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Proceedings

**The Research Symposium on
Alcohol and Other Drug Problem Prevention
Among Lesbians and Gay Men**

Prepared for:

California Department of Alcohol and Drug Programs
1700 K Street
Sacramento, California 95814

Prepared by Jill Kelly, Consultant for:

EMT Group, Inc.
3090 Fite Circle, Suite 201
Sacramento, California 95827

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Among Lesbians and Gay Men

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This Research Symposium was held concurrently with, though independently of, the 14th National Lesbian and Gay Health Conference, 10th Annual AIDS/HIV Forum, sponsored by the National Lesbian and Gay Health Foundation and the George Washington University Medical Center. Some of the presenters appeared at both events. We wish to acknowledge the organizers of the Conference for bringing together a wide variety of experts in gay and lesbian health, including a number of researchers and practitioners in alcohol and other drug prevention and treatment.

Disclaimer

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The Research Symposium on Alcohol and Other Drug Problem Prevention Among Lesbians and Gay Men

Introduction

Lesbians, gay men, and bisexual men and women, estimated to include six to ten percent of the general population, comprise a substantial minority population in this country.¹ Societal attitudes towards these sexual minorities are a volatile mixture of religious disapproval, pathologizing, and criminalization, colliding head-on with a growing support for gay political rights and a belief that homosexuality is a normal variation of human sexuality.

It is a common belief that gay men and lesbians abuse alcohol and other drugs (AOD) in substantially greater proportions than the heterosexual population. The stereotype of the typical gay man or lesbian, for example, is exemplified by the phrase, "alienated, isolated and drunk," echoing the title of an early study of homosexual AOD use. Yet, because of a lack of funding to study large cross-sectional samples of lesbians and gay men, these early studies focused on easily accessible yet biased samples such as bar patrons, patients at mental health clinics, and prisoners. Thus while prevailing wisdom assumes a higher incidence of alcoholism among lesbians and gay men, little hard evidence has been available to substantiate this claim.

Since the 1980's, the HIV epidemic has brought the general health-related behavior of gay and bisexual men, including their AOD use, under closer scrutiny. Public health officials needed to determine the extent of intravenous drug use (IVDU) among gay men, since IVDU is one of the primary modes of HIV transmission. As knowledge about the virus grew, researchers and medical practitioners identified the use of alcohol and other non-injected drugs as co-factors in compromising the immune system, as well as in impairing judgment about unsafe sex practices.

To develop effective HIV prevention strategies, it became important to learn more about AOD use patterns among gay and bisexual men. In recent years, several large cross-sectional studies have been produced which examined the use of AOD by both gay men and, in some cases, lesbians.

Much less is known about the AOD use of lesbians and bisexual women as compared to gay and bisexual men. This dearth of knowledge parallels the traditional lack of research on the AOD use of women in general. The current focus of women's AOD use is on perinatal effects, and while many lesbians do get pregnant, this focus clearly excludes the majority of lesbians. What is certain is that services for lesbians are virtually non-existent, and there are serious questions about whether mainstream treatment programs adequately address their specific needs.

Background of this Symposium

In 1990, EMT Associates, a consulting and research firm in Sacramento, California, was asked to conduct a needs assessment to determine the AOD problems of the San Francisco gay, lesbian and bisexual communities. The request came from the Lesbian and Gay Substance Abuse Planning Group, or LAGSAP, a network of local AOD service providers. Funding was obtained from the San Francisco Community Substance Abuse Services.

The study included three components:

- A review of the existing literature of gay and lesbian AOD use;
- A survey of service providers; and
- Anonymous questionnaires distributed throughout the San Francisco gay, lesbian and bisexual communities. The survey was published in a local gay newspaper, and also was distributed through organizations, businesses, and services which focus on the lesbians, gays and bisexuals. A strong effort was made to widen distribution beyond those already identified with an AOD problem, and to reach people of color.

A total of 734 questionnaires were returned, 318 from lesbians and bisexual women, and 416 from gay and bisexual men. The questionnaire gathered data on current AOD use patterns, problem indicators, and basic demographic information.

A two volume report was produced. EMT became interested in further exploring research in this area, and approached the California State Department of Alcohol and Drug Programs Office of Prevention (DADP) to sponsor a research symposium on the subject. DADP agreed, and the result was a day-long symposium held on July 8, 1992, and these written proceedings.

Purpose and Structure of the Symposium

The purpose of the Symposium was to provide a forum for researchers, policy makers, and prevention practitioners to come together for dialog about the AOD problems and needs of lesbians, gay men and bisexual men and women. Throughout the day, four researchers and seven prevention practitioners presented information about their studies and programs, with considerable time for questions, answers and dialog. An audience of 50 people, including state and county level policy makers, prevention and treatment service providers, and advocates for specific populations listened to the presentations and engaged in dialog.

The following questions guided the discussion:

- What is the most recent evidence concerning lesbian, gay and bisexual AOD use patterns?
- What are important correlates of AOD use that appear specific to these populations, and to sub-populations within the groups?
- How are prevention programs addressing the needs of their target populations?
- How can current research assist in the design of better prevention programs, and how can practitioners help researchers design more relevant research?

Throughout the day all four of these questions were addressed simultaneously through the interplay of presentations and dialog. As a result, important themes emerged which may not have appeared without the active participation of people with different perspectives. While unable to cover the breadth of the topic, the Symposium was a successful first step in creating dialog among people who rarely have the chance to share their views on this important topic.

Format of the *Proceedings*

These Proceedings attempt to reproduce the key contributions of that day, and include the following:

- ◆ Symposium agenda;
- ◆ Overview of important themes which emerged from the day, and biographies of researchers;
- ◆ Summaries of the presentations of the prevention practitioners;
- ◆ Conclusion;
- ◆ List of presenters;
- ◆ List of participants; and
- ◆ Papers presented by the four researchers.

RESEARCH SYMPOSIUM AGENDA • July 8, 1992

8:45 - 9:00 Welcome and Introduction

- ♦ Jim Kooler, Director, Office of Prevention Department of Alcohol & Drug Programs
- ♦ Jill Kelly, EMT Group San Francisco Lesbian & Gay Substance Abuse Needs Assessment Project

RESEARCH PRESENTATIONS

In the morning sessions, each presenter spoke for 20 minutes, followed by 20 minutes of question and dialogue.

- 9:00 - 9:40 *Gay & Lesbian Alcohol and Drug Abuse Epidemiological & Psychosocial Perspectives*
♦ David McKirnan, Ph.D., University of Illinois, Chicago
- 9:40 - 10:20 *Drug & Alcohol Use in the Lesbian and Gay Community: Findings From the Trilogy Project* ♦ William F. Skinner, Ph.D., University of Kentucky, Lexington
- 10:35 - 11:15 *Changes in Drug & Alcohol Use Practices Among Gay/Bisexual Men in San Francisco During the 1980s: The San Francisco Men's Health Study*
♦ Ron Stall, Ph.D., M.P.H., University of California, San Francisco, Center for AIDS Prevention Studies
- 11:15 - 11:55 *Lesbians' Experiences With Alcohol Problems: A Critical Ethnographic Study of Problematicization, Helpseeking and Recovery Patterns* ♦ JoAnn M. Hall, RN, Ph.D., University of California, San Francisco
- 11:55 - 12:05 Summary: Jill Kelly, EMT Group

PROGRAM PRESENTATIONS

In the afternoon sessions, each presenter in each subgroup spoke for ten minutes, followed by 20 minutes of question and dialogue.

- 1:05 - 2:05 **Prevention Approaches for Lesbians and Gay Men of Color** ♦ Miguel Aguilar-Zapata, 18th Street Services, San Francisco ♦ Msindo Mwinyipembe, LAPIS Program, Alcoholism Center for Women, Los Angeles ♦ Randy Burns, Gay American Indians, Native American Center, San Francisco
- 2:05 - 2:45 **Prevention Approaches for Lesbian and Gay Youth** ♦ Beth Kivel, LYRIC Program, San Francisco ♦ Stephen D. Kornfeld, Dean of Students, San Gabriel High School, Los Angeles
- 3:00 - 3:40 **Environmental Risk Reduction Approaches for Lesbian and Gay Communities** ♦ Flash Tarbell, Santa Clara County Bureau of Alcohol and Drug Programs ♦ Pam Rahn, Stepping Stones, Inc., San Diego
- 3:40 - 4:00 Summary: Jill Kelly, EMT Group

Overview of Important Themes

In an ideal world, the experiences and viewpoints of researchers, program implementers and policy makers would contribute to an ongoing information exchange. In the real world, each group, with its very different viewpoint, language and experience, often finds it difficult to communicate to the others.

What is needed to design a scientifically rigorous research study may appear irrelevant and even intrusive to some practitioners. Practitioners, faced with vastly underserved populations, may press researchers to design studies skewed to demonstrate need. And policy makers, always caught between the imperatives of politics and rational planning, must try to balance those competing interests.

As a result, important research fails to reach those who plan and implement programs; vital practice knowledge from the field is not communicated to researchers as they design studies; and policy makers are left with an incomplete picture as they weigh service priorities.

These issues were addressed head on during the Symposium, as research findings were continually reframed into both policy and program contexts. The discussion was frank and at times impassioned. The result was not a list of tidy solutions, but a delineation of important themes articulated from the policy, program and research perspectives. This section discusses those themes.

Theme #1: The politics of research on and services to gay men and lesbians influence how research questions are formulated and findings are interpreted.

Researchers and policy makers, for different reasons, share a similar interest in determining more precisely the extent of AOD abuse within the gay and lesbian communities. Researchers are scientists and value precision and objectivity. Policy makers value reliable data when making policy decisions. For these two groups, then, a shared starting point of interest is determining the extent of AOD use and abuse within the gay and lesbian communities.

Biosketch: Ron Stall, Ph.D., M.P.H.

Ron Stall is an Assistant Adjunct Professor of Epidemiology and Biostatistics at the University of California, San Francisco. Dr. Stall's work has primarily concerned understanding the sociocultural contexts of behaviors that can result in poor health. He is currently working on several research projects. The first of these is to evaluate an intervention to reduce sexual risk-taking for HIV infection among a clinical population of recovering gay male alcoholics. The second is to evaluate the effects of a community mobilization project to enhance primary and secondary prevention of AIDS. The third is to evaluate, in a national random-digit dial telephone survey, the extent of behavioral risk for HIV infection among older Americans. Also included among his research projects is ongoing work with the AIDS Behavioral Research Project, the Communication Technology surveys, and the San Francisco Men's Health Study. Dr. Stall has worked extensively in drug and alcohol epidemiology and has authored a series of papers concerning the relationship between non-intravenous drug use and AIDS.

Program people, on the other hand, view this starting point with mixed feelings. They begin with first-hand, experience-based knowledge of the problem and of the virtual lack of services to this population. They "know" the need is great, but struggle with how to paint a picture of great need that will attract additional resources for services without providing ammunition to those who view gay men and lesbians as somehow fundamentally impaired.

With these differing positions on formulating the basic research question, interpreting findings becomes complex and sensitive. Three of the Symposium researchers, David McKirnan, William Skinner and Ron Stall, conducted studies to find answers to this question. All were in agreement, with minor variations, that overall, lesbians and gay men do not appear to differ that much from similar heterosexual populations in their use of alcohol, and that there seems to be no evidence that 30 percent of either group is alcoholic.

Program practitioners are right to worry about the implications of these findings.

Stall identified the reason behind this fear:

"Some individuals will take the finding that rates of drug and alcohol abuse among gay men did not approach the 30 percent mark, and appear to be declining over time, as evidence that drug and alcohol prevention/treatment programs are not needed...it is important to remember that if (the 30% rate) were true...this would be among the highest rates of drug/alcohol abuse ever measured for any social group in the world. Requiring that gay men manifest the highest alcoholism/drug addiction rates in the world as a pre-condition for...services is transparently homophobic."

The politics of research in this field is a delicate matter. Since gay men and lesbians are a politically unpopular minority who struggle to obtain services at even minimal levels, documenting the extent of the problem carries a "damned if you do, damned if you don't" flavor. This is a dilemma faced by many minority groups: a problem must reach a crisis proportion to merit response. The HIV epidemic has done this for gay and bisexual men; no parallel health crisis has yet emerged for lesbian and bisexual women.

Current research, then, seems to be establishing that while AOD abuse among gay men, lesbians and bisexuals is not dramatically different or worse than that of heterosexuals, different correlates and patterns exist which need to be understood in order to provide effective prevention and treatment. That this population deserves adequate treatment and prevention services as does any other minority group needs to be a basic assumption, not one that must be earned through radically higher abuse rates.

Theme #2: Gay men and lesbians are not a monolithic entity. Diversity abounds.

For the most part, research on gay and lesbian AOD use is based on samples of self-identified gay men and lesbians who are predominantly white, well-educated, and middle class. Most studies focus on gay men, although two of the studies presented at the Symposium included large lesbian samples. Most are based on urban populations, although one of the studies presented at the Symposium drew from some rural communities.

The practitioners were adamant about the need to improve research methods so that the true diversity of lesbians and gay men is reflected in research samples. They urged that lesbians and gay men from specific population groups, particularly people of color, be involved when studies are designed. Separate studies that target different groups were recommended.

From a research perspective, these are key sampling issues. All of the studies presented at the Symposium made concerted efforts to cast wide nets to capture data from a more diverse population. Two used "saturation sampling methods", seeking survey respondents from a variety of networks, and using several dissemination avenues within the gay and lesbian communities. Skinner, for example, hired "indigenous researchers" in two Kentucky cities to locate respondents for their longitudinal study. These were 15 self-identified gay men and lesbians, four of whom were African American, who worked through their own personal networks to locate subjects who might not be reached through the other dissemination strategies.

Stall emphasized the need to "over-sample" people of color (that is, construct samples which include a larger number of people of color than is representative of their actual percentage of the population) in order to build an adequate knowledge base about their AOD problems. He believes that an effective over-sampling method is through random digit dial telephone surveys. McKirnan reported on an ongoing study in Chicago which is conducting in-depth interviews with African American men in public housing projects. All recognized the need to include research staff who represent the target population being studied.

Gender Differences

Symposium participants continually pointed out the need to further explore the role of gender differences when studying gay and lesbian AOD use. For example, Skinner's and McKirnan's studies explored the relationship between changing social roles and AOD use. In the heterosexual population, AOD use appears to decline naturally with age when people assume responsible social roles in marriage, and parenthood.

Although legal marriage is denied to gay men and lesbians, parenthood is not.² Many lesbians (and some gay men) are raising children from previous heterosexual relationships; a rapidly growing number are becoming parents through donor insemination, foster parenting or adoption. Skinner found that for lesbians, having children predicted a decline in the frequency of alcohol use but not, interestingly, of marijuana use. Having children can also be seen as a stressor, both economic and social, which has important ramifications for a lesbian's recovery process.

Skinner and McKirnan also found that substantially more lesbians reported being coupled (whether living together or not) than did gay men. The tendency of lesbians to become coupled more readily, and to stay coupled longer, has implications for understanding co-dependency dynamics in the treatment process.

While lesbians do appear to use AOD at lower rates when compared to gay men, their

Biosketch: William F. Skinner, Ph.D.

William F., Skinner is an Associate Professor in the Department of Sociology at the University of Kentucky. He received his Ph.D. from the University of Iowa in 1984. His research interests include drug and alcohol use, homosexuality, research methods, and statistics. He is the principal investigator of a five-year longitudinal study of drug alcohol use among gay men and lesbians, funded by the National Institute on Drug Abuse. Recent publications on drug use have appeared in Social Problems, Journal of Applied Social Psychology, Journal of Health and Social Behavior, American Journal of Drug and Alcohol Abuse, and Sociological Inquiry. He is also co-editor of a book entitled AIDS and the Social Sciences: Common Threads.

use rates are clearly higher than for women in the general population. Again, McKirnan theorizes that social role expectancies of lesbians may not be as disapproving of AOD use as they are for heterosexual women. This may be changing, however, with the strong influence of the recovery movement in many lesbian communities.

Thus, prevention programs focusing on lesbians need to take into consideration their roles as partners and mothers. The Lapis Program of Los Angeles, one of the programs highlighted at the Symposium, is an example of a prevention approach which provides clean and sober socializing activities for lesbians of color, and includes child cares.

Another gender difference which emerged in McKirnan's research was the degree to which lesbians linked mental health problems with AOD use. More lesbians than gay men said that they drank or used drugs to cope with mental health problems (such as depression or anxiety). But about the same number of lesbians and gay men reported mental health problems. This finding illustrates how women's AOD use has historically been pathologized — seen as a sign of mental illness — while men's AOD use is viewed as a physical illness. McKirnan noted that gender socialization is a more likely foundation for these differences.

A history of childhood sexual abuse was also a strong predictor for serious AOD-related problems among lesbians. For example, Joanne Hall found that among her subjects, those who described the most serious addictions and cross-addictions including eating disorders, also had histories of persistent, chronic, and severe childhood sexual abuse. In her interviews, Hall did not ask direct questions about sexual abuse history; nevertheless, 46 percent of her subjects volunteered that they were survivors. As Hall explained, "Although I didn't ask the question in this study, I will always ask in the future. (Childhood sexual abuse) has been in the closet too long."

Geographic Differences

The three large studies presented at the Symposium were conducted in different parts of the country: San Francisco (Stall); Louisville and Lexington, Kentucky (Skinner); and Chicago (McKirnan). Variations emerged regarding AOD use patterns that suggest some regional differences. For example, the use of amphetamines among gay men appears higher in San Francisco than among gay men in Chicago, Lexington or

Biosketch: David McKirnan, Ph.D.

David McKirnan is an Associate Professor of Psychology and the Director of the Office of Applied Psychological Services at the University of Illinois, Chicago. Dr. McKirnan has conducted research in the areas of substance abuse, normative behavior, multi-cultural research, and AIDS-related behavior. Currently, he is the Principal Investigator of the Chicago Cohort HIV High Risk Study and the Study of AIDS-Related Behavior Among Bisexually Active African-American, Hispanic, and White Younger Men, both of which are funded by the Centers for Disease Control. Recent research publications have appeared in the Journal of Sexuality, Journal of Primary Prevention, Psychology and Health, Addictive Behaviors, and the American Journal of Community Psychology.

Louisville. When compared to the general male population, alcohol abstention rates were higher for gay men in San Francisco, and lower in Chicago and Kentucky.

Geographic differences are not only reflected by different AOD use patterns, but also by differences in attitudes, community history, and the existence of a visible gay and lesbian community. As Stall pointed out, San Francisco is a "city of refugees", a characteristic which applies to the large numbers of gay men and lesbians who have flocked there for decades to find a more tolerant environment. McKirnan describes Chicago as the home of "heartland gays and lesbians" who either were born there, or who arrived there for reasons other than a search for tolerance of their lifestyle. Skinner characterized the Kentucky sample as sharing many of the characteristics of more conservative Southerners. As his colleague

Melanie Otis pointed out, "our gay men and lesbians who live in small towns like small town life, including its more conservative values."

These differences are paralleled in California, itself a collection of many diverse "Californias." It would be inaccurate to uncritically extrapolate findings about lesbians and gay men in San Francisco to those in Bakersfield, Santa Rosa or Redding. Policy makers and practitioners need to understand the uniqueness of each community before assumptions about the local lesbian and gay population can be made. The need for more local research is imperative.

Theme #3: Bisexuals do exist; or, the "unicorn" lives.

Many people who engage in sexual behavior with members of their own sex do not self-identify as gay or lesbian. Some identify as bisexual; others, perhaps most, consider themselves heterosexual. It has been a popular belief among many self-identified gay men and lesbians that bisexuals are like unicorns — they simply do not exist. Yet such a view negates the self-perceptions of many people who will never identify with the labels "gay" or "lesbian."

This controversy affects research into gay and lesbian AOD use. The use of saturation and more randomized sampling methods has achieved success in gathering representative samples of self-identified gay men and lesbians. Yet these samples have not reached a substantial number of people who consider themselves bisexual, or those who identify as heterosexual yet who engage in sex with people of the same sex.

These distinctions are particularly important in communities of color. Both researchers and practitioners at the Symposium described how in African American and Latino communities, for example, "gay," "lesbian" and "bisexual" do not translate into meaningful cultural concepts. Skinner reported the observation of one of his study's African American indigenous researchers who explained that in the Black community, a man may consider himself to be heterosexual, and describe his sexual behavior with other men as "fooling around".

Miguel Aguilar-Zapata, a Latino AOD prevention and treatment practitioner from San Francisco, echoed this assessment for Latino men, explaining that "there is a saying in our community that bisexuality is a matter of how many drinks you have." The role of alcohol as a disinhibitor for sexual activity is well-known. Often, unsafe sex practices are the result. (This is true for all cultural groups, not just within communities of color.)

The implication for future research is two-fold. First, it will be important to design separate studies for communities of color which are based on a careful understanding of the way in which members of these communities identify and construct meaning of various sexual behaviors. Labels such as "gay", "lesbian", "homosexual" and "bisexual" should be avoided, and more behavioral descriptors, e.g., "men having sex with men, women having sex with women", should be used, along with culturally-relevant language that describes the behavior or lifestyle.

Second, similar care should be taken in general population studies. When a study targets gay men or lesbians, it will exclude people who may engage in homosexual sex, but who eschew the labels. By simply adding the word "bisexual" to a study, a greater percentage of self-identified bisexuals will respond. By using behavioral descriptions, people who see themselves as heterosexual, while engaging in sex with the same sex, can be included.

Significant differences between gay men, lesbians, and the general population.

- Gay men appear to use alcohol in patterns similar to non-gay men.
- Lesbians appear to use alcohol at higher rates than non-lesbian women.
- Gay men and lesbians use other drugs at substantially higher rates than men and women in the general population; however, alcohol is clearly the drug of choice.
- Fewer gay men and lesbians abstain from alcohol than their general population counterparts.
- Although more lesbians and gay men use alcohol than their general population counterparts, most appear to be moderate drinkers.
- As people get older their AOD use tends to decrease. Among gay men and lesbians, this decrease is not as substantial as among the general population.
- Although there is little evidence that addiction rates are higher among lesbians and gay men, some studies find that lesbians and gay men reported higher rates of AOD-related problems. There appears to be either "more problem for the drink" among lesbians and gay men, or, this population is more likely than the general population to admit AOD problems.

Theme #4: Understanding Gay and Lesbian AOD Use Patterns Provides the Key to Effective Prevention Approaches.

Research is making headway on the fundamental task of describing "what is" regarding lesbian and AOD use. With each well-designed study, important similarities emerge that suggest significant differences between gay men, lesbians, and the general population. Some important findings that appeared across the three large-sample studies presented at the Symposium are presented in the box above.

In interpreting the differences shown in the box, McKirnan warned against the "main effects fallacy" which concludes that simply being gay or lesbian leads to, for example, a greater likelihood of AOD-related problems. Discovering different use patterns is only the first step; investigating other factors that might contribute to differences in the AOD use patterns of gay men and lesbians is essential. Toward this end, McKirnan's study measured a series of psychosocial variables that have been identified by other AOD

researchers as correlates to AOD abuse, and investigated how these are experienced by gay men and lesbians. Three are highlighted on the following pages.

Discrimination

Previous AOD research has postulated that among the general population, social stressors are an important predictor of likely AOD abuse. McKirnan theorized that discrimination based on one's sexual orientation would be a social stressor specific to gay men

Biosketch: Joanne M. Hall, R.N., Ph.D.

Joanne M. Hall is a recent graduate of the doctoral program in nursing at the University of California, San Francisco. Her nursing career spans 18 years during which she has focused her practice, research, and education efforts in the area of women's mental health, especially lesbian health concerns. Joanne will continue her research in the area of lesbians' alcohol problems and recovery as a postdoctoral scholar at UCSF.

and lesbians. His study found that for gay men, having been a victim of discrimination, particularly hostile or violent personal discrimination (e.g., "gay bashing"), was a clear predictor of self-reported AOD-related problems.

Hall's study of 30 recovering lesbians identified key images in their recovery process. She discovered that for many of these women, "empowerment" was a significant theme in their recovery. Lesbians of color, in particular, described the linkage

between their experience of discrimination as a person of color and their addiction. They felt that only when clean and sober could they begin the process of empowerment to help them deal with racism.

McKirnan also reported on an ongoing study of African American gay and bisexual men, in which the experience of racism within the gay and lesbian community was identified as a key social stressor linked to AOD problems. This observation was confirmed by Miguel Aguilar-Zapata of 18th Street Services in San Francisco, who described racism as a more stressful and common form of discrimination than homophobia.

"Bar Orientation" and Alcohol Availability

"Bar orientation" was another important predictor. This variable was not measured by how often an individual reported going to a bar, but by how important the bar setting was to him or her for a sense of community, comfort, and connection. Bar orientation emerged as one of the strongest predictors of self-identified AOD-related problems—even when the heaviest drinkers were excluded from the analysis.

While not a surprising finding in and of itself, it is particularly significant for gay men and lesbians. The gay bar still holds a central position in the gay and lesbian communi-

ties. It is more than a bar — it is a community center, communication hub, and usually the community's most significant business force. It is often the first stop for a lesbian or gay man in her or his "coming out" process.

This central role of the gay/lesbian bar developed over decades in response to a hostile environment which denied gay men and lesbians a variety of opportunities to gather in public. For this reason, it would be more likely for a gay man or lesbian to have a strong bar orientation at some point in his or her life than it would be for a heterosexual person.

Related to this is the overall availability of alcohol in social settings in the lesbian and gay communities. McKirnan's study found that those people who reported that alcohol was available at a high percentage of settings in which they socialized also were more likely to report a higher rate of AOD-related problems.

Reducing alcohol availability is a key strategy in the environmental approach to AOD prevention. Two of the prevention practitioners, Flash Tarbell from Santa Clara County and Pam Rahn of San Diego County, described their programs' efforts which included restaurant and bar server/manager training; working with gay and lesbian organizations to reduce the availability of alcohol at meetings and other social gatherings; reducing the amount of alcohol-related news and advertising in gay/lesbian papers; and convincing local groups to decline funding from companies which make alcohol products.

Positive Gay/Lesbian Identity as a Buffer

McKirnan's study found that people who indicated a strong, positive identification with being a lesbian or gay man were least likely to report AOD-related problems. This finding was so strong it suggests that a positive identity should be considered a buffer for gay men and lesbians against AOD-related problems.

In Hall's study, the most common way in which recovering lesbians understood their recovery was to see it as a process of "reconnecting" — with oneself, a clean and sober lesbian community, one's cultural heritage. Thus, a positive identity as a recovering person is contingent upon developing a connectedness with those parts of self and environment that can support the healing process.

A strong, positive self-identity as a gay man or lesbian depends on a number of things. For young people, positive older role models are important. The availability of a variety of socializing opportunities besides bars is critical, as is involvement in a supportive network of friends and family is essential. In short, the greater the opportunities for a gay man or lesbian to experience his gay/lesbian identity mirrored in a positive way, the more likely that identity will be positive.

Two of the prevention programs reported on at the Symposium focused on providing these opportunities for gay and lesbian adolescents. Beth Kivil described a San Francisco program which provides "normal, All-American socializing opportunities" for teen-aged lesbians and gay men from which they otherwise would be excluded. These include camping, sports, dances, support groups, and community involvement. Stephen Kornfeld, Dean of Students at a Los Angeles area high school, described organizing a school-based support group for previously ostracized gay and lesbians students. His efforts eventually led to the sensitizing of faculty about the homophobia these students face, and acceptance of the support group as a bona fide student organization.

Msindo Mwinyipembe, an African American prevention practitioner from a Los Angeles program, detailed how socializing opportunities such as dances give lesbians of color a chance to break their isolation in a clean and sober setting. And Randy Burns, a Native American who works with HIV positive Native American gay men in San Francisco, reported on how gay men and lesbians from many tribes are forging a strong, positive identity that combines their cultural heritage and their sexual orientation. These self-described "Two-Spirit People" attend Indian dances sponsored by different tribes, as well as create their own rituals and ceremonies to honor their heritage in an affirming way.

Thus, creating a positive gay and lesbian identity holds a central place both in the recovery process as well as in the design of prevention programs. The importance of this factor is affirmed by current research.

Conclusion

The preceding themes emerged from dialog among policy makers, practitioners and researchers. From this dialog it was clear that each perspective is essential to provide a complete picture of the AOD problems of lesbians and gay men. The remainder of these Proceedings include expanded versions of the contribution of each presenter. By presenting the important themes first, it is hoped that each presenter's thoughts can be understood as a crucial part of a whole.

Notes

1. Bell, A.P. and Weinberg, M.S. 1978. *Homosexuality: A Study of Diversity Among Men and Women*. New York: Simon and Schuster.
2. This is not entirely true. In many jurisdictions across the country, lesbians and gay men lose custody of their children simply because of their sexual orientation.

Summary of Prevention Panel Presentations

Format

Three panels of prevention practitioners represented a variety of approaches to reducing alcohol and other drug (AOD) problems of gay men and lesbians. The panels were organized as follows:

- Programs focusing on people of color;
- Programs focusing on youth;
- Programs using environmental risk reduction strategies.

This section summarizes the presentation of each panelist.

Panel #1: Programs Focusing on People of Color

Several themes united the perspectives of the three presenters who described working with lesbians and gay men of color. Frustration with the failure of studies to include significant numbers of people of color in research samples was the top concern, along with dissatisfaction over the lack of involvement of people of color in the design and implementation of research projects.

A second key theme related to the dual discrimination faced by gay men and lesbians of color. Presenters felt that racism within the lesbian and gay communities is for many a more pervasive and difficult experience than homophobia among the heterosexual population.

The third theme focused on the need to understand the unique experience of sexual

diversity within different cultural contexts. "Gay", "lesbian" and "bisexual" are labels which have little meaning for many people of color whose lives vary from the heterosexual norm. In addition, communities of color have traditional ways of "fitting in" people who are "different" -- and that these ways need to be understood and respected.

Miguel Aguilar Zapata, 18th Street Services, San Francisco.

As one of the handful of AOD treatment programs focusing on Latino gay and bisexual men, the Latino Services program of 18th Street Services in San Francisco was able to

Biosketch: Miguel Aguilar-Zapata

Miguel A. Aguilar-Zapata is the Latino Services Coordinator of 18th Street Services, an outpatient substance abuse clinic providing therapy and counseling for the gay, bisexual, and male-to-male communities in San Francisco. The Latino Services Program was created by Mr. Aguilar-Zapata in 1989. He has participated in the foundation of several Latino social services and programs in the San Francisco Bay Area for the last eight years, and has been providing therapy and counseling for substance abusers among the people of color communities for the last seven years.

gather data on the demographics and AOD patterns of 75 Latino gay and bisexual clients over a two year period. Although not a prevention effort, this program offers important insight into Latino gay/bisexual male AOD use that is helpful to constructing effective prevention approaches.

According to Miguel Aguilar-Zapata, program coordinator, nearly two thirds of the program's 75 Latino clients were immigrants, mostly from Mexico or Nicaragua.¹ Three quarters identified as gay, 12 percent as bisexual and 4 percent heterosexual. Aguilar-Zapata believes that the large percentage of self-identified gay men indicates that the program is not suc-

cessfully reaching bisexual Latinos. "I can walk into any straight Latino bar in the Mission District and find bisexual men. We send brochures for our services to them, but more outreach is necessary."

According to Aguilar-Zapata, "most Latinos self-medicate for physical pain. They cannot afford to see a doctor. So we find a lot of polydrug abuse that mixes alcohol both with prescription and over-the-counter drugs." Two-thirds of the clients were HIV positive; more than half have died since entering treatment. "When a Latino is diagnosed with HIV, the disease usually has progressed quite far."

Forty percent of the program's clients were mono-lingual Spanish speakers; 39 percent were bilingual, but preferred to speak Spanish in counseling sessions. "They are more comfortable with Spanish when speaking about sensitive matters," he explained. Yet in San Francisco, no Spanish-speaking AA groups currently exist for gay men or lesbians.

Aguilar-Zapata also stated that until 18th Street Services placed an advertisement for its Latino Services program, no local gay paper previously had run any ad in Spanish.

Similar to research findings about lesbians in recovery, Aguilar-Zapata found that a little over half of his Latin gay and bisexual male clients reported childhood sexual abuse. Finally, Aguilar-Zapata described how some of the standard recovery terminology and concepts, notably that of "co-dependence", can be insensitively applied to traditional Latino cultural values. "Being responsible for one's family is taken very seriously by Latinos," Aguilar-Zapata asserted. "What an Anglo might call co-dependent behavior, a Latino sees as what is expected of him as a member of his family."

***Msindo Mwinyipembe, Lapis Program of
The Alcoholism Center for Women, Los Angeles.***

Msindo Mwinyipembe's presentation discussed some of the larger issues related to working with lesbians of color and AOD problems. She described the common dynamics of oppression on the basis of race, gender or sexual orientation. "I have not yet met a

Biosketch: Msindo Mwinyipembe

Msindo Mwinyipembe is currently Director of Prevention and Community Services at the Alcoholism Center for Women (ACW). She oversees the prevention-oriented Lapis Program, which focuses specifically on African American, Latina, and other lesbians of color. Her responsibilities include supervision of the agency's pioneering specialized services for women with alcohol and other related drug problems; coordination of the statewide Technical Assistance contract for women's services, as well as a new environmentally focused media campaign on the linkage between alcohol advertising and violence against women. She previously lent her media and community organizing skills to the California Women's Commission on Alcohol and Other Drug Dependencies (CWCADD) Black Women's Alcohol Demonstration Media Project.

woman who isn't in some way a 'lesbian' — because as an idea, lesbianism means being aggressive, dangerous, different. Women of color deal with this (assumption) all the time."

She saw parallels in the recent uprising in Los Angeles in the wake of the Rodney King/police brutality trial to the ongoing experience of all people of color, and of all women. She described how news reports gave the impression that the entire Los Angeles area was under siege, when in reality the violence was contained with specific neighborhoods. According to Mwinyipembe, the fear that permeated all of Los Angeles, as well as other big cities across the country during that week, echoed the fear that people of color and women live with every day. "For awhile, South Central (site of the worst violence) became a metaphor for all of L.A. — for being unsafe," she explained. "And for a

moment L.A. understands what it means to be a woman and not be sure of where I can go to be safe."

This sense of fear and marginality is felt acutely among lesbians of color. "When I deal with lesbians of color, I have to deal with internalized self-repression. Lesbians don't have an identity crisis: society does."

Mwinyipembe pointed out that historically in the African American community, abstinence from AOD has been associated with a commitment to social change, a necessary first step in taking back power, self and community. Echoing the women in Hall's study, Mwinyipembe described recovery for lesbians of color as a profound process of empowerment.

Randy T. Burns, Co-founder, Gay Native Americans (GAI), San Francisco.

A community activist for 17 years, Randy Burns' current work focuses on gay and lesbian Native Americans with HIV, many of whom also have a history of AOD abuse. Alcohol and other drugs have been devastating to Native American people. Burns

Biosketch: Randy T. Burns

Randy T. Burns is an enrolled member of the pyramid Lake Paiute Tribe, Nixon, Nevada. He is the past Co-chair of the People of Color AIDS Advisory Committee, for the Office of AIDS in San Francisco. He is co-founder of GAI (Gay American Indians), whose objectives are to provide culturally sensitive education, materials, and resources to the Native American community; to provide social, emotional, and practical support to Native American persons with AIDS; and to advocate for HIV/AIDS prevention. GAI has published Living the Spirit, an anthology of writings, artwork, and photographs of gay American Indians; and has produced a video entitled Two Spirits People, a documentary about past and present homosexual roles in native society. GAI's current priority is the HIV/AIDS epidemic and its effects on the American Indian community.

described how on many reservations, AOD addiction affects either directly or indirectly the lives of nearly everyone. As with African Americans, becoming clean and sober is a critical first step in reclaiming the self, and finding empowerment as a Native American. To this end, all GAI events are clean and sober settings.

Burns' comments returned again and again to two key themes. First was the importance of reconnecting with one's spiritual and cultural roots as an essential part of recovery, as well as for self-acceptance as a Native American gay man or lesbian. Members of GAI participate frequently in traditional Native American ceremonies, such as pow-wows and sings.

Spirituality, he believes, is the key to recovery, and to becoming whole. His group has adopted the name "Two Spirit People", after the term used by a Native

American tribe to describe people who embody both the male and female spirit. "We are creating our own spiritual space by taking traditional ceremonies and adapting them to our lesbian and gay lives," he explained.

A second theme emphasized by Burns was the failure of research and the service system to attend to the needs of people of color. He emphasized the need for researchers and policy makers alike to take pains to listen and learn about the cultural values and experiences of communities of color. Native Americans, for example, value group harmony over individual needs, a cultural value which can be mislabelled "co-dependence". Patience also is highly prized. He described Native American people with AIDS waiting uncomplainingly all day long for services at an AIDS agency, only to be turned away at closing time. "Our sense of time is now, not in the future," he explains. "If you turn people away, they won't come back."

He implored the audience to learn the value of listening. "I spent my childhood listening to my grandmother, respecting the wisdom of my elders. I think that is not such a high value among non-Indians. I ask that you learn this from us, to listen with your heart, so that you can come to understand us and our needs."

Panel #2: Programs Focusing on Youth

Current research suggests that one's sexual orientation is most likely set long before puberty. But it is at puberty when young gay men and lesbians begin in earnest the struggle to understand confusing sexual feelings that were previously experienced as an unfocused sense of being different.

Adolescence is painful for most people. It is a time for establishing an identity apart from one's parents, as well as to experience one's sexuality. For gay men and lesbians, adolescence can be agonizing. Typically, these young people have no access to positive gay and lesbian role models to help them develop a healthy identity. On the contrary, gay and lesbian adolescents usually suffer virulent homophobia from their peers, a product of societal attitudes combined with adolescent insecurity. Parents usually are appalled by the prospect that one of their children may be gay or lesbian. It is not surprising that recent studies are uncovering a suicide rate among gay and lesbian adolescents that is substantially higher than for heterosexuals.²

The two panelists who work with gay and lesbian youth offered different yet complementary views of these issues. One panelist works in a community-based program, the other in a high school. One panelist saw the need for her program through her own experience as a lesbian; the other from his experience as a heterosexual father of a gay

son. Both attempt to provide healthy socializing and support alternatives for gay and lesbian youth.

Beth Kivel, LYRIC Program, San Francisco.

At first glance, the LYRIC Program appears to be the 4-H Club, Boy and Girl Scouts, and high school service club all rolled into one. Dances, softball tournaments, basketball, field trips, outreach to senior citizens, bake sales, camping trips, support groups:

Biosketch: Beth Kivel

Beth Kivel, M.S., was co-founder of the Lavender Youth Recreation & Information Center (LYRIC) in San Francisco. She received her undergraduate degree in journalism from the University of Wisconsin-Madison, and recently completed her Master's degree at San Francisco State University. In the fall of 1992, she will begin work on her doctorate in education at the University of Athens in Georgia. She will focus her research on the impact of recreationally-based programs on the self-esteem of lesbian/gay/bisexual young people. In addition to aspiring to be a university professor, she hopes to one day own and operate a summer camp for the children of lesbian/gay men and provide job opportunities for lesbian/gay young people to become camp counselors.

the program offers a typical array of social activities available to most adolescents. Because gay and lesbian youth are excluded from opportunities such as these, the LYRIC Program attempts to fill this gap.³ Serving a wide range of youth, including homeless as well as those living at home, students as well as drop-outs, LYRIC Program participants encompass the cultural diversity of San Francisco.

Beth Kivel, Director of the LYRIC Program, noted that it is in social and recreational activities that young people strengthen their identities. Since gay and lesbian youth are ostracized from traditional activities, their social and sexual identities are forged within a context of rejection and fear. The LYRIC Program was founded on the belief that the mental health problems of lesbian and gay youth have as much, if not more to do with the lack of positive socialization opportunities for

gay and lesbian youth as with any other factor. As suggested by David McKirnan's research, the program is an example of what can be done to create a positive self-identity buffer against AOD problems.

LYRIC participants also learn leadership skills. They are responsible for planning the program and implementing activities. Adult gay men and lesbians in the community provide sponsorship and assistance with program activities. The interaction with positive role models is vital to the development of a healthy gay or lesbian identity.

"I'm amused by the irony of it all," said Kivel. "Here we are, providing wholesome, all-

American activities for gay and lesbian young people — things that every other young person can take for granted.”

Stephen D. Kornfeld, Dean of Students, San Gabriel High School.

As Dean of Students in a 3,300-student high school, Stephen Kornfeld was used to working with “problem students.” But until he learned that his own son was gay seven years ago, he was unaware of the presence of gay and lesbian students on campus. With

Biosketch: Stephen D. Kornfeld

Stephen D. Kornfeld is Dean of Students at San Gabriel High School, a large multi-racial high school in the Los Angeles area. He has been a counselor, Dean and Administrator in the Alhambra High School district for the past 22 years. He served as a Peace Corps volunteer in Malaysia as a psychiatric social worker. Kornfeld is a member of the Advisory Council of the Asian Pacific Family Center, a mental health counseling program serving the West San Gabriel Valley. He was recently appointed to the newly established Los Angeles Unified School District commission on Gay and Lesbian education. Kornfeld just completed his sixth year as founder and coordinator of Project 10 at San Gabriel High School, a self-help, stay in school, support project for Gay and Lesbian students.

the help of his son, Kornfeld learned more about the problems facing these students, and began a process to address their needs that resulted in significant changes at San Gabriel High School.

Early on, he contacted Virginia Uribe, creator of Project 10 in Los Angeles, a program to provide support to gay and lesbian students in Los Angeles Schools⁴. Using Project 10 as a model, Kornfeld’s early efforts revolved around getting to know the 20-or so openly gay and lesbian students. These young people, as a way to defend themselves against the homophobia of their environment, dressed “outlandishly” and were aggressive in proclaiming their presence. Informal discussion groups, led by Kornfeld, allowed students a safe place to vent their frustrations at being harassed in school. Kornfeld also learned about the students’ high risk behavior on the weekends,

including significant AOD abuse, hustling, and fighting. Most were on the way to dropping out of school. In the words on one boy, “There’s no way I’ll ever get a diploma. I can’t go to P.E.—I get bashed every time.”

Over the next five years, Kornfeld worked patiently to bring the needs of these students to the attention of the administrators and faculty. With the help of another heterosexual faculty member, the group solidified into an ongoing support group. Physical education teachers were approached about counteracting the overt homophobia gay male students faced in P.E. classes. Most teachers were willing to work to eliminate this discrimination within their classes through consistent enforcement of rules against homophobic comments and actions.

Today, the school district recognizes the group as an official student organization: "We're in the school newspaper and the daily bulletin," Kornfeld reported. Recently, the only openly gay teacher at San Gabriel High School has become involved in the group. While Kornfeld is aware of several gay and lesbian teachers in the school, he acknowledges the justifiable fear that keeps them from being open about their sexual orientation. Yet for the members of the lesbian and gay student support group at San Gabriel High School, even one openly gay teacher offers a positive role model to counter the negative images these adolescents struggle with.

Kornfeld's work also underscores the important role that heterosexuals play in bringing about changes within homophobic systems. Gay men and lesbians working in institutional settings risk a great deal when they assume advocacy roles. Their work must be supported and carried forward by heterosexual people who are committed to eradicating homophobia and promoting justice for lesbians and gay men. When the institution in question is a school, heterosexual support is absolutely critical.

Panel #3: Programs Focusing on Environmental Risk Reduction

Environmental risk reduction as a strategy to reduce AOD-related problems derives from the public health model of understanding disease prevention. In this model, health problems are a result of the interaction among "host", "agent" and "environment". Traditional AOD prevention programs focus on the person who uses AOD (the "host") and attempts to modify individual attitudes and behavioral choices. Law enforcement prevention approaches focus on restricting the supply of the "agent", whether legal (alcohol and prescription drugs) or illegal (illegal drugs.)

The environmental approach, on the other hand, analyzes the environment in which the "host" comes into contact with the "agent". This approach does not focus on individual choice, nor does it attempt to eradicate the agent; rather, it tries to determine what factors in the environment contribute to or mitigate against the problematic use of AOD.

Environmental factors are many. They include ordinances and laws which regulate the accessibility of legal drugs; the number of alcohol or drug paraphernalia retail outlets within a community; the intensity of alcohol related advertising within a community; community group norms regarding the use of alcohol and other drugs at public events; alcohol advertising targeting specific groups, such as adolescents and communities of color; and the degree of enforcement of existing laws against drunk driving, serving alcohol to minors, and illegal drug dealing.

The environmental approach has spawned a wide variety of prevention strategies in several California communities. In San Diego and Santa Clara Counties, the gay and

lesbian communities have been the focus of environmental strategies for AOD problem prevention. The final panel of the Symposium presented information on these programs.

Flash Tarbell, Santa Clara County Bureau of Alcohol and Drug Programs.

Like Stephen Kornfeld, Flash Tarbell is an example of a heterosexual person working within a large bureaucracy whose personal and professional commitment to addressing the health issues of the gay and lesbian population was crucial in launching an important prevention effort.

Biosketch: Flash Tarbell

Flash Tarbell has been a Health Education Specialist for the Santa Clara County Bureau of Alcohol and Drug Programs Prevention Division for eight years. Her special interest is in responsible beverage service as an HIV risk-reduction strategy. In 1989-1990, she coordinated the Server/Manager Training Project in the county's gay and lesbian community. This led to the formation of the Health and Hospitality Council which has continued to meet monthly two years before the project's end.

Tarbell described organizing the Health and Hospitality Council, an unlikely group of people with widely differing viewpoints. These included gay and lesbian bar owners; representatives of the police Vice Squad; Health Department staff; the owner of the local gay bath house; representatives from the Alcohol Beverage Control Bureau (ABC); and advocates from the gay and lesbian communities. These disparate individuals formed a coalition to address the way in

which gay and lesbian social settings, primarily bars and bath houses, can be targeted for change to decrease AOD related problems as well as HIV risk.

The initial focus of the Health and Hospitality Council was to implement server and manager training for lesbian and gay bar personnel. These trainings led to other activities geared toward gay/lesbian bars such as seminars on AIDS and Alcohol, ABC Laws, a condom matching distribution program, and a workshop on hate crimes.

While these events were important, Tarbell felt that the most important result of the project was the creation of the Council itself. "The Council was a place where people who would never have the chance to communicate with each other came together to address common concerns. I believe that that alone was a tremendously important achievement."

The initial funding is over, but the Council continues. "We did this on a shoestring budget," Tarbell said. "If we want to continue server/manager training we'll need to find additional sources of funding. But the work of the Council is volunteer, and I have the support of my Bureau to continue to assist the group."

Tarbell underscored the importance of heterosexuals' role in advocating for lesbian and gay men's issues. "Homophobia will get solved when straight people get personally involved."

Pam Rahn, Stepping Stones, Inc., San Diego.

Like Santa Clara County's Health and Hospitality Council, Stepping Stones Prevention Program has provided server/manager training for gay and lesbian bar personnel. The program's scope is broader, however, and is based on a county-wide environmental prevention model.

Citing the earlier research presentations which found that most gay men and lesbians are moderate drinkers, Pam Rahn described Stepping Stones' goal as reducing AOD problems of moderate drinkers through modification of the social environment. "We're talking about people who aren't necessarily alcoholic but who drink and drive; or who

drink and have unsafe sex; or who drink and have physical fights with their lovers," she explained.

Biosketch: Pam Rahn

Pam Rahn obtained her Master of Health Science (Public Health) from Johns Hopkins School of Public Health in 1977 and her Master of Business Administration from National University in 1982. She is currently Prevention Coordinator for Stepping Stone Prevention Program in San Diego, California. Ms. Rahn is the founder of this alcohol-problem prevention program for the gay community, the first of its kind in the United States to use the public health model of problem-oriented prevention. She has also directed Quality Assurance Programs in psychiatric hospitals, owned two businesses, and has experience in research and social work.

The project conducted a needs assessment of the San Diego lesbian and gay community. This study disclosed a high proportion of social contexts in which alcohol was available; including clubs, religious groups, professional groups, and other social organizations. In addition, an analysis of the local gay and lesbian press revealed a substantial amount of alcohol-positive reporting and advertising.

Based on this needs assessment, Stepping Stones Prevention Program devised strategies to work with clubs and organizations to decrease the amount of activi-

ties which include alcohol. A major coup was to convince a large fundraising effort in the lesbian and gay community to refuse financial support and advertising from the alcohol industry. As a result of the program's efforts, the lesbian and gay press have increased their coverage of AOD problem prevention related news.

Rahn described Stepping Stones' overall message as positive. "What we are saying is that being gay or lesbian is healthy — and that part of being healthy is making appropriate choices about alcohol."

Conclusion

The Research Symposium on Alcohol and Other Drug Problem Prevention Among Lesbians and Gay Men demonstrated the value of sharing research, policy and practitioner perspectives. Much of what the prevention field is doing to address lesbian and gay AOD problems was borne out by the research. In particular, the importance of developing a strong, positive lesbian or gay identity as a buffer against AOD problems was highlighted as an essential ingredient in any prevention program.

Practitioners urged both researchers and policy makers to move beyond the historical emphasis on white, middle class gay men and recognize the great diversity among the lesbians and gay population. Studies focusing on the unique characteristics and needs of lesbians; lesbians and gay men of color; bisexuals; youth; and those living in non-urban settings are sorely needed.

Sensitivity to the politics of gay and lesbian research is also a prerequisite for expanding knowledge in this area. If estimates of addiction rates among gay men and lesbians have been overstated in the past, more accurate lower estimates should not provide policy makers an excuse for denying services to an already underserved population. As with our entire society, alcohol and other drug problems abound among lesbians and gay men. What is essential is understanding the unique AOD patterns and problems of gay men and lesbians, so that they may receive their fair share of services, research, and prevention efforts.

Notes

1. He also has treated a few Native American men in this program, and emphasizes the common cultural roots of Latin Americans and North American Native Americans. Both are descended from the original people of the Americas; both were enslaved and subjugated. The key difference is that North American indigenous people were segregated from their European invaders, while indigenous people of Latin America were not. Aguilar-Zapata discerns "common psychological issues" among Latinos and Native Americans—as well as with Filipinos, whose history of conquest and domination by Europeans is similar.
2. US Department of Health and Human Services. 1989. *Report of the Secretary's Task Force on Youth Suicide*. DHHS Pub (ADM)89-1623. Washington, D.C.: General Printing Office.
3. The current controversy over the Boy Scouts of America's policy excluding gay men and boys from membership is an example of the ostracism gay and lesbian adolescents face.
4. Project 10 refers to the estimate that one in ten people are gay or lesbian.

SYMPOSIUM PRESENTERS

Miguel Aguilar-Zapata
18th Street Services
217 Church Street
San Francisco, CA 94114

Randy T. Burns
Gay American Indians AIDS Project
1347 Divisadero St.
Box 312
San Francisco, CA 94115

Dr. Joanne M. Hall, RN
University of California San Francisco
1612 Noriega Street
San Francisco, CA 94122

Beth Kivel, M.S.
LYRIC Program
3543 18th Street #31
San Francisco, CA 94110

Stephen D. Kornfeld
Dean of Students
San Gabriel High School
801 Ramona Street
San Gabriel, CA 91776

Dr. David McKirman
University of Illinois, Chicago
Department of Psychology M/C 285
Box 4348
Chicago, IL 60680

Msindo Mwinyipembe, Director
Prevention and Community Services
Alcoholism Center for Women
1147 South Alvarado Street
Los Angeles, CA 90006

Pam Rahn, M.H.S. (Public Health)
Stepping Stones, Inc.
3425 Fifth Avenue
San Diego, CA 92103

Dr. Ron Stall, M.P.H.
University of California San Francisco
Center for AIDS Prevention Studies
UCSF, Box 0886
San Francisco, CA 94143

Dr. William F. Skinner
University of Kentucky
Department of Sociology
1523 Patterson Office Tower
Lexington, KY 40506

Flash Tarbell, M.P.H.
Santa Clara County
Bureau of Alcohol and Drug Programs
595 Millich Drive, Ste 100
Campbell, CA 95008

SYMPOSIUM PARTICIPANTS

Kimberly Arino
EMT Group, Inc.
3090 Fite Circle, Suite 201
Sacramento, CA 95827

Andrew Black
LAST CALL, Inc.
Post Office Box 2186
Berkeley, CA 94702

Susan Blacksher, Chair
Women's Leadership Council
CAARH
650 Howe Avenue, Suite 1060
Sacramento, CA 95825

Wendy Bradach
Saddleback College
28000 Marguerite Parkway
Mission Viejo, CA 92692

Robert Bruner, Chair
California Alcoholism Advisory Board
155 West Hospitality Lane, Suite 200
San Bernardino, CA 92408

Richard Burhenne, Prev. Coordinator
Alcohol & Drug Programs
San Diego County Dept of Health Services
Post Office Box 85222
San Diego, CA 92138-5222

Curtis Christy
LAST CALL, Inc.
Post Office Box 2186
Berkeley, CA 94702

Tom Colthurst
UC San Diego Extension Program, 0176
9500 Gilman Drive
La Jolla, CA 92093-0176

Carol Delgado, Director
Community Education and Prevention
Women's Alcoholism Treatment Center
2261 Bryant Street
San Francisco, CA 94110

Susan Foster
Lesbian & Gay Substance Abuse Programs
265 Laidley Street
San Francisco, CA 94131

Richard Frantz
CA Dept. of Alcohol & Drug Programs
1700 K Street
Sacramento, CA 95814

Rich Goodman
CAADE
Saddleback College
28000 Marguerite Parkway
Mission Viejo, CA 92692

Cheryl Houk, Executive Director
Stepping Stone of San Diego, Inc.
3425 Fifth Avenue
San Diego, CA 92103

Paul Hyman
San Luis Obispo County
Alcohol & Drug Programs
994 Mill Street, Suite 201
San Luis Obispo, CA 93401-4221

Marjorie Kari
Los Angeles County
Dept. of Alcohol & Drug Programs
714 West Olympic Blvd, Rm 914
Los Angeles, CA 90015-1442

Jill Kelly
EMT Group, Inc.
3090 Fite Circle, Suite 201
Sacramento, CA 95827

Jim Kooler, Director
Office of Alcohol & Drug Prevention
CA Dept. of Alcohol and Drug Programs
1700 K Street
Sacramento, CA 95814

Ronald LaPorte, Administrator
Orange County Alcohol Programs
Health Care Agency
1200 North Main Street, Suite 826
Santa Ana, CA 92701-3606

Ben Marte
Special Services for Groups
1313 West 8th Street, Ste. 201
Los Angeles, CA 90017

Robert Matthews, Deputy Director
Alameda County
Dept. of Alcohol & Drug Programs
160 Franklin Street, Ste. 300
Oakland, CA 94607-3777

Lidia Mena-Hermida
Latino Services Coordinator
UCSF—AIDS Health Project
3180 18th Street
San Francisco, CA 94110

Roy Morales
Special Services for Groups
1313 West 8th Street, Ste. 201
Los Angeles, CA 90017

Susan Nisembaum
CA Dept. of Alcohol & Drug Programs
1700 K Street
Sacramento, CA 95814

Carol Nottley
San Diego County Drug Programs
Dept. of Health Services
Post Office Box 85222
San Diego, CA 92138-5222

Suzanne Ostermann
NALGAP/NCADD
127 North Madison Avenue, Suite 204
Pasadena, CA 91101

Melanie Otis, M.S.W.
University of Kentucky
Dept. of Sociology
1535 Patterson Office Tower
Lexington, KY 40506-0027

Chip Pope
Orange County Drug Abuse Services
405 West Fifth Street, Suite 212
Santa Ana, CA 92701-4519

Cathy Reback, Ph.D.
Prototypes
5601 West Slauson Ave., Ste. 200
Culver City, CA 90230

Joanne Rosen
Mendocino County Alcohol and Drug
Programs
302 West Henry Street
Ukiah, CA 95482

Terry Runney
Santa Clara County
Bureau of Alcohol and Drug Programs
976 Lenzen Avenue
San Jose, CA 95126-2727

Wayne Sauseda, Chief
State Office of AIDS
830 S Street
Sacramento, CA 95814

Lance Segars
San Diego County Alcohol Programs
Post Office Box 85222
San Diego, CA 92138-5222

Anthony Smulders, Chair
California Drug Advisory Board
c/o Loyola Marymount University
7101 West 80th Street
Los Angeles, CA 90045

George Staub, HIV Services Coordinator
San Francisco County
Community Substance Abuse Services
1380 Howard Street, Fourth Floor
San Francisco, CA 94103-9705

Brenda Underhill, Director
Alcoholism Center for Women
1147 South Alvarado Street
Los Angeles, CA 90006

Kathy Watt
Van Ness Recovery House
1919 North Beachwood Dr.
Hollywood, CA 90068

Al Wright, Administrator
Los Angeles County Alcohol Programs
714 West Olympic Boulevard, Tenth Floor
Los Angeles, CA 90015-8517

**Papers Presented at
The Research Symposium on
Alcohol and Other Drug Problem Prevention
Among Lesbians and Gay Men**

Drug Use Among Lesbian and Gay People: Findings, Research Design, Insights, and Policy Issues from the Trilogy Project

William Skinner
University of Kentucky

Melanie D. Otis
University of Kentucky

Introduction

In the introduction to *Gay and Lesbian Identity: A Sociological Analysis*, Richard Troiden states,

“Over the past fifteen years, research into homosexuality has undergone a major shift in emphasis. A concern in documenting the etiology, treatment, and psychological adjustment of homosexuals has been replaced by an interest in understanding how homosexuals themselves perceive and experience the homosexual situation in contemporary Western society” (1988:1).

Research on the use of drugs and alcohol by lesbians and gay men is a good example of this shift. Early psychoanalytic research primarily focused on alcohol abuse and its relationship with latent homosexuality and personality traits (Buss, 1966; Bieber et al., 1962; Machover et al., 1959; Gibbins and Walters, 1960). Using small samples of clinical and hospital patients, prisoners, and other captive populations along with producing unconvincing findings, these studies have given way to a new “genre” of efforts to examine the complex nature of drug and alcohol use from social and cultural perspectives (for a review of this literature see Israelstam and Lambert, 1986; Nardi, 1982).

The research conducted in the 1970’s and early 1980’s provided a first glimpse at the

use of alcohol and to a lesser extent, illicit drug use, among gay men and lesbians. Most studies had small samples, employed bias sampling techniques, lacked heterosexual comparison groups, had low response rates, focused on licit drugs such as alcohol while excluding many illicit drugs, and targeted gay men. Despite these limitations, an empirical generalization emerged from these studies which suggested that gay men and lesbians were more likely to use and abuse chemical substances than their heterosexual counterparts. Most frequently quoted are the findings from Fifield (1975), Saghir et al. (1970a;1970b), and Lohrenz et al., (1978) that indicated homosexuals are 3 times more likely to be alcoholics or experience problems with alcohol than heterosexuals. Some recent studies report findings that refute this estimate and have attempted to overcome previous methodological problems (Stall and Wiley, 1988). Nevertheless, much of extant research on gay and lesbian drug use lacks methodological rigor. Clearly, there is need for research that is specifically designed to address these limitations so as to provide reliable and meaningful data on the epidemiology of drug use among gay men and lesbians.

For policy makers, administrators, and substance abuse counselors, an additional concern is raised by research that indicates a high level of homophobia in service delivery systems. Studies done in the 70s and 80s indicate that homophobia is a pervasive problem among mental health professionals (Berger, 1977; DeCrescenzo, 1984; Dulaney & Kelly, 1982; Gramick, 1983; Tievsky, 1988; Wisniewski & Toomey, 1987). DeCrescenzo (1984) found the highest homophobia ratings among social workers. This becomes a particularly disturbing fact when you consider the large number of clients a social worker sees compared to a psychiatrist or psychologist.

The purpose of this paper is to present findings from a study that examined drug and alcohol use among gay men and lesbians living in and around two metropolitan communities in a southern state. This study, known as the Trilogy Project, investigated numerous social issues such as victimization, discrimination, stress, social support, AIDS testing, sexual practices, and psychological well-being. The central focus of the study, however, was on the epidemiology and etiology of licit and illicit drug use. As described below, the Trilogy Project was specifically designed to improve on previous research by (1) examining the prevalence and frequency of using 11 licit and illicit drugs by a large sample of self-defined gay men and lesbians, (2) using questions taken from the National Household Survey on Drug Use to facilitate comparisons with this nationally representative sample of households, and (3) employing sampling strategies that help to obviate bias found in the selection of research subjects in previous studies, and (4) conducting the study in an area of the country not considered to be a "magnetic area" for the gay and lesbian population.

Results and Limitations of Previous Research

As noted by Israelstam and Lambert (1986), the "hidden" nature of the homosexual population has made it difficult to obtain data on anything that comes close to a representative sample of gay men and lesbians. Early studies relied on convenience samples drawn from hospitals, prisons, clinics, and treatment programs (McCord and McCord, 1960; Rosenberg, 1969; Roth et al., 1971; Swanson et al., 1972; Tyndel, 1974). Other studies obtained data from opportunistic-based samples such as bar patrons and bartenders (Fifield, 1975) and homophile organizations (Saghir et al., 1970a, 1970b). The majority of all these studies had small sample sizes (less than 100), producing statistical results that were suspect and problematic in terms of providing accurate, stable, and representative estimates. Finally, the emphasis of early research has been on examining alcoholism among gay men while the nature of illicit drug use (Stall and Wiley, 1988; Morales and Graves, 1983) and a focus on lesbians (Diamond and Wilsnack, 1978; Saghir et al., 1970b; Hawkins, 1976; Anderson and Henderson, 1985) has only recently been a concern.

Methodological problems of previous research on gay and lesbian substance use warrant caution when interpreting the results. However, an empirical generalization has been reached based on these studies that gay men and lesbians experience are at risk for consuming alcohol at a level defined as problematic or indicative of alcoholism. A corollary to this would be that this community also has high levels of drug use. These conclusions are typically couched in the terms that homosexuals are 3 times more likely than heterosexuals to abuse alcohol or that approximately one-third of the homosexual population experience problems with alcohol or are alcoholic. Support for this contention come from a handful of studies.

For example, using self-reports from bar patrons (N=200) and opinions from bartenders in Los Angeles county, Fifield (1975) found in the sample that 10% were in the "crisis stage" of alcoholism and 21% were in a "high risk" category for alcoholism. This lead to the conclusion that one-third of the gay population in Los Angeles abuse alcohol on a regular basis. A similar finding was reported by Lohrenz et al., (1978) in their study of midwest gay men. Using the Michigan Alcoholism Screening Test (MAST) on a self-report questionnaire that was returned by 37.8% of their sample (145 gay men and 29 lesbians), these researchers found that 29% of the men surveyed were classified as alcoholics (the number of lesbians completing the survey was too small to conduct any meaningful analysis). Based on this, Lohrenz et al. state,

"Since the combined categories of Fifield (31%) and the finding of the present study (29%) are similar, one is tempted to conclude that at least 3 out of 10 members of the homosexual community have or will have serious problems with alcohol." (1978:1962).

Findings from other studies offered some credence to this characterization. Weinberg and Williams (1975) study of approximately 2500 male homosexuals in the United States, the Netherlands, and Denmark found that 29% of their sample reported drinking more than they should and 31% of these men reported doing so "pretty often". Finally, a study conducted by Saghir and colleagues found that when comparing a sample of gay men and lesbians who were members of homophile organizations with a control sample of people living in an apartment complex, 19% of the gay men and 33% of the lesbians were characterized as excessive drinkers compared to 11% of heterosexual men and 7% of heterosexual women (Saghir et al., 1970a; Lewis et al., 1982).

Recognizing the methodological problems of previous research, some researchers have begun to question the prevailing characterization of drug and alcohol use among gay men and lesbians and have called for "a systematic, rigorous epidemiological survey of alcoholism or of drinking patterns [and drug use] among the gay subculture" (Nardi, 1982: 13). Some studies are beginning to move in that direction. One good example is the research of Stall and Wiley (1988). Using interview data drawn from a large-scale random household sample of homosexual and heterosexual men living in an urban district in San Francisco, this three year prospective study measured the quantity and frequency of alcohol and drug use (marijuana/hashish, inhalants or "poppers", cocaine, MDA, PCP, hallucinogens, barbiturates, tranquilizers, sedatives, amphetamines, and opiates).

The results of this study indicated that 19% of gay men and 11% of heterosexual men age 25 to 54 exhibited frequent/heavy drinking patterns, defined as having 5 or more drinks on the same occasion during the past 6 months. While these percentages differences were not statistically significant, significant percentage differences were found between the gay and heterosexual samples for those age 45 to 54 (13% vs. 7.6% respectively). Moreover, when examining the maximum number of drinks consumed at any one time during a 6 month period, significant differences between the two samples were found in the youngest age cohort (25 to 34) and for the men as a whole. However, these differences were due to "a slightly higher probability of *heterosexual* men drinking at the heavy maximum consumption level" (Stall and Wiley, 1988:70).

Significant differences in the prevalence rates for the use of all drugs except cocaine and opiates were found for the two samples with these differences primarily occurring in the drug use of the youngest cohort. For instance, 82.9% of the gay men age 25 to 34 had used marijuana/hashish in the past 6 months compared to 73.2% of the heterosexual sample. The largest difference in drug use occurred for poppers, with young gay men being 58 times more likely to use "poppers" than their heterosexual counterparts (58.8% vs. 1.5% respectively). Such a disparity in the use of inhalants is not that surpris-

ing, however, given that amyl, butyl, and isopropyl nitrites are a distinctive "gay culture" drug.

The importance of studies such as Stall and Wiley's lie in the fact that, finally, scientifically sound research designs are being employed to investigate the diversity of substance use in the gay culture with an eye towards developing epidemiological, etiological, and comparative data. These data should provide more accurate and meaningful information on the role that drugs and alcohol play in the lives of lesbians and gay men. However, the Stall and Wiley study has its limitations in that it does not contain lesbians, has somewhat of a restricted age range, and is regionally specific.

McKirnan and Peterson (1989a, 1989b) also found high prevalence of substance use in their sample of 3400 lesbians and gay men in the Chicago area. The sample was acquired through distribution of surveys in gay/lesbian oriented newspapers, events, community organizations and advertisements in mainstream newspapers. The 2652 gay men and 748 lesbians who responded to the survey represent a return rate of 16%. The responses of lesbians and gay men were compared to a general population group responding to the 1979 National Institute on Alcohol Abuse and Alcoholism Survey (Clark & Midanik, 1982).

A significantly greater number of respondents to the NIAAA survey reported abstaining from alcohol use as compared to McKirnan & Peterson's respondents, with rates of 14% and 29% respectively. Comparisons of moderate levels of use also demonstrated a higher prevalence among lesbians and gay men with a rate of 71% compared to a rate of 57% for the general population sample. However, when heavy consumption was examined these differences disappeared with comparable rates of 15% for gay men and lesbians and 14% for the NIAAA respondents.

Use of marijuana, cocaine and inhalants was also analyzed. Lifetime and past year use of marijuana and cocaine were found to be significantly higher among the gay and lesbian sample as compared to the general population. Additionally, use of inhalants by the general population and by lesbians was relatively low, while a substantial number of gay men continue to use this drug.

McKirnan and Peterson note on the diminished effects of age and gender on substance use among lesbians and gay men. Using a role theory interpretation they conclude that the absence of the traditional role expectations of marriage and parenthood leave lesbians and gay men free to continue substance use beyond the traditional period of young adulthood.

The Trilogy Project

The Trilogy Project is a 5-year longitudinal study of social issues relevant to gay men and lesbians living in and around two metropolitan communities in a southern state. The goals of the study are to (1) develop statistical profiles on gay men and lesbians regarding the lifetime, past year, and past month use and changes in the patterns of use of 6 illicit drugs (marijuana, cocaine, crack, inhalants, hallucinogens, and heroin), the non-medical use of 4 types of psychotherapeutic drugs (stimulants, sedatives, tranquilizers, and analgesics), and 2 licit drugs (alcohol and cigarettes); (2) compare the prevalence rates of drug and alcohol use of gay men and lesbians to that of respondents from the 1988 National Household Survey on Drug Abuse (NHSDA); and (3) examine the etiology of substance use among gay men and lesbians by elaborating, refining, and testing causal models derived from the literature on stress, social supports, and personal well-being. This paper contains the relevant data for the goals (1) and (2).

Sample and Procedures

Respondents for this study were self-defined gay men and lesbians who lived in and around two metropolitan cities located in a southern state (1985 county population sizes were 212,000 and 683,00). These two cities are the largest in the state and contain well-organized gay and lesbian communities. Participants in the study completed a self-report survey and were offered no monetary remuneration. Three different sampling strategies were used.

Organization mailing list were used as a sampling frame to recruit respondents. Organizations in each community ran an announcement of the project in their newsletters and included a negative consent form. If a person did not want to participate in the study, (s)he could return the form to the organization. In total, only 6 negative consent forms were returned. Organizations were then provided research packets to send to members. A total of 455 (51.9%) surveys mailed to members of organizations were returned.

Chain referral sampling using indigenous researchers was used to recruit participants who were not on organizational mailing lists. Use of this procedure allowed for a more diverse sample and was employed under the assumption that people who were less open about their lifestyle would be less likely to be on mailing lists. Twenty-four indigenous researchers (10 gay men and 14 lesbians) were hired in Lexington and 26 in Louisville (12 gay men and 14 lesbians). Four of the researchers were African-American. All attended training sessions where the specifics of the project and their duties were discussed. Each indigenous researcher had an opportunity to pretest the instrument and suggest revisions. Researchers were paid \$200 to distribute a minimum of 20 questionnaires to people they knew in the gay and lesbian communities. A total of

547 (54.0%) surveys distributed by indigenous researchers were returned.

Convenience sampling of respondents occurred during a Gay Pride Week picnic in Community 2. An information booth was set up where people attending the picnic could request information about the study. If someone wanted to participate, they completed a mailing label that was not seen by the staff and affixed it to a research packet. The packet was then placed in a mail bag. Everyone who visited the booth was also given a pin bearing the project name, logo, and phrase "Our Numbers Are Growing." A total of 65 (58.0%) surveys distributed in this manner were returned.

Table 1 contains the sample sizes and return rates resulting from these techniques for each community. Overall, 1067 surveys were returned, resulting in a return rate of 53.3%. Note that the return rates within community are quite similar. Between community comparisons, however, show a somewhat higher rate for Lexington than for Louisville. This may relate to the fact that Lexington is the smaller of the two communities. Another significant note is the return rate for individuals contacted at the Pride Week picnic. This very respectable return points to the benefit of using such an approach, particularly in connection with an event that promotes community involvement and personal pride. Indeed, sample sizes and return rates using these three sampling techniques are impressive given that the following characteristics of the study work against having high participation: access to a target population such as gay men and lesbians has traditionally been very difficult, the survey was very lengthy (26 pages), no monetary incentives were offered, and sensitive questions were asked.

There are at least four major factors that contributed to the high level of participation in this study. First, during the 18 months prior to the distribution of the first Trilogy Project questionnaire, the initial stages of instrument testing and researcher-community relationship building began. Numerous meetings took place between the principal investigator and gay men and lesbians in the research site communities — Lexington and Louisville. Attendees were invited and encouraged to ask frank questions about the goals and procedures of the Trilogy Project and the research interests of the principal investigator. From the outset, it was made clear to these communities that the Trilogy Project was not conceived to simply be an academic exercise. The desire to make information accessible to the lesbian and gay community was an explicit part of the the project design and clearly added legitimacy to the process.

Second, while sections of the questionnaire were specifically designed to provide comparison measures corresponding to previous research, other questions were the result of interests and concerns of gay men and lesbians in the community. Questions on adoption, relationship issues, homophobia, and social activities all came as a result of a collaborative effort between the research staff and the "community". The inclusion of

respondents as active, rather than passive, participants in the process benefitted both the Trilogy Project and the lesbian and gay community and is an essential component that contributed to the success of the study.

A third major factor has to do with project recognition. The name Trilogy Project and the project's logo were chosen because of their symbolic meaning in the gay and lesbian community. The movie and play "Torch Song Trilogy" portrays the lives of people in the gay culture and is well-known. The project logo depicts three overlapping pink triangles. The pink triangle has symbolic meaning because it was used by Nazi Germany to identify gay men in concentration camps (Plant, 1986) and currently appears on cultural artifacts of the lesbian and gay community such as flags, posters, and buttons (e.g. the SILENCE=DEATH AIDS button).

The fourth contributing factor relates to procedures use to assure confidentiality and anonymity. Each research site had what was called a community coordinator. This person was responsible for handling all personal information such as names and addresses of participants in their respective communities. The principal investigator never saw the names or addresses of project participants or the mailing lists of organizations. On the other hand, each respondent mailed the survey back to the principal investigator. Thus, individual survey data was never seen by the community coordinators or indigenous researchers. By keeping this information separate, we were able to allay some of the participant's concern over being identified and exposing confidential information.

Moreover, a confidentiality certificate from the National Institute on Drug Abuse was obtained. This certificate represents the federal government's assurance that all person's with access to identifying information about project respondent's are "authorized to protect the privacy of the individual's who are the subjects of that research by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research."

Table 2 presents the demographic characteristics of the sample. Of these respondents, 53.1% are gay and 46.9% lesbian, 93.3% are white, 61.8% are currently in a same-sex relationship (44.6% cohabitating), 78.9% are currently employed full-time, and 80.2% live in a city or suburb. The average age of respondents is 34.4 and average years of education is 15.1. These characteristics are similar to those found in other studies and suggest that gay men and lesbians who are accessible to researchers tend to be primarily urban, well-educated, and young to middle age. Yet, the sampling techniques used were somewhat effective in reaching older people (6% of the sample is over 50) and those living in rural areas (7.4%). There is very little difference in the demographic composition of the sample for each community.

Prevalence of Illicit and Licit Drug Use

The prevalence rates for lifetime, past year, and past month illicit and licit drug use for gay men and lesbians appear in Tables 3 and 4. These data were calculated from responses to the question "When was the most recent time you used ... [marijuana or hash], ...[cocaine], ... [crack], etc.? The response categories ranged from never to within the past week. These questions were taken from the National Household Survey on Drug Abuse (1988) in order to establish comparable drug and alcohol measures. Three patterns are noteworthy about these tables.

First, the lifetime prevalence rates for lesbians on most of the drugs are slightly higher than that of gay men although most of these differences are not significant. This would suggest that lesbians may be more likely than gay men to experiment with different types of drugs sometime in their life but do not currently use these drugs. Lesbians are more likely to currently use marijuana than any other illicit drug. Second, gay men are significantly more likely to have ever and currently used inhalants than lesbians. Prevalence rates for past year and past month use of stimulants and sedatives are also significantly higher for gay men than lesbians. Clearly the differences in inhalants use point to its popularity among gay men, although almost 40% of lesbians have tried this form of drug. While a greater proportion of gay men currently use both marijuana and inhalants than other types of drugs, these proportions are substantially lower than those reported by Stall and Wiley (1988). For instance, 77.5% of the gay men in Stall and Wiley's study used marijuana during the past six months while only 36.5% of the gay men in our study used marijuana in the past year. Rates for current use of cocaine and inhalants are also substantially higher in the Stall and Wiley study. These differences are undoubtedly affected by the geographic location of each study and a more inclusive age range in our study. Finally, gay men are significantly more likely to currently use alcohol while significantly less likely to have ever or currently used cigarettes than lesbians.

Comparisons of Drug and Alcohol Use with the NHSDA

In order to more fully examine whether gay men and lesbians have a higher rate of drug use than the general population, past year prevalence rates of alcohol, marijuana, inhalants, and cocaine for the Trilogy Project were compared to that of the 1988 National Household Survey on Drug Abuse (NHSDA). The NHSDA is the ninth in a series of studies conducted by the National Institute on Drug Abuse. The primary purpose of the study is to measure the prevalence and correlates of drug use in the United States. The target population for the 1988 NHSDA was the household population aged 12 and older. A multi-stage area probability sampling design was used to obtain personal interview data from approximately 8,000 people. At the end of data collection, sample weights were assigned to reflect various stages of the sampling procedure (for a complete description of the study see NIDA, 1991).

A subsample of these data (N=1250) was selected that contained respondents age 18-79 (this matched the age distribution in the Trilogy Project) who lived in two census divisions. These divisions contained the states of Alabama, Kentucky, Mississippi, Tennessee, Illinois, Indiana, Michigan, Ohio, and Wisconsin and were selected in an effort to geographically match the samples. It should be noted that these selection procedures do not bias the representativeness of the NHSDA survey. Rather, they just place some parameters around generalizations that can be made about the subsample. Moreover, the NHSDA does not contain a question measuring sexuality. Thus, in a strict sense, the following comparisons refer to members of households, not heterosexuals per se.

Figures 1 and 2 present comparisons of prevalence rates for past year use of alcohol, marijuana, inhalants, and cocaine by males and females. In general, Trilogy Project participant's past year use of alcohol, marijuana, and inhalants was significantly higher than that of NHSDA participants. Noted exceptions were cocaine use among males 18-25 and 26-34, inhalant and cocaine use among females 18-25 and 26-34, and inhalant use among females 35 and older. A complete discussion of each drug follows.

Alcohol Use and Abuse

Although differences in prevalence of alcohol use are significant, the percent differences between the two samples are not that great. When we couple this information with data from Table 5, the findings indicate that the differences between Trilogy Project participants and NHSDA participants have to do with two things — differences in levels of abstinence and differences in the number of days in a month alcohol is consumed. As Table 5 indicates, a significantly larger number of males and females in the Trilogy Project have used alcohol in the past month. Additionally, differences in use for 5-19 days and 20-30 days are also significantly higher for Trilogy Project participants.

Problem drinking has been cited by past research to be a major issue in the gay and lesbian community. The second part of Table 5 seeks to address this issue by looking at levels of high consumption of alcohol. While significant differences do exist between the two groups when looking at the number of days alcohol is consumed, few differences are noted when we look specifically at a high level of consumption, defined by having 5 or more drinks within a couple of hours of each other. Three differences between the samples appear. Firstly, a significantly larger portion of the NHSDA respondents had never consumed 5 or more drinks on one occasion in the last month. Secondly, a significantly larger percentage of Trilogy Project respondents had consumed 5 or more drinks on one occasion during 1-4 days of the past month. And, finally, a significantly larger number of lesbians had 5 or more drinks on the same occasion in the 5-30 day group than women in the NHSDA. However, as demonstrated in the final section of Table 5, the removal of

abstainers from both the Trilogy Project and NHSDA samples eliminates any significant differences between the two groups. It should be noted that high levels of consumption on 20-30 days in the past month are relatively uncommon for both samples.

Marijuana Use

As previously mentioned, marijuana use among lesbians and gay men in the Trilogy Project is significantly higher than use found among males and females in the NHSDA. In fact, levels of use by lesbians is not only higher than that of females in the NHSDA, but it is comparable to levels of use by gay men. For Trilogy Project respondents lesbians and gay men had prevalence rates of 36.1% and 36.5%, respectively. Their NHSDA counterparts reported rates of 8.2% for women and 14.7% for men.

By controlling for age and gender, prevalence rates of 18-25 and 26-34 year old males are approximately 30% higher for Trilogy Project participants than those found in the NHSDA. For women, we find that 18-25 year olds in the Trilogy Project sample have a prevalence rate that is nearly double that of the women in the NHSDA study — 48.8% and 25.1% respectively. This difference becomes even more marked in the 26-34 age group with prevalence rates among lesbians reaching 4 times that of women in the NHSDA study — Trilogy Project respondents 42.6% and NHSDA respondents 10.8. For respondents 35 and older, prevalence rates for males and females within each sample are very similar. For the NHSDA sample, these rates are 3.2 for females and 3.5 for males. For Trilogy Project respondents, these rates are 26.9% for females and 28.0% for males. However, between sample comparisons for this age group indicate that Trilogy Project respondents have a rate for past year use of marijuana that is about 8 times that of NHSDA respondents.

Inhalant Use

Use of inhalants, i.e. "poppers", has long been deemed a particular phenomenon of the gay male culture. Although, recent research provides some evidence that AIDS education may have reduced the level of use among gay men, the findings of the Trilogy Project indicate that inhalant use remains a significant part of gay male culture. Males in the Trilogy Project used inhalants at a rate of 36.5% compared to a rate of 1.9% among male NHSDA respondents. These differences were consistent for men across all age groups. Most notably, among men 35 and older, NHSDA respondents indicate no use of inhalants while Trilogy Project reported a prevalence rate of 28.0%.

Among women differences between prevalence rates of Trilogy Project and NHSDA respondents also existed in inhalant use. However, highlighting the reality of inhalant use as primarily a gay male activity, the rate for Trilogy Project females was 4.5%, while

the rate for NHSDA females was 1.0%. Although the rate for females in the Trilogy Project is 4 times that of NHSDA respondents, we are talking about a relatively small number of women.

Cocaine Use

Overall prevalence of cocaine use is relatively low for both samples. For males, rates for the Trilogy Project were 9.7% and a rate of 6.5% was reported by NHSDA respondents. By controlling for age among male respondents in both samples, we find that prevalence rates for males in the NHSDA are higher than those of their Trilogy Project comparison group. For instance, among 18-25 year old males, the rates for NHSDA and Trilogy Project were 20.4% and 15.2% respectively. A similar pattern is seen among 26-34 year old males, with a rate of 12.7% for NHSDA and 10.3% for the Trilogy Project.

Among women, a wider gap exists between females in the Trilogy Project and those in the NHSDA, with rates of 7.1% and 2.7% respectively. However, once again we are talking about relatively small percentage for both samples.

Concurrent and Simultaneous Use of Licif and Illicif Drugs

Additional analysis was done to examine concurrent use of alcohol, marijuana, inhalants, and cocaine. Concurrent use refers to use of one or more of these substances within the past year. As might be expected, alcohol plays a pivotal role in substance use. Few gay men and lesbians in the Trilogy Project reported use of marijuana, inhalants, and/or cocaine in the past year, while abstaining from alcohol use. In fact, of the 489 lesbians, only 1.6% indicated use of marijuana only in the past year. Additionally, none of the lesbians responding indicate use of only cocaine or inhalants. A similar pattern existed among gay men. Of the 557 men responding only 0.5% indicated use of marijuana only and 1.1% indicated use of inhalants only. None of the gay men indicated use of only cocaine in the past year. These figures can be juxtaposed against prevalence rates when alcohol was used in the past year. For lesbians, 25.4% used both marijuana and alcohol in the past year; for gay men, the prevalence rate was 13.5%.

The substantial role of alcohol in substance use is again demonstrated in analysis of simultaneous use of marijuana, inhalants, and cocaine. Simultaneous use refers to use of a combination of drugs on the same occasion or within a couple of hours of each other. For example, respondents were asked, "In the past 12 months, when you have used alcohol how often have you also used on the same occasion or within a couple of hours marijuana?" In response to the above question, 32.8% of lesbians and 36.0% of gay men in the sample said they had used marijuana simultaneously with alcohol. Asking the reverse of this question, however, provides a clearer picture of alcohol as a

linchpin in substance use. When asked, "In the past 12 months, when you have use marijuana how often have you also used on the same occasion or within a couple of hours alcohol?", 79.9% of lesbians and 87.3% had done so on at least one occasion.

Lesbians and Alcohol and Marijuana Use

Some suggestions in the literature have been made to indicate that differences in social roles for lesbians and their non-lesbian counterparts allow for higher levels of substance use among the former. Specifically, absence of the expectations of parenting and marital roles create a different lifestyle for lesbians (McKirnan & Peterson, 1989a). Data from the Trilogy Project indicates that the lifestyle of many lesbians may include some of the same social roles of heterosexual women. Among lesbians responding to the survey, 21% either had children of their own or had a partner with children and 73% of the respondent's were involved in a primary relationship.

Recognizing that many lesbians do live in cohabitating relationships and do have children, an analysis of variance was done controlling for age to determine the effects of children and partners on alcohol and marijuana use. The findings raise some interesting questions. The grand mean for frequency of alcohol use was 3.33 (the range of responses was from (1) Never to (6) Daily). Controlling for relationship status in terms of three categories, single lesbians had a mean frequency level of 3.42, noncohabitating lesbians had a mean of 3.51, and cohabitating lesbians had a mean of 3.23. These means were not significantly different. Similarly, relationship status had little effect on marijuana use (grand mean=1.85) with respective means of 1.88, 1.78, and 1.87 for the three categories.

The effect of children, either the respondent's or their partner's, on the use of alcohol and marijuana was somewhat different. The effect of children on alcohol use was notable and significant, with a mean of 3.48 for women without children and 2.86 for women with children. On the other hand, children seemed to have little effect on the use of marijuana among lesbians responding. The mean for marijuana use among lesbians without children was 1.91 and the mean for lesbians with children was 1.68, a non-significant difference.

Two possible explanations come to mind for these findings. One factor could be the effect children have on going to bars — while the consumption of a licit substance such as alcohol might be curtailed by not going out to bars, the consumption of an illicit substance, in this case marijuana, would be virtually unaffected. Also, the communal nature of marijuana use and the increased likelihood that many lesbians may socialize in small groups in private homes may also contribute to the minimal effect that children have on levels of marijuana consumption.

Discussion and Conclusions

Drug and alcohol use among lesbians and gay men is an issue that has been examined from a number of perspectives. Much of the early research has been plagued with methodological limitations and it has been only within the last ten years that studies have been designed to compensate for these shortcomings. This paper has presented data from a study known as the Trilogy Project. It was specifically designed to obtain epidemiological data on all types and patterns of illicit and licit drug use using multiple sampling techniques for a relatively large sample of lesbians and gay men living in areas other than the "magnetic" urban centers of San Francisco, Chicago, or New York. The Trilogy Project also has the advantage of using measurement techniques comparable to that of a national drug and alcohol study of household residents. Taken together, the findings from this study have hopefully provided new substantive and methodological insights regarding the complex nature of drug and alcohol use and how to study it in this population.

It is evident from the findings on the lifetime use that a fairly large proportion of gay men and lesbians have used some type of illicit and/or licit drug in their life. However, current use of some drugs (defined as either in the past year or past month) is not that common. Less than 10% of gay men and lesbians have currently used cocaine, crack, hallucinogens, heroin, stimulants, sedatives, tranquilizers, and analgesics. Gender differences were evident in the use of some drugs, particularly use of inhalants.

The analyses comparing rates of use for drugs and alcohol between participants in the Trilogy Project and a subsample of the NHSDA revealed some interesting findings. Contrary to the empirical generalization that homosexuals are 3 times more likely than heterosexuals to exhibit drinking patterns indicative of alcoholism and problem drinking, we found minor differences in the two groups regarding heavy or problematic alcohol use as defined by having 5 or more drinks on 20 or more days during the past. Not only were these differences minor, the prevalence rates for gay men and lesbians regarding this pattern of alcohol use never approached the 30% figure found in other studies. Based on these data it is reasonable to conclude that the prevalence of problematic alcohol use among gay men and lesbians is not higher than that occurring in the general population.

Differences in the past year use of marijuana and inhalants were evident in the comparisons. The dramatic difference in inhalant use was expected. What is also clear is that marijuana is fairly popular. In particular, gay men and lesbians 35 and older were about 8 times more likely to use marijuana in the past year than those in the NHSDA. It appears that along with inhalants, marijuana is also a component of the gay and lesbian drug culture. On the other hand, the use of cocaine in the past year, especially for the

18-25 and 26-34 year old age groups, was very similar.

It is important to remember that despite a large sample size and good return rates, probability sampling techniques were not used. Thus, the findings from this study cannot be generalized to the entire population of gay men and lesbians living in the communities. In fact, to date, no study has been conducted that contains a nationally representative sample of homosexuals, although procedures have been examined that allow for this possibility (Harry, 1990). However, this study does illustrate the importance of using multiple sampling techniques, developing symbolic meaning, collaborating with community organizations, and employing community members as stewards for personal information for obtaining large samples. These methodological initiatives are many times ignored by researchers and their absence contributes to biased and limited data.

Although the large sample found in this study represents a wide range of ages from 18-79, the demographic profile highlights the limitations experienced when trying to achieve diversity. Differences in experiences of gay and lesbian persons from different racial or ethnic backgrounds are a primary factor. Being an African-American or Hispanic gay man or lesbian is a different experience than being a Caucasian lesbian or gay man. Additionally, being a woman in our society results in yet another type of oppression and discrimination. For many lesbians and gay men, the oppression they experience may be linked more strongly to their gender, race and/or ethnicity, leaving concerns about issues surrounding sexual orientation to take a secondary or tertiary role in their lives. Research on the lives of gay men and lesbians may be less significant to them than, for instance, research on the experiences of racial minorities.

A second factor which may limit accessibility stems from political realities. Research, and the individuals and institutions that tend to conduct it, are often linked to the bodies that are responsible for much of institutionalized oppression. For many would-be respondents a political issue is raised by the suggestion of their participation in research. As Shulamit Reinharz (1992:256) states that "volunteers are themselves a self-selecting group". Fear of how the findings of any research on an already marginalized group might affect that group often curtails the willingness of some individuals to participate. This concern is heightened when the researcher is seen as an outsider to the group being asked to participate. As Charlene Depner (Reinharz, 1992:258) points out, "a feminist researcher standard of maximum diversity is perhaps logically and practically impossible while desirable as an ideal type".

Past research points to two important issues for policy makers and program developers in the area of substance abuse. First, research indicates that a problem with substance use and abuse may exist in the lesbian and gay community. While the extent of that

problem is uncertain and, in fact, may not be as pervasive as previous research indicates, it does exist. Secondly, the recognition that homophobia and/or lack of knowledge about homosexuality remains an issues among service providers points to the likelihood that lesbians and gay men with substance abuse issues may not be receiving appropriate services.

Regardless of the extent of the substance abuse problem in the lesbian and gay community, the existence of such a problem is documented and points to the need for programs specially designed to meet this populations needs. Programs need to recognize both the differences and similarities between gay and lesbian substance abusers and their nongay/lesbian counterparts. Targeted community outreach programs, similar to many of the safe sex campaigns of the current AIDS era, can act as methods of education and awareness for the community as well as a way of spotlighting available agency services.

Key to the development of any successful program is the recognition that it has to be used before it can work. For many lesbians and gay men, willingness to use any service relates directly to how they anticipate being perceived by that agency and its staff. The existence of homophobia among social workers, psychologists, psychiatrists, and other helping professionals can have numerous deleterious effects on clients. Homophobia takes many different shapes. For instance, by assuming all clients are heterosexual, many mental health professionals contribute to the invisibility of gay and lesbian clients. While the client's sexual orientation may not be the focus of their presenting problem, being gay or lesbian contributes significantly to the process of addressing any issue. This heterosexual bias sets the stage for a void in communication which may lead to the absence of pertinent information about that client and her/his needs.

For many agency staff members, homophobia may be synonymous with lack of knowledge about the gay/lesbian lifestyle and/or a stereotypical view of persons who are gay or lesbian. Research indicates that homophobia is often tied to religious beliefs, education, and whether a person knows someone who is gay or lesbian (Britton,1990; Millham et al., 1976; Nyberg & Alston, 1976). A study done by Carla Lee Anderson (1982) demonstrated the effectiveness of contact with gay men and lesbians in working to reduce homophobia. Recognition of the major contributing factors to the existence of homophobia helps to pave the way to develop procedures for homophobia reduction among agency staff. Staff development efforts should include education about (1) the nature of lesbian and gay culture (particularly the role of the bar in many individual's lives), (2) the difference between myths about homosexuality and reality, (3) the nature of "family" for many lesbians and gay men, and (4) the impact of being part of a stigmatized group. Staff development workshops lead by lesbians and gay men allow this information to be conveyed while also providing an opportunity for nonconfrontational interaction.

In his concluding paragraph, Harry (1990) states, .

“While gay studies have progressed far from the decades when homosexual respondents were obtained from the prison and mental hospital..., it is now necessary to attempt probability surveys in order to locate the rarer and less visible homosexual subgroups and to know the all-important demographics of the homosexual population”(103).

This is certainly the direction for future research. However, community-based studies can help fill the gap in our knowledge base until such studies are conducted. It is our contention that there is a genuine interest in the gay and lesbian community to learn more about themselves. Researchers and practitioners need to realize this and design studies, programs, and policies that make participation nonthreatening, safe, and worthwhile.

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Table One: Number of Surveys Mailed/Distributed and Return Rates for Sampling Procedures

	Lexington		Louisville		Total	
	n	Return Rate	n	Return Rate	n	Return Rate
Mailing Lists						
Packets Mailed	279		673		952	
Not Completed*	49	17.5	26	3.8	75	7.9
Completed	145	63.0	310	47.9	455	51.9
Indigenous Researchers						
Packets Distributed	473		558		1031	
Not Completed*	9	1.9	9	1.6	17	1.6
Completed	308	66.4	239	43.5	547	54.0
Picnic						
Packets Distributed	NA		112		112	
Completed	NA		65	58.0	65	58.0
Total						
Packets Mailed or Distributed	752		1343		2096	
Not Completed*	58	8.3	35	2.7	83	4.1
Completed	453	65.3	614	46.9	1067	53.3

* Surveys that were returned because (1) the person was not a self-defined lesbian or gay man, or (2) no forwarding address was available.

Source: Trilogy Project, National Institute on Drug Abuse, 1992.

Table Two: Demographic Characteristics of Sample

	Lexington		Louisville		Total	
	N	%	N	%	N	%
Gender						
Male	228	50.3	292	53.2	567	53.1
Female	225	49.7	257	46.8	500	46.9
Race						
White	410	91.1	525	95.6	996	93.3
Black	29	6.4	12	2.2	45	4.2
Other	11	2.4	11	2.0	22	2.1
Relationship Status						
Single	148	32.9	200	36.8	376	35.5
Cohabiting	218	48.4	230	42.4	472	44.6
Noncohabiting	70	15.6	99	18.2	182	17.2
Other	14	3.1	14	2.6	28	2.6
Employment						
Full-time	349	77.0	447	81.4	842	78.9
Part-time	55	12.1	52	9.5	117	11.0
Unemployed	16	3.5	17	3.1	37	3.5
Other	33	7.3	33	6.0	71	6.7
Residence						
City (over 100,000)	344	76.6	456	84.1	847	80.2
Town (under 100,000)	61	13.6	55	10.1	131	12.4
Rural	44	9.8	31	5.7	78	7.4
Education						
12 Years or less	53	11.8	87	15.9	149	14.0
Some college	124	27.5	162	29.6	318	29.9
College +	274	60.8	298	54.5	596	56.1
Mean Years of Education	15.3		15.1		15.1	
Mean Age	33.9		35.3		34.4	

Source: Trilogy Project, National Institute on Drug Abuse, 1992.

Table Three: Lifetime, Past Year, and Past Month Prevalence Rates for Illicit Drug Use: Gay Men and Lesbians, Age 18 and Older

	Gay	Lesbian	Total
Marijuana			
Lifetime	76.5	85.9*	80.9
Past Year	36.5	36.1	36.3
Past Month	19.1	20.6	19.8
Cocaine			
Lifetime	34.2	35.0	34.6
Past Year	9.7	7.1	8.5
Past Month	1.8	2.4	2.1
Crack			
Lifetime	3.8	2.2	3.1
Past Year	1.1	0.0	0.6
Past Month	<0.5	0.0	<0.5
Inhalants			
Lifetime	65.1*	39.1	52.9
Past Year	29.8*	4.5	17.9
Past Month	18.5*	2.0	10.8
Hallucinogens			
Lifetime	28.9	32.3	30.5
Past Year	5.4	3.0	4.3
Past Month	1.1	1.6	1.3
Heroin			
Lifetime	2.3	3.2	2.8
Past Year	<0.5	<0.5	<0.5
Past Month	0.0	<0.5	<0.5
Illicit Drugs			
Lifetime	83.6	85.8	84.6
Past Year	48.0*	36.8	42.7
Past Month	30.0*	22.2	26.3
Minimum N	557	491	1048

* Differences in proportion test significant at .05 level.

Source: Trilogy Project, National Institute on Drug Abuse, 1991.

Table Four: Lifetime, Past Year, and Past Month Prevalence Rates for Nonmedical use of Psychotherapeutics, Alcohol, and Cigarettes: Gay Men and Lesbians, Age 18 and Older.

	Gay	Lesbian	Total
Stimulants			
Lifetime	40.7	45.7	43.1
Past Year	9.5*	6.1	7.9
Past Month	3.9*	1.8	2.9
Sedatives			
Lifetime	27.5	29.8	28.6
Past Year	5.5*	2.2	4.0
Past Month	2.1*	0.6	1.4
Tranquilizers			
Lifetime	31.6	32.3	31.9
Past Year	10.4	8.9	9.7
Past Month	3.6	2.6	3.1
Analgesics			
Lifetime	22.4	24.4	23.3
Past Year	7.3	6.9	7.1
Past Month	2.2	2.0	2.1
Psychotherapeutics			
Lifetime	49.4	54.4	51.6
Past Year	18.5	15.6	17.2
Past Month	7.6	5.2	6.5
Alcohol			
Lifetime	98.2	98.8	98.5
Past Year	89.3	87.0	88.2
Past Month	79.8*	72.7	76.5
Cigarettes			
Lifetime	68.0	77.0*	72.2
Past Year	40.4	50.2*	45.0
Past Month	35.2	42.5*	38.6
Minimum N	548	491	1041

* Differences in proportion test significant at .05 level.

Source: Trilogy Project, National Institute on Drug Abuse, 1991.

Table Five: Percent Distribution of Number of Days During Past Month Respondent Used Alcohol and Consumed 5 or More Drinks on the Same Occasion; by Gender: Trilogy Project and the 1988 National Household Survey on Drug Abuse.

Number of Days	Male	Trilogy Female	Total	Male	NHSDA Female	Total
0	21.3 (117)	30.6 (149)	25.7 (266)	39.7 (180)*	57.9 (390)*	49.4 (570)*
1-4	28.7 (158)	31.8 (155)	30.2 (313)	26.7 (136)	28.3 (230)	27.8 (366)
5-19	32.4 (178)*	25.5 (124)*	29.1 (302)*	22.1 (122)	10.8 (75)	16.1 (197)
20-30	17.6 (97)*	12.1 (59)*	15.0 (156)*	11.6 (53)	2.4 (16)	6.7 (69)

Number of Days Having 5+ Drinks	Male	Trilogy Female	Total	Male	NHSDA Female	Total
0	68.5 (379)	74.5 (366)	71.4 (745)	74.8 (353)*	91.0 (657)*	83.4(1010)*
1-4	18.3 (101)*	17.9 (88)*	18.1 (189)*	13.6 (88)	6.5 (56)	9.9 (144)
5-19	11.4 (63)	6.7 (33)	9.2 (96)	9.4 (58)	2.4 (15)	5.7 (73)
20-30	1.8 (10)	0.8 (4)	1.3 (14)	2.1 (14)	0.1 (2)	1.0 (16)
[5-30]	13.2 (73)	7.5 (37)*	10.5 (110)*	11.5 (72)	2.5 (17)	6.7 (89)
1-4	58.0 (101)	70.4 (88)	63.2 (189)	54.2 (88)	72.8 (56)	59.5 (144)
5-19	36.2 (63)	26.4 (33)	32.1 (96)	37.4 (58)	26.4 (15)	34.3 (73)
20-30	5.7 (10)	3.2 (4)	4.7 (14)	8.4 (14)	0.8 (2)	6.3 (16)
[5-30]	42.0 (73)	29.6 (37)	36.8 (110)	45.8 (72)	27.2 (17)	40.6 (89)

Number of cases in parentheses; unweighted N for NHSDA.

* Differences in proportion test significant at .05 level.

Source: Trilogy Project, National Institute on Drug Abuse, 1992.

Figure One: Comparison of Past Year Prevalence Rates for Males: Trilogy Project and 1988 NHSDA.

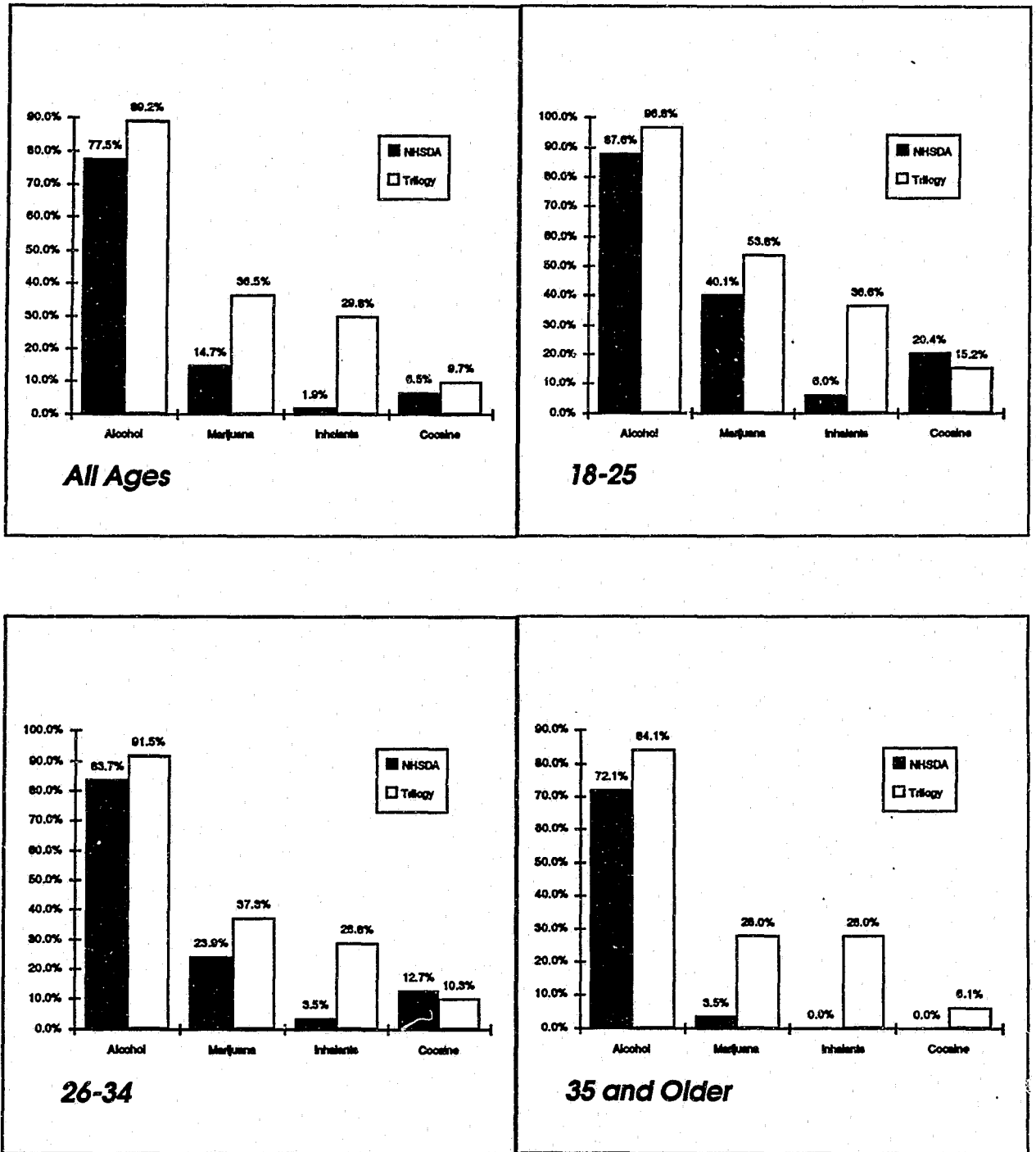
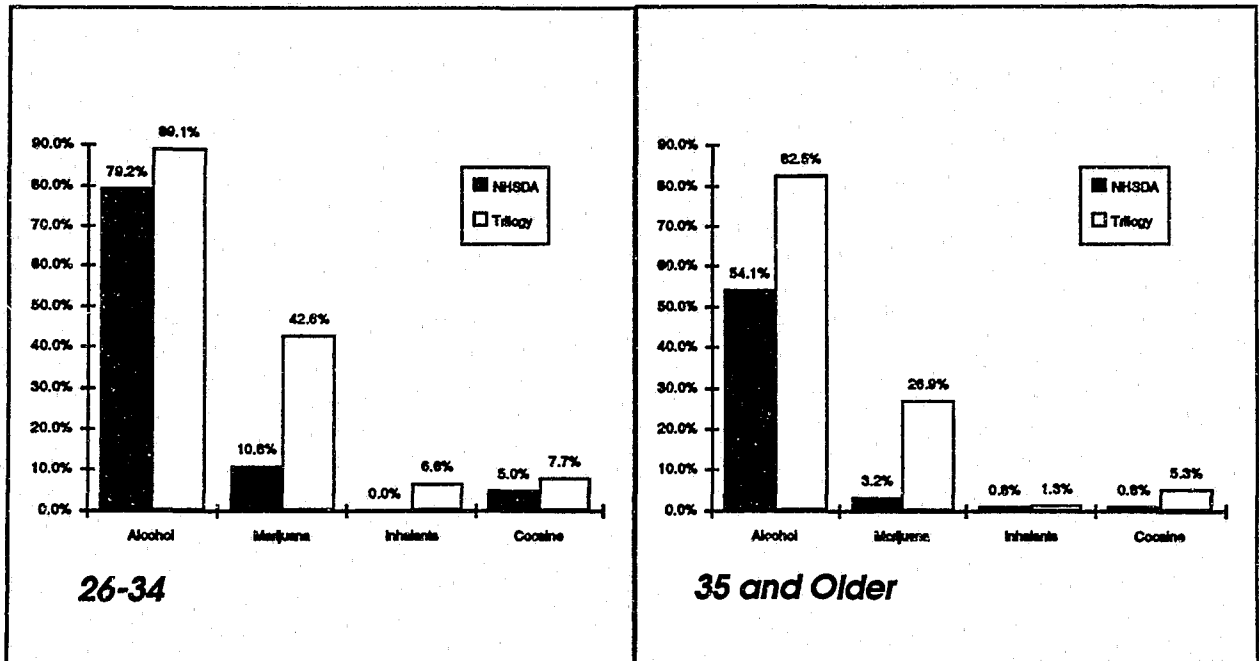
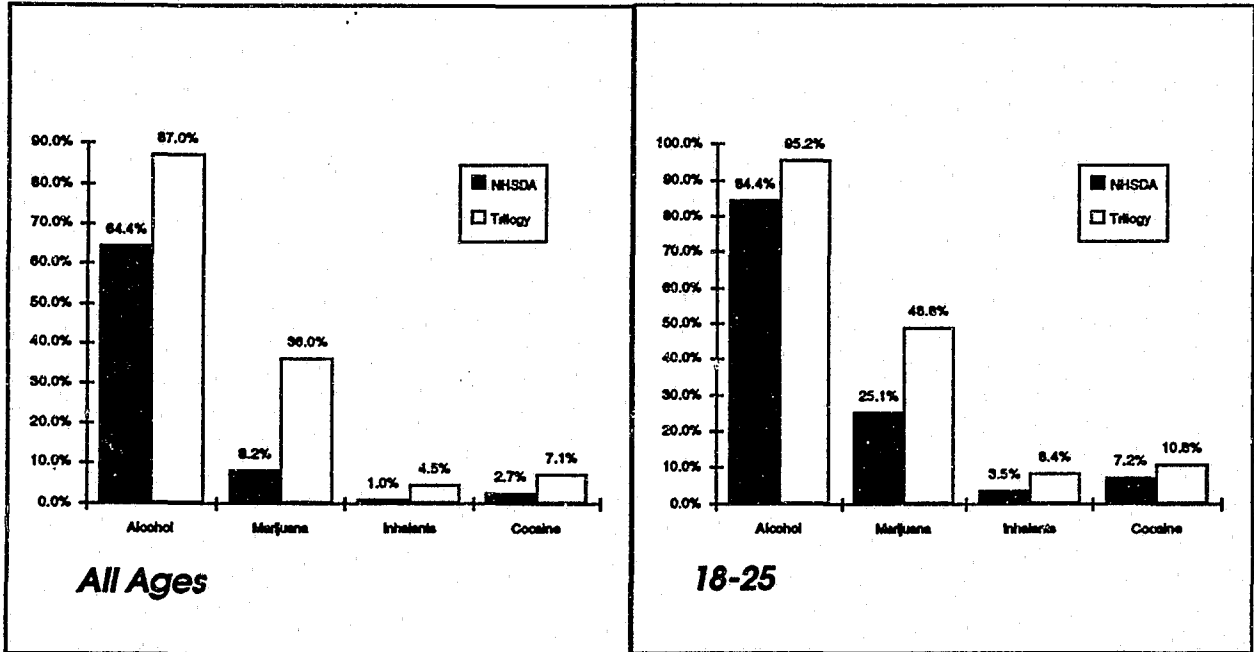


Figure Two: Comparison of Past Year Prevalence Rates for Females: Trilogy Project and 1988 NHSDA.



Gay and Lesbian Alcohol Use: Epidemiological and Psychosocial Perspectives

David J. McKirnan and Peggy L. Peterson
The University of Illinois at Chicago

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Abstract

Gay men and women have been described as at high risk for alcohol and drug abuse, due to psychosocial variables such as stress levels or the cultural importance of bar settings. However, few studies have attempted to systematically sample gay and lesbian communities. The first part of this paper presents the findings of a large survey of a gay-lesbian population regarding population characteristics and patterns of alcohol and drug use. The second part presents the results of an interview study regarding psychosocial variables that may be related to substance use patterns both generally and in this population.

Higher proportions of the gay-lesbian sample used alcohol or drugs than would be expected from the general population. This was not accompanied by more heavy use, although gays and lesbians did show higher rates of alcohol problems. In the general population women consume less drugs and alcohol than do men, and substance use substantially declines with age. Neither of these patterns were found for the gay-lesbian sample, thus creating overall higher rates of substance abuse. In part this may reflect differences between the gay and general populations in adherence to sex-role stereotypes and age related social role changes.

Both general and culturally specific psychosocial variables related to substance use. Gay men and lesbian women differed in the effect of such variables; men tended to respond to discrimination, while women were responsive to general negative affect and stress. Psychological vulnerability to alcohol — in terms of expectancies of alcohol effects, and an attitudinal orientation toward gay bars — strongly related to consumption and abuse. These patterns were strongly affected by respondents' identification with the gay community, as were the effects of substance use on high risk sexual behavior. Thus, culturally specific psychosocial variables — discrimination, an orientation toward gay bars, and gay identification — are important to understanding substance use in this population.

Substance Abuse Among Gays and Lesbians

Many researchers and clinicians have proposed that gays and lesbians are at particular risk for alcohol and drug abuse (see Ziebold & Mongeon, 1982). For example, a major treatment facility has routinely advertised that one out of three gays or lesbians suffers from the "disease" of chemical dependence. This 33% number has been commonly accepted by human service providers, editorialists, and others both within and outside of the lesbian and gay communities. Some social or cultural factors make this plausible; the importance of bars as social settings in gay/lesbian communities, as well as stressors of membership in a sexual minority, discrimination, or concern over AIDS, may induce particular vulnerability to chemical dependency.

When we began our research we assumed that this figure was basically correct, so we set out to examine the social and psychological factors that dispose so many gays and lesbians toward substance abuse. In examining the literature, however, we were surprised to find that the 33% figure was based on very little actual research. None of the few broadly based studies of gay-lesbian populations have systematically assessed substance abuse (e.g., Bell & Weinberg, 1978; Shagir & Robins, 1973), and general epidemiological studies of substance abuse do not measure sexual orientation (e.g., Clark & Midanik, 1982; Miller, 1983). More distressing, several of the few extant studies were badly flawed or biased.

The 33% figure initially came from a famous study by Lelene Fifeld (1975) conducted in the early 1970's. She found about a third of gay men in Los Angeles County to be "alcohol abusers," with about 10% "alcoholics". Although Fifeld distinguished "abusers" from "alcoholics," many people citing her research have not, and the one-third figure has come to be taken as the rate of gay "addiction" generally. Even using Fifeld's original wording, her figures are much greater than what one would expect in the general population. This is of some import, given both the size of the gay-lesbian community, and the fact that substance abuse, besides being a problem in itself, may increase behav-

ioral or immunological risk for the transmission of HIV (McKirnan & Peterson, 1988a; Stall et al., 1986).

How accurate is this picture? An examination of Fifeld's methods cast considerable doubt on her findings. Her primary source of interview respondents was from snowball sampling within gay bars. An often cited study by Lohrenz et al. (1978) also found high substance abuse rates among gays, again using bar samples (see, however, Lewis et al. 1982). It should be noted that the gay "bar scene" does represent a better cross-section of that community than would be the case among heterosexuals, given that the gay bar operates as a community meeting place, somewhat akin to the British "pub". Still, finding high rates of substance abuse among bar patrons is no surprise, and may not represent rates of substance abuse among the general gay/lesbian population.

This sampling bias stems from two sources. First, it is not clear who is or is not a member of the "gay-lesbian community". Does having sex at least once with someone of the same sex qualify? Must one self-identify as "gay", independent of behavior? Second, given the stigmatization, discrimination, or even violence faced by gays and lesbians (NGLTF, 1987; Peterson & McKirnan, 1988), many potential respondents are motivated to keep their sexual orientation covert. Typical probability sampling methods, which often employ telephone or doorstep contacting of respondents, may thus be ineffective.

The consequence of these difficulties is that studies have tended to rely on convenience sampling, drawing respondents from existing settings that are largely or exclusively oriented toward gays or lesbians. Unfortunately, in many studies such settings have consisted of bars, self-help or support groups, psychiatric clinics, or even prisons (for a discussion of such sample bias see Gonsiorek, 1982). Acquiring samples in such settings may seriously bias results toward participants who have social or personal problems. Further, these biases may not always be apparent to researchers or clinicians, who are likely to read the results of such studies in review form. The extent to which Fifeld's results have been accepted as valid is ample evidence of this.

The first objective of the research described here was then to provide a more general, less biased perspective on the rates of alcohol and drug use among the members of a large, urban, gay-lesbian community. We attempted to avoid the obvious sources of sample bias that affected other studies, by employing as diverse a sampling procedure as possible. In particular, we attempted to avoid sampling through bars or other "problem biased" sources.

Cultural and Psychological Factors in Gay-Lesbian Substance Use

In addition to simple epidemiology we were interested in psychosocial variables that might affect substance use in this community. The alcohol and drug abuse literatures suggest several generally important social or psychological factors, that may also be particularly relevant to gay and lesbian populations.

Social "Marginality" and Substance Use

Researchers have long proposed that increasingly constrained social roles tend to moderate alcohol use. That is, as people adopt roles such as marriage, family, or career, "problem behaviors" such as substance use, automobile hazards, and the like decrease (see Bachman, O'Malley, & Johnson, 1984; Miller, Leonard, & Windle, 1991). We felt that this may be important to gays and lesbians, for two reasons. First, many gay or lesbian people tend to not adopt such roles — particularly child rearing and traditional marriages. Second, the discrimination faced by many gays and lesbians may lead to a sort of "underemployment" phenomenon, wherein people choose to direct their time and energy into the gay community rather than the mainstream, often higher status career world. Both these trends may insulate gay and lesbian people from the normative social role changes that, in the general population, tend to limit alcohol or drug use.

Negative Affect

Negative affect — e.g., depression, or anxiety — has been often cited as a correlate or cause of alcohol and drug use (Aneshensel & Huba, 1983; Phil & Yankofsky, 1979). We felt that this may be relevant here due to the vulnerability of gays and lesbians to "self-homophobia" — i.e., self-hate over one's own sexual orientation — that may stem from discrimination or stigmatization by the larger society (see Garnets, Hereck, & Levy, 1990). Thus, we assessed both general negative affect, and self-homophobia in relation to substance use and problems.

Social Stress

There has been considerable discussion regarding the role of stress in substance abuse. While simple stress models typically are poor predictors of substance abuse, stress in the absence of coping resources, or that is specific to the population in question, may be more strongly related (e.g., Hobfoll, 1985; Marlatt, 1976). This may be relevant here, in that many lesbians and, in particular, gay men, experience considerable discrimination in the form of verbal harassment, employment difficulties, or even assault (NGLTF, 1987). Gender differences in discrimination may reflect the greater stigmatization of male vs. female homosexuality (Marmor, 1980). We thus assessed the relation of general

stressors, and of the experience of discrimination, as they related to substance abuse.

Psychological Vulnerability

Several variables may induce psychological vulnerability to substance abuse. A general factor is one's expectancy regarding the effects of alcohol consumption; people with "positive" or "tension reduction" expectancies of alcohol or drugs are more likely to abuse these substances (Brown et al., 1980; McKirnan & Peterson, 1988). As well, bars have traditionally been an important social focus in gay culture (Achilles, 1967). This may contribute to substance abuse through simple exposure, through cultural norms that sanction alcohol use (Nardi, 1982; Ziebold, 1979), or by gays and lesbians viewing the bar — and attendant alcohol consumption — as a gay-positive "haven" where the stresses of discrimination or stigmatization are not present.

A third component here was gay identity. A number of mental health perspectives led us to propose that a positive gay identity — that is, a positive attitude toward the gay community, and a strong sense of identification with that community — may "buffer" tendencies toward alcohol abuse. Social support, self-esteem, strong ethnic identity among minority populations, and similar variables have all been shown to generally relate to psychological well being and/or resistance to stress (Peterson & McKirnan, 1990). We speculated here that gay identity may operate in a similar fashion (see Cass, 1984; Troiden, 1984).

For this section we therefore measured: 1) tension reduction expectancies of alcohol use; 2) a variable we called "bar orientation", referring to peoples' use of the gay bar as a focus for social interaction, stress reduction, and as a setting where they can be openly gay, and; 3) gay identification, consisting of attitudes toward, and identification with, the gay community.

The Data

This paper reports the results of two studies. The first was a large (n = 3400) survey of a major urban gay and lesbian population. The survey assessed general population characteristics and the epidemiology of drug and alcohol use. We hypothesized that rates of substance abuse would be higher than in the general population, but lower than that found among previous, more biased samples (see McKirnan & Peterson, 1989b & c).

The second study was a more intensive, face-to-face interview study with 230 participants, designed to follow-up the more general survey. Here we more systematically assessed several of the psychosocial variables described above, particularly the effects of positive gay-lesbian identification, and assessed risk behavior for HIV transmission

among the male participants. The two data sets will be discussed in turn, described as the survey and the interview data.

Survey Methods

Survey Distribution

Over 21,000 surveys were distributed in late 1985 through 1986, of which approximately 3400, or 16%, were returned. Approximately 17,000 were distributed in a large gay-lesbian oriented weekly newspaper accompanied by editorials in support of the survey, 200 posters displayed in gay-lesbian settings, and advertisements placed in mainstream publications. Forty five political, social, religious, or professional organizations serving the gay-lesbian community distributed the remaining surveys at meetings or by direct mailings to members, and via large events such as a film festival and a benefit for AIDS research. See McKirnan & Peterson (1989b) for a discussion of sampling. Fifty-five percent of the respondents who returned the survey received it through the newspaper, 21% through a community organization, 9% from a clinic or health related organization, 10% through personal distribution or community events, and 5% in bars or similar settings.

Survey Measures

The epidemiological data are from a self-report, anonymous survey of the gay and lesbian populations of Chicago. Demographics were assessed via direct self-report items. Quantity-frequency of alcohol use, and the frequency of marijuana, cocaine, and other drug use were measured using standard scales targeted to the previous six months (see Clark & Midanik, 1982; Miller, 1983). Alcohol problems were measured by five items assessing common behavioral symptoms of dependence or "loss of control" over alcohol use (e.g., conflicts with others over alcohol use, loss of control within a drinking episode, drinking in response to hangover; $\alpha = .83$). This scale was designed to allow comparisons with general population data (Clark & Midanik, 1982). Respondents used five-point frequency scales to rate the occurrence of each behavior over the previous year.

Population Characteristics

Most of the sample were primarily or exclusively gay (83%), with a smaller number who were "more homosexual than heterosexual" (15%), and few bisexuals (2%). Twenty-two percent were women ($n = 748$) vs. 78% men ($n = 2652$), consistent with other estimates of the proportion of gay men to lesbians. The great majority of the sample was White (88%), with a small percentage of Blacks (7%), few Hispanics (3%) and a very small Asian group (.75%). Mean age was 35 for males and 32 for women, $t [1476] = 9.41, p < .001$.

The sample had high socio-economic status, as is typically reported (e.g., Bell &

Weinberg, 1978). Over 60% had a college degree, and 62% were in the highest two occupational categories of the Hollingshead (1975) index. This was not reflected in high incomes ($M = \$25,000$), due to the high proportion of respondents in less well paid service professions. Gay men were similar to lesbians in education and occupational status, although women were paid less ($M = 22K$ vs. $27K$, $t [1286] = 11.12$, $p < .001$).

Many respondents experienced discrimination and harassment due to sexual orientation, and many males reported personal concern over AIDS exposure, yet rates of depression, alienation and general stress were relatively low (Peterson & McKirnan, 1988). Some 80% of the sample reported a personal or mainstream religious affiliation, 44% of males and 65% of women were in a stable relationship, and respondents' number of "confidants," an important predictor of psychological well-being (Stokes, 1983), was the same as that of the general population. Thus, the sample was generally "psychologically healthy" and well socially integrated.

In addition to recruiting a less problem biased sample, an important sampling objective was accessing the entire range of disclosure of sexual orientation. We assessed whether respondents' were "out" as gay or lesbian to each of nine people or groups (e.g., parents, health care professional, immediate work group). The sample contained all levels of this important variable: 11% were out to zero or one person, while 16% were out to eight or nine of the people/groups. The remaining respondents were evenly distributed across the other levels of disclosure, with no difference between men and women (mode = 5). This gave us substantial confidence in our sampling strategy.

Survey Results: Alcohol and Drug Use

Alcohol Consumption

We hypothesized that psychosocial factors would produce more alcohol consumption among gays and lesbians than in the general population, but less than that found in previous, more biased samples. These results are given in Table 1. General population data are taken from Clark & Midanik (1982); the stability of long term trends in alcohol use make these data appropriate as a comparison. We examined the proportion of abstainers vs. drinkers, with a broad distinction between moderate and heavy drinkers, defined as 1 to 60 drinks per month and over 60 drinks per month, as per NIAAA categories. A log linear regression analysis of these consumption categories on sample and gender showed a significant difference between the gay-lesbian and general population samples, $\chi^2 [2] = 107$, $p < .001$.

The overall proportion of gays-lesbians who were abstainers was about half that found in the general population (14% vs. 29%). Individual chi-square analyses within each

sample, using males as the expected value, showed significant gender differences in the general population ($\chi^2 [2] = 15.58, p < .001$) — many studies show more women to abstain and more men to be heavy drinkers — that was not found in the gay-lesbian sample ($\chi^2 [2] = 4.58, n.s.$). Lesbians showed the same low rate of abstention as gay men, while general population men and women differed more substantially. As well, general population men and women differed considerably in heavy consumption, while these proportions were more similar between gays and lesbians. Gay men did, however, report higher overall average consumption than did lesbians, $t [1525] = 8.58, p < .001$.

Although fewer gays and lesbians abstained from alcohol, they were not more likely to be heavy drinkers; more of the gay-lesbian sample were moderate drinkers than in the general population, with similar rates of heavy drinkers across sample. A similar pattern emerged among drinkers only, using finer consumption categories (bottom of Table 1). Here gay men were half as likely as general population men to be in the highest drinking category, with the difference being made up in the middle categories. Thus, there were two major differences from the general population: 1) fewer gays and lesbians abstain from alcohol altogether, although these additional drinkers fall in the middle, not the high drinking categories, and; 2) gay women and men were more similar to each other than is the case in the general population.

Table 1: Percentages of Respondents in NIAAA Alcohol Consumption Categories: General Population vs. Gay Sample, by Gender.

A. Overall Consumption, All Respondents

Consumption Category	General Population		Gay Sample	
	Men	Women	Men	Women
Abstain	23	34	13	15
Moderate	54	59	70	76
Heavy	21	7	17	9

B. Specific Consumption Levels, Non-Abstainers Only

Number of Drinks Per Month	General Population		Gay Sample	
	Men	Women	Men	Women
1-2	15	31	13	25
2-10	19	29	25	33
11-60	37	31	43	32
61-120	13	6	12	7
Over 120	16	3	7	4

Alcohol Problems

Although they did not report more heavy drinking, lesbians and gays did report high rates of alcohol problems. This was measured by a condensed version of the dependency and loss of control scales used in national studies of the general population (Clark & Midanik, 1982). A "problem" was defined as at least two symptoms over the previous year, and cannot be taken to reflect rates of the actual diagnosis of alcoholism. The data for the gay-lesbian sample are based on condensed scales, which may under-represent problem rates. Comparisons with the general population must be therefore be interpreted with caution.

Approximately twice as many gays and lesbians reported an alcohol problem than did the general population (23% vs. 12%, $\chi^2 [1] = 56.9, p < .001$). This was due to two important effects. First, the percentage of the general population reporting a problem differed considerable for women vs. men, while lesbians did not differ from gay men (sample by sex $\chi^2 [1] = 14.4, p < .001$). Second, general population rates of alcohol problems decreased substantially as age increased, while such differences were less pronounced among gays and lesbians (sample by age $\chi^2 [3] = 16.4, p < .001$).

As shown in Table 2, younger males from the two samples showed similar rates of alcohol problems, although gay males showed far less decrease in problem rates over age. Lesbians reported more symptoms in all age groups and, as with males, showed far less decrease across age than the general population. In particular, in the older three groups three times as many lesbians reported alcohol problems than would be expected in the general population. The combination of these effects led to an overall higher rate of problems for the gay-lesbian sample.

Table 2: Percentage fo Respondents Reporting Alcohol Problems: General Population vs. Gay Sample, by Age Group and Gender

Age Group	General Population		Gay Sample	
	Men	Women	Men	Women
18-25	29	16	26	24
26-30	25	7	25	23
31-40	16	8	24	25
41-60	7	5	19	15
(Overall)	(16)	(8)	(23)	(23)

Drug Use

The trends characterizing alcohol problems were also found for marijuana and cocaine use ("hard" drug use was unusual in the general population and the gay-lesbian samples, and is not discussed). We examined these substances for lifetime and frequent use, defined as 10 of the previous 30 days for marijuana and five of the previous 30 days for cocaine. General population data for these analyses are taken from Clayton et al., (1986).

Marijuana Use

Gays and lesbians differed from the general population in lifetime marijuana use, with significant differences across sample in effects of sex ($X^2[1] = 53, p .001$) and age ($X^2[2] = 131, p < .001$). These effects are clear in Table 3. Lifetime marijuana use was very prevalent among young people, more so within the gay-lesbian sample. In the general population, fewer women than men have used marijuana, and older cohorts consumed far less. Neither of these trends were evident for the gay-lesbian sample. Frequent marijuana use was most common among younger general population males. Otherwise, these data replicated the pattern found for lifetime use, in that gays and lesbians significantly differed from the general population vis-a-vis: 1) lesbians showing rates more similar to men, and 2) older gay-lesbian cohorts not showing the decrease in use found in the general population (sample by gender $X^2[1] = p < .005$; sample by age $X^2[2] = 41, p < .001$).

Table 3. Percentage of Respondents Reporting Lifetime and Frequent Marijuana Use: General Population vs. Gay Sample, By Age & Gender.

Lifetime Marijuana Use

Age Group	General Population		Gay Sample	
	Men	Women	Men	Women
18-25	68	60	79	85
26-34	65	47	83	88
35 & Above	17	7	67	67

Frequent Marijuana Use

Age Group	General Population		Gay Sample	
	Men	Women	Men	Women
18-25	23	9	16	11
26-34	11	7	16	14
35 & Above	2	0.2	8	6

Cocaine Use

The gay-lesbian sample substantially differed from the general population in lifetime cocaine use; within the first two age groups the gay-lesbian sample showed double the general population use rates (54% vs. 25%; Table 4). As with alcohol problems and marijuana use, lesbians were more similar to gays than general population men were to women ($X^2[1] = 19.3, p < .001$), and there was far less of a decrement in use across age group ($X^2[2] = 21, p < .001$). Frequent cocaine use was too uncommon to allow for valid analyses, but showed the same trends.

Table 4. Percentage of Respondents Reporting Lifetime and Frequent Cocaine Use: General Population vs. Gay Sample, By Age & Gender.

Lifetime Cocaine Use				
Age Group	General Population		Gay Sample	
	Men	Women	Men	Women
18-25	35	22	52	57
26-34	26	18	56	51
35 & Above	7	2	216	23

Frequent Cocaine Use

Age Group	General Population		Gay Sample	
	Men	Women	Men	Women
18-25	2.7	0.3	3.3	3.3
26-34	0.8	0.2	3.7	1.8
35 & Above	0.1	0.0	0.5	0.9

Summary: Alcohol and Drug Use in the Gay-Lesbian Community

We attempted to assess the epidemiology of substance abuse within as diverse a cross-section of a major gay-lesbian community as possible. Since there are not census-like data for us to validate our sample against, we can never know how representative it is. However, we have avoided the more obvious sources of bias such as convenience sampling within clinics or bars. The size of our distribution network and the volume of surveys returned suggests that few segments of the gay-lesbian community were systematically excluded. Consistent with this, participants showed considerable social and personal resources. In marked contrast to other reports—Fifeld's (1975) famous study was titled "Lonely, Isolated, and Drunk..."—this more systematic sample of a gay community was not socially isolated, and showed considerable psychological well-being.

In terms of the gay bar, we might note that our data showed that many gays and lesbians who participate in the "bar scene" do not have alcohol or drug problems, and report considerable psychological well-being. The gay bar does serve as a "normative" community center. Nonetheless, two bar-related variables—the frequency of gay bar-going, and an attitude measure reflecting a reliance on gay bars as a social focus—significantly related to all measures of alcohol and drug use and problems ($r_s = .3$ to $.5$, $p_s < .001$) and, as presented in the next section, related to unsafe sex in some gay men. Hence, as might be expected, bars do contain a higher proportion of "problem" respondents. Any study that derives a sample from gay bars must be read with considerable caution.

Fewer gays and lesbians abstain from alcohol than is the case in the general population. However, they were not more likely to be heavy drinkers; the increased proportion of drinkers is the moderate, not the heavy drinking categories. Despite not reporting more heavy use, rates of alcohol problems were relatively high among gay men and, in particular, lesbians. This finding does indicate some additional risk for substance abuse. Overall rates of marijuana and drug use were also substantially higher than in the general population, although here again frequent marijuana or drug use was not more common.

The data showed two noteworthy trends. Within the gay sample women were much more similar to men in their use of alcohol or drugs than in the general population—making lesbians generally heavier users than are general population women—and the gay-lesbian sample showed far less decline in alcohol problems and drug use in older age groups. There may be several causes for this trend, although we suspect that an important one is that of social roles. In the general population age is associated with increasingly restrictive demands of a traditional occupation, marriage, and child-rearing. These age-related role shifts may be less common among gays and lesbians, and

may combine with the continuing importance of bars or similar settings to those who actively participate in gay-lesbian culture. Such settings may not only be occasions to use alcohol and drugs, but may provide more exposure to younger people and values. The similarity of lesbians to gay men may be a product of these two factors: Lesbians are likely to have shifted away from traditional sex role behaviors (see Chomak & Collins, 1987), and an equivalent of a "lesbian bar" is not typically found in the general population.

Consistent with anecdotal and clinical reports there is some cause for concern about substance abuse among lesbians and gays. However, we did not find the very heavy alcohol and drug use that has often been ascribed to this population. The interview data described below was designed to evaluate some psychological aspects of gay-lesbian substance use.

Interview study: overview and methods

This section reports the results of a face-to-face interview study designed to follow-up the epidemiological data. Here we examined substance use in terms of participants' identification with the gay community, as well as negative affect, stress, and psychological vulnerability. The latter measures each had a general version—psychological symptoms, stressful life events, and positive expectancies toward alcohol—as well as a version designed to be specific to gay-lesbian culture, consisting of self-homophobia, discrimination, and an orientation toward gay bars as a social focus. Finally, this section briefly examines the roles of substance use and gay identification in unsafe sexual behavior among gay men.

Recruitment

Participants were 140 gay males and 91 lesbians recruited through gay community organizations, advertisements in both gay and non-gay newspapers, social and political events, and through snowball sampling. The interview sample closely approximated the survey sample in terms of demographics and "outness" of sexual orientation.

Measures

Gay Identity was the sum of 6 items indicating the importance of being gay to one's self-concept (e.g., "Being gay is very important to my sense of whom I am."; $\alpha = .77$).

Negative Affect: General negative affect was measured by a subset of 21 items from the Brief Symptom Inventory (Derogatis & Melisaratos, 1983. "...how much are you bothered by feeling nervous or shaky inside?"; $\alpha = .86$). Self-homophobia was measured by

four face-valid items ("Sometimes I wish I were not gay." $\dagger = .83$).

Stress: General stress was measured via a stressful life event checklist adopted from Moos et al. (1986). Respondents indicated whether each of 20 events (e.g., traffic accident, job change...) had occurred over the previous year. Discrimination due to sexual orientation represented ratings of the frequency with which a series of discriminatory events (verbal harassment, problems on job...) had occurred over the previous year.

Psychological Vulnerability to Substance Abuse: Alcohol expectancies were assessed by seven items reflecting positive or "tension reduction" expectations of the effects of alcohol ("A drink or two makes me feel more relaxed." $\dagger = .75$). "Bar orientation" was measured by five items regarding the use of gay bars as a primary social setting ("Bars are about the most important place for me to meet people." "Gay bars are one of the few places where I can be openly gay." $\dagger = .87$).

Substance Use: Alcohol Use and problems were measured via a standard quantity-frequency and consequences indices, as described above. Alcohol Use During Sex was assessed by ratings of the percentage of time any amount of alcohol is consumed in conjunction with sex. This was asked both for sex generally and for sex with a new partner. Due to skewed distributions of the alcohol measures log transformations were used in all analyses.

A score representing the use of alcohol as a coping mechanism was derived from a larger coping index. Respondents described a type of event they found particularly stressful, and rated the frequency with which they employed each of 25 coping responses. The responses involved alcohol use; scores on these were summed to reflect "Alcohol Coping".

AIDS Risk Behavior was self-reported for the previous six months by male respondents only. Respondents report of the number of partners with which they had insertive and sex, receptive anal sex, and receptive oral sex were each multiplied by the inverse of the percentage of time a condom was used. The index was a summed score of the risk behaviors, with the oral sex measure weighted .5.

Interview Results: Psychosocial Variables and Substance Abuse

Psychosocial Variables in Substance Use

The first question concerned the extent to which general and gay-specific psychosocial variables related to alcohol use and problems. Table 5 presents simple correlations between the general and gay-specific psychosocial variables and three alcohol use mea-

tures. Where gay men and lesbians differed in these correlations they are given separately.

One finding that emerged here and in other analyses of these data was that self-homophobia had no effects of alcohol use or problems. This is in marked contrast to various clinical and anecdotal reports that self-hate or internal conflict over sexual orientation may lead gays or lesbians toward substance abuse and/or other problem behaviors. Since we were somewhat surprised by this lack of finding, we more systematically examined self-homophobia by measuring and analyzing it in several ways both here and in the survey data. In neither data set did any of the measures of this general construct have reliable effects on any measure of substance use or abuse.

Table 5. Correlations of Psychosocial Variables by Alcohol Measures: Gay Men vs. Lesbians

Predictor	Alcohol Use (men/women)	Alcohol Problems (men/women)	Alcohol Coping (men/women)
Negative Affect	n.s.	n.s./ .29	n.s./ .35
Self-Homophobia	n.s.	n.s.	n.s.
Social Stress	n.s.	n.s./ .22	n.s./ .26
Discrimination	.22/n.s.	.24/n.s.	n.s.
Alcohol Expectancies	.45	.41	.32
Bar Orientation	.30	.34	.57

n.s. = not statistically significant, all others $p < .01$.

Where men and women did not differ a single correlation is given.

The second finding here was that psychosocial variables may operate differently among gay men vs. lesbians. As we and others have noted, discrimination is generally more prevalent for gay males, and more strongly relates to (lower) psychological well-being. This pattern was evident here, in that discrimination significantly related to alcohol use and problems, but only among gay men. Discrimination did not directly relate to the use of alcohol for coping. None of the other affect or stress measures had any effects on alcohol variables among the gay males.

In contrast to gay men, for the lesbian sample the negative affect measure—that is, numbers of psychological symptoms reported during the previous week—and overall

social stress both relate to the two more "serious" alcohol measures, those of alcohol problems and the use of alcohol as a coping mechanism. The experience of discrimination, which was certainly not absent for the lesbian sample, did not relate to any alcohol measure. In these data, the lesbian sample tends to look more like what one would expect in the general population; there were moderate correlations of alcohol variables with general negative affect and general stress, but no effects of several variables specific to the gay-lesbian community.

Both of the alcohol vulnerability measures had consistent effects on the alcohol outcome measures, with no differences between gay men and lesbians. As we have discussed elsewhere (McKirnan & Peterson, 1988, 1989c), expectations of positive or "tension reduction" effects of alcohol increase risk for abuse in the general population, and may be particularly salient for gays and lesbians, given the importance to this community of bars and other settings where alcohol is present. Similarly, an orientation toward bars as a social resource was a predictor of alcohol use and problems for both men and women. We were somewhat surprised at the lack of a gender difference here, given that the "bar scene" is more strongly associated with men. However, these findings are consistent with the epidemiological data, where lesbians were more similar to gay men than we would have expected from the general population. Our discussion of lesbians' departure from traditional sex roles, above, provides one possible interpretation of these findings.

The Role of Identification With The Gay-Lesbian Community

We hypothesized that identification with the gay community would act as a "buffer" regarding psychosocial pressures toward substance abuse. Psychosocial data regarding mental health and substance abuse generally, as well as studies specific to minorities, indicate that identification with a cohesive, supportive community may be crucial to buffering the effects of stress, discrimination, or other variables (see Peterson & McKirnan, 1988, 1990). Although the gay community is under recent attack from political and other fronts, gay and lesbian political mobilization, responses to AIDS and other health threats, and the increasing economic power of this community suggest that gay identification may be a significant source of psychological health for lesbian and gay people.

Table 6 presents correlations between the psychosocial and substance use variables for gay men who are low vs. high in identification with the gay community. Several trends are clear here. First, gay men who are low vs. high in gay identification show some distinctiveness in the psychosocial variables that predict substance abuse. High identified gay men show significant effects of negative affect on alcohol problems and coping, as might be expected within the general population. In contrast, low identified gay men

respond more strongly to the effects of discrimination among some men.

Gay identification also influenced the effect of the alcohol vulnerability variables. In general, men with a stronger identification with the gay community responded less to the effects of alcohol expectancies or bar orientation than did those with a weaker identification. Hence while, for example, positive alcohol expectancies predicts alcohol problems in both groups, low gay-identified men are significantly more "at risk" due to this variable than are high identified men.

Table 6. Correlations of Psychosocial Variables by Alcohol Measures: Gay Men With Low vs. High Gay Identity

Predictor	Alcohol Use (low/high)	Alcohol Problems (low/high)	Alcohol Coping (low/high)
Negative Affect	n.s.	n.s./ .31	n.s./ .35
Self-Homophobia	n.s.	n.s.	n.s.
Social Stress	n.s.	n.s.	n.s.
Discrimination	.28/n.s.	.30/n.s.	.32/n.s.
Alcohol Expectancies	.62/.42	.56/.41	.43/n.s.
Bar Orientation	.36/n.s.	.29	.65/.50

Low identity n=69; high identity n=71.

n.s. = not statistically significant, all others $p < .01$.

Where the low and high identification groups did not differ a single correlation is given.

The effects of identification are particularly pronounced among lesbians (Table 7). The increased role of negative affect, found for the male sample, is evident on one alcohol measure, as is the effect of discrimination among the low identified respondents. The effects of social stress were difficult to detect with these smaller samples, although there were non-significant trends toward social stress affecting alcohol abuse primarily among the low identified women. Particularly clear in these data is the extent to which identification with the lesbian community buffered the effects of the psychological vulnerability measures. Positive alcohol expectancies had strong effects on alcohol abuse among the low identified women, and no effects among those with high identification. With one exception a similar pattern was found for bar orientation.

Table 7. Correlations of Psychosocial Variables by Alcohol Measures: Lesbian Women With Low vs. High Gay Identity

Predictor	Alcohol Use (low/high)	Alcohol Problems (low/high)	Alcohol Coping (low/high)
Negative Affect	n.s.	n.s./ .38	.35
Self-Homophobia	n.s.	n.s.	n.s.
Social Stress	n.s.	n.s.	n.s.
Discrimination	n.s.	.39/n.s.	.32/n.s.
Alcohol Expectancies	.42/n.s.	.44/n.s.	.50/n.s.
Bar Orientation	.49/n.s.	.60/n.s.	.57

Low identity n=45; high identity n=46.

n.s. = not statistically significant, all others $p < .01$.

Where the low and high identification groups did not differ a single correlation is given.

In summary, both general and gay-specific psychosocial variables related to substance use and abuse are in this sample. For lesbian women the general factors of negative affect, social stress, and alcohol expectancies were predictive of substance abuse, as was the culturally specific variable of bar orientation. Men also responded to expectancies and bar orientation, although they showed consistent, if moderate, effects of discrimination on substance abuse. As predicted, the relation of these predictor variables to substance use was attenuated among those who had a stronger identification with the gay-lesbian community.

Gay Identification and High Risk Sexual Behavior.

The final set of analyses concerned the role of substance use in sexual behavior that places gay males at risk for exposure to HIV. There has been considerable speculation on this, and some evidence that the effect of substance use on sexual risk is changing over the course of the AIDS epidemic. An overview of the literature is beyond the scope of this discussion (see Leigh & Stall, 1992). We did, however, measure the rate of high risk sexual behavior in our cohort of gay men. Hence, it is appropriate that the measures we have been discussing be addressed to that crucial behavior.

Both our own data and those of others show at best modest correlations between substance use and high risk sexuality. In our data there are significant correlations between high risk sexual practices and alcohol problems ($r = .20, p < .05$), alcohol use with sexual

partners ($r = .21, p < .05$), and bar orientation ($r = .27, p < .01$). These findings suggest that substance use does constitute a risk factor. However, here, as in psychosocial studies of alcohol use general, "main effects" may be less important than interactions. That is, the more appropriate conceptual and empirical question may not be whether alcohol in and of itself leads to unsafe sex, but the conditions under which it induces unsafe sex among men (or women).

Given our finding that gay identification plays a role in substance use among gay men, we examined whether gay identity might affect the relation of substance use to high risk sexuality. Table 8 presents correlations between several alcohol-related risk variables and high risk sexuality, for men reporting low vs. high identification with the gay community.

Table 8. Correlations of Alcohol-Related Variables with Rates of Unsafe Sex: Men with Low vs. High Gay Identification

Predictor	Gay Identification	
	Low	High
Alcohol Consumption	.23*	n.s.
Alcohol Problems	n.s.	.28**
Alcohol Use with Sexual Partners	.36***	n.s.
Alcohol Use with New Sexual Partners	.25**	n.s.
Frequency of Gay Bar Going	.20*	n.s.
Bar Orientation	n.s.	.47***

Low identity $n = 69$, high density $n = 71$.

n.s. = not statistically significant;

* = Trend level, $p < .075$; ** = $p < .05$; *** = $p < .01$.

One immediately apparent trend in this exploratory analysis is that none of the alcohol variables that relate to unsafe sex among low identified men are significantly related to unsafe sex among high identified men, and visa-versa. Beyond this, for low identified gay men the variables that relate to unsafe sex all hinge on the simple presence of alcohol. Thus, simple usage, usage with sexual partners, and simply going to bars are all moderately related to higher rates of unsafe sex. In contrast, the two alcohol measures

that related to unsafe sex among high identified men were actual alcohol problems, and bar orientation, itself a predictor of substance abuse.

Our interpretation of these findings is that alcohol may serve different functions among men who are or are not identified with the gay community. Men with low gay identification may "drop in" to the gay community, and may therefore use alcohol to reduce anxiety they experience over gay sexuality. This is consistent with the greater role of tension reduction alcohol expectancies among low identified men (above), and the finding that alcohol use with sexual partners relates to unsafe sex among them. In contrast, high identified men do not show a pattern where simple alcohol use relates to sexuality; rather, among these men actual alcohol abuse may be a stronger predictor of unsafe sex.

Of course these findings need to be extended and clarified. Still, they do suggest that the effects of alcohol use on sexuality are not simple, and may differ depended upon other, important social or psychological variables. We feel that one's identification with the gay community is one such variable.

Summary: Psychosocial Variables In Gay-Lesbian Alcohol Use

This study clearly did not exhaust psychosocial variables in alcohol use in the gay and lesbian communities. Rather, we have attempted to articulate several important variables, and present preliminary findings. We found gay men and lesbian women to differ in the variables that related to alcohol use and abuse. Discrimination played a role among men that was not as strong among women, while general affect and stressors were more salient among lesbians. Both the causes of this difference, and its implications for treatment and prevention, need further study and discussion.

Psychological vulnerability toward alcohol was, as expected, important for men and women. The importance of "Bar Orientation" as a predictor of substance use is perhaps most noteworthy here. This is explicitly an attitudinal variable, more concerned with the participants' outlook on and social use of bars than with the simple frequency of bar use. In fact, "Bar Orientation" predicts alcohol problems even when we statistically control for both the simple frequency with which respondents go to bars, and their level of alcohol use. We feel this to have significant treatment and prevention implications. Gays and lesbians who, attitudinally, have the "bar scene" as too integral a component of their social or community life are at enhanced risk for problems, whereas the simple frequency with which people go to bars is not nearly as strong a risk factor. This emerged as a very strong correlate of unsafe sexual practices among high gay identified men, a finding of some import.

Gay identification emerged as an important consideration in understanding the effects of stress or psychological vulnerability on substance abuse. Those with higher gay identification show different patterns of risk and, in general, experience less strong effects of other psychosocial inducements to risk. There may be a number of reasons for these findings. The gay community may provide social and emotional resources that help "buffer" other factors. Hence, the gay bar scene may be a general risk factor, that is diminished among those who receive emotional and social support from a cohesive community. Alternately, gays and lesbians who are generally more "healthy" may express that, in part, through a greater identification with their community.

We saw in the epidemiological data that the gay and lesbian community, while evidencing additional risk for substance abuse, is not at the dire risk levels suggested by other writers. As well, our general psychosocial data have shown this to be a generally positive community in terms of demographic indicators and levels of psychological well-being. Consistent with this, here we have found positive identification with a gay-lesbian community to be an important resource and, in general, to have important effects on our participants' attitudes and behavior.

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Correspondence:

David J. McKirnan
The University of Illinois at Chicago
Dept. Psychology, m/c 285
Box 4348, Chicago, IL 60680

Changes in Drug and Alcohol Use Patterns Among Gay Men in San Francisco: The San Francisco Men's Health Study

*Ron Stall, Don Barrett and Jay Paul
Center for AIDS Prevention Studies (CAPS)*

Introduction

During the 1980's research on gay men's drinking and drug use practices increased substantially, largely as an unanticipated outcome from research projects designed to study the HIV epidemic. One important finding from this body of research has been that rates of alcoholism and/or problem drinking — previously found through the use of opportunistic samples to be about 33% of the gay population — probably substantially overestimated the true rate of problematic substance abuse within this community (Stall and Wiley, 1988; McKirnan and Peterson, 1988, 1989; Martin, 1990).

A second series of papers have more recently emerged to indicate that rates of use of alcohol and drugs as well as heavy substance use are declining among gay men, presumably as a behavioral response to the ongoing AIDS epidemic (Martin, 1989; Ostrow, 1990; Remien et al., 1990). This paper will determine if these trends are also found within longitudinal data from the San Francisco Men's Health Study.

Methods

The design of the San Francisco Men's Health Study (SFMHS) has been previously described (Stall and Wiley, 1988; Winkelstein, et al. 1987). Briefly stated, the SFMHS is a longitudinal study of gay and bisexual men who were originally selected through a random household sampling technique of the 19 census tracts in San Francisco with the highest cumulative incidence of AIDS as of 1984. Follow-up of the HIV seropositive men allows ascertainment of the long-terms effects of HIV infection within a cohort of gay men. Follow-up of the HIV seronegative men allows the measurement of rates of incidence of new HIV infection within the cohort. Measures of drug and alcohol use were included at baseline and were repeated throughout the course of the study.

Because we are interested in following changes in drug and alcohol use within this

cohort over time, we took care to include men who participated in the study at the beginning and at the end of the study. Consequently, we defined the cohort as those gay or bisexual men who responded to either wave 2 or 4 (1984 or 1985) and either wave 8 or 10 (1987 or 1988).

The men in the cohort (n=584) were not significantly different by chi square tests from the drop-outs (n=192) according to: *white/non-white ethnicity* ($p < .09$), *education* ($p < .25$), *employment status* ($p < .30$), *occupational status* ($p < .14$), *quantity/frequency of alcohol use at wave 1* ($p < .72$), or *level of drug use at wave 1* ($p < .39$). The men in the cohort were significantly different from the drop outs according to: *Positive HIV status* ($p < .00001$), *AIDS diagnosis* ($p < .00001$), *Death due to AIDS* ($p < .00001$), with men who belonged to each of these categories more likely to be lost to follow-up. Accordingly, we will devote particular attention to HIV/AIDS status in this analysis of changes in drug and alcohol use habits over time.

Findings

Table 1 describes self-reported changes in the prevalence of drug use during the previous 6 months from 1984 to 1988 within this cohort. As can be seen from this table, substantial declines for the prevalence of each of the types of drugs use, and for any drug use, during the course of the 1980's.

Table 1: Any Use of Specific Drugs During the Previous 6 Months
San Francisco Men's Health Study
 N=584

Wave	2	4	6	8	10
Year	1984	1985	1986	1987	1988
Marijuana	75.7	67.3	61.8	55.5	53.9
Cocaine	43.7	34.6	25.0	22.5	17.9
LSD, etc.	10.7	6.9	4.7	5.0	3.2
Downers	20.4	11.3	6.0	5.7	4.7
Opiates	1.9	0.9	0.9	1.1	0.4
MDA/Uppers	24.6	20.3	14.9	13.9	13.6
Any Drug Use	85.0	76.8	70.6	64.1	64.2

Table 2 shows that weekly use of drugs — perhaps indicative of chronic or heavy use — was (with the exception of marijuana use) unusual in this cohort on intake and declined

over time.

Table 2: Weekly Use of Specific Drugs During the Previous 6 Months
San Francisco Men's Health Study
 N=584

Wave	2	4	6	8	10
Year	1984	1985	1986	1987	1988
Marijuana	37.5	33.8	30.1	25.3	26.3
Cocaine	5.8	4.3	3.0	2.8	2.4
LSD, etc.	0.4	0.2	—	—	0.2
Downers	2.6	0.7	0.8	0.7	0.6
Opiates	—	—	—	—	—
MDA/Uppers	2.8	2.8	1.3	2.4	2.6
Any Weekly Drug Use	48.1	41.8	36.3	31.8	32.3

Table 3 replicates these trends for quantity/frequency of alcohol use during the previous 6 months. Notable within this table are the increases in abstinence over time as well as the declines in heavy/frequent use (five or more drinks during a single occasion at least once a week).

Table 3: Quantity/Frequency of Alcohol Use During the Previous 6 Months
San Francisco Men's Health Study
 N=584

Wave	2	4	6	8	10
Year	1984	1985	1986	1987	1988
Abstainer	6.5	8.2	10.4	13.1	11.9
Infreq.	5.1	4.1	5.1	5.3	7.8
Occasional	14.6	17.9	19.0	21.0	20.9
Frequent-Light	62.9	62.2	58.2	53.6	53.2
Frequent-Heavy	10.9	7.6	7.3	7.0	6.2

Because we were concerned about the effects of HIV status of drug/alcohol use pat-

terns over time, we re-ran these tables controlling for HIV status. On each occasion we found declines over time for both HIV positives and negatives, although the HIV positives tended to report higher levels of drug and alcohol use on intake. We report here two tables showing trends in prevalence of drug use during the previous 6 months as overall examples of these trends for HIV positives and negatives separately.

Table 4: Any Use of Specific Drugs During the Previous 6 Months, HIV Negatives
San Francisco Men's Health Study

Year	1984	1985	1986	1987	1988
Marijuana	60.0	62.4	52.4	48.0	48.1
Cocaine	32.8	26.7	18.7	16.5	14.5
LSD, etc.	7.5	5.1	4.4	4.7	2.7
Downers	14.2	7.5	4.4	3.5	3.1
Opiates	0.4	0.8	0.4	1.2	0.4
MDA/Uppers	14.6	15.3	9.5	9.8	10.7
Any Drug Use	78.4	71.8	59.5	57.5	60.7

Table 5: Any Use of Specific Drugs During the Previous 6 Months
HIV Seropositives
San Francisco Men's Health Study

Year	1984	1985	1986	1987	1988
Marijuana	81.1	71.1	68.4	60.9	57.7
Cocaine	51.1	39.8	28.7	26.1	19.7
LSD, etc.	13.3	7.6	4.9	5.2	3.3
Downers	24.2	13.3	7.0	7.2	4.6
Opiates	3.4	1.2	1.6	1.2	0.4
MDA/Uppers	32.2	21.7	17.6	14.3	14.2
Any Drug Use	90.2	81.1	79.8	68.3	66.1

Discussion

Consistent with other reports from around the United States, rates of use and of heavy

use of drugs/alcohol among respondents from the SFMHS appear to have declined during the 1980's. This analysis also temporally expanded an earlier cross-sectional finding, in that we found that while gay men in general use many different kinds of drugs, they are generally not characterized by frequent use of drugs. Despite the fact that the cross-sectional prevalence rates of alcohol abuse do not appear to have been as high as 30%, and the rates of use and of heavy use seem to be declining over time, substantial numbers of gay men use drugs/alcohol at levels that are dangerous to their health.

Some individuals will take the finding that rates of drug and alcohol use among gay men did not approach the 30% mark, and appear to be declining over time, as evidence that drug and alcohol prevention/treatment programs are not needed. Regarding this question, it is important to remember that if it were true that the prevalence rates of drug/alcohol abuse were over 30% in the gay male community, this would be among the highest rates of drug/alcohol abuse ever measured for any social group in the world. Requiring that gay men manifest the highest alcoholism/drug addiction rates in the world as a pre-condition for alcoholism/drug abuse services is transparently homophobic. Individuals who advocate for drug/alcohol programs within the gay community should argue that these programs are a health care right of citizens of the United States. Whatever the background rate of substance abuse within the gay community, gay men and lesbians should have access to substance abuse treatment in settings where other peoples' issues with sexual orientation/gender do not compromise successful treatment.

Finally, the methods that have been used to study health behaviors of gay men during the AIDS epidemic could also be used to study health behaviors among lesbians, including drug/alcohol use behaviors. A great deal more could be learned about lesbians' drinking/drug use practices, and studies of gay men have shown that quantitative methods can be modified to produce reasonably accurate measures of drug and alcohol use behaviors with gay communities. The time has come to apply these methods to expand our understandings of gay and bisexual womens' drinking and drug use practices.

Correspondence

Ron Stall, Don Barrett, Jay Paul
Center for AIDS Prevention Studies (CAPS)
Box 0886
University of California
San Francisco California 94143

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An Exploration of Lesbian's Images of Recovery From Alcohol Problems

Joanne M. Hall, RN, MA

**Department of Mental Health, Community, and Administrative Nursing
School of Nursing, University of California, San Francisco**

Abstract

The author's purposes in this article are to explore the images lesbians used to describe their recovery from alcohol problems and to derive from this exercise relevant implications for health care. Lesbians' experiences in recovery are particularly significant because of growing concerns about the prevalence of alcohol problems among lesbians, the vulnerability of lesbians as an aggregate, and the cultural trend away from substance use in lesbian communities. Images of recovery are the descriptions that people offer about their healing from alcohol problems. They are the frameworks by which problem drinkers interpret the meanings of their experiences and determine which aspects of their lives are most pertinent to their recovery efforts. The images persons use to represent their progress and the difficulties they encounter in recovery also provide important bases for developing relevant resources, therapeutic techniques, and social support. Excerpts from an ongoing ethnographic interview study about the recovery experiences of lesbians with alcohol problems illustrate the diversity of recovery images that are characteristic of this population.

Lesbians' experiences in recovery from alcohol problems are of interest to health care providers because of growing concern about the prevalence of alcohol problems among lesbians, the established vulnerability of lesbians as an aggregate, and the recent cultural trend away from substance use in lesbian communities. In this article, I establish the significance of lesbians' alcohol problems and explore the images lesbians use to

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describe their recovery from alcohol problems. Examples of lesbians' descriptions of their recovery are taken from an ongoing ethnographic interview study on the help-seeking and recovery experiences of lesbians with alcohol problems. Insights from these images are then used to derive relevant implications for health care.

Researchers, clinicians, and lesbians themselves believe that substance abuse problems among lesbians are more prevalent and more severe than those seen in the general population (Burke, 1982; Cantu, 1985; Fifield, Latham, & Phillips, 1977; Hastings, 1982; Hepburn & Gutierrez, 1988; McKirnan & Peterson, 1989a, 1989b; McNally, 1989; Morales & Graves, 1983; Nicoloff & Stiglitz, 1987; Saghir & Robins, 1973; Schilit, Clark, & Shallenberger, 1988; Stevens & Hall, 1988; Weathers, 1976). Skepticism is appropriate in interpreting prevalence rates of alcohol problems among lesbians, however, because accurate estimates are not obtainable in this largely hidden, stigmatized group (Morin, 1977; Nardi, 1982). In the only available study (Bradford & Ryan, 1988) based on a national, convenience sample of lesbians (N = 1,917), 25 % of lesbians reported drinking several times a week and 6% reported drinking daily. Fourteen percent of the sample reported being worried about their substance use, and 16% had sought help for alcohol or drug problems in the past. These figures provide evidence that lesbians may be both susceptible to alcohol problems and prone to self-criticism regarding their use of alcohol.

Lesbians are an important source of information about alcohol use and recovery patterns because of the particular social and political vulnerabilities they experience. Lesbians have been frequently overlooked and/or pathologized in research and clinical endeavors (Stevens & Hall, 1991). Substance abuse in women is highly stigmatized. To be a lesbian problem drinker entails additional stigmatization, which may pose difficulties in recognizing the problem, feeling safe in seeking health care, and maintaining a positive self-image in the recovery process (Hall, 1990a, 1990b; Johnson & Palermo, 1984; Stevens & Hall, 1988; Szasz, 1970; Ziebold, 1979).

Lesbians seem to be on the cutting edge of a generalized cultural trend away from substance use (Room, 1988). Lesbian communities have been engaged in dialogue about alcohol use and recovery from alcohol problems for the past several decades. Lesbians' association of substance use with internalized oppression, sexism, and the ghettoization of lesbians in the bar subculture has contributed to this movement (Hall, 1991). Twelve Step and other mutual- and self-help programs can be viewed as meeting important social needs within lesbian communities, often replacing those formerly met by the lesbian bar subculture. These include the needs for affiliation, privacy, safety, socialization, and spiritual expression (Hall, 1991; Herman, 1988).

Why are images of recovery important? The ways in which problem drinkers conceptualize recovery serve as frameworks for interpreting the meaning of their experiences

and determining which aspects of life are salient to their recovery efforts. Images of recovery are the descriptions that people offer about their healing from alcohol problems. These images may be metaphorical. They may communicate the totality of the experience or only particular features. The images persons use to represent their progress and the difficulties they encounter in recovery provide important bases for developing relevant resources, therapeutic techniques, and social support. Individuals may use a single image of recovery, or they may describe a repertoire of images, each representing a particular aspect or period of recovery. The potential clinical value that images of recovery hold in terms of revealing individual and collective meanings about recovery indicates that much more information is needed about the sources, variety, and uses of these images in recovering populations.

In the ongoing ethnographic interview study of which this analysis is a part, 35 lesbians in recovery from alcohol problems living in the San Francisco Bay Area were interviewed during 1990 and 1991. Sixty-eight percent of the participants were Euro-Americans, 17% African-Americans, 9% Latinas, 3% Asian-Americans, and 3% Native Americans. Participants' ages ranged from 24 to 54 years, with a mean of 37. The socioeconomic backgrounds of participants were as follows: 46% were working class; 31% were middle class, and 23% were impoverished. Their years of education varied from 12 to 22 years, with a mean of 16. All 35 women reported abusing alcohol; 91% reported they had abused other drugs as well. Many also reported difficulties with other compulsive behaviors concerning food (34%), "codependency" (23%), sexual activity (11%), or money (6%). Length of time in recovery was self-reported and ranged from 1 to 25 years, with a mean of 6. Seventy-four percent of the participants were actively involved in Alcoholics Anonymous (AA), and the 26% who did not participate in AA were at least familiar with the AA program format through literature, prior involvement, or the influence of friends.

The term *alcohol problems* is used herein to avoid the limitations of the narrower, traditional disease model, signified by the term *alcoholism*. Abstinence from alcohol and other drugs, although not the sole focus, is considered to be a sound foundation for recovery. However, the occurrence of relapses is recognized as potentially meaningful in facilitating positive transitions in recovery for some individuals (Hall, 1990b). The term recovery has historically been used in health care to designate the period and process of restoration after illness or injury. This definition carries the implication that recovery is a process that ends or is completed within a specific, if variable, period. *Recuperation* and *rehabilitation* are related terms reflecting this temporally limited quality. The medical notion of recovery is primarily focused on physical and mental changes that move the individual away from the illness condition, such that recovery can be measured according to the presence or absence of symptoms of pathology or trauma. In terms of alcohol problems, recovery has a more complex set of dimensions, dimensions

that go beyond the disappearance of symptoms to include behavioral, social, and cultural considerations (Tomko, 1988). In the following section, notions of recovery represented in AA, a major cultural source of recovery imagery, are explored as a point of comparison for the images lesbians described in the interviews.

AA As a Source of Cultural Meaning for Recovery

The concept of "alcoholism" as a disease entity was advanced by medicine to counter the idea that alcohol overuse was simply a matter of moral weakness. AA, perhaps the most important source of cultural meaning regarding alcohol problems, was formally established in 1935 by a group of self-defined "alcoholics" who found a way to abstain from alcohol and improve the quality of their lives through group identification and the Twelve Steps that they followed in the process (Kurtz, 1988). AA rhetoric has it that "alcoholism" is similar to an "allergy" to alcohol that renders the "alcoholic" physiologically incapable of drinking in a reasonable manner. It also describes the problem as being "powerless over alcohol," with the result that one's life becomes "unmanageable" (Alcoholics Anonymous World Series, 1976). The term for recovery initially used by AA, and the term that dominates its literature, is *sobriety* (Alcoholics Anonymous World Services, 1976). Sobriety has two basic aspects: abstinence from alcohol and other mind-altering substances not medically sanctioned and continued improvement of one's social and spiritual relations through practice of AA's Twelve Steps.

The term *recovery* has gained currency as an increasing number of aspects of life have become associated with the healing process in the experience of recovering persons and groups. Recovery is therefore an evolving concept (Tomko, 1988). Some persons with alcohol problems integrate the idea of sobriety with the processes involved in addressing other, non-alcohol-related compulsive problems they face. An ever increasing number of Twelve Step programs have been based on the AA model, such as Narcotics Anonymous, Gamblers Anonymous, Overeaters Anonymous, and Cocaine Anonymous. The Twelve Step model has even been adapted for nonaddictive problems, as in the case of Incest Survivors Anonymous.

The AA view, which has contributed heavily to predominant mainstream views of alcohol problems, combines moral and spiritual difficulties related to excessive drinking with the medical profession's disease notion of "alcoholism" (Earle, 1982; Jellinek, 1960; Levine, 1984; Peele, 1986; Shaffer, 1986). Rather than a radical departure from the moralistic discourse of the temperance movement, AA can be viewed as a transformation of this discourse, preserving some of the moral overtones surrounding alcohol problems (Levine, 1984; Royce, 1986). The obvious Christian imagery and terminology used in AA writings is illustrative of this. AA's dual focus on "alcoholism" as both a disease and a cause for "defects of character" relieves addictive drinkers of guilt for having the

problem while holding them accountable to do something constructive about it.

The primary image of recovery in AA is one of conversion. The conversion image of recovery has three general phases or dimensions, which are reflected in the format of telling one's story in AA: What it was like, what happened, and what it is like now (Maxwell, 1984; Rudy, 1986; Thune, 1977). In religious terms this might be expressed as sin or moral decline, transformation, and then moral virtuousness. This image of recovery is one of unidirectional change from negativity to positivity. As in the notion of being "born again," conversion implies the creation of a new person and the abandonment of old ways of living. Contrasting terms such as *lost/found*, *condemned/saved*, and *drunk/sober* reflect the unidirectional change seen in the conversion image. Classically, conversion is conceptualized as a once-in-a-lifetime occurrence (James, 1902/1961). However, clinical experience reveals that a once-and-for-all transition from problem drinking to continual abstinence is the exception rather than the rule. This is corroborated by references in AA literature to "slips" or relapses, which are not uncommon (Alcoholics Anonymous World Services, 1976).

Lesbian's Images of Recovery

Conversion is one image lesbians use to describe their recovery experiences. But conversion alone is inadequate to describe all the experiences lesbians have in recovery. In the following sections various alternative images of recovery expressed by lesbians are described, and examples of each are provided in the form of quotes from the ethnographic interviews. Although these examples may seem to suggest that each woman had only one view of recovery, in most cases a number of images were reported. Images varied depending on the temporal period of recovery being described and which specific issues or conflicts were being addressed. In other words, a repertoire of images was ordinarily used to express the meaning of recovery.

Recovery as Physical Transition

Some participants emphasized physical changes, improvements, or awarenesses as exemplifying what recovery meant to them. These images were most often used in discussing early recovery (the first year or two). Themes about physical transition included increased perception of health and illness phenomena, initiation of more appropriate exercise and daily living habits, and taking responsibility for pre-existing chronic illnesses.

"When I stopped drinking, and I was a daily drinker, I got one virus after another for a year. My immune system must have been in shambles from the damage I had done. It wasn't like I was just getting sick in recovery, but that only without the

alcohol was I really aware of just how physically messed up my addiction had made me."

"I didn't deal with emotions or anything for the first year. I had to learn how to physically live, and that meant learning to make my bed every day, shower, eat. And that was all I could do. I rarely left my house."

The doctors told me I had liver damage. It took a long time for it to sink in what that meant. It was serious. And when I was drunk and stoned I never took care of my diabetes. A big thing in my recovery is that I show up for the appointments, I follow my food plan, and I have to be responsible for my illness. I already have neuropathies. But I can regulate the diabetes now so those things don't get worse. I can't go back and do it over, I have to look ahead.

Recovery as Personal Growth

Some lesbians referred to recovery as a journey of personal growth and spiritual development. They recalled various phases in this journey, which were characterized by specific focal issues. Among these issues were isolation, self-centeredness, judgmentalness, lack of belief in a power greater than themselves, willfulness, dishonesty, and grief. For these women, abstinence from alcohol and other drugs was a prerequisite to the journey, but not the journey itself. They reported that progress in the journey was marked by increases in serenity, that is, self-acceptance, wisdom, and inner peace. Most of these women were involved in AA, which is reflected in their choice of language. Often these women would say that recovery was, for them, an "inside job."

"It's about growth, it's a stretch . . . I don't isolate now. I don't want to judge people. I don't gossip. . . . I haven't had major awakenings but gradually I have changed . . . I couldn't do this without the AA program."

"I had a great deal of guilt. I would tell everybody everything, compulsively. It was overexposure. I had to stop doing that because it was really like beating myself up all the time. I was still atoning for sins or something."

"I used to be self-centered, egotistical, omnipotent, but under that was pure fear. I dealt with fear by showing anger or rage. I was this mean cobra. I can own my fears now, and I don't have to convince myself of being superhuman, like I am beyond such primal emotions."

Recovery as Struggle with Compulsivity

Patterns of recovery from alcohol problems for many women, including lesbians, are related to and interwoven with the course of recovery for similar problems, such as eating disorders, overspending, smoking, or codependency (Hepburn & Gutierrez, 1988; Tomko, 1988; Wilson-Schaefer, 1987). Many of the lesbians interviewed described having several addictive problems. Alcohol abuse was seen as only one symptom of a larger, often nameless life disturbance characterized by compulsivity. Other drug abuse, overeating, anorexia, overspending, sex addiction, and codependency (focusing excessively on other's needs) were some of these concurrent problems. For these women, recovery was a serial or simultaneous struggle with one or more of these compulsive syndromes, for which similar strategies were applied. Twelve Step programs such as Narcotics Anonymous, Overeaters Anonymous, Sex and Love Addicts Anonymous, Debtors Anonymous, and Codependents Anonymous were typically used. For these women, approaches to recovery that included all of their compulsive tendencies were valued. Involvement in AA could be problematic if concurrent problems were deemed unimportant or unrelated by fellow AA members. These women also battled a sense of fragmentation fostered by health services that specialize in only one compulsive behavior.

"My strongest conviction says that the professionals shouldn't discount the power of food, that addiction. Don't belittle it. Cross addiction and poly-addiction are real, and it could be lots of things—gambling for instance. You have to treat all these things across the gamut because they can all kill you. Also, we don't all fit the "stages" that are in the books, so you should keep the doors open for different experiences."

"I did some work on codependency after I stopped drinking. I depended on therapeutic support groups and went to AA only periodically. From the fourth year on I have had a lot of money problems. I have lots of debts from that. And the alcohol and my eating disorder were very much related. I was always aware that alcohol had calories. To keep my weight I'd fast all day so I could give myself permission to drink The speed allowed me not to eat. I hope to get to the place where the self-hatred and shame go away, because they tie in with the alcohol and the weight thing."

Recovery as Reclaiming the Self

Some lesbians reported that their alcohol and drug use were symptoms of underlying, unresolved trauma from the past. They found that when they stopped using alcohol and other drugs, they began to experience the emergence of memories and feelings that had been denied or dissociated from painful prior, usually childhood, events, such as

rape, incest, battering, and/or neglect. As memories were recovered and feelings named, these women believed that they were literally retrieving and restoring parts of themselves. They often used individual and group therapy, art therapy, and other non-medical means of understanding their own responses to the trauma as well as to explore family-of-origin dynamics. This work was often kept separate from AA involvement, and in some cases AA was seen as not fully sensitive to the impact of these family and trauma issues for women. For instance, AA advocates forgiveness as a core element of recovery. Many of these women did not feel it was appropriate to forgive the perpetrators of their abuse. The work of reclaiming the past can be problematic in some AA environments. Some lesbian interviewees, for whom the issues of childhood trauma were not pertinent or not currently relevant, perceived the discussion of family-of-origin dynamics and childhood abuse as straying from the focus of AA, which they deemed to be abstinence from alcohol and working the Twelve Steps.

"The problem with AA is that they take out the newcomer's brain at the door and insert the Twelve Steps. How can you really recover, how can you learn about yourself? What happened to me as a kid has everything to do with who I am now."

"The slip I had when I was sober two months was about sexual abuse, incest. My therapist had said, "Have you considered that you may have been raped in the past?" The next two days I had intense self-hatred, and I knew she was right even though I had no memories yet. . . . My sponsor didn't get it, so I accused her of not giving a damn about me and immediately got drunk. . . . But after three days I started back, because I knew I had to deal with this in sobriety."

"I got really scared at a group meeting and started remembering childhood things I went out of my body, everything was in slow motion. This lasted five days, where I was helpless and a friend had to take care of me. . . . But I realized I had survived this pain without a drink. . . . For me it was feeling responsible for my whole family, feeling I didn't help them, didn't measure up and there was physical abuse, threats I'd have these out-of-body experiences whenever I had a crisis, and my emotions were becoming flat. I had big black gaps in my memory, I mean before I ever used drugs or alcohol I realize now that I wasn't a horrible, inadequate person, but that there was this stuff that had happened to me, and that the effects were reversible."

Recovery as Connection/Reconnection

Isolation and a feeling of being alien in the universe are common experiences for those with alcohol problems. It is not clear which occurs first, the feeling of being "outside" or the alcohol abuse. For many of the women, being lesbian was a strong basis for feeling like an outsider, a feeling that often plagued them from adolescence on. Recovery was presented by many of those interviewed as a process of finding meaningful connections with others like themselves and of opening up to the possibilities of new relationships.

Connecting with other women, and especially with lesbians, became a key part of their recovery. They often described being unable to accept fully the idea of being lesbian in a positive way before they stopped drinking and using drugs. Many referred to Sober Living, an annual lesbian/gay AA gathering in San Francisco, as a turning point in their connection or reconnection with the recovering lesbian community. Likewise, some of the African-American and Latina women interviewed described recovery as a process of accepting their racial and ethnic heritages and confronting painful racial conflicts that they had buried through their substance abuse. Choosing which AA meetings to attend reflects the need to connect with others "like me," although the basis for such identification changes during different periods of recovery (Vourakis, 1989). Some lesbians chose to attend lesbian AA meetings, but many others reported feeling out of place or intimidated even in these meetings. The milieu of comfort in AA tended to change over time for individuals, depending on their needs. General mainstream AA meetings or those specifically for people of color, women, atheists, etc., were examples of meetings chosen to meet specific needs for connectedness.

"You get this higher power connection when you realize that to sit with someone, really be with them, is a spiritual experience There's something powerful about being in a room full of people who have something in common I'm bigger than what's in here, in this body of mine."

"I go to all-lesbian meetings now. I have to be able to be myself, to feel safe. This wasn't a big deal for me at first, because then I just wanted to get by one day without drinking or using dope.

I got to straight AA meetings I think it is a chance for me to learn tolerance, and for me to teach them tolerance about gay people. It's a way of connecting with other parts of the world I would never have before recovery."

"I think the AA Big Book has historical significance. . . . I like to see myself as a part of that tradition going all the way back to the beginning of AA."

"It's about comfort levels. Some lesbians can't deal with all-

lesbian meetings, and some people of color can't start out at the people of color meetings. You know, it can feel too close to home It shouldn't be assumed where someone will feel comfortable. Sometimes you connect with the most unlikely people."

"I used to think as an adolescent that one of these days I'd be white. Even cocaine was a way of disconnecting from the blackness, the black community. . . . Black-on-black crime disgusted me. . . . All my life my education was all about proving to me that I am not black. After two years in recovery I can say education is for education's sake."

Recovery as Cyclical/Celebratory

Recovery was characterized by some women as a temporal, cyclical process, often highlighted by celebration and commemoration. These temporal markers of recovery included both positive and negative events, such as detoxification, AA "birthdays" (anniversaries of sobriety dates), commonly designated "difficult periods" in sobriety, the timing and precipitants of relapses, the attachment to people who entered recovery at the same time as oneself, annual AA conferences such as Living Sober, and the celebration of holidays in a "clean and sober" state. This image of recovery was also reflected in statements about the need for predictability in recovery. Individuals sought knowledge about recovery as a universal experience and tried to develop insight into their own individual rhythms wherein similar issues re-emerged in a cyclical fashion through recovery.

"I always remember the women who got into recovery the same time I did, especially each year when we celebrate our sobriety date together. I grieve for the ones who are not in recovery any longer And then every year there is Living Sober when for five days I am intensely immersed into the issues and victories of my recovery."

"Lately I feel overwhelmed, with my birthday coming up. You know I was really sick. Really sick. I guess I feel pretty grateful. Getting in touch with the goddess and my own feminine aspects, my cycles, was like coming home for me. I began to study and do rituals."

"When I was sober two years, I had a weird experience, which changed everything. It was a ceremony, called a "spiritual cleansing." This ritual loosened me up so that I could access my memories of my childhood and be present emotionally like

never before. The compulsion to drink left me I hardly ever talk about this, except in general terms. My friend says she doesn't know what it was all about, but it sure worked."

Recovery as Vocational Change

Many of those interviewed made decisions in their early recovery to return to school or change careers. They saw recovery as an opportunity and perhaps a duty to contribute to society through their work. Often they chose helping fields such as nursing, counseling, and social work. Of course, these are also among the occupations most open to women in general. Significantly, many chose to specialize in substance abuse work. They described how they are encouraged to continue their own recovery by firsthand observation of the ravages of addiction that they encounter in their work.

"When I was using drugs and booze, I was doing the corporate ladder climb; everything on the outside looked good but I hated my life, I didn't know how to live my life So in recovery I just dropped out of that. I am in school to study massage and holistic healing techniques."

"I was a client in a newly formed, nonprofessional gay/lesbian treatment program on the East Coast What they had to say rang true for me I ended up as an alumni, then a staff member, and eventually an administrator of this program. I had a degree in psychology, but I was hired more for my recovery experience."

Recovery as Empowerment

For many, alcohol abuse was seen as a product of an addictive, racist, patriarchal society, and therefore recovery was viewed as a process of personal and collective empowerment as women, sometimes as women of color, and as lesbians. AA. was viewed negatively by some, but not all, of these women because it retains the trappings of white, male, Christian, middle-class culture and recommends that the person with an alcohol problem surrender his or her will. This seemed incongruous to many interviewees because of their perception that most women, lesbians in particular, have felt powerless for much of their lives. An empowerment image of recovery encouraged them to take control, to be critical, and to trust their own instincts. Further, they gained the insight that issues of addiction should not be separated from the politics of race, class, gender, disability, sexual orientation, and age.

"I got married very young and it didn't work. I used to think,

when I was still drinking, 'What's wrong with me?' Now I think, 'What's wrong with the setup?'"

"Recovery" isn't the way I define my whole existence any more, like I did in the beginning. Now the daily problems I face are due to being a woman in a misogynist culture and a lesbian in a homophobic culture.

"AA needs to get out of the patriarchy and incorporate blacks and women, lesbians more This stuff didn't matter to me when I first came into the program."

"I still hate the Lord's Prayer and I refuse to say it at AA meetings. The Christian flavor of AA is insulting to me as a lesbian."

"As a Latina I have a lot of issues around race and cultural and living in the U.S. that I have not really resolved yet in sobriety. But I know these are the issues which can make me relapse. And I have a real hard time with sexual abuse, which is so active in the ghettos and barrios And it's not a multicultural lesbian community yet. We have to deal with the reality of our oppression in recovery."

Recovery as Social Transition

Lesbian bars have traditionally been centers for socialization, where friendships and affectional relationships can form and where lesbians can be themselves, away from societal scrutiny and prejudice. These bars have also served a stigmatized community's collective needs for family, church, affiliation, and protection from violence. To leave the bar scene therefore presents a threat to many lesbians that is not paralleled in the experiences of straight people in recovery (Hall, 1991). For this reason, recovery becomes for many lesbians a process of rebuilding a social network that is not centered around alcohol use and lesbian bars. In recent years, Twelve Step groups have become more acceptable among lesbians as collectively they have moved away from substance use, particularly in urban coastal regions. Gradually, where available, lesbian and lesbian/gay AA groups and "clean and sober" social events organized by lesbian communities seemed to absorb some of the social functions previously provided by the lesbian bar subculture. Lesbian-and-gay-only treatment programs, lesbian support groups, and various self-help or mutual-help groups were used by lesbians in recovery to make new friends and to stay in touch with lesbian community life in recovery. For some the social transition was a great upheaval and change, whereas for others it was a smooth move from a niche in one social milieu (the bar) to a similar role in the recovering lesbian community.

"At first I was really interested in meeting lesbians in the AA groups. I was chasing the girls in the program, just like before."

"For nine years I hung out at the same lesbian bar on a daily basis. I would get there about 5 pm and sit talking to the owner until it got busy. There were about five of us regulars who did that. The owner was more than just an owner. She kept the community safe, and made sure we had this place where we could be ourselves. I couldn't imagine not going there every day When I quit drinking I found out there was this coffee shop where all the AA dykes hung out, and I was back in my element. It was even easier to be there than in the bars, because people would talk to you more willingly. And I discovered I could even sometimes go to the bars with lesbians in recovery, and not drink alcohol."

"Now it's easier for lesbians to be sober because it has become a strong cultural value here on the coast. . . . I remember being at a party two years ago when, out of 15 women, I was the only one drinking Lesbians don't go to bars anymore, they go to AA meetings."

"Party of recovery for me was learning not to go to bars, closing the doors I still had left open that could lead back to alcohol and drug use. I had to call my dealer up and say I wouldn't ever be talking to him again."

Implications for Health Care

Given the diversity of images for recovery that are relevant to lesbians who have alcohol problems, health care providers need to expand their awareness of recovery images and learn to apply these images more flexibly and interchangeably in their interactions with clients. Clients' images of recovery can be expected to change over time and circumstances, and individuals may hold several images simultaneously. These images are important ways in which change and stability are framed within personal and collective recovery experience. The provider who has a fixed theory or vision of what recovery is or should be unduly constrains the creative dimensions of the process in favor of a "recipe" approach. This is especially unsuitable for those whose life experiences differ significantly from the mainstream culture. Lesbians definitely fall into this category.

The uncritical promotion of AA and other Twelve Step groups as the single or even the best model of recovery is inappropriate. The Twelve Step model does not incorporate

many of the images of recovery reflected by the lesbians whose experiences are described here. Recovery as vocational change, as empowerment, and as reclamation of the self or past are at best only partially or indirectly addressed by the Twelve Steps.

The conversion aspects of the AA view of recovery may falsely characterize past trauma experienced by these women, such as incest or other sexual abuse, as moral weakness or "character defects." Valuable survival strategies that were employed in the period of alcohol and drug use may unfortunately be rejected as remnants of the old self under the conversion image of recovery. Lesbians necessarily develop survival strategies to counter the damaging effects of social stigmatization. To think of beginning recovery as a new person, largely abandoning past ways of life, may not only present too great a threat to lesbians, but may inappropriately discount the validity of their experiences and the usefulness of their prior survival tactics. Although much of the stigma of having an alcohol problem abates when one begins recovery and finds a support group of other recovery persons, the stigma against being lesbian still operates in society, in health care contexts, and within Twelve Steps groups as well.

Counseling, psychotherapy, social work, and nursing have offered important opportunities for lesbians to talk about recovery issues that are not easily addressed in the AA scenario. It is important that in becoming well versed about substance abuse issues these providers avoid packaging their wares exclusively in the language and principles of Twelve Step programs. If anything, more, not fewer, images of recovery are needed to validate the range of life experiences lesbians have had in this area. Those lesbians who have experienced a number of compulsive tendencies appreciate therapy that helps them make decisions that take all of their problems into consideration, without minimizing any, in a way that integrates strategies rather than fragments them.

For incest and other abuse survivors, interaction with providers not only offers an avenue for understanding some of the reasons why alcohol and drug use began and accelerated, but deals with the trauma in the larger sphere of life as a whole. There are legitimate times in recovery when the focus ought to be shifted away from the issues of drinking and drug use per se to more pervasive, lifelong difficulties that may have been engendered much earlier, in childhood. This does not necessarily mean that clients do not need to continue their recovery strategies for alcohol problems. Many lesbians report that during their work on incest, child abuse, etc., they experienced significant discomfort and anxiety but did not seriously consider substance use as an option. Provider fears that arousing these sleeping dogs will precipitate a substance abuse relapse do not appear to be well founded on the basis of these interviews. Just as images of recovery change and are expanded at various intervals for each individual, the emergence of earlier trauma issues seems to have its own natural timetable that sensitive providers wisely respect. In other words, the optimal time for past trauma issues

to be addressed seems to be when the client begins to speak about them.

The notion of recovery as empowerment has not been effectively incorporated into most mainstream recovery programs. There are a few remarkable projects serving women and, in some cases, specifically lesbian clients (Sandmaier, 1980). They serve as models for how empowerment can be incorporated through group work and emphasis on feminist, antiracist principles. To be open and supportive of this image of recovery, providers must acknowledge that women are the best authorities regarding their own healing and liberation, a tenet that conflicts with the compliance and control so often used in clinical interaction. Health care providers must be open and responsive to critiques from clients regarding the racist, classist, and sexist aspects of treatment programs, Twelve Step programs, and policies affecting minority communities with regard to alcohol and other drug use.

Recovery as social transition is uniquely expressed among lesbians, because it reflects the cultural developmental processes that are currently creating drug- and alcohol-free social structures in lesbian communities. The closure of many lesbian bars, the institution of clean and sober lesbian social environments, and the influence of lesbians on the organization and practices of Twelve Step programs are aspects of social transition at the collective level. Individually, lesbians must negotiate the transition from drinking to recovery in the face of social obstacles such as economic pressure, lack of lesbian-sensitive treatment programs, prejudices of health care providers, the white male biases of some AA members, and, for some, even the tension of seeing their self-conflicts reflected in lesbian AA meetings.

Lesbians in recovery also have some images of recovery involving celebration. The impact of Living Sober, with its openness to address the interests of so many subgroups of lesbians and gay men within Twelve Step programs, including the development of theater and artwork as expressions of recovery, is in fact influencing and reshaping AA as a whole. Albeit slowly, lesbians and gay men are challenging AA's straight, white, male Christian assumptions by publicly celebrating the existence of minorities within AA.

At the community level, outreach, education, and prevention efforts concerning alcohol problems must also expand images of recovery. The fragmentation of programs, each addressing a specific compulsive problem, may be unnecessarily expensive and ineffective. Exclusive dependence on Twelve Step programs as the foundation of other interventions may alienate minority groups who want recovery but do not wish to use the Twelve Step programs. Lesbian communities represent an excellent example of community-based efforts to face alcohol problems. They have organized themselves to combat a problem they perceive as a personal, social, and political threat to their health. If more resources could be made available to lesbian communities, it is certain that many cre-

ative new interventions for outreach, treatment, mutual support, and social alternatives to drinking and drug use would be developed by these communities themselves.

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