# Women, Addiction, and Sexuality

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## WOMEN, ADDICTION, AND SEXUALITY

Although research has been done on women and addiction since the 70s, the subject of sexuality is still often neglected in both the research and treatment of chemically dependent females. Part of the reason for this omission in treatment programs is the lack of strong models that assist clinicians to honestly address and help heal sexual issues and concerns. This is unfortunate, because healing in the sexual/relational area is crucial to the whole process of recovery from addiction. According to noted sex therapist Helen Singer Kaplan (1974), healthy sexuality is integral to one's sense of self-worth. It represents the integration of biological, emotional, and social aspects of who one is and how one relates to others. Addiction is often defined as a physical, emotional, social, and spiritual disease. If we define healthy sexuality as the integration of all these aspects of the self, we can easily see why addiction can have an impact on every area of our sexuality. Therefore, addressing and healing all aspects of the sexual self is critical to a woman's recovery process. This chapter will present an overview of a model for the sexual recovery of addicted women that can be used by clinicians and other health care professionals, as well as by women themselves.

The neglect of much serious study in the field of addiction and female sexuality is surprising in light of the fact that for thousands of years human sexuality and the consumption of alcohol and other drugs have been closely linked in the mythos of many cultures. To the ancient Greeks, Bacchus, the god of wine, provoked licentiousness. When the ancient Hebrews became intoxicated at the foot of Mount Sinai, the Bible tells us that they lost all restraint and engaged in adultery. We can see a 20th century version of these beliefs in the deliberate association of sexuality and some of the legal drugs (alcohol and tobacco) in advertising.[1] The myth propagated by contemporary advertisers is that beer, wine, and liquor promote sexual arousal, and that alcohol consumption is directly connected with sexual attractiveness, flirtation, dating, and romance. The underlying message is that drinking makes men more viral and women more sensual and available. The subtext of magazine and billboard ads, which portray attractive, smiling men and women in intimate poses, is that alcohol will not only enable a person to meet

1. In addition to the connection between sexuality and the legal drugs of alcohol and tobacco, there is also the belief that some illegal drugs, such as cocaine and marijuana, are aphrodisiacs (sex enhancing).

more beautiful and desirable partners, but to have a more exciting and deeply satisfying sex life. The same images of independence, power, and sexual enhancement are also portrayed in cigarette ads. Even though alcohol and tobacco use are undergoing a slow decline in our culture, a considerable number of people still buy into the image of the desirable and sophisticated man or woman holding a drink or a cigarette. So great is the power of advertising to deny the negative effects of addiction and present images of alcohol and cigarettes as normal, appropriate, and innocuous that very little is ever heard to counter the implied connection between sexuality and addictive substances (Kilbourne 1991).

**Socialization of Men and Women**

In spite of the glamorous magazine image of a woman in an evening gown holding a martini in one hand and touching the cheek of a man in a tuxedo with the other, the general societal perception of women who drink and use drugs is negative. The German philosopher Immanuel Kant could have been summing up contemporary attitudes when he wrote that women should avoid drunkenness because their privileged place in society was ensured only if they adhered to a higher moral code of behavior than men (quoted by Jellinek 1941). And little has changed from the days of Chaucer when it was believed that women who drank were inviting sexual assault: "A woman in her cups has no defense. As lechers know from long experience" (Chaucer, translated by Coghill 1951).

The boundaries of what is considered acceptable and unacceptable behavior for women and men begins with early childhood socialization. Whereas, traditionally, boys have been encouraged to be aggressive, physically combative, independent, non-emotional, and outwardly oriented, girls are more often taught to be passive, dependent, emotional, and oriented toward relationship. Much has been written in the last two decades about the limiting and negative effects of such socialization upon both men and women. Even though many parents are aware of these effects, and try to raise their children along more flexible gender lines, the stereotypical standards of male/female behavior still prevail in the culture at large (Covington and Beckett 1988).

There is even less awareness of how these behavioral norms affect the healthy expression of male and female sexuality. In spite of the "sexual revolution" of the 60s, men and women still have a separate sexual socialization that places gender roles above the spectrum of differences found among individual men and women. Men are taught to act knowledgeable about sex, comfortable with their bodies, and to unselfconsciously touch themselves and their genitals. One can't even imagine female athletes engaging in the kind of nonchalant physical behavior that male athletes display on the playing field, adjusting their jock straps, scratching their chests, and patting each other playfully on the derriere (Covington 1991). As the sexual initiators, men are also expected to know all about sex before marriage (Harrison and Pennell 1989, Richmond-Abbot 1983).

Women, on the other hand, are discouraged from learning about sex, touching or thinking about their genitals, or being sexually assertive (Shaffer 1981). Many women can't even speak about the sexual parts of their bodies without using euphemisms such as "down there," and many more have never even looked at themselves. Traditionally, the value of a virgin has been her inexperience and her trust in her husband to awaken her sexually. Whereas a sexually

uninformed male may be ridiculed by his peers, a sexually experienced woman is at risk of being considered "wild" by hers.

Men are expected to be assertive in physical relationships, the ones who seek out and choose a partner, initiate sexual behavior, produce an erection, and orchestrate the sexual encounter. The performance anxiety that results from these one-sided expectations is the primary cause of some male sexual dysfunction (Harrison and Pennell 1989).

Women, on the other hand, are socialized toward passivity in their intimate relationships, and to wait for another to approach them. Any sexual signaling a woman gives must be extremely subtle. When she is assertive, overtly signaling her sexual interest, she risks being branded as a "slut" or a "loose woman," and possibly even sexually abused. So much punishment and disdain is meted out to the sexually assertive woman in our society that many women are disconnected from their own sexual feelings. This situation is exacerbated by the expectation that women will orient their behavior outward toward the satisfaction of their partner. Many recovering women alcoholics and drug users have spent so many years focussing on the needs of their partners that they don't have any idea what would be sexually gratifying for them (Covington 1991). Even though, in the general population, only 30 percent of women report experiencing an orgasm during intercourse (Hite 1976), it is still the preferred sexual activity among men, and for many is synonymous with "having sex."

### Social Stereotypes of Women Who Drink and Use Drugs

This polarization of sexual roles is mirrored in society's beliefs about male and female drinking and drug use. Women who drink and use are perceived as being more eager for sex, more vulnerable to seduction, and less selective about partners (George et al. 1986, 1988). In light of this, the stigma against addicted women is often expressed in sexual terms, branding such women as promiscuous, loose, or "looking for it." Sexual terms are rarely used to describe addicted men (Covington 1993). Unlike drunken men, drunken women can never be perceived as just spending a pleasant night out on the town with "the boys."

Several studies by W.H. George and colleagues (1986, 1988) have documented the attitudes that contemporary society has toward women who drink. In one, 96 male colleagues were asked to watch videos of a woman drinking either beer or cola under a variety of conditions. Without exception, the situations where the young woman was drinking alcohol were rated higher by the viewers in terms of sexual responsiveness and promiscuity. The authors concluded:

> These results imply that men view a woman's drunkenness as an exploitable weakness. In real-life dating situations, such a biased view of a drinking woman could support or even precipitate unwelcome sexual advances. Moreover, these perceptual biases could potentially play a mediating role in sexually violent acts that involve a drinking female victim (Georges et al., 1986).

In another study by Richardson and Campbell (1982) 187 male and female undergraduates were asked to evaluate four rape scenarios. In the first, the rapist was drunk; in the second, the victim was drunk. In the third scenario, both were intoxicated; and in the last, neither had been

drinking. Both male and female students rated both the man and the woman as more accountable for the rape when drunk. Even when the rapist wasn't drunk, the victim was still considered more responsible than her attacker for the violence perpetrated against her if she herself was intoxicated at the time. The societal expectation that women are more eager for sex when drunk strongly suggests that women will suffer from more sexual and physical aggression when intoxicated, and that the actions of the sexual aggressor will be more easily rationalized or excused at such times (Blume 1991).

### Sexual Victimization of the Addicted Woman

The societal perceptions represented by these studies are reflected in the experiences of addicted women. A study of alcohol and sexuality (Covington and Kohen 1984), compared a group of alcoholic women with another sample of nonalcoholics.[2] Although high rates of physical, emotional, and sexual abuse were reported by all women, addicted women consistently suffered greater levels of abuse in all of these areas. Seventy-one percent of the alcoholic women reported emotional abuse, including ridicule, degradation, harassment, jealous accusations, blame, yelling, lying, unfaithfulness, and the emotional withdrawal of their partner. Only 44 percent of nonalcoholic women experienced these behaviors (Covington 1986). Alcoholic women also experienced more physical abuse, 51 percent compared to 34 percent of the nonalcoholic women. This type of abuse included being hit with fists and/or objects, pulled by the hair, spanked, thrown, and slapped. Though all abuse is violent, the physical abuse against alcoholic women had a more brutal quality to it. Alcoholic women reported being beaten, given black eyes, forced to have unneeded surgery, held in arm locks and police holds, and purposely being held under water until they had nearly drowned. Although all of the physical abusers were known by the women, 82 percent of the perpetrators of physical abuse against alcoholic women were male compared to 75 percent for nonalcoholic women (Covington 1986).

Seventy-four percent of alcoholic women reported experiencing some form of sexual abuse during their lifetime, compared to 50 percent of nonalcoholic women, a significant difference. Alcoholic women were also likely to experience the more extreme forms of sexual assault--rape, rather than attempted rape. One possible reason for this is that an intoxicated woman is not able to fight off her attacker or be as clear about her non-consent as a nondrinking woman (Norris 1994). Only the alcoholic women reported sexual abuse with the same perpetrator extending for a period of 10 years or more. In most cases, alcoholic women experience their first instance of abuse in childhood. One hundred percent of the alcoholic women who experienced sexual abuse (incest, childhood molestation, rape, or attempted rape) had been violated at least once by the age of ten, compared to 65 percent of the nonalcoholic women (Covington 1986). The high incidence of alcohol and substance abuse among survivors of physical or sexual abuse in childhood suggests that, in the absence of healthy parental relationships, women turn to addictive substances for support (Covington and Surrey 1996).

TABLE 1

| Alcoholic Women | Nonalcoholic women |
|---|---|

2. The majority of the alcoholic women in this study were poly-drug addicted, with a primary identity of "alcoholic."

| | |
|---|---|
| *Experienced Emotional Abuse:* | |
| 71 percent | 44 percent |
| *Experienced Physical Abuse:* | |
| 51 percent | 34 percent |
| *Experienced Sexual Abuse:* | |
| 74 percent | 50 percent |
| *Experienced Sexual Abuse Before the Age of 10:* | |
| 100 percent | 65 percent |

The great amount of abuse suffered by addicted women has a tragic impact upon their lives and a negative impact upon their ability to function sexually. In view of the high rates of abuse (Table 1), it is not surprising that addicted women have trouble trusting enough to express themselves sexually or to enjoy themselves in intimate relationships. When the majority of one's intimate relationships have been filled with violence, violation, and fear since childhood, it is nearly impossible to relax into the trust that an intimate sexual experience requires (Covington 1993).

The high correlation between addiction and abuse in women's lives makes it of paramount importance that both abuse and sexual issues be addressed during recovery. Treatment should be focussed on assessing the history of abuse of addicted women, understanding their sexual dysfunctions, addressing their fears, helping them to develop the ability to trust, and, *most important*, creating a *sense of safety* (Herman 1992). For women to be able to express their sexuality in fulfilling ways, they must first be able to begin healing their abusive pasts.

## DISTORTION OF SEXUALITY

As mentioned above, addiction is a physical, emotional, social, and spiritual disease. Sexuality also depends upon the healthy integration of all these aspects of the self. Therefore, we can see why addiction impacts upon every area of our sexuality.

### The Physiological Effects of Addiction

Alcohol and other drugs interfere with sexual sensitivity and enjoyment in many ways. They disrupt the delicate balance of a woman's hormonal system, interfering with her body's proper emotional, reproductive, and physiological functions. Alcohol, as well as heroin and marijuana, act upon the body as depressants, decreasing sexual desire, and retarding blood congestion and swelling in the genitals and pelvic area, creating lessened sensation, numbness, or a sense of disconnection. Under such conditions, excitement to orgasm will take longer and require more pressure, if it can occur at all. Alcohol deadens sensory input, making women less sensitive to touch (Covington and Kohen 1984).

Clinical research in the last twenty years has shown that, although the consumption of alcohol

and other drugs creates a greater desire for sex in the mind of the user (especially in those who use cocaine), alcoholics and drug users report a greater incidence of sexual dysfunction than do moderate- or non-users. In fact, S. Wilsnack, Klassen, Schur, and R. Wilsnack (1991) list sexual dysfunction as the best single predictor that a woman might be having chronic problems with alcohol. Though only 6 percent of women who use alcohol are heavy drinkers,[3] as opposed to 21 percent of men (Midanik andClark 1992), studies have shown that the physiological consequences of women's alcohol abuse is greater than men's. At the same body weight, women reach higher blood concentration levels than men, and may develop liver disorders after shorter periods of use and lower levels of consumption (Wilsnack, Wilsnack, and Hiller-Sturmhofel 1994).

Types of sexual dysfunctions caused by addiction include lack of desire, arousal, lubrication, and orgasm; dyspareunia (painful intercourse); and vaginismus (vaginal spasms) (Covington and Kohen 1984). One study found that 69 percent of alcoholic women reported having experienced sexual dysfunction before addiction, 85 percent while addicted, and 74 percent suffered from continued sexual dysfunction during early recovery (Covington 1982). The following is a table (Covington and Kohen 1984) comparing the sexual dysfunctions reported by alcoholic and nonalcoholic women (Table 2).

TABLE 2

| | Alcoholic | Nonalcoholic |
|---|---|---|
| Lack of orgasm | 64% | 27% |
| Lack of sexual interest | 64% | 44% |
| Lack of sexual arousal or pleasure | 61% | 30% |
| Lack of lubrication | 46% | 24% |
| Painful intercourse | 24% | 9% |
| Muscular spasms (Vaginismus) | 6% | — |

Though healthy sexual functioning is clearly a problem for alcoholics both during active drinking and sobriety, this is the one area least likely to be mentioned by either the client or her family members during the initial assessment and subsequent treatment for chemical dependency. Unfortunately, few addiction recovery programs make any provision for re-establishing healthy sexual function. Although recovering alcoholics report fewer sexual problems in sobriety than when they are drinking, they still admit to general dissatisfaction in their sexual lives (Covington and Kohen 1984). For these reasons, strong models are needed to

3. The term "heavy drinking" is defined as taking two or more drinks each day. A standard drink is defined as 12 fluid ounces of beer, 5 fluid ounces of wine, or 1.5 fluid ounces of distilled spirits and contains about 0.5 fluid ounces of pure alcohol.

help women to address and heal their sexuality during recovery.

The use of alcohol and other drugs during sexual intercourse also increases the risk of contracting sexually transmitted diseases, including the human immunodeficiency virus (HIV) that causes acquired immune deficiency syndrome (AIDS) (Norris 1994). As of this writing, women account for the highest percentage of new AIDS cases in this country, either through heterosexual intercourse or the sharing of needles during drug use (Norris 1994). There are three primary reasons for this increase in female AIDS patients. When drunk or high, many women neglect to protect themselves by using a condom during intercourse or making sure that they do not use a contaminated needle. Often women who are addicts find themselves in relationships with men who are chemically dependent themselves, therefore increasing the risk that their partner may be carrying the HIV virus. The use of alcohol and drugs also weakens the immune system, making chemically dependent women more susceptible to infection (Covington and Surrey 1996).

### Relational, Emotional, and Social Aspects of Addiction

Since recovery from addiction is about facilitating wholeness and balance, it is essential to have a theoretical understanding of women's psychological development, as well as a theoretical understanding of addiction. Sexuality is at the core of the relational self,[4] and many women use alcohol and drugs to establish and maintain intimate connections to others. The link between sexuality, relationships, and drugs often becomes established at an early age when girls are given their first alcohol and/or drugs by their boyfriends. Boys, on the other hand, are more likely to have their first alcohol or drug experience with their peers and to buy these substances on their own. Girls, therefore, are often romantically involved with their "supplier." This early association between substance abuse and love can often lead to "using" with chemically dependent partners in order to join them in their experience. As girls grow into womanhood, they often continue to receive their drugs from their sexual partners, a strong factor influencing women's treatment and recovery (Freeman & Landesman 1992).

Studies of high school students have also shown that many girls have their first drinking experience and their first sexual encounter at the same time. In our society, alcohol is still the favorite drug of choice for seduction, and many still believe in its power as an aphrodisiac, despite physical evidence to the contrary (Kilbourne 1991). Men generally drink to feel more powerful and aggressive, while women drink to overcome shyness and to feel more "feminine" (Goodwin 1981; National Institute on Alcohol Abuse and Alcoholism 1986).

Also, women may trade sex for their drug of choice. This is a fairly common practice for women who are cocaine or crack-cocaine addicts. However, prostitution can take many forms in the lives of addicted women.

## A MODEL FOR TREATMENT

4. The "relational self" refers to the Self-in-Relation Model developed by The Stone Center, Wellesley College, Wellesley, MA and the Covington and Surrey application of relational theory to addiction (Covington and Surrey 1996). For more information on the relational model, see Chapter __ in this volume.

Many women in recovery programs from alcoholism and other drugs express dissatisfaction with their sexuality. These perceptions are accompanied by feelings of inadequacy and the sense that one lacks the understanding necessary to implement real changes in one's emotional and sexual life. Even non-substance abusers have difficulty understanding what it means to be a sexual woman in our society. Honesty and openness about sex are not always supported by a woman's counselor, partner, or family while she is involved in a recovery program, and many counselors avoid any mention of sexuality in the early stages of treatment because the subject seems to complex to discuss.

It takes great courage for recovering women to explore their sexual and relational self, and counselors have an obligation to support them in their struggle for healing and growth, giving them hope and guidance. To aid counselors in their wish to help in these area, two models are outlined. The first is a four-level approach called the PLISSIT model developed by Jack Annon of the University of Hawaii School of Medicine (Annon 1975). The second, called the "Inner and Outer Journey," is described in *Awakening Your Sexuality* (Covington 1991).

### The PLISSIT Model

P-LI-SS-IT is a four level approach for addressing sexual problems based upon *p*ermission, *l*imited *i*nformation, *s*pecific *s*uggestions, and *i*ntensive *t*herapy. The first two levels can be handled by a counselor who has had some sexuality training and is comfortable about addressing these issues. The last two levels require special training in sex therapy.

*Permission.* Sometimes women in recovery just want to know that they are all right and that they are not the first person in the world to have their particular sexual difficulties. It is intensely reassuring to hear a counselor say that one's sexual concerns are not unusual (Annon 1975). This method of treatment is especially effective within a same-sex group setting. In this context, peer support can enable women to discuss issues such as where they received their sexual information, how little they know about their bodies, and how their early family experiences affected their sexuality. In such a setting many common issues will emerge, and women will feel less isolated.

Permission also works well in a one-on-one setting with a counselor. If a client says that she is afraid of having sex clean and sober, a counselor might reassure her that this is a common problem among most alcoholic/addicted women who have had the majority of their sexual experiences while intoxicated or high. A counselor can also give a client permission to abstain from sexual activity if the client does not feel interest, a common experience in the early stages of recovery (Covington 1986; Kaplan 1979). Permission may also be given to engage in a wider variety of sexual behaviors, or to abstain from a variety of behaviors.

*Limited Information*. In contrast with permission, which simply reassures the client that it is all right to continue whatever she has been doing, limited information goes one step further, providing her with specific factual information that directly relates to her experience (Annon 1975). For example, when a woman in the early stages of recovery expresses her concern that she can no longer masturbate to orgasm, her counselor might inform her that some women in her

situation are able to achieve orgasm by means of a vibrator because of the level of consistent stimulation it provides. Areas where providing limited information is most helpful include penetration during menstruation, breast size, genital shape and configuration, sexual frequency and performance, and oral-genital contact (Annon 1975).

*Specific Suggestions*. This level of help requires that a clinician have specific training in sexual counseling, which one member of a staff might be willing to acquire. For this treatment to be effective, a sexual history of the client should be taken, including a description of the current problem, its onset and course, past treatment and its results, and the client's expectations and goals for the present treatment.

*Intensive Therapy.* This level of treatment is useful for clients with personal or family sexual problems who have not responded to other forms of treatment. It begins with a sexual history and continues with long-term psycho dynamically oriented therapy aimed at exploring and resolving problem areas.

The effective use of the PLISSIT model requires a commitment on the part of alcohol and drug recovery programs and counselors to extend their knowledge of sexuality and become comfortable with sex education in general, with the discussion of sexual difficulties, and with the use of explicit sexual terms.

### The Inner and Outer Journey of Sexual Recovery

Whereas the PLISSIT model looks at general issues and levels of intervention, the Inner and Outer Journey is a more comprehensive level of treatment based on women's experiences. When treating women in alcohol and drug recovery programs, counselors should be aware that recovery from addiction involves the healing and reintegration of both the inner and outer aspects of a woman's being. The Inner Journey has to do with a client's internal world, her thoughts, beliefs, and feelings about herself. The Outer Journey involves her exterior world, her relationships with others. The tasks a client needs to accomplish while being guided through these two journeys are shown in the following table. (For a more comprehensive discussion of the Inner and Outer Journey, see *Awakening Your Sexuality: A Guide for Recovering Women and Their Partners* [Covington 1991].)

TABLE 3

The Inner Journey of Sexual Recovery

- Recognizing the effects of female socialization on sexuality
- Accepting one's body
- Feeling good about one's genitals
- Accepting sexual pleasure from oneself
- Becoming aware of one's sexual feelings

- Facing one's fears of being sexual while sober

The Outer Journey of Sexual Recovery

- Exploring childhood and family sexual issues
- Honestly naming the sexual events of one's personal past
- Looking at one's sexual behaviors, including charting the sexual/chemical lifeline (See figure 1)
- Looking at one's selection of sexual partners and filling out the relationship chart (See figure 2)
- Learning to live in the present

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**The Inner Journey**

Women seeking recovery from alcohol or drugs have reached the end of a long cycle of confusion, disempowerment, dependency, and isolation. After years or evendecades of living with an addiction, their inner and outer lives are out of balance. They are probably out of touch with their feelings and unable to act on them, even if they knew what they were. An understanding and exploration of the following six key areas will help women to develop a stronger sense of what they want and need, and who they are as feeling, sexual women.

*Socialization*. As we have seen above, our culture gives women very clear messages about what is considered appropriate and inappropriate feminine behavior. Most women have learned to obey these rules, even though they may find them contrary to their own desires. Ironically, even women who have benefited from the "sexual revolution" and have learned how to be assertive and outspoken about their needs are still often unable to really express what they want sexually. It's as if the cultural message of the "good" passive woman and the "loose, wanton, and whorish" sexual woman is still operating on a deep level. Before a woman can feel fulfilled sexually, she must learn to accept this part of her nature and to communicate her needs to a partner. This is an area where a counselor can provide a supportive atmosphere for clients to begin to break free of the limitations and inauthentic messages of female socialization.

*The Body*. Most women, no matter how attractive, feel uncomfortable about some aspect of their body--their weight, their height, their hair color, the shape and size of their breasts, the amount of cellulite on their thighs--the list is endless. While actively involved in addiction, many women neglect, ignore, or cover up their bodies. Others become obsessed with having the "perfect" body, not from a sense of self-love, but solely to attract and please partners. All of these attitudes hinder a woman's ability to accept herself as she is.

When a woman becomes fixated upon improving or changing the shape of her body, she plays right into the addictive pattern. An old Jefferson Airplane song sums this up when it says "One

pill makes you larger and one pill makes you smaller." When women feel too "big"--too angry, sexual, passionate, powerful, or needy, or too small--too fearful, childlike, dependent, or vulnerable, they often use alcohol/drugs to regulate their size. This disconnection and disrespect women feel toward the natural size, shape, and variety of their personal body type is profoundly supported by our culture. This can be seen in the proliferation of self-help book authors and medical doctors who encourage women to change themselves to fit ideal societal images of weight and beauty. Sixty percent of psychoactive drugs, 71 percent of antidepressants, and 80 percent of amphetamines taken by women are prescribed by their doctors (Covington and Surrey 1996).

When a woman is so caught up with pursuing a physical ideal that she will relentlessly abuse her body with drugs to fit into that image, her whole sensitivity to her body, her feelings, and her deep levels of knowing will eventually be cut off. An important step in the recovery process is for women to learn to love, respect, and accept their bodies, whatever their form.

*The Genitals*. In our culture it is difficult to even find language that speaks positively about the female genitals. Many of the terms used--pussy, cunt, beaver, box, hole--create feelings of unease, embarrassment, and shame. Others, such as vulva, labia, majora, vagina, and clitoris, sound too technically correct. Some women have tried to create language that celebrates the value and beauty of the female genitals, using words such as inner flute, labia flower, mound of Venus, or even the Sanskrit term *yoni*, a term associated with the erotic paintings of India. Whatever terminology a woman in recovery chooses to speak about this important part of her body, it is vital that she begin to feel comfortable with her genitals, learning to look at herself, accept herself, and discover what gives her pleasure.

*Pleasure*. Though many women have been conditioned to provide others with pleasure, giving it to themselves or accepting it from a partner is something that often needs to be learned. Women in our culture are seldom taught or encouraged to consider their own sexual needs, fantasies, or desires. To many, "having sex" does not include seeking one's own gratification or having an orgasm, but making sure that one's partner is satisfied.

An important first step in learning how to ask for and receive pleasure from another is to give pleasure to oneself. In the 70s Shere Hite queried 3,000 women and found that 82 percent masturbated compare to only 62 percent in Kinsey's study form the late 40s. Although the number of women who are learning to pleasure themselves is increasing, many still have ambiguous feelings about "sex with one." There are good reasons for this. Historically, women have received many negative messages about masturbation. We have been told that any sexual activity that does not relate to procreation is a sin, or that pleasuring ourselves will make us lose desire for partnered sex. Some religions even teach that masturbation is a carnal activity that debases a person. Another social view of masturbation is that it is only a for women without partners, to be used as a last resort. When self-pleasuring is viewed in this light, it is likely to be accompanied by feelings of personal inadequacy (one does not have what it takes to attract a partner) and loneliness.

In spite of the contradictory cultural messages women receive about masturbation, self-pleasuring is an important part of developing positive inner feelings. It teaches a woman to

know her body, to learn about what she enjoys and does not enjoy. Masturbation is especially important for women recovering from substance abuse because it is a powerful tool to help them reconnect with their sexuality. Women who have been alcoholic or chemically dependent have depressed responses and limited physical sensation and need to get back in touch with what it feels like to experience sexual satisfaction. Women who have been sexually abused may associate sex with guilt, shame, or danger, or they may have difficulties trusting enough to enjoy sex with a partner. Masturbation can help these women to feel sexually safe again.

*Sexual Feelings*. For many women in our culture, it is difficult to know when they are feeling sexual desire. Men see the beginning of their arousal in an erection, but for women the issue can be much more complex. In light of this difficulty, it is important for a woman in recovery to learn to talk about her sexual desires and needs apart from the context of her partner's.

Desire is traditionally defined as those specific feelings and sensations that create a state of receptivity and sexual excitement. Many women would not be able to recognize their own sexual activity in that definition because they almost never engage in sex to gratify personal desire. Many women use sex as a means to fulfill needs that have nothing to do with actual physical desire--affection, touching, comfort, physical release, and escape. During recovery, sexual exploration often involves the process of learning to separate sexual feeling from other types of feeling. Only when a women learns how to be in touch with her sexual desire can she begin to learn about her sexual self.

*Sober Sex*. As we have seen above, alcohol, as well as other drugs such as cocaine, have long been considered as aphrodisiacs by our society. In a study done by Klassen and Wilsnak (1986), 60 percent of women drinkers said that they felt less sexually inhibited after drinking. This belief was most prevalent among the heaviest drinkers in the study. Leigh and Schafer (1993) found that, for both men and women, the likelihood of sex occurring on a given occasion was directly connected to the amount of alcohol consumed; and Temple and Leigh (1992) found that men and women were more likely to drink when with a new partner than with someone they were familiar with. Another study (Covington and Kohen 1984) found that alcoholic women participated in a wider variety of sexual activities than did sober women. As we have seen, the advertising industry equates sex with alcohol and tobacco, and many adolescent girls have their first sexual experience under the influence of alcohol or some other drug.

All of these findings confirm that many women in recovery have had little sexual experience without the aid of some kind of addictive substance. This reliance on alcohol and drugs to relax them, and the conviction that these substances enhance sexual pleasure (contrary to actual physiological evidence), creates an aura of fear around the thought of having sex while clean and sober. This fear may occur on three levels. A woman who has never had sex sober may be fearful because she doesn't know what the experience will be like. A second concern is that sex won't be fun or satisfying in sobriety and that one has a lifetime of mediocre sex to look forward to. A third category is made up of women who are afraid to have sex at all, especially if they feared or avoided it when involved in addictive behavior.

An important thing to remember is that sexual responses are learned responses. Counselors can help clients to understand that any behavior that has been learned can also be unlearned with

time, patience, and support. Clients need to discover the necessary conditions that will make them feel comfortable in a sexual encounter, and to rediscover their own needs as they begin to understand their sexual feelings. It is important for women in recovery to acknowledge the inner life of feelings, and for counselors to support them on this journey.

**The Outer Journey**

The strength, self-knowledge and insights into her sexuality a woman gains from doing her inner work can be used to help her evaluate her sexual interactions and relationships, both past and present. It is not always easy to face up to the pain, guilt, or shame connected with memories of former sexual encounters. In spite of this, one must look at these experiences and patterns honestly because they can sabotage present relationships, make women fearful of intimacy, take away their hopes of ever having a fulfilling sexual life, and be a trigger for relapse. In assessing a client's outer relational dynamics, there are certain key areas to consider.

*Childhood and Family Sexual Issues*. One of the most important steps a woman in recovery must take is examining and appropriately labeling her past sexual experiences and patterns of relationship. At the core of this process is the family. Some of the family issues women must face and understand are sexual or emotional abuse, inappropriate emotional or sexual boundaries, and negative attitudes toward sexuality in general. Helping a client to think about her sexuality in early life, and/or keep a journal of her memories and experiences is a good way to begin.

Our basic ideas about sex are formed in early family encounters, and these attitudes stay with us throughout life. A counselor needs to help clients sift through these memories and beliefs to see which ones are useful to them as adults and which serve as a hindrance to the healthy expression of sexuality. Important questions are how the parents expressed affection to each other and the children, how the family spoke about someone who "had" to get married, and how the women in the family spoke about sex. If a woman's mother or aunts spoke about their husbands with disrespect or revulsion as wanting only "one thing," this will have colored the client's adult views of sexuality. If nothing at all was ever said about sex, this omission will also have had an impact upon the client.

Sexual boundaries are often unclear in a dysfunctional family, and it is not unusual for parents in such situations to be both overly rigid and intrusive at the same time. Teenagers may find that they have no privacy in the bathroom, yet their parents will make them adhere to an unrealistic set of regulations about dating. Parents may express shock at inadvertent nudity and act as if the body were something to be ashamed of, yet touch their children in inappropriate sexual ways. As a girl matures into womanhood, the effect of these contradictory messages can be devastating, creating confusion, emotional paralysis in sexual situations, and predisposing her for fragmented ideas about sex and herself as a sexual being.

*Honestly Naming the Past.* One of the most crucial tasks of recovery from addiction is to honestly name our past sexual experiences. When exploring this difficult task, many women find that they have been minimizing the abusiveness of their adult sexual encounters. A women who believed she was merely "having sex when I didn't want to," may discover that she was being forced to have sex against her will. Many women have shut out the awareness of the

reality of their sexual experiences in order to survive. In order to recover and move beyond old behaviors, however, it is important for a woman to be able to tell the truth about where she has been.

*The Sexual/Chemical Lifeline.* A powerful tool for sorting out the truth about one's sexual past is the Sexual/Chemical Lifeline (Figure 1). By charting the development of one's sexuality in tandem with one's addiction, a client can see how the two have become intertwined. This chart is crucial to helping a woman learn how her chemical dependence has affected her past sexual behavior. A woman filling out this chart may remember events she had forgotten or be surprised at how painful some memories are. She may discover that her drinking or drug use and her sexual experiences are closely linked, or that her sexual encounters became more and more infrequent as her addiction became unmanageable. Only when a woman can see graphically how her sexuality and her addiction developed can she clearly see how these patterns are interdependent and choose to change them.

*Partner Selection*. Often a women in recovery will relate to others in a codependent manner because of unmet childhood needs, abuse, lack of mutuality, and socialization. Because of this pattern, it is important to understand the dynamics of partner selection from the perspective of family systems and personal pain. People pick their partners not only to satisfy romantic desires, but often in reaction to childhood wounds. This is why it is vitally important for a woman in recovery to understand her childhood sexual and familial patterns. An important tool that can help in this understanding is the Relationship Chart. (Figure 2) For example, Theresa's Relationship Chart helped her to understand her sexual/chemical lifeline in some additional ways. She could see that addiction was part of each relationship, and that some aspects of her childhood relationships with her mother, father, and step-father were either being repeated in her adult relationships or impacting upon them.

Though women in our culture are conditioned to passively wait to be chosen, the truth of the matter is that we *do* choose our mates, consciously or unconsciously, by actively seeking or passively accepting their attentions. For many women, looking at the characteristics of the partners they choose can be more disturbing than examining their own sexual behavior because it might mean changing their present relationship. It is important to remember that no dramatic steps should be taken early in the recovery process. Later, however, when a more secure emotional foundation has been established, a woman can look seriously at whether her wants and needs are being met by her present relationship. Staying with a physically or sexually abusive partner can be hazardous to a woman's sobriety and the well-being of her children.

Once these patterns are understood, a counselor can help her look at her present actions and discern which are rooted in present needs and which are reactions from the past. A useful therapeutic tool is Bowen's intergenerational family systems approach, which provides the foundation for an improved ego identity, the monitoring of one's personal boundaries, and overall sexual functioning (Bowen 1974).

*Living in the Present*. Living in the present with an awareness of what is going on in our lives *right now* is essential to a woman's recovery from addiction. Most people spend most of their time either worrying and feeling about past mistakes and patterns or worrying about and

planning for the future. When a woman thinks constantly about the past, she might live in fear that negative experiences will continue to happen to her. If she lives in the future, perhaps fantasizing that each new relationship will come to a depressing conclusion, she might become paralyzed, ending encounters before they even begin. Healthy sexuality can only take place in the present moment between two people who are really there for each other and for themselves. Reclaiming one's past does not mean reliving it. One can break old patterns by reconnecting with one's true self and being firmly grounded in the present.

### Sexual Identity

One of the things a counselor must help a woman in recovery with is discovering her true sexual identity. If substance abuse began during adolescence, the process of developing a sexual identity may have been interrupted. Some women use drugs to act out their erotic attachments and then feel "dead" sexually in recovery. Others may use drugs to numb themselves to their feelings for another women. Once the addictive substance has been removed from a woman's life, the counselor can help her discover whether her identity is heterosexual, lesbian, or bisexual.

### Support Groups

It is always easier for women to talk with other women about sexuality, and naming one's past may be facilitated by participation in a woman's support group or Twelve Step program. When women discover that others have had similar experiences, they feel intense relief that they are not alone or crazy for having ambiguous or uncomfortable feelings about sex. Recovery groups can also remove the tremendous burden of individual responsibility that women often feel about their sexuality, allowing them to see that unhealthy ways of acting and relating are not part of their legacy as women.

### Conclusion

The special needs of women, and particularly issues of sexuality in recovery, have not generally been met by existing substance abuse treatment programs. Sexuality is a fundamental aspect of being and, as such, is integral for women's physical, psychological, social, and spiritual healing. For full recovery to take place, a woman does not just stop drinking or using drugs, but heals her relationships with others since these form the framework of her life. Some of the steps that counselors can take to promote this healing and understanding were outlined in the paper "Alcohol Addiction and Sexual Dysfunction" (Covington 1993) and are listed below:

1. Become aware of the interconnections between issues of chemical dependency, sexuality, and family relationships.

2. Incorporate sexual issues into individual counseling programs and into family treatment and group therapy sessions to enhance natural helping tendencies of family members and peers.

3. Become aware of one's own sexual attitudes and beliefs and the need to refrain from projecting them on clients.

4. Create a referral network for sexual issues that go beyond each practitioner's level of experience based on the models presented in this chapter.

5. Become aware of the special sexual issues of women, including the influence of female sexual socialization and the extent of sexual abuse.

6. Create women's groups that provide a safe place for women to begin to explore the connections between their addictions, family relationships, sexual abuse, and sexuality.

The spontaneous recovery of sexual health is not assured by just being clean and sober. It is up to counselors, social workers, and therapists to insure that these issues are raised and that sexual issues are integrated into treatment programs. Group therapy within women's groups can be vital to this process, enabling clients to begin to see other women as resources, thus enhancing their individual strengths and their family and peer support networks.

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