Ladies Don't: A Historical Perspective on Attitudes Toward Alcoholic Women

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Stigmatic and sex-biased attitudes toward contemporary alcoholic women can be traced back to the 1800s. Reinforced by Western culture, these attitudes are oppressive in that they exacerbate women's shame, diminish their self-esteem, and undermine their recovery. This article discusses the trends and historical events that have shaped societal attitudes toward alcoholic women and the effects of social workers' attitudes on policy formulation and professional behavior toward clients who are alcoholic women.

Alcoholism was once considered a problem for men, but an estimated 3.9 million, or about one third of all alcohol-abusing or alcohol-dependent persons, are women (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1995). Although societal attitudes toward alcoholic men have become more enlightened since the 19th century, attitudes toward alcoholic women have not changed substantially (Blume, 1991). Throughout Western history, alcoholic women have been subjected to more restrictions than alcoholic men and have been

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punished more harshly for defying codes against drinking (Sandmaier, 1992). As a result, alcoholic women confront many of the same negative attitudes today as did their counterparts of the 1800s.

By adopting a historical perspective, this article documents that stigmatic and sex-biased attitudes toward alcoholic women have not only persisted over time, but have oppressed women. It discusses the impact of certain national trends, events, and issues on the shaping of alcohol-related societal attitudes and the adverse effects of these attitudes on alcoholic women.

Because social workers are influenced by the cultural context (Berlin, 1993; Meyer, 1993) and are subject to the same negative attitudes toward alcoholic women as is the general population, this article explores the effects of their attitudes on the helping relationship and the formulation of social policy. It demonstrates how sex-biased attitudes of clinicians (including attitudes that infantilize or devalue females) can reinforce negative stereotypes of alcoholic women. It also explains why some of the male-oriented alcoholism interventions that practitioners commonly use are harmful to women and the ways that child welfare policies can inadvertently discriminate against alcoholic women. Stigmatic attitudes of clinicians are presented as barriers to the appropriate diagnosis of women as alcoholics and as deterrents to women entering alcoholism treatment facilities. Specific ways in which practitioners' sex-biased and stigmatic attitudes can increase the shame of alcoholic women, diminish alcoholic women's self-esteem, and undermine their sobriety are examined.

Sex-biased attitudes refer to attitudes that discriminate against women on the basis of sex-role stereotypes and generalizations (Barker, 1987), including those that set double standards and/or attempt to protect women. Stigmatic attitudes are those that attach degrading or dishonorable meanings to the behavior and reputation of alcoholic women.

ALCOHOL-RELATED ATTITUDES

The 1800s

Societal attitudes are inextricably linked to the historical context. Examples are the manner in which gender-role expectations (expectations of "ladies") affected alcohol consumption during the 1880s and the disparate legal sanctions that were imposed on women who drank to excess.

The term *lady* was redefined in the 1880s to include not only upper-class women, but other women who managed their households, depended on men for economic support, accepted subordinate positions in their homes, and developed feminine traits (Abramovitz, 1992; Hymowitz & Weissman, 1978). In return for ladylike behavior, women were afforded the favor and protection of men.

Whereas the definition of lady was expanded, attitudes toward women's drinking behavior were not. Women's use of alcohol was restricted to culinary and medicinal purposes, although upper-class ladies were permitted to drink alcohol in small amounts at their homes or private gatherings. Women who drank publicly or became drunk were considered sexually indiscreet and irresponsible mothers (Barrows, 1910; Morell, 1993; Riis, 1890/1970).

The legal repercussions faced by alcoholic women were also sex biased and stigmatic. Chronically drunk or alcoholic women could be committed to insane asylums, lose their children, or be subject to involuntary hysterectomies (Hymowitz & Weissman, 1978; Sparks, 1897).

The 1900s

During the 1920s, women began to drink openly. Their behavior was influenced by the economic independence created during

World War I, the right to vote, and the relaxed sexual mores associated with Freudian philosophy. Women protested patriarchal attitudes by drinking in public places, accelerating their drinking behavior, and wearing shorter dresses (Hymowitz & Weissman, 1978). Despite their protests and behavior, societal attitudes toward women who drank publicly remained linked to promiscuity and parental neglect.

There were also strong social forces that discouraged drinking by women in the early 1920s and 1930s, partly because of sex biases and stigmatization. Three such forces were Prohibition, the Great Depression of the 1930s, and the Temperance movement, led by the Women's Christian Temperance Union (Bordin, 1986; Lender & Martin, 1982). Although both women and men could be arrested for drinking during Prohibition and the Temperance movement, drinking by women remained linked to sexual misconduct and the absence of femininity (Hymowitz & Weissman, 1978; Sandmaier, 1992). The avoidance of stigmatic attitudes was a major incentive for some women to abstain from drinking.

The Great Depression drastically reduced employment opportunities for women and forced many female employees out of the labor market. In returning to their unpaid labor in the home, these women experienced diminished autonomy and a resurgence of traditional values and attitudes. Both in response to sex-role stereotyping and to evade stigmatic attitudes, many women stopped drinking and others tended to drink less openly (Sandmaier, 1992).

Between 1940 and 1945, millions of women were employed for the first time to replace men who were fighting in World War II. When the war ended, women, including widows and single female heads of households, were coerced out of the labor market because they now had men to take care of them (Coleman, 1995). Women resisted these sex-biased expectations, partly by increasing their consumption of alcohol (Hymowitz & Weissman, 1978).

Federal studies of alcoholism were also sex biased in that they focused primarily on middle-class White men, were gen-

erally conducted in male-oriented work settings, and used male-dominant or all-male samples. The studies, which gained popularity during the 1950s, virtually ignored women and did little to offset pejorative societal attitudes toward alcoholic women.

Although the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (Pub. L. No. 94-371) paid special attention to the needs of alcoholic women, sex-biased research and treatment persisted (Raymond, 1991; Vannicelli, 1984). As of 1978, only 17 of the 578 treatment programs funded by the NIAAA were designed specifically for women (*Request for Proposal*, 1978).

The combination of the women's movement and expanded advertising for alcohol had a unique effect on attitudes toward alcoholic women in the 1960s and 1970s. For the first time, the liquor industry was permitted to show women in advertisements for alcohol (Jacobson, Atkins, & Hacker, 1983). However, whereas commercials consistently portrayed women as liberated, free-spirited individuals with a growing desire for alcoholic beverages (Jacobson et al., 1983; Morrissey, 1986), societal attitudes continued to be oppressive. For example, women were offered half-price drinks on ladies' nights but risked having their personal or professional reputations viewed disparagingly if they drank to excess or could not contain themselves. These attitudes were sex biased because they advocated double standards for men and women and were stigmatic in that degrading meanings were attached to the characters of women on the basis of drinking patterns.

Women's roles continue to be based primarily on sexual, reproductive, and child-rearing functions (Walther & Young, 1992). Examples abound both in women's personal and professional lives. For instance, a man who becomes drunk may be considered the life of the party, whereas a woman who drinks excessively is usually viewed in a more pejorative manner (as "loose"). Male recovering alcoholics are often commended, whereas female recovering alcoholics are blamed for their previous lifestyles (van Wormer, 1995).

In the corporate world, where the alcohol-related entertainment of clients is a common practice, women are generally castigated if they fail to drink like ladies. Male employees in need of alcoholism treatment are frequently referred for service, whereas female employees are generally ignored (Lukina-Wiersma, 1990). Women, more so than men, are not charged by police officers with alcohol-related vehicular offenses, and judges sometimes ignore symptoms of alcoholism in women when sentences are rendered. Even when women acknowledge that they have alcohol-related legal difficulties, they are sometimes referred to relatives, rather than for treatment. The failure of criminal justice personnel to charge or appropriately refer alcoholic women is sex biased because the purpose is to shield women from criminal records or a diagnostic label of alcoholism (Sandmaier, 1992). In turn, women are protected from the consequences of their behaviors.

Sex biases are also evident among researchers. Studies that use predominantly male samples and generalize the findings to females are still being conducted (Davis & Srinivasan, 1994). Policies and practices related to women are sometimes based on the results, disregarding gender differences. For example, because current alcoholism treatment programs are based on the needs of male subjects, child care services are rarely provided. The lack of reliable child care then becomes a major barrier to alcoholic women entering treatment (Sandmaier, 1992).

Despite supportive legislation, protest movements, and efforts to glamorize female drinkers, contemporary women face many of the same attitudes as did their predecessors of the 1800s. Society still regulates women's drinking behavior, and alcoholic women remain the targets of unyielding stigmatic and sex-biased societal attitudes (Blume, 1991). Practitioners are influenced by these attitudes and, as is discussed in the next section, the attitudes of clinicians can compromise the helping relationship in a variety of ways.

EFFECTS ON CLIENT-WORKER RELATIONSHIPS

Three important aspects of the relationships of social workers and their clients are trust, authenticity, and empathy (Hepworth & Larsen, 1993). Social workers have the additional responsibility of affirming clients' strengths and respecting their uniqueness, problem-solving skills, and right to self-determination. Stigmatic and sex-biased attitudes can undermine each of these values and practices and increase the shame and diminish the self-esteem and recovery efforts of alcoholic women.

Sex-Biased Attitudes

Sex-biased attitudes of clinicians can lower the self-esteem of alcoholic women clients because they stereotype women and disaffirm women's value as individuals or adults. One way that clinicians demonstrate sex-biased attitudes is by perpetuating male-oriented alcoholism interventions; for example, by facilitating mixed-sex therapy groups to the exclusion of women's groups. Studies have found that women are reluctant to discuss sexual issues in mixed-sex groups (Reed, 1987; Sandmaier, 1992) and that 30% to 75% of alcoholic women were sexually assaulted as children (Root, 1989). Women also find it difficult to discuss more recent sexual assaults, gynecological problems, or lesbian issues in mixed-sex groups (Blume, 1991).

Using strategies that ignore alcoholic women's fragile self-esteem is also sex biased. Confrontation, for example, is a common tool that is used during the early stages of treatment to penetrate the denial of alcoholic clients (van Wormer, 1995). Because of their low self-esteem, confrontation can be extremely threatening to alcoholic women (Zankowski, 1987) and may be contraindicated during the early stages of therapy.

Clinicians in in-patient settings may reflect sex-biased attitudes when they coerce alcoholic women to participate in eve-

ning or weekend mixed-sex activities or assume that women who do not participate are being resistant. Zankowski (1987) found that women often fail to participate in these activities because they feel inadequate and outnumbered by men. Clinicians sometimes overlook spatial and boundary issues, such as men outnumbering women 3 to 1 in alcoholism treatment settings (NIAAA & National Institute on Drug Abuse, 1990).

Requiring women to participate in evening and weekend activities without the opportunity to plan more appropriate ones and assuming that women are resistant to treatment recommendations are sex-biased notions because the needs of male clients are being projected onto female clients. According to Reed (1987) and Sandmaier (1992), most alcoholism programs were designed for men, and the strategies are seldom flexible enough to accommodate the needs of women. Therefore, these programs ignore important issues, such as women's lack of health insurance and the inordinate number of losses experienced by alcoholic women (of husbands, families of origin, and jobs).

Clinicians likewise demonstrate sex biases in the examples just presented by ignoring the significance of child care issues to the recovery needs of alcoholic women. The lack of reliable child care is one of the primary reasons that mothers drop out of treatment and, as was previously noted, is a serious impediment to women entering treatment. Denying women the privilege of visiting with their children reinforces their shame and beliefs about being unfit mothers (Zankowski, 1987). It is also plausible that when treatment activities occur on weekends, mothers may feel torn between their recovery and visiting their children.

Relieving mothers who are alcoholic of child custody rights, a related issue, severely challenges their self-esteem. A subject in Sandmaier's (1992) nationwide study of alcoholic women stated that when she lost custody of her children, she lost all hope and contemplated suicide. Routinely removing children from the homes of alcoholic mothers or otherwise criminalizing the drinking behavior of women is sex biased in at least two

ways. First, similar actions are not taken with men. Second, these actions are often based on the belief that women who drink excessively can no longer satisfactorily perform traditional feminine tasks, such as caring for their children (Sandmaier, 1992). Increasing family preservation services to alcoholic women would seem a more appropriate intervention.

An examination of the educational policies related to fetal alcohol syndrome reveals sex biases as well (Gustavsson, 1991). In an effort to protect children, some child welfare workers inadvertently advise pregnant alcoholic women to avoid drinking because of the risks to their unborn children without emphasizing the ill effects on the women's own bodies (Gustavsson, 1991). Although unintentional, the message devalues women and is life threatening in that the effects of alcoholism are progressive and ultimately lead to death (NIAAA & National Institute on Drug Abuse, 1990).

Clinicians' sex-biased attitudes can also lead to gender-differentiated therapeutic expectations of alcoholic women. Broverman's (1970) classic study of clinical behavior indicated that the therapeutic expectation for female clients was submissive, childlike, excitable, dependent behavior. If alcoholic women are perceived by clinicians to be immature adults who are unable to negotiate their environment or interact as equals, these women may not be expected to assume the assertive roles that are expected of men in practice situations.

When practitioners hold gender-differentiated therapeutic expectations, clinical relationships and ultimately the recovery of alcoholic women are jeopardized in a variety of ways. First, in lieu of learning to assert themselves, women are taught to disregard their right to self-determination and respond in ways that are not authentic. The right to self-determination and authenticity are hallmarks of effective helping relationships. Second, women are also encouraged to avoid conflict and risk-taking behavior. When female alcoholic clients are unable to resolve conflicts easily, they tend to drop out of treatment, rather than engage in problem solving (Sandmaier, 1992). These findings suggest that the sex-biased attitudes of clinicians can

undermine recovery by diminishing authenticity and, by extension, trust and ultimately lead to the premature departure of alcoholic women from treatment.

Stigmatic Attitudes

The stigmatic attitudes of clinicians can lower the self-esteem of alcoholic women, exacerbate their shame, and indirectly undermine their recovery. The tendency of alcoholic women who have been sexually abused to denigrate themselves is often exacerbated when the women are told, for example, that girls desire or fantasize about sexual experiences with their father figures (Root, 1989). Clinicians' messages concerning girls' childhood sexual fantasies can be especially shame producing or esteem lowering to alcoholic women, who attribute their abuse to having been seductive or promiscuous as children. Questions such as, "Why do you think your father molested you but not your sisters?" can cause alcoholic women to blame themselves. Failing to inform women that they were victims (and their assailants, perpetrators) when they themselves question their role in childhood sexual abuse may reinforce their shame. Blaming and other shame-producing messages can undermine sobriety because alcoholic women frequently use alcohol to suppress their feelings of shame (Hurley, 1991).

Clinicians also stigmatize alcoholic females by conveying the message that alcoholic women are sicker than alcoholic men (Sandmaier, 1992). This message portrays women as more needy, manipulative, deceptive, and difficult to work with than men (Zankowski, 1987). Despite the insufficient number of treatment facilities for alcoholic women nationwide, this argument was used by the staff in Zankowski's study of hospitalized alcoholic clients to justify the lower number of clients in the women's unit of the facility.

Although some practitioners view alcoholic women as sicker than alcoholic men, clinicians are more reluctant to assign alcohol-related diagnoses to women (Rhodes & Johnson, 1994). That clinicians believe they must protect women from a diag-

nosis of alcoholism may reflect their moralistic perception of alcoholic women. If it does, and women sense this attitude of clinicians, the already fragile self-esteem of alcoholic women may be further diminished.

Social workers who maintain stigmatic attitudes toward alcoholic women can adversely affect their clients' recovery and self-esteem in other ways. When clinicians demean alcoholic women, according to Bersak (1990), it causes the women to respond in an alienating, defensive, and anger-producing manner. Individuals with whom alcoholic women subsequently interact tend to reciprocate, and negative transactions further decrease the women's self-esteem.

On occasion, social workers may direct stigmatic attitudes toward alcoholic women because of their own issues, rather than in response to the clients with whom they are working. One issue is unresolved shame about parents who were alcoholic. A study of 60 social work students (Marsh, 1988) reported that 59% had close family members who were alcoholics. Similar to other adult children of alcoholics, social workers who are adult children of alcoholics may have internalized the pejorative societal attitudes that were directed toward their parents and may harbor shame that they project onto their alcoholic women clients. The extent to which clinicians have not resolved their own shame-related issues may limit their ability to help their clients who are alcoholic (Russell, Gil, Coyne, & Woody, 1993).

There are other consequences of stigmatizing alcoholic women. To avert stigmatic attitudes, such as the ones that were just described, some women become hidden alcoholics and drink alone in the privacy of their homes. In spite of the fact that women are more likely than men to seek mental health treatment (Conte, Plutchik, Picard, Galanter, & Jacoby, 1991; Hurley, 1991), alcoholic women tend to conceal their drinking to avoid being stigmatized. Concealment, in turn, allows their alcohol-related problems to progress, so that women are at more advanced stages of alcoholism when they report for treat-

ment. In addition, the death rate of female alcoholics is 50% to 100% higher than that of male alcoholics (NIAAA, 1990).

IMPLICATIONS FOR SOCIAL WORK

Stigmatic and sex-biased attitudes are oppressive to alcoholic women and can adversely affect their relationships with helping professionals. Therefore, social workers have an ethical responsibility to confront these problems. Because work with women requires attention to both policy and practice issues (Hagen & Davis, 1992), effective approaches to improving social workers' attitudes toward alcoholic women should take into account clinical tasks, education, and advocacy.

First, clinicians need to address the esteem issues of alcoholic women by developing rapport early on, allowing the women to experience success, and rewarding even their smallest achievements (Zankowski, 1987). Alcoholic women experience low self-esteem with greater frequency than do alcoholic men (Levin, 1995) and are more likely to drink to relieve their feelings of worthlessness. Second, clinical interventions must focus on the emotional effects on women of losing the custody of their children. Increased suicide rates and depression have been correlated with alcoholic women losing such rights to custody (Sandmaier, 1992).

Third, it is essential for educational programs to emphasize the unique needs of alcoholic women. At a minimum, effective educational modules should address depression, insomnia, nutritional issues, and other physiological conditions that can camouflage the alcohol-related problems of women. Sensitizing clinicians to the grave consequences of alcoholism may increase their empathy and ensure that they make appropriate alcohol-related diagnoses and referrals.

Fourth, social workers must propose policies on fetal alcohol syndrome that are sensitive to women as well as to their unborn fetuses. In an effort to protect children and unborn fetuses,

family preservation policies sometimes criminalize the drinking behavior of alcoholic women (Bernard, 1992).

Fifth, because women are often abandoned by their husbands and families of origin and hence are deprived of social and economic supports, it is critical for social workers to help women to become activists in their work settings by confronting pay inequities and harassment, for instance. Possible benefits of workplace activism are personal, interpersonal, and political empowerment (Almeleh, Soifer, Gottlieb, & Gutierrez, 1993), all of which are esteem building and crucial to the recovery of alcoholic women.

Sixth, because concealment of alcoholism can be life threatening, creative outreach programs that motivate hidden alcoholic women to seek professional help are essential. Obtaining familial support and advocating for child and medical care policies for women could greatly enhance the quality of case-finding efforts.

Finally, social workers must resist the tendency to support patriarchal practices and policies (Dinerman, 1992) and advocate on behalf of alcoholic women. Gender-sensitive programs would not only affirm the worth of alcoholic women but give attention to problems such as limited detoxification facilities, homelessness, victimization, and the absence of support systems among alcoholic women.

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