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This chapter explores the issues involved in the relationship between lesbianism and alcoholism. It examines the constellation of health and related problems created by alcoholism, and it critically interrogates the societal factors that contribute to the disproportionately high rates of alcoholism among lesbians by exploring the antecedents and consequences of alcoholism.

Alcoholism and Lesbians

Julie Gedro

Alcoholism is a problem in the United States among the general population (Gedro, Mercer, & Iodice, 2012) and it is particularly problematic in the lesbian population. Lesbians face challenges in establishing their identity, in negotiating life as "outsiders," and in relating to each other as a community (Ettore, 2005; Gedro, 2006). As a double (at a minimum) minority, and part of a historically stigmatized population in the United States, lesbians face particular types of pressures that include heterosexism, homophobia, sexism, and invisibility. These factors, which marginalize lesbians, serve as catalysts for alcohol use and abuse, and alcoholism among lesbians.

This chapter explores the issues involved in the relationship between lesbianism and alcoholism. It examines the constellation of health and related problems created by alcoholism, and it critically interrogates the societal factors that contribute to the disproportionately high rates of alcoholism among lesbians by exploring the antecedents and consequences of alcoholism. The underlying orientation of this chapter accepts the disease model of alcoholism, which is supported by the fact that alcoholism is listed in the Diagnostic and Statistical Manual, as well as the International Classification of Diseases (NIAAA, 1995). Factors such as marginalization, stigmatization, and stress place lesbians at higher risks for alcoholism than the general population. This presents unique opportunities for adult educators, who can serve as agents of education, sensitivity, and awareness to help reduce stigma against lesbians in society, and also for counselors and related professionals to more skillfully work with lesbians who are alcoholics or at risk for alcoholism.

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Definition of Alcoholism

Despite the research and resources dedicated to studying alcoholism, it remains a multifaceted and often misunderstood problem that has deleterious personal and societal consequences. Brewer (2006) characterized alcoholism as a maladaptive pattern of drinking that results in great physical, psychological, and social problems. One hallmark of alcoholism is an inability to stop drinking once drinking has begun, and afflicted persons are often unable to cease drinking alcohol despite continued negative consequences in every aspect of their existence (Brewer, 2006). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) explains that alcoholism is an extreme form of "alcohol use disorders." According to the NIAAA, alcohol use disorders are characterized by craving, loss of control, physical dependence, and tolerance (NIAAA, 2013a). A *craving* is a strong need or a strong urge to drink. *Loss of control* means that one is unable to stop drinking once drinking has begun. *Physical dependence* means that when an alcoholic stops drinking, he or she suffers withdrawal symptoms such as nausea, shaking, sweating, or anxiety. *Tolerance* means that an alcoholic needs to consume increasing amounts of alcohol in order to achieve the same effect. Alcoholism is a chronic and often fatal disease. The DSM-IV criteria for alcohol abuse are: hazardous use of alcohol, problems with the law, the failure to fulfill roles and obligations, and the continued use of alcohol, despite relationship or interpersonal problems (Hasin, Van Rossem, McCloud, & Endicott, 1997).

According to the National Comorbidity Survey Replication, which is a nationally representative U.S. survey, it is estimated that the lifetime prevalence of alcohol abuse is 13% (Green & Feinstein, 2012). "Alcohol and drug dependence are prevalent problems in the U.S. and major public health concerns that affect individuals, families and communities" (Green & Feinstein, 2012, p. 265). Furthermore, alcoholism is a costly disease, affecting health and wellness for those it afflicts (Gedro et al., 2012) and creating collateral damage in the form of healthcare costs, workplace productivity, criminal justice expenses, and motor vehicle crashes (Centers for Disease Control and Prevention [CDC], 2013). Excessive drinking cost the United States $223.5 billion in 2006 (CDC, 2013).

Models of Treatment for Alcoholism

There are a variety of perspectives about alcoholism as a *disease*, versus alcoholism as a *personal weakness*, and this variety results in differing and sometimes contested views about alcoholism and recovery. The American Medical Association provides resources for physicians to discern when they feel that a patient has a problem with chronic and health-impairing alcohol use, if the patient is *abusing* alcohol (NIAAA, 2005). This resource recommends that for patients who have alcohol use disorders, abstinence is the "safest course" (p. 11).

There are a variety of ways that someone who is afflicted with alcoholism can pursue recovery. Self-help groups such as Alcoholics Anonymous (AA) "outlines 12 consecutive activities, or steps that alcoholics should achieve during the recovery process" (NIAAA, 2000, para. 2). Psychosocial therapies include motivational enhancement therapy, which "begins with the assumption that the responsibility and capacity for change lie within the client" (NIAAA, 2000, para. 6). Couples therapy is another treatment modality in which the involvement of the nonalcoholic spouse engages with the process of recovery for the drinking spouse, and learns and rehearses a relapse prevention plan (NIAAA, 2000, para. 2). Finally, brief intervention is a treatment modality in which a primary care physician or nursing staff provides information to the alcoholic about the adverse consequences of drinking and provides practical advice about how to achieve moderation or abstinence (NIAAA, 2000).

Lesbians and Alcoholism

The primary challenge facing lesbians who are either at risk for developing alcoholism, or are suffering from alcoholism, is the lack of visibility and awareness of them as a discrete population. Lesbians are sexual minorities, and they are gender minorities. Lesbians are subsumed into the category of "women" and seen only as gender minorities for purposes of population statistics on alcohol. To be specific, the National Institute on Alcohol Abuse and Alcoholism presents drinking statistics (NIAAA, 2013b) that have two categories: *Women* and *Men*. There are no distinctions made between heterosexual women and lesbians, and between heterosexual and gay men. There are no categories for bisexual or transgender men and women. The oversimplification of data presentation is emblematic of the persistent marginalization of sexual minorities. In particular, lesbians face double minority stress as women and as lesbians. Lesbians have higher risks for alcoholism than gay men (Bux, 1996, in Green & Feinstein, 2012) and lesbians "appear to have higher rates of alcoholism than do heterosexual women" (Becker & Walton-Moss, 2001, p. 16).

Saghir and Robins (1973) posited that lesbians have alcoholism rates that are three times the rates of the general population. Swallow (1983, in Faderman, 1991) said that "38 percent of all lesbians are alcoholics and another 30 percent are problem drinkers" (p. 282). However, evidence that refutes this claim has since been presented in no small part because of the identification of the methodological limitations of the study (Herbert, Hunt, & Dell, 1994; Parks & Hughes, 2005) "such as the recruitment of participants from bars . . . " (Bux 1996, in Green & Feinstein, 2012, p. 266). Even though more recent research has found "overall lower rates of heavy drinking among lesbians" (Parks & Hughes, 2005, p. 32), lesbians do have higher rates of alcohol-related problems (Parks & Hughes, 2005). Hughes and Wilsnack (1997, as cited in Hughes, 2003) provided insights around the methodological limitations of research on lesbians and alcoholism that also included small homogenous samples, inconsistent use of definitions of sexual orientation, lack

of appropriate control or comparison groups, and an absence of standard measures of drinking and drinking-related problems. Nevertheless, even though Hughes contests the claim that lesbians have approximately 30% greater rates of alcoholism than the heterosexual population, she does confirm that lesbians tend to be more likely to experience problems related to alcohol. No matter the methodological debates among research and researchers, whether the accepted rate is 30%, or whether it is a smaller number, lesbians have higher rates of alcohol use than heterosexual women (Kerby, Wilson, Nicholson, & White, 2005) and Hughes's (2003) study found that "lesbians were significantly more likely than heterosexual women to report having experienced one or more adverse drinking consequences . . . and a greater proportion of lesbians than heterosexual women reported one or more dependence symptoms" (p. 1751). There is an absence of conclusive findings that establish the reasons for higher rates of problem drinking among lesbians and it is likely, instead, that a constellation of factors provides such explanation. A fundamental explanation could reasonably be that the minority status of lesbians in society, and all that results from that status, creates the conditions around which lesbians engage in drinking behaviors that can lead to alcohol abuse and alcoholism. The fact that lesbian life has historically been organized around lesbian bars, where lesbians can find each other as well as enjoy a safe haven (particularly in the post-Stonewall era, as police raids on lesbian and gay bars were less acceptable and less routine), has been a major factor explaining the risk of alcohol use and abuse, and alcoholism. In concert with bar culture as an explanatory factor, the stress of being a stigmatized minority plays a significant role as well.

Alcoholism's deleterious consequences, which include health, relationship, legal, financial, career, and other related problems, affect lesbians just as they affect other demographics. In terms of consequences, then, alcoholism could be considered an "equal opportunity disease." There is an unevenness, however, with respect to lesbians' *risks* for alcoholism, and their *challenges* with respect to achieving and maintaining sobriety. Lesbians face higher risks for alcoholism, they have higher rates of alcoholism than the general population, and they face particular challenges with respect to negotiating sobriety (Anderson & Henderson, 1985; Bobbe, 2002). There are two fundamental challenges for lesbians to strive for recovery from alcoholism. First, there is the challenge of identifying other lesbians in order to access social support, friendship, and romance in contexts that are not framed by alcohol consumption such as happy hours, parties, or similar contexts that have copious amounts of alcohol consumption or have alcohol-related themes. Because of the relative importance of the bar as an organizing aspect of social life, for example, a lesbian who strives for recovery from alcoholism, particularly one who is early in recovery, faces the daunting task of negotiating the tension between distancing herself from bars, and the inherent resulting possibility of distancing from lesbians. Although, certainly, engagement in bars and bar culture is not the only way to meet and socialize with other lesbians; however, a lesbian bar provides a "shortcut" way of meeting other lesbians, since they are a small population,

and one that is not necessarily easy to identify or locate. Without physically defining attributes (Barnard, 2005) that distinguish them as members of this minority group, it is difficult for lesbians to identify other lesbians in locations of general social space such as restaurants, parks, theatres, and even mundane locations of daily modern living such as grocery stores and shopping malls. This means that being a lesbian presents an array of difficulties with respect to negotiating connection with other lesbians. A lesbian bar presents a relatively uncomplicated way of identifying other lesbians because, although it is certainly possible if not likely that a lesbian bar might have patrons who are not lesbians, lesbian bars are patronized by lesbians. Going to a lesbian bar has historically presented an element of self-selection and identification:

> Not only were American lesbians without a history such as helped to guide other minority groups, but they were also without a geography: there were no lesbian ghettos where they could be assured of meeting others like themselves and being accepted precisely for that attribute that the outside world shunned. There was little to inherit from the past in terms of safe turf, through safe turf was crucial to lesbians as a despised minority. (Faderman, 1991, p. 161)

Second, there is the challenge of identifying safe, lesbian-friendly resources such as counselors, Alcoholics Anonymous meetings, and other related resources that provide environments that foster and encourage success in sobriety.

There are several reasons that lesbians are at "elevated risk for heavy drinking and alcohol-related problems compared to heterosexuals" (Green & Feinstein, 2012, p. 266). Because of the homophobia and heterosexism of the larger society, lesbians face pressures and a constellation of difficult choices related to their sexual minority status. To be clear, other sexual minorities, such as gay men, bisexuals, and transgender people face challenges and pressures. As such, they have their own particular considerations with respect to alcoholism. Because the focus of this chapter is on lesbians and alcoholism, it is beyond the scope of the chapter to explore these other populations. The risk factors, or the antecedents of alcoholism among lesbians which elevate their risk, include the centricity of the lesbian bar in lesbian life, internalized homophobia and heterosexism, which result in internalized shame and minority stress (Green & Feinstein, 2012). The consequences of alcoholism among lesbians include health and wellness, career, financial, legal, and interpersonal issues.

Stigma. Goffman (1963) is widely credited with conceptualizing and defining the term stigma. According to Goffman, society creates categories that specify attributes that are considered natural and normal, and people use these normative expectations as a benchmark around which they measure strangers. When that stranger has an attribute that is undesirable, then that person is perceived to be weak, or discounted. When such weakness or shortcoming has an intensely discrediting effect, it is considered a stigma. Lesbians, who

are women with same-sex romantic affiliation, suffer the stigma borne by their presence in a society pervaded by the assumption that heterosexuality is what is normal and natural. Gedro, Cervero, and Johnson-Bailey (2004) noted that "To be same sex oriented in a society that is undergirded by the heterosexual assumption is a stigma" (p. 181). Hatzenbuehler (2009) noted that the social stigma of homosexuality, which perpetuates chronic experiences of discrimination and rejection among sexual minorities, results in their hyper vigilance around disclosure, or coming out. The constant monitoring of one's behavior, speech, and mannerisms, which can serve as signals of sexual identity, presents mental and emotional stress. Were it not a stigma to be a sexual minority, the stress of this constellation of decisions around disclosure would not exist. Therefore, stigmatization leads to negotiation of one's identity and decisions around disclosure, which lead to stress. Borden (2007) observed that "despite our modern understanding of alcoholism as a disease, and a growing acceptance of gay people in our society, stigmas against homosexuality and alcoholism remain strong" (pp. 1–2).

The heteronormative nature of society, combined with the persistent challenges faced by women to gain equal footing as men with respect to jobs, income, political might, and other types of power and privilege, creates the conditions by which lesbianism remains an identity that is transgressive and as a result can foster a sense of self-consciousness and shame, sometimes resulting in self-hatred. Barnard (2005) noted that "unlike minority groups for whom physical attributes identify their differences from the dominant culture, lesbians are a hidden population, and little is known about the scope of lesbian lifestyles" (p. 38). Lesbians are likely to be part of every type of racial, ethnic, and socioeconomic demographic and yet little research has been done on them not only because of their invisibility, but also because of the social stigma attached to being a lesbian, an additional cause of this invisibility (Barnard, 2005). Even though lesbians have become more visible, in particular, in the popular media (e.g., there are out lesbian celebrities such as Ellen DeGeneres and Jane Lynch), and there are certain states that have enacted antidiscrimination laws based upon sexual orientation, being a sexual and gender minority brings with it a set of challenges. Swim, Ferguson, and Hyers (1999) observed that the stigma of being a lesbian is a source of social pressure that inhibits behaviors associated with nontraditional gender roles, and that the fear (for lesbians or for any women) of being labeled "lesbian" is a basis of gender role socialization. Lesbians are "devalued because they are women, they are again devalued, more severely, because their existence is not dependent upon a relationship with a man" (Bobbe, 2002, p. 218). They face internalized homophobia (Anderson & Henderson, 1985; Bobbe, 2002; Ettore, 2005; Hall, 1990; Weber, 2008) and disconnection with each other (Gedro, 2006). One way that lesbians manage their stigmatized identity (Anderson & Henderson, 1985) is to employ a variety of strategies such as closeting, passing as straight, distracting, or even

lying and making up fictitious "cover stories" in which they present themselves as heterosexual.

"Sexual minority women share many of the same health risks as women in the general population; however, their status as part of a stigmatized minority group is believed to increase their risk for certain health problems or health risk behaviors" (Meyer, 2003, in Bostwick, Hughes, & Johnson, 2005, p. 8). All of these factors serve to constrain their abilities to live lives that are healthy and characterized by the ability to make choices about how to establish relationships (both platonic and romantic), and how to socialize. Kerby et al. (2005) observes that research into lesbian health challenges is limited, and that not only is healthcare access restricted for lesbians (p. 46) but also that homophobic attitudes persist among healthcare professionals. Sauliner (2002) notes that lesbians experience, for example, challenges with respect to high-quality healthcare access because of long-standing provider biases, and that the negative attitudes possessed and demonstrated by providers continue to hamper the ability for lesbians to get quality healthcare. The stigma, therefore, of being a lesbian presents, in part, an explanation for higher rates of alcoholism among lesbians, and it also creates challenges for lesbians who recognize that they might have problems with alcoholism, and seek help. Even though discrimination, homophobia, heterosexism, and fear of disclosure put lesbians at increased risk for alcoholism, in the United States, lesbians "often do not feel they are receiving culturally competent care" (Dinkel, 2005, p. 10). According to Dinkel, culturally competent care consists of five constructs: (a) cultural desire, which is the genuine desire to work with culturally different groups; (b) cultural awareness, which is the act of acknowledging changes in society and in healthcare; (c) cultural knowledge, which is the process of seeking out opportunities to become educated about various world views and biological variations; (d) cultural skill, which is the ability to collect data in a sensitive way; and (e) cultural encounters, which are consistent interactions with cultural groups to extend and support the process. This cultural competence among practitioners forms part of the basis for the recommendations presented at the conclusion of this chapter, because in order to address the problem of alcoholism among lesbians, it is important for adult educators to understand the issues that are specific and unique to lesbians and to provide resources for counselors and related practitioners, to help them become culturally competent as they work with lesbian clients.

Minority Stress, Identity, and Shame. Lesbians are at heightened risk for alcoholism because of the stress associated with being a gender minority and a sexual minority. "As a result of being sexual minorities in a predominately anti-gay society, LGB individuals experience physical and emotional stress, a phenomenon that DiPlacido (1998) referred to as *minority stress*" (Weber, 2008, p. 31). Weber observed that the realization of a minority sexual identity is a factor in LGB substance abuse. Weber created an adaptation of McCarn and Fassinger's (1996) model of sexual minority identity development as a way of contextualizing the strain that sexual minorities

(LGB) experience as they travel through the stages of identity formation. Weber noted the usefulness of understanding the stages of sexual minority identity formation developed by McCarn and Fassinger (1996) because implicit in the model is the journey that one traverses on the way to feeling whole, content, comfortable, and complete about one's sexual minority identity. The stages of this model in brief are: awareness of feeling "different," exploration of sexual feelings, deepening commitment to one's sexual identity, internalization of one's status, and finally, synthesis of one's status (Weber, 2008, p. 36). Weber offered that the model of sexual minority identity development "does underscore the emotional intensity and difficulty of the process of developing an LGB sexual identity in the context of societal oppression" (p. 44). Weber confirmed that those sexual minorities who had a substance abuse or alcohol disorder reported that they experienced more heterosexism than those who were not classified as having such a disorder. It is clear that the stress of being a sexual minority is a contributing risk factor for lesbians. It is also clear that the double stress of being a sexual minority and a gender minority presents a heightened risk for lesbians. Cabaj (2000, in Weber, 2008) "posited that substance use and abuse disconnects LGBT people from feelings of shame and anxiety, provides acceptance, fosters social comfort in bars or unfamiliar social settings, and allows for denial and even blackouts about sexual behavior" (p. 35). Additionally, the separation or ostracism that occurs for sexual minorities, including lesbians, from their families, and the difficulty in finding other lesbians for friendship or for romance, can lead to "limited social support and feelings of isolation, both of which can lead to substance abuse or mental health problems" (Green & Feinstein, 2012, p. 272). Bobbe (2002) noted that "the dynamics of unconscious shame continue to negate the lesbian child's experience of herself through dissociation of emotion, and often through self-abuse in the form of addiction" (p. 219).

Other Issues: Sexual Abuse and Depression. Hughes (2003) noted that childhood sexual abuse presents a risk factor. Rates of childhood sexual abuse were 68% for lesbians and 47% for heterosexual women. Although research has demonstrated that approximately 10–20% of women report being sexually abused in childhood, women who are in treatment for alcoholism report much higher rates, which suggests a relationship between the experience of childhood sexual abuse and alcoholism (Fleming, Mullen, Sibthorpe, Attewell, & Bammer, 1998). It has been established that childhood sexual abuse results in difficulties for victims. These difficulties include depression and substance abuse:

> Children and adolescents who experience sexual abuse are more likely to experience depression and dysthymia, borderline personality disorder, somatization disorder, substance abuse disorder, posttraumatic stress disorder, dissociative identity disorder, or bulimia nervosa; to attempt suicide; to become pregnant earlier; to engage in HIV sexual risk behaviors; to perform poorly at school; to

> be arrested for sex crimes; or to commit other criminal offenses. (Friedman et al., 2011, p. 1481)

In their meta-analysis of medical and social science journals from 1980 to 2009 of studies that compared the likelihood of self-reported childhood sexual abuse, physical abuse perpetrated by parents or guardians, and peer abuse, Friedman et al. (2011) discovered that sexual minority youths were 2.9 times more likely to report childhood sexual abuse. Lesbian rates of childhood sexual abuse were 32.1%, compared with 16.9% for heterosexual females. Hyman (2009, as cited in Galvin & Brooks-Livingston, 2011, p. 17) examined the mental health of lesbians, the effect upon them of living in a heterosexist society, as well as the prevalence of child sexual abuse and the association of lifetime alcohol abuse (among sexual abuse clients) and discovered a strong correlation between these variables. In particular, Hyman discovered that there is a high prevalence of substance abuse among lesbians who have experienced child sexual abuse. Depression, a "serious mood disorder" (Barnard, 2005, p. 36) that deleteriously affects intrapersonal and interpersonal relationships, has been found to be twice as prevalent in women as men (Barnard, 2005). However, there is little research that has been conducted on depression and lesbians, who "are a unique and often hidden population within American society" (Barnard, 2005, p. 36). Bobbe (2002) noted that homophobia presents an "ongoing oppressive force" (p. 218) and that internalized homophobia can lead to depression, which can lead to drinking. However, alcohol exacerbates depression, which makes the original problem worse and can result in the downward spiral of increasing dependency (Bobbe, 2002).

Bostwick et al. (2005) similarly identified factors that co-occur and/or contribute to alcoholism in lesbians. Those factors include discrimination, homophobia, and heterosexism, leading to anxiety and depression, resulting in a higher risk for alcoholism.

Alcoholism, Alcoholics Anonymous, and Lesbian Recovered Alcoholics

There is no cure for alcoholism. It is suggested that once one has crossed the line into alcoholic drinking, abstinence is indicated. Although there are different schools of thought about this matter, again, this chapter operates with the understanding that alcoholism is a disease characterized by an inability to stop drinking once an alcoholic has begun drinking. Therefore, there are different approaches that alcoholics (and lesbian alcoholics) can take toward maintaining sobriety. Perhaps the most well-known method is Alcoholics Anonymous, which is a peer support based treatment program in which participants self-identify as alcoholics and work with others to "share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from alcoholism" (Alcoholics Anonymous, 2013a,

para. 1). There are multiple perspectives about the inclusiveness of Alcoholics Anonymous that bear highlighting.

Alcoholics Anonymous: Noninclusive. With respect to lesbians and Alcoholics Anonymous, it is accurate to claim that the organization was pioneered by two heterosexual, White men, Bill Wilson and Dr. Robert (Bob) Smith, and that it has its roots in religion:

> The origins of Alcoholics Anonymous can be traced to the Oxford Group, a religious movement popular in the United States and Europe in the early 20th century. Members of the Oxford Group practiced a formula of self-improvement by performing self-inventory, admitting wrongs, making amends, using prayers and meditation, and carrying the message to others. (Alcoholics Anonymous, 2013b, para. 1)

Wilke (1994) noted that Alcoholics Anonymous uses sexist language. Other criticisms of AA have included that "AA is a religion or cult with a suspiciously white, male, dominant-culture, Christian God" (Davis & Jansen, 1998, p. 172). Alcoholics Anonymous was founded by heterosexual, White men, and was based upon a Christian God; although there are meetings that are exclusively for LGBT people in recovery, criticism of AA as heterosexist, White, and patriarchal seems to persist (Matthews, Lorah, & Fenton, 2006; Pettinato, 2005; Staddon, 2005). Despite these criticisms, AA is seen as an effective method for abstinence and sobriety, and Matthews et al. (2006) suggest that gay and lesbian AA meetings are helpful.

Alcoholics Anonymous: Inclusive. There is evidence, as has been presented here, to suggest that there are lesbians who feel that Alcoholics Anonymous has a culture characterized by patriarchy and religious fundamentalism. It is important to note that although these criticisms are valid for those who offer them, and that although it has roots in the Oxford Group, Alcoholics Anonymous is not a religious organization, and it does not require religious affiliation or faith. The primary text of Alcoholics Anonymous (2008), called the "Big Book," explains its spiritual orientation (and corresponding lack of religious affiliation) by indicating the following: "When, therefore, we speak to you of God, we mean your own conception of God . . . Do not let any prejudice you may have against spiritual terms deter you from honestly asking yourself what they mean to you" (p. 47). Early in its history, Alcoholics Anonymous had a focus on helping an alcoholic, no matter what demographic, get sober. Borden (2007) described an interchange between Barry L. and Bill Wilson in which Barry asked Bill his thoughts about setting up an AA meeting for gay men, to which Bill Wilson responded that if setting up such a meeting represented the lengths to which Barry must go to help these (gay) men get sober, then it was important for Barry to do it. There are other examples that demonstrate Bill Wilson's phlegmatic orientation toward sexual minorities, but for purposes of brevity, this incident hopefully proves sufficient. Over the course of its history, Alcoholics Anonymous has included LGBT people in its

literature, and has had LGBT meetings. In 1973, a pamphlet entitled "The Homosexual Alcoholic: A.A.'s Message of Hope to Gay Men & Women" was printed (Borden, 2007). In 1974, the General Service Conference of Alcoholics Anonymous voted to include homosexual groups in its World Directory, and in 1989, AA published a pamphlet entitled "A.A. and the Gay/Lesbian Alcoholic" (Borden, 2007). In the face of what this chapter presents as arguably conflicting points of view regarding Alcoholics Anonymous, and its appropriateness for lesbians as a means resource for achieving and maintaining sobriety, the tension produced by this conflict is important to note and presents an opportunity for further exploration.

Conclusions and Implications for Adult Educators and Related Professionals

Adult educators, particularly those in health education, have an opportunity to disrupt the particular problems that beset lesbians who are at risk for alcoholism, and lesbians who suffer from alcoholism. There are three fundamental ways that adult educators can address the issue, at three different levels. The first, through working to transform negative societal attitudes toward sexual minorities, and thus work to minimize or hopefully eliminate heterosexism, sexism, and homophobia, is admittedly a tall and ambitious order. The second is more direct, perhaps more immediate, which is to create programs for healthcare professionals to raise their awareness around lesbian identity and culture, and the particular challenges that lesbians face, and the factors that put them at risk for alcohol abuse and alcoholism. Hall (1990) noted that lesbian recovery from alcoholism is a "complex human phenomenon" (p. 109) and that there is a lack of exploration of long-term recovery in lesbian women. Weber (2008), for example, noted that sexual minorities have "special treatment concerns" in addition to recovery, such as grappling with and recovering from internalized homophobia. Weber suggested that counselor and health educators who teach and supervise mental health counselors should increase their students' awareness of the impacts of homophobia, heterosexism, and internalized homophobia on sexual minorities. With respect to lesbians and alcoholism in particular, adult educators have an opportunity to serve as agents of emancipatory change, by creating programs and services that uncover the double (or more, depending on other factors, such as race, ethnicity, religion, and disability) minority stress of being lesbian. The third way that adult educators can address the issue is to conceive, develop, and deliver programs that help lesbians successfully negotiate alcoholism, treatment, and recovery, and to, when it co-occurs as an explanatory factor, overcome the deleterious effects of homophobia and heterosexism.

Adult educators have an opportunity to serve this triply stigmatized population by providing education that raises awareness about the elevated risks for alcoholism that lesbians face. Programs that help sensitize healthcare professionals to the unique risks and needs of this population would be

appropriate, so that lesbians who seek help are treated with respect, compassion, and understanding. Adult educators can work on a larger scale to create programs that work to lessen societal heterosexism and homophobia, which seem to be the fundamental underlying factor in lesbians' risk levels of alcoholism. Therefore, by addressing preventative measures, as well as the recovery measures, related to lesbians, adult educators have a unique opportunity to work for social justice through better health, wellness, and well-being for lesbians. What helps any minority helps all of society.

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