ALCOHOLISM RECOVERY AND TREATMENT NEEDS OF WOMEN

By

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ABSTRACT

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Among American women, alcohol is the single leading drug of abuse, yet research in addiction has concentrated on male subjects. Most models of treatment were developed to meet the needs of male patients. Contemporary research indicates that clear differences in substance abuse effects exist between men and women. This study identified specific issues or themes that could help augment recovery for women who are in treatment for alcoholism. Structured interviews were conducted with seven adult women, 21 years or older who are in recovery from alcohol dependence and who regularly attend AA meetings. The study addressed several issues pertaining to women's alcoholism that formed themes relating to factors that could help women obtain treatment earlier and elements of treatment programs that could be more responsive to female clients and improve their aftercare services. The respondents were asked ten open-ended

questions concerning issues that were important in their recovery from alcoholism but were not adequately addressed while in treatment and aftercare. It was found that the two youngest women sought treatment earlier than most of the older women, and that other women often were the impetus for many of the participants seeking treatment. The participants' answers indicated that if women's emotional concerns were addressed more in treatment, they likely would have benefited more from treatment. Relationship health was an important topic for women in this study. It was also found that, in general, the women in this study were not satisfied with their counselors in treatment or in aftercare. Information gathered through this study may be helpful to identify the specific recovery and treatment needs of women with alcoholism.

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CHAPTER ONE: INTRODUCTION

Introduction

Research regarding female substance abuse, treatment, and recovery is emerging. The inception of the modern disease theory of alcoholism was based upon a blatantly flawed survey conducted in 1945 (Ragge, 1998). The survey consisted of 36 questions that were published in the Alcoholics Anonymous (AA) magazine *The Grapevine*. The editors thought that these questions were important and enlisted E. M. Jellinek to analyze and compile the results. Jellinek had some misgivings about the methodological deficiencies of the survey, but he believed that the credibility of the AA members' responses would overcome this. "All subjects were members of Alcoholics Anonymous . . . . It is difficult to get truthful data on inebriate habits, but there need be no doubt as to the truthfulness of the replies given by an AA member . . ." (p. 27). Jellinek was an admirer of AA and considered the information acquired from the members' responses to be the only source of credible information. From the survey, 158 questionnaires were received. From those returned surveys, 60 questionnaires were eliminated due to being incomplete, having multiple responses to one question, or from women. Even though a control group of non-AA members was not used in the study and all the women's responses were thrown out, these 98 responses form the "factual" basis for the disease concept of alcoholism.

Historically, women's specific recovery issues in addiction treatment and self-help groups have been overlooked. It was assumed that what would be good treatment for men would also be good treatment for women (Galanter & Kleiber, 1999). Contemporary research indicates that clear differences in the physiological, psychological, and sociocultural effects of substance abuse exist between men and women. Effective substance abuse treatment for women must accommodate and address these differences. Since drinking can be a more insidious

problem for women than men, the fact that more women than ever before use alcohol regularly is a potentially dangerous trend, particularly women under age thirty five (Jersild, 2001).

Physiological Aspects

Women represent one-third of the estimated 14 million alcohol-abusing or alcohol-dependent people in the United States (U. S. Department of Health and Human Services, n. d.). Studies show that while women tend to drink less and generally have fewer alcohol-related problems than men, women who drink the most heavily equal or surpass men in the number of resulting alcohol-related problems (Galanter & Kleiber, 1999). Women are more sensitive to alcohol, and they absorb and metabolize it differently than men. Women tend to have lower body water content and more fatty tissue than men of the same size. Women who drink the same amount of alcohol as men will have higher blood alcohol concentrations (BAC) because alcohol is more soluble in water than in fat and diffuses uniformly through all body water. Activity levels of gastric alcohol dehydrogenase (ADH), a stomach enzyme that breaks down alcohol, are thought to be lower in adult women than in adult men. Lower levels of ADH activity would allow more alcohol to be made available to women's body systems. Also, fluctuations in women's hormone levels during the menstrual cycle affect the rate of alcohol metabolism, resulting in higher BAC's at different points of the cycle. All of these physiological factors may explain why alcohol dependence progresses more rapidly in women than in men.

Regular and heavy drinking have been associated with menstrual problems such as pain, heavy flow, and irregular or absent periods (Galanter & Kleiber, 1999). Chronic heavy drinking is a major contributor to female sterility and other sexual dysfunctions. Also, alcohol depresses female sexual arousal and orgasm. Cirrhosis, hypertension, malnutrition, and anemia are just a few physical complications that develop and worsen more rapidly in women than men. Women

who drink to excess experience more brain damage and are affected sooner than males who drink the same amount. Overall, women appear to experience more severe long-term alcohol-related effects than men (Jersild, 2001). Data suggests that the brains of alcoholic women are smaller compared to a normal population of women who are not alcoholic. Alcoholism is also linked to dementia, making alcoholic women more prone to this disability than males (Galanter & Kleiber, 1999).

According to the National Institute on Drug Abuse (2002) at least five million women are alcoholics—chronic, compulsive drinkers who cannot control how much they drink and suffer withdrawal symptoms if they quit. For men, it usually takes ten years of chronic heavy drinking (twenty drinks or more a week) for alcohol to cause significant damage to internal organs and for alcoholism to develop. In women drinking half as much, this process escalates to a period as short as five years. Women become dependent on alcohol more quickly, and its toll on their bodies is high. Female alcoholics develop cirrhosis of the liver and a life-threatening heart condition called cardiomyopathy at an earlier age than men, and are twice as likely to die prematurely. On average, women alcoholics lose an average of fifteen years of life expectancy.

Psychological Aspects

There have been few longitudinal studies examining psychological predictors of alcoholism that include women subjects. For every female alcoholic, another three or four women drink in a manner that could be harmful to their emotional or physical well-being (Jersild, 2001). They do not tend to drink—or lose control of their drinking—in the same ways as men, who typically drink because they want to blow off steam, blot out problems, or have a good time. In men, heavy drinking increases their risk of depression. In women, it works the other way around; when they become depressed, they reach for a drink to feel better. However,

since alcohol is a mood depressant, they end up feeling worse. They may drink more or also take mood-altering prescription drugs, such as sedatives, and become dependent on them as well. Tolerance for alcohol and prescription drugs decreases with age and because women, especially those over the age of sixty, are more likely than men to abuse these drugs together, this can cause confusion, delirium, heavy sedation, and accidents.

In a pioneering fifteen-year study involving approximately 1,100 women, psychologist Sharon Wilsnack of the University of North Dakota found that most women use alcohol like medicine: something they need to help them cope, relax, feel less anxious, get to sleep, or feel comfortable at parties (1984, as cited in Galanter & Kleiber, 1999). Wilsnack noticed that as long as the women were drinking for a reason, they saw it as acceptable

Studies utilizing clinical populations of chemically dependent patients regularly demonstrate high levels of co morbid psychopathology (Lowinson, Ruiz, Millman, & Langrod, 1998). Female patients characteristically have higher levels of psychopathology. In addition, females have higher levels of anxiety and depressive symptoms, lower self-esteem and higher levels of shame, while male patients display more antisocial trends. Often, it is difficult to distinguish preexisting psychopathology from symptoms caused by the substance dependence itself.

Many studies have found the lifetime prevalence of dual diagnosis higher among women than men in the general population and in clinical patients (Lowinson et al., 1998). Evidence for preexisting psychiatric disorders was obtained by separating the primary diagnosis from the secondary diagnosis. Past studies also found that a history of being sexually abused increases the chances for both drug and alcohol abuse and dependence in women (Galanter & Kleiber, 1999). Women problem drinkers often use alcohol as a form of self-treatment. More often than

men, women cite a traumatic event as precipitating heavy drinking. These events include divorce or abandonment, a death in the family, miscarriage, or health problems (Jersild, 2001).

Sociocultural Aspects

Alcohol abuse in women not only has adverse affects on their own lives and health, but also on their children, families, and communities (Kaufman, 1996). These ties to the family and community often prevent or delay women from entering treatment. In addition to the shame many women alcoholics feel for having a drinking problem, their families often deny the problems of their matriarch. Many women who seek therapy get much less psychological and social support from spouses and other family members than do men (Hyde & Rosenberg, 1980). These women not only are more likely than men to have an alcoholic spouse, but also are more likely to have other alcoholic family members for whom they are the caretakers.

Contrary to popular assumptions, busy women who manage a variety of responsibilities do not necessarily drink more than others (Wilsnack, Wilsnack, & Klassen, 1986). The more roles women play as wives, mothers, and employees, the less likely they are to have drinking problems, perhaps because they have less time, higher self-esteem, and more sources of emotional support. The exceptions are women in occupations still dominated by men, such as engineering, science, law enforcement, and top corporate management. Often women in these fields drink as a way of fitting in; drinking takes on symbolic value. It's a way of signaling power, equality, and status.

While both men and women may reach for the bottle after a marriage breaks up, for some women the loss of any important role can trigger heavy drinking (Jersild, 2001). Such women turn to alcohol to fill, at least temporarily, the emptiness they feel when they lose a job, a partner, or a way of life they once loved. If they find themselves drinking too much, they face a special

burden: intense social disapproval. Nice girls, good wives, and responsible mothers are not supposed to have drinking problems. Because of this stigma, women are especially likely to push themselves to function as normally as possible despite heavy alcohol use. The more competent and in control women appear (or convince themselves that they appear), the easier it is for them—and those close to them—to deny any problems.

Alcoholic women often develop depression, psychosomatic disorders, or eating disorders in addition to their drinking problem (Galanter & Kleiber, 1999). Physicians and other health professionals are more likely to miss a substance abuse diagnosis in women than in men, even though women see physicians more often. Physicians are slow to recognize the markers of female substance abuse and often mistake related symptoms of depression and low self-esteem for a mood or personality disorder. In addition, the stigma surrounding female substance abuse, which for cultural and historical reasons is greater than that for men, has discouraged women from seeking help. The social blame attached to heavy drinking by women labels her a failure. A woman who drinks excessively also is assumed to be sexually available. The societal stereotyping promotes sexual assault and date rape against women who drink.

Statement of the Problem

This study identifies specific issues or themes that could help augment recovery for alcoholic women who are in treatment for alcoholism. The study involves interviewing seven adult women, 21 years or older who are in recovery from alcohol dependence and who attend AA meetings in a large Wisconsin town. The interviews were conducted during the summer of 2002.

Research Questions

The following questions were of interest in this study:

1. What factors could help women obtain treatment earlier?
2. What aspects of treatment programs need to be changed for women?
3. What would make aftercare better for women?

Definition of Terms

There are eight terms defined below for clarity of understanding:

Alcohol/Substance Abuse: The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) states that "The essential feature of substance abuse is a maladaptive pattern of substance manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems" (American Psychological Association [APA], 1994, p.182). Alcohol/substance abuse is also known as problem drinking.

Alcohol/Substance Dependence: According to the DSM-IV "the essential feature of substance dependence is a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues use of the substance despite significant substance related problems. There is a pattern of self-administration that usually results in tolerance, withdrawal, and compulsive drug taking behavior" (APA, 1994, p.176). Alcohol/substance dependence is also known as alcoholism or addiction.

Co-morbidity: The co-occurrence of psychoactive substance dependence and other psychiatric diagnoses is called co-morbidity, which can also be called dual diagnosis (L'Abate, Farrar, Serritella, 1992).

Post-Traumatic Stress Disorder: A persistent psychological reaction to a traumatic experience "involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror (APA, 1994, p. 424).

Primary diagnosis: A diagnosis that appears before a secondary diagnosis (Lowinson et al., 1998).

Secondary diagnosis: Symptoms of a diagnosis that occur after criteria for another psychiatric diagnosis has been met (Lowinson et al., 1998).

Shame: This affect can lead to a humiliating loss of face, honor, or dignity. It is a sense of personal failure that directly affects one's self-definition and perception of worth (Kaufman, 1996).

CHAPTER TWO: LITERATURE REVIEW

Introduction

This study examines how the needs of women in treatment for alcoholism can be better addressed. This chapter reviews research relevant to this topic. The literature review is divided into three sections. The first section explains the prevalence and nature of alcoholism as it manifests in women. The next section focuses on the effects of alcohol consumption on women. The last section describes factors that contribute to alcohol abuse in women.

Prevalence of Alcohol Abuse in Women

Alcohol is the single leading drug of abuse among American women. Women's alcohol use has increased over the last half century, as have their alcohol problems (Jersild, 2001). About 10 to 15% of women report some type of drinking-related problem, and about four percent meet the diagnostic criteria for alcohol abuse or dependence according to the DSM-IV (APA, 1994). Forty percent of women reported alcohol as their primary substance of abuse compared to 53% of men (Williams, Grant, Hartford, & Noble, 1994).

Williams and colleagues (1994) estimated the prevalence of alcohol related problems in women based on earlier general population surveys that were updated to account for population changes. Using DSM-IV criteria, nearly four million American women ages 18 and older were classified as alcoholic and 1,950,000 women ages 18 and above were considered problem drinkers. Williams et al. estimated that 2,068,000 women ages 18 and above abused alcohol and were dependent.

Wilsnack, Wilsnack, and Klassen's (1984) "Problem Drinking in Women—A National Longitudinal Study" is a national survey on drinking among U. S. women that took place in the fall and winter of 1981. It has provided much important information about trends in women's

drinking practices. The participants consisted of 500 moderate to heavy drinkers, 39 women who were self-reported problem drinkers, and 378 lighter drinking or abstaining women. The demographic characteristics of women with the highest rates of alcohol-related problems were correlated with age. The survey over-sampled women who abused alcohol to isolate and study their behavior in greater detail. The highest rates of alcohol-related problems occurred in the youngest age group, aged 21-34, while the highest proportion of heavy drinkers were in the 35-49 year old group.

The number of women who abused alcohol over the age of 60, compared to the other age groups, was very small (Wilsnack et al., 1984). Surprisingly, researchers found a pattern that typifies the activating events and outcomes that would lead to the elderly women to seek treatment. In older women, the pattern of abuse of alcohol began with a husband or significant other, was followed by becoming a widow, then they drank progressively more due to personal losses including financial stress, depression, or illness. Tolerance for alcohol falls with age, leaving elderly women more prone to becoming addicted at an accelerated rate and more prone to co-morbid illness and other health- related complications. In addition, women who drink heavily have a tendency to die fifteen years earlier than men who drink heavily.

Married women had the lowest overall problem drinking rates, while those women who were not married but living with a partner had a 50% higher risk rate of heavy drinking (Wilsnack et al., 1984). The researchers broke down drinking prevalence by age-related roles that women take on during various stages of their lives. Contrary to popular belief, women who had *multiple roles* (e.g., married women who work outside the home) had lower rates of alcohol problems than women who did not have multiple roles. Women aged 21-34, described as *role-less* (never married, no children, not employed full time) were most likely to have had problems

resulting from heavy drinking. Also, *role deprivation* (e. g., loss of role as wife, mother, or worker) might increase a woman's risk for heavy drinking. For women aged 35-49, women characterized as *lost role*, had the highest problem rates. In the oldest cohort, aged 50-64, women characterized by *role entrapment* (married, children not living at home, not working outside the home) had the most alcohol problems.

The prevalence of alcohol abuse has also been identified by racial categories (SAMSHA, 1994; CSAT, 1994). Alcohol abuse was most prevalent among African American women. However, for African American women, the consequences of alcohol abuse, such as the comorbid health problems of cancer, pulmonary disease, malnutrition, hypertension, and birth defects occurred at disproportionately higher rates. Available data suggested that while African American women began their problem drinking later than Caucasian women, the onset of alcoholic problems began earlier and occurred at an accelerated rate. However, among the heaviest drinkers, the data showed little difference between the two ethnic populations.

For Native American women, alcohol abuse was the fifth leading cause of death (SAMSHA, 1994; CSAT, 1994). Also, Native American women suffer health related and other consequential problems due to drinking onset at an earlier age and an accelerated rate compared to their Caucasian counterparts. The alcohol related mortality rates were higher for this ethnic group at all age levels compared to all the other female ethnic groups.

For Asian American women, there is less reliable data due to recent migration and acculturation factors (SAMSHA, 1994; CSAT, 1994). However, available data suggest that there is significantly lower prevalence of alcohol use by Asian American females until they acculturate over several generations. Even then, the prevalence rate was lower than Caucasian rates, which is possibly attributable to cultural and religious traditions.

Hispanic women are not a unitary population (SAMSHA, 1994; CSAT, 1994). They are comprised of heterogeneous groups from Latin American origin. Therefore, alcoholism data is less reliable due to the diverse nature of this ethnic population. However, available data suggest that Hispanic female alcohol consumption is lower than Caucasian female consumption. However, even though rates of infant mortality and low birthrates were lower for the Hispanic American population than for other minorities, Hispanics are more prone to diabetes, a condition that can be exacerbated by alcohol abuse.

The prevalence of female alcohol consumption by sexual orientation also has been studied. Lesbian and bisexual women were thought to be a high-risk group for alcohol abuse due to the stigma of their sexual orientation and of the gay bar meeting places for these women (Jersild, 2001). However, it has been hard to determine the actual prevalence in this population because people do not always admit their sexual orientation. Due to the heterosexual bigotry in our society, lesbian or bisexual women may internalize the homophobic stigmatization, shame and negative self-concept. Adaptive and sensitive treatment approaches could enhance treatment outcomes in the population. Counselors and their clients should be taught to recognize the adverse effects result from prejudice and discrimination and are not a consequence of one's sexual orientation (SAMSHA, 2001).

Effects of Alcohol Abuse on Women

Shame.

Shame is an unacknowledged core affect that can be devastating for a female alcoholic throughout all areas of her life. It is an inner sense of being completely diminished as a person.

"A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of her or his dignity or exposed as basically inadequate, bad or worthy of rejection" (Fossum & Mason, 1986, p. 5).

The stigma of alcohol use and abuse seems to have a greater negative impact for women than men (Kaufman, 1996). For some women, drinking challenges the definitions ascribed to her by society, which in turn can perpetuate even more shame. Females are socialized to be nurturing and altruistic. Many women in American culture are ostracized for outward expressions of anger and aggression. A woman who asserts her own wants and needs in all types of societal roles is at risk for harsh criticism. Whether the woman is a homemaker or a CEO of a multi-national company, assertive behavior can have a profound effect on both the women's shameful perception of herself and the negative stereotypes that are ascribed by society and even by her peers.

Shame plays a profound role for women who have addiction issues (Underland-Roscow, 2000). The shameful societal stigma of the 'fallen woman' can perpetuate even more shame. Due to this stigma, women can go to great lengths to hide their addictive behavior from others. Powerlessness is fed by her shameful perception of herself (Kaufman 1996). This powerlessness can make her feel that "nothing can be done, that something vital has been wrenched away, and that (she) is powerless to stop it. . ." (p. 80).

Shame can also have a profound negative impact in which society, peers, and self-perceptions label a woman alcoholic as a '*fallen woman'* (Jersild, 2001). This stereotype results in the flawed presumption by both women and society that alcohol is a sexual stimulant. A double standard exists where "'A man who drinks is a drunk, but a woman who drinks is a slut.' Worse, alcoholic women are seen as fair targets for sexual aggression" (p. 4). People mistakenly

believe that alcohol is sexually arousing, and alcoholic women are presumed to be promiscuous. But in truth, alcohol reduces physiological sexual responsiveness in both men and women. Often the sex that occurs results from the use of an inebriated state to overcome a lack of self-confidence to manage the situation.

Some women are frantically searching for some kind of human connection. Convinced they are unworthy, they believe they have only their bodies to offer (Jersild, 2001). Many are economically dependent on men and feel they need to comply with men who buy them drinks. In all of these cases, the woman's sexual behavior is a symptom of her belief that she is powerless. The shame heaped on her by society only confirms her self-loathing, which she drowns out with another drink. Young women can also become trapped by dependency in unhappy marriages and are most vulnerable to anxiety disorders. However, epidemiological research has shown that half of such problems begin well before age 15 and 70% start before age 25—well before most women's wedding days. Nonetheless, dependency can perpetuate anxiety. In one study of men married to phobic wives, the husbands were no more—and often significantly less—unhappy in their unions than other men. Indeed, some seem to enjoy their protective or controlling role in a marriage so much that they may not want their wives to become less dependent.

Physical health.

Three times more men than women meet the diagnostic criteria for alcohol abuse and dependence (Baron-Faust, 1998). However, women become alcohol dependent sooner and suffer much greater impairment over the same period of time than do men. Women also suffer from internal organ damage at lower levels of drinking than men. For example, women can

suffer liver damage drinking as little as one and a half drinks per day over an extended period of time, compared with four drinks a day for men.

One of the factors for the disparity between onset and prevalence of symptoms is that women are more sensitive to the effects of alcohol due to their higher percentage of body fat compared to men (Jersild, 2001). This is due to the fact that alcohol dissolves more readily in water than in fat so that alcohol becomes more concentrated in a woman's body. Women also metabolize alcohol less efficiently than do men, so alcohol concentrate levels rise faster and stay more elevated, resulting in women getting drunk more quickly and remaining intoxicated longer than men after drinking the same (or smaller) amounts of alcohol (Galanter & Kleiber, 1999). Tolerance for alcohol decreases with age, and with an increasing ratio of body fat to water, the adverse effects of heavy drinking on older women, are doubled (Lowinson et al., 1998).

Compared with men, average women produce half as much of a stomach enzyme called alcohol dehydrogenase (Baron-Faust, 1998). This enzyme is needed to metabolize alcohol before it enters the bloodstream. If the alcohol is not broken down, it can enter the bloodstream and damage such vital organs as the brain and liver. With heavy alcohol consumption, both in women and men, the amount of this gastric enzyme decreases, which begins a downward spiral trend where the addiction feeds on the symptoms it produces.

Heavy drinking among adolescent girls and young women may have even a more profound effect, biologically and emotionally (Baron-Faust, 1998). Young women are vulnerable due to physical changes in their bodies at puberty and the overall emotional maturation process inherent at this point in their lives. Their immune systems are compromised because normally produced white cells are reduced when they drink. They exhibit higher levels of liver enzymes. Because of this, these young women are more prone to suffer higher

incidences of damage to their internal organs and greater risks of brain damage and other neurological problems than are mature women. Other health related symptoms include ulcers, loss of appetite, weight loss, eczema, headaches, and loss of consciousness

Thompson and Wilsnack (1984) reported concrete evidence that heavy drinking has potential to damage and hinder brain development in young women. Alcohol abuse contributes to poor functioning in language skill development. Because the damage occurs at a stage when the brain is still developing, the damage to the brains of young women can be detrimental to later neurological functioning and cognitive activities.

Hormonal level fluctuation occurs when a woman has her period, which can hinder the metabolic processing of alcohol (Jersild, 2001). Oral contraceptives are also another factor that slows down the rate of alcohol metabolism. Unlike the predictable and reproducible blood alcohol levels (BAL) in men, day-to-day BAL variability with higher peaks during the premenstrual phase have been observed in women by investigators (Lowinson et al., 1998). With increased BAL variability, faster ethanol metabolism, and less marked acute alcohol tolerance, women's symptoms and the damage to their health occur earlier in their lives as compared to men. In short, this reemphasizes the fact that women will both react more intensely to a given dose of alcohol and be less able than a man to foretell the effects of any given amount of alcohol she consumes.

Alcoholic women also have higher rates of gynecologic problems, including irregular menstrual cycles, miscarriage, infertility, and early menopause (Baron-Faust, 1998). Studies show that such problems can occur in any woman who consumes four to eight drinks per day. Recent studies have also found that daughters of women who drink during pregnancy are more likely to have fertility and reproductive problems.

Women alcoholics develop hypertension and cardiovascular disease sooner than men who are alcoholic (Baron-Faust, 1998). Thus, indirectly, alcohol consumption can be a contributing factor to high blood pressure, increasing the risk of stroke. Postmenopausal women are more prone to contract cirrhosis of the liver than men at the same age. Also, these women are more likely to suffer from alcoholic-related enlargement of the heart (cardiomyopathy) as compared with males.

Furthermore, long-term alcohol use is associated with many forms of cancer, such as oral cancer and cancer of the esophagus, liver, and pancreas. Some studies have suggested that alcohol consumption by women could increase their risk of breast cancer by at least 40%. However, later studies, such as the Framingham Heart Study (National Heart, Lung, and Blood Institute, 1999, as cited in Jersild, 2001), which consisted of a large sampling of women in scope and was longitudinal in depth, found that the incidences of rates of breast cancer between alcoholic and non-alcoholic women to not differ significantly. However, researchers in this study have noted that the heavy drinking women were under-sampled in this particular study. Several large studies have demonstrated weak correlations between alcohol intake and a risk for breast cancer in women and another yielded evidence for a weak association at best. Other studies have found weak correlations between alcohol use and the prevalence of higher breast cancer rates (Lowinson et al., 1998). Although these correlations are weak, breast cancer is one of the primary sources of premature death in women; therefore, further investigations are needed to determine any possible etiological relationship between them. Also, any evidence should then be explored to determine whether any causality and/or co-morbidity exist and what are the strengths and significance of these relationships (Lowinson et al., 1998).

Studies involving both men and women show differences in hereditary patterns in alcoholism between the sexes (Lowinson et al., 1998). There is evidence that inherited risk factors in women are strongly influenced by environment. Studies comparing identical twins have been used to show evidence of genetic and environmental effects on various behaviors and problems. Research has shown a genetic influence on drinking practices as well as on the development of alcoholism when studying male twin data. Lowinson and colleagues (1998) describe both specific genetic influences for alcoholism and the interplay of genetic and environmental influences in the causation of both alcoholism and psychiatric co-morbidity in women.

Lukas and Lex, (1996, as cited in Lowinson et al., 1998) compared a small number of nonalcoholic young women, in which one group had first degree relatives that were suffering from alcoholism and another group, where their first degree relatives did not suffer from alcoholism. The groups did not differ when blood samples were drawn to determine alcohol levels in their system after they had ingested a measured dose of ethanol. The rate of their bodies processing and breaking down the ethanol also was similar between the two groups. However, in field type sobriety tests, the higher risk women made *fewer* errors on a cognitive motor task and had *less* body sway under the influence of alcohol. These findings were comparable to those observed in male samples. They point to the possibility that these individuals might have a predisposition where they are less responsive to the effects of alcohol and might not be able to judge their own levels of intoxication as the members of the other group were able to do.

Effects on pregnancy and childbirth.

One out of every five pregnant women use drugs or smokes cigarettes during pregnancy (National Institute of Drug Abuse, 2001). These activities by the pregnant women can have lasting effects on the physical and mental development of their children. For women who do not drink during their pregnancy, infant mortality rate is 8.6 per 1,000 births. For women who average at least two or more drinks a day, the infant mortality rate rises to 23.5 per 1,000 births.

According to the Centers for Disease Control and Prevention (CDC) statistics from 2002, from 1979 to 1993, alcohol use during pregnancy increased six fold. Their research found a correlation that the rates of defects and health problems in infants whose mother abused drugs or alcohol increased at the same rate as the increase of mothers using alcohol during their pregnancy.

Chief among those problems is fetal alcohol syndrome (FAS), caused by heavy drinking during pregnancy (Streissguth & Little, 1994, as cited in Fleming, 1999). Fetal alcohol syndrome is the leading preventable cause of birth defects in children. The criterion for a diagnosis for FAS includes prenatal alcohol exposure; growth retardation, which is weight less than 10^{th} percentile, length of height less than 10^{th} percentile; facial characteristics such as short palpebral fissures, thin upper lip, abnormal philtrum, hypoplastic midface; and neurodevelopment problems such as memory problems, attachment concerns, impaired motor skills, learning disabilities, hyperactivity, delayed development, problems with reasoning and judgment, and the inability to appreciate consequences of actions; and other additional health and neurological problems.

These children may have an alcohol-related birth defect (ARBD) or isolated physical abnormality (Streissguth & Little, 1994, as cited in Fleming, 1999). Others may be limited to neurodevelopmental abnormalities, such as lack of full cognitive development (intelligence,

communication skills, memory, and learning ability), impairments in visual/spatial skills, and disruption of motor development. These children were classified as having an alcohol-related neurodevelopmental disorder (ARND). Other infants might be affected by some of the criteria listed above. When an infant does not meet some of the four criteria, they are diagnosed as having fetal alcohol effects (FAE). The term FAE has been replaced by the terms ARBD and ARND in medical practice, although the term FAE still appears in educational materials.

Unfortunately, the CDC reports that, despite increasing awareness that avoiding alcohol prevents FAS, approximately one fifth of women continue to drink even after learning they are pregnant (Jersild, 2001). Pregnant women should be warned that there is no safe level of alcohol consumption (Fleming, 1999). Studies thus far have been inconclusive as far as a safe level of alcohol consumption for pregnant women, if there is one at all.

Fetal alcohol problems and the levels of severity include racial and socioeconomic issues (Fleming, 1999). For example, the effects of drinking on an unborn child by black women can have seven times the risk for ARBD or ARND and for Native American women this factor is thirty times greater than that of white women. Some of these factors are biological or genetic; however, other such factors can also have an impact on the higher incidences of prenatal problems amongst the minority populations. For example, researchers have found that lower socioeconomic status has a strong influence on FAS, and that this factor cuts across all racial groups. Some of these discrepancies for the rates of differing FAS syndromes between racial groups are directly linked to the fact that women of a lower class with inadequate health care and environmental factors are living in deprived areas (Fleming, 1999).

In 1999 and 2000, 12.4% of pregnant women aged 15-44 years used alcohol and 3.9% were binge drinkers (National Institute of Drug Abuse, 2001). These rates were considerably

lower than for non-pregnant women, where the rates are 48.7% and 19.9% respectively. Jersild (2001) also described comparable alcohol consumption data for pregnant women; however, the rates were slightly higher for 2001. Jersild also states that 12.9% of pregnant women aged 15-44 years used alcohol and 4.6% of these women were binge drinkers. For non-pregnant women, the rates were 49.8% and 20.5%, respectively, for 2001. While the infant death rate nationally was 8.6 per 1000 for women who did not drink during pregnancy, the death rate rose to 23.5 per 1000 births among instances where the mother averaged two or more drinks per day during the pregnancy.

Psychological co-morbidity.

According to the National Institute of Drug Abuse's Co-morbidity Survey (2002), 30% of women in general develop an anxiety disorder over the course of a lifetime. Compared with men, women are three to four times more likely to develop a phobia, an inordinate fear of a specific object or situation, and are two to three times more prone to a panic disorder or post-traumatic stress disorder (PTSD), a persistent psychological reaction to a traumatic experience. Women are also more vulnerable to the co-occurring mix of anxiety and depression and more prone to turn to alcohol to self-medicate both of these conditions.

The Wisconsin Certification Board, Inc., (1998) revealed that many women report that their use of alcohol began as a way to self-medicate emotional pain arising from family problems or from prior physical or sexual abuse. Survivors of abuse often show symptoms of PTSD, which they may not recognize. Such symptoms are the re-experiencing of the trauma, mentally and physically and avoidance of trauma reminders that can be very frightening, especially if the person experiencing them does not understand what they are and why they are occurring.

In PTSD, the trigger of anxiety is always external: a traumatic event that has threatened a person's life or safety (Wisconsin Certification Board, Inc., 1998). Perhaps because of complex chemical and hormonal reasons, women seem more vulnerable to such stressors. More women than men (31% versus 19%) exposed to major trauma develop symptoms are more likely to persist for more than a year (National Institute of Drug Abuse, 2002). For women, a rape or brutal assault was the most frequent trigger of PTSD. While any woman may be extremely distressed and require time to work through such terrible events, some women repeatedly re-experience their fear and helplessness in their dreams or thoughts (Jersild, 2001). To block this psychic pain, they may enter a state of emotional numbness or become so anxious and fearful that they cannot venture out by themselves. Women who have experienced previous traumas (such as childhood abuse) may be especially vulnerable. Depression is common in PTSD, as is a state of emotional anesthesia in which women feel cut off from others, uninterested in activities they once enjoyed, and incapable of intimacy, tenderness, and sexuality. They may not be able to fall asleep or stay asleep, in part because of recurrent nightmares in which they relive the trauma. They experience startle reactions to benign stimuli. During the day, they are always on guard and may have difficulty remembering, concentrating, or completing tasks.

Without treatment or other intervention, chronic PTSD patterns can be very disabling (Wisconsin Certification Board, Inc., 1998). Because they get overwhelmed with fear during a trauma, survivors often have particular symptoms that begin soon after the traumatic experience. Alcohol temporarily helps the women to deal with these recurring symptoms. Such women use alcohol or other drugs to anesthetize themselves as a way of coping with the discomfort.

Alcohol abuse is often accompanied by a number of other psychological disorders; depression is more pronounced with alcohol dependent females (Galanter & Kleiber, 1999). The

increased ratio for developing alcohol abuse or dependence is 4.10 for a female subject with major depression, compared with 2.67 for a male with the same disorder. Studies of clinical and volunteer populations of alcohol-dependent adults have discovered that for women who meet DSM-IV criteria for depression and alcohol dependence, major depression is the primary diagnosis about two-thirds of the time. However, in men who are alcoholic and meet depression criteria, the alcohol diagnosis is primary about two-thirds of the time and depression is more often alcohol related.

Depression can be a reaction to loss or trauma, or it can be a chronic, long-term underlying condition (Jersild, 2001). The Epidemiologic Catchment Area (ECA) data (1989, as cited in Frances & Miller, 1991) indicate that major depression and dysthymia occur at least one and half times more often in alcoholics than in the general population. In male alcoholics, major depression has a five percent lifetime prevalence rate, compared to three percent for the total male population. Female alcoholics, however, have an occurrence rate for major depression of 19%, compared to seven percent in the total female population.

In the DSM-IV, mood disorders must be of sufficient duration and intensity that they cause significant subjective distress or dysfunction in one or more of life's roles (relationships, work, and school) (APA, 1994). In addition, depression is associated with an elevated risk of suicide (Bernheim, 1997). The epidemiological data taken from the National Institute of Drug Abuse's Co-morbidity Survey (2001) indicate a higher lifetime prevalence of co-morbid psychiatric disorders in females than in males who satisfy diagnostic criteria for alcohol abuse or dependence. Also, women used alcohol more as a form of self-treatment because they often refer to traumatic events as triggers for their abusive drinking. Such events include divorce or abandonment, a death in the family, a miscarriage, or other health problems. Galanter and

Kleiber (1999) state that “The high prevalence of psychiatric co-morbidity in addicted women makes careful psychiatric evaluation important; and in the evaluation, the clinician should determine which disorder occurred first, because a primary disorder is less likely to improve spontaneously with the establishment of abstinence from substances of abuse and is more likely to require specific treatment” (p. 486).

Patrice Selmari, manger of the Chemical Dependence Unit at Hazelden Center for youth and family, believes that girls who are substance abusers are still slipping through the cracks. “‘The girls are much more apt to be diagnosed with depression or other mood issues, and have their chemical dependency overlooked.’ ” (Jersild, 2001, p. 105).

Factors Contributing to Alcohol Abuse in Women

Childhood trauma.

Studies have shown that there is a high correlation between a history of childhood trauma and later alcohol abuse for women. The Oakland Growth study (Jones, 1971, as cited in Hyde & Rosenberg, 1980) was a seminal longitudinal study in which data was first collected in the 1920’s with ongoing follow-ups. When the women in the study were in their late forties, investigators graded the drinking patterns of these women. There were five defined categories that fell along a continuum: abstainers, light, moderate, or heavy drinkers, or problem drinkers. Retrospective analysis was used to determine what could be significant factors that characterized the problem drinker as compared with others. The analysis and subsequent follow-up studies found that factors pertaining to adolescence had significant effects on later drinking behavior.

According to the Oakland Growth study, female adolescence was fraught with factors that could later be precursors to alcohol abuse. The researchers found that, ". . . at fifteen, life is full of adolescent self-doubt and confusion. She fears and rejects life, is distrustful of people, follows a religion that accentuated judgment and punishment. She escapes into ultrafeminity" (Hyde & Rosenberg, 1980, p.117). A history of emotional deprivation during this time of a young girl's life along with personality factors such as submissiveness adds extra stress to her life (Jersild, 2001). The young woman compensates for this by being fearful of relationships, and the relationships that she does develop typically are overly dependent. For most adolescents, this would be the time where most development and differentiation of a person's personality and a sense of self and perspective are at the highest levels of development. Adolescence is also the period of a person's life when personal growth is most important and where most changes are made in a person's make-up, which is defined and cultivated. However, a young woman with a history of emotional deprivation along with a personality of being submissive overcompensates by becoming passively dysfunctional. These women might, for reasons of temperament and circumstance, have less capacity to cope with major stress and, therefore, become more vulnerable to alcoholism (Hyde & Rosenberg, 1980).

Possible childhood traumatic issues are violence, sexual abuse, loss of a parent, psychiatric illness, or alcoholism in the family (Hyde & Rosenberg, 1980). Research has shown that 87% of female alcoholics were victims of childhood sexual or physical abuse (Miller & Downs, 1993). Also, research has identified a significantly higher level of childhood sexual or physical abuse for alcoholic women in treatment centers than women in the general population (SAMHSA, 1994). These two variables indicate that female childhood victimization contributes to the development of later alcohol abuse (Miller & Downs, 1993). There is an especially strong

reason to believe that long-term harm occurs when the abuse involves vaginal penetration before puberty – physically, mentally and emotionally. In addition, childhood rape doubles the number of alcoholic symptoms in women (Jersild, 2001).

The clinical implication of this research is that these sub-populations of women are at a greater risk for alcohol abuse because of their perception that alcohol would block the painful memories (Lowinson et al., 1998). Early recognition of childhood abuse issues could greatly enhance positive treatment effects. Another implication is that effective coping mechanisms need to be developed to alleviate the negative consequences of childhood trauma. The previous studies emphasize the importance of focusing prevention efforts in school and college age women on a broad audience, rather than limiting the programs to girls already in trouble with alcohol.

The previous studies have been criticized for small sample sizes, poor design, bias with the retrospective reports of women in treatment, and the whether or not these women are representative of the target population. However, in May 1997, Wilsnack and Wilsnack published the results of a landmark study with a sample size of nearly 1,100 women that was representative of the general population (Jersild, 2001). Also, Wilsnack and colleagues studied 354 women longitudinally since 1981. They found that 51% of the women who were not problem drinkers in 1981, but who had reported a history of childhood sexual abuse, became problem drinkers by 1986 compared to 19% of the women who had not reported child sexual abuse. This study supported the validity of the previous treatment center studies in that "Childhood sexual abuse is the single strongest predictor of alcohol dependency in women, even stronger than a family history of drinking" (Jersild, 2001, p. 195).

There are a number of factors stemming from childhood sexual abuse that contribute to the revictimization of female alcoholics. One is the lowered self-esteem and the use of alcohol to deal with shame. Also, due to the stigmatization of sexual abuse, these women will seek out social peer groups where abuse is more prevalent and, thus, not as stigmatized (Miller & Downs, 1994).

Victimization.

Besides looking at victimization as factors for later alcohol abuse, there are also victimization factors that stem from alcohol abuse. In a study of social victimization related to drinking by another person, Jersild (2001) states that unlike men, women who drink in bars are much more likely to be victimized, even if they do not abuse alcohol themselves.

Women suffering from alcoholism were more likely to have been victims of violent crime (38% versus 18% matched controls), including rape (16% versus none of the control women) (Lowinson et al., 1998). These women were victimized not only by outsiders, but also by their own spouses. A study of spousal abuse among alcoholic and non-alcoholic women found that "Alcoholic women were nine times more likely to be slapped by their husbands, five times more likely to be kicked or hit, five times more likely to be beaten, and four times more likely to have had their lives threatened" (Jersild, 2001, p. 30). The stigma of alcoholism tends to isolate the relationship, and this increases the risk for even more serious forms of domestic abuse. There is a high rate of alcoholism among husbands of alcoholic women; however, the reverse occurs less often (Hyde & Rosenberg, 1980).

Women who drink too much are often the targets of sexual abuse and rape (Baron-Faust, 1998). A survey by Baron-Faust regarding college women found that 53 % of rape victims had used alcohol or other drugs beforehand and 64% reported alcohol or drug use by their assailant.

Many times a double standard is applied by society to further blame and/or shame the victim of a rape (Hyde & Rosenberg, 1980). If she is under the influence of alcohol at the time of the assault then she is vilified and to blame because she was intoxicated. Meanwhile, if the rapist was intoxicated, the alcohol tends to lower the responsibility of his committing a crime of physical and sexual assault due to his intoxication, bringing the woman more shame and mental distress.

Summary and Conclusions

Among American women, alcohol is the single leading drug of abuse (Jersild, 2001). According to the DSM-IV, nearly 4 million American women ages 18 and older were considered alcoholic and 1,950,000 women over age 18 were classified as problem drinkers (APA, 1994). Women suffer across all cultures from alcoholism; however, out of minorities, alcohol abuse was most prevalent among African American women (SAMHSA, 1994; CSAT, 1994).

Alcohol abuse has profound effects on women. One of these effects is shame (Fossum & Mason, 1986). The more a woman drinks, the more shame she feels; as a consequence of shame, the alcoholic woman continues the vicious cycle of alcohol abuse. Women also suffer from the physical effects of alcohol abuse at a much higher rate than male alcoholics (Jersild, 2001). Developmental effects on the children of women alcoholics such as fetal alcohol syndrome or birth defects are another result of alcohol abuse. There is also a high instance of psychological co-morbidity with alcoholism (L'Abate et al., 1992). Women with alcoholism may also experience anxiety disorders, post-traumatic stress disorder, and depression.

Two factors contributing to alcohol abuse in women are childhood trauma and victimization. Longitudinal studies have shown that there is a high correlation between childhood trauma and alcoholism (Hyde & Rosenberg, 1980). In addition, women alcoholics were more likely to have been victims of violent crime when drinking (Lowinson et al., 1998). It would be important for health professionals to recognize this correlation as well as the prevalence of alcoholism and its effects to better serve women with alcoholism.

CHAPTER THREE: METHODOLOGY

Introduction

This chapter is divided into five sections. The first section describes the subjects of this study and how they were selected. The second section provides details of the instrument that was used, followed by a description of how data was collected. The fourth section describes the data analysis procedures. To conclude, the apparent limitations in this methodology are described.

Subject Selection and Description

The subjects were seven women volunteers from four different AA meetings in the town of Wisconsin Rapids, Wisconsin. A woman AA member from each of these meetings announced the request for women volunteers for an interview prior to the meeting, stressing that the interviews were confidential, would last approximately one-half hour, and each participant would have access to the findings. The volunteers collected the names and phone numbers of female AA members who were interested in participating and relayed them to the researcher. The purpose was to collect women subjects from a broad age range in order to get a diversity of

female treatment experiences. There were a total of seven women who volunteered for this study, whose ages ranged from 21 to 65. Informed consent was explained in detail to each volunteer and a consent form was dated and signed before each interview. Each volunteer was given a copy of the questions asked at the formal interview. It was explained to each volunteer that she had the right not to answer any of the questions at any time.

Instrumentation

A structured interview procedure was used for this study. The following demographic information was gathered from the subjects:

1) Age
2) Number of treatments the subject had experienced
3) Length of sobriety in months and years
4) Employment status
5) Whether receiving counseling at the time

The ten questions asked of each subject were:

1) What or who (if any) influenced you to seek treatment?
2) How long did it take you to seek treatment?
3) What feelings or emotions did you have while in treatment?
4) What social and/or family problems did you have when entering treatment?
5) Were these problems addressed in treatment and, if so, how were they addressed?
6) What problems do you wish were addressed while you were in treatment?
7) What do you think was the best part of the treatment program(s) you've attended?
8) What was the worst part of the treatment program(s) you've attended?
9) What was your aftercare like and what would have made it better?

10) What problem(s) do you still have that treatment and AA have failed to address for you?

All sessions were tape recorded after consent was obtained from the subjects. The purpose of taping the sessions was to help the researcher collect and analyze each subject's responses. Confidentiality was stressed at several points throughout the interview.

Data Collection

Each volunteer was contacted in advance of the interview in order to set a time and place for the interview in a private setting of her choosing. At the interview, each participant was asked if she understood the consent form or if she had any other questions regarding confidentiality issues. If there were no questions or if the questions were answered to her satisfaction, then the participant signed and dated the consent form. All participants agreed and all consent forms were signed and collected at the time of the interview. The demographic questions were asked in order to collect relevant sample background information. Then subjects were asked the ten structured questions that allowed open-ended responses. This facilitated the development of themes and issues from these women's treatment and recovery experiences. All participants granted permission for the investigator to ask clarifying follow-up questions to better understand and investigate the subject's responses.

Data Analysis

The demographic data was tabulated in order to provide some quantitative descriptive measures of the backgrounds of the subjects. By analyzing the responses of the subjects, themes and relevant issues were identified for each question. The tapes of the interviews were reviewed

three times in order for themes to be properly identified and to facilitate greater accuracy of the collected and recorded information.

Assumptions and Limitations

All subjects were recovering alcoholic women 21 years of age or older. Subjects were able to communicate freely regarding the important aspects of their recovery from alcoholism that were not adequately addressed while in treatment or in aftercare. One limitation to the investigation is that the answers are retrospective in nature and memory often is distorted or incomplete. Also, the subjects may have wanted to provide information to please the researcher, distorting their true responses. Because the questions are open-ended, data from the subject's answers cannot be analyzed with traditional statistical methods. In addition, results from this small sample size cannot be generalized to all alcoholic women because it is not a representative sample of the larger population. There is also researcher bias that is introduced through the interactions the researcher had with the participants in the personal interviews and in the recording and analysis of the data.

The qualitative data collected from this study describes the individual experiences of seven Caucasian women between the ages of 21 and 65 who attend AA meetings in a small central Wisconsin city. Although there are limitations to this study, the information collected from these interviews may provide guidance for the improved treatment of female alcohol dependence.

CHAPTER FOUR: RESULTS

Introduction

This chapter describes the results of this study. Demographic information, analysis of structured question responses, and underlying themes are discussed. As previously noted, the interviews were structured. However, the responses were open ended to allow for collection of further unsolicited information.

Demographic Information

Seven recovering alcoholic women agreed to be interviewed. The ages of the respondents ranged from 21 to 65. The number of formal alcoholism treatments ranged from one to over sixteen attempts at sobriety through treatment. The total amount of current sobriety ranged from 1 year to 10 years and 10 months. The subjects' jobs or areas of employment varied from being a student (1), to working in the helping professions (3), to working in a factory setting (1), and being a housewife (1) (and "proud of it" as she added). Only one respondent, the youngest, was seeking other professional counseling at the time of the interview.

Structured Question Analysis

Question One: What or who (if anyone) influenced you to seek treatment?

Two of the respondents in the study sought treatment voluntarily, due to the need for medical intervention. Another two respondents reported that they had legal problems that required them to enter detoxification and treatment. The decision to enter treatment was supported by both of the previous women's mothers, even though their relationships were strained. Another woman was encouraged by her mother to seek treatment, and one woman was encouraged by her daughter to seek treatment. The remaining respondent was helped to seek treatment through her job's Employee Assistance Program (see Appendix A).

Question two: How long did it take you to seek treatment once you realized that your drinking was out of control?

The two youngest respondents took less time to seek treatment compared to most of the older participants. The older respondents from ages 39 to 65, except for the respondent who was 49 years old, took a longer time to seek treatment after they realized they had a problem with alcohol than the two youngest participants (see Table 1).

Table 1

How long did it take you to seek treatment once you realized your drinking was out of control?

Age of participant	Item response (in months)
21	12
27	36
36	72
39	96
43	60
49	24
65	48

Question three: What feelings or emotions did you have while in treatment?

The most prevalent emotion reported by five participants was fear. One woman said she was afraid of treatment and did not know what to expect from it. Four of the respondents were afraid of failing at being either a good mother or wife. The one woman who gave more elaboration on her answer said that she was afraid of not being able to stay sober to hold her family together. She was afraid her kids were not being taken care of properly.

The three oldest respondents reported that they felt shame. These women were ashamed of being an alcoholic and of being unable to control their drinking. One woman was ashamed of her lack of social skills and of the fact that she had to drink to be comfortable socially. The other two women who reported shame stated that they were ashamed that they did not do what they thought was expected of them by society: being a good wife and mother, holding a job, and/or being a good person in general.

Question four: What social and/or family problems did you have when entering treatment and have those issues been resolved?

The most prevalent problem cited by participants revolved around their parents. Five of the seven respondents said that they had problems with one or both of their parents. The three youngest women reported bad relationships with their fathers and the next two older women had problems with both of their parents. Only the two oldest respondents did not mention their parents as a problem.

Two of the respondents reported that they suffered abuse from one or both parents. The youngest said that her father abused her, but did not specify whether it was physical, verbal, or sexual abuse. This was the only problem that she mentioned. The 43-year-old said that both of her parents were abusive, and she also did not specify what type of abuse she suffered. Her parents showed no emotion when her son moved in with his father and were not very caring for her throughout her life. She stated that now they only communicate with her through other family members.

The 27-year-old stated that she had a bad relationship with her father and her parents did not trust her. She also had legal problems that were the cause of her entering treatment. Her father, due to her drinking, gave her an ultimatum that if she did not seek help or straighten out

her life, she could not live at home. Both of her parents lacked trust in her and this was one of the biggest issues she had to face. She reported that she developed a better relationship with her parents in the time after treatment.

The 39-year-old participant stated that she had a very domineering father who was also an alcoholic. He treated her in a very condescending and demeaning way and she felt that this was a primary reason for her developing an eating disorder. Her father never attended any of her family treatment sessions and her mother only attended one. Therefore, the family sessions were discontinued and she remarked there were still family problems that needed to be resolved.

The 36-year-old respondent had a father whom she reported was very militant and strict with her. She felt that she could never please him. Her mother tried the "tough love" approach with her by refusing to help her with drinking related problems; however, the mother tended to give in when her daughter's situation would get desperate.

Three of the seven respondents had problems with boyfriends who were also alcoholics. The 49-year-old merely mentioned that she had an alcoholic boyfriend and that was a problem for her. The 36-year-old had relational difficulties with her boyfriend who is an active alcoholic. He tried to prevent her from attending AA meetings; however, she continued to go to AA in spite of his objections. She stated that she found AA supportive and an important socialization factor outside of her relationship with her boyfriend.

The 43-year-old respondent lived with an alcoholic partner who was abusive to her for many years until "just recently." She couldn't get out of the relationship, she "hated nursing" and she was tired of taking care of others and wanted somebody to take care of her because she could not even take care of herself. When her son was eight years old, he moved and lived his

father. She stated that there were many repercussions from her son's moving in with his father and it robbed her of the only purpose to live. She stated, "I had a purpose, and then I didn't."

The oldest respondent claimed that she had no problems other than alcohol, which she denied as a problem until she entered treatment. Her daughter and the rest of her family felt that she needed help. Through attending treatment she realized the destruction she was causing herself and her family (see Appendix A).

Question five: Were these problems addressed in treatment and, if so, how were they addressed?

Four of the seven respondents replied that some of their issues were addressed to an extent in therapy and some were not. The 39-year-old respondent felt that her eating disorder was not addressed, and her family problems were handled alone. She did not elaborate further. One respondent's abusive father was addressed somewhat in a family session; however, her co-dependency issues were not addressed and are still a problem. She did not state that co-dependency was a problem for her in the previous question. Another respondent felt that her feelings about her parents' lack of trust in her were not addressed, but her bad relationship with her father was addressed somewhat by writing him a letter. The fourth respondent's biggest issue was her using boyfriend; talking about the relationship in treatment made her feel better, but she was not sure if that was enough to resolve the issue. She left treatment feeling apprehensive and fearful about her relationship with her boyfriend.

Only one respondent, the youngest, felt that her problems were not addressed at all in therapy. She felt that her feelings about her abusive father were not addressed at all.

Two respondents felt that all of their problems were addressed adequately. The oldest respondent who did not report any social or family problems except for her alcoholism (which she did not think of as a problem until she entered treatment) learned a lot about her alcoholism

and how it negatively affects her family. One respondent felt that for the most part her issues such as her abusive parents and alcoholic boyfriend were addressed through individual counseling sessions.

Question six: What problems do you wish were addressed while you were in treatment?

All of the respondents replied in at least part of their answer that issues more pertinent to women needed to be addressed. Some of the women's issues that other participants brought up consisted of men, self-esteem, eating disorders, co-dependency, childhood trauma, and especially sexual and physical abuse. The oldest respondent thought that more "women's issues and family issues" needed to be addressed, although she did not elaborate. Both the 27-year-old and the 43-year-old felt that more women's groups and female counselors were needed to better address the previously mentioned issues that are more specific to women. The 43-year-old mentioned that her low self-esteem was not adequately dealt with and felt that she did not learn the skills in treatment needed to build up her self-esteem and self-confidence. She also felt that the acceptance of being an alcoholic needed to be further explored. The 27-year-old stated that she thought sexual assault and abuse issues needed to be addressed more in treatment although she did not have these issues herself. The 21-year-old also thought that abuse needed to be addressed further.

The 39-year-old felt that dealing with basic life issues after treatment needed further attention along with dual disorders, which affect alcoholic women more often than alcoholic men. She also stated that she wished her mood swings and her eating disorder were addressed. She did not understand her different emotions and how to deal with them and stated that her feelings were confusing to her.

The 36-year-old stressed that social and relationship skills needed further emphasis. She felt that this was a big part of the problems she had with co-dependency. She felt that getting into a relationship too early in her recovery did not allow her to get to know and accept herself better (see Appendix A).

Question seven: What do you think was the best part of the treatment program(s) you've attended?

The respondents had a wide range of responses for this question. The youngest respondent noted that just the realization of the destructive life course she was taking was important. She also noted that she learned to deal with her family abuse issues better.

The 43-year-old found the best part of her treatment was the fun and camaraderie she had with her peers. The 39-year-old liked how relying more on her peers in a less restrictive environment rather than on the strictness of the counselors helped her to become self-motivated with her own treatment. On the other end of the spectrum, the 36-year-old found a more controlled environment to benefit her. She also liked the all women groups.

The 27-year-old liked doing more written and journal related work. She also liked the one-on-one weekly counseling sessions with her male counselor. The 49-year-old found it beneficial to do personal inventories in order to see her destructive patterns. The oldest respondent stated that just learning about herself and how to deal with her alcoholism on a daily basis were all an important part of an effective "treatment package" for her (see Appendix A).

Question eight: What were the worst parts of the treatment program(s) you've attended?

Three of the participants mentioned their counselors in response to this question. The youngest and the 43-year-old respondents both felt that their counselors were condescending or negative. The 43-year-old also thought that the fact that her counselor was not in recovery

herself added to that condescending attitude. The 39-year-old wished that her counselors were around for more one-on-one sessions, even though she previously stated that being more reliant on her peers made her more self-motivated for her own recovery.

Three of the participants disliked how much information they were given. The 43-year-old also felt that more emphasis should have been placed on Step One (the admittance of being an alcoholic) instead of on ". . . nonsense classes that tried to jam shit into our heads." She did not like any of the classes. The oldest respondent was more positive in reporting that the amount of information she needed to digest was overwhelming at first, but that it got easier to deal with as time went on. The 27-year-old thought there was too much initial information.

The 36-year-old felt that her treatment program did not prepare her for the "real world." She felt that she was released from treatment too soon because she lacked the social skills for situations outside of the bar scenes. She was afraid that she was going to relapse and requested more structured treatment through a halfway house.

The 27-year-old thought that there were too many men in her treatment group. There was only one other female in her group and the men were "hitting on them."

The 49-year-old responded that her treatment group was really not helpful at all. She reported that she was put in a "group of people who *had* to be there" due to driving under the influence and were not there on a voluntary basis as she was. She found that these people were not being honest in the group or with themselves as far as their alcoholism was concerned (see Appendix A).

Question nine: What was your aftercare like and what would have made it better?

Five of the respondents did not find aftercare very useful and four of them did not attend it for very long, if at all. The youngest respondent found her aftercare group boring and liked

going to AA because there were more “social” things to do. The 43-year-old did not like the aftercare counselor; she thought the counselor was “inexperienced.” She stated that she might have attended aftercare if she felt better about the counselor. The 36-year-old did not go to aftercare counseling because she did not want the counselor to tell her that she should not be in a relationship during the first year after her recovery. She is the participant that previously mentioned co-dependency problems.

The 27-year-old again mentioned that she was put in an aftercare group comprised of people she did not know who were in the group because they had to be there legally. She did not learn anything new and said that it did nothing to help her further her treatment.

The 49-year-old did not find her aftercare group helpful either. She said that the group usually comprised of five to eight women where the counselor would ask each in turn how her week went. She said that her problems were not as bad as the other women’s struggles, resulting in her not being able to relate very well. She found AA more helpful for her and more focused on dealing with her alcoholism.

Two of the respondents were satisfied with aftercare. The 39-year-old said that it was “pretty good,” but remarked that she could not find any female aftercare counselors and was often the only woman in a lot of the aftercare meetings. The oldest respondent felt that aftercare helped to fill in some of the information gaps; however, she also found AA more successful in preventing her from drinking again (see Appendix A).

Question ten: What problem(s) do you still have that treatment and AA have failed to address for you?

Three of the respondents replied that their remaining problems had to do with issues that are more specific to women. The youngest stated that problems with her family and her history

of abuse need further attention. The 39-year-old stated that her "boundary issues" and low self-esteem needed to be dealt with. Another participant mentioned her co-dependency again.

Two of the participants stated that they still had problems relating to men. The 36-year-old stated that her co-dependency and other relationship issues needed to be further addressed. The 27-year-old elaborated quite a bit on this question. She felt that a lot of problems she had with men such as power and dominance needed to be worked on and that some of these problems would be difficult to work on within the confines of AA. Another problem she had with men was "thirteenth stepping," meaning that male AA members were trying to start a sexual relationship with women in the AA group. She noted that treatment did not prepare her for this. She also stated that another issue that AA and/or treatment had not addressed adequately was the improvement of interpersonal social skills. She also felt that women were very vulnerable when first getting out of treatment. She stated that treatment and AA told people to avoid any significant relationships for their first year of sobriety, but that they were not told specifically how to do this.

The 43-year-old discussed her problems with spirituality or what she called "the God thing." She elaborated that this part of her alcoholism treatment, the concept of a Higher Power, proved to be one of the most baffling for her to deal with. She also stated that AA helped her more with her alcoholism than her inpatient treatment. She believed that she "just needed the medical intervention" of the inpatient treatment.

Finally, the oldest respondent stated she was fairly happy with the outcomes of treatment and her AA group. She stated, "I just feel that I have more to learn about myself and AA." (see Appendix A).

CHAPTER FIVE: DISCUSSION

Introduction

This study identifies specific issues or themes that could help augment recovery for alcoholic women who are in treatment for alcoholism. The study involved interviews with seven adult women, 21 years or older who were in recovery from alcohol dependence and attended AA meetings in a large Wisconsin town. The interviews were conducted during the summer of 2002. This study revealed many issues relating to women's alcoholism that formed themes relating to the research questions. The research questions involved finding factors that could help women obtain treatment earlier, aspects of treatment programs needing change for women, and changes that would make aftercare better for women.

Summary of Findings

The respondents were able to identify issues that were important in their recovery from alcoholism but were not adequately addressed while in treatment and/or in aftercare by answering ten open-ended questions. It was found that the two youngest women sought treatment earlier than the most of the older women and that other women often were the impetus for many of the participants to seek treatment. The participants' answers led the researcher to believe that if women's emotional issues such as shame, fear, and apprehension were emphasized in treatment they may have benefited more from the treatment program. Relationships, both family and intimate, were an important topic for women in this study. In general, the women were not satisfied with their counselors in treatment or in aftercare.

A qualitative and descriptive analysis of the collected data was used to understand the experiences of these women. The data collected is limited due to the retrospective nature of the answers and the fact that memory often is distorted or incomplete. Due to the use of open-ended

questions, data from the subject's answers could not be analyzed with traditional statistical methods. The small sample size cannot be generalized because it is not a representative sample of a larger population. However, the information collected from these interviews may provide guidance for the improved treatment of female alcohol dependence.

Conclusions

Factors that could help women obtain treatment earlier.

It seemed that the mothers of the younger generation and the daughter of the older woman were less inhibited in suggesting treatment for their loved ones, possibly due to the societal change in thinking that alcoholism is a disease rather than a defect in character. Although society has become more accepting of women and alcoholism, much stigma still exists, particularly regarding public drunkenness and alcoholism in mothers. The two youngest participants sought treatment earlier than most of the older participants, possibly due to being more exposed to the disease theory of alcoholism and lessened stigma. In addition, the older women in the study experienced more shame than the younger women. This leads the researcher to believe that changing attitudes over time may improve the speed at which women seek treatment.

Another theme that emerged from the study was that female family members, especially the mothers of the participants, were the primary catalysts for many of the participants seeking treatment. Their mothers, despite poor relationships with them, supported the two women who were legally mandated to seek treatment. This demonstrates the strong bond that can exist between mother and daughter, even in hard times. Whether it is the mother seeking help for the daughter or the daughter seeking help for the mother, there seems to be a strong bond between the two. Relationships with female family members seem to help women seek treatment earlier.

Strengthening these relationships and ensuring that there is a support system available may help women to seek treatment earlier because their friends or relatives are close enough to recognize symptoms earlier.

Aspects of treatment programs needing change for women.

The researcher found that some of the participants would have benefited more from treatment if they were nurtured more at first rather than just fed facts about alcoholism. If they were helped to feel safer and less fearful, they probably would better handle and be more receptive to treatment. It might be beneficial to begin with attention towards the woman's feelings about entering treatment rather than facts about alcoholism/drug abuse. The researcher got the impression that the treatment program needed a slower pace. Possibly, women in treatment would be more receptive to the educational portion of the program during the latter part of treatment, when they are more cognitively alert and better detoxified. For example, one participant said that there was a lot of information first, but she got used to it. In addition, some participants did not like how many classes there were and how much information they received initially.

One aspect of treatment that was important to women in this study was the social aspect: the camaraderie of the group and relating to other people in the group, especially other women. Subjects felt more alienated when their groups were heterogeneous and when there were few other women participants. One woman did not like how her aftercare group was made up of people who were forced to be there when she was voluntarily there and another woman could not relate to women in her group who all had more severe problems than her. Yet another woman mentioned that she did not know anyone in her aftercare group and another said that no one in her aftercare group was from Hazelden, where she was treated. This leads the researcher to

suggest that more attention to treatment placement matching maybe important for women's success in treatment. Some of the participants stated that they benefited more from interacting with their peers than the therapeutic group sessions. It could be beneficial to emphasize healthy peer relationships in order to increase women's support systems during and after treatment.

A pervasive theme derived from this research is that more issues and topics relating to women need to be addressed in treatment. Important issues related to women such as self-esteem, physical abuse**,** social living skills, shame, men, stereotypes, mood swings, stigma, sexuality, co-dependency, family relationships, and relationships as a whole need to be addressed. Some participants wanted more complex issues addressed such as sexual abuse, eating disorders, and co-occurring psychological disorders. One participant said that counselors tell women to stay out of relationships during treatment, but do not tell them how or why. The research indicates that patients must learn about healthy relationships before entering new ones after treatment.

The researcher observed that treatment providers should have addressed more emotional aspects of recovery for these respondents. Shame, apprehension, and embarrassment seemed to be difficult issues that were not adequately addressed throughout the duration of treatment. It appeared that none of the participants felt comfortable with themselves during the treatment process. Had their discomfort been addressed more thoroughly or in-depth, they might have benefited more from treatment.

In general, the participants were not satisfied with their counselors. Reasons the participants were dissatisfied with their counselors were that they were either condescending, negative, inexperienced, or male. A few participants stated that they wanted more women counselors. The treatment program received a negative review from two of the participants who

stated that there were too many groups and too few one-on-one sessions. Personalizing treatment programs for clients may alleviate these problems. Women could be asked if they would prefer a woman counselor and if one was available, they could be matched together. In addition, improved training for counselors, especially on women's issues, could benefit women with alcoholism. These recommendations are ideal, but may not be possible due to funding constraints.

The participants' answers lead the researcher to suggest that some women would benefit more from women-only groups or women-only treatment. One participant complained that she disliked being hit upon by men in treatment groups. In mixed groups, some of the participants reported that males and their themes dominated the group sessions. A few participants disliked being the only woman in a group or the women being a minority. The respondents also felt apprehensive and embarrassed to talk about female related issues with men in groups.

Another issue of great concern to these subjects was how to deal with life after treatment. A few participants stated that they wanted to learn how to cope in the "real world," but they were not given adequate information on how to adjust to a sober lifestyle. Some participants were not taught practical ways to avoid relationships with men early in recovery nor how to invite healthy relationships. Other participants also stated that they did not know how to adjust to their families after treatment.

Changes that would make aftercare better for women.

Most of the participants did not benefit from aftercare very much. Many stated that they benefited more from AA than they did from their aftercare sessions. Reasons that some participants did not like aftercare were lack of female or experienced counselors, or because it was "boring". Some of the issues that women wanted addressed in treatment were not addressed

in aftercare either. Some of the women in the study had problems that were not addressed in either aftercare or AA. This points to the need for more comprehensive treatment that emphasizes issues more specific to females, such as abuse and relationships. For some participants, AA was more beneficial than aftercare in dealing with alcohol issues, but they also recognized that AA was often limited because they can only talk about alcohol issues there.

The second part of the question relating to aftercare asked what would make aftercare better and most of the participants did not address this part of the question. In order to answer this part of the question, one may assume that improving the aspects participants did not like would make it better. Almost all of the participants mentioned dissatisfaction with their aftercare counselors when discussing their experience in aftercare. One woman was afraid to go because she did not want to be ostracized by her counselor for being in a relationship, another said that the counselor was inexperienced, one mentioned a lack of female counselors, and the last thought that the counselor did not put forth much effort.

It became apparent that some of the participants were not placed in the proper group setting for their level in recovery. One woman in the study was sent to a group made up of people who were in the group due to driving under the influence, which was inappropriate for her. The participant was bothered because the other people in her group were not there voluntarily. Another woman was in a group with women whose alcoholism was far advanced than hers. She could not relate to them. Continuity should exist between the treatment and aftercare counselors to ensure the proper placement in aftercare groups. Little effort was put into these participants' aftercare plans.

Unanticipated findings

The researcher was surprised to find the importance of relationships with women in helping the participants seek treatment. Also, the general dissatisfaction with aftercare and lack of effort put forth by counselors in placing participants in aftercare surprised the researcher. In addition, the amount of information given to the participants early in treatment and how strongly they disliked this was surprising.

Also unanticipated by the researcher were answers to question nine "What was your aftercare like and what would have made it better?" Participants responded to the first part of this question, but most did not clearly answer the second part if they did address it at all. This question probably should have been split into two questions that would have better emphasized the second part of the question.

Recommendations

One area that could be explored further is the differences in older and younger women with alcoholism and their feelings of stigma and shame. The researcher thought that since the older participants felt shame more than the younger participants, there may be differences in stigma and shame among women according to age.

Determining differences in women's treatment experience among various types of treatment programs such as inpatient, outpatient, and residential is a recommendation for further research emerging from this study. This was not specifically explored among the participants in this study but the researcher noted differences in the participant's impressions and responses from different treatment settings.

A recommendation, not for research but for general medical practice, is for physicians to look at women from a more holistic viewpoint. It is critical for physicians to be more educated about the symptoms of alcoholism because it could help women seek treatment before alcohol

abuse progresses into dependence. Additionally, when a woman is alcohol dependent, it is important for a health care provider to help the woman seek treatment before her alcoholism progresses further. Alcoholism can have a huge prenatal effect on a fetus, making it even more important to determine if alcoholism exists in pregnant women.

The most important recommendation from this research concerns treatment programming for women's issues. The substance abuse treatment needs for women are markedly different than for men. Family problems, relationships, co-dependency, mood swings, abuse issues, sexuality, eating disorders, stigma, and shame all need to be emphasized in treatment for women.

This study represents a small-scale investigation into the treatment needs of women with alcoholism. Additional research may further assist mental health professionals in determining the specialized needs of women with alcoholism in recovery and treatment. There is also a need for professionals to gain additional training in this area to be more effective in treating women with alcoholism. Although there is now more available information on the topic of women and alcoholism than in the past, it would be beneficial for the information gained from this research and to be applied to practice and future research.

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APPENDIX A

Questionnaire and Subject's Individual Responses by Age

Question 1) What or who (if any) influenced you to seek treatment?

Subject's Age	Subject's Responses
21	Mother
27	Mother and legal intervention
36	Mother and legal intervention
39	Self
43	Self
49	Employee Assistance Program
65	Daughter

Question 2) How long did it take you to seek treatment?

Subject's Age	Subject's Responses
21	12 months
27	36 months
36	72 months
39	96 months
43	60 months
49	24 months
65	48 months

Question 3) What feelings or emotions did you have while in treatment?

Subject's Age	Subject's Responses
21	Fear and apprehension
27	Distrust
36	Fear
39	Fear and relief
43	Fear and shame
49	Fear and shame
65	Shame

Question 4) What social and/or family problems did you have when entering treatment?

Subject's Age	Subject's Responses
21	Bad relationship with abusive father
27	Bad relationship with father and legal issues
36	Bad relationship with father, family, alcoholic boyfriend
39	Controlling and demeaning parents, eating disorder
43	Controlling and abusive parents, alcoholic boyfriend
49	Alcoholic boyfriend
65	Reported no problems; didn't realize she needed help until she entered treatment

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Question 5) Were these problems addressed in treatment and, if so, how were they addressed?

Subject's Age	Subject's Responses
21	No. Issues with father were not adequately addressed.
27	Yes/No. Trust issues were not addressed. Bad relationship with father was addressed by writing a positive letter to him.
36	Yes/No. Co-dependency not addressed, but family session with father helped the relationship
39	Yes/No. Eating disorder not addressed but worked on family issues alone which seemed to help a little.
43	Yes. Through private sessions. Abuse issues were dealt with by writing letters to those who abused her which seemed to help
49	Yes/No. Talking about abusive boyfriend and AA seemed to help, but she did not feel like the issue was resolved.
65	Yes. Learned about her alcoholic issues and how they affected her family.

Question 6) What problems do you wish were addressed while you were in treatment?

Subject's Age	Subject's Responses
21	Abuse, especially family abuse.
27	Power and control, sexual assault, need more female counselors
36	Co-dependency, getting into relationships early in treatment, social skills, how to deal with life after treatment.
39	Mood swings, eating disorders, how to deal with life after treatment, dual disorder.

43	Self esteem and personal issues such as intimate relationships that she felt uncomfortable talking about with the group and counselors.
49	More “women’s issues” and dealing with life after treatment.
65	Women and families

Question 7) What do you think was the best part of the treatment program(s) you’ve attended?

Subject’s Age	Subject’s Responses
21	Realizing the destructive path she was on and learning to deal with her abusive past.
27	Liked the workbooks and weekly one-on-ones with male counselor.
36	The controlled environment. Sessions with all women groups were the best.
39	The need for self-motivation helped her in her recovery. Relying on peers in a less restrictive environment.
43	Camaraderie, the friendships, the humor and laughter.
49	Made her see her negative behavior patterns.
65	Learning more about herself: her alcoholism and how to deal with it.

Question 8) What was the worst part of the treatment program(s) you’ve attended?

Subject's Age	Subject's Responses
21	Felt that the counselors were sometimes condescending.
27	Too many men, not enough women. Men would "hit" on the women. Too many groups, too much initial information.
36	Program did not prepare her for the "real world" i.e., how to socialize when sober and outside of bars. Felt she was discharged too soon.
39	Wished counselors were available for more one-on-one sessions.
43	Disliked all the classes and found a non-recovering counselor negative.
49	The group was not voluntary: most were there for DUI violations and she felt that there was not a lot of motivation or honesty.
65	There was a lot of information to digest, but it got better as time went by.

Question 9) What was your aftercare like and what would have made it better?

Subject's Age	Subject's Responses
21	Aftercare was boring, liked AA better
27	Did not know the people in the group, most of which were there because of DUI violations. It was not very helpful.
36	Avoided aftercare because she started a relationship in early recovery and thought she would get negative feedback about it.
39	Pretty good; however, there were no female counselors and she

	was the only female in the group.
43	Disliked the counselor because she felt she was inexperienced and would have attended aftercare if there was a different counselor.
49	Not much help. Counselor just went around the table and asked how the week went. AA was more helpful
65	Aftercare filled in some of the questions she had. AA proved more successful.

Question 10) What problem(s) do you still have that treatment and AA have failed to address for you?

Subject's Age	Subject's Responses
21	Family problems and abuse.
27	Men issues such as power and dominance. "13th Stepping" (where male AA members would try to pick up women at AA meetings who were in early recovery in AA).
36	Co-dependency.
39	Boundary issues and self-esteem.
43	The "God" thing: AA has helped me with the issue more than treatment did. Treatment was good for medical intervention.
49	Socialization, but thinks it will come with time.
65	Felt that she has more to learn about herself, her recovery, and AA.

APPENDIX B

Consent Form

I understand that my participation in this study is strictly voluntary and I may discontinue my participation at any time without prejudice. I understand that the purpose of this study is to investigate and identify specific issues or themes that could help augment recovery for alcoholic women who are in treatment for alcoholism. I further understand that any information about me that is collected during this study will be held in the strictest confidence and will not be part of my permanent record. I understand that at the conclusion of this study all records, which identify individual participants, will be destroyed. In addition, I am aware that I have the right to view the specific information I personally provided to the researcher and the final results and outcomes of this study.

Signature of Participant: _____ Date: _____

NOTE: Questions or concerns about the research study should be addressed to Judy Milton, the researcher, who can be contacted at (715) 424-5833 or Steven Shumate, the research advisor, at (715) 232-1300. Questions about the rights of research subjects can be addressed to Sue Foxwell, Human Protections Administrator, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research, 11 Harvey Hall, Menomonie, WI, 54751, phone (715) 232-1126.

APPENDIX C

Instrumentation

The subjects were asked 10 structured questions. All sessions were tape recorded after consent was obtained from the subjects. The purpose of taping the sessions was to help the researcher in analyzing each of the subject's responses. Confidentiality was also stressed at this point.

1) What or who (if any) influenced you to seek treatment?
2) How long did it take you to seek treatment?
3) What feelings or emotions did you have while in treatment?
4) What social and/or family problems did you have when entering treatment?
5) Were these problems addressed in treatment and, if so, how were they addressed?
6) What problems do you wish were addressed while you were in treatment?
7) What do you think was the best part of the treatment program(s) you've attended?
8) What was the worst part of the treatment program(s) you've attended?
9) What was your aftercare like and what would have made it better?
10) What problem(s) do you still have that treatment and AA have failed to address for you?