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To the Graduate Council:

I am submitting herewith a thesis written by Laura L. Clingan entitled "Women in recovery : a qualitative study of chemical dependency from a female perspective." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Counseling.

James H. Miller, Major Professor

We have read this thesis and recommend its acceptance:

Wayne Mulkey, John Ray

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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We have read this thesis and recommend its acceptance:

Stephanie Mulkey

Joel R. Ray

Accepted for the Council:

Lew Minkel

Associate Vice Chancellor and
Dean of The Graduate School

Women in recovery: A qualitative study of chemical dependency from a female perspective

A Thesis
Presented for the
Master of Science
Degree
The University of Tennessee, Knoxville

Laura L. Clingan
August, 1995

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ABSTRACT

The study was developed to explore the nature of chemical dependency from a female perspective. The main focus of the research was on the issues and concerns of recovering women, the barriers to recovery, and the key factors in continued recovery success. Interviews were conducted with 5 women who had a minimum of 9 months' abstinence and who had successfully completed the adult inpatient and aftercare programs at the Detoxification Rehabilitation Institute in Knoxville, TN. The results of the interviews were analyzed to identify patterns of responses characteristic of all participants. Further research is indicated including similar research with male subjects and research focusing on the vocational concerns of chemically dependent persons.

TABLE OF CONTENTS

CHAPTER		PAGE
I.	INTRODUCTION	1
	Introduction	1
	Statement of the Problem	2
	Purpose of the Study	4
	Significance of the Study	5
	Procedures	7
	Assumptions	8
	Limitations	10
	Definition of Terms	10
	Organization of Study	17
II.	REVIEW OF THE LITERATURE	
	Introduction	18
	Theories of Chemical Dependency	19
	Women and Alcohol	21
	Women and Treatment	25
	Qualitative Methodology	29
	Interview Studies	30
	Summary	32
III.	METHODOLOGY	
	Introduction	33
	Research Questions	33
	Interview Studies	34
	DRI Adult Program	36
	Subjects	37
	Data Gathering Process	38
	A Pilot Interview	40
	The Interview Process	41
	Data Analysis	42

CHAPTER PAGE

Reliability and Validity 43
Validity 43
Reliability 46
Summary 47

IV. RESULTS
Introduction 48
Results 48
What were the primary issues and concerns of women in recovery from chemical dependency? 49

What were the barriers which hinder successful recovery for women? 52
What were the definitive key factors which contribute to the recovery of chemically dependent women? 55
Other Information 56
Summary 59

V. CONCLUSIONS AND RECOMMENDATIONS
Introduction 60
Summary of Study 60
Findings 61
Conclusions 63
Recommendations 67
Summary 69

REFERENCES 71

APPENDICES 77

VITA 88

CHAPTER I

INTRODUCTION

Introduction

A person suffering from chemical dependency is often described by self and others as being emotionally, physically and spiritually bankrupt. Indeed, addiction to alcohol and other mood-altering substances can affect every aspect of a person's life to the extent that chemical addiction has been called a bio-psycho-social disease. This term refers to its adverse effect on the health of the body and mind as well as social relationships (Gorski & Miller, 1986). Treatment for chemical dependency therefore must be of a holistic nature to address the varied problems caused by the addiction and not merely the addiction itself. Recovery must be a process of continued psychological, physical, spiritual, behavioral and social change with the objective being the long-term maintenance of a lifestyle conducive to abstinence in which a person can be productive and reasonably content (Gorski & Miller, 1986).

This study was an exploration into the world of addiction and recovery through the eyes of people who were experiencing it. Perhaps more significantly, it was a glimpse into the nature of addiction and recovery from the perspective of women. This perspective made the study unusual and certainly unlike the norm in which the study of chemical dependency has traditionally been approached from a male point of view. There were no attempts in this study to compare the experiences of men and women nor to draw conclusions about what differences may or may not exist in the nature of men and women's addiction, recovery, barriers to recovery or key factors in recovery success. Briefly stated, this study offered women the opportunity to tell their story and share their experiences concerning addiction and recovery so that an enhanced understanding of chemical dependency in women could be achieved.

Statement of the Problem

Chemical dependency and its treatment is a growing area of interest and research in the United States. The problem of treating chemically dependent persons and addressing other issues related to addiction is

proving to be extremely costly. Every year Americans spend approximately $10 billion on the treatment of chemically dependent individuals (Tomko, 1988). This figure does not include the cost of related health problems, legal issues, accidents, time lost from work and social implications. With considerable resources targeted to treat persons suffering from addiction, it seems logical and appropriate to define the factors which relate to successful recovery of chemically dependent persons and to be able to incorporate these factors into a suitable treatment modality. As Mary Kay Tomko (1988) pointed out, however, there is too much inconsistency and confusion involved with trying to define the concept of recovery, mainly because there exists several different theories concerning the concept of addiction itself. Tomko states: "The criteria used to define recovery differ according to the theoretical framework being applied to each addictive disorder being reported. It appears that the concept of recovery as it applies to addiction is still evolving. It began as a very narrow concept of abstinence and has slowly evolved into a multidimensional concept by some theorists" (Tomko, 1988, p. 140).

The current study was designed to address the problem of defining the concept of recovery and identifying key factors in continued success in recovery. The unique perspective of this study was that it incorporated as its primary source of information recovering people themselves. The assumption was that people experiencing chemical dependency and struggling to continue towards successful recovery from addiction are best prepared to relate their own experiences and to define the elements in their own life which have contributed to their success and long-term sobriety.

Purpose of the Study

The purpose of this study was to explore the nature of chemical dependency, in a holistic manner, using as the primary source of information, women who have experienced addiction and who are now experiencing continued success in recovery. The overall objective was to gain an understanding of chemical dependency and recovery from a woman's perspective. As part of this effort, three basic research questions were addressed. First, what were the primary issues and concerns of women in recovery from chemical dependency? Second, what were the barriers

which hinder successful recovery for women? Finally, what were the definitive key factors which contribute to the recovery of chemically dependent women? The women involved in this study told their story and shared their experiences, ideas, thoughts, feelings, and opinions to help the researcher gain insight into the issues that confront women in recovery.

Significance of the Study

Historically, chemical dependency (specifically alcoholism) and its treatment has been approached from a male's perspective as "most research and treatment efforts have been directed toward male alcoholics" (Schlesinger, Susman, & Koenigsberg, 1990). Research with males has prevailed despite the fact that estimates indicate roughly one third of alcoholics in the United States (i.e., 4.6 million alcoholics) are women (Perez, 1994). In response, numerous articles have been written to address the issue of providing gender-sensitive treatment services for women with alcoholism and drug dependency (Brady, Grice, Dustan & Randall, 1993; Duckert, 1987; Finkelstein, 1994; Kress, 1989; Moyar, 1987; Oppenheimer, 1991; Naegle, 1988; Reed, 1987; Toneatto, Sobell & Sobell, 1992;

Turnbull, 1989; Underhill, 1986; Wallen, 1992; Wilke, 1994). One of those articles (Reed, 1987) describes the rehabilitation components necessary for specific treatment of women:

> Women-oriented drug dependence treatment services are defined as those that (a) address women's treatment needs; (b) reduce barriers to recovery from drug dependence that are more likely to occur for women; (c) are delivered in a context that is compatible with women's styles and orientations and is safe from exploitation; and (d) take into account women's roles, socialization and relative status within the larger culture. (p. 151)

The focus of the literature concerning gender-sensitive treatment is primarily on the initial recovery process and short-term goals. Attention also needs to be directed to the long-term recovery goals and process for women, however, in order for recovery to be sustained. The current study focused on the complete addiction and recovery process, and attempted to illustrate the nature of chemical dependency in a holistic fashion and from a

woman's perspective. Louis Murdock Smith (1994) reported on the nature of chemical dependency in men. Smith employed the use of medical records, genograms and personal interviews with men to illustrate the phenomenon of addiction in men and to identify the "success points" which enabled each man to recover and to maintain that recovery for a prolonged period of time. In the description of the implications of the study and recommendations for future research Smith stated: "A study with the same objectives, of understanding the nature of recovery from chemical dependence, but from the perspective of women is needed" (Smith, 1994, p. 263). The current research was designed to parallel Smith's work and focus on the female perspective of addiction and recovery.

Procedures

The principle source of information for this study was women who chose to participate in the research study and share their experiences, thoughts, opinions and feelings about their process of recovery from chemical dependency. The criteria for selection to participate in the study were (1) successful completion of the Detoxification Rehabilitation Institute

(DRI) inpatient and aftercare program, (2) a minimum of nine months' sobriety, and (3) willingness to participate in an audio-taped interview with the researcher. A total of five women participated in this study and were interviewed by the researcher. The audio-tapes from each interview were transcribed by the researcher with all identifying information altered or deleted. The tapes were destroyed and the transcriptions were then used to compile and analyze the data.

Assumptions

There were two main assumptions which prefaced this study and which must be accepted in order to give the study meaning and credibility. One is that a woman with at least nine months' abstinence from drugs and alcohol has enough knowledge about her recovery to identify key factors in her success. The second is that each woman was truthful and candid with the researcher during the interview.

The director of the aftercare program at DRI facilitated the selection of subjects appropriate for the study by identifying women who were

successful during both the inpatient program and the aftercare program. The director was also familiar with the subjects' post-aftercare progress through follow-up contacts with each client. This method of participant selection was utilized to identify with greater certainty women who were successful in their recovery and who had a minimum of nine months' sobriety.

Nine months' abstinence was chosen as the minimum length of sobriety for participants of this study. This duration of sobriety was accepted by the researcher and the DRI aftercare director as a reasonable amount of time for a woman recovering from chemical dependency to establish a foundation in recovery, to develop a support network and to implement the principles of recovery into her life. Less than nine months was considered inadequate because of the greater instability of recovering persons and the higher risk of relapse in the first six months of recovery following treatment (Knouse & Schneider, 1987).

Limitations

This study had two primary limitations. One obvious limitation is that the results of the study were dependent upon accurate self-disclosure of the participants. The accuracy and dependability of information obtained from each participant was critical to the outcome of the study. Although measures were taken to minimize this limitation, it was neither possible nor appropriate to attempt to verify accuracy of the self-disclosures. The second limitation was the fact that some women may have chosen not to participate because they were not comfortable with the interview being audio-taped. It is not possible to determine how their absence from participation might have affected the results of this study.

Definition of Terms

The following is a list of terms which were used throughout this study. Some of these terms may have more than one accepted definition, and the definitions themselves may be controversial. The following list

outlines these terms and their definitions as they were be employed in this study.

Chemical Dependency. Chemical dependency and addiction were used interchangeably in this study to describe the state of compulsive use of mood-altering substances despite adverse consequences.

Alcoholism. The National Council on Alcoholism (NCA) and the American Medical Society on Alcoholism (AMSA) define alcoholism as "a chronic, progressive and potentially fatal disease...characterized by: tolerance, physical dependency and/or pathological organ changes, all of which are the direct or indirect consequences of the alcohol ingested" (Fox, Conway & Schweigler, 1981). There exists an ongoing controversy as to whether alcoholism is truly a disease or merely a maladaptive behavioral pattern. In the current study, the term alcoholism was used to describe the compulsive and obsessive use of alcohol despite adverse consequences.

Mood Altering Substances. Gorski and Miller (1986) define mood-altering substances as "chemical agents that produce changes in brain

function by altering the chemistry of the brain" (p. 37). The changes in the function of the brain directly result in changes in the physical, psychological and behavioral functions of the individual using the mood-altering substances. These chemical agents can include any drugs from nicotine and tobacco to alcohol, narcotics and hallucinogens.

Treatment. For purposes of this study, the term treatment refers to any formal program designed to facilitate a person's recovery from chemical dependency. Elements of treatment could include medical detoxification, educational and therapy groups in a clinical setting, relapse prevention programs, and/or continuing care groups aimed at helping recovering persons maintain abstinence.

Sobriety. This term refers to a physical state of "being" in which the body is free of alcohol and is functioning without chemically-induced impairment. For purposes of this study, it includes freedom from all mood-altering chemicals which can adversely affect cognitive abilities and the body's ability to function normally. The terms sobriety and abstinence were used interchangeably throughout this study.

Recovery. Unlike sobriety, recovery describes the state of not only being physically free from mood-altering substances but also of having attained a state of emotional and spiritual stability in which a recovering person is reasonably happy and content. This study focused on women who were continuing towards successful recovery. Recovery is much more than simply putting down the bottle or whatever other substance serves as a person's source of addiction. Alcoholics Anonymous alludes to this notion of recovery being a continual process when it states, "We feel that elimination of our drinking is but a beginning. A much more important demonstration of our principles lies before us in our respective homes, occupations and affairs" (p 19).

Relapse. The Merriam-Webster Thesaurus defines 'lapse' as being a "temporary deviation or fall especially from a higher to a lower state" (p. 329) and 'relapse' is considered synonymous with this term (Merriam-Webster, 1978). In recovery, a relapse is considered to have occurred when a person uses alcohol or drugs again after a period of abstinence. However, relapse is now becoming accepted as more of a process with identifiable traits and characteristics which develop over time and which can be

prevented or halted. Gorski and Miller (1986) describe the notion that a person can relapse long before they resume drinking or using drugs. They maintain that relapse is a process of becoming dysfunctional in sobriety before returning to the use of or instead of using alcohol or drugs. This dysfunction can be characterized by changes in patterns of behavior and thought. A person in recovery who is experiencing the early stages of relapse may begin to practice 'old' behaviors characteristic of how they were when they were actively using mood-altering chemicals. They may begin to have difficulty coping with life problems and become irritable and depressed. Eventually they may begin to believe that their addiction is not very serious and turn away from their program of recovery. They may entertain thoughts of returning to the use of mood-altering chemicals. According to Gorski and Miller (1986), if these warning signals are not recognized and addressed, the person will eventually begin to use mood-altering chemicals again. In Alcoholics Anonymous this process and these warning signals are known as a "dry drunk".

Twelve-Step Program. Twelve-step programs refer to the numerous self-help groups which have been developed and which are based upon a list of

twelve steps or principles which guide the recovery and the behavior of each member of the group. These groups exist to help people with various types of problems from excessive gambling to eating disorders. The largest of these twelve-step programs is Alcoholics Anonymous (AA) which was founded by two alcoholic men, Bill W. and Dr. Bob in 1935. By 1988 there were 73,000 different AA groups operating in 114 different countries around the world. Today, AA dominates alcoholism treatment in the United States and is often credited with helping more alcoholics recover than all other forms of treatment combined (Goodwin, 1994). A complete list of the twelve steps is located in Appendix 1.

Spirituality. Spirituality is a concept in twelve-step programs which refers to the state of being "in touch" with a power greater than oneself. It is the acknowledgment that there exists in the world a power greater than that of man and that this power can be used as a source of strength and serenity to facilitate recovery. The book entitled Alcoholics Anonymous or the "Big Book" describes the phenomenon of a "spiritual awakening" which is necessary for an alcoholic to successfully recover from alcoholism. It states about the AA member: "He finally realizes that he has undergone a

profound alteration in his reaction to life; that such a change could hardly have been brought about by himself alone" (Alcoholics Anonymous, 1976, p. 569).

Barriers. A barrier is commonly defined as being anything which hinders or prevents movement from one point to another. Some barriers are more tangible than others, for example, physical barriers such as a fallen tree across a road. This barrier may not be easily removed but it can be clearly defined and quickly recognized. Other barriers are much more subtle such as the barriers created by social prejudice and cultural bias. The obstacles which are established by perceptions, morals, ignorance or fear can be much more formidable than any physical barriers could ever be. This study posed questions about the types of barriers confronting women in recovery. The women who participated in this study shared their experience about the barriers they faced in their addiction and in their treatment and which they still face in their continued sobriety.

Organization of Study

This study is outlined into five chapters. Chapter one provides an introduction to the study and includes the following sections: Introduction, Statement of the Problem, Purpose of the Study, Significance of the Study, Procedures, Assumptions, Limitations, Definitions of Terms and Organization of Study. Chapter two provides a review of pertinent literature and includes six sections: (1) Introduction, (2) Theories on Chemical Dependency, (3) Women and Alcohol, (4) Women and Treatment, (5) Qualitative Methodology, (6) In-Depth Interviews, and (7) Summary. Chapter three details the methodology. Chapter four presents the findings and data analysis. Chapter five provides a summary and conclusions as well as recommendations for further research.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The focus of the current research study is both broad and complex and requires an understanding of the various aspects of the nature of chemical dependency and of the issues surrounding the holistic nature of addiction and recovery. The nature of addiction is controversial and there are numerous theories concerning its definition, its causes and its treatment. Vocational rehabilitation or the lack thereof for persons recovering from chemical dependency is a growing topic of interest and study as is the issue of providing gender sensitive treatment and of addressing women's issues in recovery. There is seemingly a never ending supply of literature, research, theory and opinion on the subject of chemical dependency. It would be impractical and nearly impossible, however, to attempt to identify and review every piece of available research on the subject. This section, therefore, will provide an overview of selected reports that address issues which are the core of chemical dependency research and which are relevant

to this study. The section pertaining to gender-specific effects of chemical addiction focuses on alcohol in particular although the concepts as related to diagnosis, treatment and recovery, are generally applicable to all types of chemical addiction.

Theories of Chemical Dependency

The most predominant theory concerning chemical dependency today is the disease concept which describes chemical addiction as a physical manifestation of an illness. This illness is characterized by tolerance, craving, withdrawal and a 'loss of control' or inability to abstain (Meyer, 1989). The disease concept is an idea which gained more popularity with its advancement and advocacy by Alcoholics Anonymous in the 1930's (Burman, 1994). In 1943, Haggard and Jellinek explored the idea of alcoholism as a disease and in 1960, Jellinek described alcoholism as a chronic, progressive, fatal illness with recognizable symptoms and stages. It should be noted that most of the research and theories concerning the disease concept have been directed towards alcohol dependency more than addiction to other drugs. Addiction to other mood-altering substances is

usually explained by psychological or sociological theories. (Schilit & Gomberg, 1991). Much of the research specifically concerning alcoholism has been carried over to apply to the field of chemical addictions in general (Peele, 1986). Therefore, the theories concerning alcoholism are, in general, considered applicable to chemical dependency. Although some writers oppose the disease concept (Faulkner, Sandage & Maguire, 1988; Fingarette, 1988; Peele, 1986), this theory has been widely accepted and has had a significant influence on the diagnosis and treatment of chemical addiction (Burman, 1994).

Other explanations concerning chemical addiction include behavioral theories (e.g., tension reduction hypothesis, expectancy and cognitive models, conditioning theories), psychosocial theories (e.g., family systems approach, social-learning theory) and psychological theories (e.g., psychoanalytic approaches, dependency theory, and power theory) of addiction (Rivers, 1994; Schilit & Gomberg, 1991; Segal, 1988). There has been a recent trend to integrate some or all of the various theories concerning addiction into multi-factored models. One such approach which includes all three general types of theories is the biopsychosocial model.

The biopsychosocial model recognizes all of the factors associated with addiction: biological, psychological and sociocultural (Gorski & Miller, 1986; Lewis, 1991; Schilit & Gomberg, 1991). It proposes that any one theory, particularly the biological theories, are too limiting and do not allow for the development of more holistic models of treatment. Lewis (1991) proclaims: "The biopsychosocial model is an innovative way to move away from excessive reductionist thinking about the biological basis of disease. It presents an interactive paradigm, not only for understanding personality, behavior, and the environment, but also interactions between the individual and treatment" (p. 264).

Women and Alcohol

Until recently, research and literature available concerning the nature of alcoholism has focused on the male alcoholic and has assumed that the physiological, psychological and sociological effects of alcoholism are the same for women as they are for men (Burman, 1991; Hughes, 1990; Schlesinger et al., 1990; Smith, 1986). As the significance of the problem of alcoholism among women becomes more apparent and more readily

acknowledged, this assumption is being challenged and studies are now being conducted which are directed at defining gender differences in the effect of alcoholism and other forms of chemical addiction. These studies are important as they can help to redefine the methods of diagnosis and treatment that are currently available for chemically dependent women (Brady et al., 1993; Hughes, 1990; Wilke, 1994).

A review of the literature reveals a general consensus concerning various aspects of female alcoholism. Even though women tend to begin drinking at an older age, they experience a phenomenon known as "telescoping" which causes them to develop physiological and psychological difficulties related to alcohol earlier in their drinking careers (Burman & Allen-Meares, 1991; Dawson & Grant, 1993; Gomberg, 1993; Piazza, Vrbka & Yeager, 1989; Turnbull, 1989; Wilke, 1994). Women seem to be more susceptible to biomedical consequences of alcohol abuse at lower levels of intake including cirrhosis of the liver and brain damage (Burman & Allen-Meares, 1991; Fellios, 1989; Hennecke & Gitlow, 1985; Murray, 1989; Naegle, 1988; Wilke, 1994). Women experience higher blood alcohol levels than men after consuming the same quantity of alcohol

adjusted for body weight. This is due to the fact that women metabolize alcohol faster than men as a result of having less muscle mass and a higher percentage of body fat (Fellios, 1989; Murray, 1989).

The psychological effects of alcohol also seem to be different for women. Studies indicate that alcoholic women more often report depression, low self-esteem, poor self-concept and powerlessness (Brady et al., 1993; Burman & Allen-Meares, 1991; Dawson & Grant, 1993; Hennecke & Gitlow, 1985; Murray, 1989; Taylor & St. Pierre, 1986; Turnbull, 1989; Wilke, 1994). Studies also indicate that alcoholic women have a higher incidence of attempted and completed suicides than alcoholic males (Burman & Allen-Meares, 1991; Fellios, 1989; Hennecke & Gitlow, 1985; Murray, 1989).

The motivational factors in women's drinking also may be different than for men. Women often cite some emotional crisis as the precipitating factor in their drinking behavior (Fellios, 1989; Gomberg, 1993; Murray, 1989; Turnbull, 1989; Wilke, 1994). Although women tend to be introduced to drinking by their husbands or other men, they are more

frequently abandoned by their spouses or lovers than is the case with male alcoholics (Burman & Allen-Meares, 1991; Fellios, 1989; Gomberg, 1993; Murray, 1989; Wilke, 1994). Further, women often combine alcohol abuse with the use of other mood-altering substances (Dawson & Grant, 1993; Murray, 1989; Naegle, 1988; Turnbull, 1989).

Despite increased attention to female alcoholism, there remains a strong stigma attached to female drunkenness and society continues to accept male alcoholism more readily than alcoholism in women. Women who drink are perceived as being more promiscuous and sexually responsive (Blume, 1991; Fellios, 1989). Perhaps partially as a result of this stereotype, alcoholic women are more often victims of physical and sexual aggression (Blume, 1991; Cyr & Moulton, 1993; Miller, Downs & Gondoli, 1989). Women alcoholics are often "hidden" by family, friends and medical professionals who are either embarrassed or ashamed of the woman's drinking or who minimize the significance of the problem (Fellios, 1989; Hennecke & Gitlow, 1985; Murray, 1989; Turnbull, 1989). Compounding this problem for women is the fact that more female than male alcoholics drink alone and at home (Burman & Allen-Meares, 1991;

Dawson & Grant, 1993; Gomberg, 1993). Since alcoholism manifests itself differently in men than women and because women alcoholics tend to remain "hidden", alcoholism in women is less often diagnosed despite the fact that women seek treatment more often than men (Hennecke & Gitlow, 1985; Wilke, 1994).

Women and Treatment

Despite the evidence which indicates that women generally seek help for all kinds of problems sooner than men, men are still significantly more likely to utilize chemical dependency treatment services than women. Even correcting for the fact that there are more men alcoholics than women, men still significantly outnumber women in treatment settings (Duckert, 1987). Duckert (1987) suggests that this may be because women seek help for problems which arise due to the addiction instead of the addiction itself. For example, women are more likely to seek help for physical, emotional or marital difficulties but the chemical dependency is never discovered or addressed. Finkelstein (1994) states that three obstacles stand between

women and treatment: denial, stigma, and lack of gender-specific treatment services. Concerning stigma, Finkelstein writes:

> In the case of women, alcoholism and other drug abuse remain very much a moral issue. Substance-abusing women are often viewed as sexually promiscuous, weak-willed, negligent of their children, and irresponsible in their decisions to bear more children. (p. 8)

The stigma which is placed on women alcoholics often results in lower self-esteem, depression, guilt, shame, and subsequently, greater isolation. All of these factors contribute to greater denial of alcoholism and other chemical dependency. It is not only the female alcoholic who denies such a problem, but also her family, friends, and professionals such as doctors and counselors (Finkelstein, 1994). In a study conducted concerning differences in denial patterns between alcoholic men and women, Smith (1986) concluded that denial in women is often reinforced or even created by other people in their lives including family and professional care-givers.

This reinforcement of denial creates a barrier to adequate and timely treatment for chemically dependent women (Smith, 1986).

Controversy exists among researchers as to whether or not women require gender-sensitive treatment services and/or all-women counseling groups. Joanne Turnbull (1989) writes that there is no research which supports the idea that women should be treated for chemical dependency differently than men. Turnbull also claims that the current ineffectiveness of treatment for women, which has led to the belief that women are sicker and harder to treat than men, would indicate that perhaps women do require different treatment modalities and would benefit from gender-specific programs which address their unique issues. Turnbull states that treatment programs which emphasize and combine support with education are more effective for women and that the issues of child care, housing and health must be addressed. Turnbull also indicates that group therapy is effective in helping chemically dependent women learn new interpersonal skills to develop healthy relationships and overcome the social withdrawal that many chemically dependent women suffer in addiction (Turnbull, 1989). It is uncertain whether or not all-women groups or mixed groups are more

effective in the treatment of chemically dependent women. Brenda Underhill (1986) posits that women benefit more from women oriented groups. Underhill states:

> ...the issues that women bring to early sobriety and treatment--low self-esteem, extreme stigmatization, high probability of sexual abuse, lack of social support, and the need for support services such as child care--are the same issues women bring to the aftercare phase of recovery. Addressing these issues in a positive, women-oriented environment that promotes empowerment is essential if the recovering woman is to develop a positive self-image. (p. 47)

The development of a positive self-image is vital to the long-term recovery of chemically dependent women. Low self-esteem is a continuing issue for women in recovery. Other needs which must be addressed in the treatment of chemically dependent women include vocational and educational services, parenting skills, health care services, and issues of sexual abuse and incest (Underhill, 1986).

The preceding three sections have been an overview of the issues concerning chemical dependency which are relevant to this study. Presented were some of the numerous theories concerning addiction and descriptions of various issues confronting women in recovery. The following two sections will provide a description of qualitative methodology and interview studies.

Qualitative Methodology

"The phrase qualitative methodology refers in the broadest sense to research that produces descriptive data: people's own written or spoken words and observable behavior" (Taylor & Bogdan, 1984, p. 5). Qualitative methods provide the researcher an opportunity to view people holistically and in the context of the people's own frame of reference. The researcher, utilizing qualitative methodology, seeks to understand other people's perspectives on the issues in question and attempts to discern insights and understanding from the patterns in the information obtained from the research (Taylor & Bogdan, 1984). The current study used qualitative methodology to explore the nature of chemical dependence in women and to

describe, from a female perspective, women's experiences in addiction and recovery. It was not an attempt to reach conclusions about the nature of chemical dependency in all women, but presented the experience of five women who were willing to share their story and assist in describing the nature of chemical addiction in women.

Interview Studies

Qualitative research can employ various methods of data collection, the most prominent being participant observations and in-depth interviews. In this study, in-depth interviews were used as the means of gathering data. According to Merriam (1988), an interview is usually a "person-to-person encounter in which one persons elicits information from another" (p. 71). Interviewing is necessary and useful when a researcher seeks information which is not observable (e.g., feelings, opinions, past events). "The purpose of interviewing, then, is to allow us to enter into the other person's perspective" (Patton quoted in Merriam, 1988, p. 72).

In order for an interview to be effective, the interviewer must ask good questions and accurately record and evaluate the information obtained. Patton (1980) outlined six different types of questions which can be used to gather various types of information from participants. These six types include: experience/behavior questions designed to have the respondent describe observable events, actions or behaviors; opinion/value questions which elicit the respondent's values and thoughts about a particular subject; feeling questions to promote greater understanding of the respondent's feelings about an issue; knowledge questions to determine what the respondent thinks the facts are about an issue; sensory questions to determine the type of sensory stimuli to which the participant most readily responds; and background/demographic questions to identify the participant in relation to other people. Specific interview questions are based on these different types of questions in order to illicit different responses and obtain different types of information from the person being interviewed (Merriam, 1988).

Interviews can range from being extremely formal and structured to being completely unstructured in format and questioning. Highly structured

interviews have a preset list of questions to be answered by each informant. Examples of this type of interview include surveys or censuses. Completely unstructured interviews have no predetermined set of questions. In general, the most common interview is semi-structured where the interviewer has a predetermined guide outlining the issues to be explored. This allows for a certain amount of flexibility in the questioning procedure to accommodate individual participants. The participants are all asked the same questions so that the interviewer can discern patterns in responses between participants and evaluate comparisons.

Summary

This chapter has provided an overview of the current literature relevant to this study. Presented was a summary of issues concerning theories of chemical dependency as well as women's issues in addiction and recovery. Also presented was an overview of the principles of qualitative methodology and relevant interviewing procedures. The purpose was to establish a foundation for this study which was an exploration into the female perspective of chemical dependency.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this chapter is to restate the research questions and to outline the basic process used to gather the data for this study. Further, this chapter will include a description of the subjects, the interview process and the data analysis procedure. Reliability and validity concerning interview studies and the current study in particular will also be explored.

Research Questions

This study was designed to explore the nature of recovery from chemical dependency. More specifically, it was concerned with the experience of recovery from the perspective of women who have suffered addiction and who have reconstructed their lives and are experiencing continued success in recovery. The focus was on the holistic nature of women in recovery, their experience with addiction and treatment, and their

subsequent success in abstinence from drugs and alcohol and in rebuilding their physical, emotional, mental and spiritual health. Specifically, three questions were addressed: (1) What were the primary issues and concerns of women in recovery from chemical dependency? (2) What were the barriers which hinder successful recovery for women? and (3) What were the key factors which contribute to the successful recovery of chemically dependent women? In order to gather the data for this study it was both practical and useful to utilize in-depth interviews as the primary research method. In this way, women who know their experience could best share their thoughts and feelings and give the researcher (and all who read this report) a deeper understanding of the factors which create a foundation for and facilitate continued success in drug and alcohol rehabilitation.

Interview Studies

The utilization of in-depth interviews was both practical and useful as it provided a method of exploring the holistic nature of recovery from the perspective of the women's experience. It provided the opportunity for each woman in recovery to share her experience with the researcher and to

offer ideas that may not have otherwise been developed in the course of other research methods (e.g., surveys, questionnaires). Patton (1980) explained the philosophy behind interviewing as a research method: "We interview people to find out from them those things we cannot directly observe...We cannot observe feelings, thought, and intentions. We cannot observe behaviors that took place at some previous point in time...We cannot observe how people have organized the world and the meanings they attach to what goes on in the world-we have to ask people questions about those things" (Patton quoted in Merriam, 1988, p. 72).

The purpose of the current study was to describe the experience of women in recovery from chemical dependency. In order to do that, women were asked to talk abut their introduction to treatment, concerns they had during and after treatment and their feelings and opinions about their recovery at the time of the interview. The in-depth interview process was determined to be an effective means of gathering this information.

DRI Adult Program

The DRI Adult Center is a thirty-two bed residential treatment facility for chemically dependent men and women ages eighteen and older. DRI is a private, non-profit organization which has various sources of funding including state funds, donations through the United Way, and volunteer contributions. The only criteria for admission is that the chemically dependent individual not require medical detoxification, as DRI is a non-medical setting. Insurance is accepted but not required. Those clients who lack insurance or the financial resources to pay for treatment can still receive assistance. A discount rate can be negotiated and an affordable payment plan can be established with DRI at the time of admission. The residential phase of treatment lasts approximately twenty one to twenty eight days depending on the needs of the client. The aftercare program generally lasts six weeks. The residential rehabilitation program includes group and individual therapy, education regarding the disease concept of chemical dependency, recreation, and Alcoholics Anonymous and Narcotics Anonymous meetings. According to statistics taken from the official log books at DRI, the total number of adults admitted to the adult facility from

April 1993 to March 1995 was 1,219. Of that total, approximately 20% were women. Approximately 74% of those women completed the prescribed program. A complete monthly analysis of these statistics for the designated period is located in Appendix 2.

Subjects

There were five participants in this study all of whom had successfully completed the alcohol and drug treatment program at DRI in Knoxville and subsequently participated in the DRI after-care program. Each subject had a minimum of nine months' abstinence from alcohol and drugs and had participated in a twelve-step program in the Knoxville area such as Alcoholics Anonymous. Each participant was identified by the director of the DRI after-care program as being successfully recovering and willing to consider participation in this project. The director made the initial contact with each person to identify those women who would be willing to consider participation in the study. An attempt was made to contact twenty nine of the sixty five women who completed treatment during the time period between October 1993 and July 1994. The twenty

nine women were those whom the aftercare director had reason to believe were still recovering through aftercare and follow-up contacts. Of the twenty nine women, the director was able to contact only six. Four of the women expressed interest in the study, and the other two were no longer abstinent. The remaining twenty three people could not be contacted due to disconnected phones, no answer, wrong numbers, and lack of response to messages left for the clients. The director suggested names of two additional women who he knew to be successful in recovery. They were contacted and expressed interest in participating.

Data Gathering Process

The women who demonstrated interest in the project were mailed a Client Packet which included a cover letter, an Information Sheet, a Consent to be Contacted form, a Release of Confidentiality from DRI and a stamped, addressed, envelope (Appendix 3). Each woman was informed of her freedom of choice in returning the consent form and the release to DRI which would give the researcher permission to contact the client to discuss the details of the study, answer any pertinent questions and, if appropriate,

schedule a meeting. Client Packets were sent to six women; five responded positively. One of the women who responded to the mailing (one that the aftercare director had suggested) was not used in the study, however, because she had not gone through the DRI program. Another woman became aware of the study and contacted the researcher with an offer to participate. The five remaining women were contacted to schedule an interview.

Each client signed a Statement of Informed Consent (Appendix 3) before the interview began. The interviews were approximately one hour in length and were recorded on audio-tapes which were subsequently transcribed by the researcher with all identifying information removed or altered. The audio-tapes were then destroyed by erasure. Each participant received a copy of the Statement of Informed Consent she signed.

Each woman participated voluntarily and had the right to withdraw from the study at any time with no penalty. There was no compensation or incentive given to participate. Also, if a participant did decide to withdraw during the project, she had the right to keep the audio-tape and all copies of

the consent forms she had signed. Extensive measures were taken to ensure the confidentiality of each participant. Total anonymity could not be preserved, however, as it was necessary to personally interview each woman.

A Pilot Interview

A pilot interview was conducted prior to the five participant interviews. The pilot interview was audio-taped although the results of the interview were not included in this study. The pilot provided an opportunity to test the interview guide and evaluate its appropriateness. Also, the pilot interview provided an opportunity to rehearse the interview process and observe how the interviewee responded to the interview experience. The woman who participated in the pilot interview had at least nine months' sobriety and agreed to participate in the pilot interview. She had completed the DRI out-patient program and was involved in Alcoholics Anonymous in the Knoxville area. Although she had not been involved in the DRI in-patient or aftercare program, she had gone through a treatment program and had met all of the other criteria for participation in this study.

Since this study was not an evaluation of DRI but rather a study about women's experiences in recovery, this participant was considered appropriate for the pilot interview.

The Interview Process

Each participant was interviewed for approximately one hour. The interview was conducted by the writer and was audio-taped. An interview guide (Appendix 4) was used to ensure that each participant was asked the same questions in an effort to maintain consistency in data collection. The guide was developed around the three main research questions.

The ultimate purpose of each interview was to obtain information necessary for describing each woman's experience in addiction and recovery. Information obtained from the subjects would help to (1) define the general nature of chemical dependency in women, (2) identify barriers to treatment and to recovery, and (3) define the key areas of support which enable each woman to maintain successful recovery. The questions were designed to be open-ended in order to encourage each woman to talk about

the issues in her experience which she believed to be important and upon which she wanted to focus. Additional questions appropriate to each individual interview were used to supplement the core questions.

Data Analysis

The transcripts of each interview were used to analyze the data. Each transcript was evaluated to identify the emerging themes and patterns in the answers given by each participant in the interviews. The themes were then labeled and categorized. The guide was structured around the three main research questions and was divided into three corresponding sections. The emerging patterns from each of these sections were classified under one of three headings corresponding to the research questions. After each transcript was analyzed, the patterns from each interview were compared to identify items which were characteristic of all participants. Conclusions were drawn about the participants based on these characteristic themes, patterns, and similarities between interviews.

Reliability and Validity

The concepts of reliability and validity in qualitative research can be unique in many respects because of the methods employed and the phenomena studied. This section of the report will explore these concepts as they relate to qualitative research in general and to this study in particular. It will also describe how each of these concerns was addressed.

Validity

Validity is traditionally viewed as a statistical concept which addresses the question of whether the data collected in a study and the conclusions drawn from that data match reality. In other words, did the research measure what it was designed to measure? In the current study, interviews were used to gather data from five participants. Identical questions were asked of each participant so that data could be integrated for comparisons. Establishing validity required that (1) the interview guide address the issues it was designed to address, (2) the participants disclose accurate information, and (3) the analysis of data is appropriate and accurate. Measures were taken to address these three aspects of validity.

Before the five participants were interviewed, the researcher conducted a pilot interview to test the interview guide. The purpose was to evaluate the quality of the questions (e.g., were any of the questions vague or leading?), and to determine if the interview guide addressed the issues it was designed to address. The pilot interview also provided an opportunity for the researcher to observe how the interviewee responded to the interview setting (e.g., disclosing personal information and being audio-taped). Further, the pilot interview provided the researcher an opportunity to rehearse and become comfortable with the interview process. In this way, the validity of the data-collection process itself was tested and evaluated prior to engaging in the actual research.

One of the primary assumptions made in the study was that the information obtained from the participants was reliable and accurate. It is important to bear in mind, however, that although the information given may have been accurate, the participant might not have disclosed all information available. As Weiss (1994) points out, "... while we as interviewers can anticipate that we will be told the truth, we cannot assume that we will be told the whole truth nor the precise truth" (Weiss, 1994, pp.

148-149). Weiss maintains that people will withhold information they do not feel comfortable disclosing, they will experience lapses in memory which will affect the accuracy of the information they give, and they may be prone to provide responses which position them in a more favorable light. Weiss does believe, however, that in spite of these tendencies, respondents can still be considered reliable. Weiss states: "Despite all the ways in which interview material can be problematic, richly detailed accounts of vividly remembered events are likely to be trustworthy" (Weiss, 1994, p. 150).

The analysis and classification of data was done systematically as previously described in this chapter. In order to ensure that the conclusions drawn from this data were accurate and credible, the transcripts and the method of analysis were examined by the researcher's advising professor. In this way, the analysis and classification of data was evaluated to ensure that the conclusions drawn from the data were consistent with the data collected.

Reliability

Reliability basically answers the question of whether the study could be replicated and if the replication study and/or subsequent studies would produce the same results as the original study. Replication of a qualitative study can be problematic primarily because the human condition is not static and each individual's perspective on any given situation will be unique. Merriam addresses this issues and states: "Reliability in a research design is based on the assumption that there is a single reality which if studied repeatedly will give the same results...Since there are many interpretations of what is happening [in the world], there is no benchmark by which one can take repeated measures and establish reliability in the traditional sense" (Merriam, 1988, p. 170). There are several ways in which a researcher can add to the reliability of a qualitative study. Reliability in the current study was achieved by providing a detailed description of the methodology of the study including processes of subject selection, data collection and data analysis (LeCompte & Preissle, 1993; Merriam, 1988; Yin, 1994).

Summary

This chapter has provided a detailed description of each step taken throughout the research process. It has included a description of the procedures for selecting subjects and for collecting, interpreting, and classifying data from which conclusions were derived. Attention was also given to reliability and validity issues as they related to the current study.

CHAPTER IV

RESULTS

Introduction

This chapter provides a summary of the data collected through the interview process and includes some of the comments and opinions of the women interviewed in the study. It also details the similarities and differences between the five participants in their responses concerning the three main research questions.

Results

The participants in the study were all Caucasian females ranging in age from the late twenties to late forties. The length of abstinence for the participants ranged from just under one year to approximately five years. Although three of the five women had each participated in other treatment programs prior to DRI, they had each successfully completed the DRI inpatient and aftercare programs. The following is a summary of the results

of the interviews classified under three main headings. These headings correspond to the three original research questions.

What were the primary issues and concerns of women in recovery from chemical dependency?

There were six issues which most of the women in the study cited as being concerns that they needed to confront in recovery. There were also numerous issues which were unique to each woman and which made each woman's experience different from that of the others. This section will discuss those issues which were cited by at least three or more of the women interviewed. Other issues which were unique to one or two women are located in Appendix 5.

When talking about the issues and concerns they had in recovery, four of the five women described fear of not being able to stay abstinent. Responding to the question regarding concerns after leaving treatment, one woman stated: "The only concern that I had was of using. My only concern was I knew how bad that I had gotten and I was miserable and I did not want to do that again and I was scared." The other three women who

emphasized this feeling as a concern described similar fears of "letting [themselves] down" and "not following through".

Four of the five women also talked about learning to take responsibility and care for themselves. These four women described how in the past they had been cared for by other people including family members and significant others. As one woman stated: "...having to take care of myself was very scary cause the whole time I was using I always had somebody to take care of me...I always found somebody to take care of me and, of course, I didn't want that anymore...". One woman described her experience in getting a job. She had had little or no previous work experience and did not have the skills needed in locating or maintaining employment. She explained: "I didn't even know how to get up in the morning. I didn't know how to pack my lunch, you know, I'd get there and I'd be hungry and it was like, what are we gonna eat, and she's like, you didn't bring lunch?" Another woman described the feeling of learning to care for herself without being in a relationship with a man: "And there's that fear of not being able to take care of myself and now I'm, I'm really a little prideful because I'm able to take care of myself better now than I was

ever able to take care of myself when a man was involved, financially and emotionally."

Four of the five women also described abuse issues (e.g., sexual, physical, verbal) as important concerns that they needed to confront in the recovery process. They each had experienced abuse at some point in their lives and had residual problems as a result of that abuse. These residual problems included lack of trust, anger and grief.

Other issues which were common to some of the women included depression and ignorance of the disease concept of addiction. Three of the five women suffered from depression and had sought other help in addition to treatment (e.g., therapy, medication). In addition, three of the five women stressed the importance of learning about the disease concept of chemical dependency while in treatment. One woman explained: "I learned what...alcoholism was and why I was doing what I was doing, you know, and that was an important thing because I had no idea, you know, about the disease concept or anything so that, that was an, a real important issue..."

Although each woman's experience was unique in many ways, there were several areas of concern which were common to them. Fear of not being able to stay sober, taking responsibility for self, and abuse issues, including sexual, verbal and physical abuse, were all issues which four of the five women cited as concerns they needed to confront in their recovery.

What were the barriers which hinder successful recovery for women?

The responses of the women to questions regarding factors which may have hindered their recovery were more diverse than their responses to other questions. There was only one item upon which most of the women agreed. Three of the five women stated that the reason they had not gotten into recovery sooner was the fact that they had enablers in their lives who helped them in some way while they were still active in their addiction. An enabler is someone who supports a chemically dependent person (who is not in recovery) in some way so as to ease the consequences of that person's addiction. Often the result is that the chemically dependent person is not encouraged to enter recovery. One woman stated: "I think that's one thing that kept me using a lot because as long as I made messes [my parents] came and cleaned them up so I could go on and make the next one."

The only other factors that any of the women (two of the four) agreed had been barriers to recovery included ignorance of the disease, denial, focusing on the men in the treatment center and not having counselors in past treatment programs who confronted them with the truth about their addiction. One of the women had been through numerous other treatment centers before going to DRI and she stated: "...it was like somewhere along the line I wish somebody had sat me down and said look, if you don't stop using, you're gonna die."

Primarily, the five women in the study described different factors which they felt had been a hindrance to their recovery and these factors varied by individual. One woman stated that although she knew she had a problem with addiction, she simply had no desire to stop. Another woman described her difficulties with reading, writing, and communication skills which she thought prevented her from becoming more involved with the treatment program. One of the women had two small children and she spoke a great deal about the problems she had in simultaneously pursuing recovery and caring for her family. She described her feelings of being in a treatment facility and knowing that her children wanted her to be at home.

She spoke of feeling powerless over situations at home of which she had previously been in control. She described how on two different occasions her children were sick while she was in treatment and how she was often tempted to leave treatment in order to care for them. This same woman went to a half-way house for three months after completing the inpatient program at DRI and she talked about how hard it was to explain the situation to her children: "...I kept explaining to them that I was sick and mommy needs help...but when they'd come to visit or I'd bring them over it wouldn't look like a hospital, it was just a house and they couldn't understand..." This woman stated that the treatment center should have provided more assistance in helping the families of clients become more involved and more knowledgeable about the disease of addiction. She stated: "...I don't have the skills to teach [my eight year old] about, you know, the whole scope of [addiction] and why it happened and how I can stay clean..."

The interview questions concerning barriers to recovery prompted a more diverse set of responses from the women than did the other questions. In general, each woman had her own unique ideas about why she had not

gotten into treatment sooner, reasons for why she had been tempted to leave treatment early, and factors which prevented her from getting more involved in treatment. A complete list of the individual responses concerning barriers to recovery is located in Appendix 5.

What were the definitive key factors which contribute to the recovery of chemically dependent women?

Most of the women had similar ideas about how they remained abstinent and what factors contributed to their success in recovery. All of the women interviewed cited AA or NA meetings as being a key factor in their recovery. Four of the five women talked about the importance of support from family and friends. Three of the five women described meditation and/or prayer as key factors in their success. One woman described her experience: "God is an ever..he's ever present with me and...that's the...basic foundation of my program is my, my communication with God." Three of the five women also talked about desire and motivation to be abstinent and three of the five women were also involved in individual therapy. Finally, three of the five women described the importance of building relationships with other recovering people. As one

woman stated: "I do hang with recovering people a lot and...I have a lot of recovering alcoholics around me because...we can talk, we have a lot in common." Some other factors that individual women cited included sponsorship (having one particular person who acts as a mentor in recovery), helping other alcoholics, church, learning to love and accept self, and thinking of alcohol as the "enemy".

The questions concerning key factors in recovery prompted the least diverse set of responses. Although each woman stated one or two unique items relating to her success, most of the women responded with similar ideas about maintaining sobriety and experiencing continued success in recovery.

Other Information

There was one topic of significance which emerged in the interview process, although not as a direct result of the interview questions. This topic is related to the current research, however, and is significant to mention in this chapter. Three of the five women brought up the topic of

"women's issues" during the interview and expressed the idea that women have issues that are unique and that should be addressed in the recovery process. Some of these issues included: sexual abuse, single parenting, domestic abuse, depression, vocational concerns (e.g., locating and maintaining employment), dependency, stigma, shame, sexual identity, and playing the victim or martyr. The three women who discussed women's issues expressed the belief that these issues are more common for women and that they are important concerns for women in recovery. One woman expressed her feelings concerning the subject of women becoming independent in recovery: "Most of my friends in recovery are single mothers and...the program teaches you to be a responsible, productive member of society but how can you come out of treatment and not know how to work, not ever having to work, having no job skills, job training or anything whatsoever and be able to go to work, pay rent and light bill and daycare as outrageous as it is...to go from being on welfare and foodstamps to being a responsible, productive member of society, it's just unrealistic."

One woman had participated in an outpatient program which consisted of group therapy twice per week. She discontinued her

participation when the group changed from an all women's group to a coed group. The three women who talked about women's issues all thought that women benefited from being in all women therapy groups as opposed to mixed groups of women and men.

Another woman talked about the stigma that she thought alcoholic women face in society. She had experienced a great deal of shame in her addiction and thought that, for most women, it is harder for them to admit they have a problem. She felt this was mainly due to a stigma associated with women's alcoholism and stated: "...society accepts a man's alcoholism more than they do a woman because a woman is so put down by men because there is no man wants a drunk woman. No man. He don't wanna fool with it. He'd rather you take care of him. But they don't...they just can't take a drunk woman."

Although the study was not an attempt to draw conclusions about how recovery may differ between men and women, the fact that three women brought up the idea of women's issues in recovery is important to note in this chapter. It is significant in that it further describes the

experience of the women who participated in the study and could have implications for further research.

Summary

This chapter has provided a summary of the data gathered through the interview process. It has described the responses which were similar among the five women in the study with regards to the three main research questions. Some of the unique individual responses to questions were mentioned in this chapter, however, if there were numerous individual comments, they were placed in Appendix 5. The section concerning women's issues was included as it was a significant piece of information which emerged through the interview process.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter provides a brief summary of the current study and outlines the specific findings from the data gathered through the interview process. This chapter also includes a discussion of the conclusions drawn from the findings. Recommendations for future studies are also discussed.

Summary of Study

The study was designed to explore the nature of recovery for chemically dependent women in terms of three main research questions. Those questions were: (1) What were the primary issues and concerns for women in recovery from chemical dependency?, (2) What were the barriers which hinder successful recovery of chemically dependent women? and, (3) What were the definitive key factors which contribute to the recovery of chemically dependent women? In order to address the questions, five

women were interviewed and asked a series of identical questions from an interview guide developed by the researcher. The interviews were audio-taped and were approximately one hour in length. The tapes were transcribed by the researcher with identifying information removed or altered. The tapes were then erased. The transcripts were used to analyze the data gathered during the interview process. Responses to the questions were categorized and then compared for each of the five women to identify items characteristic of all or most of the women. The results were then summarized in chapter four of this report.

Findings

A summary of the data collected through the interview process revealed certain findings concerning the five women interviewed and their experiences in recovery.

These findings are as follows:

* Four of the five women interviewed in the study had experienced some form of abuse (e.g., physical, verbal, sexual) during their lives prior to their current success in recovery.
* Four of the five women had not had significant past experience in being responsible for or in taking care of themselves.
* Upon leaving the treatment setting, four of the five women had fear that they would not be able to remain abstinent.
* It was important to three of the five women interviewed to learn about the disease concept of addiction and to develop a greater understanding of the aspects of chemical dependency.
* Three of the five women suffered from depression and had sought additional therapy.
* Factors which hindered recovery varied widely among the women interviewed in the study.
* The presence of enablers was cited by three of the five women interviewed as a barrier to entering treatment.
* Attendance of AA and/or NA meetings was significant in the maintenance of recovery for all five women interviewed.

* Four of the five women emphasized the importance of support from family and friends in recovery success.
* Meditation and prayer was important for three of the five women interviewed.
* Three of the five women believed that desire and motivation to maintain recovery was critical to their success.
* Building relationships with other recovering people was cited by three of the five women as an important aspect of their recovery.
* Three of the five women believed that women in recovery have unique issues that are different from those of men and that those issues need to be adequately addressed in the recovery process.

Conclusions

The opportunity to draw conclusions from the results of the study are limited due to the small sample size. It is possible, however, to make inferences about the nature of recovery in women based upon the findings.

First, it is important that all of the women interviewed cited attendance at AA and/or NA meetings as a significant component of their

recovery. In light of this, it is probable that the incorporation of a twelve-step program into the recovery process for chemically dependent women provides an essential element to continued recovery success. Three of the five women emphasized the importance of surrounding themselves with other recovering people and building relationships with other women in the twelve-step programs. Other recovering people provide support and an essential opportunity for communication of feelings and problems. Sponsorship, a concept alluded to by one of the women, is a more formal process of establishing a mutually beneficial relationship with another recovering person. The woman who discussed the benefits of sponsorship not only had a sponsor who guided and supported her but also sponsored other women with whom she communicated on a daily basis. For her, sponsorship was an integral component of recovery and further illustrates the significance of other recovering people in the lives of recovering chemically dependent women.

Four of the five women talked about the significance of support they received from their family in their continuing recovery. The woman who did not mention family support spoke a great deal about the importance of

involving the family in the recovery process. It may be inferred that rehabilitation programs which make efforts to communicate with and educate the family may be more beneficial to recovering women than programs that do not emphasize the significance of the family system. In addition, three of the five women spoke of enablers as barriers to entering treatment and that the enablers were always family members. This finding emphasizes the significance of education and involvement of the family in the recovery process.

Four of the five women in the study had experienced some form of abuse in their lives, and three of those women also cited issues of depression, anger, and/or grief as concerns they needed to confront in the rehabilitation process. These three women also had sought additional assistance in the form of individual therapy. Obviously no statistical conclusions can be drawn concerning the entire population of chemically dependent women. It is important to note, however, that all but one of the women interviewed had experienced abuse issues. Further, it is appropriate to infer that a high percentage of chemically dependent women probably suffer from similar abuse issues. A rehabilitation professional working with

chemically dependent women should be aware of the possible existence of abuse issues and related residual problems in the women with whom they work.

Four of the five women discussed various fears and concerns they had in regard to taking responsibility for and care for self. One woman spoke of her experience in entering the workforce. Another talked about her fears of being a single parent. Each of these women had little or no experience in being responsible for or caring for themselves in the past. They discussed the process of having to learn new coping skills and of developing confidence in themselves. One woman made the statement that she thought there were not enough services available for women or that if the services were available, women often were not aware that the services existed. In light of this, it is probable that another benefit for women in the recovery process would be the provision of additional vocational services, assertiveness training, and referral to appropriate community resources.

Finally, there was an extremely diverse set of comments from the five women in the study in regard to barriers to treatment and recovery. It is difficult to draw any conclusions or make any inferences concerning

barriers because of the small sample size. It is possible that factors which hinder recovery are extremely individualized and that no patterns exist with chemically dependent women. It is also possible that the limited number of subjects utilized in the current study was not adequate to produce any discernible patterns of barriers to recovery. Perhaps the diverse set of responses reflects the diversity among the five women interviewed and that any discernible patterns would only emerge in a more homogenous group. For example, a sample group of women with dependent children may reveal patterns in barriers to treatment which do not emerge in a group of women with older children or no children at all.

Recommendations

The current study prompted four specific recommendations for further research.

These recommendations are as follows:

1. The current study demonstrated that three of the five women interviewed thought women had unique issues which were different than those of

men and which needed to be adequately addressed in the recovery process. In light of this finding, it would be useful to replicate this study with male participants. In this way, responses to interview questions could be compared between men and women to determine if significant differences existed between their perceived issues and concerns, barriers to recovery, and key factors in continued recovery success.

2. One woman in the current study talked repeatedly about her children and about the problems she faced in pursuing her own recovery while concurrently caring for her family. She believed that many women with small children experienced similar problems and expressed the opinion that treatment facilities should provide more services for women like herself. She was the only one, however, of the five women interviewed, who expressed these concerns. She also was the only woman interviewed who had small children. It would be useful to conduct a study which focused on the needs of recovering chemically dependent women with dependent children. A study with this population could focus on the barriers to recovery that this particular group faces and could also evaluate their specific service needs.

3. With increasing interest in vocational rehabilitation services for chemically dependent persons, research needs to be conducted in this area to broaden the existing base of knowledge on this topic. One of the women interviewed in the current study felt strongly that women often have greater vocational rehabilitation needs than men. She thought that women completing treatment more often lack appropriate work skills, training, and experience. Research concerning vocational services, therefore, should incorporate a comparison of the needs of men and women in order to identify any differences that may exist.
4. Finally, conclusions drawn from the current study are limited due to the small sample size. Similar studies incorporating greater numbers of women would significantly add to the existing base of knowledge concerning the female experience in recovery.

Summary

Chemical dependency is a broad and complex subject which requires an understanding of the holistic nature of addiction and recovery. It is important to remember that each chemically dependent person is an individual with unique experiences and issues which must be addressed in

the recovery process. The current study was not an attempt to identify similarities in chemically dependent women in order to mold them into a "one size fits all" treatment modality. Rather, it was an attempt to identify ways in which chemically dependent women as a group may possess similar traits and concerns which need to be addressed in a treatment setting. The significance of this effort is that studies concerning addiction and its treatment have traditionally been conducted using male subjects and treatment programs. These studies and their outcomes may have produced a male-as-norm bias. The current study, however, has initiated the development of a base of knowledge concerning the female perspective of chemical dependency. Although this study is but a beginning, it provides direction for much-needed related research.

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APPENDICES

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

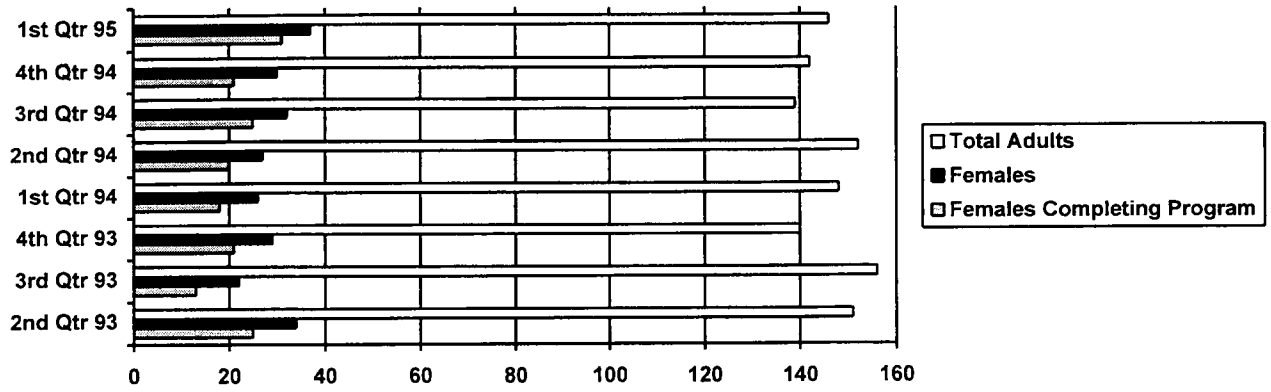
10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Appendix 1: The Twelve Steps of Alcoholics Anonymous
Source: Alcoholics Anonymous World Services, Inc. (1976). Alcoholics Anonymous. New York, NY: Author.

Month	Total Adults	Females	Females Completing Program
April 1993	48	13	9
May 1993	45	9	8
June 1993	58	12	8
July 1993	50	10	6
August 1993	60	5	3
Sept 1993	46	7	4
Oct 1993	50	11	8
Nov 1993	40	8	8
Dec 1993	50	10	5
Jan 1994	52	9	6
Feb 1994	45	5	2
March 1994	51	12	10
April 1994	51	13	9
May 1994	46	7	7
June 1994	55	7	4
July 1994	44	9	6
August 1994	54	13	12
Sept 1994	41	10	7
Oct 1994	43	6	3
Nov 1994	51	12	8
Dec 1994	48	12	10
Jan 1995	51	11	9
Feb 1995	46	12	10
March 1995	49	14	12
April 1995	45	9	7
Total	1219	246	181
% of Total	100%	20.2%	14.8%



Appendix 2: DRI population statistics
Source: DRI Adult Center

INFORMATION SHEET

This research project is interested in hearing from women like yourself who have begun a successful journey down the road of recovery from chemical dependency. There have already been many studies conducted about addiction and recovery, however, I am interested in hearing your story and learning more about what your individual experience has been.

If you choose to participate, you will be involved in at least one personal interview with me, the researcher. This interview will last about 1 hour and will be audio-taped, with your consent. The tapes will be stored in a locked filing cabinet in 104 Claxton Addition at the University of Tennessee. Only the advising faculty member and I will have access to the tapes. Each tape will be immediately destroyed after it has been transcribed with all identifying information either changed or removed to protect your identity. This is to ensure your confidentiality as much as possible.

There are no risks to you beyond those experienced in the course of every day life. The possible benefits, however, are tremendous due to the chance for greater understanding of women's needs and experiences in recovery. Your participation in this study is completely voluntary. You may withdraw from this project at anytime.

There is a great need for further research into the nature of recovery, particularly from a female point of view. I believe that this study will help to gain a better understanding of the unique issues that women face on the road to successful recovery.

You may direct any questions you may have about the nature of this study or your rights as a participant to me, Laura L. Clingan at 104 Claxton Addition, The University of Tennessee, Knoxville, TN 37996-3400, or call 974-2321.

Appendix 3-A: Information Sheet

CONSENT TO BE CONTACTED

I understand that you are conducting research about recovery from chemical dependency and I am interested in learning more about it. I am willing to be contacted by you to discuss the details of your research and to possibly coordinate a time for us to meet. I understand that confidentiality will be protected throughout the research process.

Name _____

Address _____

_____

_____

Phone _____(Home)

_____(Work)

Comments _____

_____

_____

_____

Signature _____

Appendix 3-B: Consent to be Contacted

STATEMENT OF INFORMED CONSENT

This research project is interested in hearing from women like yourself who have begun a successful journey down the road of recovery from chemical dependency. There have already been many studies conducted about addiction and recovery, however, I am interested in hearing your story and learning more about what your individual experience has been.

If you choose to participate, you will be involved in at least one personal interview with me, the researcher. This interview will last about 1 hour and will be audio-taped, with your consent. The audio-tapes will be stored in a locked filing cabinet in 104 Claxton Addition at the University of Tennessee. Only the advising faculty member and I will have access to the tapes. Each tape will be immediately destroyed after it has been transcribed with all identifying information either changed or removed to protect your identity. This is to ensure your confidentiality as much as possible.

There are no anticipated risks to you beyond those experienced in the course of every day life. No direct benefits to you as a participant are anticipated, but the possible benefits to the recovering community and to society in general are great due to a better understanding of chemical dependency and recovery in women. Your participation in this study is completely voluntary. You may withdraw from this project at anytime. There will be no compensation or incentives for participation and no penalty for withdrawal from the study.

You may direct any questions you may have about the nature of this study or your rights as a participant to me, Laura L. Clingan at 104 Claxton Addition, The University of Tennessee, Knoxville, TN 37996-3400, or call 974-2321.

I _____, have read and understand the above description of the research to be conducted by Laura L. Clingan for her master's thesis. I agree to participate in this study with the understanding that I can withdraw from the study at anytime without penalty. I agree to participate in the interview process and for the interview to be audio-taped.

_____

Signature of Participant

Appendix 3-C: Statement of Informed Consent

INTERVIEW GUIDE

I. Introduction

I would like to discuss with you again the purpose of this interview and make sure you do not have any questions or concerns before we begin. I am a student working on my masters at the University of Tennessee and I am doing these interviews as a part of my research for my thesis. This is not an evaluation of the DRI program nor am I affiliated with DRI in any way other than acquiring their help in making contact with women who are willing to participate in this study.

I expect this interview will last approximately one hour and it will be audio-taped. I will go over a consent form which I need you to sign. You will get a copy of this consent form to take with you. You have the right to discontinue the interview and your participation in this study at anytime and take the copy of the tape with you.

Do you have any questions?

[Go over the Statement of Informed Consent]

[Begin Taping]

II. Build Rapport

III. What are the issues and concerns for women in recovery?

A. Tell me how you got involved in the DRI treatment program.

B. What were your expectations of the treatment program?

C. What important issues did the program address and how were they important to you?

D. Were there issues you felt were important that were not addressed in the program?

E. How could the program have helped you more?

F. What concerns did you have when you left treatment?

G. Do you have issues today which you feel still threaten your recovery? (e.g. relationships, depression, anxiety, legal issues)

IV. What are the barriers which hinder recovery for women?

A. Tell me about factors which kept you from getting involved in treatment sooner than you did.

B. What are some issues that tempted you to leave the treatment program early?

C. What sort of problems did you have while in the treatment program itself which prevented you from getting more involved in the program?

V. What are the key factors which contribute to the recovery of chemically dependent women?

A. Tell me about your recovery program today.

B. What are the three main factors which help you maintain your recovery?

C. What is it about you that has helped you to be successful in recovery?

Appendix 4: Interview Guide (cont.)

What were the primary issues and concerns of women in recovery?

The following is a list of issues cited by one or two of the women interviewed.

Issue Cited	# of Women Citing Issue
Low self-esteem	2
Guilt	2
Juggling responsibility for self and family	2
Problems with children	2
Trust	2
Getting a job	2
Anger	2
Grief	2
Relationship with parent(s)	2
Separating from destructive family members	2
No transportation	2
Custody of children	1
Making new friends	1
Single parent	1
Daycare for children	1
Child's depression	1
Coping skills	1
Dealing with parts of personality	1
Playing the victim/martyr	1
Cirrhosis	1
Physical impairments	1
Shame	1
Suicidal	1
Acceptance of self	1
Setting boundaries	1
Co-dependency	1
Poor choices in relationships	1

Appendix 5-A: Issues and Concerns

What are the barriers which hinder successful recovery for women?

The following is a list of responses given by individual women.

Barrier Cited

Fear accepting responsibility for self
Stuck in addiction cycle
Fear of losing custody of children while in treatment
Lack of money or insurance
Lack of available beds in treatment
No one to take care of children
Children needing/wanting her at home
Feeling out of control of situations at home
Women's outpatient group changing to coed group
Thinking she could control use
No desire to stop
Shame
Fear of treatment/being arrested
Did not suffer any consequences of addiction
Anger
Difficulties reading and writing
Scapegoat in treatment community due to homosexuality

Appendix 5-B: Barriers to Recovery

VITA

Laura L. Clingan was born in Sayville, New York on June 8, 1969. She attended the public school system in Sayville and graduated from Sayville High School in June, 1987. Laura moved to Knoxville, TN to attend the University of Tennessee in August, 1987. In May, 1992, she received her Bachelors of Science in Business Administration with a concentration in Finance and began work immediately with The Travelers Insurance Companies in Knoxville. In August, 1993, she entered the Masters Program in Rehabilitation Counseling at the University of Tennessee and began attending classes while maintaining her employment with The Travelers. As part of her graduate work, she completed an internship with both the Tennessee State Division of Rehabilitation and with a private rehabilitation company called Associated Therapeutics. The focus of her work at Associated Therapeutics was vocational evaluations while at the state office she worked with a counselor handling a specialized caseload of persons with chemical dependency. Her Master of Science in Rehabilitation Counseling was received in August, 1995.