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Work in Progress

The Relational Model of Women's Psychological Development: Implications for Substance Abuse

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Work in Progress

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Abstract

This paper describes the basic tenets of the Stone Center's Relational model of women's development, and considers the model's implications for the etiology, treatment, recovery, and prevention of substance abuse in women. Attention is given also to the Relational model's implications for (a) understanding the benefits and limitations of Alcoholics Anonymous for women and (b) evaluating current concepts of "codependency."

Over the past two decades, new conceptualizations of women's psychological development have been evolving which emphasize the importance and centrality of relationships in women's lives (Belenky et al., 1986; Gilligan, 1982; Jordan et al., 1991; Miller, 1976). This relational perspective has sought to describe development from women's perspective, using language and concepts derived from women's experience. Since women in this culture have been the "carriers" of certain aspects of the total human experience, specifically carrying responsibility for the care and maintenance of relationships, this model attempts to articulate the strengths as well as the problems arising for women from this relational orientation. Theorists and clinicians at the Stone Center at Wellesley College have been developing this theoretical perspective as a base for creating relational models of healing and empowerment for women.

Traditional theories of psychology have described development as the pathway from childlike dependence to mature independence, emphasizing the importance of a self-sufficient, clearly differentiated, autonomous self. These models have more likely been representative of men's experience. The concepts of separation, individuation, and self-development characterize the models as a basis for clinical practice and treatment. In contrast, the relational model views development as growth with and toward connection, positing healthy connection with other persons as the means and goal of psychological development.

In this chapter, we will present an overview of the relational model and explore its application to the understanding, treatment, and prevention of substance abuse for women. We have found this model to be extremely useful in conceptualizing the contexts and meanings of substance abuse in women's lives and particularly helpful in suggesting new treatment models. It is also a useful frame for evaluating what is beneficial and what may be

harmful to women in traditional treatment programs and models of recovery.

The Stone Center Relational Model

The Stone Center model was built on the early work of Jean Baker Miller who published *Toward a New Psychology of Women* in 1976. Miller proposed that women's psychological development differed in fundamental ways from the traditional model of development derived from men's experience. She suggested that for women the primary motivation throughout life is toward establishing a basic sense of connection to others. She wrote that women feel a sense of self and self-worth when their actions arise out of connection with others and lead back into, not away from, connections. The experience of psychological connection is based on empathy and mutuality in relationships. Connection is experienced as a feeling of mutual presence and joining in a relational process. The "relationship" develops a new, unique, and always changing existence that can be described, experienced, and nurtured.

Women's relational yearnings and the centrality of relationship for women's psychological health has often been pathologized when viewed through the lens of traditional, "self-" centered models. Descriptions of women's dependency, passivity, caretaking fixations, and (most recently) codependency reflect this misunderstanding and distortion of women's relational orientation.

The Stone Center relational model describes the attributes and qualities of relationships that foster growth and healthy development. From the perspective of this model, healthy connections with other human beings are mutual, creative, energy-releasing, and empowering for all participants, and are fundamental to women's psychological well-being. Psychological problems or so-called pathologies can be traced to disconnections or violations within relationships, arising at personal/familial as well as at the socio-cultural level.

Mutuality is a fundamental aspect of healthy, growth-promoting relationships, and is more than equality, reciprocity, and intimacy. It suggests a way of being-in-relation which includes the whole person. This has been called a relational attitude, orientation, or stance. Each person can represent her feelings, thoughts, and perceptions in the relationship and can *move with* and *be moved by* the feelings, thoughts, and perceptions of the other. Mutual influence, mutual impact, and mutual responsiveness characterize such relationships, which can be described as forward *moving* and dynamic processes. The possibility of

change and movement is always present.

When a relationship moves from disconnection to mutual connection, each person feels a greater sense of personal authenticity as well as a sense of "knowing" or "seeing" the other. This experience of mutual empathy requires that each person have the capacity for empathic connecting. Empathy is a complex, highly developed ability to join with another at a cognitive and affective level without losing connection with one's own experience. Openness to growth through empathic joining within the relational process is fundamental to mutual relationships.

Mutual empowerment describes a process of relational interaction where each person grows in psychological strength or power. This has been described as "power-with-others," as distinguished from "power-over" others, which has been the traditional structure of relationships, where one person (or group of persons) has been dominant and the other subordinate, or one person (or group of persons) has been assigned the task of fostering the psychological development of others. Historically, women have been assigned the task of fostering the psychological development of others, including men and children.

Miller (1986) has described five psychological outcomes of healthy growth-fostering relationships for all participants. These are: (1) increased zest and vitality, (2) empowerment to act, (3) knowledge of self and other, (4) self-worth, and (5) a desire for more connection.

The relational perspective does not idealize women or relationships. The remainder of this paper discusses ways in which women's motives for connection can lead them toward substances and substance in a culture where they have been given the primary responsibility for relationship, yet where our important relationships, institutions, and political systems are frequently far from mutually empathic and mutually empowering.

Substance Use in and as Relationship

From the perspective of the Stone Center model, women frequently begin to use substances in ways that initially seem to be in the service of making or maintaining connections, and to try to feel connected, energized, loved, or loving when that is not the whole truth of their experience (Surrey, 1991). Women often use substances to deal with hurt and pain in their relationships and also to try to provide for others (especially children) a safe and loving relational context. Women also turn to drugs in the context of relationships with drug-abusing partners—to feel

joined or connected through the use of drugs. Women may actually use mind-altering substances to try to stay psychologically connected with someone who is using drugs.

Further, women may begin to use substances to maintain relationships, often to try to alter themselves to fit the relationships available. Miller (1990) has described this basic relational paradox—when a woman cannot move a relationship towards mutuality, she begins to change herself to maintain the relationship. Stiver (1990) has written about children of “dysfunctional” families who frequently turn to substances to alter themselves to adapt to the disconnections within the family, thus giving the illusion of being in relationship when one is not or is only partially in relationship.

Miller (1990) has described the outcomes of disconnections, that is, nonmutual or abusive relationships, which she terms a “depressive spiral.” These are: diminished zest or vitality, disempowerment, unclarity or confusion, diminished self-worth, and a turning away from relationships. This depressive spiral lays a foundation for the use of substances to provide what relationships are not providing, for example, energy, a sense of agency and control, relief from confusion and negative feelings, a sense of self-worth, and the energy to work on relationships.

This turning toward the abuse of substances in the service of maintaining relationships, dealing with pain in relationships, or providing for others has tragic consequences, as the abuse of substances leads to diminished opportunities for practice and growth in real connection. When such relational development is constricted, there develops a vicious circle of increased isolation which in turn leads to further use of substances. In Alcoholics Anonymous this is described as the “progressive disease of isolation.” Theologian Dorothy Soelle (1978) described this alienation or disconnection from relationships as spiritual death or “death by bread alone,” biological life without that which is most truly human—real connectedness to others.

One way of viewing addiction is as a kind of relationship. The addicted woman is in a relationship with alcohol, other drugs, food, sex, money, another person, that is characterized by obsession, compulsion, non-mutuality, and an imbalance of power. It is a kind of love relationship in which the object of addiction becomes the focus of a woman’s life. Addicted women frequently use relational imagery to describe their drug use, for example: “Alcohol was my true love, I never went to bed without Jack Daniels; “ “My most

passionate affair was with cocaine, “ or “Food was my Mother, my Friend, whom I turned to for solace and comfort, who was always there for me when I needed it.”

The drug of choice seems at first a good friend, bringing with it a positive, soothing experience and feelings of comfort or euphoria. Over time, however, the drug becomes “necessary for the addict’s peace of mind or continued existence” (Byington, 1993, p. 4). It becomes the organizing principle of the addict’s life, causing her life to become more constricted and externally focused. The friend then becomes lethal and toxic. “I turned to Valium, but then Valium turned on me.” Such imagery is frequently heard in women describing the progression of their addiction. We could speak of addiction as a contraction of connection and recovery as an expansion of connection (Covington & Beckett, 1988).

If we contrast this with what we know about healthy relationships, we see that addictive relationships lack growth-producing characteristics. In the Stone Center model, healthy relationships are characterized by a mutuality of involvement: both parties move with and are moved by the thoughts, feelings, and perceptions of the other.

In addiction, however, there is no mutuality of involvement; a woman gives nothing of her true self to the object of her addiction. Paradoxically, she ends up giving up herself, but not in any mutually beneficial way. According to Diane Byington (1993):

Addiction is considered to have occurred when a relationship with a drug is pursued and believed by the individual to be essential in spite of continuing negative consequences to her. In addiction, the relationship with the drug is at least as important to the individual as relationships with people. (p. 5)

Another aspect of addiction as relationship is the experience the addict has when recovery begins – when the relationship is over. When the addict gives up the object of her addiction, she experiences grief and loss. As with the ending of any relationship, there is a myriad of intense feelings. The grieving experience is generally characterized by anger, loss, and a drive to fill the void.

Relational Underpinnings of Substance Abuse

The Stone Center model draws attention to aspects of the familial and cultural relational context that lay the groundwork for the development of substance

abuse in women. The particular drug (legal or illegal) or coping behavior a woman chooses is multiply determined by genetics; physiological makeup; familial history; ethnic, race, or class factors; availability; chance; and many other factors. We appreciate that once a person is addicted, all attention needs to be paid to the withdrawal and recovery from that particular substance. However, it is crucial to address the relational and cultural contexts in which the substance develop and the implications for psychotherapy, prevention, and treatment programs.

At least five patterns of relational disconnection may foster substance abuse and increase risks of relapse in women: (1) nonmutual relationships, (2) effects of isolation and shaming, (3) limiting relational images, (4) abuse, violation, and systemic violence, and (5) distortion of sexuality.

Nonmutual Relationships

Rather than focusing on women's "pathological" or problematic orientation toward caretaking or maintenance of relationships, we believe the focus should be on the failures of mutuality in relationships as the source of problems. Women's desire to make and then to maintain connection becomes problematic when it is one-sided or distorted and not mutual. Over time, the impact of nonmutuality leads to confusion, distorted relational patterns such as compulsive caretaking, or retreat from real relationships. The primary relationships in our culture have not been rooted in the search for mutuality. In particular, the male-female relationship has been historically rooted in a power-over, nonmutual model. Further, the idealized images of "good mothers" have left mothers struggling to try to fit themselves to such unrealistic images without a relational context of mutuality for themselves. The media and culture promote the use of drugs or substances to solve all problems, including relationship problems such as these.

Effects of Isolation and "Shaming"

Many writers have described American culture as very alienated. Community, familial, and religious structures are breaking down and life-style demands and lack of support for child care lead to increasing isolation of individuals and families, with little time or opportunity for community building. In fact, women who are at high risk for drug abuse are frequently socially isolated—single parents, unemployed, or recently separated, divorced, or widowed (Finkelstein, 1993; Finkelstein & Derman, 1991; Wilsnack, Wilsnack et al., 1986).

From a clinical perspective, psychological isolation

occurs when there is some failure of the relational context to validate and respond to a woman's experience or her attempts at connection. Miller (1990) has described the state of "condemned isolation" where a woman feels isolated in her important relationships, and feels that she is the problem; that she is condemned to be isolated, with no possibility of changing this situation. In our clinical experience, this terrible state of shame and condemned isolation is highly correlated with drug use, as drugs become a way of coping with feelings that are seemingly beyond the scope of what is human and could possibly be brought into connection with any good outcome. Such feelings may come to feel increasingly monstrous, crazy, evil, or dangerous.

Women are highly prone to isolation when "shaming" occurs. Jordan and colleagues (1991) have described the tremendous degree of cultural shaming around women's yearnings for connection, sexuality, and emotionality. Women are prone to develop a sense of personal deficiency—"something is wrong with me"—thus taking responsibility for problematic relationships and seeking all kinds of ways to change or alter themselves. In nonmutual relationships, women often become the "carriers" of the disavowed feelings of others, thus carrying the pain, anger, or fear of those with whom they are connected.

Limiting Relational Images

The culture, as well as individual families, often promotes distorted or limiting images of what it is to be healthy, worthwhile, physically attractive, or successful. Psychological theories both reflect and shape cultural images of what is healthy. Women internalize images of what one must look like, act like, or even feel like to be worthy of connection.

Women often use drugs to manipulate their bodies and selves into these problematic images of self in relationship. An old Jefferson Airplane song, "One pill makes you larger and one pill makes you small," describes such changes. Women often use substances to alter mood, intensity, body size, or emotional tone to fit such cultural images. We regulate ourselves when we feel too big (too angry, sexual, passionate, powerful, needy) or too small (too fearful, childlike, dependent, or vulnerable). Poly-drug use is often related to such relational images—different drugs may be used to achieve different changes—and is a frequent characteristic of addicted women. Self-help book authors and medical professionals are frequently complicit in this enterprise of encouraging women to change themselves to fit cultural images. According to recent studies, medical doctors prescribe

approximately 60% of psychoactive drugs, 70% of antidepressants, and 80% of amphetamines to women (Galbraith, 1991). In order to alter the self in this way, a woman's sensitivity to body, feelings, and deep levels of knowing must be cut off. This alienation from self is supported by a pervasive cultural disrespect for the body, especially real adult women's bodies (e.g., Kilbourne, 1991).

Abuse, Violation, and Systemic Violence

Another source of relational disconnection that contributes to the development of substance abuse, addiction, and relapse in women is the experience of abuse and violence.

It is estimated that four million American women are victims of domestic violence each year (see *Nation's Health*, 1994). According to one estimate (Kilpatrick et al., 1992), approximately 639,500 rapes occurred among American women aged 18 and older in 1992. By age 18, 38% of all female children in this country have been sexually abused, in comparison to 7% of male children (Russell, 1984). With the increased acknowledgment of childhood sexual abuse of boys and girls, the gender differences are often minimized or overlooked. While both male and female children are at risk for abuse, females are at much greater risk than males for interpersonal violence throughout their adolescence and adult lives.

While all women are at risk of being abused, the risk of childhood abuse is higher for women raised in an alcoholic family, and the risk of being abused as an adult is higher for women who have an alcoholic male partner. In one study (Faller, 1988), 67% of sexually aggressive acts against children and 39% of such acts against women had involved alcohol use. Other studies estimate that between 70% and 80% of husbands who batter their wives use alcohol (Coleman & Strauss, 1983; Roberts, 1988), and that 35% of incest perpetrators are heavy drinkers (Crewsden, 1988).

Women who have been abused are in turn at greater risk to abuse alcohol and other drugs. One national study found that 70% of battered women were frequent drinkers (Roberts, 1988). A study of alcoholic women and matched nonalcoholic women (Covington & Kohen, 1984) revealed that 74% of the alcoholic women had experienced sexual abuse, 52% had experienced physical abuse and 72% had experienced emotional abuse. By comparison, 50% of the nonalcoholic subjects reported sexual abuse, 34% physical abuse, and 44% emotional abuse. Moreover, the alcoholic women were found to have been abused sexually, physically and emotionally by more perpetrators, more frequently and for longer periods

of time than their nonalcoholic counterparts. The alcoholic women also reported more incidents of incest and rape.

Women recovering from childhood molestation, rape or battering are teaching us about the impact of such trauma on relational development. When early parental relationships are abusive, violating, and dangerous, all future relationships are impacted. The very high rate of substance abuse and addiction among survivors of abuse and violence suggests the likelihood of turning to substance abuse when healthy relationships are unavailable and when faith or trust in the possibility of growth in human connection is impaired. The use of alcohol and other drugs has become a way for women to deal with the emotional pain resulting from earlier abuse by someone close to them, someone they trusted.

Personal violence toward women must be understood in the larger societal context of systemic violence and oppression. We would include in the factors contributing to substance abuse the impact of racism, classism, heterosexism, and ageism, as these intersect with sexism for women.

Distortion of Sexuality

Sexuality is at the core of the relational self (Covington, 1991; Jordan, 1987; Schnarch, 1991). Since female sexuality has historically been defined by men, and women have been silenced about their own experience, few women feel totally comfortable with this aspect of themselves.

Linking sexuality to sexual abuse, Wilsnack and associates (1991) found sexual dysfunction as the best single predictor of women's chronic problems with alcohol over a five-year study period. Given the association between substance abuse and sexual abuse, a woman's sexual dysfunction may be connected to early childhood abuse and/or to current domestic abuse. Women who have been abused often use alcohol or drugs in a self-medicating way, in order to numb the emotional pain of the abuse experience. This can create a spiraling relationship where many women, believing that alcohol and drugs reduce sexual inhibition and facilitate sexual pleasure, drink or use substances to alleviate the sexual difficulties they are experiencing. But alcohol and drugs, which decrease physiological sexual arousal and interfere with orgasm in women, only exacerbate the problem. Thus substance abuse can become both a cause and a consequence of sexual dysfunction (Covington, 1986, 1993).

Addiction is often defined as a physical, emotional, social, and spiritual disease. Our definition

of sexual health is the integration of all these aspects of self; therefore, addiction can have an impact on every aspect of sexuality. Physically, alcohol and drugs can affect hormonal cycles and deaden the senses, thus diminishing the pleasure of the physical sexual experience. They can also increase the likelihood of sexual dysfunction.

Emotionally, several areas can be impacted. As discussed earlier, many women use alcohol and drugs in order to establish and maintain relationships. Sexuality, relationship, and mood-altering drugs become interconnected at an early age. For example, girls are often given their first alcohol and drugs by someone with whom they are emotionally involved, whereas boys are more likely to have their first alcohol/drug experience with their peers and to buy the alcohol themselves. Girls, therefore, often are in relationships with their "supplier." Adolescent and adult women who are in relationships with chemically dependent men often begin to drink and use drugs in order to join their male partner in his experiences.

Emotional connection can also be impaired by dissociation, a common defense mechanism used by people who have been abused. The dissociative process often begins as a result of the abuse experience, then later becomes part of the ongoing defense structure. Alcohol and drugs play a role in that they can recreate the dissociative experience. Dissociation has a very serious impact on relationships and on one's capacity for intimacy, because, when a person is dissociated, she is essentially "not there"—not present in the relationship nor capable of deep connection. Women who have been sexually abused often dissociate during sexual encounters.

Socially, one need only look to liquor commercials to see the strong association between sex and alcohol. Through its advertising, the liquor and beer industry essentially promises more romance, more fun, and more sex in your life if you drink a particular brand. Studies of high school students have shown that girls very often have their first sexual experience and their first drinking experience at the same time. Not surprisingly, alcohol is the favorite drug of choice for seduction purposes, and many people in our society still see alcohol as an aphrodisiac, despite physiological evidence to the contrary (Kilbourne, 1991).

Implications for Treatment

Alcoholics Anonymous as a Recovery Model for Women

As discussed above, relational disconnections may propel women into substance abuse. Conversely, the creation of positive, mutually enhancing connections may be exceptionally useful as an approach for helping women to break out of patterns of substance abuse. This principle is illustrated by the widespread use of mutual-help groups to recover from drug and alcohol abuse. Women are joining *Alcoholics Anonymous* and other 12-Step programs in increasing numbers (Alcoholics Anonymous World Services, 1990). Many 12-Step groups today have a majority of women members (for example, Overeaters Anonymous, Al-Anon, Codependents Anonymous).

Strengths

Self-help or, more accurately, mutual-help groups have made many important contributions to the recovery field for women, as they provide a growth-fostering relational context. They offer their members social support through the creation of a caring community. People come together voluntarily to discuss a common problem and to share their experiences, feelings and coping techniques. Face-to-face interactions are stressed and members are taught to transform negative self-images into positive ones.

Mutual-help groups reflect the relational model in their design. Their structure is nonauthoritarian and nonlinear. Mutuality is emphasized. There are no supervisors, no professionally trained staff, who wield either authority or knowledge. Nor do such programs rely on outsiders for financial support or legitimacy. The sharing that occurs in mutual-help groups is not dependent on hierarchy or status. In this way, it is very different from the dominant culture. It is also in contrast to the power differential that is usually inherent in the therapist-client relationship. The value of participation in a program like *Alcoholics Anonymous* (AA) is twofold: one benefits by giving as well as by receiving. A woman is valued both for what she shares for herself and for what she offers to others.

A major advantage of mutual-help groups for women is that they are free and, in most urban communities, readily available throughout most parts of the day. It is in this respect that they are most unlike conventional problem-solving techniques, where help is provided only on occasion, almost exclusively as a response to a specific request from a particular individual.

Twelve-Step programs of recovery are based on a

relational psychology and spirituality that are very congruent with the Stone Center relational model. The core relational movement from isolation to connection is basic to recovery. Asking for help, sharing one's experience, strength and hope, speaking authentically, accepting vulnerability, and being there for others—the typical ingredients of a 12-Step meeting—are basic steps in building connection.

Reaching out for connection at the moment when the momentum of the past is drawing one into isolation and into the addictive process is the core relational movement of healing. The AA slogan, "You're as sick as you are secret," makes this point. The program teaches that sharing and bearing pain together is the only possible alternative to drug or alcohol use. This emphasis on the necessity of relationship and mutuality to work constructively with emotions is also congruent with Stone Center theory, and thus, in the authors' experience, highly beneficial for women.

Another relational benefit of mutual-help programs is the alcohol- and drug-free social activities they offer, and the opportunities to make new friends who are similarly committed to living free of addiction.

Of great value within the 12-Step program are special groups for women only. Women attending same-sex groups are freed from the pressure to remain attractive to males while revealing feelings of shame or remorse about some previous or current behavior or thought. They are more easily able to talk about childhood experiences of oppression or abuse by males. And they are able to discuss their current lives more openly, talking about their lovers, husbands and families to other women who will not find fault with their interpretations or reality. In these settings women's shared relational strengths greatly foster mutual empowerment.

Another important contribution made by 12-Step programs is their holistic vision of health. The physical, emotional and spiritual aspects of addiction are all seen as important. This challenges clinicians to pay attention to all aspects of a woman's recovery and to become comfortable integrating spirituality into the therapeutic setting, as well as working with the physical and sociopolitical levels.

Limitations

For all its contributions, the 12-Step model also has some limitations. Part of the current wave of criticism of *Alcoholics Anonymous* and similar programs (e.g., Rieff, 1991) stems from their insistence on the locus of pathology within the individual and individual change as the solution to life's problems.

In AA, alcoholism and other problems that may be related to one's drinking are not viewed from a social context. AA ideology does not encourage attention to the relational, cultural, or sociopolitical factors that foster substance abuse. Little attention is paid to the fact that, especially for women, the larger context contributes to the abuse of substances, and an awareness of these factors is essential to women in recovery.

AA is not geared to address specific life issues that contribute to a woman's substance abuse. For example, issues of rape, battering, or incest often prevent a woman from achieving comfortable or long-lasting sobriety. As much as they may threaten her attempts at sobriety, these problems are unlikely to find resolution at AA meetings. Repeated relapse can be the signal that she requires more than a self-help or mutual-help program can offer; she needs the help and care of a trained professional who will work with her—with concurrent use of the recovery group—to prevent repeated returns to drinking.

Another limitation of *Alcoholics Anonymous* and other recovery programs is their use of outdated language. Much of the AA literature was written 20 to 50 years ago and is overtly sexist in its content and connotations. Despite use of the gender-neutral phrase "Higher Power," the 12 Steps of AA repeatedly mention God as a masculine entity. Although people are encouraged to define God in their own terms, some argue that the very concept of God or Higher Power is patriarchal and therefore sexist. Many women have difficulty accepting the patriarchal theology and language of the programs, and we as professionals need some background in feminist theology (Plaskow & Christ, 1989) to help clients deal with these contradictions.

One might argue that AA meetings are only places to find out about alcoholism and recovery from it, and that they need not be "politically correct." But it is also true that, for people to "hear" things, they must be said in appropriate ways using non-offensive language.

Newer groups, such as *Women for Sobriety* and *Save Our Selves*, have gone out of their way to correct this language bias. And, to their credit, some traditional 12-Step groups have taken it upon themselves to review their literature substituting gender-neutral pronouns. There is also a movement seeking to have AA's "Big Book" rewritten in its entirety to become nonsexist. Although the possibility of this occurring any time soon is rather remote, there is certainly evidence of a recognition that some of the program's materials are limited in their appeal.

Another aspect of 12-Step language that has proved troublesome for many people is the word “powerless,” which appears in the very first Step. AA members are called upon to admit that they are powerless over alcohol. Critics of AA say that to urge women to admit their powerlessness over alcohol—and, by elaboration, their powerlessness in the program, over people, places and things—is to set them up as victims who are discouraged from taking control over their own lives (see Berenson, 1991). These critics are missing one of the enduring paradoxes of AA that perhaps contributes to its success in many people’s lives: that admitting where you are powerless in life actually empowers you. It allows you to identify areas of your life in which you do have power and control. For example, an alcoholic woman in an abusive relationship may admit to her powerlessness over drinking and, once sober, realize that she does wield important power in other areas of her life. She doesn’t have the power to change the behavior of her abuser, but she may find she has the power to leave him.

When people get to AA, it is because they are in fact powerless to bring about desired feelings or to accomplish their goals without using alcohol. Removing alcohol from their lives with an admission of powerlessness over it is not the passivity and immobilization that typically characterizes a victim. Rather, it is taking a positive action to realistically assess one’s own capacity for change and potential growth.

Codependence

Another useful illustration of the limitations of the 12-Step model is the concept of codependence. Women are defining themselves as “codependent” in increasing numbers and seeking treatment in 12-Step programs or specialized treatment centers.

Originally, the term referred to people whose lives were significantly affected by living with chemically dependent people, especially “over-functioning” for the addicted family member or being obsessed with trying to control him or her. To help people focus on their own lives and issues, therapists coined the term “codependency” to define a disease or syndrome inherent in the person him- or herself which significantly affects all of that person’s relationships. The disease is believed to be related to growing up in a “dysfunctional” family, or experiencing abuse or less-than-nurturing parenting as a child (Mellody et al., 1989). Characteristics of codependence vary according to each writer. Symptoms include “caretaking, low self-worth, obsession, controlling behavior, denial, external referencing, weak boundaries, lack of trust,

anger, and sexual problems” (Beattie, 1987).

One concern about the codependency movement is that the syndrome’s definition is so inclusive, yet so vague, that nearly everyone in the culture fits the criteria. Another is that, since women in the culture are *expected* to be the primary caretakers of others and of relationships, codependency appears to be highly gender-linked. Rather than affirming and revisioning women’s potential strength in relationships, and validating their motive for connection, the codependency concept tends to pathologize their relational orientation, thus putting women in a cultural double bind.

The codependent label reflects an intrapsychic paradigm, that the disease is in the individual, not in the relationship. For women, taking sole responsibility for problems in a relationship does not enhance psychological development. As we have discussed, the Stone Center paradigm seeks to locate problems in the movement of the relationship and to study the impact of non-mutual, abusive or disconnected relationships.

Current applications of the concept of codependency are for the most part highly individualistic and separate from any sociocultural or political framework. This leaves no room for studying how women are socialized in patriarchal culture or for any power-analysis of relationships. The effects of trauma, abuse, and power-over relationships could produce many of the symptoms of codependency, which could in extreme forms represent aspects of posttraumatic stress disorder. Further, this model incorrectly suggests that full recovery is possible in an interpersonal and societal system that promotes and continuously creates such symptomatic responses.

Recovery from codependency is often seen as requiring a strengthening of self, for example, solidifying boundaries, focusing on one’s own needs, putting oneself first, and esteeming oneself from within. All of these have value as long as the importance of the relational context is also acknowledged, with healthy mutual connection regarded as both the healing energy and the goal of recovery—as both the means and the end.

Specialized Treatment Programs for Women

In general, existing substance abuse treatment programs are not gender sensitive. Some of the limitations of *Alcoholics Anonymous* become magnified in traditional psychiatric settings where the structures are hierarchical and nonmutual. Such a medical model is antithetical to the relational model. Women’s unique patterns of substance abuse and psychological recovery have not been the basis for the design of

these programs.

Beth Glover Reed (1987, p. 152) explains that the reasons addiction recovery programs have been designed primarily for men are complex:

Many of the reasons are related to the social acceptability of various drugs at different times in history, and the types of social and personal costs that society wants to reduce or control. Others are related to stereotypic views of women and men, as well as general knowledge about women within the social sciences and human services. The researchers, theorists and policy makers are predominantly men, as were the majority of those within drug dependence programs (e.g., Henderson & Anderson, 1982). In research studies, women were either ignored, combined with men for data analysis, assumed to be the opposite of the men, or their results were so puzzling that they were called unpredictable and, thus, not interpreted.

Reed (1987, p. 151) also states that developing effective treatment services for women requires more than merely adding new components or staff training to existing programs:

The primary barriers to the provision of more women-oriented services are theoretical, administrative and structural, and also involve policy and funding decisions. Assumptions about drug dependence, some key policy areas and funding patterns, as well as the structures, practices and culture of existing treatment organizations must be examined.

Not only do we lack treatment programs designed especially for women, but we have treatment programs designed especially for men, and women are expected to fit into them. Moreover, within the traditional programs, we have a lack of gender-specific groups. This is an important point because studies have found markedly different patterns of small-group interaction between men and women in same-gender and mixed-gender groups.

One study for example, looked at men in group together, women in group together, and men and women in group together (Aries, 1976). Findings indicate that, when men and women group together, the women help facilitate the men's talking about their experiences more, and women share their experiences and feelings less than when they're in an all-female group.

Studies of mixed-gender alcoholic groups have produced similar results. Priyadarsini (1986) found

that compared to alcoholic women, alcoholic men more frequently took the initiative in introducing topics for discussion, choosing the topics and issues discussed, and regulating the level of affectivity exhibited.

Nicolina Fedele and Elizabeth Harrington (1990) concluded that the connection forged by women's group interactions have an essential role in women's treatment: "For where women gather together, there exists a potentially rich relational context to foster growth" (p. 10). In mixed-gender settings, it is also essential to provide specialized groups for women on such topics as trauma, body image, sexuality, and empowerment strategies.

Whenever possible, specialized treatment programs for women are the preferred treatment settings. Programs built on an appreciation and application of the relational model are extremely effective and powerful, based on the authors' clinical experience and observation. Programs are most successful when the relational model provides the underlying treatment philosophy, shapes the dynamics of staff and patient relationships, and is reflected in the patterns of staff interactions and decision making.

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