WOMEN WHO DRINK: A STUDY OF
MATURE AGED WOMEN WHO MISUSE ALCOHOL

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Women who drink: A study of mature age women who misuse alcohol

This study aims to explore the subjective experiences of mature aged women who misuse alcohol. Specifically the goals are to gain an understanding of how the women viewed themselves, how they experienced and made sense of their alcohol use, their experiences of seeking help for their alcohol misuse, motivation to quit or reduce their drinking and possible barriers to seeking and receiving help. An overarching goal is to gain greater insight into the factors that make mature aged women vulnerable to substance misuse and how detection and treatment may be facilitated for such women.

The sample used in this study consisted of nineteen middle-class women between the ages of forty and sixty. All of the participants were volunteers who self-identified as problem drinkers. The women were interviewed using a semi-structured format. The data was analysed using interpretive phenomenological analysis.

A number of findings emerged from this study. First, due to negative relational images that were possibly formed in childhood, the participants brought a sense of worthlessness and powerlessness, as well as mistrust of others and a fear of vulnerability, into their current relationships. This creates disconnection in family relationships, which can make women vulnerable to alcohol misuse. This progression of disconnection leads towards increasing isolation. Next, as a result of such isolation, it appears as though the women who participated in this study felt a deep sense of alienation from both the self and from others, which manifested through intense feelings of emptiness, loneliness, and worthlessness. Such feelings are strongly linked to the use of avoidant coping mechanisms. The participants in this study seemed to use alcohol as their primary coping strategy. However, it seems that using alcohol in order to cope created more problems than it actually solved; it could be liked to solving a problem with a problem. As women avoided coping with their problems they seemed to lose the capacity to cope and as a result their lives became unmanageable to a point where they could not longer deny their difficulties.
With regards to seeking and receiving help for alcohol misuse, it appears that the stereotypes associated with female alcohol misuse pose the biggest barrier to seeking treatment. Because these stereotypes are at odds with the real experiences of the women who participate in this study, they were less likely to identify their alcohol misuse as a serious issue until their lives had become completely unmanageable. The stereotypes also tend to lead to underdiagnosis or misdiagnosis of the problem by health professionals. Finally since such stereotypes also create stigma around female alcohol misuse, there was a significant amount of guilt and shame associated with the participants’ drinking, which created a tendency for the participants to hide their drinking, which means it took longer for women to seek out help. With regard to treatment for alcohol misuse it appears that the most effective forms of treatment are those that focus on self-awareness, that promote growth-fostering connection, and that provide a safe and empowering environment, in which women are able to explore their emotional experience and to reach out for help. In order to recover, women must move from a place of isolation and pain to one of mutuality and relational resilience.
Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in other part from a thesis for any other degree or diploma.

No other person’s work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

During the execution of the research, which this thesis reports, all the research procedures approved by the Swinburne University Human Research Ethics Committee were followed.

Signed:

Date:
Acknowledgements

I would first like to acknowledge the women who volunteered to participate in this study. These women generously took time out from their busy lives to share their experiences with me. I have great respect for the bravery of the participants, who spoke honestly and forthrightly about their relationships, their feelings, their alcohol misuse and about how it had affected their lives. In sharing such intimate aspects of their lives with a stranger, these women showed a tremendous capacity for trust and I can only hope that this thesis has done them justice.

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Chapter 1 Introduction

1.1 The personal context for this study

My first job after obtaining my Bachelor of Arts degree in psychology was as a “supportive care worker” at a drug and alcohol recovery house for women in Vancouver. Through this job I had the opportunity to know many women who were trying to change their lives and find a new way of being in the world. With some of these women I formed strong therapeutic bonds and became privy to their histories as they shared the stories of their lives with me. Working at a recovery house also provided me the opportunity to witness the recovery process that many women go through from their first weeks of sobriety to the end of their first year of sobriety. I witnessed both success and failure and saw the best and the worst of these women. What I learned from this job was to see past the substance misuse, to understand that this was just a part of who these women were. I also gained an understanding of the various contexts in which women feel the need to abuse substances.

Since that first job my work as a counsellor has brought me into contact with numerous women who have struggled with substance misuse and while some of these women appeared to fit the stereotype of a substance abuser, the majority did not. Additionally while each woman has been unique, all of the women told stories of emotional pain and alienation for which they used substances to cope. I began to understand that the substance use, while significant, was not the primary problem, but a symptom of something bigger. I’ve come to realise that to understand the symptoms one must know the story.

When I began my doctoral degree my supervisor (knowing my experience in the drug and alcohol field) approached me with the idea of studying women and alcohol for my thesis. I accepted his suggestion and began to do my reading into the topic. Through my preliminary investigation I came to understand that there was very little information on alcohol misuse among mature aged women. I also came to realise that very little had been done to target alcohol misuse amongst women, particularly older women; there were governmental campaigns addressing binge drinking in young people and alcohol-fuelled violence in men, but that appeared to be the extent of it. I
began to wonder who was falling through the cracks, so to speak. I came to the conclusion that it might be mature aged women.

As mentioned previously, in order to understand a phenomenon one must know the story and for this reason I chose a qualitative design. I was less interested in why mature aged women drank; I wanted to understand how these women came to a place in their lives where they felt the need to misuse alcohol, what had contributed to the need to misuse alcohol, and how these women learned that alcohol was the most effective coping strategy. I feel that by understanding how one can start to develop strategies for addressing alcohol misuse and to help women find new strategies for dealing with their pain.

1.2 Alcohol use in Australia
Alcohol has long been a significant part of the Anglo-Australian culture. Australians drink for a multitude of reasons; for relaxation, for pleasure, to celebrate, to ‘drown one’s sorrows,’ out of habit, and for some it becomes a compulsion. According to the Victorian component of the National Drug Strategy Household Survey, alcohol is the most widely used drug in Victoria, with almost half of all Victorians over the age of 14 drinking on a daily or weekly basis, (Victorian State Government, 2008). It has been found that in 2008 90% of people over the age of 14 had tried drinking at some point in their lives and 82.9% had consumed alcohol within the last 12 months, (National Health and Medical Research Council, 2009). “Considering both short-term and long-term harm, high risk drinking or dependence in Australia is estimated at 5% of the population, 15% are considered ‘at-risk’ drinkers, 65% ‘low-risk’ drinkers and 15% are non-drinkers,” (p. 8). The increase in those drinking at a risky/high risk level since 1995 has been greater for women than men. From three surveys since 1995, the proportion of females who drank at a risky/high risk level increased from 6.2% to 11.7%, while for males the increase was from 10.3% to 15.2%, after adjusting for age differences, (Australian Bureau of Statistics, 2006). In Australia there are over 5000 deaths per year as a result of alcohol consumption and for each death approximately 19 years of life are lost, (National Health and Medical Research Council, 2009). It is also important to note that 41-70% of violent crime in Australia is committed under the influence of alcohol. There has also been a connection made between family violence and alcohol consumption. In 28% of family incident reports submitted in
Victoria between 2002 and 2003 alcohol was identified as a definite factor. Mental health issues are also prevalent with anxiety and depression frequently co-occurring with alcohol problems, (Victorian State Government, 2008).

It is becoming increasingly evident that alcohol can cause significant harm to both the community at large and to the individual. As a result of the mounting evidence, the State and National Governments are attempting to implement strategies to help reduce the harm caused by at-risk alcohol consumption. This is evident through the increased advertising campaigns geared towards curbing both binge-drinking and alcohol-fuelled violence. The Victorian Government (2008) has developed an action plan for 2008 to 2013 called Restoring the Balance, which aims to:

- reduce risky drinking and its impact on families and young people
- reduce the consequence of risky drinking on health, productivity, and public safety
- reduce the impact of alcohol-fuelled violence and anti-social behaviour on public safety
- provide people seeking assistance for problematic alcohol use access to a range of community-based and residential treatment services. These would include counselling, residential withdrawal services, rehabilitation, outreach services and day programs.

At the present time it is unclear to what extent this action plan has been implemented, with the exception of the increased number of advertising campaigns previously mentioned. It is also unclear as to which populations this strategy will reach since “many Australian drinkers, particularly those who drink at risky or high-risk levels, incorrectly estimate safe drinking levels,” (p. 27) and may not believe they have a problem and therefore would not actively seek help.

One subgroup of the population that is particularly unlikely to seek help for problematic alcohol use is mature aged women. Women who abuse alcohol are more likely to seek help for depression or anxiety and often they view their alcohol misuse as secondary and often blame their drinking on external factors, such as relationship difficulties or a general dissatisfaction with their lives. They are also less likely to identify themselves as alcoholic or alcohol abusers due to the stigma (and shame as a result) attached to women who drink to excess, (van der Walde, Urgenson, Weltz &
Hanna, 2002). This is of particular concern since the proportion of females drinking at risky and high-risk levels was highest amongst mature-aged women. In 2004-05, 13% of females aged 45-54 years were risky/high-risk level drinkers. This compares to 10% in 2001 and 6.7% in 1995, (Australian Bureau of Statistics, 2006).

1.3 Research goal
This study aimed to explore the subjective experiences of mature-aged women who misuse alcohol. Specifically the goals were to gain an understanding of how the women viewed themselves, how they experienced and made sense of their alcohol use, their experiences of seeking help for their alcohol misuse, motivation to quit or reduce their drinking and possible barriers to seeking and receiving help. An overarching goal is to gain greater insight into the factors that make mature-aged women vulnerable to substance misuse and how prevention and treatment may be facilitated for such women.

1.4 Motivation for the study
There appears to be a discrepancy between the literature on men and women’s experience of substance misuse such that there is still a great deal to be learned about women’s experiences of misuse, treatment and recovery. Women “differ from their male counterparts in specific ways, such as patterns of use, psychosocial characteristics, and physiological consequences of alcohol use,” (Nelson-Zlupko et al. 1995). Additionally the negative impact of being identified as a misuser of alcohol appears to be much greater for women, (Hood, 2003).

Compared to men, women’s biology causes them to suffer from severe organic damage due to alcohol consumption at a much quicker rate; women are much more susceptible to the physiological consequences of alcohol misuse. It has been shown that alcohol is more soluble in water than fat and women have more fatty tissue in their bodies than men. Therefore a woman consuming the same amount of alcohol as a man of similar size will have a higher blood alcohol level. Women also produce less alcohol dehydrogenase, a stomach enzyme that breaks down alcohol, which means that women break down less alcohol during digestion, which also leads to a higher blood alcohol level than men. Women also have a greater risk of developing cirrhosis of the liver, and once contracted, women deteriorate at a quicker rate than men.
Alcohol misuse has also been related to infertility, miscarriage, spontaneous abortion, and foetal alcohol syndrome, (van der Walde, et. al., 2002). Finally with regard to health risks, “moderate alcohol consumption increased the circulating oestrogen levels of post-menopausal women by 300%. This finding is particularly alarming given that circulating oestrogens have been linked to a marked increase in the development of breast cancer,” (p. 146).

In general it appears that society is more accepting of heavy drinking in men, and indeed the literature seems to support this. According to van der Walde et. al. (2002), men and women have very different psychosocial realities and for women the emotional and social consequences for drinking are unique. Women who misuse alcohol tend to experience greater discrimination and there is an increased sex bias and social stigma towards these women. It is important to note that, “a woman’s development and experience throughout her lifetime are in the context of relationship to others. It is within this context of relationship to others that societal attitudes toward alcoholic women and women’s views of themselves exist,” (p. 147). Most often it is women’s traditional roles as wives, mothers, caretakers and sexual partners that form society’s expectations of women. Should a woman deviate from such roles they are often disparaged, (Beckman, 1994). Because of such stigma, women tend not to identify alcohol as their primary problem, so not only do attitudes and stereotypes regarding women and alcohol misuse create barriers to treatment they also create barriers to detection and diagnosis. These general misconceptions serve to strengthen denial by both the woman and her family members, and healthcare professionals, which leads to under-diagnosis of the problem until the woman reaches the advanced stages of alcoholism. Because of the social stigma women often deny alcohol-related conditions, hide their drinking, and may drink alone. Thus those close to them, including their physicians are less likely to suspect alcohol misuse or alcoholism, (Blum, Nielsen & Riggs, 1998).

A great deal of the literature appears to focus on specific subgroups of women with severe alcohol problems within treatment populations and there is little research that explores the drinking behaviours of women in the general population. Research appears to have studied the phenomenon within a vacuum, without acknowledging that, “drinking behaviour is a complex phenomenon, mediated by a variety of
individual, social, and environmental factors, and that research and intervention activity should mirror that reality,” (Hands, Banwell & Hamilton, 1995 p. 18). While most of the literature on women and alcohol focuses on women in general, or even younger women, more specifically, there appears to be a dearth of literature that specifically explores the experiences of mature aged women who are struggling with alcohol misuse. So, this study attempted to explore the every day realities of mature aged women who misuse alcohol. It aimed to understand their patterns of use, their views of themselves, how they make sense of their alcohol use, any efforts to seek help and any perceived barriers to help seeking. This population appears to have fallen through the cracks with a number of participants referring to the hidden epidemic of alcohol misuse within their demographic. It was this researcher’s belief that it was society’s misconceptions and prejudices towards these women that had contributed to a lack of understanding and identification of alcohol misuse amongst this population, even by the women themselves. It was hoped that this study would bring the problem to light and provide greater understanding and intervention for this population.

1.5 Theoretical frameworks
Since this study aimed to explore the subjective experience of female alcohol misuse, the researcher believed that the use of a feminist theory was appropriate. As West (2005, p. 94) eloquently stated, “early theories addressed the individual, observed from a clinical distance, excised from context, specimen-like in study, pathology-driven in practice, male-dominated in interpretation- a sort of ‘this is your experience and I will tell you about it approach.’” These theories then permeated psychological research. However, feminist theory acknowledges that any theory that does not recognise the diversity of experience is tremendously limited in its validity and usefulness.” In keeping with this ideal the findings that emerge from this study will be viewed from a Relational-Cultural Theory prospective.

As was previously mentioned women’s experiences and development tend to occur in the context of relationship to others. In many societies women have been given the responsibility of caring for and maintaining relationships and therefore much of their self-worth and sense of self is dependent upon their feelings of connection with others, (Covington and Surrey, 1997). Relational-Cultural Theory (RCT) posits that
connection is central to human growth and development and that isolation is the primary source of human suffering. It is believed that human beings grow through and toward connection. We develop through movement to increasingly differentiated and growth-fostering connection, (Jordan & Walker, 2004). “When we are hurt, misunderstood, or violated in some way, when we attempt to represent our experiences to the injuring person and we are not responded to, we learn to suppress our experience and disconnect from both our own feelings and the other person, (p. 2). However, when one is able to express her feelings and is responded to with care and one can see that she has had an effect, then she will feel that she is effective in relationship with others, that she can participate in growth-fostering, healthy relationships. The result is that one feels anchored in community and has a feeling of relational competence. According to Jordan (1994 a.) when women do not feel as though they can represent themselves effectively, when they do not feel heard or responded to by others, they will falsify, detach from, or suppress their responses. When this happens women learn that they cannot have an impact on other people in important relationships. As a result they develop feelings of isolation, immobilisation, self-blame, and relational incompetence. It inhibits engagement with life and the capacity to love, to act with a sense of awareness, to meet others, to grow and to contribute to the growth of others. A feeling of disconnection, which is at the root of distress and the development of psychopathology, ensues (West, 2005). Consequently, this theory lends itself well to the exploration of the phenomenon of alcohol misuse in middle-aged women and will be explored further in Chapter 2.

1.6 Terminology

When discussing substance abuse there is a variety of terminology that is used to describe high levels of alcohol use. The most frequently used terms are alcohol misuse, alcohol abuse, alcohol dependence and alcoholism. The DSM-IV-TR (2000) describes substance dependence as “a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern or repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behaviour,” (p. 192). Substance abuse is described as a “maladaptive pattern of substance use leading to clinically significant impairment or distress, occurring within
a 12-month period,” (p. 199). While the participants of this study may very well meet all the criteria for both substance abuse and dependence, they were not screened using any diagnostic tools, and self-identification was the primary criteria for participations. So, for the purpose of this study the term alcohol misuse will be used to describe the participants’ problematic consumption of alcohol. The researcher believes that alcohol misuse reflects the problematic and behavioural nature of alcoholism without requiring that a particular set of criteria be met.

1.7 Discussion of the following chapters
Chapter 1 has provided a brief introduction of this study. In Chapter 2 an introduction to the phenomenon of alcohol misuse amongst women, with a focus specifically on mature aged women, will be provided. Chapter 2 will also provide a discussion of alcohol misuse from the prospective of Relational-Cultural Theory as well as exploring motivation to stop using alcohol, possible barriers to seeking help and various theoretical views of treatment of alcohol misuse amongst women. Chapter 2 will also provide a brief discussion of some of the concepts implicated in alcohol misuse. Chapter 3 outlines the research method of this study; it provides information regarding the method used and the various stages of the research process. Chapter 4 presents the results of the study. Although certain interpretation by the author is unavoidable during analysis of the data, little theory is attached at this stage in order to present the results as naturally as possible, with the aim of getting as close as possible to the lived realities of the participants. In Chapter 5 the findings are integrated with relevant theory. The final chapter, Chapter 6, is the conclusion, which provides recommendations for further study.
Chapter 2  Literature Review

2.1 Women and alcohol
There appears to be little known about the factors associated with women and alcohol misuse. Even as recently as 1990 alcoholism was often studied exclusively in men. It is also important to note that the majority of research has not explored the development of alcohol misuse and abuse from the perspective of the women themselves and because of this there seems to be a lack of information and understanding of women’s experience of alcohol misuse, (Boyd & Mackey, 2000 a.). The majority of literature focuses on the ‘why’ of women and alcohol misuse or on the effects of alcohol misuse, rather than on ‘how’ women get to the point where they feel the need to misuse alcohol on a daily basis. There is also a large amount of literature that provides recommendations for the treatment of female alcohol misusers, but without understanding how women developed this practice these recommendations may actually fall short of effectively helping women address their problematic consumption of alcohol.

There appears to be a number of factors that might contribute to women misusing alcohol. More than men, women tend to attribute their alcohol misuse to critical life events such as the death of a loved one, divorce, family dysfunction, or to psychological distress, such as depression or anxiety, (Chatham, 1990). According to Middleton Fillmore and colleagues, there is a more consistent association between drinking and depression in women than there is in men and that separation and divorce are related to an increase in alcohol consumption amongst younger women, (Middleton Fillmore, Golding, Leino, Motoyoshi, Shoemaker, Terry, Ager & Ferrer, 1997). It is thought that women channel such difficulties into internalised distress (i.e. feeling isolated, distrustful, or helpless) and this is manifested externally as emotional upset, which is dealt with through the use of alcohol, (Lex, 1994). Also, a causal link has been found between women who misuse alcohol and heavy drinking spouses; women are more influenced by partners who drink, (Redgrave, Swartz & Romanoski, 2003). Indeed, it is often the drinking patterns of male partners that predict alcohol use in women, (Blum, Nielsen & Riggs, 1998). Additionally, it is important to note that higher rates of alcohol misuse and dependence have been found in women who
report having only one or no friends for support when compared with women with more friends, (Rundberg, Lindfeldt, Norbrand, Samsoioe, Romelsjo & Ojehagen, 2008)

Relationship difficulties and emotional distress are not the only factors thought to be associated with alcohol misuse amongst women. There is much research connecting alcohol misuse to childhood abuse and neglect, (van der Walde et al. 2002, Boyd & Mackey, 2000a, Copeland & Hall, 1992). “It is estimated that somewhere between 30 and 80% of alcoholic women were victims of incest,” (van der Walde et. al. 2002 p. 147). However, according to van der Walde and colleagues there is disagreement as to the correlation between sexual abuse and alcohol misuse and there may be other relevant factors such as the lack of a nurturing family environment. There is also a greater prevalence of anxiety and depression among women who misuse alcohol than their male counterparts, and women often receive secondary diagnoses of mania, somatization, major depression, panic disorder and phobic disorder. These women also tend to have dysfunctional coping styles, which involves denying or minimising their problems, (Beckman, 1994). Indeed, alcohol is used by many to temporarily forget problems and facilitates the avoidance of problems through the ‘numbing’ of negative feelings, (Cooper, Frone, Russell & Pierce, 1997). However, it may be difficult to determine whether poor coping mechanisms and inability to deal with stress leads to alcohol misuse or if they are a product of alcohol misuse, (San Jose, Van Oers, Van de Mheen, Garretsen & Mackenbach, 2000).

2.2 Mature aged women and alcohol

While there is little research into women’s misuse of alcohol, it is unclear as to why this may be, but what little research there is often addresses the issue within the context of alcohol use across the lifespan and the focus has primarily been on young or mixed-age samples of problem drinkers. Perhaps part of the reason that so little is known about mature aged women who misuse alcohol is that this group is less likely to seek help specifically for drinking problems, but more often seeks help from mental health professionals or their general practitioners (GP’s) for personal or family difficulties. Mature aged women tend to have more stressors in the areas of spousal relationships and their extended families; they report significantly more spousal difficulties and fewer spousal resources. Marital conflict and lack of support typically
are serious challenges for older problem drinking women, (Brennan, Moos & Kim, 1993).

Loss has been associated with alcohol misuse amongst women of mature age. Women of this age group may face a number of losses: retirement, children leaving home, death of parents or a partner, any one of which can lead to feelings of loneliness, and depressed mood (Rundberg et. al., 2008). Gomberg (1997) also found that mature aged women often deal with the issue of lost roles; women in their forties who misuse alcohol are more likely to be divorced or separated, unemployed and be struggling with a child’s recent move from the family home. Gomberg (1994) has identified a number of life event patterns that emerge in other age groups but seem to be of greater significance in mature aged female problem drinkers, these include:

- minimal likelihood of acquiring new roles, a new job, new interests (failing to adapt to growing older)
- empty nest status, distress, feelings of abandonment
- heavy spousal drinking and marital disruption
- the most frequent drinking pattern engaged in is at home and often alone
- abuse of prescribed psychoactive drugs
- patterns of comorbidity, including previous or current diagnoses of depression, eating disorder, a phobia, a panic disorder, or anxiety state, (p.224)

All of the above can leave women with a feeling of disconnection, they attempt to alleviate, temporarily, with alcohol.

2.3 Concepts implicated in alcohol misuse

2.3.1 Depression

Many women who misuse alcohol report suffering from depression. Depression is the most common mental health disorder accompanying female alcohol misuse and a greater number of women than men who are depressed develop alcohol problems, (Hartling, 2004). The rate of lifetime diagnosis of major depression in women who misuse alcohol is approximately three times that of the general population and is the primary diagnosis in 66% of alcohol misusing women, (Boyd & Mackey, 2000a). However, it is not clear whether depression is the primary cause of misuse or if it is a consequence of misusing alcohol. Researchers speak of primary and secondary alcohol misuse, with secondary alcohol misuse preceding the depressive symptoms.
Secondary alcohol misuse is associated with an earlier onset of drinking and earlier loss of control over use. Here alcohol is used for the purpose of self-medicating, whereas with primary alcohol misuse there is more likely to be family history of alcohol misuse and family dysfunction, (Kumpfer, Prazza & Whiteside, 1990; Gomberg, 1994). Beginning in childhood, women who misuse alcohol tend to experience feelings of despair and hopelessness, (Lillie, 2002). Additionally, women entering treatment for alcohol misuse are more likely to have a history of both psychiatric counselling and suicide attempts, (Davis, 1990).

2.3.2 Poor self-concept
Feelings of low self-esteem and poor self-concept as well as a tendency to experience feelings of inadequacy and futility are frequently reported by women with a history of alcohol misuse, (Kumpfer et. al., 1990). Women who drink tend to have lower self-esteem and are likely to have an inadequate or distorted self-concept, (Lillie, 2002). Women who misuse alcohol often believe that they are fundamentally flawed and as a result tend to experience a great sense of self-loathing, (Boyd & Mackey, 2000a). The stigma attached to women who misuse alcohol only serves to reinforce this poor self-concept.

2.3.3 Dysfunctional family relationships
According to Kumpfer and colleagues, depression and poor self-concept are often linked to poor familial relationships; this appears to be particularly true for women who misuse alcohol. Such women are more likely to come from dysfunctional family environments and are more likely to have a family member who misuses alcohol. They are also more likely than men who misuse alcohol to have a spouse who has problems with alcohol. As children, women who misuse alcohol more often had poor relationships with their parents and had more behavioural and emotional problems. This population often had less parental approval and more feelings of childhood deprivation and lack of social support than did women who do not misuse alcohol, (Kumpfer et. al., 1990). A large number of women who misuse alcohol report a history of abuse, emotional deprivation and neglect from significant others. As a result these women may develop feelings of inadequacy, which can lead to loneliness, isolation, and intensified stress, (McDonough, et. al., 1994). Feelings of despair, hopelessness and self-loathing tend to begin in childhood when affected women
receive little nurturing and limited positive feedback on which to build a healthy sense of self, (Boyd & Mackey, 2000a). Additionally, women who misuse alcohol tend to have less supportive and happy relationships and have higher divorce and separation rates; husbands are not as tolerant as wives of alcohol misuse and divorce their wives more frequently, (Kumpfer et. al., 1990). Also, these women report a greater number of spouse stressors and fewer spousal resources, highlighting the fact that marital conflict and a lack of support can contribute further to the misuse of alcohol, (Brennan et. al., 1993).

2.3.4 Coping
Coping refers to cognitive and behavioural attempts to overcome, lessen, or tolerate the internal or external pressure created by stressful events or situations. According to Cooper and colleagues, coping can be broadly categorized into two styles- active coping and avoidance coping. With active coping one recognises that a problem exists and that a coping effort is needed. With avoidance coping, on the other hand, one fails to confront a problem by denying its existence, minimizing its severity, diverting attention away from it and/or venting negative feelings. Research shows that women tend to engage in more avoidant coping, whereas men tend to utilise more active coping strategies in dealing with stress, except when seeking help from others; here the pattern is reversed, (Cooper, Frone, Russell & Peirce, 1997).

Research also shows a link between stress and alcohol misuse, with a significant positive correlation between negative events and alcohol use. It has been theorised that alcohol is used to cope with negative emotions or to relieve tension. Since alcohol is believed to have properties that facilitate the avoidance of problems (i.e. ‘numbs’ negative emotions, helps one to forget problems) it would seem to be particularly likely to be used as an avoidant coping strategy. Therefore it would appear that alcohol use is negatively correlated with active coping, (Cooper, et. al., 1997). Since women have a tendency to use more avoidant coping strategies it would seem that some women might choose alcohol as a means of dealing with negative emotions or difficult life circumstances.

Women who misuse alcohol often report that drinking makes everything seem more manageable. These women say that drinking makes it easier to cope with social,
work, and domestic situations; that alcohol is a confidence booster; that it makes them feel more connected to peers; that it makes them feel better about themselves and alleviates negative feelings, (Lillie, 2002). “Women are much more likely to attribute their drinking to a traumatic event or stressor and often view their drinking as self-medication,” (Brienza & Stein, 2002). Indeed how a woman reacts to stressful events and her ability to cope with these circumstances can increase or decrease the likelihood of her misusing alcohol. Certain coping mechanisms such as wishful thinking, escape or avoidance, and denial tend to appear more frequently among female problem drinkers, (Gomberg, 1994). As Boyd and Mackey (2000b) claim, women misuse alcohol as a means of escaping the unbearable pain associated with feelings of intense sadness, or of feeling unloved or unwanted. Drinking may become the primary and most powerful strategy to deal with the pain and stress of every day life.

2.4 Relational-Cultural Perspective of alcohol misuse

According to Relational-Cultural Theory (RCT), connection with others is the key to growth and development. Isolation is considered to be the primary source of suffering and human beings grow through and toward connection. The path of development is through movement to increasingly differentiated and growth-fostering connection, (Jordan & Walker, 2004). It is important to note that, “the path of connection is filled with disconnections, the vulnerability of seeking reconnection and the tension around needing to move away, possibly to hide in protective inauthenticity,” (p.3). However there is still a yearning for connection, a need to contribute to others, and serve something larger than the self. But, when one cannot represent herself authentically in relationships, when her real experience is not acknowledged by the other person, then she will falsify, detach from, or suppress her response. When this happens a woman learns that she cannot have an impact on other people in important relationships and as a result she develops feelings of isolation, immobilization, self-blame, and relational incompetence. This inhibits engagement with life, the capacity for love and to move with a sense of awareness to meet others, to grow and to contribute to the growth of others, (Jordan 2004a).

Most of the dominant psychological theories view substance misuse as an individualistic problem; the problem lies with the individual who is, in some way,
deficient (i.e. weak-willed, immature, has poor decision-making skills, has low self-esteem, no self-control). Because of this a number of preventative recommendations for substance misuse emphasize providing information or teaching skills that encourage women to stand alone, think independently and be self-sufficient; prevention through self-sufficiency, disconnection, or separation. However, research has shown that being in relationship and feeling connected to others can reduce the risk of developing a problem with substance misuse. RCT considers substance misuse to be a “disease of disconnection,” which separates and isolates women from essential relationships that can act as preventative measures and separates them from relationships that are required for growth and well-being, (Hartling, 2004). “This disease of disconnection is characterized by a complex interaction of factors that affect an individual’s ability to overcome serious relational disruptions or adverse experiences that can trigger or intensify substance use or abuse. These factors also influence a woman’s ability to find and maintain relationships that would lead her toward well-being, healing or recovery,” (Hartling, 2004 p. 200).

According to Covington and Surrey (1997) women often begin using alcohol as a way of feeling connected to others; they may even be trying to change themselves in order to maintain mutuality or a relationship with a partner or friendship group that uses alcohol excessively. Alcohol can reduce social inhibitions, diminishing fears of rejection and isolation in social settings, but it can easily become entangled with efforts to find authentic relationships and fulfil the natural desire for connection, (Hartling, 2004). However, rather than fostering connection, the opposite frequently occurs, leaving one feeling even more disconnected. As a result women may experience a depressive spiral, which leads to feelings of diminished zest and vitality, lack of clarity or confusion, disempowerment, diminished self-worth and a turning away from relationships. It is at this point that women are most susceptible to alcohol misuse as a way of alleviating these feelings; they look to alcohol to meet the needs that are not being met by their relationships, (Covington & Surrey, 1997). Women often drink to achieve a sense of connection, but because of the social stigma of alcoholism, drinking only serves to increase women’s sense of isolation, loneliness and disconnection, (van der Walde, et. al., 2002). Substance misuse frequently contributes to many serious forms of disconnection. It may provide women with a precarious but easily accessible method for coping with this profound sense of
disconnection, but, it is like a vicious cycle, the alcohol misuse prevents the woman from achieving the connections she desires and prevents any real growth, which leads to greater isolation, and greater substance misuse. A relationship (a toxic one at that) is formed with the alcohol rather than with people, (Covington & Surrey, 1997).

2.5 Motivation to stop using alcohol

It is important to understand what might motivate women to seek help for their alcohol misuse as well as the process women go through to get to that point. Through this understanding health practitioners may be able to offer more effective and relevant services to these women. Some researchers argue that clients should be offered different kinds of information and counselling depending on their motivation to change, (Miller, 1995, Brown, Melchoir, Panter, Slaughter & Huba, 2000).

According to the Stages of Change or Transtheoretical Model, (Brown, et. al., 2000) there are five stages of change: precontemplation, contemplation, preparation, action, and maintenance. In the precontemplation stage an individual is not thinking about change, that comes during the contemplation stage, in which she is seriously thinking about changing behaviour within the next six months. Next is the preparation stage, in which the person is planning to take action to change behaviours in the next month. People who get to the preparation stage have often tried, unsuccessfully, to change in the past. In the action stage the individual has begun, over the past six months, to implement behavioural changes. Finally one comes to the maintenance stage, in which she has successfully changed her behaviour and is now trying to prevent relapse. Greater self-efficacy comes as the person progresses through the stages. It is important to note that when the behaviour to be changed is an addictive behaviour, people do not always move systematically through the stages of change; they could relapse and cycle back through the stages in a spiral fashion. Out of the Stages of Change Model came the Steps of Change Model. This is based on the idea that women may want to make simultaneous changes in several areas of their lives. When women enter into treatment for substance misuse they not only go through a process of contemplation, preparation, and action to obtain help with substance misuse issues, but also experience a series of other conflicting needs and priorities, such as current struggles with depression and anxiety and relationship difficulties. The Steps of Change Model hypothesises that women will focus on the most immediate or most threatening problems first. These women need to start by addressing the immediate
problems that they are most ready to change, usually interpersonal difficulties, (Brown, et. al., 2000).

Copeland (1998) speaks about the idea of spontaneous remission. She argues that there are several factors that may facilitate spontaneous remission, or natural recovery. These include: health concerns, strong social sanctions (i.e. a charge of driving under the influence, threat of incarceration), life events, such as pregnancy, the positive influence of family, and spousal support. There are four stages of natural recovery:

1. Resolving to quit, which is often preceded by a negative personal experience (this may be what is referred to as ‘hitting rock bottom’), or labelling oneself alcoholic or alcohol dependent.
2. Breaking away from the lifestyle associated with ones addiction, or misuse (i.e. social circles, accommodation, recreational activities)
3. Staying abstinent, which requires a relapse prevention plan
4. Entering mainstream or conventional society

This could be considered self-managed change, which requires women to make radical changes in their lives. Women who choose this path must make serious adjustments to social networks, intimate relationships, and social activities. Women must be aware of and avoid high-risk situations, develop new skills and ways of being, and develop a more positive attitude; not an easy feat, and one that many women would struggle to achieve on their own.

Women have all sorts of reasons to want to quit drinking. According to Copeland (1998) there are three major themes: concerns for physical and psychological health; a sense of losing a sense of self or identity; and concern for the welfare of others. In a study conducted by Gomberg and Schilit (1986) it was found that while women with alcohol problems tend to be criticised and rejected by friends or family, the interactions clearly can be reciprocal. “The women’s drinking behaviour, unsurprisingly, tends to elicit negative responses from family and friends, but the outcome of increasing isolation and loneliness is related to many of the alcoholic women’s behavioural choices, as well as to rejection by others,” (p. 313). Women with alcohol problems are not always passive victims: family and friends avoid or argue with them and they reduce their social circles, feeling increasingly lonely and
isolated. Women who abuse alcohol tend to get caught in a vicious cycle or downward spiral of drinking to cope with life, to enhance mood, to ‘numb’ negative feeling, which can lead to dependence. This increases depression and leads to feelings of guilt, shame, and worthlessness, (Lillie, 2002). At first alcohol misuse feels like a protective strategy, but in the long run it acts to further isolate the women, (Banks 2006). The solution has become the problem, and once women are able to acknowledge this fact and the role they have played, they begin to contemplate getting out. This is when women begin to think about giving up alcohol.

2.6 Barriers to seeking help
There is little information about the barriers to seeking help that specifically addresses women of mature age. Because of this the following discussion focuses on women in general.

In order to determine the best course of treatment for women who are struggling with alcohol misuse problems, one must have a clear understanding of the multiple barriers women face when seeking help for their alcohol misuse. One of the most significant barriers for women is understanding and identifying that they have a problem with alcohol. Often women do not believe that their drinking is the primary problem, they frequently use alcohol to cope with a crisis or a difficult situation, something that is supported somewhat by our society, (van der Walde, et. al., 2002, Thom, 1986.) Also, it appears that women have a tendency to seek alcohol-specific treatment less frequently than men; they will generally seek help from less specialised services such as general practitioners, gynaecologists, or therapists, despite reporting more severe alcohol symptoms than men. Women are more likely to see anxiety or depression as the primary problem and seek treatment accordingly (Greenfield, 2002). Women also are likely to deny that their drinking has negatively impacted their ability to fulfil their roles as wives and mothers, and tend to minimize the harmful effects of their drinking, (Thom, 1986).

A significant factor that may contribute to women not identifying alcohol as their primary problem or denying the deleterious effect alcohol is having on their personal lives is the stigma associated with women who misuse alcohol. Such women are frequently seen as lacking femininity, as sexually promiscuous, and as poor mothers,
They are also seen as demonstrating greater pathology and having poorer treatment outcomes than their male counterparts, (Walitzer & Connors, 1997). This stigma can lead to low self-esteem, and a tendency for women to hide their drinking, (Jarvis, 1992). There is often so much shame and guilt that women will deny their drinking problems, (van der Walde, et. al., 2002), which results in women withdrawing socially in order to remain undetected for as long as possible thereby delaying treatment, (McDonough, Bradley & Russell, 1994).

The stigma surrounding female alcohol misuse has led to misconceptions about the type of women who misuse alcohol. Because of this a large population of women who are experiencing problems with alcohol remain under diagnosed and undetected. Literature shows that healthcare professionals are less effective in diagnosing women than men and women are frequently misdiagnosed and as a result physicians will prescribe medication to treat a psychological disorder and miss a diagnosis of alcohol misuse altogether, (van der Walde, et. al., 2002). Part of the problem is that traditional screening tools for alcohol misuse have been developed and validated mainly using men, quite often hospitalised male alcoholics, which can negatively influence the effectiveness of screening techniques used with women. For example, a number of criteria necessary for a diagnosis of alcohol misuse or dependence are based on a history of acting out behaviours, legal difficulties, and tolerance and withdrawal symptoms, which are more typical of men with alcohol problems. Women on the other hand are more likely to exhibit passive symptoms, such as depression and anxiety, and more often enter the mental health system than the alcohol treatment system, (Russell, Chan, and Mudar, 1997).

Lack of understanding or misconceptions of women who misuse alcohol also permeates women’s personal lives, where their friends and partners may not realise the full extent of the problem and if they do they may not be particularly supportive of efforts to seek treatment. “The delayed or ignored diagnosis and treatment has been attributed to denial and stereotyping by the family, denial by friends and employers and misdiagnosis by family doctors, (McDonough, et., al., 1994, p.461). Indeed women with alcohol misuse difficulties report less social support than their peers in general as well as receiving little support in seeking treatment. Perhaps spouses or professionals are less likely or may even refuse to recognise that the woman has a
problem. This can lead to feelings of powerlessness to change their circumstances, which has important implications for treatment, (van der Walde et., al., 2002). Women have reported that they experience a greater number of negative consequences upon entering treatment than men, these include: disruption in the family, loneliness and discomfort, financial difficulties, loss of employment, loss of friendships, and anger from one’s spouse. Significantly more women than men have reported opposition to their treatment by spouses, family members and friends during the month prior to entering treatment. Also, once women are in treatment they tend to experience greater external pressure to leave, often due to the belief that a woman’s place is at home with her family, (Jarvis, 1992).

2.7 Treatment for alcohol misuse

Just as many of the traditional screening tools for alcohol misuse were designed for men, the majority of existing treatment models used with women have been developed by and for men, and until very recently continued to be refined on the basis of research largely conducted on male subjects. Because women have not traditionally been considered in research there has been, in the past, a failure to consider potentially crucial treatment concerns for women. This could be the reason for the failure of traditional services to attract women into treatment, (Copeland & Hall, 1992). There has been a major misconception that it is harder to treat women, but perhaps this is due to the fact that the majority of treatment programmes used male oriented treatment methods. Most of the recent literature calls for gender-specific treatment as it has been found to be the most effective. Women in women’s only groups tend to stay in treatment longer, and more women actually completed treatment, something that has been difficult to achieve in the past. In women only groups there is no danger, as compared to mixed groups, of having the men and men’s issues dominate group discussions. In order to successfully treat women for alcohol misuse, it must be acknowledged that women have unique characteristics that must be factored into any treatment programme for women. Studies have shown that women tend to be more successful in alcohol treatment with providers who are more adept at interpersonal skills, more empathic, and less focused on problem solving, at least initially. Also crucial is optimism regarding treatment outcomes, understanding and respect, (van der Walde, et. al., 2002).
As was suggested above, it is necessary to provide gender-specific treatment approaches since some of the causes and consequences of alcohol misuse are different for men and women. It is also important to realise that women who misuse alcohol are not a homogenous group and will have different needs, and that these subgroups’ differences have implications for treatment content. In order for treatment to be most effective, clients need to be given treatments that are geared toward their unique lifestyles and problems. In female-oriented treatment programmes it is important for services to be delivered in a manner that is compatible with women’s interaction styles; it must take into account gender roles, female socialization, and women’s status in society. Women must not be exploited, nor should treatment support dependent roles for women, and women-specific treatment issues (i.e. family counselling, education about dependence, development of self-esteem, coping mechanisms, etc.) should be addressed, (Beckman, 1994). Research has also shown that women who attended predominantly male groups continued to drink after treatment at a higher rate than women who attended treatment groups containing a greater percentage of women. There tends to be different interaction styles in all-female groups than in mixed gender groups. In all female groups there seems to be more flexibility in the rank order of speaking and more one to one interaction and self-revelations about feelings and relationships. Women in mixed gender groups tended to display fewer interactions with other women and there was less discussion about family and home, and less overall interaction. In all female groups women tended to view the group setting as an opportunity to speak about life issues and arrange contact outside of treatment. It appears as though women receive more emotional and social support from women only groups, (Jarvis, 1992). Indeed, women may benefit from treatment programmes that foster confidence and much needed caring and supportive relationships with others. It can be beneficial for women to share their feelings and experiences with women who have experienced similar feelings (McDonough, et. al., 1994). For middle-aged women reconstructing social networks, evaluating positive and negative features of family structure and providing support and encouragement for the development of marketable skills should also be included as part of treatment, (Gomberg, 1997).
2.7.1 A Relational-Cultural perspective

Of critical importance to women’s psychological development are their relationships and their connections to others. Unfortunately women who misuse alcohol tend to receive less support from friends and family than their non-using counterparts. Also, research has shown that women who are not married, or who are unemployed, or who have lost certain social roles (i.e. the empty nest) are more likely to misuse alcohol than women who have multiple roles. Thus, an important treatment goal for these women is the development of supportive relationships, friendships and family ties, (Beckman, 1994). RCT argues that it is important for treatment programmes for women to foster positive, mutually enhancing connections in order to break the cycle of alcohol misuse. Programmes that are based on social support and that aim to provide a caring community and enhance personal connections and promote healthy relationships serve women well, (Covington & Surrey, 1997). Different emotional states tend to either guide us toward connection or take us away. Depression, anxiety, feelings of isolation all take us out of connection into an unclear state, (Jordan, 2004a). As stated previously, substance misuse frequently contributes to numerous forms of disconnections and to women often becoming involved with alcohol in order to find relief from the ravages of depression and profound feelings of disconnection. So, the goal of treatment is to help women move from a place of isolation and disconnection to one of authentic connection to others, (Hartling, 2004). “Putting relationships at the centre of our thinking about substance abuse prevention gives us a new lens through which we can review existing strategies and formulate new, more effective approaches to prevention,” (p. 199). A group that promotes relational awareness is possibly a good model for the treatment of substance misuse as relational awareness “allows women to address imbalances, pains, and failures of mutuality before they become too big, before impasses develop,” (Jordan, 2004a p. 60).

2.7.2 Harm reduction as treatment

Currently the most frequently recommended mode of treatment for alcohol misuse is harm reduction or moderation management. According to Kosok (2006) harm reduction provides people with a choice of outcome goals and a variety of change techniques in a stepped care approach. Here alcohol misuse is treated as a learned habit that is amenable to cognitive behavioural change. It has been suggested that cognitive behavioural interventions achieve an impact through helping people who
misuse alcohol acquire specific knowledge and skills aimed at monitoring and reducing alcohol intake, (Sitharthan, Kavanagh & Sayer, 1996). It has also been found that women seem to achieve positive results through self-monitoring programmes that emphasize behavioural self-control, and that this can be achieved either through work with a therapist or in a group setting, (Beckman, 1994, Jarvis, 1992). In self-help groups women were more likely to be drinking moderately, to be free of alcohol-related problems, and to display a reduction in the number of heavy drinking days after 12 months. The hypothesis is that women participating in self-instruction are able to minimize the risk of social stigma and experience greater responsibility through self-initiated change, (Jarvis, 1992).

The Government of Australia in their National Guidelines for the Treatment of Alcohol Problems (Haber, Lintzeris, Proude & Lopatko, 2009) promotes moderation through a stepped care approach that is based on cognitive behavioural principles. With this approach the client is offered the intervention that is judged to be the most appropriate given her presentation. If that is not effective in helping the client, then the next level of intensity of treatment should be offered until the desired treatment goals are met. This approach requires continuous monitoring and re-assessment of the client and their response to treatment. The interventions are generally based on social learning theory, with the belief that alcohol misuse develops within the social environment and can be replaced by more adaptive, learned behaviours. The goal is for those affected by alcohol misuse to develop more functional coping mechanisms and to implement behavioural self-management. Behavioural self-management programmes include goal setting, self-monitoring of daily alcohol consumption, controlled rate of drinking, and identifying problematic drinking situations and triggers. However, it should be noted that for people with moderate to severe alcohol difficulties it is recommended that they undergo a period of abstinence (3-6 months) before attempting controlled drinking programmes.

2.7.3 Self-help groups
The most popular self-help group worldwide is Alcoholics Anonymous (AA). AA is a self-help organization whose primary goal is to help its members achieve and maintain sobriety, (Haber et.al., 2009). AA supports the medical model of addiction, which views it as a “genetically based chronic, relapsing, biophysical condition,”
(Kearney, 1998 p. 496). AA is founded on the assumption that shared experience and mutual support are necessary for recovery from alcohol misuse. The primary principle of AA is that sobriety can only be achieved once one acknowledges her inability to control her drinking and has made a commitment to a comprehensive overhaul of her identity and lifestyle. AA uses a core program that is based around 12 steps that promote increased awareness and a heightened sense of meaning in life. Research has suggested that abstinence that has been achieved through AA is partly due to an increase in self-efficacy, (Haber, et. al. 2009). While AA has proven to be very effective for a great many people, there have been some criticisms. According to Wilke (1994) AA was originally created exclusively by men and uses sexist language. She believes that the programme advocates powerlessness, dependency, and sacrifice in order to achieve long-term sobriety. The 12 Steps reinforce traditional gender role stereotypes, which may be associated with a higher prevalence of depression, low self-esteem, and lower self-confidence. Also, AA does not address an individual’s unique experience or the life issues which may have contributed to her alcohol misuse, (Surrey and Covington, 1997).

Women for Sobriety is the first self-help programme strictly for women who misuse alcohol. Women for Sobriety upholds the belief that women require a different kind of programme in recovery than the types of programmes available to men. Women for Sobriety’s New Life Acceptance Programme consists of 13 affirmations aimed at promoting positive thinking and self-talk. The basic principle is that women are in charge of their lives and through positive self-affirmation can make the necessary changes. Self-understanding and changing faulty thinking are at the root of this programme; women are encouraged to discover a new way of being in the world, (Women for Sobriety Inc., 1999).

Regardless of the programme chosen, self-help groups can be beneficial for women seeking support in overcoming their alcohol misuse. Self-help groups can foster positive, mutually enhancing connections, which facilitate the breaking of the cycle of alcohol misuse. These programmes are based on social support and their aim is to provide a caring community, enhance personal connections, and promote healthy relationships. The core values of self-help programmes- asking for help, sharing experiences, strength and hope, speaking authentically, accepting vulnerability, and
being there for others, are all key ingredients in the creation of connection. These programmes also give women the opportunity to make new friends, who are practising abstinence, (Surrey & Covington, 1997). Since it has been found that women who misuse alcohol often lack support and are isolated, groups can help women make connections to others and gain the support they so greatly need. Setting up and reinforcing attendance to self-help and support groups is an important element in recovery maintenance, (van der Walde, et. al., 2002).

2.8 Conclusion
One can conclude from this literature review that alcohol misuse in women is a complex, multifaceted phenomenon. Women who misuse alcohol do so for a myriad of reasons and suffer a number of consequences. This thesis proposes to examine the phenomenon holistically, exploring how women experience and make sense of their alcohol use rather than attempting to pinpoint any one particular cause or effect.

RCT takes into consideration the culture in which we live and the ways in which it fosters or impedes personal development and growth towards or away from mutually enhancing personal connections. This is a key concept to understanding how women see themselves and make sense of their world, as nothing in life is experienced in a vacuum, free from cultural standards or messages about how we are supposed to live. It is these messages that often are internalised and influence self-concept. Further, understanding the self in relation to others and our wider society has implications for both the barriers to seeking help for alcohol misuse and for implementing effective treatment programmes. In order to provide sensitive and appropriate treatment to mature aged women who struggle with alcohol misuse, professionals must be able to identify and break down the barriers that have prevented these women from speaking out about their experiences and asking for help.
Chapter 3  Methodology

3.1 Research method

3.1.1 A phenomenological approach

A phenomenological study is concerned with trying to understand an experience or concept from the point of view of the participant. The emphasis is on how the participant makes sense of her world. The researcher assumes a chain of connection between a person’s talk and her thinking and emotional state. Here the researcher is not testing a hypothesis, but instead the aim is to say something in detail about the perceptions and understandings of a particular group rather than to prematurely make more general claims, (Smith & Osborn, 2008). The aim is to determine how the participants perceive their alcohol misuse, and how they are making sense of the ways in which it is affecting their personal and social worlds. As Kvale (1996) explains, “the purpose is to describe rather than to explain or analyse. “Phenomenology is the attempt at a direct description of experience, without any considerations about the origin or cause of an experience” (Kvale, 1996, p. 53).

3.1.2 Motivation for using a qualitative approach

The objective of this study is to explore and describe the subjective experience of women who misuse alcohol. The aim is to gain insight into the lived world of these women and how they relate to it; what is their experience of alcohol misuse, what is their reality and how do they make sense of it, but not why they drink.

Qualitative research methods answer the how or the what rather than the why. Qualitative research is most useful in providing the researcher with an understanding of the meanings that people make of their experiences, (Morrow, 2007). “ A primary purpose of qualitative research is to describe and clarify experience as it is lived and constituted in awareness” (Polkinghorne in Morrow, 2007, p.211). The objective is to glean richer meaning that may not be easily observable or obtainable using more traditional quantitative methods. Quantitative research methods allow researchers to obtain a broad understanding of a phenomenon, whereas qualitative methods allow one to investigate complex processes and illuminate the rich multifaceted nature of human phenomena (Morrow, 2007). The exploratory nature of qualitative research
allows the information gained from the study to guide the research process, which provides an opportunity for the meaning that interviewees attach to their alcohol use to emerge.

3.1.3 Motivation for using semi-structured interviews

The qualitative interview allows one to gain knowledge that has been constructed from the direct interaction between the researcher and the participant. The data gathered from the interview emphasizes the participant’s lived experiences from her point of view and gives the researcher a greater understanding of the meaning behind the experience (Suzuki, Ahluwalla, Arora & Mattis., 2007).

Qualitative, in-depth, semi-structured interviews were conducted to explore mature aged women’s experience of their patterns of alcohol misuse, their experiences of use, their views of self and their experiences of seeking or obtaining help for their misuse of alcohol. As mentioned previously, much of the research into this phenomenon has not explored alcohol misuse from the perspective of women themselves, (Lilly, 2002). Therefore the interview questions sought not only to illicit information that could support or dispute the current literature, but also to gain a rich and meaningful understanding of the participants’ lives and the role alcohol has played.

Semi-structured interviews were used not only to explore common themes amongst participants but also to further engage the participants in the interviewing process. While there were set questions, which probed various themes, the majority of the interview consisted of questions that arose out of participants’ responses and as the meaning interviewees attached their experiences emerged.

The interviews consisted of open-ended questions aimed at gaining an understanding of participants’ subjective experience of alcohol misuse. However there were certain set questions that were asked of all participants in order to gain a more comprehensive understanding of the women’s experiences. These questions explored the following themes:

- self-identification of alcohol misuse
- patterns of drinking (how much, when, where, with whom)
- history and context of the problem
- primary issue or problem as seen by the woman
- views of self
- impact of drinking on relationships
- connection to others
- consequences of drinking
- attempts to quit or seek help

3.2 Recruiting of participants

3.2.1 Selection criteria for participants

In order to obtain an accurate and well-defined sample several selection criteria were put in place. The first criterion was willingness to participate. Each participant volunteered to participate and written informed consent was gained. The second criterion was, of course, being female. Third, all participants had to be of mature age, which was identified as being between the ages of forty and sixty. The fourth criterion was for the participants to either be currently struggling with alcohol misuse or to have a recent history of alcohol misuse, recent being defined as within three years of the interview date. The idea behind this was to obtain relevant information through exploring the issues that women who misuse alcohol are facing now. Finally, before being accepted all prospective participants were required to obtain a minimum score of ten on the Alcohol Use Disorders Identification Test (AUDIT), which was administered telephonically. The AUDIT is the recommended screening tool of the World Health Organization. A total score of 8 is indicative of hazardous and harmful alcohol use (Babor, Higgins-Biddle, Saunders & Monteiro, 2002). However, in order to obtain a greater certainty, a cut-off point of 10 was used. This was done in order to ensure that the women who had volunteered to participate did indeed have a significant problem with alcohol misuse.

Participants were recruited via three avenues. First, The Progress Leader (November 11, 2008), which is a local newspaper circulated in the city of Boroondara, published an article about this study, stating that the researcher was recruiting volunteers to participate in a study exploring alcohol misuse amongst mature aged women, and the researcher’s contact details were given. From this article ten women contacted the researcher and nine of those ten were accepted and completed the interview process, with one woman choosing not to participate.
Participants were also sought through drug and alcohol services operating in the Melbourne area. A large number of agencies were contacted, however, this method proved somewhat fruitless, only one participant was recruited through such services.

The most successful avenue of recruitment was through various Alcoholics Anonymous (AA) meetings in the Melbourne area. The researcher attended several ‘women only’ meetings of AA, where she addressed the meetings either just before they commenced or just after they had finished. Approximately twenty women from these meetings expressed interest in participating and all were contacted, and nine of the women were able to make themselves available to be interviewed.

No volunteers who met the selection criteria were excluded from the study.

3.3 The data collection process

Once it had been determined that a prospective participant was suitable for the study an appointment was made for an interview. Sixteen of the interviews were conducted at the Swinburne University of Technology Psychology Clinic; the remaining three were conducted in the participants’ homes at their request.

Prior to the interview participants were given a document that outlined the aims and nature of the study as well as what was expected of them and what they could expect from the researcher during the interview process. It was also made clear that the participants could decline to answer any question and could end the interview at any time. Confidentiality was assured and written consent was obtained from each participant for the interview to be audiotaped and the information to be used. Included in the informed consent form was the researcher’s and supervisor’s contact details as well as the numbers for a drug and alcohol service and a 24-hour crisis support hotline.

In order to establish rapport and put the interviewees at ease, the researcher engaged in an informal discussion with each participant before commencing the interview. During this time they had the opportunity to ask any questions and discuss any possible concerns they might have about the style of the interview. It is the researcher’s belief that through rapport comes a level of trust, which may induce
participants to be more open in sharing their experiences, and therefore providing the researcher with richer information.

The data collection technique used was a semi-structured interview, consisting of open-ended questions. As previously stated some questions were asked of all participants in order to gather information relative to the previously identified themes, which had been determined relevant to the subject matter. However, a number of impromptu questions at the interviewer’s discretion were also used in order to obtain greater insight into the participants’ answers and explore their meaning more fully.

The interview was consistent with the characteristics of the qualitative research interview described by Smith & Osborn (2008) and by Neuman (1997) as follows:
- there was an attempt to establish rapport
- the ordering of the questions was less important and were tailored to the participant and the situation
- the interviewer was freer to probe interesting areas that arose and elaboration was encouraged
- the interviewer followed the interviewees’ interests and concerns
- it was like a friendly conversation, but with more direction from the interviewer
- it was interspersed with asides, stories, and anecdotes, which were recorded
- open-ended questions were frequent
- the interviewer and participant jointly controlled the direction and pace of the interview
- the interviewer adjusted to the participants’ norms and language usage

The nineteen interviews were conducted over a period of eleven months. The interviews were on average about an hour long. After each interview the researcher inquired about the participant’s experience of the interview and any questions were addressed. Four of the participants were referred to a psychology clinic for personal counselling, but it is not known how many actually pursued these psychological services. All of the participants expressed satisfaction with the interview process and experienced the interview as an overall positive experience.
The interviews were taped and later transcribed and all interviews were crosschecked for accuracy.

3.4 Data analysis

With phenomenological research, according to Giorgi & Giorgi (2008), there are three major goals for data analysis. The first is to transform the implicit into the explicit, particularly with respect to psychological meaning. This allows the analysis to reveal meanings that are lived but not necessarily clearly articulated or in full awareness. The second aim is to generalize somewhat so that the analysis is not so situation specific. In order to obtain the psychological meaning of a situation one must move from viewing the concrete lived situation as an example of something to clarifying exactly what it is an example of. Finally, where possible one must describe what took place in ways that are psychologically sensitive. This study aimed to meet these goals using Interpretive Phenomenological Analysis. Smith & Osborn (2008, p. 66) state that, “while one is attempting to capture and do justice to the meanings of the respondents, to learn about their mental and social world, those meanings are not transparently available- they must be obtained through a sustained engagement with the text and a process of interpretation.” In this study the researcher applied Interpretative Phenomenological Analysis using four steps as described by Smith & Osborn (2008) and outlined below.

Step 1: Look for themes in the first transcript
The first transcript was read a number of times and interesting or significant responses were noted. The transcript was read several times in order to become as familiar as possible with the account and because with each reading there was the potential for new insights. Here the researcher was able to get as close as possible to a free textual analysis. At this point some preliminary interpretations were made and notes regarding any similarities and differences, reiterations and contradictions were made.

Step 2: Emerging themes are documented
The aim here was to capture the essential quality of what was found in the text. The themes moved the responses to a higher level of abstraction while simultaneously
threading back to what was actually said. The researcher aimed to allow for theoretical connections within and across the interviews.

Step 3: Connecting the themes
During this phase of analysis connections began to be made between the emerging themes and required a more analytical ordering as the researcher attempted to make the connections. It was in this stage that meaning began to emerge. During this phase the researcher was sure to cross-reference the themes with the transcripts in order to ensure that the connections worked for the primary source material. It was crucial that the interpretation fitted with what the interviewee was actually saying.

Step 4: Categorizing the themes
At this point in the analysis clusters of themes were identified and categorized into superordinate themes. During this process certain themes were excluded if they did not fit well into the emerging superordinate themes or if they lacked rich evidence within the transcript.

Once each transcript was analyzed a final list of superordinate themes was produced. It is important to note that the themes from the first transcript were used to help orient the subsequent analysis. However, the researcher made efforts to identify the convergences and divergences in the data, identifying ways in which accounts were both similar and different.

3.4.1 Establishing reliability
In qualitative research reliability refers to consistency or stability. Stability in this study was established through repeatedly cross-referencing the themes with the transcripts to ensure that the connections continued to fit with the raw data. As was mentioned previously, if the themes did not appear to be supported by the data they were excluded from the superordinate themes that were finally decided upon.

3.4.2 Establishing validity
Validity in qualitative research involves correspondence between what the researcher claims about knowledge and the reality (or participants’ construction of reality) being
studied (Cho & Trent, 2008). Here the researcher incorporated methods to establish validity that correspond with transactional validity. According to Cho & Trent (2008):

“Transactional validity in qualitative research is an interactive process the researcher, the research, and the collected data that is aimed at achieving a relatively higher level of accuracy and consensus by means of revisiting facts, feelings, experiences and values or beliefs collected and interpreted.” (p. 321)

The goal was to achieve credibility, or accurate reflection. This was achieved using three techniques. The first was data quantity, using a sample size of 19. The second method used to establish validity was investigator triangulation (Yeh & Inman, 2007)- the researcher’s supervisor read through a number of transcripts and their interpretations and was in agreement with the researcher as to the superordinate themes that had been established. Finally, member checking was used, (Cho & Trent, 2008). This is a technique whereby the researcher checked with the participant to ensure that she was accurately interpreting the meaning the participant placed on what had been expressed. The researcher used this method throughout the course of each interview, reflecting back in order to clarify meaning, as well as establish the next questions in the interview.

3.5 Results
In this study results are written up in two sections. In Chapter four the findings are reported applying as little theory as possible to them. It is the researcher’s belief that by describing the results and subsequent themes first, before attaching any theory, one can provide an account that is as true to the participants’ experiences as possible.

Chapter five provides an integrated discussion of the results including relevant theory. As Aronson (1994) states:

“This is done by reading the related literature. By referring back to the literature, the interview gains information that allows him or her to make inferences from the interview. Once the themes have been collected and the literature has been studied, the researcher is ready to formulate theme statements to develop the story line. When the literature is interwoven with the findings the story that the interviewer constructs is one that stands with merit.
A developed story line helps the reader to comprehend the process, understanding, and motivation of the interviewer” (p.3)

This process is also known as deduction, which, according to Kelle (in Punch, 1998), is a necessary process, where theory generation includes theory verification.

3.6 Confidentiality
In order to maintain confidentiality all names and identifying information have been changed.
Chapter 4  Results

4.1 Participants
As mentioned previously, all of the participants were Anglo-Australian women aged between forty and sixty years old and all of the participants would fall under the socio-demographic of middle-class. The participants varied with regard to employment, with some being employed full-time, some part-time, and some being unemployed. The women also varied in marital status, with some married, some divorced, three widowed, and some had never been married. Twelve of the nineteen participants had children.

The participants fell within three subcategories. The first included women who were currently misusing alcohol and had never sought help for their misuse, nor had they attempted to cut back or quit on their own. For six of the participants the research interview had been their first port of call for obtaining information and help for their excessive alcohol use. Each of these women felt that they had a problem with alcohol and believed that they struggled to control their drinking. Each of them also expressed a desire to cut down or stop drinking altogether, but they were unclear about what sort of help they needed or exactly how bad their problem was. All of the women in this subgroup questioned whether or not they were alcohol dependent.

The second subgroup of participants consisted of five women who had a history of seeking help for their alcohol misuse but were currently drinking in ways that they found unacceptable. These women were distressed by the amount of alcohol they were consuming, but admitted to being unable to stop. These women had made a number of failed attempts at abstinence, and were unsure if they would ever be able to stop drinking completely.

The final subgroup of participants consisted of eight women who were abstinent at the time of the interviews. These women had been sober for a significant amount of time ranging from nine months to two and a half years. All of these women had sought help for their alcohol misuse and regularly attended Alcoholics Anonymous (AA).
With the exception of two, they had all participated in an in-patient alcohol treatment programme.

When questioned about their history of alcohol misuse three of the participants said that their drinking had become a problem quite recently, within the past three years. However, the vast majority of the participants had a long history of heavy drinking, twenty years or more. All of the women who participated in this study said that their alcohol misuse first began in the form of binge drinking.

4.2 Motivation to participate
There were two major reasons why women chose to participate in this study. All of the women who were currently experiencing difficulty in controlling their drinking volunteered in the hope that they could gain some insight into their drinking and gain a clearer understanding of what exactly was going on for them. These women also hoped that the researcher could suggest the most appropriate intervention (i.e. counselling or specialised alcohol treatment). Amy knew she had a problem with alcohol, but was looking for some insight into what she might do about it,

“Well I guess for many years now I have drunk more than the recommended limit... so of course this wasn’t a new revelation to me and I just wondered where you were going with your research and perhaps what you might suggest.” (Trans. p. 1)*

Some women knew that they were consuming too much alcohol, but were unsure if alcohol was the primary problem. As Jan put it,

“I suppose I’ve got various ideas, but none of them actually fitted with my scenario. So um... incidences in my life I’ve come across- well is it being a sole parent, is it the age of the kids, is it...? I’m running around in circles thinking it could be this and if I can fix this then this other problem might go away. Or is it something more deep-seated? So you can never actually say, ‘this is my source of, this is what’s going to help me.” (Trans. p.1)

Other participants had tried to stop drinking, either on their own or with the help of specialist services, but had been unsuccessful in remaining abstinent. For these

* This indicates where in the participant’s transcript one may find a particular quote.
women this study was another attempt at finding something to help them deal with their alcohol misuse. As Deborah said,

“Well I’ve been battling alcohol for 30 years probably, but I guess the last 10 years have been particularly bad and I’ve accessed a lot of the services around Melbourne, and find that I’m not really getting better. When I saw it on the front page, I thought it was a message to me, ‘Try again’”. (Trans. p. 1)

It seems that these women were participating in the hope that they would get some answers about their alcohol consumption as well as some guidance on how best to address it.

The second major reason women gave for participating was a desire to help other women who might be struggling with alcohol misuse. The women who gave this reason were the ones who had had some success with alcohol treatment and wanted to give something back or share their experiences. As Jeanette put it “a bit of altruism. Just if my experience can help anyone, even if it’s one person, to overcome the hell that is active alcoholism that would really make my day, basically,” (Trans. p. 2).

These women wanted to share what they had been through and what had helped them to stop drinking.

Several women who had been in treatment wanted to participate in order to share their experiences in the hope that they could somehow contribute to the improvement of alcohol services available to women,

“when you came to the meeting and was doing research on women recovering from alcoholism or even in active addiction. To make it easier on other women, you know, because I know the struggles that I’ve gone through. Yeah, so, if I could make services out there more approachable, and more, you, know, being able to identify what’s out there.” (Laura, Trans. p. 1)

Jill believed that there are not enough specialist services for women and that what is available is not sufficiently visible,

“I just feel- I suppose because I’m so involved now- there’s not enough done for alcoholics. I just think if there’s anything that can be done- and I was just thinking about that coming over here- and I could
say ‘Look there’s not enough out there,’ but I suppose because of the nature of the disease, well speaking personally, I probably did disregard a lot of help, or offers of help along the way. But when it came to the big crunch, when I was really desperate, it was frustrating.” (Trans. p. 2)

These women wanted to share their experiences in the hope that it would make things easier in the future for women who are struggling with alcohol misuse to receive help when they are ready to address their alcohol problems.

Women also cited a desire to help other women because of the stigma they believe is associated with women who misuse alcohol. Pam wanted to help other women who were misusing alcohol, but felt that it went deeper than that, “I mean there’s such a stigma. I feel like there’s a stigma on alcoholism, but it’s so out there. I think, especially being female, it’s kind of like frowned upon,” (Trans p. 2). Michelle agrees, “I think there’s a real stigma associated with alcohol and drug use with women. Women aren’t supposed to have problems and if we do we usually feel so much guilt and shame that we hide it. The thing is that it’s there and it needs to be brought up so women don’t feel isolated.” (Trans. p. 2)

These participants wanted to put forth the message that anyone can have issues with alcohol misuse, and that it does not need to be a shameful secret.

4.3 Patterns of alcohol use
As was previously mentioned, all but three participants had been using alcohol heavily for twenty years or more and all of the women had progressed in their misuse from binge drinking. For the majority of the participants wine was their drink of choice, while the four remaining participants drank spirits, beer or a combination of wine, spirits and beer. The amount of alcohol consumed varied, but for all of the participants it was a minimum of seven drinks per drinking occasion and all of the women reported drinking this amount or more at least 3 or 4 days a week. For most of the participants their drinking had progressed to a daily occurrence.

Most of the participants did not drink during the day, but would wait until 4:00 or 5:00 pm to start drinking, a time which, they felt, was more acceptable. As one of the
participants reported, “I never drink during the daytime, but after work I’ll have, for example, today, if I went home I’d have a gin and tonic and then I could easily have a bottle and maybe a little more than a bottle, of wine,” (Amy, Trans. p. 2). However, some of the participants did not limit their drinking to the evenings and would drink at any time of the day. Jill recalls,

“Towards the end- no I couldn’t put a time frame on it- I started drinking before work. With the shift work that of course could mean any time, it could 3:00 in the morning, or 7:00 at night, that I would start drinking, or continue to drink. It really got down to, if I was awake, there was alcohol around.” (Trans. p. 4)

So the pattern of consumption was not uniform across the sample.

While the participants did drink socially, all of them reported doing the majority of their drinking at home, alone, where they could drink the way they wanted to drink. Two of the participants reported drinking more when they were in social situations, but the majority of the participants did their heaviest drinking alone,

“It’s mainly on my own. Yeah if we go out to dinner with friends I might drink, but I’ll come home and drink again. I try to [drink less], until I get home, yep. Because it’s very socially unacceptable to drink heavily in front of people, so yeah, I try to watch what I’m drinking and then wait till I get home to really hit it hard.”(Deborah, Trans. p.3)

It seems that the participants were concerned to behave in ways that they considered socially appropriate and would attempt to control their drinking in order to keep up appearances. Some of the participants reported even going to lengths to hide their alcohol misuse from family members. One of the participants reported having to drink in secret in order to hide the extent of her drinking from her adolescent children, “I suppose needing to hide it more now, which means that I tend to go off and have it quickly without anyone noticing, so I’m drinking more quickly,” (Rachel, Trans. p. 2).

Another woman would often drink early before her husband came home, because he was not a heavy drinker,

“I would have a drink before he came home, and then have two drinks, and then have a drink afterwards, and just slowly increase my intake until the fact that- because he didn’t drink the way I drank- I would then have most of my drinks before he came home,” (Kim p. 2).
Not only were women attempting to appear as though their alcohol consumption fitted into societal norms, but also met familial expectations.

All of the participants spoke of their inability to stop at just one drink. As Lynette put it, “I don’t actually understand the concept of why you’d sit down and have a glass of wine. I don’t get that. I get pissed at a wine tasting because I don’t understand why you have only one or two,” (Trans. p. 17). Other participants spoke about just slipping over that edge from having one or two drinks to consuming far more than was intended,

“I can tip over the edge a lot more where I become...on the whole I’m a functioning mother at home, with my drinking, but I have more time now where I go too far, or too quick and it becomes a problem.”

(Rachel, Trans. p. 2)

Amy reports a similar experience, “Once I’ve had a couple of drinks, I just have to have a couple more; I just don’t know when to stop drinking after that time,” (Trans. p. 7). The intent for the participants was always to control their drinking and have only one or two drinks, but their belief that they could successfully manage their drinking appears to have been illusionary.

4.4 Family relationships
In order to understand the experiences of women who misuse alcohol, it is important to explore their personal relationships, particularly family relationships. All of the participants spoke about their families within the context of their drinking. Twelve of the nineteen participants reported a history of alcohol misuse in their families of origin. Rachel spoke of her father, who was an abusive alcoholic,

“My father was an alcoholic, a very- not physically abusive- very verbally abusive. My memories are always drinking, always drunk, like a bottle of vodka a night. Always lots of running away in the middle of the night, and get up the next morning, and it’s like nothing ever happened.” (Trans. p. 6)

Laura told of how both of her parents were alcoholics, “Both my parents are alcoholic. Well my dad died of alcoholism when I was eight and my mum, I don’t even know whether my mum’s alive... She’s been an alcoholic all her life,” (Trans. p. 7).

Some of the participants spoke of multi-generational alcohol misuse in their families,
as Pam said, “My brother’s a big drinker; I believe my mum’s an alcoholic and my grandfather was an alcoholic when he came back from the war,” (Trans. p. 8). Lynette also spoke of her siblings’ struggles with addiction, “We’ve all got some kind of addiction… we’ve formed this little committee where we do help each other and acknowledge what our addictions are,” (Trans. p. 8). Whether or not there is a correlation between parental alcohol abuse and these women’s alcohol misuse, the impact must be considered.

While not all of the participants had a history of alcohol misuse in their families of origin, all of them did report a level of dysfunction within their families. This ranged from an emotionally unavailable parent to parents who were verbally or psychologically abusive. Jill described life in her family,

“It’s that old cliché, but definitely family life. My mother, she was an alcoholic, but she’d been a dry drunk for probably fifteen, twenty years. My father, I don’t know whether he was an alcoholic, but he was a heavy drinker. It does impact. As kids we weren’t physically abused, but life at home was pretty ordinary. Yeah but you see that was all hidden too. I was the eldest and I took the brunt of it.” (Trans. p. 7)

A number of participants spoke of having mothers who were very cold and critical, or mentally ill and fathers who were uninvolved. According to Jeanette,

“I had a relationship with my parents such that my father- look I loved him. Don’t get me wrong, but I always felt that if anything happened he dumped me in the shit. He didn’t stand up for me basically. My mother and I always had a lot of problems. She was mentally ill when I was 13, 14.” (Trans. p. 9)

Annette tells of a mother who rather narcissistic and at times neglectful,

“My mother was the star attraction in the family, she wanted to be loved and whatever…my father told me that she’d had an affair when I was three. I asked what would happen, and he said the fellow would come to the house. I said, ‘Yes, but what would mum do with me?’ and she’d locked me in my room.” (Trans p. 7)

Several of the participants also told of difficulties with their siblings, which often involved periods of estrangement. As Michelle told the researcher,
“I don’t speak to my sisters- we don’t have a relationship anymore. I think that they might have seen me as being like Mum and because they’ve got issues with our mother and haven’t been able to deal with it, they’ve projected it on to me.” (Trans. p. 7)

Other participants spoke of feeling on the outer in their families and as though their siblings judge them. Amy spoke of her experiences with her family,

“In my family just about everyone thinks I have a drinking problem up in Sydney- I don’t go up there very often. So sometimes I feel that they’re excluding me from certain things- I don’t think it’s just paranoia, I think it’s just how they function, Or else that they- I don’t know, they just get a little bit distant I suppose.” (Trans. p. 8)

It appears as though familial dysfunction created a sense of disconnection, which has resulted in the women feeling quite isolated from significant others, which is likely to have contributed to their problems with alcohol.

Not only did the participants speak of dysfunction in their families of origin, many of them reported a high level of discord within their marriages and with their children. One woman, Gina, spoke of how she had not been getting along with her husband as well as she once had, “I don’t think my husband and I get on as well as perhaps we used to. I suppose it’s gotten worse just recently. When I say worse I got cross with him and threw a glass of wine in his face,” (Trans. p. 9). Janet reported that she does not feel as though her partner values her, “He’s using my drinking to blame me for everything that goes wrong, to put me down all the time, there’s no positive reinforcement,” (Trans. p. 5). Both Jeanette and Kim spoke about how their marriages had become violent as a result of their alcohol misuse. Jeanette:

“I was not getting on with my husband at all. As I said he absolutely hated the place. No matter what I did it wasn’t good enough. I felt like I couldn’t dare talk about my work successes because he was so depressed. Everything got all too much; I used alcohol to suppress anger. I came home one night and completely went into a complete psycho blackout and physically attacked my husband. I’m not a violent person at all basically.” (Trans. p. 7)
With Kim it was her husband who became violent,

“A couple of times I’d wake up with bruises. I’d fallen over and had no memory of that. One morning I woke up with this awful chest pain and he said ‘Don’t you remember?’ and I said, ‘No.’ He said ‘I got so angry with you that I punched you.’ That really confounded me because he’s not a violent person, and he’s never hit me or anything. He just put his head in his hands, he said, ‘I just felt so angry with you, I punched you, I just wanted to hurt you, and I wanted you to remember it the next day because you never remember what happens, and you don’t remember the pain you cause.’” (Trans. p. 9)

Participants also spoke about difficult relationships with their children. Some report having children that they find particularly trying, “you get a lot of crap from teenagers. They’re fairly critical and vicious and just a pain in the arse,” (Jan, Trans. p. 3). Janet spoke about her daughter, with whom she was really struggling, “I wake up every morning feeling physically ill not knowing what’s she’s going to be like. I mean, she at 11, has been talking about suicide and all that sort, so it’s been pretty bad,” (Trans. p. 6). Other participants spoke of the problems they have had with their children due to their alcohol misuse. Some of the women spoke of how their children have hidden their alcohol, “Yeah, well she was hiding bottles of wine, you know. She went from nothing to all of a sudden very restrictive,” (Gina, Trans. p. 7). Other women’s children were more confrontational about their mother’s drinking, as one participant recalled,

“I remember one particular Sunday morning- because she played tennis on a Sunday morning- and the night before I had been drinking Pernod. It was after she went to bed, and I put it in the cupboard- the glass in the cupboard- and she came up to the bedroom and said to me, ‘What’s this.’ I felt guilty and I said, ‘Oh look, don’t start,’ and she said, ‘I’ll never be like you!’” (Annette, Trans. p. 14).

One of the participants told the researcher that, because of her alcohol misuse, some of her children no longer speak to her,

“The two children that don’t speak to me, I’m sure my drinking affected my children in many ways. My second eldest daughter, she believes that I wasn’t strong enough to look after them, that she had a terrible childhood and it’s all my fault,” (Michelle, Trans. p. 7).
Here it appears as though the participants are caught in a vicious cycle, where they are misusing alcohol to cope with a sense of disconnection from their partners and children, but the misuse is serving to create even greater disconnection.

As was mentioned in the literature review, a causal link has been found between women who misuse alcohol and heavy drinking spouses; women are more influenced by partners who drink, (Redgrave, et. al., 2003). Five of the participants spoke about partners who were heavy drinkers and these women had increased their alcohol intake to match their partners’. As Annette recalled, “I married somebody that was heavily into alcohol, not that he was an alcoholic, but he’s a very social person, and I would drink- he was a big person- and I was drinking drink for drink with him,” (Trans. p. 4). Laura shared a similar experience, “My partner was also an alcoholic and we would drink together... I was getting more greedy, you know, because I wanted to drink as much as my partner because he was getting them down. I thought, ‘You’re not drinking it all, so I’m going to get it in.’” (Trans. p. 3)

Jill also spoke about her husband, who had been an alcoholic. For Jill, her husband’s drinking served to normalise her own, “there was my drinking partner. Yeah that’s when my drinking really took off, and I’m not blaming him, but it was just an excuse to... it was almost normal, so that I didn’t have to justify it,” (Trans. pp. 7-8). Their partners’ misuse of alcohol seems to have created a false sense of normality for these participants with regard to their alcohol consumption.

4.5 Themes
4.5.1 Loss
The experience of loss has been associated with alcohol misuse in middle-aged women. Such loss includes loss of role due to children moving out of home, retirement or divorce and interpersonal loss due to the death of parents or a spouse. All of the participants spoke of experiencing a significant loss at some point in their lives. The majority of participants spoke of a number of losses that they had experienced over the course of their lives. Six of the women spoke about the death of their mothers as being a significant contributor to their increased alcohol use. Nancy recalled,
“My mum had a massive stroke and I was very, very, very close to my mother. My mum had a massive stroke, ended up in a nursing home, was totally paralysed down one side, was blind, couldn’t really talk, couldn’t really feed herself. So it was very hard watching my mum like that, because I know that’s not how my mum wanted to end up. When I look back now, that’s when I started drinking more, and started drinking of a day.” (Trans. p. 2)

Michelle also spoke of being very close to her mother and struggling to cope with her illness and subsequent death,

“My mother was dying; she had several strokes. She was very brain damaged and didn’t know who we were. So with my mother being in the state she was, having a very unsupportive and cruel partner who hated her guts and wouldn’t support me, I was in so much pain that I started to drink.” (Trans. p. 4)

Other participants spoke about having unresolved issues with their deceased parents,

“It really started when we came back to live in Australia in ’93. It probably just gradually built up, and it probably accumulated around about the time of my mother’s death, which was ’98, a bit after that. There were a few issues that I had a lot of difficulty with, with relation to her and my relationship, and I assumed that it would resolve before she died, but it didn’t so there was all that hanging on to that business.” (Kim, Trans. p. 2)

The participants also spoke about the loss of partners, either through death, or divorce. One woman recalled how her drinking escalated after the suicide death of her boyfriend. Another woman spoke about never fully recovering from the death of her partner thirteen years ago,

“He died thirteen years ago. So then the drinking got rid of that and that was like ¾ of a bottle or more a night and with the odd sleeping pill to just get right bombed out and yeah, collapse in bed. It was about 10 years of grieving.” (Barb, Trans. p. 3)

Two of the participants’ partners died of alcohol-related illness. Women also spoke about the loss of relationships through divorce or separation. Jan spoke of how she began to drink more after the failure of a second long-term relationship,
“I think those relationships didn’t work out and there was an element of disappointment and I think there was an element of despondency. I think I just thought it’s all too hard and that’s probably where the shift, I became conscious that this wasn’t usual behaviour.” (Jan, Trans. p. 3)

Amy spoke of how her drinking increased during and after her divorce,

“Classically, when my marriage was breaking up I drank more prior to the marriage break-up because I guess that’s when I identified it was an emotional painkiller. Then I continued to drink after I was divorced because there were many, many issues pertaining to property settlements and child support and custody.” (Trans. p. 3)

Amy and others also spoke about the loss of social belonging

“Then when I had a marriage break-up again I was ooh, being a single woman in the Balwyn set doesn’t help either and see it doesn’t help either when you’re used to doing dinner parties with lots of couples. I don’t know whether you’re viewed as a threat by other women in what I thought was quite a definite dinner party group. Suddenly you’re divorced and you’re not invited to dinner parties anymore.” (Trans. pp. 10 -11)

It seems that when these women lost significant others, there was sense of a loss of self. The participants no longer knew where they fit in. They had defined themselves through others as wife, daughter, partner, or friend and when that was lost the women seem to have been left wondering, “who am I and how do I now relate to others?”

Two women spoke about losses in childhood that they felt had a significant effect on their sense of wellbeing. Rachel spoke about her brother, who is twelve years older, moving out of the family home,

“ My brother left very, very early on; he couldn’t wait to get out. He married and then moved to the other side of town, so I lost a lot of contact with him. He was the one person I could lean on.” (Trans. p. 6)
Lynette was also separated from a sibling during childhood,

“I lost my twin sister through illness, and the way my mother dealt with it. The way she dealt with it was to remove my twin. My twin sister spent a lot of time in hospital, but my mother suffered from depression and couldn’t cope with the fact that she was ill. So often she [Lynette’s twin] would live with my grandparents, or she would be shipped off to my auntie’s house... So for many years growing up, my twin was not around, physically. (Trans. p. 5)

For these women they no longer had siblings with whom they could share their experiences, who understood and could offer emotional support.

Interestingly, two of the participants spoke of a loss of cultural identity due to living away from their countries of origin for many years and subsequently the felt loss of role within their families of origin. Kim spoke about returning to Australia after living abroad,

“Australia was – when we left it was 1986- and we weren’t such a consumer society as what we are now. It wasn’t anywhere near as sexually overt as what it is now with such blatant sexual advertising. People weren’t as wealthy; there wasn’t a huge amount of money. We came back to a very, very different environment.” (Trans. p. 5)

Living abroad for an extended period of time also impacted on Kim’s family relationships since the dynamics had changed,

“It was a whole network of another family, kids that I didn’t know. Of course my relationship with my youngest siblings, because I was the third, I was like a little mother, and so my relationship had changed, particularly because they were now mothers. There were a lot of issues with how I fitted back in.” (Trans. p. 5)

Deborah is an American who has been living in Australia for 25 years. She reported feeling a loss of identity as well as a loss of connection with her family.

“Yeah, I don’t belong, and my brothers and my sister, I tried to express this to them and they’re like, ‘well, you decided to move to Australia.’ I haven’t been back in 2 ½ years now and I make all the
contact because they all have families and they’re busy, and I’m only a small part of their world. Not one of them ever said, ‘well, if you were to come back you can stay with us,’ because we lost our mother a couple of years ago and I stayed at her house and now that’s been sold. So every time I went back to visit I always stayed with her and now it’s like they don’t understand that I need them to say, ‘Come stay with us,’ or ‘We’ll help you get on your feet.’” (Trans. p. 3).

For these women it was more than a loss of family connection, there was a loss of cultural identity, which resulted in a disconnection from both others and to society in general.

Two of the participants spoke about feeling the loss of both employment and an active mothering role as their children grew up and moved out of home. Gina spoke about how she had recently retired from her job and she also had two children living overseas,

“Well I think also two of my children have gone overseas and because I was home... dunno, I think because I’m sort of spending more time at home and I missed my children... But you know I sort of loved being with the kids. I loved being with the kids, their friends when they’d come over. So it just all of a sudden went very quiet.” (Trans. p. 4)

Kate shared a similar experience, “Just feeling a bit useless. And the children, you used to look after people and you don’t anymore,” (Trans. pp. 4-5).

All of the women who participated in this study had experienced significant loss, which they feel has contributed to their misuse of alcohol. It seems as though the overarching theme is a loss of connection. The women no longer felt connected to significant others, to their culture, or to a sense of community. When connections became severed the women seem to have lost a sense of where they fit, and with that came feelings of isolation and despair.

4.5.2 Social isolation

All of the women who participated in this study spoke about feeling lonely or socially isolated, having few, if any, close friendships. Most of the participants spoke about their difficulties in making friends or reaching out to others,
“I probably struggle with friendships. I tend to be a bit of a... friendships are a bit threatening, unless I feel really, really close with someone, for some reason I don’t tend to overly open up with people, so to develop the really close friendships, I don’t find easy at all.”

(Rachel, Trans. p. 13)

Kim spoke about her struggle to fit back in to life in Australia and with her family, which made her feel very isolated,

“I was like that person on the outside. I found it very difficult to fit back in with my family. I had very little friends; I had one friend who was my drinking buddy and we’d get shitfaced. That was about it.”

(Trans. p. 11)

Amy also spoke about feeling on the outer, “I haven’t really had many significant others in my life to maybe talk things through with, or maybe go out and do things with,” (Trans. p. 10). The participants seemed to really struggle to reach out to others and to have difficulty understanding the dynamics of friendship. As Laura told the researcher, “[I was] absolutely afraid and not knowing how. How do you do this friendship thing? I just don’t know how to be friends with people. How much do you talk about or what do you talk about? When do you ring them?” (Trans. p. 11). These women appeared to struggle with general social skills. Their felt ineptitude made it difficult for them to reach out to others and to form important friendships.

A number of participants also spoke about how their drinking prevented them from making any real connections to others and how this served to isolate them even further. As Jill recalled,

“In my wisdom, my way of dealing with that was just to cut out a lot of socialising. For a long, long time we basically didn’t go anywhere where there wasn’t alcohol. That dictated what we did. Probably from about 1991 when we did move, it slowly increased that I just didn’t socialise, and so all my drinking was done at home pretty much. My world just got smaller, and smaller, and smaller, so I did less, and less, and less.”

(Trans. p. 5)
Women spoke about not being in the position to make friends or reach out to others because of their drinking. Lynette spoke about being unable to nurture friendships because she was unable to make the effort,

“I never built new relationships, and towards the end, it was just too much hard work. Sometimes I would- at the beginning of the drinking session- hang out with someone because it looked stupid sitting at a bar by yourself, but in the end I didn’t care.” (Trans. p. 14)

Jeanette told of how the shame of her drinking isolated her, “I felt completely isolated, alone. I thought I was the only person on earth who would be arsehole enough to hide alcohol in my bedroom. It really isolated me, it really did pull that connection away,” (Trans. p. 19). Alcohol impaired the participants’ motivation and their ability to maintain relationships.

Women also spoke about purposely withdrawing and isolating themselves in order to maintain their alcohol misuse, choosing to be alone in order to drink the way they wanted to drink. As Kate said,

“The reason why I normally don’t drink with other people is because I prefer to drink alone. If I start to drink with other people, I’ve got to get home and I can’t drink like they drink. I don’t have many friendships. I’ve got like four or five people I’ve known for 30 years and I just don’t see- never really see them…. I don’t really want anymore friends.”

(Trans. p. 7)

Another woman shared a similar experience,

“The friendships I’m not talking about have lapsed because I just haven’t kept them going. It goes back to you don’t drink as much when you’re with other people and you’re conscious of what you’re doing…. I go into those situations thinking I need a drink. So I don’t put myself in those situations because I think that’s not on.” (Jan, Trans. p. 7)

All of the participants felt socially isolated on some level. For some participants they were able to clearly link the isolation and loneliness to their alcohol abuse, they either purposely isolated in order to continue drinking the way they wanted to drink, or their alcohol misuse made it more difficult to connect with others. However, for some of
the women the isolation had always been felt, even before alcohol had become a problem.

4.5.3 Low self-esteem

All of the participants spoke of having low self-esteem; for some women their negative self-concepts originated in childhood or adolescence. Women spoke of feeling less than or of having very little self-worth from a young age, “no matter what I did it wasn’t good enough. I was stupid, I was fat, I was ugly, I was this, I was that, I was the other.” (Jeanette, Trans. p. 10) As a young girl Annette also remembered never feeling good enough, “I felt very self-conscious and as though it wasn’t good enough.” (Trans. p. 14).

Both Laura and Jill spoke about growing up in alcoholic families where there was very little nurturance and as a result, felt very uncared for and worthless. Laura recalled,

“I was a very shy girl; I always felt on the outer with my family and always felt different. A lot of insecurities and that goes back to my childhood, you know, how I was raised. So, yeah, I had a shocking low self-esteem. I was never able to really develop as a child because of my childhood.” (Trans. p. 5)

Jill shared similar feelings,

“I had very low self-esteem. I was very much- again from a very early age- was very much a people pleaser. That started out with my parents, and then went on to, as I got older, with other people. I didn’t like myself; there was a lot of self-loathing... I realise that it’s just that I didn’t feel as though I was worth being loved, and I was never good enough.” (Trans. p. 9)

These women did not receive positive messages of worth from their families of origin, which affected their feelings of worth throughout their adult life.

Women spoke about how they were feeling now and their feelings of self-loathing or insecurity. Kate gave quite a powerful account,

“Yes, I think a lot of it is self-hatred. You know, you hurt yourself because you don’t like yourself and yet you look in the mirror... but
they’ve got a mirror in the bathroom [at work]- I don’t look in it ever. I just can’t bear it. I just don’t like myself.” (Trans. p. 6)

Another woman spoke about how her self-worth had deteriorated over the years, “now, now I feel I don’t have an identity, I don’t have, you know as I hear myself speak I remember being someone with a bit of spunk, being not overly confident but happy to engage with people. Now I’m sort of worn out.” (Jan, Trans. p. 5)

A number of the women spoke about feeling as though they had nothing to offer anybody, “I was very cautious of letting people in because I always thought I had nothing to offer. Who would be interested in me?” (Jeanette, Trans. p. 19). Laura also spoke about feeling less than and as though she had nothing to offer or contribute, “So I always felt as if I was just so less than other people that I was just so insignificant, I never felt as good or good enough for anything. That’s what really stood in my way of wanting some form of career. I thought, ‘Oh no I can’t do that. It’s too hard. I’m too dumb. I’m not smart enough. I’m not all these things I see in other people in everyday life.’ So I thought that I was no good, that I wasn’t capable of much. I wasn’t worthwhile.” (Trans. p. 6)

The participants’ report that they felt that they had nothing to offer, or were worthless and for many these feelings originated in childhood due to a lack of nurturance and support within their families of origin. It is likely that such poor self-concept has affected their ability to make connections in adulthood. There seems to be a strong sense of self-hatred and if these women cannot perceive themselves as worthy then how could anyone possibly want to get to know them? If they were unable to have an effect in their families of origin then how could they be effective in relationships as adults?

4.5.4 Unhappiness and depression

All of the women who participated spoke about being unhappy with their lives. This unhappiness ranged from a general dissatisfaction with life to major depression and suicidal ideation. Janet spoke about her overall dissatisfaction, “Sometimes you think, ‘Bloody hell, hang out another shirt’ and it does, it becomes really- again it’s a cycle
where it’s the same thing, day in and day out,” (Trans. p. 9). Rachel also expressed feelings of dissatisfaction with her situation,

“There’s a sort of lack of feeling good about my life, there’s a nothingness there a lot of the time. Boredom, I feel life just sort of consists of doing everything that needs to be done around the house. Not many things bring me pleasure; I suppose that’s what I’m trying to say. I don’t have a lot of stuff that I look forward to that I enjoy doing.” (Trans. p. 5)

One of the women spoke about the disillusionment that she felt, “I just have an element of dissatisfaction with my life; it’s disillusionment, maybe it’s feeling boxed in, not having any choices,” (Jan, Trans. p. 4). While these women may not have considered themselves to be depressed there was an overall sense of discontentment and perhaps some despair with their lot in life.

Other participants shared their experiences of deep depression. Several of the participants spoke of being diagnosed with depression, some participants had been on anti-depressants for a number of years, or had sought professional help for depression. One participant was on a disability pension as a result. Five of the participants spoke of being suicidal at certain points during their heavy alcohol use. As Lynette reported, “I felt very depressed. I had suicidal thoughts, and tendencies, which is just not me,” (Trans. p. 3). Jeanette expressed a similar experiences, “I was severely depressed in London. In 2002 I was suicidal,” (Trans. p. 24). Laura also spoke about depression and suicide, “I had depression all the way through my drinking and the depression was just huge. It was becoming- it was drawing out longer, it was darker. I was contemplating suicide. I had a plan and that was right at the end,” (Trans. p. 5). Two of the women who were interviewed did actually attempt suicide. As Deborah told the researcher, “It was probably two or three years ago I got really drunk and I took a tray of Xanax, which is a Valium and tried to kill myself,” (Trans. p. 1). Nancy also spoke about her suicide attempt, “I decided that was it, I was going to end it all, I’d had enough, I couldn’t go on like this. No one knew where I took off, I went off and I was going to kill myself. I didn’t really want to kill myself, but I didn’t want to live either. I booked myself into a motel room and I stabbed myself, but it really wasn’t a serious attempt.” (Trans. p. 6)
While the majority of the participants were unhappy or depressed it is unclear as to whether their low moods were a direct result of their alcohol misuse or if they drank to cope with the low mood. There appeared to be a cycle where women drank because they were unhappy and were unhappy because they drank.

4.6 Integration of the themes
4.6.1 Coping
All of the women who participated in this study spoke about negative feelings that they often found overwhelming. These difficult feelings often came from multiple sources so that at any given time a woman could have been struggling with family discord, loss, social isolation, poor self-esteem, depressed mood, or any combination of the five. All of the women in the study chose to use alcohol to cope with their negative feelings. At some point in their lives they learned that alcohol was the most effective method of dealing with their problems; there was an overarching idea that nothing seemed as bad after having a few drinks.

All of the participants who had children and or partners spoke of familial disharmony and of how drinking tended to make their family conflicts more manageable or seem less important. Amy told of how alcohol made it easier to deal with her husband when he came home in the evening, “He was more caught up in the frenzy of his world and unable to unwind when he got home. I guess by having a “mother’s little helper” in the homicide hour it actually got me through dinner with him,” (Trans. p. 6). Gina also spoke about how after a few drinks she was less concerned about her marital difficulties, “I don’t think my husband and I get on as well as perhaps we used to. [The alcohol] makes everything easier, I sleep better,” (Trans. p. 9). Women also spoke about their difficulties with their children and how alcohol seemed to make things seem less daunting. Jan said this of her situation,

“Well it’s funny. I don’t know if I can actually draw this conclusion, but you let your mind wander but I think it’s actually helped me be more objective about my family. Instead of being so intensely analytical about what he said and she said and what does that mean and why is it always my fault. I’ve gone oh well; it’s actually allowed me to say ‘I actually don’t care what you think.’” (Trans. p. 8)
Another participant spoke about how both she and her children were struggling with a divorce, “There were a lot of reasons why my children acted out. Everyone was acting out, I was acting out, they were acting out. So you know, I was desperate to still get medicated,” (Michelle, Trans. p. 8).

Participants discussed how alcohol made it easier to interact socially. Women spoke about the confidence that alcohol gave them,

“It just gave me the confidence I believed I never had. I looked at the world in a different way, you know. They say the magical elixir and that’s how it felt to me. When I drank the anxiety just went away and everyone was okay. When I didn’t drink no one was okay. I just completely changed. Everyone was okay and I was confident and I’m an okay person. So it just changed my outlook on life in general. Everything was good, yeah.” (Laura, Trans. p. 4)

Annette spoke about how alcohol made her feel like a more exciting person, “I think when I was young that’s what alcohol gave me. I would become a much more exciting person,” (Trans. p. 19). Pam also believed that alcohol gave her more confidence to get out and socialise with others, “You know, drinking, you’ve got confidence. No alcohol, yeah pretty shy, unless I was around people I’d known for years. I always loved drinking. I’ve loved losing the inhibitions and getting the false confidence,” (Trans. p. 10). Barb shared a very similar experience,

“Yes well I used to find if I had a few drinks I’d meet people. People at work a few years ago, my boss said to me, ‘Oh God, you’re so much better when you’ve had a few.’ Yeah, softer, but also more lively, more like, ‘Hey let’s go and do...’ like more active, more whatever. I can be a bit dull. I was probably shyer so alcohol is less inhibiting so I was more cool.” (Trans. p. 13)

So, it appears as though alcohol helped the participants to engage more socially, thereby alleviating feelings of isolation or feeling on the outer. It had the additional effect of making women feel more confident and served to mask feelings of inadequacy and bolster self-esteem, at least in the moment.

All of the participants spoke about how they have used alcohol to cope with or numb feelings of dissatisfaction, unhappiness, and depressed mood, as was mentioned
before and reiterated by participants, “It always just helped to be a bit numb so you
didn’t feel. It’s just easier to have a drink and go, ‘Oh well, it ain’t so bad we’ll try
again tomorrow,’” (Jan, Trans. p. 3). Rachel told the interviewer how she used
alcohol, “purely to numb the shit feeling.” (Trans. p. 16). Jeanette spoke about using
alcohol as an escape,

“I wasn’t getting on with my parents. Work sucked. Nothing at work
was going right. Just everywhere. It was shit at home and shit at work.
The only way I felt I could get away from it was through imbibing in
whatever substance I could get my hands on.” (Trans. p. 8)

Jill also used alcohol to cope with her dissatisfaction with life, “I literally didn’t go a
day without thinking, ‘Oh, I wish I could change this shit.’ But I’d pick up another
drink and it didn’t seem as bad for a while. I used alcohol as a crutch,” (Trans. p.
13). Deborah drank to cope with disappointment,

“I guess it just makes it easier to cope with the disappointment of life.
It just sounds ridiculous but I guess there’s a lot of disappointment in
my life so the alcohol makes that easier for me to accept. I can sit
down, I can start drinking two or three glasses of wine and I think, ‘it
doesn’t matter, I’ll sort it out somehow. Tomorrow is another day.”
(Trans. p. 8)

Kate who is on a disability pension because of depression had this to say about her
drinking, “I suppose if you drink you become a bit numb and if you drink at home,
you’re okay in a way, you’re protected. It’s numbed my life a bit and I suppose in
some ways it’s okay to be like that,” (Trans. p. 7). It appears that for these women it
was preferable to go through life feeling a bit numb rather than feeling the pain of
dissatisfaction and depression.

Personal loss was something every woman in this study had experienced. Some of the
participants were able to acknowledge how it had influenced their drinking and how
they drank to cope with the pain of loss. Amy spoke about how her alcohol intake
increased during and after her divorce,

“I drank more prior to the marriage break-up because I guess that’s
when I identified it was an emotional painkiller. Then I continued to
drink after I was divorced because there were so many, many
issues...so, obviously I used it as a crutch for a long time because it
did help me escape from those problems that were bombarding me."

(Trans. p. 3)

Annette also spoke about struggling to cope with the break-up of her marriage,
“When I left my husband I had been drinking heavily because I wasn’t coping,”
(Trans. p. 2). Barb spoke about how she used alcohol to cope with the death of her partner,
“When Jim died I just knew that I was hitting the bottle. You don’t mean to but you just seek solace in the bottle,” (Trans. p. 4). Another participant who had experienced numerous personal losses all around the same time, shared her experience,

“I didn’t realise how much I didn’t want to have the abortion. I feel like it was the same baby trying to come back again. I’ve always felt there’s been a big hole missing, not having that fifth child. So with that, my mother being in the state that she was in. I was in so much pain that I started to drink.” (Michelle, Trans. p. 4)

Bev too had experienced a great amount of interpersonal loss and told of how she used alcohol to cope with the death of her siblings,

“Well if you’ve been sad or of you’ve been in pain like on that night with my sister, it didn’t make it easier, really. I just thought this is awful I just want to go to sleep so I drank even more. It was the same with my brother.” (Bev, Trans. p 12)

For these women the loss of connection was too great and they appear to have lacked the coping skills to deal with the pain in any way other than alcohol misuse.

4.6.2 Alienation from self and others

Alienation is defined as the state of being withdrawn or isolated from the objective world. It is the feeling that you have no connection with the world around you. In their study of alcohol-dependent rural women Boyd & Mackey (2000) concluded that the women were experiencing an alienation from self and others. Alienation from self and others referred to an “unarticulated, all consuming, continuous and escalating meaninglessness of existence, (Lillie, 2002 p.100). Alienation from self was reflected in the women’s descriptions of painful feelings of despair, hopelessness and self-loathing. Alienation from others refers to being disconnected from significant others, (Boyd & Mackey, 2000).
Alienation from self goes far beyond low self-esteem and depression, but it is the combination of the two that can greatly contribute to this phenomenon. The women who participated in this study could relate well to the concept of alienation from self and many spoke about deep feelings of emptiness, of a painful nothingness. As Jill recalled,

“There was just this huge sadness that I just couldn’t get it together, and there was really no- well there was a reason- but I just couldn’t see the reason why my life just... I just had no soul. There was a huge hole, huge,” (Trans. p. 9).

Jeanette also spoke about having no soul, “I was stupid, I was fat, I was this, I was that, I was the other. Very much a hole in my soul, which I filled with alcohol basically. I needed more alcohol to shut the self-loathing up,” (Trans. p. 10). Laura spoke about her feelings of an emptiness that felt almost like death, “It’s horrible, it really is. It’s like being that far from death really; it’s just a void. There’s nothing there,” (Trans. p. 12). Lynette spoke about her need for love and her feelings of emptiness that she attempted to fill with alcohol,

“I drank because I wanted to fill up something inside of me, this terrible emptiness. I look at this shameful behaviour, but I’m now learning that I was searching for love. I was searching for someone or something to fill me up and make me feel good,” (Trans. p. 5).

Alcohol appears to have momentarily filled the void that was causing so much pain for these women.

Alienation from others can be defined as a disconnection from significant others. All the participants spoke about a lack of connection with others, which could be the result of social isolation (and perhaps poor social skills) and the experience of interpersonal loss. Participants spoke about their feelings of disconnection, of not knowing how to relate to others, or an inability to show their true selves, all of which served to create this phenomenon of alienation. As Pam told the researcher,

“No none ever got to know the real Pam. They only saw the pissed Pam with the fake confidence, la, la, la, but no one probably knew me deep down... I don’t think any of them knew how unhappy I was, and lonely, and all of that. I don’t think any of them knew. Not even, I don’t
Laura shared the deep disconnection that she felt,

“They weren’t real friends and I knew that, and there was that real deep sense of absolute loneliness that no one on earth knows how that feels. Yeah, it’s a horrible feeling, you know. That horrible deep, deep, deep loneliness that was so soul destroying.” (Trans. p. 12)

Deborah spoke repeatedly about feeling lost; she felt no connection to others or to the country to which she had immigrated,

“I think that it’s really sad that I can’t even say that my close friends here mean as much to me as a couple of my close friends that I grew up with in the States. Like, you know, if I never saw any of these people again I really wouldn’t care,” (Trans. p. 5)

Rachel also spoke about her struggle to feel connected to others,

“It’s like if I’m around people it’s like there’s a bit of a barrier between you there. I don’t know, just maybe feeling like when I’m with other people, I feel, what is it I feel? It’s like I’m putting myself out there and it just feels a little bit threatening. If I’m drinking and smoking, I feel like they’re there with me to have a drink or a smoke, take that away and there’s just me.” (Trans. p. 14)

Kate also shared her experience of disconnection,

“I don’t really feel much connection. I feel like I isolate myself because of the alcohol and I think a lot of it is shame, shame as well. You live a lie, like when you’re out with people you’re trying to be okay, but you’re not really.” (Trans. p. 8)

The participants had become so isolated in their drinking that they no longer felt as though they were able to find meaningful connections; it seems as though they did not know how.

Connections with significant others had been severed, for some participants, through interpersonal loss, leading to feelings of isolation from others. Nancy spoke of the loss of her mother,

“I was very close to my mum, and my mum and I used to talk about everything. There was nothing I didn’t talk to my mum about. I
suppose in a way when that happened with mum, I lost my confidante, the person I spoke to about everything. So I think I just started bury things and not deal with them.” (Trans. p. 3)

Annette also spoke about how connections and support were severed through interpersonal loss, leaving her feeling very much alone,

“ The fact that I left my husband in ’91, and then my mother was diagnosed with cancer, ’95 my dad was diagnosed, and in ’98 my only sister and only sibling moved to Sydney. I just think... like I was very dependent on my mum back then, and I wondered how I’d cope when she dies, and when my sister left, I think that was just the last straw, I just didn’t have any support.” (Trans. p. 5)

Participants also spoke about how losing a partner had resulted in the loss of a social group as well. So not only was there a loss of the connection between husband and wife, the women also became alienated from people they believed were their friends. As previously mentioned, one participant spoke about losing her social circle after her divorce and Barb shared a similar story,

“He was a very entertaining, exciting person; that was a life I could just hang on the edges and thoroughly enjoy and be very supportive of him. So it was just fantastic. So all that just went. I tried to keep some of it up as friends tried to too, but that key personality that they all responded to wasn’t there, so everybody fell away and they weren’t wanting to do other things that would have fitted my personality more.” (Trans. p. 4)

Women who perhaps felt connected to only one person or who relied on other for vicarious connections, often suddenly found themselves alone and had no understanding of how to change this, so they slipped further into isolation.

4.6.3 The solution becomes the problem

The women who participated in this study had all used alcohol to help them cope with their feelings of alienation, to cope with unhappiness, with their feelings of worthlessness, and with their loneliness. However, at some point the alcohol stopped working, it could no longer do its job. Instead this solution actually became the problem. Lynette spoke about how in the end her drinking became a vicious cycle,
where she repeatedly attempted to solve a problem with a problem, “In the last year before I went into recovery it was my coping mechanism and it was about running away. I was like a vicious circle- the more I drank, the worse I felt, and the worse I felt, the more I drank,” (Trans. p. 3). Jill shared a very similar experience, “It was the same old story, I would feel just so bloody awful, and put myself through absolute sheer hell, and then after a few drinks it dissipated, and back I got onto the treadmill. That just went on for a long, long time, and things gradually went down hill.” (Trans. p. 6)

Later in the interview Jill continued to discuss what the alcohol did to her, “Somebody said it’s like being held prisoner, you can’t live without the alcohol, but just what it did to my everyday life was just dreadful,” (Trans. p. 16). Participants also felt that in the end their alcohol misuse had contributed to a lower sense of worth and a decrease in self-esteem. As Kate told the interviewer, “I think a lot of bad self-esteem and of course the more you drink the worse it becomes, escalates,” (Trans. p. 3).

Many of the participants told of how they originally used alcohol to mask their feelings of insecurity in social situations and found that they were able to socialize more easily after having a few drinks. However as time progressed and alcohol consumption increased, these women found that their alcohol misuse served to increase their feelings of isolation and to alienate them from others. Deborah spoke at length about her feelings of loneliness and her belief that she does not belong anywhere. She also told of how alcohol makes it seem less painful. However, the alcohol has also served to sever connection, “I mean, my husband said there are times when we’ll go out, I’ll have 2 or 3 drinks and it’s like he can see me shut down. He said the blinders come on and he knows I’m just not there anymore, even though I’m still talking and participating. I’m gone. I just shut down,” (Trans. p. 8). One woman reported that while when she was young alcohol helped her to socialise, she felt like a much more exciting person, yet as she has gotten older and her alcohol misuse had escalated, she has tended to isolate and no longer has the confidence to form meaningful connections. Another participant shared a similar sentiment saying that she has difficulty going into social situations without having a few drinks, but believes that it is not socially acceptable, so instead she just doesn’t put herself into
new social situations, thereby increasing her feelings of disconnection. As Jill told the interviewer,

“With other people, yeah, I told myself that I needed a drink to be able to function.... Well the social isolation really started, if I was going out I would make a total fool of myself, and so I’d go through the usual remorse and whatever the next day. I just repeated that behaviour over and over. In my wisdom, my way of dealing with that was to just cut out a lot of socialising. My world just got smaller, and smaller, and smaller, so I did less and less and less.” (Trans. p. 5)

The women isolated in order to drink the way they wanted to, but with this came intense feelings of loneliness and disconnection.

Participants told of how connections with friends or significant others had been severed due to their alcohol misuse,

“When I wasn’t too bad, people would have said I’m great, I’m the party person, fun, friendly, outgoing, good friend, always happy. Then as it was getting worse I think they would have said, ‘She’s an embarrassment, she’s lost the plot, she used to be fun.’ I did lose a lot of friends along the way.” (Pam, Trans p. 12)

Annette also spoke about losing friends due to her alcohol misuse,

“Yeah, one girlfriend I had, she and her husband were having problems. We were out one night and her kids were there and that, and I got drunk. I can’t remember exactly what I said, but I think the daughter was upset. I don’t know exactly what I said to her, but I’m sure whatever I said wasn’t appropriate. So, she just cleared the slate with me, and that’s fair enough.” (Trans. p. 17)

Women also spoke about how their alcohol misuse affected their connection with family members. Janet spoke about how her drinking had affected her relationship with her husband,

“Well it’s had a huge impact on our marriage obviously, but I know that it’s not a good thing and I know, yes, it’s had a huge impact on our relationship because he’ll now just use it against me. In some respects I use it as a barrier against making it easier to deal with him.
Then I can see he’s using my drinking to blame me for everything that goes wrong. So it’s just a circle that goes on and on.” (Trans. p. 12)

Amy also spoke about how her drinking has created disconnection with her sons,

“I can tell with my boys; they’ve both on numerous occasions tackled me about it. They usually retreat to their study in their bedrooms or their friends when I’ve had too much to drink. Usually at that stage I’m not really willing to take their opinions on board. I think that’s impacted on that relationship, unfortunately. I wish it never had, but I’d be lying to say that that wasn’t the truth.” (Trans. p. 5)

Significant others no longer tolerated the alcohol misuse and withdrew from the participants leaving them with feelings of increased disconnection and shame.

So eventually the alcohol stopped having the desired effect. No longer did life seem more manageable after a few drinks. The participants had all come to realize that their alcohol misuse had become a serious problem and the consequences had begun to far outweigh the benefits.

4.7 Motivation to seek help
At some point all of the women who participated in this study came to the realization that their drinking was out of control and that they needed to either greatly cut down on their alcohol consumption or quit altogether and that perhaps they needed some help to do so. What led to this realization varied across the sample. For some of the participants it was the acknowledgement that they were consuming more than was physically healthy. As Annette told the interviewer, “So I realise that I have to start looking after myself, and just being a lot more healthy, or otherwise I’ll just kill myself.” (Trans. p. 10). Annette said that she wanted to live the second half of her life to be better; she wanted to stop poisoning her system and become healthier, both physically and emotionally. Another of the participants spoke about her deteriorating health due to her alcohol misuse; her liver enzymes had started to become affected. Barb spoke about how she would like to continue to drink, but was aware that it was not good for her health, so she needed to cut down significantly,
“Well, I guess probably not because I don’t want to take the pleasure away, but I know it’s not a good thing to do. I’d really like to get back to at least two nights of the week, which is recommended for a woman my age.” (Tran. p. 15)

A health threat can be a strong motivator for one to make positive life changes.

For some of the women who participated there was a realization that they had a serious problem with alcohol and that they were not going to be able to change on their own, they needed help. It was an “ah ha” moment for them. Jeanette told of her realisation,

“When I got home I was crawling into bed because I was sick, I basically pulled out- there was a little bit left in a bottle in my underwear drawer, downed it and suddenly it dawned on me. I thought, ‘you’re an alcoholic.’ It took me a long time. I mean I was doing crazy things. Like I’d knock off work and I’d go to the local Bottle-O and get two or three little bottles, just skol them so I could get home on the tram, basically. So to be fair, I was pretty damaged by the time I got to the realization that I might have a problem. So I think a lot of that impetus was weighing down on me and it was a case of I just really didn’t have a choice. Well, I do have two choices. I can die or I can do something about it. I went to my first AA meeting the next day.” (Trans. p.5)

Laura also spoke about her realisation that she had a problem and could not fix it herself,

“It was a realization I had one morning that told me, ‘this can go on forever. This is not going to change; it’s not going to get better. All the times I’ve tried to give up, it’s not going to happen and I can’t do it by myself.’ You know, that was just a huge realization that I have a real problem and I can’t do anything about it on my own.” (Trans. p. 5)

Not all of the women had such dramatic realisations, many of them spoke about getting to a point where life had just become completely unmanageable or they had hit their absolute ‘rock bottom.’ Pam told of her experience of losing her driver’s licence for driving drunk and how that impacted her, “That’s when I went, ‘Shit, I’ve got to do something. I’m either going to die, or I’m going to kill someone.’ Yeah,
basically I thought my life was over if I didn’t do something,” (Trans. p. 4). As another participant told,

“I suppose everything that led up to that and looking around at where I was, was confirmation to me that these choices that I was making were very destructive choices, and look where I was. It was like a living nightmare for me. It’s everything I’m not. It was my absolute bottom, absolutely.” (Michelle, Trans. p. 15)

Nancy also shared how her life had become absolutely unmanageable, to the point where she had little choice, but to seek help for her alcohol misuse,

“I know in November of last year, I realised one day that I had to do something, that this had got ridiculous. I had already lost my licence twice for drink driving, and knew Maroondah Hospital had a drug and alcohol section. Knew that much, don’t know what I was thinking, because every day I promised myself that I wasn’t going to drink the next day, I was going to do something about it. Then the next day would roll around and I wouldn’t do anything about it. So this particular night I knew that I had to do something, so I took my daughter to the neighbours and drove myself down to Maroondah. Have absolutely no memory of driving to Maroondah Hospital whatsoever. I remember I woke up in casualty. I remember getting into the car to take myself there, but as I said, woke up in casualty. I didn’t know whether I’d driven myself there, whether I’d had an accident and that’s how I ended up there. That’s when the shit really hit the fan. That’s when we decided something really had to be done, because the Department of Protective Services got involved, so I wasn’t allowed to be left alone with my daughter.” (Trans. p. 5)

These participants had reached the lowest point in their lives and had come to realise that their drinking was destroying them.

While all of the women had come to the realisation that their drinking was out of control and that they needed to quit or cut back, not all of them made a conscious decision to seek help. Some of the participants just got to the point where they had not other choice; they were physically and emotionally exhausted and could no longer carry on as they had been. As Jill shared,
“There was a huge hole, huge. With that emptiness also came, I now know, I knew best. I thought I could continue drinking, and I could still find some happiness. I knew also that I’d made my life, a lot of it was up to me, but I couldn’t... I don’t know, I think towards the end, I’d run out of steam, I was just too tired. I just couldn’t do it any more.” (Trans. p. 10)

Lynette was at a similar point, but the decision to go into treatment was made for her, "I was very drunk, but I just sat there, and I guess I gave up. I let people handle the decision-making. They could see what was happening, but I couldn’t. The decision was made for me, I didn’t go kicking and screaming; I had no other option left.” (Trans. p. 5)

It seems as though these women had surrendered; they could no longer carry on as they had been, so they stopped trying to fight a losing battle and allowed others to step in and help.

4.8 Barriers to receiving help
All of the participants spoke about how they, either presently or in the past, had been unsure of what sort of help they needed. The main reason for this was that the women were unsure if alcohol was the primary issue; they did not classify themselves as alcoholics, mainly due to their misconceptions about alcoholism. As Janet told the interviewer, “I don’t wake up with a hangover every morning and can’t get up, I don’t have a drink first thing in the morning. Nothing in terms of the day to day activities is hindered by the fact that I drink,” (Trans. p. 13). Most of the women who were interviewed were able to maintain the schedule of their houses, go to work, look after their children, and did not drink during the day, but were still consuming very large quantities of alcohol in the evenings. As Rachel put it,

“When I’m at work I don’t desire alcohol. I don’t drink if I’m going out for the day, I don’t have a bottle where I’m guzzling in the car, it’s not that type of drinking. I can go to work, I can work full time all week. I drink only when I can, when it’s okay to, at home when I’m not having to go driving around in the car or whatever. The rest of the time I don’t crave it because I can’t. If I can’t, I can’t, and that’s the end of it.”
(Trans. p. 24)
However, they still understood that they needed help because they were not functioning effectively in their personal lives. Other participants shared their views of what they considered to be alcoholic, “I suppose people visualise you sleeping on park benches drinking methylated spirits,” (Pam, Trans. p. 23). Jeanette had a similar idea,

“beer swilling people who had, we call it the brown paper telescope, brown paper bag and had pissed themselves. That’s what I thought alcoholics were. I didn’t realise that they were in every walk of life. Because I thought if I didn’t have a drink in the morning I can’t be an alcoholic.” (Trans. p. 18)

So because the participants did not fit the stereotypical image of what an alcoholic is, even though they had admitted that they could not control their alcohol intake and that their misuse had made their lives unmanageable, they were unsure as to what services they needed to access, or if they, in fact, really needed any help at all.

Along with misconceptions about alcoholism came misconceptions about AA. While some of the women did eventually start attending AA, their misconceptions about who attends AA either prevented women from accessing this service altogether or prolonged the time spent avoiding this service. As Barb said in her interview, “in the evenings I sometimes go past the AA building up in St. James Park and I see people wending their way up there and I think I could never walk in there, yet I know I actually consume too much alcohol every evening. I think it might be really bad drunks, being blunt, yes.” (Trans. p. 1-2)

Janet shared a similar sentiment, “I see AA as the diehards, which I probably am, but those on the street like who don’t really have a life and they’re drinking 24 hours a day, rather than a person, to have someone like me sitting next to me.” (Trans. p. 13)

Laura spoke about her fear of attending AA, “I’d heard of AA, but I was nowhere near game enough to go to AA. That was just, you know, the beliefs that everyone thinks it’s all for men. They’ve got overcoats on and they smell,” (Trans. p. 15).

Lynette also did not think that AA was suitable for her, “I thought it was daggy, I thought it was a bit cultish, and I thought it was a group of people sitting in a room
singing Kumbaya, and that was not for me,” (Trans. p. 2). Kim sums up perfectly how people often view AA, “I was so condescending, and I remember thinking, ‘Those poor bastards, they have to go to AA too.’ It didn’t occur to me that that might be a good thing to do. My perception of AA was deros in the street,” (Trans. p. 20). This misconception about AA either delayed or prevented women altogether from accessing a service that has been proven to be extremely beneficial in helping people to stop drinking.

When the women did come to the realisation that their alcohol misuse was out of control and that they were not able to quit or cut down on their own, many of them struggled to access appropriate services. Jill shared her experience, “When it came to the big crunch, when I was really desperate, it was frustrating. I went to my GP, and he was sympathetic, etc., but there’s nowhere really that they can send people straight away,” (Trans. pp. 2-3). Annette had a similar experience, “No, no, GPs don’t know a lot. My GP even said, ‘Look, I might go to that meeting down in South Yarra,’ and I said, ‘well, you should go, because you might learn a lot more.’ There just doesn’t seem to be enough known about it.” (Trans. p. 25)

One of the participants felt that AA was not visible enough. She believed that if AA advertised more and was more open about what is was really about, there would not be such a stigma and more people would be willing to try it. There was certainly a consensus that treatment options were not easily accessible and that both GPs and counsellors knew little about treatment options. Participants also spoke about certain treatment options not being appropriate for them. Several participants reported that moderate drinking had been recommended to them, but they felt that this was not a viable option, it just didn’t work for them, one drink always led to two, and so on from there. As Rachel reported, “The psychiatrist that I used to see, when I eventually told her that I thought I was an alcoholic, her suggestion was why don’t I go and do a wine course so that I can learn about other aspects of wine, and develop an appreciation for a really good wine, so that then I can just sit down sometimes and just have a glass of really good wine and enjoy it. What a dumb thing to say to an alcoholic.” (Trans. p. 20)
Other participants spoke about being told that their alcohol misuse was not as bad as they believed it to be. When Laura spoke to her counsellor about entering an alcohol treatment facility, she was discouraged from making such a choice,

“The counsellor I was seeing before I went in, she was trying to talk me out of going in. I’m like, ‘Yeah, I need to do this.’ Just her ignorance really baffled me. That I’m telling her how bad it was and my drinking was out of control, my life is a mess, my kids are running wild and all of that and she’s saying, ‘Do you really need to do that?’” (Trans. p. 15)

There was consensus that the professionals recommending moderation simply did not understand these women’s reality.

Some of the participants spoke about the shame they felt due to their alcohol misuse; they were hesitant to seek treatment because they felt fearful of being exposed and wanted to avoid being stigmatised. Kim, who is a nurse, shared the feelings she had experienced when she began to consider getting some help,

“I certainly didn’t want to tell any medical person how much I drank. Fear of stigma, and fear of being looked down upon. Relationships that I had with medics were very much partnership relationships. I didn’t go to a doctor to be fixed up, I went to a doctor to discuss issues. And shame, there was shame there.” (Trans. p. 20)

Pam also told of what it was like for her to admit that she had a problem with alcohol misuse,

“Scary. It was the scariest thing I’ve ever done. I knew I had a problem, but I was in denial. Then, yeah, to say, ‘No, I am an alcoholic.’ I’m embarrassed and ashamed a bit. Like an alcoholic... how could you let this happen? I still feel like there’s a stigma about it.” (Trans. p. 23)

Participants also spoke about their denial, due to the shame of being labelled an alcoholic. There was a tendency to lie to significant others and to health professionals about the quantities of alcohol that they were consuming. As one participant told the researcher, “A lot of alcoholics don’t like to tell them how much. They might say to you, ‘I drink a bottle a night,’ but I don’t, I drink two. So I think people are so ashamed of it that they don’t like to say,” (Annette, Trans. p. 26).
4.9 Experiences of seeking treatment

It is important to note that six of the nineteen participants had not received any form of help or treatment for their alcohol misuse. The remainder of the sample had accessed a variety of services with varying degrees of success. Services included self-help groups, drug and alcohol counselling, residential detoxification, and residential treatment. Some of the women had tried all of the above.

Half of the women who participated in this study had been in residential treatment facilities. Of these women a number of them had been patients in more than one facility and the consensus was that not all facilities are created equally. The most common criticism of a treatment facility was that it was not a good fit for that particular woman. As Kate told the interviewer,

“Look, I didn’t like Delmont at all and this is terrible to say, but you’re mixing with a lot of alcoholics and some of them aren’t nice people. Some are really angry and some are rough, so when you’re putting a whole lot of people in together like that it’s not easy.” (Trans. p. 13)

Kim also felt as though the first residential rehabilitation programme that she tried was not appropriate for her

“It was very confronting because I certainly wasn’t the stereotype client there. A lot of people were dodging jail, and people had been living on the streets or were going back to live on the streets. It was certainly an eye opener. I stayed there a week.” (Trans. p. 3)

The residential treatment facilities that women considered helpful had a number of similarities. Women spoke highly of facilities that offered a holistic approach to treatment. Patients were able to attend psychoeducational classes, they received both individual and group counselling, the staff was well educated and professional, and physical health as well as mental health were promoted. Women also spoke of these facilities as being places where they were able to take a break from the demands of every day life and focus fully on their recovery. As one participant reported,

“Fantastic, fantastic place. It’s exactly what I needed. I needed to get away from my family, and out of all the dynamics, or misdynamics,” (Kim, Trans. p. 22). Another participant had this to say of the programme she went through,
“These people are much more educated. There’s a lot of attention on self-awareness; self-awareness is basically the theme of everything. They’ve got proper counselling set up so everybody is allocated their own counsellor. They have individual counselling twice a week. You get together as a group and talk about the weekend, talk about whatever, how you’re feeling.” (Michelle, Trans. p. 13)

Some of the facilities also offered supported accommodation for women after they had completed their treatment programmes. The women in this study who had been in assisted living found it to be extremely beneficial,

“…The supported accommodation, someone suggested it, and I wouldn’t be so dramatic to say it saved my life, but it really gave me the foundation. It really puts you back into the community, but fairly gently, but you’re still accountable, obviously. To me, I called it a safe way of making mistakes. I just felt it gave me enough independence, sort of, but help wasn’t too far away.” (Jill, Trans. p. 20)

So it appears as though treatment facilities that offer a variety of services and that are a good fit for the client can be extremely helpful in treating alcohol misuse in women.

The women who successfully completed residential treatment and then went on to access a self-help group appeared to have the most success in reaching their goal of sobriety.

The majority of participants who were active in self-help groups spoke very highly of them. The most common group attended was AA. Women found AA to be helpful for a variety of reasons. What they found most helpful was being able to hear others share their experiences, which made them feel less isolated. Laura had this to say, “It took away the real loneliness of it because that sense of loneliness I thought nobody knows. And then I went to a place where everybody knows,” (Trans. p. 17). Jeanette shared a similar experience,

“The thing that really got me was the empathy. To be able to say, ‘Oh look I felt like I...’ things like, ‘I felt like I had no skin on,’ and people basically go, ‘Yeah, yeah I know how that feels,’ basically. For me it was the empathy of knowing and knowing as I said, that I wasn’t the only person on earth who hid bottles, who lost it with my husband, who
lied, who cheated, who took days off sick. Yeah, the empathy, that I
was not alone basically. Yeah, not alone.” (Trans p. 24)

Women also spoke about the community, or fellowship they found in AA,
“The word fellowship came to mind straight away. It sounds so basic,
but I knew that I had to phone someone, I had to talk to someone, and I
couldn’t be alone. Also, I thought that if I drank, forget about
disappointing myself and my family, I had these other women. I found
a lot of strength in the women’s group.” (Lynette, Trans. p. 20)

A number of women spoke about how valuable they found the women’s groups to be,
“I suppose it’s that whole, if I had known about AA and what it’s really like, and this
incredible network of women... You probably felt their vibes. It’s good. You get vibes
there that you don’t get in other meetings,” (Kim, Trans. p. 24). Participants also
spoke about how women’s only AA groups created a safe place for them to speak
about issues specific to women. Lynette shared her experience,
“I feel a lot more comfortable, safer. I can say things...so I wouldn’t
perhaps talk about my promiscuity at an open meeting, as I would at a
women’s. At a women’s meeting, women openly share about
terminations, promiscuity, a lot of things I just wouldn’t be
comfortable to say.” (Trans. pp. 22-23)

The majority of participants shared this sentiment. Finally, the women spoke about
the hope AA had given them,
“I went to an AA meeting, and people said that your life can change,
and you can’t imagine how much it can change, and they looked
happy. I guess, they talk about getting some hope, and that’s what it
was. I felt like there could be some hope.” (Lynette, Trans. pp. 19-20)

Meeting others who had had similar experiences and who had successfully recovered
from alcohol misuse seems to give the women hope and provide a community where
the women felt safe to reach out for help and attempt a life of sobriety.

Not all of the participants who attended AA found it to be the most helpful mode of
treatment. Annette has attended both AA and Women for Sobriety and found the
latter to be more beneficial, as she said,
“I feel sometimes when I go to AA, I think it would be nice to talk
about your week, and how you’ve coped with your week. That’s what
Women for Sobriety often did. They would go around the group, and you’d say how you coped with your week, and you talked about that. Whereas AA, they’re very big on stories. I don’t know, it seems a little bit airy-fairy sometimes, instead of touching on the basics.” (Trans. p. 26)

Another participant said that she felt that AA was only helpful to the extent that one followed its philosophy and that AA’s help was limited to what it promotes. Two participants spoke about finding AA intimidating,

“I wasn’t making friends at AA, probably because of me, you kind of put your guard up. Yeah so when everyone was getting up and talking and you’re listening to them, I was fine with that, but then afterwards you get social and intermingle, but I don’t have anyone to mingle with, and I just felt awkward there.” (Pam, Trans. p. 17)

There was also some discomfort over feeling as though one had get up and speak to a room full of strangers, and over approaching someone to be one’s sponsor. Some of the participants who believed that AA had helped them also spoke about repeated relapse. They attributed their relapses to trying to do things their way rather than following the AA philosophy and the Twelve Steps to the letter. Laura described her experience,

“Well that was the first 17 months, you know, and I just tried picking bits and pieces out of AA and going, ‘Well I’ll just do this,’ and it didn’t work’. In the end I was pretty much relying on my own thinking to keep me sober. A cliché that I often say is trying to fix a broken machine with a broken part. You know, yeah, and that’s what I was trying to do, trying to fix myself with my own limited knowledge and whatnot of how to go about it. But I found once I came back into the program and was really able to just really be honest about how I was travelling because beforehand I wouldn’t.” (Trans. p. 2)

So it appears that while AA can work, it is only as effective as one is dedicated and able and willing to completely surrender to its philosophy and methods.
Some of the women who participated also spoke about accessing drug and alcohol counselling. They felt that specialist counselling was much more helpful than just seeing a general counsellor. There was a belief that drug and alcohol counsellors had a better understanding of what they were experiencing and could offer more practical help. As Pam told the researcher, “*She knows everything, she doesn’t judge, and she’s been there, so she knows how I feel. When I’m explaining to her how I feel, she understands,*” (Trans. p. 24). For another participant, it was her drug and alcohol counsellor who was able to refer her to a detoxification programme and then to a residential treatment programme, whereas her GP had little idea of where to refer her. It appears as though the women who had received help for their alcohol misuse were much more trusting of health professionals who had knowledge of drug and alcohol services. Counsellors who promoted moderation, which is the standard practice, appeared ignorant to these women’s experience, and therefore, were not trusted.

4.10 Conclusion
The objectives of this chapter were threefold. First the researcher aimed to present the data in a manner that was as close to its natural form as possible. By presenting the raw data with as little interpretation as possible the reader receives a realistic and natural image of the information obtained through the interviewing process. It is the participants’ experience that comes through rather than the researcher’s interpretation.

The next objective was to provide the reader with rich insight into the lives of these women who shared their stories. This was accomplished through describing who the participants were, through discussing their motivation to participate, their patterns of alcohol misuse and their family relationships. Frequent use of verbatim material was also used to serve this end.

Finally, it was the researcher’s aim to provide a clear understanding of the experiences of middle-aged women who misuse alcohol. This was accomplished through exploring the emerging themes of loss, social isolation, low self-esteem, and unhappiness or depression. By integrating the themes one gained an understanding of how these women used alcohol to cope with their difficulties and how alcohol served to alienate women from both others and themselves. One also gained an understanding of how turning to alcohol misuse as a solution for dealing with
difficulties ultimately becomes a problem in and of itself by exacerbating the difficulties one was aiming to avoid. Finally, this section aimed to provide an understanding of what motivated the participants to seek help for their alcohol misuse, the barriers that have made it difficult for the women to stop misusing alcohol and their experiences of seeking help, what they have found helpful and what has not been particularly useful.
Chapter 5  Discussion

5.1 Introduction
This chapter presents a discussion of the findings presented in the previous chapter integrated with the relevant literature in order to provide an understanding of mature aged women’s experience of alcohol misuse. The aim of this chapter is to provide an understanding of how these women came to rely on alcohol, what has motivated them to seek a new way of being that is free from the misuse of alcohol, possible barriers to seeking help for their misuse, and their experiences of treatment for their misuse.

5.2 Family relationships and disconnection
The majority of the participants discussed their family relationships within the context of their drinking. Women reported experiencing difficulties within their families of origin either due to parental alcohol abuse and or a lack of emotional availability. Most of the women had at least one parent who they reported was emotionally or psychologically abusive or who was simply not able to fulfil a parental role due to issues with alcohol. This finding is supported by Kempfer, Prazza and Whiteside (1990) who claim that women who drink problematically are more likely to come from dysfunctional family environments and are more likely to have an alcoholic family member. As children these women were more likely to have reported poor relationships with their parents, and to have had more emotional and behavioural problems. They also tended to experience less parental approval and had greater feelings of childhood deprivation. It could be said that because of such childhood experiences the women who participated in this study lacked a sense of connection within their families of origin.

According to Relational-Cultural Theory (RCT) connection with others is central to human growth and development and isolation is the primary source of human suffering. It is believed that human beings grow through and toward connection. We develop through movement to increasingly differentiated and growth-fostering connection, (Jordan & Walker, 2004). Relationship is the process and goal of human development. Psychological health is not defined as movement toward increased autonomy; instead, increasing levels of complexity, fluidity, choice and articulation
within relationships are the markers of developmental maturity. So in order for one to grow emotionally and psychologically one must have a sense of authentic connection, which fosters an increased sense of worth, clarity, zest, and desire for more relationship, (Walker, 2004). The first people with whom authentic connection may be formed are family members, parents, in particular. If the participants were not able to establish a connection and a sense of relationship during their early years, emotional development may have been stunted leading to an experience of isolation and disconnection, which are at the root of any number of pathologies, including alcohol misuse.

RCT theory speaks about relational images, which are the inner constructions and expectations each person creates out of her experiences in relationships. These develop early in life and one’s expectations of relationships are held in these images. However, when one’s first relationships are with individuals who are emotionally unavailable (e.g. due to alcohol abuse) or who are abusive, then negative relational images are formed resulting in feelings of chronic disconnection, (Jordan 2010). When one is personally injured or violated, especially when this is a frequent occurrence, one will withdraw into defensive isolation and fear connection. Pathological disconnection may result from repetitive and ongoing violations in close relationships, particularly those that involve dependency and an inability to self-protect, such as in a parent-child relationship, (Jordan 2004 a).

The women in this study frequently spoke of a lack of connection within their families of origin. A number of the participants described parents who could be quite cold, criticising, neglectful, or even threatening. Because many of the participants reported having parents who were not emotionally available, or who were emotionally or verbally abusive, they may have learned from a young age that their efforts to make connections would not be reciprocated, resulting in feelings of rejection and low self-worth, as well as a mistrust of others. With this comes a sense of vulnerability, which can at times feel quite threatening. This appears to have created a situation in which many of the women withdrew further into themselves, believing that they were unable to rely on others for emotional support and nurturance. As a number of women told the interviewer, they often found relationships quite threatening, and were very selective with whom they allowed into their lives. “A common response to the
Chronic absence of safety and respect in relationships is to resort to strategies of disconnection,” (Walker, 2004 p. 9). These strategies refer to methods of withdrawing from relationships in order to protect oneself. The result is a condemned isolation, which is a “fixedness and pain of the relational images that keep us locked out of relationship and therefore out of hope” (Jordan 2010, p. 28). One feels frozen worthless, and alone believing that she has created this reality; she feels that she is to blame for her hopelessness and powerlessness and that there is something fundamentally wrong with her, (Jordan, 2010). Perhaps, as a number of women reported, wishing for greater connection and wanting things to be different, but feeling powerless to make a change left them feeling stuck, wanting to move into connection, but unwilling to risk being rejected or misunderstood.

The concept of relational images fits well with attachment theory and negative relational images can be likened to insecure attachment as both speak to one’s early relationships with primary caregivers. Like RCT’s concept of relational images, attachment theory suggests that individuals develop working models of intimate others and the self in relation to others that provide one with prototypes for intimate relationships, (Molner, Sadava, DeCourville & Perrier, 2010). “Repeated interactions with the primary caregiver form a set of expectations and beliefs about the reliability and supportiveness of others and such beliefs influence notions of the self that further guide emotional experiences and behaviours throughout life,” (Kassel, Wardle & Roberts, 2007 p. 1166). Understanding of relationships can only originate from the relationships one has experienced in the past. It appears as though a number of the participants had chosen relationships in their adult lives that replicated the relationships they had had with their parents. All of the women who spoke about poor parental relationships reported having dysfunctional and dissatisfying relationships with their spouses or partners. These women spoke of partners who were critical and emotionally unavailable or who misused alcohol. Indeed, a number of participants who had parents who were alcoholics had also chosen partners who misused alcohol and with whom they connected through alcohol misuse. It is likely that these women had developed insecure attachments, which had endured into adulthood and had influenced current relationships. This idea is supported by Karen (1998) who proposes that the way one forms images of the self and others and of how they fit
together has a powerful hold on the personality and provides a blueprint for future relationships.

The concept of insecure attachment can be applied to a variety of relationships. According to Karen, “children whose attachments are predominately anxious, who have no experience and therefore no model, of secure relating may have a hard time recognizing, may not want to recognize, that another person is able to be steady, loving, and available,” (p. 205). If one expects to be rejected she will give little of herself, be mistrustful, ignore, or misread friendly overtures, appear ‘standoffish’ and then others may back away from her, resulting in a self-fulfilled prophecy. An absence of a secure base appears to leave one wrestling with a deep and painful loneliness, (Karen, 1998). Evidence of this was observed repeatedly throughout this study as the participants spoke about their personal relationships and their views of self. Virtually all of the women spoke of their difficulty in connecting with others. The women reported feeling threatened by the idea of reaching out to others for friendship. These women reported feeling mistrustful that others would actually want to engage with them; they also spoke of a fear of being rejected should someone get to know the real woman inside (who was unworthy, or crazy, or uninteresting). Instead these women chose to remain at home where they did not have to risk the vulnerability required to make authentic connections. So whether it is insecure attachment or negative relational images, the outcome is the same, a deep sense of loneliness and disconnection. The majority of the women who participated in this study spoke of such loneliness and isolation, a sense of disconnection, that often originated in childhood and appears to have carried over into their adult lives and has impacted on their current relationships.

The participants in this study spoke of discord with their partners and with their children. It seems as though the women were experiencing a deep sense of disconnection, which appears to be cyclical in nature. Due to negative relational images that were possibly formed in childhood, the women bring a sense of worthlessness and powerlessness, as well as mistrust of others and a fear of vulnerability into their current relationships. This prevents one from developing deep meaningful relationships, which in turn leaves one feeling even more isolated and as though there is something inherently wrong with her. All of the women in this study
who had children spoke about difficulties with them. These women loved their children very much but at times struggled to relate to their children or felt misunderstood by them. These participants wanted to have more meaningful and satisfying relationships with their children, but appeared unsure of how to achieve this. This seems to have left a number of these women feeling inadequate as parents, and quite often they used alcohol in order to cope with their sense of powerlessness as well as to protect themselves from possible emotional rejection.

However, as these women consumed more alcohol their children seemed to withdraw further or become more judgemental of their mothers, which exacerbated their mothers’ feelings of inadequacy and disconnection. Jordan (2010) calls this the “central relational paradox.” (p. 28). We deeply desire and need connections, but we are terrified of what will happen if we move into the vulnerability necessary to make deep connections, so we keep large aspects of ourselves out of connection. We develop strategies of disconnection (such as alcohol misuse) in order to protect ourselves. By disconnecting we keep part of ourselves split off. One develops such strategies to avoid isolation, but paradoxically they contribute to a sense of isolation and being unseen. When one feels unseen she may come to believe that she is unable to represent herself authentically in relationships, when her real experience remains unheard, she will falsify, detach from, or suppress her response.

When this occurs one learns that she cannot have an impact on others in important relationships and as a result she develops feelings of isolation immobilization, self-blame and relational incompetence, (Jordan 2004a). It “inhibits our engagement with life and our capacity to love and to move with a sense of awareness to meet others, to contribute to their growth, and to grow ourselves,” (p. 11). This may result in a drop in zest, decreasing clarity, withdrawal from connection, less self-knowledge, and a decreased sense of self-worth, (Miller & Stiver, 1997). At this point a constructive, enriching, and intimate relationship with one’s partner or children is not possible.

5.3 The role of alienation in alcohol misuse
Alienation occurs when one becomes withdrawn from the objective world, when one feels a lack of connection with the world around her. One can become alienated from both self and others, which refers to an “unarticulated all encompassing, continual and
escalating meaningless of existence,” (Lillie, 2002, p. 100). Alienation from the self often manifests as painful feelings of despair, hopelessness, and self-loathing, while alienation from others manifests as a disconnection from others, (Boyd & Mackey, 2000). There is actually a deep sense of disconnection from a sense of self as well as from others, which frequently begins in childhood when images of self and others are formed through relationships with primary caregivers.

Alienation from self is reflected in painful feelings that reach to the core of one’s being. There is a belief that one is fundamentally flawed and has no purpose in life. Along with this come feelings of despair, hopelessness and self-loathing. As mentioned previously these feelings tend to take root during childhood when one receives little nurturing and limited positive feedback and validation on which to build a healthy sense of self. Often one is left feeling lonely, depressed, ashamed, guilty and unloved, (Boyd & Mackey, 2002). Insecure attachment mediates the relationship between negative parenting experiences and dysfunctional attitude and poor self-esteem. So it appears likely that early insecure attachment forms the basis for a depressive dysfunctional attitude about the self in adulthood, which is the first link in the proposed chain between attachment, or relational images and substance use. Low self-esteem is associated with psychological distress so it makes sense that poor self-esteem has also been linked with substance misuse. Substance misuse that is motivated by the relief of negative affect appears especially likely amongst those who have poor self-esteem, heightened negative emotionality and fewer resources for reducing stress through social support, (Kassel et. al., 2007). So, it appears as though alcohol is used as a panacea for a sense of alienation from self. Indeed women who misuse alcohol tend to report feelings of low self-esteem, have poor self-concept and tend to have a sense of inadequacy and futility, (Kumpfer et. al., 1990).

It would seem that the women who participated in this study are experiencing a sense of alienation from self. In addition to describing childhoods that lacked positive reinforcement and emotional security, the women spoke about their low self-esteem and their sense of inadequacy. Also, each woman reported a great sense of dissatisfaction or unhappiness with her life. However, it appears to go much deeper than poor self-concept or unhappiness. The women in this study experienced feelings that went far beyond depression and poor self-esteem, it was a painful emptiness,
which was to be filled with alcohol. A number of participants spoke of deep despair, of feeling worthless and unlovable. Many likened the feeling to having no soul, or a hole in their souls. The women spoke of a nothingness or a void that they filled with alcohol. One woman spoke about consuming any substance she could get her hands on in order to quiet the self-loathing that plagued her. Alcoholism has been described as an emotional, spiritual, and social disease, which seems to resound with this population who spoke about what can only be described as spiritual and relational death.

As mentioned previously alienation from others manifests as a lack of personal connection or a lack of mutually enhancing relationships. Like alienation from the self, a sense of alienation from others also begins in childhood, often with abusive, distant and or alcoholic parents (Boyd & Mackey, 2000). These feelings, like a sense of disconnection or insecure attachment carry through to adulthood, where one struggles to make connections with others, having been deprived of a positive working model of intimate relationships. When one is unable to engage in mutually empowering and mutually empathic relationships, the result is disconnection, which is experienced as a damaging sense of isolation and immobilization. When one is alienated from others there is a sense of being separate from others, being ‘on the outer’, and it is in this state that one is most at risk of psychological dysfunction (Jordan, 2004 b.). Alienation from others is both a cause and a result of alcohol misuse. Women report drinking in order to relieve feelings of isolation, but also report withdrawing from others as alcohol takes over their physical, emotional and social beings, (Lillie, 2002). Research has found that women who misuse alcohol may experience more difficulty forming and maintaining intimate and satisfying relationships than their peers who do not misuse alcohol. They are also more likely to report a history of emotional deprivation and neglect from significant others. As a result these women may develop feelings of inadequacy, which can lead to loneliness, isolation, and intensified stress, (McDonough et. al., 1994). Substance misuse may provide women with a precarious but readily accessible method for coping with this profound feeling of disconnection, but in fact substance misuse can be seen as a progression of disconnection leading women toward increasing isolation, (Hartling, 2004).
The participants of this study spoke about their feelings of alienation from others that were manifest through their feelings of loneliness, isolation and interpersonal loss. A number of women spoke of living a lie, of presenting an integrated image to the outside world while in actuality they were dealing with increasing fear, distress, and alienation on the inside. Much of the alienation or disconnection for the women in this study appears to come from a fear of showing their true selves. Many of the participants spoke about their social discomfort in early life (most likely due to feelings of poor self-worth) and this appears to have carried over into adulthood. There seemed to be a belief that if others were to truly know them, they would be seen as deficient and be rejected. Rather than take such a risk, the women kept to themselves, moving deeper and deeper into painful isolation. Some women chose to numb this pain through alcohol. However, with the alcohol use came an element of shame. The women saw their drinking behaviour as shameful and as something that must be hidden. So they chose to stay home and drink alone, thereby disconnecting even further.

Alienation from others at times was the result of interpersonal loss. A number of the participants told of how their drinking escalated in order to cope with loss. As women moved out of relationships that they may have experienced as mutually empowering and mutually empathic they experienced a damaging sense of isolation. Chronic disconnection from others can leave one feeling empty, which is a major factor in alienation from the self, so, a woman may lose a sense of self when she loses people on whom she feels she could depend or who were her confidantes. Rather than being able to rely on the other for nurturance women turned to alcohol use as a way of self-nurturing, of coping with the loss of connection. Unfortunately it appears as though the women who drank to deal with the felt sense of alienation became even more alienated from others as alcohol masks the true self thereby preventing one from forming authentic, mutually enhancing relationships.

5.4 Alcohol misuse as a coping strategy
According to Boyd and her colleagues, “coping includes all cognitive and behavioural strategies used to manage stressful situations,” (p. 225). It serves two major functions, the management of emotional distress and the management of difficulties that are causing the stress, (Boyd, Bland, Herman, Mestler, Murr & Potts, 2002). Kohn and
colleagues suggest that there are basically two forms of coping, approach or active coping and avoidance coping. Active coping is an attempt to directly address a problem and incorporates both cognitive and behavioural strategies. Cognitive strategies include logical analysis, which is an attempt to understand the problem, and reappraisal, which is an attempt to positively restructure the problem while still accepting the reality of the situation. Behavioural strategies include problem solving, which involves taking action to deal directly with the problem, and seeking guidance or support, which involves asking others for help, (Kohn, Mertens, and Weisner, 2002).

The subgroup of participants who were in active recovery from alcohol misuse and who were experiencing success in maintaining their sobriety appeared to be using a number of active coping strategies. These women had come to realise that they had a significant problem with alcohol and accept that they could not make successful, lasting changes on their own. These participants were able to evaluate their situations and had come to the conclusion that the coping strategies that they had been using were not working; in fact they were creating even greater difficulties. This subgroup of women sought out specialist help for their alcohol misuse and then took the opportunity to utilise all of the services that were available to them, such as AA, psychoeducational classes and supported accommodation. These women also began to reach out to others for support, moving past their fears of rejection in an attempt to build meaningful relationships. Also, a number of these participants reported seeking individual counselling in order to evaluate their lives in the hopes of finding the root of their pain and to take steps to address it. It would seem that the use of active coping strategies is a strong determinant of one’s success in recovering from alcohol misuse. However, while actively misusing alcohol all of the women who participated in this study reported using coping strategies that can be considered avoidant.

Avoidance coping is an attempt to ignore or avoid a problem, and like active coping, involves both cognitive and behavioural strategies. The cognitive strategies of avoidant coping include cognitive avoidance where one tries not to think about the problem, and resigned acceptance, which is like a learned helplessness reaction. Behavioural strategies include finding alternative rewards where one attempts to substitute activities and create new sources of satisfaction, and emotional discharge,
which involves attempts to relieve tension by expressing negative feelings, (Kohn, Mertens, and Weisner, 2002). The women who participated in this study reported utilizing coping strategies, which are consistent with an avoidant coping style. Women across all three subgroups reported that they avoided dealing with distress or personal turmoil through avoidance, choosing to drink rather than address the stressor head-on and there appeared to be a resigned acceptance that this was the life they had been given and that it was too difficult to make changes. Women also spoke about using alcohol as a reward, it was as if it was the only thing that could bring them a modicum of pleasure; they had substituted pleasurable activities, such as spending time with others, with alcohol in order to gain some sense of satisfaction. Women spoke about deserving a drink after a long day, or after having to deal with a stressful situation. However, alcohol was not only a reward, but also a panacea.

Another way to view these women’s negative coping style is through the lens of alcohol expectancy. Alcohol outcome expectancies are the immediate effects of alcohol that are anticipated by an individual and they are often key in the development and maintenance of alcohol misuse, (Demmel & Hagen, 2004). This means that a woman will use alcohol in order to achieve an expected result. Alcohol consumptions is characterised by particular patterns of precipitating factors and consequences for changing moods and attaining desired outcomes. Moods that typically precipitated a drinking episode were predominantly negative. Such feelings include irritation, sadness, pessimism, nervousness or tension. However a drinking occasion may also be precipitated by positive mood states such as feelings or joy, wanting a reward, and pleasure in anticipation of drinking, (Scheffel Burath, DeMarinis & af Klinteberg, 2010). All of the women who participated in this study spoke about their belief that alcohol could create a desired outcome; it could provide them with an escape from negative feelings as well as enhance positive feelings and facilitate social interactions. This means that women who are unable to implement positive coping strategies and have expectations that alcohol will minimize or alleviate negative feelings while enhancing positive feelings are increasingly likely to misuse alcohol; it becomes their avoidant coping strategy of choice.

Personal resources influence what somebody can and cannot do as she attempts to achieve goals and cope with stress caused by life’s demands. When a person lacks the
resources to meet demands then she is likely to experience intense psychological distress and other negative outcomes. Such resources include intelligence, self-esteem, social skills, supportive others, education, money, and health. Without these one will struggle to successfully engage in mainstream society. Self-esteem is an important personal resource for coping. Research shows that those with lower self-esteem use more avoidant coping strategies than their counterparts with higher self-esteem. Moreover, those with higher self-esteem will try to change a situation to benefit themselves because they believe in their competence to make changes successfully, (Boyd et. al., 2002). In addition to poor self-esteem, those who engage in more avoidant coping strategies tend to display low mood and lower levels of social competence. Women with a negative self-view tend to have more difficulty regulating affect in stressful situations and tend to use alcohol as a coping strategy, which can lead to the development of a drinking problem, (Doumas, Blasey & Mitchell, 2006). Women who misuse alcohol are more likely to view themselves as failures and to negatively evaluate their coping abilities. This negative self-view contributes to a reduction in self-confidence and self-respect, (Michels, Johnson, Mallin, Thornhill, Sharma, Gonzales & Kellett, 1999). All of the abovementioned literature is consistent with the findings of this study. All of the women who participated in this study appeared to lack crucial personal resources. Primarily, the women lacked self-esteem. A vast majority of the women reported a negative self-view; they reported always feeling less than or not good enough. Many of the women spoke of a lack of positive messages of worth in childhood. This can create a sense of futility, which may deleteriously affect one’s perceived ability to engage in active coping strategies. The participants also spoke about their lack of social competence. With many women there was a discomfort with personal relationships, or in some cases women had lost the people with whom they felt closest. These women did not seem to know how to reach out to others, or how to open up without the use of alcohol to ease their anxiety, so they found it quite difficult to look to others for support. Many of the participants seemed to share the sentiment that they had become failures; they had failed in many aspects of their lives. The result is a lack of belief in one’s ability to make effective changes, so active coping strategies were not utilised as frequently, if at all.
Alcohol misuse is an avoidant coping strategy used by people when they do not have the resources to effectively manage difficult life circumstances. Although alcohol use may provide temporary relief from emotional distress, it is escapist and avoidant in nature and does very little to address the problems that are causing the distress, (Boyd et. al., 2002). Women who misuse alcohol appear to demonstrate a paucity of active coping strategies and an excess of maladaptive coping strategies. These women are more likely to engage in denial, displacement, avoidance, pessimistic thoughts, and substance misuse, (Michele, et. al., 1999). For those who have few adaptive coping skills, alcohol may become their primary coping strategy in all stressful situations. Indeed, according to Boyd and colleagues (2002), in the face of powerful stressors women who misuse alcohol tend to have fewer resources to manage stressful situations. Women who are unable to address the source of their problems frequently resort to emotion-focused, avoidant coping strategies to deal with the emotional turmoil associated with the stress response. Alcohol lowers this stress response thereby reinforcing its efficacy as a coping tool.

All of the participants reported frequently experiencing negative feelings that they found overwhelming, and which they chose to deal with through the consumption of alcohol. When asked about why they drank, or to what they attributed their alcohol use a number of the women responded by saying that if the researcher had their lives, she would be drinking too. This is evidence of a lack of active coping skills. Rather than attempting to utilize active coping strategies such as reappraisal, logical analysis, or even simply asking others for help, the participants chose to drink. The participants appeared, on some level, to share the belief that alcohol solved their problems. Women who were not getting along with their partners or children drank to ease the tension. Women who felt socially inept drank in order to interact socially or feel as though they were more exciting. Participants also drank to numb their feelings of discontent and to quiet the voice of self-loathing. At some point it appears as though these women came to expect that alcohol was the most effective treatment for any emotional ailment. Alcohol was their primary coping strategy.

It is important to note that none of the participants were happy about their alcohol misuse; they were ashamed in actual fact. It appears as though they wished for things to be different, but were unable or unwilling to utilize active coping strategies. As
mentioned above, personal resources are imperative for managing the stress of everyday life. It appears as though the participants lacked some of the key resources, including self-esteem, supportive others, and social skills. These are also necessary in implementing adaptive coping strategies. If one does not believe that she is capable of effecting change, then it is likely that she will look for other means to deal with difficult circumstances. Also if one feels shame or diminished, or does not feel able to connect with others, or is socially isolated, it is unlikely that she will feel able to reach out to others for help and support. The women who participated in this study spoke about deep, unbearable emotional pain, but lacked the understanding of how to make effective, positive changes. So they turned to the most familiar and at the time what they thought was the most effective strategy for coping, alcohol. In the words of one participant, “It’s just easier to have a drink and go, ‘Oh well, it ain’t so bad, we’ll try again tomorrow,” (Jan, Trans. p. 3). The alcohol made things seem more manageable for the moment.

5.5 The vicious cycle of alcohol misuse

The women who participated in this study spoke about using alcohol as a panacea for a multitude of problems. The aim was to feel less alienated from both the self and from others. As mentioned above participants told of how alcohol made them more sociable, feel more exciting, and less dissatisfied with their apparent lot in life, and it quieted their negative self-talk that was telling them that they were unlovable, or inadequate. Unfortunately, while the strategy of alcohol misuse may feel protective at the time, in the long run it only serves to alienate one further from others and from one’s own sense of self. Alcohol misuse as a coping mechanism ultimately leaves one full of shame and more disconnected from the self and others, (Banks, 2006). Alcohol misuse can be viewed as a disease of disconnection, which separates and isolates women from essential relationships that can act as protective factors and separates them from relationships that are required for growth and wellbeing, (Hartling, 2004). Many of the women tended to keep their alcohol misuse a secret so that they could hide how much they were consuming, and the misuse progressed even further. Keeping secrets from others often prevents women from feeling completely accepted and contributes to feelings of isolation even when they are with others. As alcohol misuse progresses it contributes to painful feelings more often than it eases them, (Boyd & Mackey, 2000 b.). The women in this study often spoke about feelings of
guilt and shame that were associated with their alcohol misuse. Such feelings seemed to result in women withdrawing and moving away from authentic, growth-fostering relationships. This withdrawal creates a sense of disempowerment and a sense of being unseen, which if it is prolonged, develops into a condition of chronic disconnection. Under such circumstances women tend to feel as though they are to blame and feel immobilized and increasingly isolated. Here, women will bring less and less of their true experiences into relationships and they frequently lose touch with their feelings and inner experience, (Jordan, 2010).

Alcohol misuse can also be viewed as a self-nourishing habit. Such habits are used in order to cut off painful feelings as well as to establish pseudo-independence, (Firestone, 1985). So as the women felt more disconnected from others and were less able to engage in growth-fostering relationships, there was a need to feel more independent, to feel as though they were able to cope on their own, that the need for close relationships was not necessary. It would seem that many of the women who participated in this study used alcohol in a self-nourishing manner in order to meet certain needs that were not being met through mutually empathic relationships. As a self-nourishing habit, alcohol is used as a substitute for fulfilment and satisfaction from objects in the external world. “In order to ease their suffering people learn to block out painful episodes and emotions. Unfortunately they simultaneously limit feelings of joy and exhilaration as well,” (Firestone, 1985, p. 156). Methods and means used to numb pain, usually become addictive. So, alcohol may temporarily reduce anxiety and make one feel better, but because it is closely associated with the destructive process of self-denial, those who depend on it as a painkilling habit become increasingly disabled in their ability to function and find satisfaction in personal relationships. The women in this study spoke repeatedly about such experiences. A large number of the participants reported feeling a great deal of social anxiety for which they used alcohol to cope. Unfortunately, as their alcohol misuse progressed they became less able to make meaningful connections and some of the women came to a point where they no longer felt that they even desired more meaningful connections, they were no longer interested in forming friendships. In addition the connection that the women did have (to partners, children and long-time friends) began to deteriorate and become increasingly strained as their alcohol misuse progressed. Some participants even lost relationships altogether due to their drinking.
Alcohol as a self-nourishing habit temporarily satisfies emotional hunger and longings for nurturance, providing a degree of control over the internal state. It is used to support the illusion of self-sufficiency, the fallacy that one can take care of herself without the need for others. Personal feelings are shut off. “Eventually, well-established self-nourishing habits usually become self-destructive because they progressively limit the person’s capacity to cope with everyday experiences,” (p. 157). While those engaging in self-nourishing habits such as alcohol misuse often rationalise their use (i.e. they make one more exciting, they give one confidence, make one more relaxed in social setting, etc.), by repeatedly turning to alcohol misuse for relief and a sense of control over pain, they progressively block out important emotional reactions. As a result these individuals become more incapacitated in their ability to be productive, (Firestone & Catlett, 1985). “When these habits do become associated with a more generalised retreat from the real world, they no longer feel acceptable to the self and cause the person considerable guilt,” (p. 157). The guilt leads to self-accusation, which results in self-hatred, which causes one to engage in their self-nourishing habit (i.e. alcohol misuse), which leads back to feelings of guilt, and a vicious cycle ensues. The idea of a self-nourishing habit was evident in the participants’ reports of their alcohol misuse. Many of the women who participated in this study spoke about their use of alcohol in terms of trying to solve a problem with a problem. Women spoke about how their alcohol misuse had made them prisoners; they were unable to live without the alcohol, but it made their lives unmanageable.

Participants reported using alcohol in order to feel more confident, to enhance their ability to socialise and connect with others. However, as their alcohol misuse progressed and became more severe, those who were most important to the women, friends and family members, withdrew from the women due to their behaviour while intoxicated. As a result the participants were left feeling even more disconnected from others. The alcohol served to separate the women from important relationships. Participants also spoke about hiding their alcohol misuse from friends and family members because they knew their level of consumption was not socially acceptable. However, they also felt unable to socialise or interact with others without having a few drinks, so instead they chose to stay home and to drink in secret, thereby isolating themselves further and feeling even more disconnected. So alcohol reduced feelings of emotional pain, but it also served to sever vital connections to significant others.
and as the alcohol misuse progressed the women often felt worse about themselves, which resulted in a lack of confidence to make meaningful connections. There was a sentiment of, “who would want to spend time with me, I’m useless and unlovable.” Many of the participants spoke of living very inauthentic lives, hiding their true selves from others for fear of rejection. For many, hiding at home with a bottle felt like the safest choice.

As mentioned above, alcohol misuse can temporarily ease emotional pain and can satisfy the desire to be nurtured. When one is drinking, there is a feeling of independence and a lack of need for others, but this is temporary. Women reported that alcohol made their lives feel more manageable, problems lost their potency and challenges did not seem as great, they were able to say “I don’t care” and go it alone, but it was an illusion. In actual fact problems and challenges were never addressed, they were just left for another day and accumulated. As women avoided coping with their problems they lost the capacity to cope. As a result their lives became unmanageable to the point where they could no longer deny their difficulties. The women had difficulties with their partners, with their children, and at times with employment. The women were no longer productive in many areas of their lives, but particularly in their ability to participate in growth-fostering relationships. A vicious cycle was truly in motion. The majority of women drank because they felt alone and isolated; they drank to numb the pain that comes from disconnection from self and others and to quiet the guilt and self-loathing they felt. Yet it was their alcohol misuse that perpetuated the isolation and the guilt and the disconnection. The women drank because they felt bad and they felt bad because they drank. It was when the women finally came the realisation that they were stuck in this cycle and how destructive it truly was, that they started to look for a way out.

5.6 Motivation to seek help and barriers to receiving it
Brown and colleagues (2000) outline a Stages of Change Model, which involves five stages of change: precontemplation, contemplation, preparation, action, and maintenance. In the contemplation stage, an individual is seriously thinking about changing behaviour within the next six months. Next is the preparation stage, in which the person is planning to take action to change behaviours in the next month. People who get to the preparation stage have often tried, unsuccessfully, to change in
the past. In the action stage the individual has begun, over the past six months, to implement behavioural changes. It appears as though all of the women who participated in this study spent a lengthy amount of time in the contemplation and preparation stages, where they knew that their alcohol misuse was causing some problems in their lives and that they did not receive as much enjoyment from the alcohol as they may once have. Many women may have even reached the action phase, where they had begun to make some behavioural changes. In fact many of the participants spoke of their efforts to cut back on their drinking, or limit it to only a few days a week, clinging to the hope that they could drink moderately, however this often proved unsuccessful. It appears as though a number of the participants failed to make it beyond the action phase due to being stuck in the vicious cycle of abuse. Many women were still unable to implement positive changes in their personal lives or to use more active coping mechanisms in dealing with their dissatisfaction with life, or their interpersonal difficulties. It appears that for the participants, the alcohol still seemed to be the only way to cope with their difficulties. It was not until the participants came to fully understand that their alcohol misuse was destroying them that they were able to move beyond the contemplation or early action phases.

Women begin to consider giving up alcohol when they come to understand that they have no other option, when they begin the fully realize the devastation that has been caused through their alcohol misuse. Copeland (1998) argues that there are three major factors that tend to motivate women to quit or seriously cut back on their alcohol consumption: concerns for physical and psychological health; a sense of losing a sense of self or identity; and concern for the welfare of others. Strong social sanctions (i.e. a charge of driving under the influence, threat of incarceration), can also act as an impetus for change. Indeed resolving to quit is often preceded by a negative personal experience (this may be what is referred to as ‘hitting rock bottom’), or the realization that one is an alcoholic or alcohol dependent. All of these factors were present when the participants spoke about their motivation to cut down on their alcohol consumption or seek help to quit drinking. The women spoke about understanding that they were consuming amounts of alcohol that were far above the recommended healthy dose for women; they also realized that their drinking was impairing their psychological health or well-being. A number of women spoke about how the alcohol was killing them, both physically and spiritually. There was an
understanding that the choices that they were making were extremely self-destructive and that if things did not change, they would wind up killing themselves or someone else. This was particularly prevalent for the women who had hit their ‘rock bottom’. These women had lost their licences for drunk driving, or had been close to losing their relationships with their partners or their children. Women also spoke about revelations they had that they were alcoholic and needed help, “this can go on forever. This is not going to change; it’s not going to get any better. All the times I tried to give up, it’s not going to happen and I can’t do it by myself,” (Lisa, Trans. p. 5) The participants had become aware of just how destructive their alcohol misuse had become and the consequences had begun to far outweigh the benefits of their alcohol consumption.

Motivation to seek help for alcohol misuse does not guarantee that a woman will actually receive the help she requires. There appear to be a number of barriers that may prevent a woman from seeking and or receiving help for her alcohol misuse. Barriers to receiving help can be both psychological and practical. It is important to note that the psychological barriers can lead to practical barriers.

A significant psychological barrier for women is the lack of understanding that their alcohol misuse is a significant issue. Often women do not believe that their drinking is the primary problem, since they frequently use alcohol to cope with a crisis or a difficult situation, (van der Walde, et. al., 2002, Thom, 1986.) Indeed a number of the women volunteered to participate in this study in the hopes of gaining a better understanding of their alcohol misuse. Women told the interviewer that they believed that they were drinking too much and admitted that it had caused a number of difficulties in their lives, but these women were unclear as to whether or not alcohol was their primary problem; they wondered if perhaps it was that they were not as happy as they used to be, or if their difficulties with their partners or children, or their lack of close friends were the real issues.

Women may not identify alcohol misuse as their primary issue due to the stigma that is attached to female alcohol misuse. As mentioned previously, women who consume too much alcohol are frequently seen as lacking femininity, as sexually promiscuous, and as poor mothers, (Lex, 1994). There is also a commonly held belief that people
with alcohol problems drink spirits and start drinking early in the day, they tend to be homeless, or live on government benefits. According to this stereotype, women with alcohol misuse problems do not have jobs, are unable to raise children, or run a household, they do not come from middleclass families and neighbourhoods. These stereotypes are at odds with the real experiences of the women who participated in this study. All of the women spoke of how they viewed alcoholics, or people with alcohol problems as primarily men, who drank out of brown paper bags, slept on park benches, and smelled bad. This image did not fit with what was happening for the women in this study, so they found it very difficult to first realise that they had a serious alcohol problem (like those smelly men who slept on park benches) and second to know where to go to seek help for their problem. It certainly either delayed, or altogether prevented women from accessing AA. The women all spoke of being wary of AA, believing it was for the diehards, or for “men in overcoats, who smelled.” None of the participants believed that AA could possibly be for professional women, or mothers, or for women who drank wine, but only after 4:00 in the afternoon, in effect, nobody like them.

The stigma that surrounds alcohol misuse, and female alcohol misuse in particular, can lead to low self-esteem, and a tendency for women to hide their drinking, (Jarvis, 1992). There is often so much shame and guilt that women will deny their drinking problems, (van der Walde, et. al., 2002), which results in women withdrawing socially in order to remain undetected for as long as possible. This lack of movement and the negative feelings that characterize this type of acute disconnection tend to become established and create feelings of depression, alienation, and immobilization. There is a heightened feeling of fear and of shame. Their fear emerges in the belief that no empathic response from another person will be available, and there is a further belief that perhaps they don’t deserve one, (Jordon, 2004 c). A number of the participants spoke about their fear of being found out, of having their alcohol misuse exposed. The women would lie about how much they were drinking to their healthcare professionals and to their family members. There was a great deal of shame in being labelled as a woman with a drinking problem and for this reason many of the participants tried, often unsuccessfully, to deal with the problem on their own, rather than expose themselves as someone whom they felt was so shameful.
The stigma surrounding female alcohol misuse has led to misconceptions about the type of women who misuse alcohol. Men tend to display significantly higher rates of every problem that is typically associated with alcohol misuse (i.e. poor health, binge drinking, drunkenness, accidents, loss of control, symptomatic drinking, belligerence, family problems, financial and employment problems), all of which are linked to the stereotypical idea of what an alcoholic is. Because women do not tend to display such problems to the same degree, their alcohol misuse tends to remain undetected and under-diagnosed, (Middleton et. al., 1997). Literature shows that healthcare professionals are less effective in diagnosing women than men and women are frequently misdiagnosed, (van der Walde, et. al., 2002). Indeed, the women who participated in this study reported physicians and counsellors understanding little of their alcohol misuse problems. Some participants reported that when they were finally able to pluck up the courage to disclose their alcohol misuse to counsellors or physicians they were not encouraged to quit drinking or to enter treatment. One of the participants told of a counsellor actively discouraging her from entering a treatment facility, not believing that the woman was, “that bad.” Other physicians or counsellors encouraged moderate or controlled drinking, something the majority of participants did not believe was an option. Asking for help with their alcohol misuse puts women in a vulnerable position, which can be exacerbated when they are not heard by their healthcare professional. Suggesting moderation when a woman has said that she needs to quit drinking is suggestive of therapeutic non-responsiveness, which can result in further disconnection. This may also perpetuate a woman’s feelings of shame because she is not able to drink moderately, and this may contribute to feelings of being flawed, and beyond help.

It also appears as though many healthcare professionals had little knowledge of treatment options for women. A number of participants reported that their general practitioners did not know to where they could refer their patients for treatment. The women reported feeling quite frustrated that they had finally been able to get to a point where they were able to admit that they had a problem with alcohol and that they needed some help, yet when they approached physicians and counsellors, information was not readily accessible.
5.7 Treatment: What’s worked and what hasn’t

While women face multiple barriers when seeking treatment, many do access treatment services for alcohol misuse. Indeed the majority of women who participated in this study had experienced at least one treatment modality, and with varying degrees of success. Alcohol misuse can be viewed as a contraction of connection and recovery as an expansion of connection, (Covington & Surrey, 1997). It is believed that a crucial aspect of recovery is that one constructs a non-drinker identity and that this identity reconstruction takes place within the problem drinker’s narrative of recovery. The process of providing a narrative of their alcohol misuse is the mechanism by which women achieve recovery. Therefore, identity transformation is an important part of the recovery process, (Baker, 2000). When women describe their recovery, they describe a fundamental transformation: “I’m not the same person. I’m different than I was.” There is a shift from chronic neglect of self to a healthy care of self, (Covington, 2002). The women who participated in this study attempted to construct this new identity in various ways.

According to the literature, for a treatment programme to be successful it must take a holistic approach, (McDonough et., al., 1994, Covington, 2002). An effective programme should address the underlying causes of alcohol misuse (psychological, physiological, social), low self-esteem, sexuality and abuse issues, relationships with family members and significant others, grief related to interpersonal loss, attachment to unhealthy interpersonal relationships, and isolation due to lack of support systems. The staff at treatment facilities must be positive role models and need to address issues of stigma and trust in order for women to feel safe and empowered so that they feel able to explore their alcohol misuse. It is crucial that women are provided with an environment in which they are able to experience mutual, empathic, healthy relationships with their counsellors and with each other, (Covington, 2002). Further, in order for women to recover from alcohol misuse they need to become more self-aware. The initial shift in awareness is usually influenced by a woman’s immediate circumstances, but later it is broadened to incorporate insights into the role of substances in earlier events. The objective is for the woman to develop meaningful insights into the original source of her difficulties and the work required to address them, (Kearney, 1998). Women often become dependent upon alcohol in order to find relief from painful emotions. In recovery they have to address these feelings.
appropriately and contain them in healthy ways, (Covington, 2002). “Recovery involves a shift from acting out destructive behaviours in order to displace feeling or rid oneself of feeling, to accepting and integrating feeling, a process that involves learning to calm oneself through self-soothing techniques and sharing with others,” (p. 10).

One way in which the participants attempted to quit misusing alcohol and find a new way of being was through attending residential treatment facilities. A number of the participants had spent time in more than one facility and found that some were much better than others. Consistent with the literature, the women reported that the facilities that took a holistic approach were significantly more helpful. The women reported receiving great benefit from psychoeducation, in which they were able to learn more about their alcohol misuse, and the nature of addiction. The idea of addiction as a disease seemed to resonate with some of the participants as it took some of the onus off them; they had a disease, which needed treatment, but they no longer felt so much guilt and shame for not being able to control their drinking on their own. The women also found both the individual and group counselling sessions helpful, where they were able to address both their own personal issues and begin to connect with others. Of particular benefit was the emphasis on self-awareness. It was in these treatment facilities that some of the women were able to gain some understanding of why they had been misusing alcohol and were able to gain an understanding of triggers and begin to develop some new coping mechanisms. Participants also spoke about positive experiences with staff members who were professional and seemed well educated. It appears that the participants felt more secure in facilities with staff that seemed trustworthy and knowledgeable.

Some of the treatment facilities offered supported accommodation after the women completed residential treatment. One participant spoke about how it made her feel both safe and empowered; she was in a safe environment where she could be supported, but was also able to gently begin to integrate back into society. When a residential treatment facility had not been effective, it was generally because the women did not feel safe. Often the women felt as though they did not fit in with the other residents, who were described as rough, or trying to avoid jail, or had been homeless. Additionally, in such facilities the participants did not feel as though the
staff were well educated or very professional. In such facilities the participants did not feel comfortable to reach out for support nor allow themselves to be vulnerable enough to explore their alcohol misuse. So, one can see that residential treatment facilities can create excellent environments for women in early recovery to attempt sobriety and begin to explore all of the aspects of their alcohol misuse, however, these facilities must be a good fit for women, with the understanding that women who drink problematically do not fall into one homogenous group. Furthermore women must feel emotionally safe in order for these treatment programmes to be effective.

A number of the women who had received some sort of help for their alcohol misuse found AA to be a highly effective resource. This included women who had accessed alcohol treatment facilities in addition to AA and women who had only accessed AA. As mentioned previously, alcohol misuse can be viewed as disease of isolation, which causes connections to contract. AA tends to foster healing from the disease of disconnection through one of its core principles, that of social support. The aim of AA is to provide a caring community and enhance personal connections and to promote healthy relationships. The core values of the 12 Step programme, asking for help, speaking authentically, accepting vulnerability, and being there for others, are all key ingredients in the creation of connection, (Covington & Surrey, 1997). In the AA rooms a woman is valued for both what she shares of herself, and for what she offers to others. When speaking about AA the participants discussed how it had brought them into a fellowship, where they felt both connected, and accountable to others for the first time in a very long time. Women spoke about the mutual empathy they felt at AA where they believed that others genuinely understood how they felt, and who had had similar experiences. The women who had had success with AA displayed a sense of vitality and zest, which came from mutually enhancing connections with others. It also gave them hope as they saw others achieve success in sobriety. Participants believed that AA had changed their lives. As Lynette, whose sister had at one point wanted to bar Lynette from her home, told the interviewer,

“I’ve moved back in and have to share a room with my sister, they think I must be crazy at 42, but I’m not crazy. It’s almost like wrapping myself in a cocoon, and I felt happy and safe and protected. Having gone through this abysmal three, four years of catastrophic drinking,”

(Trans. p. 12).
This woman, like a number of the women had experienced immense emotional growth through their involvement in AA. It seems that active involvement with AA helps to foster the self-esteem and relational competence that is required to become a more integrated, effective person.

The participants who had benefited from AA also found the women’s only meetings to be immensely beneficial. They reported feeling safe to explore issues that they would not feel comfortable speaking about in mixed meetings, such as promiscuity, sexuality, and abortion. The women spoke about the strength and positive energy of the women’s meetings. In early recovery all female groups are important because this dynamic is more effective in helping women to share and integrate their experiences, ideas and feelings in order to create a greater sense of self, (Covington, 2002).

Alcoholics Anonymous appears to be effective for a number of reasons. First, when women begin to reach out to others in a group that feels safe and supportive they begin to feel more connected. “Women develop a sense of self and self-worth when their actions arise from and lead back to connection with others. Healthy growth-fostering relationships create increased vitality, empowerment, self-knowledge and self-worth, and a desire for more connection,” (Covington 2002, p. 4). These relationships are empowering for all participants. A personal sense of worth is achieved when one feels able to contribute to others and that one is part of a meaningful group or relationship. This was observed repeatedly throughout the interviews with the participants who had achieved sobriety. They spoke about viewing themselves in a new light, where they were women who mattered and had something to offer. These women had begun to make significant positive changes, many of which involved becoming more socially conscious and attempting to help others in their recovery from alcohol misuse.

Next, Kearney (1998) proposes that achieving healthy sobriety requires work in three areas, which appear to fit well into the philosophy of AA: abstinence work, self-work, and connection work. Abstinence work requires an increased awareness of the drive to drink, what triggers that drive, and an adoption of strategies to resist alcohol use and meet one’s needs through healthier means. Women who relapse into alcohol misuse usually have not progressed past the abstinence work. The participants who
had had some success with sobriety but had relapsed, or who were attempting to stop or reduce their alcohol consumption, but with little success, appeared to be only doing the abstinence work, without focusing on making changes within themselves. These women had not developed any new coping strategies, nor had they actively sought outside support. So, when personal problems arose, or life became difficult or unmanageable, these women tended to resort to the avoidant coping strategy of alcohol misuse.

The second phase, self work requires self-appraisal and responsible self-nurturing. Self-appraisal requires one to examine patterns of thinking and to admit vulnerability, facing up to how little one knew about oneself as an adult woman. It also requires, “a clear-eyed assessment of one’s limitations both in terms of past and present actions and the potential for future change,” (Kearney, 1998 p. 505). Responsible self-nurturing encourages women to discover and acknowledge their own needs, take responsibility for meeting them and to take care of themselves. The phase of self work is promoted in AA through the 12 Steps where one is asked to make a searching and moral inventory of herself and to revisit this inventory frequently. Self-nurturing is encouraged through meditation and a focus on spirituality, (Alcoholics Anonymous, 2010). Participants who had been successful in their attempts to stop drinking frequently spoke of their efforts to gain greater understanding into the behaviours and thinking patterns that resulted in their alcohol misuse. These women were able to admit how little they had actually known themselves and how their alcohol misuse had stunted their emotional growth. The participants seemed to understand that in order to maintain their sobriety they needed to be vigilant in their self work and in identifying their limitations and ask for support when it was needed.

The third phase, connection work encourages women to change the way they relate to significant others, acquaintances, and the community. Here women must begin to find mutually beneficial ways of interacting with others rather than always protecting themselves out of vulnerability and fear. The goal is empowered connectedness, which consists of understanding one’s limits of influence over others and other’s power over oneself, (Kearney, 1998). AA promotes this connection work through encouraging its members to share their wisdom and experiences and to reach out to new members as sponsors. AA also promotes connection through Step 8, which
requires one to make amends to those who have been hurt through a member’s alcohol misuse, (Alcoholics Anonymous 2010). Some of the participants could be seen as engaging in connection work simply through volunteering to participate in this study. All of the participants who were currently abstinent told the researcher that they were participating in order to promote awareness around alcohol misuse and to share their experiences in the hopes of helping other women who are struggling with alcohol misuse. These women seemed to have an understanding that they could grow personally through reaching out to help others.

Some of the women who participated in this study and who did not find AA to be helpful, or who had not been able to achieve sobriety appear to have been unable to move past the abstinence work; they spoke of being unable to reach out to other women, feeling too fearful to engage with others at a meeting or to ask for a sponsor. These participants also appeared to struggle to take responsibility for their past and present actions, often blaming others or circumstances for their lack of sobriety. One participant spoke of how she wanted others to take care of her sobriety and do everything for her. These women had not yet been able to surrender to a new way of living, which, according to AA philosophy, and to a number of participants, is the only way to achieve long-term sobriety. If one is to develop a sense of connection, she must be able to openly share her need for support and acceptance, (Jordan, 2004 b.). It would appear as though those who had not been successful in maintaining abstinence did not understand that in order to reduce feelings of alienation and move into meaningful connection with others, one must risk vulnerability.

In their National Guidelines for the Treatment of Alcohol Problems (Haber, et al, 2009) the Government of Australia promotes moderate drinking through a stepped care approach that is based on cognitive behavioural principles. None of the women interviewed who had sought help for their alcohol misuse believed that moderate drinking was a viable option for them. Even the women who wished to drink moderately had admitted that they had been unable to achieve it. In fact, the participants tended to be much more trusting of health professionals who could refer them to abstinence-based treatment programmes. Counsellors who suggested moderation appeared ignorant of these women’s experiences and thus, were not
trusted. Self-monitored moderate drinking may not be a viable treatment option for women who misuse alcohol.

The tools of controlled drinking, or behavioural self-management such as monitoring daily alcohol consumption, goal setting, and identifying problematic drinking situations and triggers seem to fit in with the concept of abstinence work. However, as mentioned previously, abstinence work alone is not often effective in the long term. The emphasis with this approach is self-reliance, a “going it alone” approach, which fosters independence rather than connection. Here alcohol misuse is seen as an individualistic problem; the problem is with the way the individual thinks and behaves. Since moderation requires one to use self-control and to rely on oneself to monitor alcohol consumption, and to keep oneself safe with regard to triggers and problematic drinking situations (Haber, et. al., 2009), any failure to do so, puts the blame on the woman herself. This may create feelings of shame, and inadequacy, which can lead back into the vicious cycle of alcohol misuse. Furthermore, self-monitored moderate drinking encourages one to be independent and self-sufficient, which actually promotes prevention through disconnection or separation, something that can actually be detrimental to a woman’s recovery since she is already existing in a place of separation and isolation.

Controlled drinking is recommended for those with low dependence, and who are not experiencing significant alcohol-related harms, (Haber, et. al., 2009). However, as was previously discussed, women who misuse alcohol, do not typically show evidence of dependence or appear to be experiencing significant alcohol-related harms because they do not often present to healthcare professionals with positive symptoms (those which are associated with the stereotype of women who misuse alcohol, and are more common in men). Practitioners frequently under-diagnose women (Middleton, et., al., 1997), which can lead to an inappropriate recommendation of moderate, controlled, drinking. Further, according to Haber, and colleagues (2009), it is recommended that those with moderate to severe alcohol dependence should undergo a three to six month period of abstinence before attempting controlled drinking programmes. Several of the women in this study had experienced significant periods of sobriety before they began to drink again. Without fail these women ended up misusing alcohol as problematically as before; they were
unable to maintain a level of moderate drinking. Additionally, moderation, or controlled drinking is based on a CBT approach, which assumes that affect can be addressed through cognitive process, which is too narrowly focused for women in the early stages of recovery. Women’s treatment needs to be holistic, focusing on affective, cognitive, and behavioural change. The affective component is particularly important for women because their drinking needs to be understood in the context of their emotional experience, (Covington, 2002).

So it appears that the most effective forms of treatment for alcohol misuse are those that focus on self-awareness, that promote self-esteem, that promote growth-fostering connection, and that provide a safe and empowering environment, in which women are able to be vulnerable to explore their emotional experience and to reach out for help. In order to recover, women must move from a place of isolation and pain to one of mutuality and relational resilience. Treatment for alcohol misuse must help women move from a one-directional need for support from others to mutually empathic involvement in the wellbeing of others, (Jordan, 2004 b.). It is when a woman feels connected and part of something bigger than herself, that she will find meaning, and with a greater sense of meaning comes zest and vitality, and the need to misuse alcohol is reduced.

5.8 Conclusion
This chapter presented a discussion of the findings of this study integrated with the literature based primarily in Relational Cultural and Attachment theory. The chapter aimed to provide a general understanding of the factors influencing alcohol misuse in women as well as an understanding of what might prevent women from seeking help for their misuse and of what is required for the effective treatment of alcohol misuse. The final chapter provides some broad conclusions gained from this study and a discussion of its limitations, some recommendations for further exploration into alcohol misuse in mature aged women as well as some implications for professional practice.
Chapter 6  Conclusion

6.1 Conclusions drawn from this study

- Disconnection in family relationships can make one vulnerable to problematic alcohol use.

Relationship is the process and goal of human development and for one to grow psychologically and emotionally she must feel a sense of authentic connection, (Walker, 2004). Parents are the first people with whom relationships are formed. Interactions with parents form one’s expectations and beliefs about the reliability of others and these beliefs influence one’s understanding of self that further guide emotional experiences and behaviours throughout life (Kassel et. al., 2007). Many of the women who participated in this study spoke of parents who were emotionally unavailable, neglectful or abusive from whom they appeared to learn that people cannot be trusted to care for them and to nurture them. The result was a deep sense of distrust, worthlessness, loneliness, and disconnection, which these women carried with them into many of their adult relationships. The pain of such feelings left the participants searching for relief, for something to numb the pain of disconnection and isolation, and what they found was alcohol.

- Alienation from the self and others is at the core of alcohol misuse.

Alienation from the self and others is reflected in feelings of disconnection and pain that is felt down to one’s core. There are strong feelings of being fundamentally flawed and as though one’s life has no meaning. These feelings cause significant damage to one’s self-concept; there is a deep despair, for which there seems to be no relief. The women in this study reported drinking in order to find relief from the pain of alienation, but also tend to become more alienated due to their problematic drinking. Women who misuse alcohol frequently withdraw from others as the alcohol takes over all aspects of their lives (Lillie, 2002). These women have difficulty maintaining satisfying and meaningful relationships, which results in feelings of both loneliness and worthlessness. Women become fearful of showing their true selves;
there is a fear that they will be rejected and their poor self-concept will be reinforced. Instead women turn to alcohol for nurturance, which leads women further into isolation as alcohol masks the true self, making it virtually impossible to form authentic relationships.

- Alcohol is used as an avoidant coping strategy, which ultimately creates more problems than it solves.

The women in this study used alcohol to cope with their feelings of isolation, low self-esteem, and unhappiness, as well as to cope with their personal problems. Alcohol acts as a numbing agent, quieting the voice of discontent, and making problems seem less important. Alcohol was also used as a reward and as a source of satisfaction, replacing relationships and positive activities. It appears as though women chose alcohol as a coping mechanism due to low mood and low levels of social competence, perhaps not having the personal resources to risk engaging in active coping mechanisms, which could result in failure. Unfortunately, as the women became more dependent upon alcohol to cope with negative emotions they became increasingly disabled in their ability to function. Alcohol began to exacerbate problems; it created greater isolation and disconnection, increased feelings or shame, and wreaked havoc on the participants’ relationships.

- The stereotypes associated with female alcohol misuse are the biggest barrier to seeking help.

Alcohol misuse comes with a variety of negative connotations. People who misuse alcohol are often seen as derelicts, as people who cannot maintain jobs or families. Women who misuse alcohol are often seen as irresponsible, sexually promiscuous and as lacking good maternal qualities. Stereotypes such as these did not fit for the majority of the participants, which meant that life had to become quite unmanageable before they were able to identify themselves as problem drinkers. Additionally, the stigma that is attached to such a negative stereotypes caused a great deal of shame and contributed to a greater sense of inadequacy, which led many of the women in this study to hide their drinking, which resulted in them withdrawing socially. This led to
a sense of acute disconnection creating feelings of depression, alienation, and immobilization. Further, the stigma and stereotypes associated with female problem drinking often leads to under-detection and misdiagnosis of alcohol misuse disorders. The participants did not fit the image of a substance abuser, so healthcare professionals often underestimated their problem, or suggested inappropriate treatment options.

- Movement away from isolation into connection is crucial to recovery from alcohol misuse.

The majority of women who had received help for their alcohol misuse reported that AA had been an immensely beneficial resource in their recovery from alcohol misuse. The reasons given were that through AA they had learned that they were not alone; there were other women like them, who had experienced similar problems and behaved in a similar manner. The participants also spoke about feeling part of a group to which they could contribute and to which they were accountable. A woman’s self worth and sense of self is at it’s strongest when her actions arise from and lead back into connection with others, (Covington, 2002). When a woman moves out of isolation into connection, she feels a greater sense of relational competence and self-efficacy, she is more able to form healthy growth-fostering relationships. When this occurs there is increased self-knowledge and self-worth, a desire for more connection, and feelings of empowerment, (Covington, 2002), and there is less need to misuse alcohol. The participants who had had the most success in recovery from alcohol misuse had begun to form meaningful, empathic relationships. They had also begun to connect with others through engaging in more socially minded activities.

6.2 Limitations of this study
- As this was a qualitative study the sample size was not large. However, while it was of sufficient size to elude important understandings of the lives of the women who participated, generalisability must be cautiously approached.
All of the participants were Anglo-Australian, middle-class women. This means that the participants all fell into a single demographic, which would likely have impacted on the information that was gathered. Therefore the data gained from this study is quite context specific and thus cannot be generalised to other contexts. Nevertheless, this study provides valuable information about a group of women not often studied.

Participation in this study was voluntary and participants may have belonged to a subgroup of mature aged alcohol misusers who were less vulnerable and more able to share their experiences, which would influence the results. The women who participated were willing and able to explore their alcohol misuse, which indicated that they might have had more insight into their experiences with alcohol and a greater understanding of how they came to misuse it. It also appears that these women had come to understand that their alcohol consumption was causing, or had caused more problems than it solved, and thus had greater motivation to face their substance misuse histories.

Finally, it is not entirely certain that the themes that emerged from this study are specific to middle-aged women. It is possible that they are themes that are relevant for many women of different ages and stages of life.

6.3 Recommendations

Further research exploring problem drinking in mature aged women needs to be carried out as well as conducting some comparative studies, looking at women from a variety of age groups in order to gain a clearer understanding of which issues are specific to various age groups and social demographics and which may be generalised to all women.

Research into screening practices for alcohol misuse in women would be immensely beneficial. Since many screening tools were developed by men for men, alcohol misuse in women is frequently under-detected. It would be helpful to develop screening instruments that are more sensitive to alcohol misuse in women. Also since female problem drinkers do not make up a homogenous group
it would be helpful to explore the efficacy of screening tools on various subgroups of the population.

- A great deal more needs to be done to dispel the myths of alcohol dependence. Society’s view of alcohol issues is skewed to the point of an extreme. Because of this many people, particularly women, go undiagnosed and their problematic drinking may go undetected for years. There are advertising campaigns that address binge drinking and alcohol-fuelled violence, but there is nothing that addresses an adult population of women who are mothers and wives, who are employed, who appear to be managing, yet are drinking at highly problematic levels. There is a misconception that if there is a lack of positive symptoms, then there is not a real problem.

6.4 Implications for counselling practice

- Mature aged women who present to their counsellors with anxiety, depression, poor self-esteem and feelings of loneliness need to be questioned about their alcohol consumption. Counselling professionals need to be aware of the factors that contribute to alcohol misuse in women and screen accordingly. This is particularly important since many women tend not to see alcohol as the primary problem, often minimizing the harmful effects of their alcohol use and denying the negative impact that it has on their ability to fulfil their roles within their families and at work.

- When women come to a point where they are willing to disclose about alcohol misuse it is important that counsellors take the disclosures seriously and are able to provide information about appropriate alcohol treatment services, including AA.

- Counsellors must be aware of the stereotypes and misconceptions surrounding female alcohol misuse. It is important to understand how this contributes to the stigmatisation of women who drink, creating shame and a need for secrecy. Counsellors need to ask questions about alcohol consumption in a manner that
encourages an open and candid discussion of alcohol use without invoking shame or guilt in their female clients.

- Alcohol treatment for women must go beyond addressing consumption and must be holistic. Abstinence work is important, but it is only a small part of recovery. Women need to learn how to nurture themselves by discovering their own needs, taking responsibility for meeting them and being able to take care of themselves. They also need to address their maladaptive coping styles and learn to implement more positive, active coping strategies. Women also must be encouraged to move past their fear and vulnerability to reach out to others. In order to recover women must find a way to relate to significant others, acquaintances and their communities in ways that are mutually beneficial. A good place to start is with family work or couples work where counsellors can help women and their families find new, mutually satisfying ways of communicating in a non-threatening environment where vulnerability may be risked. The goal is empowered connectedness.

6.5 Conclusion
Although narrow in focus, this study aimed to provide an understanding of the experiences of mature aged women who misuse alcohol. The aim was to gain an understanding of how women arrive to a place in their lives where they feel the need to use alcohol to cope with every day life. The researcher attempted to provide the reader with a view of this issue from Relational Cultural and attachment perspectives, examining how early relationships and connection, or lack thereof play a crucial role in women’s psychological wellbeing. This study also aimed to present an understanding of the barriers to receiving help for alcohol misuse that women face, and their treatment experiences when help was sought. Further study into this area is needed in order to develop more effective screening and treatment options for this population of women.
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