

INTERNALIZED HOMOPHOBIA, STAGES AND PROCESSES OF CHANGE AND
ALCOHOL USE AMONG GAY MEN

A Clinical Dissertation

Presented to the Faculty of
The California School of Professional Psychology
Alameda

In Partial Fulfillment
Of the Requirements of the Degree
Doctor of Psychology

By
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May 2001

INTERNALIZED HOMOPHOBIA, STAGES AND PROCESSES OF CHANGE AND
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DEDICATION

This paper is dedicated to gay men in recovery from alcoholism and other addictions. Their quest for a renewed sense of self and a positive identity are inspirational.

This paper is also dedicated to the clinicians who provide support, guidance and motivation on the journey to recovery.

ACKNOWLEDGMENTS

First and foremost, I would like to thank my committee members, Dr. Bleecker and Dr. Moore, for their guidance and patience over these last few years.

I would also like to thank my dearest friends -- Marcy Owens, Jeannette Bongiorno, Stephen Woods, David MacCarthy, and Elizabeth Benson -- for always asking me, "are you done yet?" and keeping me motivated to finish.

I would also like to acknowledge the support, guidance, and friendship of some very special colleagues from my SOS group -- Tom Farnsworth, Pam Marcucci, Pam Neels, Marilyn Ransby, and Ann Watters. I could not have come so far without the wisdom, enthusiasm and humor you shared, even during the darkest hours.

A special thanks to Ron Chase for being an admirable and honorable cohort, and to Kevin Campbell for being an insightful cynic and knowledgeable statistics consultant.

I also want to thank my mother, Lori Jensen, for teaching me the value of education and joy of adventure. I am also grateful for the support of my family over these many years. My last and most important thank you goes to my partner, Stephen Magyari, whose calmness, patience, and love helped me through the most difficult parts of this process.

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ABSTRACT

INTERNALIZED HOMOPHOBIA, STAGES AND PROCESSES OF CHANGE AND
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This dissertation examined the relationship between internalized homophobia, stages and processes of change and alcohol use. Participants were 79 gay males with an average age of 42 years who responded to advertisements. Participants completed the Revised Nungesser Homosexual Attitude Inventory, University of Rhode Island Change Assessment scale, Processes of Change scale, and the Alcohol Use Inventory. Results indicate higher internalized homophobia for alcoholics than non-alcoholics ($t = -1.70, p < .05$), a correlation between internalized homophobia and alcohol involvement ($r = .26, p < .05$), and a correlation between internalized homophobia and readiness to change ($r = .32, p < .01$). Internalized homophobia is higher in the action stage than in the precontemplation, preparation and maintenance stages. Processes of change are different across Alcoholics Anonymous participation

groups, but not across internalized homophobia groups. Stages of change and internalized homophobia are reliable predictors of alcohol involvement ($\underline{R}^2 = .26$, and $\underline{R}^2 = .27$, respectively). This study strengthens the relationship between internalized homophobia and alcohol use and demonstrates that internalized homophobia is highest in the action stage of change, acting as an impetus. Clinical recommendations include providing a safe, structured environment for clients to develop a positive sense of sexual identity and strategies for addressing the escalation of internalized homophobia in early recovery.

INTRODUCTION

This study integrates research on stages and processes of change, internalized homophobia and gay identity development to better understand patterns of alcohol use among gay men. While it has been hypothesized that internalized homophobia contributes to a pattern of alcohol dependence in gay and lesbian persons (Cabaj, 1988), no empirical research currently exists to support that assertion. Previous research has identified a variety of variables associated with higher levels of alcohol dependence, including genetic and psychosocial factors. This study investigates whether internalized homophobia is associated with alcohol use among gay men.

A specific model of addictive behavior, attitudes and change potential will be used to demonstrate the effect of internalized homophobia on alcohol use patterns. A significant aspect of the research is the application of the stages of change model (Prochaska, DiClemente, & Norcross, 1992) to the problem of addictive behavior among gay men. This model allows researchers to classify subjects into one or another stage of change. If internalized homophobia is implicated in alcohol use patterns, it follows that

homophobia would affect a gay or lesbian person's ability to transition toward freedom from alcohol dependence.

A potentially important implication from this research may be that internalized homophobia should be specifically addressed in alcohol dependence treatments with the gay and lesbian community as a component of a therapeutic intervention (Purvis, 1994). Although substance abuse treatment programs do exist for gay and lesbian clients, internalized (and externalized) homophobia are not usually formally addressed in the treatment protocols.

The results from this study may contribute to more effective treatment programs and ultimately to the improved psychological health of the community. At present, there is considerable controversy as to the epidemiology of substance abuse in the gay and lesbian community (Cabaj, 1989; Bux, 1996). Regardless of the prevalence of substance abuse in the community, internalized homophobia is researched here to determine its association with alcohol use patterns among gay men, if any.

This paper begins with an examination of the environment in which most gay men develop. The homophobia pervasive in American society is presented as background to understanding internalized homophobia. Next, the literature and research

on gay identity development is presented as a theoretical framework within which one might reach an understanding of the acquisition of internalized homophobia. This is followed by a discussion of internalized homophobia, a central construct thought to be relevant to the understanding, assessment, and treatment of the psychological functioning of gay men (Cabaj, 1988).

Literature about alcohol abuse and dependence is presented next. The concepts are defined in general terms and data regarding etiology and epidemiology are presented. Findings specific to the gay and lesbian community are incorporated into this section to highlight the potential role of internalized homophobia in identity development and hence, alcohol use problems.

Finally, the Stages of Change model (Prochaska, DiClemente, et al., 1992) will be presented as a theoretical framework for studying behavior change. An overview of the model is presented, followed by a review of the relevant research history.

Homophobia and Heterosexism

History of Homophobia

The concept of homophobia developed after the era of de-pathologizing of homosexuality in conjunction with the gay

liberation movement in the late 1960s and early 1970s (O'Donohue & Casselles, 1993). This development occurred simultaneously with a shift from the organism deficiency model, where homosexuality was the subject of study and/or cure, toward the social deficiency model, an era when the "victimizer" (e.g., the heterosexual majority) became the focus of studies of homosexuality (MacDonald, 1972, 1976).

The tradition of homosexuality as a moral and physical illness was challenged by publication of the Kinsey data in 1948 because homosexual behavior was reported to be more prevalent than originally believed (Morin & Garfinkle, 1978). A revolution in public attitudes, perceptions and cognitions about sexual behavior occurred in the next 20 years. In academic circles, there was a shift from a scientific study of the homosexual (and how to cure him or her) toward investigations of the prejudice against homosexuals. Homophobia is the social expression of the many traditions that pathologized homosexuality. Cultural attitudes toward sex, sexuality, gender, gender roles, and procreation are thought to contribute to the construct of homophobia. Although Weinberg (1972) was not the first to describe anti-homosexual attitudes, his mnemonically crisp term, "homophobia," popularized the concept. He argued that

Western society is based upon a number of religious and political traditions that support anti-homosexual sentiment. One tradition is the Judeo-Christian tradition, which prescribes formal guidelines against homosexual behavior. Among some, this religious tradition considers all sex not leading to procreation to be immoral (Fyfe, 1983). Herek (1984b) believes that homosexuality was rejected by the religious tradition because it had been historically associated with idolatry and heresy. Moreover, modern religious historians argue that the taboo has its roots in the community's need to preserve the "seed" in times when mortality rates were very high (Fyfe, 1983).

A second tradition is the Augustinian Catholic anti-pleasure value system, which in combination with the Calvinist Protestant tradition of the value of work, led to restrictive attitudes about sex and sexuality in America (Fyfe, 1983). A third tradition is that of xenophobia in western societies. Fear of foreigners, or fear of the strange, has often served as a basis for later discrimination, prejudice, stigmatization, and/or bias (Mayadas & Elliott, 1992). A full examination of the social forces responsible for the promulgation of anti-gay sentiment is beyond the scope of this paper.

It is also worth noting that biological determinism and the birth of psychiatry promoted the medical illness view of homosexuality (Fyfe, 1983; Gramick, 1983). Homosexuality has been seen as an organic disease, neurotic disorder, and/or an immature or underdeveloped form of adult sexuality (Gramick, 1983). In fact, the first "fear or dread" of homosexuality was described by the clinical syndrome of "homosexual panic" by Kempf in the 1920s (Chuang & Addington, 1988). It was in this cultural and academic context that the concept of homophobia was conceived and perpetuated. Many years later, the negative effects of internalized homophobia on the individual were clinically described (Malyon, 1982).

Definition and Description

Weinberg (1972) is credited with coining the term "homophobia" and for popularizing the construct. He defined homophobia as the "dread of being in close quarters with homosexuals," or "unwarranted distress over homosexuality" (Weinberg, 1972, pp. 4-5). This definition implies that there is a particular set of affects, cognitions, and behaviors that an individual has toward homosexuals and/or homosexuality. At the individual level, some affects that have been defined as components of homophobia are fears (irrational, phobic, unreasonable, anxiety), negativity,

disgust, discomfort, anger, and hatred (Weinberg, 1972; Gramick, 1983; Morin & Garfinkle, 1978; Isay, 1989; Smith, 1971). Cognitions associated with homophobia include attitudes against moral permissibility (i.e., society should have stronger moral standards), specific political reactions, anti-gay attitudes, beliefs (homosexuality is immoral), and stigmas (Hudson & Ricketts, 1981; O'Donohue & Casselles, 1993; Fyfe, 1983; Herek, 1984a, 1984b, 1996; Niesen, 1990). Negative behaviors often associated with homophobia include avoidance, aggression, discrimination, prejudice, and violence (Herek, 1984a, 1996; Neisen, 1990). Thus, homophobia can be defined as a set of negative affects, cognitions, and behaviors toward homosexuals and/or homosexuality.

Recently, homophobia has been re-conceptualized as "heterosexism," defined as continued promotion by major institutions in society of the superiority of heterosexual lifestyles, with the subordination of other lifestyles. Heterosexism is thus defined using similar features as other prejudices such as racism and sexism (Neisen, 1990; Herek, 1996). Homophobia will be the term used in this study because it has gained the most currency. (Refer to Appendix A for a chronological review of homophobia terminology).

Gay Identity Development

Identity Development

Development of one's individual character occurs in a social world. Models have attempted to explain how identity formation occurs through interaction with the environment. Theorists have taken different perspectives to this end, and early works on adult development focused on ego development from a psychoanalytic perspective. Erikson (1956, 1959, 1968) emphasized the important function of the ego in organizing and synthesizing development, transforming patterns of function into a sense of self, which he called the ego identity. His analysis provided the framework for many identity theories in which the ego mediated between the individual's internal world and the social context. Development occurred out of this interaction and identity was defined as a "consistency," shaped by the way the individual satisfies needs and develops preferences (Erickson, 1956). More recently, Habermas (1979) proposed an ego development stage model that reflected the reciprocal interaction between the individual and societal beliefs and values. Psychoanalytic perspectives generally focus on how the external world is taken into the ego to form part of the self through the process of internalization (Schafer, 1968).

Sullivan (1953) provided an interpersonal perspective and argued that the "self" develops and is shaped by the nature of interpersonal relationships. Cognitive theorists such as Piaget and Kohlberg have also contributed to theories of identity development by focusing on the development of cognitive processes and moral decision-making.

The influence of sociology has resulted in developmental theories based upon a model of symbolic interaction. These theories suggest that the individual interprets and constructs meanings from interaction with the environment. Ascribed meanings to personal experience within the particular social context are integrated into a self-image (Plummer, 1975). Recent models of gay identity development motivated by symbolic interaction theories include those of D'Augelli (1994), D'Augelli and Patterson (1995), and Cox and Gallois (1996). Symbolic interactionism has also been used extensively in explaining identity development in minority or oppressed populations.

Gay Identity Development Models

Homosexual identity development models proliferated in the 1970s as theory began to expand its focus from the individual and the dyad to a focus on the individual in a wider social psychological and humanistic context (Cass, 1983). This

development paralleled the growth of research on homophobia and heterosexism referred to in a previous section of this paper.

A variety of gay identity development models exist [Cass (1979, 1984, 1996); Chapman & Brannock (1987); Coleman (1981,1982); Cox & Gallois (1996); D'Augelli (1994); Dank (1971); De Monteflores & Schultz (1978); Faderman (1984); Hammersmith & Weinberg (1973); Hencken & O'Dowd (1977); Kimmel (1978); Kirkpatrick & Morgan (1980); Lee (1977); Minton & McDonald (1984); Plummer (1975); Richardson & Hart (1981); Schafer (1976); Sophie (1986, 1987); Storms (1979, 1980, 1981); and Troiden (1979, 1988)]. These models were motivated by a variety of psychological theories and resulted in a range of proposed definitions of identity.

In an attempt to "clarify and prune the overgrown garden of gay identity models," Cass (1983, p. 106) presented an analysis and synthesis of the state of the research. She explored the wide variety of meanings that identity has taken, from "self-concept" to "identity" to "homosexual identity", and posed a critical question, "Is gay identity an ego identity, a sexual identity, or something else?"

Cass (1979, 1996) proposed a six-stage model of identity formation within the framework of interpersonal congruency theory, a social construction modality. This work represented a

conceptual advance over the previous research, which focused on different types and problems of gay identity, because it offered a theoretical model with empirical support (Cass, 1979, 1984). This model is based upon two assumptions, (a) that identity is acquired through a developmental process, and (b) that this process occurs in the individual interacting with his environment (Cass, 1979). These assumptions are similar to other identity formation theories such as those advanced by Erickson (1959, 1968).

Cass (1979, 1996), however, distinguishes between public and personal aspects of identity formation, and allows for "identity foreclosure" at any given stage, meaning that development is arrested at that point. These two elements, aspects (public and/or personal dimensions of identity formation) and arrest (fixation of identity development or "foreclosure"), are critical to a sound theory of gay identity development for several reasons. First, no other minority group is as invisible as gays and lesbians. Gay and lesbian people are invisible in a heterosexist society (which assumes all people are heterosexual) until they self-identify as gay or lesbian internally, and more importantly, publicly announce that self-identification. It is not inconceivable or uncommon for a gay person to live a heterosexual existence his or her whole

life. The differentiation of aspects (dimensions) is thus a crucial element in this model. The second notion is developmental arrest, which allows for the possibility that a person may stop gay identity development at any given stage. This arrest is only possible for a developmental sequence that is self-motivated. A gay person can acknowledge their homosexuality internally but stop the identity cycle at that point only because his invisibility makes the arrest a private matter. Cass (1979) theorizes that development is driven by the incongruency between a person's internal and external world that leads to the individual's attempt to resolve that discrepancy. Cass's model (1979, 1996) is as follows:

Stage one: Identity confusion

The first stage of gay identity development occurs when the individual first realizes that his or her behavior may be considered homosexual. Some level of conscious awareness is present, such as a thought, an emotional response, or a physiological response, that initiates the developmental process. This conscious awareness stands in stark contrast to simply being exposed to information about homosexuality. The critical element in the conscious awareness involves attaching a personal meaning to the stimuli. This stage begins with the first incongruence (the possibility of the self as homosexual)

and results in inner confusion and turmoil. Several approaches to this recognition are possible and include, (a) this is a correct and desirable possibility, in which the individual searches for further information, (b) the identification is correct but undesirable, where the individual may inhibit, restrict or deny homosexuality, or (c) this is both incorrect and undesirable, in which case the individual may define their homosexuality as a "phase" or an "experiment," or define it only in terms of behavior (e.g., "I'm heterosexual, but I have sex with men on occasion"). It is rare for the individual to disclose his homosexuality at this point because this stage is focused on the intensely personal and nebulous homosexual self-identification. If identity foreclosure has not taken place, the individual may proceed to the next stage.

Stage two: Identity comparison

Cass describes this stage as the alienation phase, where the individual begins the deep realization that he or she is different. The individual realizes that behaviors, ideals, and expectations once believed are no longer applicable. There are four approaches to coping with the alienation, (a) positive reactions to being different and believing it to be desirable, (b) the homosexual behavior is accepted, but the gay self-image is undesirable, (c) both homosexual behavior and self-image are

unacceptable, or (d) both the behavior and self-image are not only undesirable, but are inhibited and the individual attempts to revert to heterosexuality. This stage leads to different coping styles in relation to homophobia. For example, the gay person will utilize "passing" (as heterosexual) in a variety of ways to manage feelings of difference. Individuals may avoid threatening situations, control personal information, deliberately cultivate a heterosexual persona, or distance themselves from the homosexuality. If identity foreclosure does not occur, the individual may advance to the next stage.

Stage three: Identity tolerance

Increasing commitment to the self as homosexual marks stage three. This may both heighten alienation and relieve confusion. The focus in this phase is to counter the alienation and isolation and to make contact with the gay community. The individual begins to interact with other gay people and/or the gay community in order to further explore and re-evaluate the self-image, and to manage the escalating feeling of not belonging to the heterosexual world. Contacts may or may not be rewarding, either furthering a positive self-image or not. The individual may handle increasing internalized homophobia by either reducing contact with gays or by inhibiting homosexual

behavior. The result of this stage completion is that the individual recognizes that he or she is indeed homosexual.

Stage four: Identity acceptance

This stage is characterized by increasing contact and/or involvement with other gay and lesbian people. Acceptance, rather than tolerance, is the demarcation of this stage from previous ones. The individual has answered the questions, "Who am I?" and "Where do I belong?" The strategies of passing, limited contact, and selective disclosure are utilized to manage the incongruence between the self-image and the legitimacy of homosexuality in society. The successful management of ambivalence and incongruence between self-image and experiences with external homophobia leads to the next stage.

Stage five: Identity pride and coming out

Pride is the result of the individual accepting his homosexual self and rejecting society's homophobia as invalid. This may be accompanied by a devaluation of heterosexual persons. The highlight of this stage is the "coming out" process, whereby the gay person announces his or her homosexuality to significant others such as family and friends. Coming out is seen as an adaptive coping strategy because it reduces the dissonance in the individual and affirms their self-image. Coming out is mediated by external factors such as

safety. It is important to note that coming out is a continuing, life long process for a gay person. New situations call for decision-making about coming out on a daily basis.

Stage six: Identity synthesis

The synthesis stage is recognition that attitudes toward heterosexuals are now integrated (both good and bad), into a more mature approach to the world. The other significant feature of this stage is the increasing congruency in the individual's life, both in behavior, self-image, and environment. This stage is marked by a consistency of affect, behavior, and cognition for the individual across life situations. In other words, the gay person is wholly integrated regardless of the environment.

Gay Identity Development Models: Analysis

A number of empirical studies have been conducted on gay and lesbian identity models (Cass, 1984; Chapman and Brannock, 1987; Dank, 1971; McDonald, 1982; Minton and McDonald, 1984; and Sophie, 1986). For example, Cass (1984) found evidence for stage theories through self-report measures. Further, she was able to support the order of the developmental sequence as defined in her model.

McDonald (1982) conducted an empirical investigation of the coming out process among 99 self-defined homosexuals. He found

that the events which defined coming out included initial awareness of same-sex attraction, same-sex sexual behavior, self-designation as gay, initial involvement in a long-term relationship, self-disclosures to others (coming out), and acquisition of a positive gay identity. He concluded that these events are part of an orderly but nonlinear developmental sequence, since not all gay men progressed in a predictable fashion from one stage to another. Rather, individual differences emerged and were correlated with measures of psychological health, including measures of anxiety and depression. He also concluded that gay identities emerge differently due to the variations in anti-homosexual prejudice and discrimination.

Internalized Homophobia In Gay Identity Development

To understand the insidious effects of homophobia, it is important to consider that homophobic attitudes may be internalized long before the gay person realizes he is gay. The effect of reckoning with the external stigma that is now attached to the self has been described by Malyon (1982). A developmental arrest occurs at the point which the individual realizes their own homosexuality because it conflicts with both the societal opinion of homosexuality and their own internalized opinion. Because of this unique circumstance, internalized

homophobia in the gay person has been the subject of theoretical and clinical interest and concern. The next section presents the theoretical and research findings about internalized homophobia, including the psychological sequelae of this construct and methods for amelioration.

Internalized Homophobia

History of Internalized Homophobia

The origins of the internalized homophobia construct can be traced to Weinberg (1972). He argued that a particular type of self-loathing developed in gay men living in a homophobic environment. In 1979, Kingdon described "internal homophobia" as a similar construct. When Malyon (1982) expounded on the need for gay and lesbian affirmative psychotherapies, he first described and elucidated the construct of internalized homophobia from a psychodynamic perspective. Since the development of the construct, authors have argued that it has value as a heuristic and as an organizer of factors unique to gays in the areas of development, psychopathology, psychotherapy, and prevention (Shidlo, 1994). They also have argued for its utility in clinical work with gay and lesbian patients (Downey & Friedman, 1995), and described psychologists' general agreement about its theoretical importance in the field (Ross

& Rosser, 1996). The purpose of this section is to define and describe internalized homophobia. The development of internalized homophobia and its relationship to psychological distress will also be examined. This section ends with a review of the literature on the methods of amelioration and some psychological measures of internalized homophobia.

Definition and Description

Internalized homophobia is defined as a set of negative affects, cognitions, or behaviors that a gay person has toward homosexuality in other persons and toward homosexual features in oneself, including same-gender sexual and affectional feelings, sexual behavior, and intimate relationships (Shidlo, 1994). Internalized homophobia is the external stigmatization (homophobia) that becomes attached to the sense of self (Stein & Cohen, 1986). Thus, internalized homophobia is self-hatred or shame (Neisen, 1990), or feelings of shame for considering oneself a deviant (Friedman & Downey, 1994).

It is likely that there is wide variability in the quality and extent of internalized homophobia among gay men (Shidlo, 1994). Cabaj (1988, 1996) contends that internalized homophobia is the main dynamic in the neurosis of gay men. He equates internalized homophobia, a

dissatisfaction with being homosexual which is associated with low self-esteem and self-hatred, with the ego-dystonic homosexuality diagnosis of the Diagnostic and Statistical Manual of Mental Disorders, Version Three, Revised (DSM-III-R, 1987) (Cabaj, 1988).

Fisher (1972) gives this vivid description,

Every time a homosexual denies the validity of his feelings or restrains himself from expressing, he does a small hurt to himself. He turns his energies inward and suppresses his own vitality. The effect may be scarcely noticeable; joy may be a little less keen, happiness slightly subdued; he may simply feel a little run down, a little less tall. Over the years, these tiny denials have a cumulative effect.
(p. 249, quoted in Coleman, 1982).

Developmental Sequence

How does homophobia become internalized, and at what point in development does this internalization occur?

Negative attitudes toward homosexuality are so widespread in our society that many authors argue that the internalization of homophobia is a normal developmental event experienced by gay and lesbian people (Forstein, 1988; Gonsiorek, 1988; Malyon, 1982; Pharr, 1987; Shidlo, 1994; Sophie, 1987).

Malyon proposed that ubiquitous homophobic beliefs are incorporated into the self through the socialization process and lead to a fragmentation of the developmental cycle. He described how internalized homophobia becomes an aspect of

the ego through socialization as both an unconscious introject and a conscious system of attitudes and related affects. Malyon's description of the internalization process utilized the psychoanalytic process of internalization described by Schafer (1968). Schafer described how the external world is taken into the ego to form part of the superego and how the subject internalizes the outside world into internal regulations (i.e., object representations), whether or not these regulations are real or imagined. The conscious system influences identity formation, self-esteem, elaboration of defenses, patterns of cognition, psychological integrity, and object relations. Internalization of the belief that homosexuality is abnormal precedes the realization of identity and contaminates adolescent identity formation (Malyon, 1982).

Stein and Cohen (1986) believe that gay identity development involves coping with a fundamental experience of difference from the mainstream heterosexual culture. They write, "the ego development of a homosexual in this culture requires reckoning with invisibility and stigma" (page 38). The sense of being different is based upon a recognition that one is unlike peers and family members (Friedman & Downey, 1995). According to Friedman and Downey, the gay person

identifies with the aggressor by adopting the same view of himself that is communicated by the society. A false image as a heterosexual is developed which may be accompanied by feelings of guilt and shame that are an identification with those who devalue him or her (Friedman & Downey, 1994).

The precise temporal stage in which internalized homophobia occurs is elucidated by the gay identity stage models presented in the prior section. An internalized belief that homosexuality is bad or wrong occurs before any recognition of same sex feelings by the person (Coleman, 1982). It is not until the recognition of one's own same sex feelings that conflict between the internalized belief and one's own identity arises. The conflict would occur during the stage of recognition, which in other models is labeled "coming out" (Coleman, 1982), "identity confusion" (Cass, 1979, 1996), "signification" (Lee, 1977; Plummer, 1975), "awareness" (Hencken & O'Dowd, 1977), or "identification" (Dank, 1971). Coleman found that this stage, whatever its label, occurred at an average age of 13 to 18 for males. The conflict has significant ramifications that are described next.

Internalized Homophobia and Psychological Distress

Internalized homophobia is a source of pervasive psychological distress that manifests itself as affective, behavioral, and cognitive symptoms as well as impairments in defensive functioning. Internalized homophobia in the clinical setting refers to a constellation of symptoms, primarily guilt and shame about being gay or lesbian, which result from object relationships that symbolically represent narratives expressing anti-homosexual attitudes and values (Downey & Friedman, 1995). Some of the basic symptoms of internalized homophobia noted in the literature include higher levels of depression and anxiety states and cognitive processes of hyper-vigilance and suspiciousness (Finnegan & McNally, 1987). Internalized homophobia increases punitive superego functioning and contributes to a propensity for intra-punitiveness and guilt (Malyon, 1982).

These affects are managed through specific defenses such as denial, reaction formation (identification with the aggressor), rationalization, hostility, anger, or passing as heterosexuals (Finnegan & McNally, 1987). This affect management process forms the basis for the symptomatology described by clinicians working with many gay and lesbian clients.

A review of the extant literature provides a wide variety of symptomatology and theory about defensive functioning. Table 1 summarizes the effects of internalized homophobia in the categories of affect, behavior, cognition, and defensive functioning.

Given this catalog of psychological distress, it is important to note that negative self-evaluations may even be unconscious at times, such that the gay person does not experience conscious levels of shame, guilt, or self-hatred (Downey & Friedman, 1995). As a result, psychological distress may not be directly attributed to internalized homophobia by the individual, and instead may be attributed to more salient/obvious life stressors (such as work difficulties). It is also possible that patients who experience life-long self-hatred may differ from patients who experience self-hatred as a result of the recognition of their sexual orientation (Downey & Friedman, 1995). In other words, internalized homophobia, while endemic to gay and lesbian persons, may be one of the major contributors to the development and exacerbation of psychological distress even in persons with severe personality or character disorders.

Table 1

Affects, behaviors, cognitions and defensive functioning
associated with internalized homophobia

Affects	Author(s)
Chronic anxiety	Malyon (1982)
Demoralization	Meyer (1995); Wagner, et al. (1994)
Depression	Alexander (1986); Bell and Weinberg (1978); Friedman and Downey (1994); Wagner, et al. (1994)
Distrust	Finnegan and Cook (1984)
Dysphoric states	Smith (1988)
Guilt and intro-punitiveness	Downey and Friedman (1995); Gonsiorek (1988); Malyon (1982); Meyer (1995); Wagner, et al. (1994)
Loneliness	Weinberg and Williams (1974); Finnegan and Cook (1984); Shidlo (1994)
Sadness and anxiety	Herek (1996)
Self-loathing (self-hatred)	Downey and Friedman (1995); Gonsiorek (1988); Neisen (1990); Weinberg (1972)
Shame	Downey and Friedman (1995); Gonsiorek (1988); Neisen (1990)
Stress and distress	Meyer (1995)

Table 1 - Continued

Behaviors	Author (s)
Alcoholism, substance abuse	Cabaj (1988, 1989, 1996); Coleman, et al. (1992); Finnegan and Cook (1984); Friedman and Downey (1994); Glaus (1988); Gonsiorek (1988)
Avoidant coping patterns	Coleman, et al. (1992); Nicholson and Long (1990); Wolcott, et al. (1986)
Difficulty or avoidance in intimate relationships	Coleman, et al. (1992); Devlin and Cowan (1985); Friedman (1991); George and Behrendt (1988)
Domestic violence	Pharr (1988)
Impaired sexual functioning; sexual problems	Brown (1986); Coleman, et al. (1992); Malyon (1982); Meyer (1995),
Psychosexual adjustment (sexual anxiety, sexual satisfaction)	Dupras (1994)
Suicide	Meyer (1995); Rofes (1983)
Under or over-achievement	Gonsiorek (1988)
Cognitions	Author (s)
At fault for victimization	Neisen (1990)
Attribution of negative self-valuation	Friedman and Downey (1995)
Innately defective or inferior	Cabaj (1988); Gonsiorek (1988), Neisen (1990)
Low self-esteem	Alexander (1986); Cabaj (1988); Lima, et al. (1993); Neisen (1990); Nicholson and Long (1990); Shidlo (1994)
Negative attitudes and beliefs	Friedman and Downey (1995); Malyon (1982)

Table 1 - Continued

Cognitions	Author (s)
Precluded identity development	Malyon (1982)
Self-blame for AIDS, reaction to being HIV+	Forstein (1988); Lima, et al. (1993); Meyer (1995); Morin, et al. (1984); Nicholson and Long (1990); Ross and Rosser (1996),
Self-doubt	Cabaj (1988)
Defensive functioning	Author (s)
Creation of false identity (elaboration of a heterosexual persona)	Malyon (1982)
Denial	Margolies, et al. (1987)
Fragmentation and borderline personality features	Gonsiorek (1982); Malyon (1982)
Identification with the aggressor (reaction formation)	Margolies, et al. (1987)
Projection	Margolies, et al. (1987)
Rationalization	Margolies, et al. (1987)

Methods of Amelioration

Authors agree that internalized homophobia and its effects can be worked through, and possibly resolved, in a variety of ways. The process of coming out, or progressing through the identity formation cycle appears to ameliorate the effects of internalized homophobia (Cass, 1979; Forstein, 1988; Herek, 1996; Malyon, 1982; Stein & Cohen, 1986; Troiden, 1979). These authors argue that the full recognition and disclosure of one's homosexuality helps to minimize the deleterious effects of internalized homophobia. Thus, as identity stage evolves or increases, internalized homophobia decreases. Malyon argues that coming out both minimizes internalized homophobia and restores both the ego and identity formation. There is no research to suggest that internalized homophobia is ever completely resolved, especially at the unconscious level or in stressful situations, although coming out and/or receiving psychotherapy may alleviate the symptoms of internalized homophobia.

Measures of Internalized Homophobia

Early research (Weinberg & Williams, 1974; Bell & Weinberg, 1978) attempted to measure internalized homophobia in terms of either regret about being homosexual or general

attitudes about homosexuality. The first significant advance in the measurement of internalized homophobia was the development of the Nungesser Homosexual Attitudes Inventory (NHAI) (Nungesser, 1983). The instrument is a set of 34 questions on a 5-point Likert scale which assesses beliefs and attitudes that can be divided into three scales, (a) attitudes toward one's own homosexual feelings and behavior, (b) attitudes toward homosexuality in general, (c) and attitudes toward the disclosure of one's own homosexuality. Higher scores indicated higher levels of internalized homophobia. This instrument was a qualitative advance because of the range of homophobic content it measured (Shidlo, 1994).

Alexander (1986) designed the Internalized Homophobia Inventory based upon a selection of items from a larger pool by gay psychological experts. The instrument evidenced adequate face and content validity, and an internal consistency of .85 (Shidlo, 1994). Another attempt to construct an internalized homophobia measure was performed by Martin and Dean (1987), who designed a scale based upon the ego-dystonic homosexuality diagnostic category (DSM-III-R, 1987). The measure included only rather extreme symptoms of

internalized homophobia and as such has limited utility (Shidlo, 1994).

Two recent developments have held more promise in designing a psychometrically sound measure of internalized homophobia. Shidlo (1994) attempted to define the conceptual and empirical issues in measuring the construct, and designed the Revised NHAI (RNHAI). Based upon his review of the existing instruments, Shidlo determined that efforts to assess internalized homophobia have been limited by improper operationalization of variables. In response, he constructed a new measure that had good face, content and construct validity that assessed both subtle and extreme forms of internalized homophobia. The RNHAI includes observable behaviors, adequate samplings of those behaviors, and is highly correlated with both self-esteem and behavioral measures such as Rosenberg Self-Esteem Scale and a scale of somatic symptoms (Shidlo, 1994).

The Reactions to Homosexuality Scale (RHS) recently developed by Ross and Rosser (1996) revealed, through orthogonal factor analysis, four dimensions of internalized homophobia, (a) public identification as gay, (b) perception of stigma associated with being homosexual, (c) social comfort with gay men, and (d) the moral and religious

acceptability of being gay. Factor loadings indicated associations between internalized homophobia and relationship satisfaction, duration of longest relationship, proportion of social time with gay people, and disclosure of sexual orientation (Ross & Rosser, 1996). They found that high levels of internalized homophobia were associated with low disclosure as being gay, shorter, less satisfying relationships, and lower social time with other gay people.

The research that has attempted to measure internalized homophobia and correlate it with psychosocial distress has borne out some of the hypothesized relationships reviewed in this section. To date, there has been no investigation of the relationship of internalized homophobia and alcohol use patterns among gay men.

Internalized Homophobia as a Risk Factor in Alcohol Use Patterns

The prevalence of internalized homophobia among gay men is not precisely known. Shidlo (1994) reviewed the research on prevalence and found that most studies were outdated and limited by methodological constraints. Bell and Weinberg (1978) and Jay and Young (1977), (cited in Shidlo, 1994) concluded that 25-33% of gay men have negative attitudes or feelings about their homosexuality at some point in their

lives. Differential rates of internalized homophobia across people or time could be due to, (a) cultural changes in the society (increasing acceptance of homosexuality), (b) the influence of gender or ethnicity (overlays with sexism or racism), and/or (c) age and development stage (cultural era or level of personal identity development). Further, a shortage of accurate prevalence measures leaves many questions unanswered.

Because the current study concludes that internalized homophobia is related to substance abuse and psychological distress, what is its relationship to alcohol use patterns? Clinicians agree that the distress caused by internalized homophobia is pervasive, although to date there is no evidence that directly ties internalized homophobia to alcohol use patterns in gay men. Investigators theorize many causes of alcohol use problems, which can be grouped along affective, cognitive, and behavioral lines.

With respect to treatment of alcohol abuse and dependence, Brownell et al. (1986) reviewed the literature on unsuccessful recoveries and determined that negative emotional states; self-destructive behavior; and internal, stable, and uncontrollable attributions all contribute to relapse. Internalized homophobia, as conceptualized by the

theory and research, encompasses all three components of relapse. As such, it may be that internalized homophobia is a risk factor that impedes recovery from alcohol use disorders among gay men. The next section will focus on alcohol dependence among the gay and lesbian community.

Alcohol Dependence

Prevalence and Incidence of Alcohol Dependence

According to the DSM-IV (1994), "a United States national probability sample of non-institutionalized adults conducted in 1990-1991 indicated that around 14% had Alcohol Dependence at some time in their lives, with approximately 7% having had Dependence in the past year" (page 202). Research on the gay and lesbian community has traditionally shown a much higher prevalence of substance dependence (for example, Beatty, 1983; Bell & Weinberg, 1978; Diamond & Wilsnack, 1978; Fifield, De Crescenzo & Latham, 1975; Lewis, Saghir & Robins, 1982; Lohrenz, et al., 1978; Morales & Graves, 1983; Saghir & Robins, 1973; Weinberg & Williams, 1974).

"Although there is considerable controversy about the incidence of chemical dependency in the gay and lesbian population, most studies and the experiences of most clinicians working with gay men and lesbians estimate the incidence of chemical dependencies of all types at approximately 30% (ranges of 28-35%), as compared with 10-12% for the general population" (Cabaj, 1989, page 387).

Bux (1996) argues that prevalence studies on the gay and lesbian community are methodologically flawed, and that while gay men may not have a significantly higher risk of developing drinking problems than the general population, lesbians may exhibit higher rates of problem drinking than their heterosexual counterparts.

Etiological Factors in Gay and Lesbian Alcohol Dependence

Much theory and research has been performed on the causes of alcohol dependence, ranging from genetic to psychological to social causes. While the etiology of alcohol dependence in the general population is beyond the scope of this paper, there are etiological factors specific to the gay and lesbian community that should be considered because they directly relate to the main hypotheses of this paper.

In spite of methodological flaws in the research, contemporary writers suggest that there may be something causing increased substance dependence in the gay and lesbian community. Causes of alcohol dependence (as well as other substances) unique to the gay and lesbian community can be categorized into psychological and social factors.

Homosexuality as a cause of alcoholism

It is worth noting that the psychoanalytic tradition once believed homosexuality itself to be a cause of alcoholism (Nardi, 1982).

Psychological factors: Self-medication, learning and affiliation hypotheses

Alcohol dependence has been attributed to psychological factors such as, (a) depression and anxiety that result from internalized homophobia, (b) perceptions that the world is dangerous and threatening, or (c) fear of public disclosure of homosexuality (Finnegan & McNally, 1987). Thus, alcohol use is seen as a form of self-medication to address anxiety and depression. Some authors have directly attributed substance dependence (including alcohol dependence and a variety of related addictions) to internalized homophobia (Ziebold & Mongeon, 1985; Finnegan & McNally, 1987; Cabaj, 1996).

Learning theories of substance dependence argue that the reinforcement of pleasurable experiences, as well as the avoidance of negative experiences, may contribute to substance dependence (Nardi, 1985). Considering that the gay and lesbian community has developed out of a social network that included socializing at bars, this perspective seems

plausible. It may be that gays and lesbians develop the habit of drinking alcohol to join with their community (Nardi, 1982; Achilles, 1967).

Social factors: Minority stress and oppression

The stress-vulnerability perspective asserts that dependence results from social causes, such as stigmatization as a sexual minority (McKirnan & Peterson, 1989a, b). Vulnerabilities to substance dependence are exacerbated by minority stress unknown to the majority in society. Addictive behavior (including alcohol dependence) is a mechanism for relieving the pain and anxiety associated with an oppressive society (Ziebold & Mongeon, 1985). Thus, substances are used to medicate the internal state resulting from oppression. Finnegan and McNally (1987) believe that internalized homophobia leads to depression that is then medicated by alcohol.

Genetic predisposition and interactions

Cabaj (1996) maintains that alcohol dependence in the gay and lesbian community is the result of a genetic predisposition to alcohol combined with the need to medicate internalized homophobia (defined as self-loathing by the author).

To summarize, some authors argue that the psychological states experienced by gays and lesbians in a homophobic and heterosexist society are medicated by substances, or that the tension of oppression is reduced by substances, and that substance abuse or dependence may occur as part of the gay identity development cycle as gays or lesbians join with their community.

Alcoholics Anonymous

Alcoholics Anonymous (AA) is a widely available, influential approach to alcohol dependence treatment (McCrary, 1994). AA is a voluntary, supportive fellowship of alcoholics who help one another stay sober (founded in 1935 by two alcoholics, Bill Wilson and Dr. Robert Smith), and is self-supporting by members' contributions only (Galaif & Sussman, 1995). Membership is estimated at well over a million people in the United States (Berernson, 1987), and more than 96,000 AA groups exist in over 130 countries including all of Europe, Mexico, Central and South America, and the Middle East (Galaif & Sussman, 1995).

Becoming sober in AA involves much more than quitting drinking (Cain, 1991) because alcoholic drinking is seen as a reflection of the human need for spiritual life and growth (Miller & Kurtz, 1994). The twelve traditions outline the

premises of the organization, while the twelve steps provide an internal process of change through which members learn to make lifelong changes (see Appendix D) (Galaif & Sussman, 1995). AA contains six major beliefs about the nature of alcohol dependence, (a) alcohol dependence is a physical, mental, and spiritual disease, (b) alcohol dependence is progressive and can never be cured, except through abstinence, (c) craving and loss of control are the major symptoms of alcohol dependence, (d) illness is a result of alcohol dependence, not a cause of it, (e) the individual distorts reality by placing himself at the center of reality, rather than a higher power, and (f) spiritual bankruptcy and personality flaws are the manifestation of self-focus (McCrary & Irvine, 1989).

Members of AA confront these beliefs about alcoholism by working the twelve steps, and the result is a process of identity acquisition and self-understanding (Cain, 1991) akin to the process described in the gay identity development model. The goal of change in AA is a transformation of identity from drinking alcoholics to non-drinking alcoholics (Cain, 1991). Peteet (1993) describes how AA, through group support and a clear ideology regarding addiction, addresses the individual's need for identity, integrity, development of

an inner life, and development of an interdependence within a larger social, moral and spiritual context. Naifeh (1995), examining AA from a Jungian perspective, explored the archetypal foundations of addiction and recovery. He concluded that AA is successful because it recognizes the need for a countervailing archetypal force to overcome the addiction, in this case, the spiritual force. AA provides an original contribution to the ancient realm of spiritual practice, an approach to the spiritual through the ongoing relation to the shadow problem (Naifeh, 1995). Carroll (1993) argued that a sense of purpose in life increases with increasing sobriety and practice of the spiritual principles of AA. Thus, the AA approach toward recovery from alcoholism involves far more than quitting drinking; it involves the development of a new identity as a non-drinking alcoholic, the development of spiritual beliefs and practices, and a shift in life purpose.

Treatment outcome research indicates a relationship between AA affiliation or participation and the recovery process. Galanter, Talbott, Gallegos and Rubenstone (1990) treated 100 alcoholic physicians with either psychotherapy or AA and found the participants rated AA as more important to recovery than psychotherapy after 33 months. Feelings of

affiliation with AA were predictors of participants perceived support for recovery. Humphreys, Finney and Moos (1994), in a longitudinal study of stress and coping among 439 problem drinkers, found that AA involvement affects members' coping responses and increases their friendship resources. McCrady (1994) concludes that although few randomized clinical trials have been conducted on AA, single-group evaluation studies have found evidence for a significant association between AA attendance and positive treatment outcomes (for example, Valliant, 1983; Sheeren, 1988; Cross, Morgan, Mooney, Martin & Rafter, 1990; and Emrick, Tonigan, Montgomery & Little, 1993). Tonigan, Toscova and Miller (1996) analyzed the findings from 74 studies on AA affiliation and outcome, and found that AA participation and drinking outcomes were more strongly related in outpatient samples, and that better designed studies reported more positive psychosocial outcomes related to AA attendance.

AA combines motivation, program involvement, behavior, spiritual, cognitive, affective and interpersonal change in its twelve step program (McCrady, 1994). As such, AA provides the best framework to study how people utilize these methods in self-change from alcohol dependence.

The Transtheoretical Model of Change for Addictive Behaviors

Prochaska, DiClemente, et al. (1992) developed a model of change which applies to understanding both self-initiated and professionally guided change for addictive behaviors. The purpose of this section is to provide a general description and overview of the model, to assess the research literature associated with the model, and finally, to demonstrate the applicability of this model to the research question of this study.

The Model: Overview

The "transtheoretical model of change for addictive behaviors" (Prochaska & Prochaska, 1991) developed out of an international conference in 1984, although the model had been evolving since 1977. The significance of this model is its integration of diverse systems of psychotherapy, its wide applicability to a range of addictive behaviors, its synthesis of both current models and treatments of change, its coverage of the entire change cycle, and its unique formulation about relapse behavior (Prochaska & Prochaska, 1991). The model does not focus on the etiology, acquisition, or nature of addictive behavior (Davidson, 1992), but instead focuses on a theory of behavior change that applies to both self-changers and individuals in

treatment programs across a wide range of addictive behaviors (Prochaska & DiClemente, 1984).

The model combines stages, processes and levels of change. Stages of change can be either continuous or dichotomous, and are defined in the Table 2.

Stages of change represent the temporal, motivational, and constancy aspects of change (DiClemente et. al, 1991), and can be measured by two different self-report formats, (a) a categorical measure, which assesses the stage from a series of mutually exclusive questions and places the person in a discrete category, or (b) a continuous self-report measure (URICA - University of Rhode Island Change Assessment scale; DiClemente & Hughes, 1990) which provides separate scales for all stages of change.

A process of change refers to the method by which people move between stages and recycle through stages. Processes of change are abstract, theoretical groupings such that, "a process of change represents a type of activity that is initiated or experienced by an individual in modifying affect, behavior, cognitions, or relationships" (Prochaska & Prochaska, 1991). Processes of change are activities and experiences that people engage in to change, and these can be categorized into broad groupings that encompass multiple

Table 2

Stages of Change Definitions

Stage	Description
Precontemplation	Not seriously thinking about changing, at least not in the next six months; either uninformed or under-informed about the consequences of the addictive behavior
Contemplation	Seriously thinking about changing behavior in the next six months
Preparation	Ready-for-action, usually intending to take action in the next month
Action	Overt modification of the problem behavior for a criterion period of time, and extending out to a six month time frame
Maintenance	From 6 months after overt behavior change until the addictive behavior is finally terminated (termination is defined as zero temptation across all situations)

Note. Adapted from Prochaska, DiClemente, et al. (1992, page 1108).

techniques, methods, and interventions (Prochaska, DiClemente, et al., 1992). From a review of 29 systems of psychotherapy, Prochaska (1979) has determined ten basic processes of change as outlined in Table 3.

Processes of change are integrated into the stages of change model in that specific processes are emphasized during particular stages of change (Prochaska & Prochaska, 1991). The first five processes are more cognitive while the latter five processes are more action oriented. This study proposes that the processes of change will vary according to the level of internalized homophobia present. For example, a high level of internalized homophobia may impede developing helping relationships as a process of change.

Levels of change are the third dimension of the model, and reflect five distinct but interrelated psychological problem levels that can be addressed in treatment (Prochaska & Prochaska, 1991). The levels are: (a) symptom/situational, (b) maladaptive cognitions, (c) current interpersonal conflict, (d) family/system conflict, and (e) intrapersonal conflicts. Prochaska and Prochaska (1991) argue that treatment often addresses only one level of change, and that maximum effectiveness can be achieved by both the

Table 3

Titles, Definitions, and Representative Interventions of
the Processes of Change.

Process	Description: Interventions
Consciousness Raising	Increasing information about self and problem: observations, confrontations, interpretations, bibliotherapy
Dramatic Relief	Experiencing and expressing feelings about one's problems and solutions: psychodrama, grieving losses, role playing
Environmental Reevaluation	Assessing how one's problem affects physical environment: empathy training, documentaries
Self-reevaluation	Assessing how one feels and thinks about oneself with respect to a problem: value clarification, imagery, corrective emotional experience
Self-liberation	Choosing and commitment to act or belief in ability to change: decision-making therapy, New Year's resolutions, logotherapy techniques, commitment enhancing techniques
Reinforcement Management	Rewarding one's self or being rewarded by others for making changes: contingency contracts, overt and covert reinforcement, self-reward
Helping Relationships	Being open and trusting about problems with someone who cares: therapeutic alliance, social support, self-help groups
Counter Conditioning	Substituting alternatives for problem behaviors: relaxation, desensitization, assertion, positive self-statements
Stimulus Control	Avoiding or countering stimuli that elicit problem behaviors: restructuring one's environment (e.g., removing alcohol or fattening foods), avoiding high risk cues, fading techniques

Note. Adapted from Prochaska, DiClemente, et al. (1992, page 1109) to show processes in the order that they are emphasized across stages of change. See Appendix E for further information.

therapist and client agreeing upon the level at which the problem is attributed. A therapist who engages a client at the appropriate level of change and then moves to the next as progress is made will more likely be successful.

Decisional balance is one of the dependent variables in the change model, and represents a change in thinking about the "pros" and "cons" of the addictive behavior. Prochaska and Prochaska find that a transition in thinking occurs by which the pros (benefits) of the addictive behavior decrease, and the cons (costs) increase, as a person progresses through the stages of change.

Self-efficacy and situational temptation are additional dependent variables used in the model. Because self-efficacy influences motivation, choice, effort, and behavioral performance, Prochaska and Prochaska have included efficacy evaluations in their study of successful changers. The efficacy measure is a rating of the level of confidence about abstention from an addictive behavior across a range of salient situations and experiences that are known to lead to relapse. Termination of an addictive behavior is defined as no temptation across all situations. The efficacy measure provides a way to determine when an addictive behavior has terminated.

Stages, processes and levels of change are integrated into a comprehensive, multidimensional model. The model is structured such that the independent variables (e.g., stages of change and processes of change) are measured in relation to the dependent variables (e.g., decisional balance, self-efficacy and temptation) (Prochaska et al., 1985). Thus, the model generates hypotheses about the process of behavior change. The empirical research motivated by the model is presented in the next section of this paper.

Another important aspect of the model is that people cycle through the stages of change in a spiral fashion, rather than a linear progression. Given these findings, the model interprets lapses and relapses in addictive behavior as recycling through the stages of change. Relapse prevention is re-conceptualized from a roadblock to recovery to an essential part of change. Thus, relapse prevention is recast as "helping relapsers recycle efficiently and effectively" (Prochaska & Prochaska, 1991).

The Model: Research Review and Analysis

The transtheoretical model was developed through research on smoking cessation [e.g., DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1983; and Prochaska, et al.,

1985, 1988]. The model has also been used in studies of alcohol dependence, which will be the focus of this section.

DiClemente and Hughes (1990) applied the stages of change model to a sample of outpatient alcoholics. This particular study examined the utility of the stage model for alcoholics to determine whether the model would provide reliable, relevant, and distinct change profiles for alcoholics, and whether these profiles would differ based on individual alcohol use patterns and history, or the model's variables (self-efficacy and temptation measures). The URICA was used to group participants into continuous stages of change. Five reliable profiles emerged, and support was found for their validity. These five groups differed significantly on alcohol use inventory subscales, temptation to drink, and self-efficacy measures, but did not differ on demographic variables (DiClemente & Hughes, 1990).

Snow, Prochaska and Rossi (1992) used the model to study smoking cessation among former problem drinkers. Rollnick, Heather, Gold, and Hall (1992) developed a short "readiness to change" questionnaire for use with excessive problem drinkers. The categorical stage of change measure was found to be useful in designing brief interventions tailored to the particular stage. Snow, et al. (1994) utilized the stages of

change model with members of Alcoholics Anonymous (AA) in order to study the processes of change associated with long-term sobriety. They found a consistent, positive relationship between the use of behaviorally oriented change processes and increased involvement with AA. Less involvement with AA was correlated with less use of these processes of change.

Synthesis and Research Question

Internalized homophobia is the internalization of external oppression and discrimination (homophobia) that occurs as identity develops among gay men. As such, internalized homophobia is both a psychological and social risk factor in the etiology of alcohol dependence. This study examines gay men attempting self-change from alcohol use to assess the variance in alcohol use patterns and stages of change associated with differing levels of internalized homophobia.

The following hypotheses were tested to further the understanding of the relationship between internalized homophobia, stages and processes of change, and alcohol use among gay men.

1. Alcohol use and alcoholism: Gay men who indicate by self-report that they self-identify as alcoholic will

have higher alcohol use scores than gay men who do not self-identify as alcoholic.

2. Internalized homophobia and alcohol use: (a) Internalized homophobia scores will be higher for gay men who self-identify as alcoholic than for gay men who consider themselves non-alcoholic, and (b) Scores on a measure of internalized homophobia will be positively correlated with scores on an alcohol use measure.
3. Internalized homophobia and stages of change: (a) Scores on a measure of internalized homophobia will be negatively correlated with a measure of readiness to change, and (b) Scores on a measure of internalized homophobia will vary across a measure of discrete stages of change.
4. Internalized homophobia and processes of change: Gay men with a high level of internalized homophobia will score lower on measures of processes of change than gay men with a low level of internalized homophobia.
5. Predicting alcohol use: Scores on an alcohol use measure can be predicted by scores on a stage of change measure and by scores on a measure of internalized homophobia.

METHODS

Participants

This study obtained valid surveys from 79 adult gay men. This study asked men to define their sexual orientation along a Kinsey-type scale that presents sexuality as a continuum rather than dichotomous categories. Men were included in the study if he identified as bisexual or homosexual. All participants were 18 years of age or older. Efforts were made to include gay men from various ethnic and socioeconomic groups by advertising in newspapers with broad reader bases and contacting gay organizations that include a representative number of gay men of color. A sentence encouraging men of color to participate was included in both the flier and newspaper advertisements.

Materials

A survey asking for demographic information and containing five instruments was distributed to each participant. These instruments were the Commitment to Change Algorithm (CCA), the University of Rhode Island Change Assessment Scale (URICA), the Processes of Change Scale (POC), the Revised Nungesser Homosexual Attitudes Inventory (RHNAI), and the Alcohol Use Inventory (AUI). A cover letter explaining the instructions and assuring participants of

anonymity was included. A brief, written statement of informed consent was included in the survey, but participants were asked to check a consent box rather than sign the form to protect their privacy.

Measures

The Commitment to Change Algorithm (CCA). Participants were classified into one of five discrete stages of change categories on the basis of their response to the CCA developed by Annis, Shober & Kelly (1996). The CCA was adapted from the University of Rhode Island Change Assessment scale (URICA; McConaughy, Prochaska & Velicer, 1983), the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller, et al., 1990), and the Readiness to Change Questionnaire (Rollnick et al., 1992) for use with alcoholics and for quick and accurate classification into a single stage.

The CCA classifies a participant into one of five stages of change based upon recent self-reported drinking, intention to change, and quit or change attempts. Participants are placed in the highest stage for which they qualify according to the following definitions:

- (a) Precontemplation Stage: participants are classified into the Precontemplation Stage if they

have engaged in drinking during the last 30 days and are not considering quitting or reducing drinking within the next 30 days.

(b) Contemplation Stage: participants are classified into the Contemplation Stage if they have engaged in drinking during the last 30 days but are considering quitting or adopting reduced drinking limits within the next 30 days.

(c) Preparation Stage: participants are classified into the Preparation Stage if they have engaged in drinking in the last 30 days but have also followed through on at least one quit attempt or one attempt to adopt reduced drinking limits during the past 30 days.

A) Action Stage: participants are classified into the Action Stage if they have been continuously abstinent from alcohol during the last 30 days or have successfully adhered to a reduced drinking limit during the last 30 days.

B) Maintenance Stage: participants are classified into the Maintenance Stage if they have been continuously abstinent from alcohol for more than the last 60 days or have successfully adhered to a reduced drinking limit for more than the last 60 days.

Test-retest reliability for the CCA has been reported as high by Schober and Annis (1995), and analyses are ongoing which examine the convergent validity of the CCA, the predictive validity of the CCA in relation to treatment retention and outcome, and the relationship of health beliefs to CCA stages of change.

The CCA was selected because it is self-administered, valid, reliable, and brief. The instrument has been used successfully in clinical settings for quick and distinct categorization of alcohol dependent participants.

The University of Rhode Island Change Assessment Scale (URICA). This scale provides a continuous measure of the stages of change (McConaughy, Prochaska & Velicer, 1983). It operationally defines four theoretical stages of change (Precontemplation, Contemplation, Action and Maintenance) identified by DiClemente and Prochaska (1982). The scale consists of 32 items, with eight items measuring each stage subscale. Responses are given on a 5-point Likert scale (1= strong disagreement to 5= strong agreement). Subscale scores are summed and scores on each of the four stages are obtained for each participant. Items are written to assess the relevant change motivation of a specific "problem," in this

case, alcohol use. The total score on the URICA represents an estimate of overall readiness to change.

Internal consistency for each scale is quite high (Coefficient Alpha ranging from .88 to .89). Interscale correlations form a pattern consistent with the Stage of Change theory.

The URICA was selected because it is self-administered, valid, reliable, and brief. The instrument has been used successfully in prior research on alcohol use patterns with outpatient participants.

The Processes of Change Scale (POC). Processes of change are assessed by a 65-item scale developed by Prochaska and DiClemente (1985) and Prochaska, Velicer, DiClemente and Fava (1988) for use with smokers. The adapted questionnaire asks participants to indicate how frequently they make use of a wide variety of activities to avoid using alcohol on a 5-point Likert style format. The processes of change are presented in Table 3 of this paper.

Extensive reliability and validity data have been reported on the Processes of Change in Prochaska et al. (1988).

The Revised Nungesser Homosexual Attitudes Inventory (RHNAI). Internalized homophobia is assessed with the

Revised Nungesser Homosexual Attitudes Inventory (RNHAI), a 36-item scale made up of three subscales that measure attitudes toward one's own homosexual feelings (RHNAI Self), homosexuality in general (RHNAI General), and attitudes toward disclosure of one's own homosexuality (RHNAI Disclosure) (Shidlo, 1994). Each item consists of a statement along with a 4-point Likert scale on which participants are asked to rate the extent to which they agree or disagree with the statement. Total scores are divided by the number of items.

RHNAI scores are positively associated with psychological distress (.43; SCL-90-R), and negatively associated with self-esteem (-.56), self-confidence (-.42), and overall social support (-.25).

Internal reliability has been reported at .90 for this instrument (Shidlo, 1994).

The RHNAI was selected because it has the highest validity and reliability among measures of internalized homophobia, and has been used extensively with gay men.

The Alcohol Use Inventory (AUI). This scale consists of 147 items in a multiple-choice format which results in 22 scales and dimensions; 16 primary scales, 4 second order factors represent broader dimensions of alcohol use, and a

final single factor which measures general alcoholism (see Appendix C). The items cover 3 conceptually distinct domains: styles of alcohol use, unfavorable consequences of drinking (symptoms), and beneficial consequences of drinking (Wanberg, Horn, & Foster, 1977; Wanberg & Horn, 1983). The single general alcoholism factor will be used as the primary indicator of alcohol use patterns in this study. Responses are given in a dichotomous presence-absence format or in a 3-point response allowing for gradations. Scores are summed and plotted against a normative sample of over 2000 hospitalized alcoholics.

The scales of the AUI were first standardized on a population of 2261 problem drinkers admitted to short-term inpatient alcoholism treatment. Internal consistency correlations between the 16 AUI scales are high.

The AUI was selected because it is a multidimensional measure of alcoholism that allows for both continuous and differential assessment of a wide variety of alcohol use patterns and effects. It has also been used successfully as a multidimensional diagnostic instrument.

Demographic items. Demographic items included in the survey include age in years, ethnicity (Caucasian, African-American, Asian-American, Latino/Hispanic, Native-American,

and other), and education in years. In addition, several items related to the development of identity as an alcoholic were included, for example, "do you consider yourself to be an alcoholic?" and "have you ever tried to control your drinking to prevent it from becoming a problem?"

Design and Procedure

Recruitment of Subjects

A variety of methods were used to obtain participants. Care was taken to avoid recruiting subjects from traditional bar outlets to prevent skewed data. Data were gathered from across the United States. Advertising using a 4" x 4" copy was placed in the Bay Area Reporter, a gay weekly newspaper with a San Francisco Bay Area circulation. Mailings were sent to 32 gay community centers across the United States. Fliers were posted in San Francisco and San Diego gay community shops such as coffee houses and alcoholics anonymous clubs. Fliers contained three ways to receive a survey; by mail, via e-mail, and via the Internet (website). Participants requesting surveys by mail were given a phone number to call to request a survey. Surveys were then mailed out the same day. E-mail surveys were sent upon receipt of an e-mail request. Internet surveys were available immediately for download and completion. Each advertisement

contained assurances that all responses were confidential and that addresses would be destroyed immediately after surveys were sent. Each survey packet contained a questionnaire with a cover letter, and in the case of mailed surveys, a preaddressed, postage paid reply envelope.

Since individuals responded anonymously to the survey, a follow-up post card was not sent as a reminder to return the surveys.

RESULTS

Demographics

Survey packets were sent to 49 gay men who responded to posted flyers or the newspaper advertisement. A total of 48 (98%) participants returned the survey. 150 surveys and accompanying flyers were sent to 30 gay community centers and sober living groups across the United States. A total of 33 participants (20%) completed and returned the survey. Of the 81 total responses, 2 surveys were considered invalid for the study because of incomplete questionnaires. For the purposes of this study, men identifying as predominantly gay, but significantly heterosexual ($n = 3$); predominantly gay, but only slightly heterosexual ($n = 10$); and exclusively gay ($n = 66$) were included.

Most of the participants indicated their state of residence was California (75%). However, responses were obtained from nine different states including Wisconsin (10%) and Colorado (6%).

Table 4 presents an overview of demographic data for this sample, and Table 5 presents an overview of scores on the internalized homophobia, alcohol use, and continuous stage of change measures. Participants were categorized into one of five discrete stages based upon responses to the CCA:

Precontemplation ($\underline{n} = 20$), Contemplation ($\underline{n} = 7$), Preparation ($\underline{n} = 5$), Action ($\underline{n} = 11$), and Maintenance ($\underline{n} = 36$).

Research Hypotheses

The first hypothesis predicted that gay men who indicate by self-report that they consider themselves alcoholic will have higher alcohol use scores than gay men who self-identify as not alcoholic. Results demonstrate significantly higher alcohol use scores for alcoholics than for non-alcoholics on three of the four alcohol use scales. Table 6 demonstrates the differences between alcoholics and non-alcoholics on the different alcohol use measures. An unexpected finding was that the alcoholic and non-alcoholic participants are equivalent on the measure of drinking to enhance functioning. The means for the alcoholic group are consistent with the norms for the AUI on a population of outpatient alcoholics.

The second research hypothesis predicted that internalized homophobia would be higher for men in the alcoholic group than for men in the non-alcoholic (comparison) group. There was a significant difference between these two groups on three of the four internalized homophobia measures (see Table 7). This finding suggests

Table 4

Means, Standard Deviations, Minimums and Maximums and
Percents of Demographic Data

Variable	<u>M</u>	<u>SD</u>	Minimum	Maximum
Age	42.95	10.94	21	79
Variable	<u>N</u>		<u>%</u>	
Ethnicity				
Caucasian	62		78	
African-American	6		8	
Latino / Hispanic	8		10	
Native American	3		4	
Education				
Did not complete high school	4		5	
High school graduate	14		18	
Some college or specialized training	17		22	
Associate Degree	8		10	
Bachelors Degree	20		25	
Masters Degree	14		18	
Doctoral Degree	2		2	
Out of the Closet	74		94	
Self-Identified Alcoholic	45		57	
Alcoholics Anonymous				
Currently Participating	37		47	
Has Ever Participated	51		65	
Family Alcoholism				
Father Figure*	50		63	
Mother Figure**	28		35	
Aunt(s)	24		30	
Uncle(s)	41		52	
Sister(s)	14		18	
Brother(s)	26		33	
Grandparent(s)	36		46	

Note. *Includes biological, adoptive, or stepfather.

**Includes biological, adoptive, or stepmother.

Table 5

Means and Standard Deviations for Internalized Homophobia,
Stages of Change and Alcohol Use Measures (N=79)

Measure	<u>M</u>	<u>SD</u>	Minimum	Maximum
Internalized Homophobia (RHNAI)				
Total Score	1.70	.48	1.06	3.75
Attitudes toward Homosexual features in one's self (RHNAI Self)	1.68	.59	1.00	3.93
General anti-homosexual attitudes (RHNAI General)	1.65	.48	1.00	3.56
Attitudes toward self- disclosure of homosexuality (RHNAI Disclosure)	1.74	.51	1.00	3.69
Alcohol Use (AUI)				
Broad involvement with alcohol (ALCINVOL)	26.94	17.97	0.00	63.00
Drink to improve sociability (SOCIALIM)	4.33	2.71	0.00	9.00
Perceptual withdrawal symptoms (DELIRIUM)	4.10	3.81	0.00	14.00
Drink to enhance functioning (ENHANCED)	7.03	4.47	0.00	15.00
Stage of Change (Continuous Measure - URICA)				
Total Score (Readiness)	3.10	.74	1.22	4.09
Precontemplation Stage	2.33	.80	1.00	3.83
Contemplation Stage	3.54	.99	1.29	5.00
Action Stage	3.57	1.12	1.00	5.00
Maintenance Stage	3.04	1.17	1.00	4.86

that internalized homophobia is higher among alcoholics than non-alcoholics, and is consistent with the hypothesis.

Table 6

Sample Means and Significance on Alcohol Measures across
Alcoholic and Comparison Groups

Alcohol Use Scale (AUI)	Alcoholic (<u>n</u> = 45)	Non- alcoholic (<u>n</u> = 34)	<u>t</u>
Broad involvement with alcohol (ALCINVOL)	37.84	12.50	-8.67**
Drink to improve sociability (SOCIALIM)	5.18	3.20	-3.41**
Perceptual withdrawal symptoms (DELIRIUM)	6.00	1.72	-6.20**
Drink to enhance functioning (ENHANCED)	7.56	6.32	-1.22

Note. ** $p < .001$.

Table 7

Mean Differences on Internalized Homophobia Measures for
Alcoholic Groups

Internalized Homophobia Scale	Alcoholic	Non- Alcoholic	Statistic
	<u>M</u>	<u>M</u>	<u>t</u>
RHNAI Total	1.77	1.59	-1.70*
RHNAI Self	1.78	1.55	-1.73*
RHNAI General	1.74	1.54	-1.76*
RHNAI Disclosure	1.79	1.66	-1.11

Note. * $p < .05$.

Part (b) of the second hypothesis predicted that scores on a measure of internalized homophobia would be positively correlated with scores on an alcohol involvement measure. Results found a significant association between internalized homophobia and alcohol use for all participants, $r = .26$, $p < .05$. As predicted, this finding indicates that alcohol use tends to be higher among gay men with higher internalized homophobia scores.

The third hypothesis of this study predicted that scores on a measure of internalized homophobia would be negatively correlated with an overall measure of behavior change. Contrary to expectations, results indicated that internalized homophobia was positively correlated with the readiness to change score, $r = .32$, $p < .01$. Thus, the prediction that internalized homophobia would hamper readiness to change was not realized. This finding, contrary to prediction, may suggest that increases in discomfort caused by higher levels of internalized homophobia may be associated with a greater readiness to change problematic alcohol use behavior.

The second part of hypothesis three predicted that scores on a measure of internalized homophobia would vary across a measure of discrete stages of change. It was expected that internalized homophobia would be highest in the

earliest stages of change, and steadily decrease as gay men worked through the stages of change. Findings instead suggest that the highest levels of internalized homophobia occur in the action stage (4th of 5 stages), and that this stage is the only one to differ significantly from the others. Post-hoc tests (see Table 8) showed that internalized homophobia scores of people at the action stage differ significantly from the precontemplation, preparation, and maintenance stages, which did not differ from each other. Also, the level of internalized homophobia in the contemplation stage did not differ from the action stage. Table 8 shows the means for the internalized homophobia measures across the discrete stages of change. This finding indicates that the highest level of internalized homophobia is associated with the action stage of change, a time in which the individual is actively taking steps to change the alcohol use pattern. Rather than the expected finding that highest levels of internalized homophobia would be associated with a stage of "not thinking about alcohol as a problem (the precontemplation stage)," this result indicates that internalized homophobia is highest when an individual is making active efforts to change their behavior. It is unclear whether the changes being made in the action stage

are causing the individual to be more aware of their internalized homophobia, whether the psychological demands of the action stage (early sobriety) confront people with anxieties which they can no longer drown out with alcohol, or whether the higher internalized homophobia is a catalyst for the behavior changes in this stage (for example, "I don't like myself and I need to change something").

Table 8

Internalized Homophobia Means by Discrete Stage of Change

Measure	PC	C	P	A	M
Internalized Homophobia (RHNAI Total)	1.53 ^b	1.72 ^{ab}	1.56 ^b	2.25 ^a	1.62 ^b
RHNAI Self	1.46 ^b	1.73 ^{ab}	1.46 ^b	2.37 ^a	1.62 ^b
RHNAI General	1.58 ^b	1.52 ^b	1.53 ^b	2.30 ^a	1.54 ^b
RHNAI Disclosure	1.58 ^a	1.84 ^a	1.69 ^a	2.09 ^a	1.70 ^a

Note. ^a & ^b signify significant post-hoc comparison

differences across cluster groups. When ^b appears more than once in the same row, these clusters do not differ from each other, but differ from the cluster marked ^a. Stages of Change (PC = Precontemplation, C = Contemplation, P = Preparation, A = Action, and M = Maintenance).

The fourth hypothesis predicted that gay men categorized as having high levels of internalized homophobia will score lower on a processes of change measure than gay men categorized as low internalized homophobia. Participants were categorized into high and low internalized homophobia groups by a median split procedure ($mdn = 1.61$). Results suggest that there are no significant differences in the processes of change used between low and high internalized homophobia groups, with one exception. Table 9 provides the means and standard deviations for each process of change for both the high and low internalized homophobia groups. This finding suggests that internalized homophobia only affects the process of change called dramatic relief. It was expected that higher levels of internalized homophobia would result in the use of fewer processes of change, but the results suggest an opposite effect. Therefore, there is little effect of internalized homophobia on the processes of change used by gay men to move from one stage to another as they attempt to change their alcohol use patterns.

Subsequent ad hoc analyses of the processes of change involved in achieving sobriety were conducted. Participants were grouped into three categories as follows: (a) never participated in Alcoholics Anonymous (AA), (b) have

Table 9

Processes of Change for Low and High Internalized HomophobiaGroups

Process of Change	Low Internalized Homophobia		High Internalized Homophobia		<u>t</u>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
Stimulus Control	2.60	1.43	3.05	1.18	-1.52
Counter- conditioning	2.92	1.02	3.08	1.10	-.72
Contingency Management	2.35	.85	2.48	.73	-.72
Helping Relationship	3.18	1.48	3.16	1.36	.04
Social Liberation	2.74	.81	2.82	.84	-.43
Environmental Reevaluation	2.78	1.14	3.18	.96	-1.65
Consciousness Raising	2.32	1.15	2.74	1.00	-1.76
Dramatic Relief	2.28	.98	2.76	.91	-2.30*
Self-liberation	3.13	1.12	3.26	1.04	-.52
Physical Interventions	1.30	.46	1.59	.82	-1.88
Reinforcement Management	3.00	1.18	3.15	1.01	-.61
Feedback	2.92	1.42	3.04	1.16	-.40
Self-reevaluation	2.94	1.26	3.20	.98	-1.03

Note. * $p < .05$. See Appendix E for variations in the processes of change.

participated in AA in the past but are not currently participating, and (c) are currently participating in AA. Results are consistent with those found by Snow et al. (1994), when participants were grouped by exposure to AA (never, past, current). Snow et al. found a significantly greater use of helping relationships, stimulus control and behavior management processes among the AA - current group than either the AA - past or AA - never groups. The current study provides additional evidence that processes of change are influenced by AA exposure and involvement. Table 10 presents the post hoc Tukey procedures for processes of change by AA exposure grouping. These findings suggest that AA exposure and involvement significantly increase the use of processes of change used to move from one stage of change to another.

Post hoc analyses found internalized homophobia to be the same across AA exposure groups.

Hypothesis five proposed that scores on a stage of change measure and an internalized homophobia measure could predict alcohol use scores. Stage of change was coded as a categorical variable using dummy coding and was entered as a block. Individual regression coefficients for any stage of change in the model represent the distance from the reference

Table 10

Processes of Change Means for AA Never, Past and Current
Groups

Process of Change	Mean Scores		
	AA Never (<u>n</u> = 28)	AA Past (<u>n</u> = 14)	AA Current (<u>n</u> = 37)
Stimulus Control	1.66 ^a	2.42 ^b	3.88 ^c
Counter-conditioning	2.17 ^a	2.71 ^b	3.74 ^c
Contingency Management	1.76 ^a	2.47 ^b	2.89 ^c
Helping Relationships	1.96 ^a	2.60 ^b	4.30 ^c
Social Liberation	2.28 ^a	2.70 ^b	3.18 ^b
Environmental Reevaluation	2.08 ^a	3.06 ^b	3.64 ^c
Consciousness Raising	1.64 ^a	2.30 ^b	3.31 ^c
Dramatic Relief	1.71 ^a	2.66 ^b	3.10 ^c
Self Liberation	2.49 ^a	2.94 ^b	3.77 ^b
Physical Interventions	1.32 ^a	1.58 ^a	1.50 ^a
Reinforcement Management	2.30 ^a	2.68 ^b	3.82 ^b
Feedback	1.83 ^a	2.78 ^b	3.94 ^c
Self Reevaluation	2.22 ^a	3.24 ^b	3.66 ^c

Note. ^a, ^b and ^c signify significant post-hoc comparison

differences across cluster groups. Means that share the same superscript do not differ from each other. See Appendix E.

group, which is the Precontemplation stage. The first model tested stages of change alone, and the second model added internalized homophobia to the regression equation. Results from a multiple regression analysis indicate that alcohol use scores can be predicted by discrete stage of change and

internalized homophobia, although the addition of internalized homophobia to the model did not produce a statistically significant increase in prediction. Table 11 summarizes the results of the regression analysis. These findings indicate that the level of alcohol involvement can be predicted by the participant's stage of change. Internalized homophobia, by itself, is also a reliable predictor of alcohol involvement.

However, internalized homophobia did not produce a significant increase in the ability to predict alcohol involvement over stage of change alone. The high correlation between internalized homophobia and the action stage of change ($r = .47$, $p < .05$) may account for this. Because these two variables are so highly correlated, the addition of internalized homophobia to the model was not statistically significant. This finding substantiates the relationship between internalized homophobia and the action stage that was demonstrated in the results for hypothesis three, which suggested that internalized homophobia is highest when an individual is making active efforts to change their behavior.

Table 11

Summary of Hierarchical Regression Analysis for Variables
Predicting Alcohol Involvement (N=79)

Variable	B	SE B	β	F
Model 1				6.70*
Precontemplation stage (reference)				
Contemplation stage	4.08	6.94	.06	
Preparation stage	11.65	7.90	.16	
Action stage	27.19	5.93	.52	
Maintenance stage	16.90	4.40	.47	
Model 2				5.50*
Block 1				
Precontemplation stage (reference)				
Contemplation stage	3.38	6.99	.05	
Preparation stage	11.56	7.91	.16	
Action stage	24.44	6.68	.47	
Maintenance stage	16.54	4.43	.46	
Block 2				
Internalized Homophobia (RHNAI Total)	3.86	4.30	.10	

Note. $R^2 = .26$ for Block 1; $R^2 = .27$ for Block 2; $F = .198$,

ns.

* $p < .001$.

DISCUSSION

The purpose of this study was to examine the relationship between internalized homophobia, stages and processes of change, and alcohol use among gay men. A positive relationship was found between internalized homophobia and alcohol use among gay men. Further, gay males who thought of themselves as alcoholics had significantly higher levels of internalized homophobia than those who indicated they were non-alcoholics, except for the self-disclosure measure. The self-disclosure scale of the internalized homophobia measure reflects the individual's attitudes toward self-disclosure of their homosexuality. It is important to note that this sample was overwhelmingly composed of men who described themselves as "out of the closet". Therefore, participants with concerns about self-disclosure were not likely to participate in the study, because those individuals probably were not affiliated with gay community centers.

The relationship between internalized homophobia and alcohol use demonstrated in this study is consistent with clinical observations (Cabaj, 1989; Finnegan & Cook, 1984; Glaus, 1988; Nardi, 1982) that suggest a relationship between a gay man's attitudes about his sexual orientation and his

alcohol use. These findings are also consistent with prior research that demonstrated a significant positive correlation between internalized homophobia and alcohol dependence (Burris, 1996) and alcohol consumption (Cherry, 1996). Cherry (1996) found that participants with the most severe drinking problems reported the highest levels of internalized homophobia. This study supports the relationship between internalized homophobia and alcohol use among gay men noted by clinical observations and other research.

The relationship between internalized homophobia and alcohol use suggests support for the hypothesis of self-medication as a cause of alcohol use. The internal discomfort caused by feelings of shame and self-loathing are effectively deadened by alcohol use. Cabaj (1996) argues that the use of alcohol to relieve self-loathing is then reinforced during the withdrawal period, when feelings of self-loathing reemerge and lead again to drinking. Further, gay men may be at a higher risk to acquire alcohol problems due to the environments in which socialization occurs, namely, bars and nightclubs. Alcohol disinhibits forbidden behaviors, such as homosexual sex, and provides comfort through numbing, dissociation, and isolation of feelings (Cabaj, 1996). In addition, the gay community has a

longstanding relationship with bars as its social foundation. This situation developed because bars were the only safe environments in which to socialize as a gay person. Although today there are many more opportunities to socialize with other gay people outside of bars, for example, community centers, the bar is still an important institution in gay communities.

The clinical evidence that internalized homophobia and alcohol use are related suggests that when providing treatment for alcohol use, practitioners should work to encourage a sense of positive sexual identity. One way to achieve this would be to utilize a clinical internalized homophobia intervention such as the one developed by Purvis (1994). He developed an interactive workbook on internalized homophobia to aid the clinician in providing treatment for internalized homophobia.

Contrary to prediction, the results of this study found that internalized homophobia is positively correlated with overall readiness to change. The discomfort caused by high levels of internalized homophobia seems to be associated with a strong desire to change alcoholic behavior, just as internalized homophobia was strongly associated with alcohol use. This suggests that internalized homophobia may be an

impetus to change, rather than the hypothesis that internalized homophobia would decrease as a result of change. In this case, it may be useful to think of internalized homophobia as a change agent. Internalized homophobia may generate readiness to change because of internal feelings of discomfort that are not yet remedied by taking action. Thus, internalized homophobia may increase push people with alcohol problems toward change.

The process of increasing internalized homophobia as the individual moves toward change parallels the move from being in the closet toward coming out in the developmental sequence described by the gay identity model (Cass, 1996). During the identity tolerance stage, an individual begins to make contact with the gay community. With the first contact there are accompanying losses of denial and suppression of one's homosexuality. This first act of coming out is accompanied by upheaval of feelings (guilt and shame about being gay) and a sense that nothing is as it once was. This shift toward disclosure results in a discomfort that parallels the increase in internalized homophobia as one moves toward change from addictive behaviors.

The development of a positive gay identity depends on an individual's ability to internalize positive experiences with

the gay community, and to ignore less positive contacts. This stage represents the external process of satisfying social, emotional, and sexual needs, while the following stage represents the development of an internal sense of gay identity. Only with a firm and positive self-identity can the individual buffer the external negativity and oppression of homophobia. Similarly, increases in internalized homophobia, as a reflection of internal upheaval, signify an internal push toward readiness to change. Thus, the increase in internalized homophobia as one begins to take action to address problems with alcohol use may signify a "coming out" about alcoholism.

One unexpected finding in this study was that internalized homophobia is highest in the action stage of change. Contrary to the notion that internalized homophobia would decrease incrementally across stages of change, the results suggest that internalized homophobia is significantly higher at the beginning of an individual's active efforts to change. Once an individual begins to make overt modifications to the problematic drinking behavior, which was defined in this study as having reduced or eliminated drinking for a period of at least 30 days, their internalized

homophobia peaks at the highest level of all of the stages of change.

A variety of internal psychological processes may contribute to the escalation of internalized homophobia in the action stage. Cherry (1996) suggests that high levels of internalized homophobia associated with being in substance abuse treatment may be the result of depression common in early recovery and detoxification from alcohol, or from a self-esteem or self-concept adjustment due to coming to terms with substance abuse. Recovery programs tend to encourage participants to be honest about their feelings and to examine unresolved issues that contribute to the alcohol problem (Cherry, 1996).

Finnegan and McNally (1987) suggested that alcohol might be used to self-medicate anxiety and depression that result from internalized homophobia. It follows that when the medication (alcohol) is removed, which occurs in the action stage, the underlying anxiety and depression would emerge.

Brown (1977, 1996) compared the self-loathing and self-hatred associated with the downward spiral of addictive drinking to a mirror process of recovery that begins with abstinence from drinking. She found that an alcoholic has a negative self-concept when drinking, but also when sober.

Data from her study (Brown, 1977) showed 90% of her sample reported depression in initial sobriety, as well as anxiety and fear (40%). During the initial abstinence phase, alcoholics reported feelings of guilt and concern about their past behavior as well as feelings of self-disgust, self-loathing and hatred. Brown argues that depression may be the first feeling to emerge after the deadening effects of alcohol, and that the depression may be due to facing up to one's inadequacies, doubts, self-destructive behavior, losses, guilt and shame. The same processes are implicated for gay alcoholics, and the shame due to their homosexuality can only compound these feelings.

For these reasons, gay men in the action stage of change may demonstrate higher levels of internalized homophobia. Clinicians should be aware of the raw and sensitive emotions (previously medicated away) that accompany this stage of change, and help the client to modulate feelings more appropriately by (a) normalizing the experience of distress at this stage, (b) providing information and practice on self-soothing techniques and (c) promoting a sense of patience and self-acceptance. Clinicians should be aware that gay AA meetings could assist the client by providing a positive environment in which to talk about both alcoholism

and internalized homophobia. Gay AA meetings affirm the individual's sexual orientation and provide a positive social contact with the gay community that can be influential in the identity development process.

Clinicians should focus treatment for individuals in early recovery on reducing anxiety by providing a more structured setting. Interventions should be concrete and need to actively support dependence on self-help organizations such as Alcoholics Anonymous (AA). The individual in the first 30 days of sobriety will seek alcohol to drown out feelings that arise, and the therapist should work at problem-solving solutions that encourage other behaviors instead of drinking. The previously obsessive relationship with drinking must be converted to a model of symptom substitution, where thinking about drinking is replaced with active behavioral changes such as going to an AA meeting or talking with a clinician. The goal for a clinician at this early stage is to encourage active sublimation of wishes to drink.

Clinicians should also be wary of the overconfidence displayed by some individuals in early recovery, which transitions to a deep sense of powerlessness as the individual realizes the magnitude of the problem they are

confronting; a problem the individual thought was solved by simply not drinking. It would be useful to clinicians to conceptualize sobriety as the first stage in a recovery process that mirrors the downward spiral of drinking (Brown, 1996). Early recovery is characterized by cyclical changes in self-esteem, not linear steps. For the gay male client, the process of recovery from alcohol is integrated with, not independent from, the amelioration of internalized homophobia and the development of a positive self-identification. The recognition of problems beyond alcohol use (redefining the self) can only begin when the drinking stops, and those problems are core to an individual's life and identity (Brown, 1977).

This study sought to explore the impact of internalized homophobia on the processes of change. This study expected to find that the processes of change involved in overcoming alcohol use problems would also significantly reduce internalized homophobia. The hypothesis that internalized homophobia would be reduced through the process of change was based upon the reasoning that the behavior change resulting from reducing or abstaining from alcohol use would similarly effect the level of internalized homophobia. Findings suggested that internalized homophobia does not impact the

specific processes of change used in behavior change, and that internalized homophobia is highest during the initial efforts to make overt behavior change. It was hypothesized that processes of change used by gay men with high levels of internalized homophobia would differ from the processes of change used by gay men with low levels of internalized homophobia. With one noteworthy exception, there was no difference in the processes of change used by gay men with low or high levels of internalized homophobia.

Gay men with high levels of internalized homophobia used the process of change called dramatic relief, which involves experiencing and expressing feelings about one's problems and solutions, more than gay men with low levels of internalized homophobia. This suggests that the discomfort of high levels of internalized homophobia, particularly in the action stage of change, may lead to more expression of these feelings. Clinicians should act to support expression of the discomfort, and in doing so, maximize the benefit of the dramatic relief process. Dramatic relief is best achieved through the methods of role-playing and psychodrama (Prochaska, DiClemente & Norcross, 1992).

Additional comparisons of the processes of change and the impact of Alcoholics Anonymous (AA) exposure demonstrated

that exposure to AA significantly increases the use of all processes of change. These findings are consistent with Snow et al. (1994), and suggest that group differences in coping activities may be attributed to exposure to AA. Snow et al. measured three dimensions of AA membership (a) exposure, (b) extent of involvement, and (c) affiliation. Exposure was measured by participation in AA across three levels (a) never participated, (b) have participated in the past, and (c) are presently participating.

Rather than internalized homophobia impacting the use of processes of change, AA exposure is the significant predictor of use of a process of change. Snow, et al. (1994), found a pattern of extremely high use of these behavior change processes by AA participants even after long periods of continuous sobriety. Results show that involvement with AA provides the permanent behavior change that many gay men with alcohol use problems may be seeking. Similarly, Snow et al. found that exposure to AA and the extent of involvement with AA were both significantly correlated with a total change score and higher levels of the processes of change. The researcher concluded that AA reflects a means to the processes of change that is more accessible, less taxing, and more structured than self-change alone. Further, processes

of change relate more to symptom-specific change (decreased alcohol use) than to long-term participation in AA.

The current study found that AA exposure did not affect the level of internalized homophobia, and this issue warrants further research. Clinicians should encourage gay men with alcohol use problems to consider involvement with AA as one step in the change process.

This study demonstrated that stages of change and internalized homophobia are both predictors of alcohol involvement. While internalized homophobia did not significantly improve prediction when added to the stage of change, the relationship between internalized homophobia and the action stage is significant and may account for the results. Again, it will be quite useful for clinicians to evaluate and provide treatment for the individual based upon their stage of change, as has been suggested by Prochaska, et al. (1992). Further, Miller and Rollnick (1991) provide detailed interventions for a two-phase model of treatment that (a) builds motivation for change and (b) strengthens commitment to change. Their work documents a variety of clinical applications of the stages of change model for changing behavior in the therapeutic environment.

Clinicians working with gay male clients who are attempting to change their alcohol use patterns should recognize the important role of internalized homophobia in their clients' success. Clinicians should be aware that clients in the action stage will have the highest levels of internalized homophobia, and should recognize that the alcohol recovery process will parallel the amelioration of internalized homophobia. Both processes occur through the course of self-redefinition that accompanies the developmental model of recovery (Brown, 1996). And finally, clinicians should be aware that the tools of change, the processes of change incorporated in the stage of change model, are most easily accessed through exposure to AA.

Limitations of the Study

There are several factors that should be considered when interpreting the results of this study. All of the measures in this research were self-report scales, asking participants to respond to personal questions about their homosexual attitudes, alcohol use, and desires to change problematic alcohol use behavior. Participants tend to be influenced by factors of social desirability, and may underreport socially undesirable, stigmatized or severely problematic behavior. Reluctance to appear undesirable may have influenced the

level of accuracy of the alcohol use data. However, since the survey was anonymous, the social desirability factor may be lessened.

The questionnaire was lengthy and required about an hour to complete, which may have decreased participation rates.

The alcohol use inventory measures lifetime involvement with alcohol, as well as many other dimensions of alcoholism. It does not provide an adequate measure of drinking patterns, such as historical and present drinking behavior. Future studies should incorporate a drinking pattern measure to facilitate the distinction between active drinkers and those in sobriety. Historical drinking patterns of those currently in sobriety may further illustrate the complexity of alcohol use behavior. The Alcohol Use Inventory measure was unclear to some participants in the study that were in recovery. Questions are worded in the present tense, but participants answered the questions for past drinking behavior. For purposes of this study, alcohol use was conceptualized as lifetime involvement with alcohol. Future research should distinguish between past and present alcohol use in order to further clarify the relationship between alcohol use and internalized homophobia.

The sample size of this study was small ($N = 79$), and the participants in this study were self-selected. While the active recovery community were well represented in the sample, it was more difficult to obtain participants in the precontemplation, contemplation and preparation stages of change. Thus, it is difficult to make generalizations from these findings to a wider population.

There are several problems that could be corrected if this study were to be replicated. First, the size of the sample should be increased, and should more evenly represent participants in all stages of change. Perhaps conducting this research in conjunction with an alcohol treatment program would provide access to a larger number of participants. It might also be useful to conduct surveys at bars, given that many prospective participants may be in the precontemplation stage, where they do not consider their drinking a problem. To increase response rates, it might be useful to reduce the size of the questionnaire, in particular the processes of change scale and alcohol use inventory. By including only those items that relate to the specific processes of change and alcohol use of interest to the study, response time could be significantly reduced without impacting the integrity of the research.

The problem of finding participants with high levels of internalized homophobia is complex because those individuals are most likely not active in the gay community. The present study utilized an advertisement in a gay community newspaper, but future research could advertise in a wider variety of newspapers. Also, these papers should be selected from a group of cities representing both urban and rural populations. While mailers to gay community centers across the United States did generate a range of data variability on the internalized homophobia measure, only gay men who frequent the community centers were exposed to advertising about the study. Mailers, in combination with local newspaper advertising, might increase the response rate and data variability of the internalized homophobia measure.

The internalized homophobia scores in this sample demonstrated a very small range of variation ($M = 1.7$, $SD = .48$) given the range on the measure (range = 4), and this could affect the power of the statistical analysis. Individuals in the sample were self-selected from advertisements in gay newspapers and gay community centers, and as such, few individuals with higher levels of internalized homophobia would be likely to respond. Individuals with higher levels of internalized homophobia are

less likely to have disclosed their homosexuality and be affiliated with gay communities.

In order to reach more participants from a wider geographic area, the Internet may be a way to contact prospective participants, although these users may tend to be from a higher socioeconomic level. Novice computer users may also not be familiar with procedures required to download documents in different formats for different computer platforms. A web-based survey, rather than a download, might have simplified this procedure.

Directions for Future Research

There are several directions for further research as a result of this study. The first issue requiring further investigation is the relationship between AA membership and both internalized homophobia and processes of change. Snow et al. (1994) concluded that a reconceptualization of AA affiliation might assist with interpretation of the relationship between AA membership and processes of change. Snow et al. concluded that the concept of affiliation should be further specified by surveying AA members on the objective and subjective measures that should be included, as well examining these measures over the recovery time span. Future research should assess internalized homophobia across AA

exposure, involvement, and affiliation. Differences in internalized homophobia across these three constructs of AA membership may provide important insights into the relationship between internalized homophobia and AA membership. It would also be useful to examine the long-term relationship between internalized homophobia and recovery from alcoholism to determine how the process of redefining the self (Brown, 1977) through recovery impacts the level of internalized homophobia.

Future research should also examine the relationship between internalized homophobia and alcohol use from a longitudinal perspective. It would be beneficial to understand the changes in internalized homophobia as an individual moves through the stages of change, rather than by grouping individuals into stages of change.

Further, future research should consider alternate ways to conceptualize the stages of change model as a participant profile similar to the method used by DiClemente and Hughes (1990). Stages of change profiles were created using a cluster analysis of the URICA utilizing the hierarchical agglomerative method. A stage of change profile is a distinct and theoretically consistent grouping of the five stages of change. Stages of change profiles were then

available for comparison across processes of change. Future research could investigate levels of internalized homophobia and alcohol involvement for different profiles of change.

An additional method to study the relationship of internalized homophobia to alcohol use and change would be to conduct an internalized homophobia intervention (Purvis, 1994) on a group of gay men in early recovery. Pre- and post-intervention measures of internalized homophobia, along with follow-up measures of alcohol use, may elucidate the role of internalized homophobia in changing alcohol use behavior. The addition of a comparison group of non-alcoholics in such a study would facilitate the understanding of the role of internalized homophobia in the acquisition of alcohol dependence and the move toward sobriety.

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APPENDIX A

Homophobia Terminology

APPENDIX A

Homophobia Terminology

There is a wide variety of terminology used to describe what we currently know as homophobia, which also serves to complicate the construct to which this study refers. A brief summary of those definitions follows (in chronological order), (a) homoerotophobia (Churchill, 1968), a pervasive cultural fear of erotic or sexual contact between members of the same sex, (b) homophobia (Weinberg, 1972; Smith, 1971), a "personality" type that displays negative, fearful, and repressive responding to homosexuals and/or homosexuality, (c) homosexism (Lehne, 1976), which refers to the full dynamic of gender role fear and sexism, of which homophobia is but one part, (d) heterosexual bias (Morin & Garfinkle, 1978), which refers to a placing of superior value onto heterosexual over homosexual lifestyles, (e) homonegativism (Hudson & Ricketts, 1981), which refers to attitudes as opposed to affective reactions to homosexuality, (f) heterosexism (Rosenthal, 1982; Lorde, 1984; Neisen, 1990; Herek, 1996), which places themes of sexism and anti-homosexuality into a construct similar to other forms of social prejudice and/or oppression, (g) homosexual bias (Fyfe, 1983), which refers to cultural, attitudinal and

personal biases against homosexuals and reserves homophobia for actual phobic avoidance, (h) anti-homosexual prejudice (Reiter, 1991), which elucidated the difference in gender identity development with respect to the psychodynamic origins of homophobia, and (i) homoaggressiveness (O'Donohue & Casselles, 1993), which refers specifically to anti-gay violence.

Originally, homophobia was considered to be a fear-based construct, hence the "phobia" suffix. MacDonald (1976) was one of the first to argue that homophobia might best be reconceptualized as something other than a phobia in traditional terms. This has resulted in the present shift toward the use of the term heterosexism.

APPENDIX B

Definitions of Alcohol Abuse and Dependence

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Definitions of Alcohol Abuse and Dependence

The DSM-IV (1994) outlines the following general criteria for substance abuse:

- A) A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
- 1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
 - 2) recurrent substance use in situations in which it is physically hazardous
 - 3) recurrent substance-related legal problems
 - 4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
- B) The symptoms have never met the criteria for Substance Dependence for this class of substance.

Criteria specific to Alcohol Abuse (305.00) include the following:

- A) school and job performance may suffer wither from the aftereffects of drinking or from actual intoxication on the job or at school

- B) child care or household responsibilities may be neglected
- C) alcohol-related absences may occur from school or job
- D) the person may use alcohol in physically hazardous circumstances (e.g., driving an automobile or operating machinery while drunk)
- E) legal difficulties may arise because of alcohol use (e.g., arrests for intoxicated behavior or for driving under the influence)
- F) individuals may continue to consume alcohol despite the knowledge that continued consumption poses significant social or interpersonal problems for them (e.g., violent arguments with spouse while intoxicated, child abuse)

The criteria for substance dependence are as follows:
A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- A) tolerance, as defined by one of the following:
 - 1) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - 2) markedly diminished effect with continued use of the same amount of the substance
- B) withdrawal, as manifested by either of the following:
 - 1) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
 - 2) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

- C) the substance is often taken in larger amounts or over a longer period than was intended
- D) there is a persistent desire or unsuccessful efforts to cut down or control substance use
- E) a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
- F) important social, occupational, or recreational activities are given up or reduced because of the substance use
- G) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

Criteria specific to Alcohol Dependence (303.90) are as follows:

Physiological dependence on alcohol is indicated by evidence of tolerance or symptoms of withdrawal.

Alcohol Withdrawal (291.80) is characterized by the development of withdrawal symptoms 12 hours or so after the reduction of intake following prolonged, heavy, alcohol ingestion. The symptoms are as follows:

- A) Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
- B) Two (or more) of the following, developing within several hours to a few days after Criterion A.
 - 1) autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)

- 2) increased hand tremor
 - 3) insomnia
 - 4) nausea or vomiting
 - 5) transient visual, tactile, or auditory hallucinations
or illusions
 - 6) psychomotor agitation
 - 7) anxiety
 - 8) grand mal seizures
- C) The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D) The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

APPENDIX C

Scales of the Alcohol Use Inventory

APPENDIX C

Scales of the Alcohol Use Inventory

The scales of the Alcohol Use Inventory (Wanberg & Horn, 1972) can be summarized as follows:

1. Drink to improve sociability - social benefit
(SOCIALIM): high scores on this scale indicate the participant is reporting that alcohol helps them to relax socially, make friends, and decrease feelings of inferiority.
2. Drink to improve mental functioning - mental benefit
(MENTALIM): high scores on this scale indicate the participant believes that some drinking improves mental functioning, to be alert, think better, work better, reach higher goals, and have better thoughts.
3. Gregarious versus solitary drinking (GREGARUS): low scores on this scale indicate a withdrawn, nonsocial lifestyle associated with drinking. High scores reflect drinking at bars, parties, with friends, and not drinking alone.
4. Obsessive-compulsive drinking (COMPULSV): high scores on this scale indicate a participant's inability to resist the attractions of alcohol and an inability to stop drinking once started. Scores represent compulsive

obsession about drinking, such as constantly thinking about alcohol, wanting a bottle nearby, and drinking at the same time each day.

5. Continuous, sustained drinking (SUSTAIND): high scores on this scale mean that the participant has sustained alcohol use (daily drinking during the week and on weekends with no periods of abstinence; somewhat intoxicated every day) for 6 months or more which could result in physical impairment and potential withdrawal symptoms, in contrast to periodic drinking. Low scores on this scale reflect short binges with alcohol.
6. Post-drinking worry, fear and guilt (GUILTWOR): high scores on this scale indicate that drinking has caused fear, depression, anxiety, worry, remorse and resentment for the participant.
7. Drink to change mood (MANGMOOD): high scores on this scale indicate the participant uses alcohol to reduce stress and to cope with anxiety or depression, for example, drinking when feeling down or depressed, or drinking to forget and/or relieve tension.
8. External support to stop drinking (HELPBEFR): scores on this scale measure the extent to which the person has made prior attempts to use established facilities and

procedures to cope with problems associated with drinking.

9. Loss of behavior control when drinking (LCONTROL): high scores on this scale indicate that the participant's drinking behavior could be harmful to themselves or others, such as becoming belligerent, harming others, or attempting suicide.
10. Social-role maladaptation (ROLEMALA): high scores on this scale indicate the extent of "skid row syndrome," which includes job loss, being put in jail, cited for public drunkenness; living alone; and no family involvement.
11. Psychoperceptual withdrawal (DELIRIUM): high scores on this scale reflect perceptual symptoms and distortions associated with delirium tremens. Scores reflect the extent of fuzzy thinking; seeing, hearing and feeling things not there; and weird and frightening sensations during the withdrawal period.
12. Psychophysical withdrawal (HANGOVER): high scores on this scale indicate a presence of physical symptoms related to withdrawal such as "shakes," hangovers, vomiting, rapid heart beat, and sweatiness and feverishness when sobering up.

13. Nonalcoholic drug use: high scores on this scale indicate a history of substance misuse or habitual involvement with drugs.
14. Quantity of alcohol used (QUANTITY): this scale gives a rough approximation of alcohol use per day.
15. Drinking followed marital problems (MARICOPE): a high score on this scale indicates that marital discord and conflict has led to a drinking problem.
16. Drinking provokes marital problems (MARIPROB): a high score on this scale indicates that drinking problems have caused marital discord.
17. Dimension A - Self-enhancement drinking (ENHANCED): a high score on this dimension indicates a person's acceptance of the use of alcohol as part of a lifestyle, but is not generally diagnosed as alcoholism. This scale is an approximate measure of a social drinker and reflects drinking to improve sociability, improve mental capability, change mood and get along under difficult circumstances.
18. Dimension B - Obsessive, sustained drinking (OBSESSED): a high score on this dimension indicates sustained compulsive drinking and a low score indicates binge drinking. High scores on this scale reflect drinking

daily over many weeks, hiding bottles, sneaking drinks, dwelling on thoughts about drinking, and drinking to go to sleep at night.

19. Dimension C - Anxiety related to drinking (ANXCONCN): this dimension provides a general measure of the anxiety associated with drinking, such as worry, guilt, shame, tension fears, and devious behaviors.
20. Dimension D1 - Alcoholic deterioration (DISRUPT1): a high score on this dimension represents broad alcohol-related disruption in the physical, psychological and social areas of functioning.
21. Dimension D2 - Alcoholic deterioration adjunct (DISRUPT2): this scale is the same as Dimension D1, and acts as a validation measure of that scale. It is a general measure of deterioration or disruption associated with alcohol use derived from different scales and items than Dimension D1.

Dimension G - General alcoholism (ALCINVOL): this is the broad, third factor which represents the positive manifold among the intercorrelations for most of the scales. This scale is made up of a set of items drawn from all of the primary and second-level scales. This scale represents an

overall conglomerate measure of alcoholism. This scale has high internal consistency (.38-.93) and test-retest reliability (.54-.89).

APPENDIX D

Twelve Steps and Twelve Traditions of Alcoholics Anonymous

APPENDIX D

Twelve Steps and Twelve Traditions of Alcoholics Anonymous

The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The Twelve Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

APPENDIX E

Variations in the Processes of Change

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Variations in the Processes of Change

The Processes of Change reported in Table 3 were derived from Prochaska, DiClemente and Norcross (1992). The nine processes of change are listed in the order in which they are emphasized across the Stages of Change model.

The Processes of Change reported in Table 9 were derived from the Processes of Change scale developed specifically for use with outpatient alcoholics (Migneault, Pallonene, & Velicer, 1994). Four additional processes are included in this instrument which are not part of the formal Stage of Change Model (Prochaska et al., 1992). Those processes are described below:

1. Contingency Management: This scale refers to the management of reinforcement for not drinking and is similar to the Reinforcement Management process of change. Sample item - "I reward myself when I don't give in to my urge to drink."
2. Social Liberation: This scale refers to the individual's awareness of increasing alternatives for non-drinking behaviors available in society. Sample item - "I see advertisements on television about how society is trying to help people not drink."

3. Physical Interventions: This scale indicates the extent the individual is using medications to avoid drinking. Sample item - "I take antabuse to help me not drink."
4. Feedback: This scale indicates the use of interpersonal and physical feedback to avoid drinking. Sample item - "Someone in my life helps me to face my drinking problem."