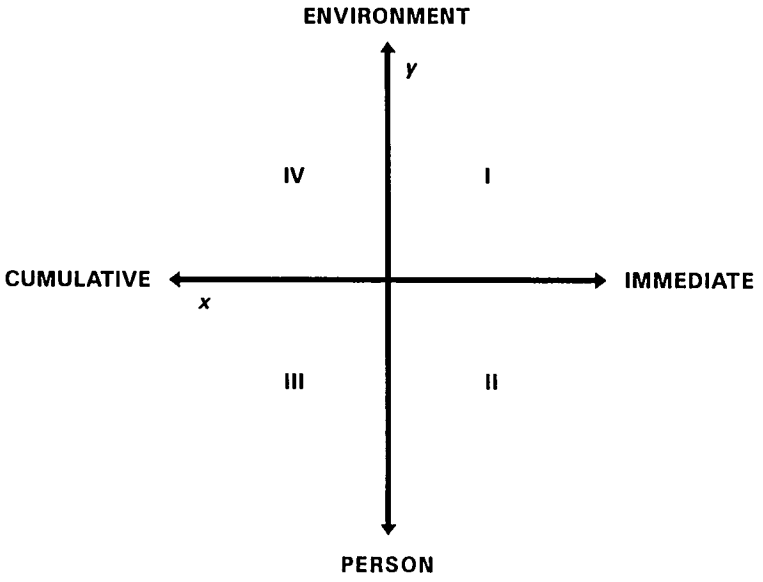


**Fig 2.** Parameters of alcohol-related problem indicators.

vs environment. The movement from recognition to response is governed by the presence of *perceptual* and *environmental constraints*. When these constraints are sufficiently overcome or removed, the response phase ensues. Response comprises a series of interrelated processes of *construction, interaction, action, validation,* and often subsequent *reconstruction* of the problem. The problematization process begins again as problems are reconstructed or new problems are discovered.

## CONCEPTS OF THE MODEL

### Recognition phase

#### *Parameters of problem indicators*

Recognition that a problem existed depended on awareness of its indicators. Indicators were defined as specific signs that "something is wrong." In addition to the more conventional signs of problem drinking such as blackouts, hangovers, frequent illness, and drunk driving arrests, indicators typically cited by participants included disturbed self-image, depression and suicidality, social isolation, unemployment, unsafe sexual behavior, relationship conflicts, internalized homophobia, internalized racism, and aftereffects of trauma. Recognition varied according to two major parameters in each woman's account. These were the *type* of indicators: cumulative vs immediate, and the *source* of indicators: person vs environment, as depicted in Fig 2. The type of indicators reflected a temporal dimension to problem recognition: Did it occur rapidly or slowly? Was it prompted by a crisis, or was it the result of a gradually increasing awareness? The source of indicators reflected whether the impetus to recognize a problem was primarily internal or external. These parameters are depicted as intersecting axes,

so that each account of transition to recovery may be conceptually plotted relative to these two continua, being roughly located in one of the four quadrants.

For some participants, indicators were immediate and environmental (quadrant I). Examples of this pattern included receiving an ultimatum from one's partner or employer, being arrested for selling drugs, being battered in a relationship, becoming homeless, and having a serious accident:

I suddenly found myself homeless, real burned out, and only 22. I had been working in the sex industry to support the kind of drug habit I had, and I was in a relationship with someone very abusive. It just became a crisis. So I finally quit (drinking and using).

I was getting a lot of negative comments from friends about how much I drank and used cocaine. Finally the police arrived and I was busted for selling marijuana. I had gone through thousands of dollars freebasing, and I didn't have a dime.

For others there were immediate, personal signals that indicated a problem existed (quadrant II). Examples of this pattern included crises related to suicidality, major depression, severe anxiety, or illness. Some women experienced the sudden emergence of traumatic memories that precipitated recognition of a problem:

I was drinking way too much, and using cocaine. I did a paper in school on incest, and suddenly I realized I was writing about me. I had these flashbacks about my father and my brothers molesting me. I had this sudden, severe anxiety and I became suicidal. I went to an emergency room because I was losing it completely.

A relatively common pattern seen in these accounts was characterized by cumulative, personal problem indicators (quadrant III). These participants referred to long-term patterns of compulsive behaviors, inadequate work performance, internalized homophobia or racism, compromised values, chronic depression, low self-esteem, social isolation, and chronic health conditions. Some expressed guilt and shame about having engaged in sexual activities that were unwanted or unacceptable to them. Despite these negative self-perceptions, these women did not receive feedback indicating that a problem existed from others in their environments:

There were hangovers, headaches, and actually a whole number of little markers along the way, markers that I worked around so as not to really see that alcohol was a major organizing factor in my life. But eventually I recognized how sick I was for so long, and though I was still working, I knew I wasn't doing a good job.

I got to the point where I just wanted to be dead. I was always feeling nauseated and afraid. I was never acceptable to myself.

If I would forget something, or get a parking ticket, or have a bad interaction with someone, it would incapacitate me emotionally. . . . I felt I wasn't a good mother . . . I always had lots of friends, but I just didn't let them know what I was feeling. Inside I couldn't stand what I had become, even though no one was criticizing any of these things about me.

Some accounts of problem recognition reflected indicators that were predominantly cumulative and environmental (quadrant IV). Participants showing this pattern often referred to experiences in their families of origin. Specifically, participants talked about histories of abandonment, parental alcohol problems, dysfunctional family dynamics, secrecy, rejection, parental criti-

cism, childhood sexual abuse, verbal abuse, and battering. Some participants believed that they had genetically inherited their tendency to overuse alcohol, but more often they emphasized the cumulative effects of their family environment as the basis for their alcohol-related problems:

I am an adult child of an alcoholic (ACA) and because of the dysfunctional family I grew up in, I didn't learn what you do when you have feelings. I first started using food for that. Then the alcohol and drugs were a kind of substitute for the food. It was a way of being numb . . . and when I was coming out as a lesbian I know I drank more heavily, because my family had cut me off.

Many of the women of color cited impoverished environmental conditions while growing up as cumulative indicators of the problem:

Where I grew up there were lots of liquor outlets. They were on every corner. And I saw a lot of violence, people being beaten, shot at. I internalized all that as fear. I drank to cover that fear. Finally when I went into (alcohol) treatment, I realized I had a real problem with my color. I didn't want to be one of those people I had seen as a child.

In a few cases, a turning point was precipitated by a combination of cumulative and immediate, personal and environmental indicators (point of axes intersection):

I had quietly worried about my drinking for years. And I was depressed a lot. And my sister had nagged me about it. But something had to hit me between the eyes. I woke up one morning and went into the living room, and there was a stranger on the couch. And I didn't remember who this person was or what was going on. All I remember was having gone to the bar the night before. So it all came together in my mind that this was a real serious problem.

### *Perceptual constraints*

Participants spoke of periods before their transition to recovery in which their recognition of problem indicators was thwarted by internal blocks. These internal blocks were termed *perceptual constraints* and defined as ideas or feelings that obscured individuals' awareness of alcohol-related problems. Typical perceptual constraints were myths about alcohol use and addiction, belief patterns learned in families of origin, misinformation, faulty stereotypes about persons who have alcohol problems, affective blocks to recognizing problems, and dissociative aftereffects of trauma. These perceptions could supersede awareness of alcohol problems, preventing women from fully comprehending their depth and seriousness. Sometimes participants referred to these constraints as "denial." Below are examples of how perceptual constraints narrowed individuals' awareness of various indicators:

I did not want to accept that it was an emotional, a psychologic problem. . . . I couldn't accept the complexity of it. I wanted it to be only a physical addiction that I could fix by medical means.

Being a dope fiend was hip, slick, and cool. But being an alcoholic, a drunk, was like the people who sleep in doorways and pee on themselves. That wasn't me.

I told my partner that just because I drink in the morning doesn't mean I'm an alcoholic. I drink because I have a hangover. I just get thirsty and drink and it cures it.

I didn't want to think of myself as needing help. . . . I had never had a DWI [driving while intoxicated]. Never been to jail. I mean I had heard all these stories. And they all got filtered through

this image of myself as the responsible citizen. A lesbian businesswoman.

There wasn't much information about alcohol, or what I did read didn't make any sense. It didn't relate to anything I had felt. The symptoms I heard about were so drastic. They didn't apply to me at all.

### *Environmental constraints*

There were other factors, related to external conditions, that stood in the way of problem recognition. These *environmental constraints* were defined as social, political, or economic conditions that limited individuals' capacities or options for action in response to alcohol problems. Common environmental constraints were racism and homophobia in the health care system, lack of social support, few alcohol-free social contexts for lesbians, lack of health insurance coverage, scarcity of women-oriented treatment options, lengthy waiting lists for treatment and psychotherapy, excessive cost of services, lack of child care, restricted social service entitlements, and the influence of significant others who opposed help-seeking:

If you had the demeaning job I had, you would stay anesthetized, too. I couldn't see my drinking as a problem until I got out of that place.

My girlfriend feared that if I got treatment for my problem, her drinking was going to be criticized as well. She kept saying, "Just cut down. Don't open yourself up to these therapists and doctors who can't deal with lesbians." I really wanted the security of being with her, so I convinced myself that my drinking wasn't the problem at all.

I didn't know what my options were, financially. I couldn't see that there was anything out there to fix whatever I had. I thought "This isn't a problem, it's just my life."

Being a dealer on campus was a power base and also a way to bring in cash . . . a bargaining tool in relating to these rich white girls. It's not like I couldn't see my problems—I just wouldn't see them as long as I had these social dynamics to deal with.

Who was going to sit with me and help me face this problem? I had no therapist, no job, no insurance. I mean health problems are for those who have access to help. Otherwise it is easier to just go on drinking and drugging.

Problematization was thus hampered by barriers outside the self that prevented action. Women were not truly free to acknowledge and name a problem until and unless the appropriate resources and support were actually available to them. In other words, problems without visible solutions could not be recognized, a phenomenon not accounted for in the conventional concept of "denial."

## Response phase

### *Construction*

When individuals gained new knowledge and insight or reached a point of distress that overrode their perceptual constraints, they were able to respond to a recognized problem. Relief from environmental constraints (ie, a change in the social, political, or economic conditions that blocked their ability to recognize problem indicators) was also necessary in many cases before response could occur. The initial part of the response phase was *construction*. Construction was defined as having two dimensions: process, the identification of an alcohol-related problem; and product, the name of the problem

and the explanation an individual used to understand and frame it. Women constructed problems based on indicators, including how these indicators affected their relationships to themselves and others. Problem constructions were bounded by cultural expectations, health knowledge, and availability of resources. Some excerpts from the data illustrate:

I got verbally abusive with my lover and was very confrontive when I drank. And she said if I didn't deal with my anger, the relationship was over. . . . I went for help, but at that time I thought I was a rage-oholic.

I had lost my children. I mean, you lose your keys, but not your children. And I was crying and I couldn't stop. To me it was a nervous breakdown.

I set fire to a car and got thrown out of the only place that was still accepting me as a human being despite my drinking. I believed I was mentally ill.

It was a bad cycle. Turn the trick, buy the dope, then needing the dope to have sex with men. My problem was all of that, the whole cycle.

I was sick all the time. I had money problems. That's what I sought help for.

### *Interaction*

After constructing the problem, that is, naming and explaining it to themselves, participants talked about it with others, usually significant others, peers, or service providers. *Interaction* was defined as communication with others concerning the constructed problem. Interactions in which alcohol problems were named and externalized were often emotionally charged as participants encountered others' criticism, challenge, support, or self-disclosure:

I had started to talk about my drinking to my girlfriend. One day she came home and said there was this queer alcoholism treatment program, and if I didn't check it out, I could check out of the relationship with her. I was blown away.

I called my sister, and she told me she had been in AA for years. I was relieved, but angry she hadn't confronted me earlier, because she could see my problem.

Participants' descriptions of these interactions revealed selectivity in seeking others out, sensitivity to their responses, troubled awareness of divergent opinions regarding the nature of the problem, and an enduring memory of their impressions of the exchanges, whether positive or negative:

At work I told the employee assistance person that I couldn't concentrate or remember things. So we did this screening test about alcoholism. I thought, "I know that. I have that. Shit, this is terrible." I found six or seven points that applied to myself.

I was depressed, suicidal, and drinking heavily. I must have said 50 times to my therapist, "I'm worried about my drinking." And she'd say, "Let's talk about how you feel about yourself." Or, "Well, I drink too. How much is too much?"

I told this outreach worker I had no place to stay and he started saying every day, "We got a bed for you—we are saving a spot for you at the detox." He kept repeating it. I didn't know why he cared. And finally I was too tired to go on, so I went into the detox.

The woman in my office who used to get high with me got into AA. My therapist had suggested I could be an addict. Right after that hap-

pened I asked this woman at work if she wanted to go to lunch. She said, "Well actually I am going to an AA meeting. Do you want to come along?" And there was a few seconds and I said, "Yes." And that is how it happened.

### *Action*

Based on their construction of an alcohol-related problem and interactions with others, participants took action. *Action* was defined as strategic behavior to address the constructed problem. Action was closely aligned with the problem construction, as shown in the following quotations:

To me the thing was that I was addicted to alcohol. Period. My therapist said, "Go to the doctor and get some Antabuse, and that will ensure that you don't have a relapse." So I took that for three months.

I went to an outpatient treatment program because my grades were failing. That was how I saw the problem. I needed to get help but I also needed to continue with my classes.

I really hated what I did, what I had become. I would fight, hit people, throw things. I was out of control. When I couldn't stand it anymore, I drove my motorcycle into the back of a bus. That did it.

I thought my panic attacks were coming back, and it scared me so much that I got back into therapy. . . . I also began to look at what I wanted, where I was going. . . . I got into school. I got into a group of women who really supported me. I began doing things for me.

Examples from the data also illustrate how interaction influenced the action taken:

I went to this colleague of mine who worked in a clinic, and talked with him about my drinking. And he recommended outpatient therapy. So I found myself a psychologist who had experience working with these problems and I did my first course of therapy with her.

There was this nurse, a lesbian nurse as I later found out. She must have seen my denial about my lesbianism all over me because she said, "I don't think you'll get sober until you get honest with yourself, about who you are." I freaked out and avoided her. I got to the point of wanting to kill myself rather than face being a lesbian. I was drunk, and had razor blades in my hands. And I called this nurse instead.

Participants acted in a variety of ways on the problems they had recognized. Some participants quietly began to decrease or stop their use of alcohol and other drugs on their own. Abstaining from alcohol was not always the initial action, and rarely was it the only action taken. Some participants went to hospital emergency departments, contacted therapists, entered treatment programs, and joined 12-Step groups. For more than half of the participants, going to AA meetings was their primary initial action. Several others attended AA in conjunction with other actions. Actions to solve alcohol-related problems did not always involve help-seeking in the traditional sense. For instance, severing negative relationships, starting school, changing jobs, reading about alcohol problems, and attempting suicide were described as actions taken in response to alcohol-related problems.

### *Validation*

Participants judged the accuracy of their problem constructions and the effectiveness of their actions through *validation*. Validation had two major aspects: confirmation of the problem construction and affirmation of the self as culturally and experientially distinct. Common validation tasks included checking whether others agreed with one's

problem construction, determining if actions were consonant with one's self-image and cultural expectations, and attending to whether problem-oriented interactions with others reinforced or undermined one's sense of value as a person. The following are descriptions of how participants felt validated in the response phase of the problematization process:

I finally got to talk to a therapist who knew about alcoholism, and she talked to me like a human being, not like I was just an addict who was always dishonest, you know. When she said, "You need treatment," I gave in and said I'd try it.

Just hearing the alcohol screening questions and knowing they were all applicable to me made me think I was finally being understood by someone.

When I hit the AA meeting I was in tears because I realized I really belonged there. A guy spoke about growing up in a really restricted Catholic family. And what he talked about was how I felt even though I'm not Catholic. I could really identify. . . . I was getting it more and more that I had a serious drinking problem.

I thought a prerequisite for being in this alcohol treatment program was being blue-eyed and blonde. . . . I wanted to be the brown one who was different and all that. But what they had to say spoke fully for me in terms of drugs and alcohol and their consequences, what was happening for me. And I knew then that I had to give it up.

The following are descriptions of how participants felt invalidated. That is, their constructions of the problem were discounted or they were made to feel unacceptable owing to race, age, class, gender, or sexual orientation:

I stopped drinking and my friends must have gotten the idea I was making a statement about them. They argued with me that I didn't really need to quit, just cut down. I started to feel isolated because as a lesbian sometimes you don't have that many friends. They made me feel I had suddenly become someone else, an outsider.

When I was in treatment if you didn't have nice clothes or cigarettes you were a big zero. I had to have these possessions, to feel OK as a person first, before I could get involved in the group sessions.

When I first got to AA, I didn't feel comfortable at all. Everybody was in their 30s and 40s and up. People would say to me, "How can you be an alcoholic if you are so young?" I wasn't 21 yet. So I decided I didn't need the meetings and drank for a few more years.

I didn't want to go for help anywhere where there were men. How in the world could that ever be supportive for me? It just wasn't relevant to who I was as a woman. I still feel that way.

When I talked about being a person of color, the other women and the counselors would say that was another trap I could get myself into, thinking I was unique or different, and then I would end up using drugs. There was no validation.

Two particular validation issues that were salient for lesbians in this study were the degree of belongingness they experienced in AA and the sense of loss in recovery due to their separation from the lesbian bar subculture. A few rejected AA after their initial contact, feeling invalidated on the basis of gender, sexual orientation, ethnicity, race, religious beliefs, or disability. Some others continued in AA, feeling marginalized but still searching for a group or meeting that felt validating to them. About half of the participants experienced an immediate sense of belonging in AA, particularly in lesbian AA meetings. Many women re-

ported that in their transition to recovery they feared that separation from the alcohol-oriented lesbian social scene would be invalidating of their identities as lesbians. The lesbian recovery subculture in the San Francisco area was somewhat unique, however, in that it offered validating social alternatives for lesbians, such as clean and sober women's dances and coffeehouses.

### *Reconstruction*

Based on the degree of validation participants perceived in their experiences of interaction and action to address alcohol-related problems, participants altered their problem constructions and revised their responses to these problems accordingly. *Reconstruction* was defined as making changes in the construction of an alcohol problem, that is, reconceptualizing and adjusting strategies for action:

> AA says: "This is the program and this is the way it is to be done." To me that is not life. Life has many more aspects. . . . I stopped going there much because I don't want to be stuffed into some mold. I stopped seeing myself as a hopeless "alcoholic."

> I thought I was your basic garden-variety drunk. But when I started therapy, these things came up about my family, you know, my parents drank and there was violence. I started to fit my drinking with a whole larger picture of what happens when you grow up in a family that is "disabled."

> I had thought of myself as a codependent, because I was always looking out for everyone but me. But other lesbians in 12-Step programs pointed out that I was using alcohol and cocaine and that this would kill me before codependency would. So I started AA and went to a treatment program.

As problems were reconstructed, the recognition phase of problematization was begun again, and the parameters of problem indicators, their type and source, often changed. New perceptual and environmental constraints were faced as a new response phase ensued. Over time, nearly all of the participants experienced reconstruction and entered the cycle of problem recognition again. This occurred in one of two ways: a change in their understanding of the identified problem, or the emerging awareness of new problems.

Many participants described a series of problems that either arose or were discovered months or years into recovery. For example, at transition to recovery one woman sought help for a conflict with her partner. A counselor suspected substance abuse and referred her to AA. She identified with women she met there and decided that alcohol use was her primary problem. A year into alcohol recovery she began to notice a pattern of compulsive overeating, and joined Overeaters Anonymous (OA). Three years later a family crisis triggered buried memories of childhood trauma for which she sought individual and group psychotherapy. This pattern of constant reconstruction of alcohol-related problems was seen in nearly half of the accounts. Among the remaining participants, the rate of reconstruction was slower and overall fewer problems were identified in recovery.

The data revealed that the transition to recovery was not a once-and-for-all turning point, followed by a steadily developing recovery process. Instead, the problematization process typically unfolded as a series of difficulties associated with their alcohol use that participants focused upon in a cyclical fashion. Individuals varied in the num-

bers of problems they identified after their transition to recovery, based on influence of significant others, degree of 12-Step program involvement, length of time in recovery, and presence of a history of childhood trauma. Each cycle of the problematization process began with the identification of a problem and ended when a period of mastery over that problem ensued or the problem was reconceptualized.

## PROPOSITIONS OF THE MODEL

To summarize the problematization model as depicted in Fig 1, there are two phases of problematization: recognition and response. Recognition is based on problem indicators, the parameters of which are type, cumulative vs immediate, and source, person vs environment. Movement from recognition to response is inhibited by perceptual and environmental constraints. When these constraints are removed or overcome, the response phase can begin. Response consists of dynamic processes of construction, interaction, action, validation, and reconstruction.

The dynamic interrelationships among the concepts in this model are summarized in the following propositions:

1. Individual recognition of alcohol problems is embedded within a larger process of problematizing related difficulties, and varies according to experience, culture, and environmental contingencies.
2. Problem recognition is based on awareness that something is wrong, indicators of which vary along two basic parameters: type (cumulative-immediate) and source (person-environment).
3. Problem recognition is opposed by both perceptual and environmental constraints, which must be sufficiently overcome or removed to allow a response to occur.
4. When constraints are sufficiently overcome or removed, construction of a problem occurs, that is, the naming and explaining of the difficulty to oneself.
5. Response to the problem involves interaction with others and help-seeking actions through which individuals search for validation of the problem they have constructed.
6. Validation further requires that persons feel affirmed in their gender, ethnic/racial, sexual orientational, and experiential uniqueness, in order to maintain their problem construction and continue a course of action.
7. Based upon perceptions of validation in their actions and interactions, individuals either reinforce their problem construction or reconstruct the problem and renegotiate their responses to it.
8. Over time, reconstruction occurs as new alcohol-related difficulties are identified, indicators of which can be viewed in relation to the parameters of type and source.
9. Reconstruction may also take the form of reconceptualizing the initial problem, as the cycle of recognition and response repeats itself in recovery.

## DISCUSSION

A fundamental finding of this study was that alcohol-related problematization was an ongoing process, encompassing an array of potential difficulties that were associated

with alcohol use and recovery. Viewing problematization as an ongoing process is consonant with the everyday life experiences that the study was designed to tap. The proposed model offers insight and a degree of predictability about problematization of alcohol use for lesbians and perhaps for other at-risk populations. It proposes that individuals vary in terms of the parameters of problem recognition, the type and source of problem indicators. These parameters have clinical and empirical significance in terms of immediate and long-term needs for intervention. For example, the woman whose problem is defined by a crisis in her environment may need concrete, instrumental intervention such as housing or protection from violence. One for whom problem indicators are more cumulatively and personally defined may benefit most from in-depth psychotherapy. Survivors of incest, a cumulative environmentally-defined problem, may need individual and group psychotherapy specifically designed to address posttraumatic issues. A woman who has recognized and responded to an immediate personal cue, such as illness, may initially need acute health care, followed by intervention to increase insight about the negative role of alcohol in exacerbating such illness. Providers should aim toward establishing trusting alliances that flexibly provide appropriate resources and validating forms of support that match clients' perspectives about their own situations.

In the model, constraints to problem recognition are viewed not only as perceptual, but also as environmental. The availability, cost, cultural appropriateness, and safety of visible solutions are factors influencing whether and how problems are named and acted upon. This stands in contrast to extant theory and practice based on the notion of personal "denial" of alcohol problems, which does not acknowledge environmental contingencies faced by clients. A comprehensive approach that minimizes stigma for at-risk women, provides a context of safety and openness, and makes alternatives visible and economically accessible will most likely decrease resistance to recognizing and responding to alcohol problems.

In the process of interacting and acting in response to a constructed problem, one seeks validation, not only in terms of the problem at hand, but as a legitimate person with unique experiences and important boundaries that must be respected. Racial, class, gender, cultural, and sexual orientation identities are relevant because invalidation on any of these grounds can affect the problematization process and its relationship to the quality of recovery experienced. Interventions must therefore be designed and evaluated with a wider set of criteria in mind beyond their effectiveness in promoting abstinence from alcohol and drugs.

More research is needed to develop specific interventions based on knowledge of how particular at-risk groups recognize and respond to alcohol problems.[25] For instance, many participants in this study were already self-critical of their alcohol use long before they actually stopped drinking. Others had stopped drinking or using drugs prior to or without identifying themselves as "addicts" or "alcoholics." Many focused on problems other than alcohol for long periods before recognizing the role of alcohol in these difficulties. These findings challenge the notion that "recovery" cannot begin while individuals are still drinking or using drugs. They also challenge models of treatment

that equate problematization with abstinence and identification as "alcoholic."[64-66] With reconstruction as integral to the process of problematization, recovery might be better viewed as the resolving of a series of problems that share some unifying features. Longitudinal studies will reveal whether this holds over the life span.

Further research testing the model will establish its relevance and transferability across populations at risk. What seems clear from this study, however, is that claims of a singular sequence of events characterizing the problematization of alcohol use and subsequent recovery should be questioned. Nevertheless, there may be basic processes of recognition and response, like those outlined in this theory, that can help clinicians, researchers, and policy makers better understand the needs of specific groups at risk for alcohol problems. Broadening our view of constraints to help-seeking, and considering the diversity of problems that may be constructed and reconstructed, a variety of interventions can be offered within a trustworthy therapeutic process, preserving the client's options and, over time, addressing each of the client's needs.

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