4-25-2000

Substance Dependent Women and Family Support

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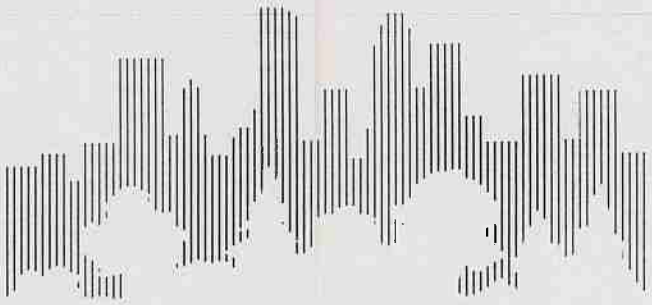

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MASTERS IN SOCIAL WORK THESIS

Christina Marie Decker

Substance Dependent Women and Family Support

2000

SUBSTANCE DEPENDENT WOMEN AND FAMILY SUPPORT: A HERMENEUTIC EXPERIENCE

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Submitted in partial fulfillment of
the requirements for the degree of
Master of Social Work

AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

2000

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

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Date of Oral Presentation: April 25, 2000

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Dedication

In loving memory of my mom, Sophie Decker (1923-1998), who still supports me.

Acknowledgments

I would like to express my gratitude to the participants in this study and to my clients. Their courage in facing their chemical dependency and moving forward is inspiring. My parents have provided me with much needed support, my love to you both and to my children, Jessica and Joseph, who also sacrificed so I could earn my degree. Thank you, Nancy, for your spiritual mentorship and for talking me through the rough spots in my journey. You keep me on course. The way you live your life is a powerful lesson in acceptance and faith, a lesson that I continually need. My colleagues have been patient and helpful, especially when I needed a day off or a fresh perspective. Thanks, especially, to Marilyn who took over for me so many times when I needed to finish a paper. You have been a terrific cheerleader when I needed one most. Your kindness is incredible. I am grateful and privileged to have all of you in my life.

Finally, Maria, I cannot put into words how inspirational it is to know you. You believed in me when I did not believe in myself and that means more to me than you will ever know. I will do everything I can to live up to your challenges and to put into practice all that you have taught me. You have made a lasting impact on my life, both professionally and personally. You have made all the difference.

ABSTRACT

SUBSTANCE DEPENDENT WOMEN AND
FAMILY SUPPORT:
A HERMENEUTIC EXPERIENCE

CHRISTINA MARIE DECKER

APRIL 25, 2000

This hermeneutic study was undertaken to discover the lived experience of two substance dependent women with family support. This study attempted to capture the experience of two women and show how this experience affected their recoveries. The use of the hermeneutic research method allowed the researcher to engage in a process with the participants, both shaping and being shaped by the experience. The women's experiences were interpreted around the theme of connection. This involved a fluid process by which the women disconnected from original family, connected with other supports and then reconnected with original family in their new role as recovering women. Implications for social work practice and policy are discussed.

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CHAPTER ONE

INTRODUCTION

This chapter contains the background and statement of the problem, discusses the purpose and significance of the research study, states the research question and describes the researcher's interest in the problem.

Background of the problem

According to the Substance Abuse and Mental Health Services Administration's 1998 report, an estimated 9.7 million people in America are dependent on alcohol and 4.1 million are dependent on illicit drugs. Each of these people have significant others who are also affected by the substance dependence. Chemical misuse is involved as a major or complicating component in a range of social issues, among these: Abuse and violence in families, homelessness, mental illnesses, unemployment, divorce, a variety of property and personal crimes, including driving under the influence, and suicides (Garrett et al., 1999). Untreated substance dependence costs the United States $165 billion annually. Treatment offsets this cost by a ratio of $7 saved for every $1 spent (Garrett et al., 1999).

Treatment programs have been developed and self-help groups begun to help substance dependent people and their families deal with substance dependence and get into recovery. These programs are underutilized for a variety of reasons. One of these reasons is that a primary psychological defense of the substance dependent person is denial (Galanter, 1999; Johnson, 1986). Denial keeps substance dependent people from identifying the chemical as the source of problems in their lives. The worse the substance dependence becomes, the stronger the substance dependent person's denial (Johnson, 1986) until s/he "hits

bottom" (Gorski, 1986), or is facing devastation in relationships and life circumstances.

Another reason treatment is neglected is misdiagnosis by professionals in which symptoms, such as depression and anxiety, are addressed without identifying the underlying cause, the substance dependence. Substance dependent women are routinely misdiagnosed (Hughes, 1990; Rhodes & Johnson, 1994) with physical and psychological problems.

Labels of alcoholic, addict, or chemically dependent carry stigma in this culture. Substance dependent people, fearing retribution from employers, family and friends, and authority figures avoid entering programs or attending groups which identify them as substance dependent. Families are often more comfortable with a mental illness diagnosis rather than one of substance dependence (Kane-Cavaiola & Rullo-Cooney, 1991) and so will resist treatment for one of their members. Women are especially vulnerable to this stigmatization. Their roles as primary caregiver, childbearer, and moral guardian cause their substance dependence to be seen as more deviant than men's even in their own families (Fillmore, 1984).

Practical considerations also complicate help seeking. These include, and especially affect women, lack of child care, lack of adequate insurance covering substance dependence treatment, and lack of family support (Finkelstein, 1990). The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that in 1997, 34% of insured women who needed treatment received treatment compared to 50% of insured men.

Statement of the problem

Research in the area of substance dependence has traditionally used male subjects and treatment facilities have developed their programs based on these male oriented models. Women's experience with chemical misuse, effects of substance dependence, and treatment and family support are qualitatively different than men's (Davis & DiNitto, 1996; Kane-Cavaiola & Rullo-Cooney, 1991; Underhill & Finnegan,1996) yet research on substance dependent women was a "nonfield" up until 1980 with only 28 studies of female alcoholics being published from 1929-1970 (Rhodes & Johnson, 1994). Interventions successful with men were often not as successful with women and women were blamed for their inability to obtain sobriety.

Family support increases the likelihood that substance dependent persons will enter and remain in treatment and have longer periods of sobriety (Edwards & Steinglass, 1995; Garrett et al., 1999). Booth et al. (1992) report recovering alcoholics having had higher levels of support from family and greater numbers of support people to turn to for assistance than relapsed alcoholics. For many women, however, family support is inadequate or nonexistent (Brooks & Rice, 1997; Rice & Longabough, 1996). In this study, I examine the lived experience of two substance dependent women with family support prior to entering treatment, during their treatment programs, and after they completed their treatment programs. Theories and treatment models are used to try to understand their experiences, their perceptions of their experiences and the impact these experiences have had on them and on their recovery programs.

Purpose and Significance of the Research Study

The purpose of this study is to use the hermeneutic method of research to capture the experiences of two substance dependent women with family support. Hermeneutics allows involvement between the researcher and the participants that adds to the depth of information obtained so that a detailed picture of the experience can evolve. This study attempts to show the meaning family support, or lack of family support, had for these women. The significance of this study is that I and other social work practitioners, particularly those dealing with substance dependent women and their families, will be able to better understand the impact of this life event. Chemical dependency may be involved in almost all areas of social work practice, so knowledge of this issue is critical to practitioners (Nelson-Zlupko, Kauffman & Dore, 1995).

The Research Question

The research question is, "How does the experience of family support impact substance dependent women?"

The Researcher's Background

As was previously mentioned, the hermeneutic methodology used in this study involves the researcher as well as the participants. The history and background I as a researcher bring to the study will affect how I interpret the participants' experiences. As part of this study, then, it is important to let readers of this study know who I am and what I bring to this experience in order to make known my experiences, and possible preconceptions (Plager, 1994).

I am a White, middle-class, divorced, thirty-nine year old female who is completing her Master's of Social Work degree program. The foundation for my interest in the topic of substance dependence and family support comes from the fact that, although I am not substance dependent, there is substance dependence

in my family. I have felt the pain and frustration of watching family members struggle with the effects and consequences of substance dependence. I am also a substance dependence counselor. I presently do group and individual counseling with substance dependent women and their families. I am witness to the shame and pain the women describe as they make efforts to change their behaviors and lives. Therefore, I am acquainted with the experience of substance dependence both from a personal standpoint as well as a professional one. One of the chief frustrations for many of the women I work with, as well as for me, is the difficulty in getting family members involved in the treatment process. As I intend to continue working in this field after graduation, it is my hope that I will be able to better understand the impact of family support on substance dependent women.

Summary

This chapter reviewed the background and statement of the problem of substance dependent women and family support, the purpose and significance of the research study, stated the research question and the researcher's background in relation to the research study. The next chapter is a review of the literature related to women and substance dependence and family support. Chapter 3 presents the theoretical framework used in this study. The methodology is presented in Chapter 4. Chapter 5 discusses the study's findings. Strengths and limitations of the study as well as implications for social work practice and policy are discussed in Chapter 6, as are areas for future research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this literature review, definitions of terms used in the substance dependence literature are described. A brief historical perspective is presented on how substance dependence and substance dependent people have been viewed and treated in the past. In addition, there is an examination of gender and how it is impacted by substance dependence, treatment and family support.

Definition of Terms

The following is a brief description of terms used in this study from the substance dependence literature.

Chemical dependency- Chemical dependency, substance dependency and addiction are used in the literature interchangeably. One of the most prevalent views of substance dependence is that of a biopsychosocial disease (Gorski & Miller, 1986). The Diagnostic Statistical Manual of the American Psychological Association, 4th edition (DSM IV) considers substance, or chemical, dependence to be a chronic, progressive disease and defines substance dependence as, "A maladaptive pattern of substance use, leading to clinically significant impairment or distress" (p.108). It is marked by a combination of at least three of the following: Tolerance, withdrawal, the substance being taken in larger amounts or for a longer period than intended, inability to cut down or control use, preoccupation, replacing of social, occupational, or recreational activities with

substance use, and continued use of the substance despite physical and psychological problems.

Although the view of substance dependence as a brain disease is still controversial, it enjoys considerable support in clinical settings and in research (Crabbe & Goldman, 1992; Di Chiara, Acquas & Tanda, 1996; Grove et al., 1990; Kendler et al., 1994). Leshner (1998) states that all drugs of abuse affect the mesolimbic reward system pathway deep in the brain. People perform behaviors that are rewarding and are positively reinforced by pleasant feelings, encouraging repetition of those behaviors. The reward pathway is activated in humans by such activities as eating, nurturing, exercising ("runners' high"), and engaging in sexual activity, behaviors required for species survival (NIDA, 1998). For substance dependent people, this pathway is activated additionally by the use of mood altering chemicals. Drug use that began as voluntary becomes compulsive, even when negative consequences are experienced, reflecting changes in brain function (Leshner, 1998; NIDA, 1998). Acute use of drugs modifies brain function while prolonged use causes pervasive changes in brain function persisting long after drug use has stopped. Leshner (1998) adds: "the addicted brain is distinctly different from the nonchemically dependent brain" (p. 1).

Leshner (1998) concedes, however, that substance dependence is not just a brain disease but that "the social contexts in which it both has developed and is expressed are critically important." (p. 2). Conditioned cues, or triggers, are major factors in persistent and recurrent drug cravings and relapses (Gorski & Miller, 1986; Leshner, 1998). These social contexts include psychological factors and environmental factors, such as the family and peer culture and society in general. Charlotte Kasl (1992) states that substance dependent people try to fill inner emptiness with substances, rechanneling longing for human connection to

the chemical. Substance dependence involves a split in personality leading to a life and death struggle between the substance dependent part of the person and the life-affirming part. According to Kasl (1992), five traits are present in substance dependence: feeling out of control; feeling life is unmanageable; harmful consequences; escalation of substance dependent behavior; and withdrawal when the chemical is not used.

Substance dependent person-Persons who misuse mood altering chemicals and experience the symptoms and effects listed above are called chemically or substance dependent individuals or substance misusers interchangeably in the literature. "Addict" has been used in the past, but because of the negative connotations and judgment attached to the term it is now avoided in literature although its use persists among professionals and substance dependent people. Alcoholics' drug of choice (the mood altering substance they use most frequently) is alcohol, although they may use other mood altering chemicals as well. Substance dependent people may have alcohol or other mood altering chemicals as their drugs of choice. For the purposes of this study, the term substance misusers may also be used.

Recovery-The DSM IV does not consider substance dependence to be a curable disorder, but lists four levels of remission based on how long the substance dependent person has been sober. Substance dependent individuals are considered to be in recovery and recovering, not *recovered.* The literature most often includes in its definition of recovery remaining abstinent from all mood altering substances and changing behaviors and attitudes that have lead to use (Kasl, 1992; Galanter, 1999; Gorski & Miller, 1986). However, simply not using chemicals is not considered recovery. It is first abstinence from mood altering chemicals plus abstinence from compulsive behaviors leading to use

(Gorski & Miller, 1986). Wegscheider-Cruse (1981) describes recovery as a journey without end, a process, not an accomplishment. A recovery program is required to keep the symptoms in remission and requires a recovering substance dependent person to address all her/his biopsychosocial needs (Gorski & Miller, 1986).

Relapse-Because recovery entails more than simply not using chemicals, relapse is more than returning to chemical use. It is a complex process that involves returning to the attitudes and behaviors that lead to chemical use. Terence Gorski is recognized as an authority on relapse and relapse prevention. He developed a relapse prevention program blending cognitive behavioral concepts with the Twelve Steps of Alcoholics Anonymous that is the basis for relapse prevention programs throughout the country. Gorski and Miller (1986) define relapse as: "a progressive process that is marked by definite, predictable, and progressive warning signs" (p.212). The end result of the relapse process, according to Gorski and Miller (1986), is using chemicals after the progression of symptoms has created an overwhelming need for the chemical. Gorski and Miller (1986) listed 37 relapse warning signs that include internal signs such as difficulty managing feelings and emotions, high stress and sleep problems; external signs such as avoidance and crisis building; and loss of control such as depression, loss of behavioral control and chemical use.

Leshner (1998) views substance dependence as a chronic, relapsing disorder for which the most reasonable expectation is for the substance dependent person to experience a significant decrease in drug use and long periods of abstinence interrupted only occasionally by return to use. This is a type of harm reduction model.

Family-Brooks and Rice (1997) define family as: "a group of people with common ties of affection and responsibility...Individuals can choose to come together through marriage or a commitment of affection and affiliation and do not need to be related" (p. 57). Cultural, socioeconomic, ethnic and religious factors shape the form and function of a family. This definition of family goes beyond genetic ties and is inclusive of a broad range of client support systems addressed in the literature which includes friends, partners, coworkers, clergy and others in the substance dependent person's life. These support people are also called concerned persons, significant others or concerned others in the literature (Galanter, 1999; Garrett et al., 1999; Gordon & Zrull, 1991; Rice & Longabaugh, 1996).

Enabler-An enabler helps the substance dependent person to maintain the substance dependence by protecting the substance dependent person from consequences of misuse. Wegscheider-Cruse (1981) states enablers "deflect the hand of fate and soften its blow" (p. 89).

Codependency-Cermak (1988) proposed diagnostic criteria to include codependency in the DSM as a personality disorder. While it has not been included as such, his criteria are consistent with descriptions of codependency in the literature (Beattie, 1987; Wegscheider-Cruse, 1981). Codependent individuals believe they are responsible for controlling others and the consequences of others' behavior; they meet other's needs at the expense of their own; their behavior is regulated by their perceived ability to control others. The behavior of others is seen as being related to the codependent individual, who has unrealistic expectations of her/himself, being unable to accept her/his own limitations. Codependency involves a dependence on compulsive behaviors used to get approval from others which the individual believes will allow her/him to

find safety, self-worth and identity (Treadway, 1990). Needs, feelings and desires are not expressed directly, so the individual learns to manipulate others to get these needs and desires met and either suppresses feelings or expresses them indirectly.

Self-esteem needs in codependent individuals become increasingly attached to the outcomes of others' behavior so anxiety and boundary distortions around intimacy and separation are experienced. They become enmeshed with substance dependent or other impulse disordered individuals. Codependent individuals fear rejection and abandonment which they attempt to avoid by being involved in and needed in every aspect of another's life. Stress related medical illnesses, anxiety, depression, compulsions, denial, their own substance abuse, hypervigilance, and constriction of emotions characterize consequences of codependent behavior (Lavick, 1998).

Some authors suggest that codependent behavior, which is oppressive, is women's basic programming and has a cultural component (Kasl, 1992; Schaef, 1986; Subby & Friel, 1984). The concept of codependency as pathology has been criticized as an oversimplification of complex phenomena and as being insensitive to cultural differences (Anderson, 1994). Behaviors common to women and some minority groups, such as self-sacrifice and caretaking, are viewed as deficits. Walters (1990) sees the label of codependent as blurring the power differential that exists between certain groups in society and others. In addition, it promotes the view that problems reside within the individual rather than in society. Behaviors described as codependent are often culturally conditioned and can be an expected response of an overfunctioning person who is in relationship with an underfunctioning person. Therefore, the concept is seen as diagnostically meaningless by many and distracting by some (Anderson, 1994).

Historical Perspective

Mood altering substances have been used by civilizations throughout recorded history. Isis, an Egyptian goddess of 3,000 B.C., promoted beer. Wine is mentioned both as a blessing and a curse in the Bible; the oldest distillery in the world was founded in 1575 in Amsterdam (van Wormer, 1995). The use of mood altering chemicals, alcohol and drugs, has been viewed as a way of life, a moral problem, and a disease.

Alcohol was credited with nutritional and medical qualities in the 1700s, and early 1800s; problems were not associated with its use until the mid 1800s (Lacerte & Harris, 1986). In the 19th century, Mary Richmond's friendly visitors felt that intervention in the lives of the poor was both a right and a duty of the upper classes; one criteria that distinguished the "unworthy" poor from the "worthy" poor was indulgence in alcohol (Trattner, 1994).

Women, being viewed as moral authorities, played a powerful role in spreading temperance ideals and in passage in 1920 of the 18th amendment establishing prohibition (van Wormer, 1995) but this image as keepers of morality has worked against women in many respects. Women were believed to be naturally more moral than men, so their substance dependence was viewed as more deviant (Fillmore, 1984; Rhodes & Johnson, 1994). Stereotypes of substance dependent women continue to be more severe than for substance dependent men and include being perceived as inadequate wives and mothers (Kane-Cavaiola & Rullo-Cooney, 1991).

Prior to the passage of the Harrison Act in 1914, which made opiates and cocaine illegal without a prescription, the image of a substance dependent female was a Victorian, white, middle to upper class woman with a secret opiate habit that enabled her to perform the social functions expected of her. This image was

changed after 1914 to the "modern stereotyped role as a criminal junkie, whore, and social outcast" (Aldrich, 1994, p. 64).

The Federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, spearheaded by Hughes, a recovering alcohol dependent congressman from Iowa, decriminalized public drunkenness and established resources for treatment so alcoholics could be seen as sick rather than bad (Lacerte & Harris, 1986). This act represented the first national use of federal funds for alcoholism and established the National Institute on Alcohol Abuse and Alcoholism (NIAAA). There was a massive infusion of public money to address alcohol problems, however, most research resources were directed at male alcoholics (van Wormer, 1995). Research on women was largely ignored until the mid 1970s, in part because there were fewer women than men in treatment programs (Rhodes & Johnson, 1994). Their low numbers made it difficult to obtain a large enough sample for research purposes and made data collection time consuming. Because funding for grants require the study to take place within a certain time period, women were often excluded from the samples due to time constraints (Schmidt & Weisner, 1995).

Another obstacle to the inclusion of women in alcohol and drug research was that women were not seen as acceptable subjects for research until their substance dependence became linked with harm to family, such as fetal alcohol syndrome (Lacerte & Harris, 1986). Lacerte & Harris (1986) discuss a "dichotomous view of female and male alcoholics [that] has strengthened the belief that the female alcoholic is a bad person because she threatens the traditional legacy assigned to her and hence no longer meets society's expectation of her as the moral guardian of her home and nation...Women are victimized by the social stigma of alcoholism and their inability to meet cultural expectations"

(p. 49). It has been suggested that concerns over women's use of alcohol and drugs heightens during times of gender-role change. For instance, media discussed a large increase in women's drinking in the 1970s, although research showed drinking rates to be stable in most age groups (Wilsnack & Wilsnack, 1995).

Due to the efforts of advocates working in the women's alcoholism movement, treatment services and programs for women only, as well as support services such as childcare, vocational and housing assistance, have increased in the last decade (Schmidt & Weisner, 1995). Hughes (1990) states that gender biases exist at every phase of substance dependence research, but currently research proposals submitted to the National Institute of Health for substance dependence studies must include women or a rationale for their exclusion.

Women and Substance Dependence

More women than men misuse prescribed drugs such as tranquilizers and sedatives. One study found drinking patterns to be more gender related than drug use patterns, with men drinking more heavily than women (Nunes-Dinis & Weisner, 1997). Women generally begin drinking at a later age than men but move more quickly from early to late stages of dependency. While fewer women than men drink, an estimated one-third of the heavy drinking population is female (NIAAA, 1990). Women have more severe physical consequences at lower doses and more quickly than do men. They are more likely to be depressed, submissive and passive (Davis & DiNitto, 1996). Women are taught to be submissive and passive, however, and often assume these roles whether or not they have a drinking problem (Van Den Bergh, 1991).

Physiological reasons for this increased severity may be that women achieve higher concentrations of alcohol in their blood than men after drinking an

equivalent amount of alcohol because women have lower total body water content than men of comparable size. There is a decreased activity in women's stomachs of the enzyme, alcohol dehydrogenase, that metabolizes alcohol, so more alcohol enters women's systems. This enzyme activity is practically nonexistent in alcoholic women (Frezza et al., 1990; Julkunen et al., 1985). Susceptibility to elevated blood alcohol concentrations may vary at different points during the menstrual cycle because of hormone level fluctuations (Sutker, Goist, Jr. & King, 1987). Effects on the liver are also more detrimental in women (Saunders, Davis & Williams, 1981).

Women's chemical misuse is likely to begin after a specific stressor or traumatic life event (Davis & DiNitto, 1996). Role deprivation increases women's risk for misusing chemicals and women are more likely to attempt suicide than men (NIAAA, 1990). Women seem to drink alone more than men. Overall levels of functioning for alcoholic women are lower than for alcoholic men (Davis & DiNitto, 1996; Kane-Cavaiola & Rullo-Cooney, 1991; Underhill & Finnegan, 1996). A number of factors, in addition to biological factors, contribute to women arriving in treatment in a more compromised state. Because of the social pressure for women not to drink, women delay dealing with the alcohol or drug problem to avoid the stigmatization attached to their misuse of these substances. Women contend with more social pressure than men not to reveal their alcohol or drug problems (Fillmore,1984; Wilsnack & Wilsnack, 1995).

Psychologically, substance dependent women have the same oppression (less power and status than men) as non substance dependent women in the United States, (Nelson-Zlupko, Kauffman & Dore, 1995), in addition to carrying higher levels of stigma attached to their substance dependence as compared to

men (Fillmore, 1984). The stigma of substance dependence and the oppression set up what Davis and DiNitto (1996) refer to as a "double whammy." Regardless of socioeconomic class, ethnicity, age or geography, women in the U.S. have lower levels of self-esteem and higher levels of anxiety and depression than U.S. men (Carten, 1996; Rhodes & Johnson, 1994).

Although women possess more risk factors in terms of relapse than do men, women are no more, and possibly less likely to relapse after treatment (Fiorentine, 1997; Stocker, 1998). One study found that only 22 % of women compared to 32% of men relapsed six months after completing an outpatient treatment program (Stocker, 1998). Women were more likely to report negative emotions and interpersonal problems prior to relapse than were men (Stocker, 1998). Survivors of childhood sexual abuse, however, are at high risk for relapse (Drabble, 1995). Brown (1996) found that substance dependent women with an additional DSM-IV Axis I diagnosis of posttraumatic stress disorder relapsed more quickly than those without this diagnosis.

Hughes (1990) lists as strengths of substance dependent women their tendency to more easily admit problems and express emotions than men, so they may need less motivation to work toward recovery. In regard to motivation, Stocker (1998) hypothesized that because women must overcome barriers to treatment, such as lack of child care and financial limitations, those that do enter programs are most likely to be highly motivated to address their issues.

Women and Treatment

Women enter alcohol and drug treatment more socially and physically deteriorated (Davis & DiNitto, 1996; Hughes, 1990) and less likely than men to have family support, health insurance, and child care than substance dependent men (Rhodes & Johnson, 1994). Substance dependent women often seek help

through family practitioners and therapists for symptoms of anxiety, depression and stress. These symptoms are often treated with medications which themselves may be addicting (Kane-Cavaiola & Rullo-Cooney, 1991). Women are routinely misdiagnosed with psychiatric and medical problems, the alcohol and drug problem being left undiagnosed by health professionals reluctant to identify substance dependence in women (Hughes, 1990; Rhodes & Johnson, 1994).

Treatment programs have been designed based on research on mainly white males (Rhodes & Johnson, 1994). As a result, interventions successful with men often are not necessarily successful with women. Women were then blamed for their inability to achieve sobriety. Confrontational approaches, concepts of powerlessness and punitive reactions to relapse view individuals as responsible for their conditions. These approaches do not take into consideration environmental factors, and therefore, tend to increase women's shame and make treatment less effective for them (Adams, 1995; Nelson-Zlupko, Kauffman & Dore, 1995; Rhodes & Johnson, 1994; Underhill & Finnegan, 1996).

Finkelstein (1990) lists issues, many of them social and familial, needing to be addressed in the treatment of women's substance dependence. These issues are: guilt, shame, stigma, sexualized images (promiscuous, "slut"), low self-esteem, feelings of powerlessness and anger, learned helplessness and depression, relationships, child care, family violence and abuse, multiple substance dependence and eating disorders, vocational and economic issues, substance dependence and pregnancy, and general physical health. In addition, 29% to 54% of women in treatment programs have been rape victims at some point in their past (Drabble, 1995). These issues can interfere with women's ability and motivation to enter and complete treatment. Nelson-Zlupko, Kauffman and Dore (1995) state that to attract and retain women clients, an open,

interdependent, nonhierarchical and nonshaming environment using a team approach and all female groups is needed. Outreach is also important for women who lack support systems to direct them to treatment programs (Kane-Cavaiola & Rullo-Cooney, 1991). Davis and DiNitto (1996) suggest including treatment strategies that focus on self-determination. Hughes (1990) reports that women are underrepresented in treatment with only 19% of clients in federally funded alcohol treatment programs being women; only 31% of clients in federally funded drug treatment programs being women. However, women are overly represented in other health care settings (Weisner, 1995).

Family Involvement

Substance dependence has been called a family disease in that it affects not only the substance dependent individual but also those around that individual (Johnson, 1986; Rolls, 1995; Wegschieder-Cruse, 1981). The effects of substance dependence on family members have been documented in research. Genetic links, family roles (scapegoat, enabler) (Wegscheider-Cruse, 1981), and rules (Don't talk, trust or feel) (Black, 1981) have been identified as ways the substance dependent individual affects other family members, especially children. In 1988, New York City's Child Protection Services had 5,000 newborns reported to them because these newborns had positive toxicology reports indicating maternal drug use (Carten, 1996). Physical, sexual and emotional abuse are three times more common in chemically dependent families than in the general population (Brooks & Rice, 1997; Platt et al., 1998; van Wormer, 1995).

It is estimated that between 38% and 75% of substance dependent women who enter treatment have been abused sexually or physically (Drabble, 1995; Nelson-Zlupko, Kauffman & Dore, 1995). Marital rape occurs more often in the alcoholic population (Drabble, 1995). Substance dependent women generally

have dysfunctional families of origin, with higher rates of mental illness and substance dependence in members, creating a more disruptive family life than the families of substance dependent men or nonsubstance dependent women (Davis & DiNitto, 1996). Family problems related to relapse include poor communication, enabling, enmeshment, alienation, distrust, dependency, guilt, and unresolved conflicts (Weiner et al., 1990). Effects of family dysfunction on the development of chemical misuse problems as well as the codependent and enabling behaviors of family members have been used as a rationale for discouraging family participation or actively excluding family from being a part of substance dependence treatment (Galanter, 1999; Garret et al., 1999). Family disagreements and conflict are related to a return to chemical misuse following treatment, especially for women who have often been introduced to chemical use by a male partner and continue to use chemicals to stay in the relationship (Hawkins & Catalano, 1985; Underhill & Finnegan, 1996).

Gomberg and Schilt (1985) note that isolation and withdrawal from family members is a common reaction by substance dependent individuals. Their study of 301 alcoholic women found their social isolation to be a result of anger and rejection by family. It was the women's choice to isolate to avoid this anger and rejection, but a vicious circle was set up that contributed to the deterioration of support seen in women seeking substance dependence treatment.

A preponderance of available studies, however, show that family support is an important component of treatment (Edwards & Steinglass, 1995; Garrett et al., 1999; Galanter, 1999; Keller & Galanter, 1998). The literature discusses inadequate or nonexistent family support, especially for women, even as studies show family involvement increases the likelihood that a chemically dependent individual will enter and remain in treatment and have longer periods of sobriety

(Brooks & Rice, 1997; Kingree, 1995; Ohennessian & Hesselbrock, 1993). One study by Rice and Longabough (1996) used an instrument for measuring perceived social support for 229 substance dependent individuals in outpatient treatment. Twenty-nine percent were women. It was found that those who reported higher levels of general social support (GSS) from family and friends had better levels of subjective well-being and better treatment outcomes than those with lower levels of GSS. GSS was also found to be a predictor of alcohol use after treatment. Women in this study reported lower levels of family support than did men (M=4.3, SD=2.4 for men; M=3.8, SD=2.6 for women). A study by Gordon and Zrull (1991) measured 156 (71 female) substance dependent clients' outcomes one year after inpatient treatment in relation to sobriety and social network support. This study found family and friend support to be a precursor of positive recovery outcomes, reporting that social networks explained 14% of treatment outcomes.

Regarding relapse prevention, Gorski and Miller (1986) state that, "family members can be powerful allies in preventing relapse in the addict" (p.171). They do this by educating themselves about substance dependence and relapse, planning their own recovery programs, communicating effectively with the substance dependent person about any relapse warning signs noticed, and reinforcing recovery behaviors (Gorski & Miller, 1986).

Women and Family Support

Not only are women's families less supportive of substance dependence treatment than are men's, but they may actively oppose and resist treatment for women (Davis & DiNitto, 1996). Several studies have discussed husbands covertly and overtly resisting their wives' entering treatment (Davis & DiNitto, 1996; Kane-Cavaiola & Rullo-Cooney, 1991; Rhodes & Johnson, 1994). This

may be due in part to their own misuse of chemicals since women are more likely than men to have partners who also misuse chemicals (Davis & DiNitto, 1998). Family members are embarrassed by women's substance dependence and seek to hide the problem by discouraging women from seeking treatment (Fillmore, 1984; Rhodes & Johnson, 1994). In addition, women have traditionally been the household managers. If a woman enters residential chemical dependency treatment, her spouse or another family member may resist assuming these household and childcare duties and pressure her to return home (Kane-Cavaiola & Rullo-Cooney, 1991; Nelson-Zlupko, Kauffman & Dore, 1995).

Because substance dependent women are more likely than men to be divorced and to have a greater disruption in family relationships, their family support network is often limited. They may reach out to professional support systems in the medical and psychological fields to make up for this lack of family support (Davis & DiNitto, 1996; NIAAA, 1990). Treatment is often seen by family members dependent on a woman's traditional role as nurturer and caregiver as a threat to her continuing in that role. Family members expect the newly sober woman to maintain her recovery but not to make any other changes in family functioning. Principles of self-care that are taught in treatment programs can be sabotaged by family members playing on a sober substance dependent person's guilt. Because of pressures from family and lack of support, women may find more reasons to leave treatment programs than to stay. In addition, because the woman is seen as the nurturer, family members may either resist taking on this role with her, or may not realize the woman needs nurturing from them (Kane-Cavaiola & Rullo-Cooney, 1991). The woman contributes by acting in an overresponsible, codependent manner, feeling guilty and ashamed for

tending to her own needs over those of her family's (Nelson-Zlupko, Kauffman & Dore, 1995; Rhodes & Johnson, 1994).

Women are more likely to be supported by children and parents than by their spouses (Davis & DiNitto, 1996; Gomberg, 1974). A longitudinal study of 143 women who misused chemicals and 157 women who did not misuse chemicals indicated that women chemical misusers who divorced or separated during the period of the study had lower levels of subsequent misuse (Wilsnack et al., year unknown). A possible explanation for this is that the women could better focus on their issues without distractions from their spouses.

The best treatment outcomes are achieved when the entire family is involved, which happens less often for women than for men (Kane-Cavaiola & Rullo-Cooney, 1991). In a study detailing the Family Rehabilitation Program in New York City, a variety of services were available to mothers whose babies tested positive for drugs at birth. Twenty of these mothers were followed and engagement of family as a support system was found to be a factor in successful recovery and in a decreased need for continuing involvement of child protection (Carten, 1996).

Studies point to the invaluable contribution family can make to providing a link between the substance dependent individual and treatment, providing history of the chemical use and consequences, recognizing early warning signs of relapse, and confronting the denial supporting chemical use (Garrett et al., 1999; Keller & Galanter, 1998). Having family members as allies of the substance dependent person and the treatment program can increase leverage and accountability in treatment, and can be key to ending the substance dependent person's denial to address the chemical problem (Galanter, 1999). Women come into treatment because of problems in their relationships with their children and

other family members and come into treatment more quickly than men when confronted by family members (Gomberg, 1974; Underhill & Finnegan, 1996).

Gaps in the Literature

Researchers have shown women's substance dependence, response to treatment, and degree of family support differs from men's. Environmental factors, family roles and an imbalance of power between the genders help explain why women receive less support from family as their use is viewed more harshly and their role as caregivers leave them isolated from receiving care. The effect of these factors and biological differences in metabolizing drugs is that women come to treatment programs more physically and emotionally deteriorated, and needing to cope with more obstacles to begin treatment, remain in treatment, and avoid relapse after treatment.

The literature has provided descriptions of components necessary for treatment programs serving women and effective ways to involve family members at various stages from intervention to maintenance. These have in common the goal of increasing the likelihood of staying in recovery.

Most of the substance dependence studies have used white males as subjects. The experiences of women and minorities have traditionally been neglected. Studies have attempted to measure and define family support, but have not sought substance dependent people's life experiences with substance dependence, recovery, and support.

The literature has identified family involvement as important in the treatment of substance dependence and has uncovered inequalities in support between men and women. The literature lacks an in-depth look at how substance dependent women define and experience family support. In spite of facing numerous obstacles, substance dependent women do get into recovery. What

support systems they use and how they use them have not been defined. An open-ended qualitative interview is needed to give women a voice to define their experiences with support or lack of support and to identify their strengths in using and creating support systems.

This study will explore the life experience of substance dependent women with family support. It will seek an understanding of how family support helped or hindered them during their decision to begin treatment, to stay in treatment, as well as the effect on their recovery programs. The participants will be given a voice to define family support and recovery themselves and their definitions and experiences will be compared to the literature.

Summary

This chapter introduced terms used in the identification and treatment of substance dependence. It offered a brief perspective on the ways chemical use has been viewed at different times in history. Literature was reviewed concerning the impact substance dependence, treatment and family support have on women. Gaps in the literature were defined as well as how the current study adds to the literature. The next chapter will introduce the theoretical framework used in this study.

CHAPTER THREE

THEORETICAL FRAMEWORK

Introduction

In this chapter, treatment models and therapies used in the conceptualization and treatment of substance dependence are introduced. Treatment models and theories are used to assist practitioners in understanding the complex processes of substance dependence and recovery. These models and therapies are used as the theoretical framework in this study.

Treatment Models

Various models have been created to explain substance dependence and to indicate ways to view those who are substance dependent. Among these are the moral model, the medical model, the psychological model, the psychosocial model, and the integrative model.

Moral Model

The moral model of alcohol and drug use holds individuals responsible for their misuse of chemicals and views individuals who misuse them as morally weak. Punishment and religious conversion are used to increase willpower (Nunes-Dinis, 1996; Siegler & Osmond, 1968). The moral model is one source of stigmatization of substance dependent women (Rhodes & Johnson, 1994). Substance dependent women are often stereotyped as unfit mothers and sexually promiscuous. Children are often more unforgiving of a mother's drinking than a father's (van Wormer, 1995). Victorian era women who worked in the Temperance Movement were viewed as an ideal of purity fighting to save their families from alcohol's effects. A double standard existed, however, in that

drinking was viewed as a passage into manhood, but alcohol use by women was viewed as deviant.

Medical Model

During the temperance era, Dr. Benjamin Rush studied the addictive qualities of hard liquor from which grew the disease concept of alcoholism. In 1892, the Journal of the American Medical Association (JAMA) stated that drinkers should be sent to hospitals and not to jails. Dr. E.M. Jellinek popularized the disease concept and divided alcoholism into five types, naming them after the letters of the Greek alphabet: Alpha, Beta, Gamma, Delta and Epsilon. Two of these types, gamma and delta, he considered diseases or substance dependence. However, Jellinek warned that no one type should be singled out as definitive of alcoholism. He observed, as well, the sociocultural factors that differentiated drinking patterns among various cultures and countries. In 1956, the American Medical Association (AMA) recognized alcoholism as a disease and the disease concept became accepted in the United States for treatment and funding purposes (van Wormer, 1995).

The medical model views substance dependence as a chronic, progressive and fatal disease with a genetic component which can be inherited (Siegler & Osmond, 1968). Substance dependence cannot be cured, but rather is put into remission. Lifestyle, attitudes and behavior related to drug misuse must be changed to achieve remission (Nunes-Dinis, 1993). Pharmocotherapy for withdrawal and maintenance, especially during the detoxification process, grew up from this model which remains a major component of treatment programs (Galanter, 1999). Pharmocotherapy includes the use of disulfirim (Antabuse), which stops the metabolism of alcohol at a toxic point, therefore, making the individual sick if s/he drinks; the opiate blocker, naltraxone, which decreases

cravings; support drugs such as atavan to control detoxification, and methadone maintenance to cope with heroin dependence.

The medical model takes the blame for becoming substance dependent from the individual and places it on the disease (Nunes-Dinis, 1996). The Hughes Act of 1970 provided federal government funding for major substance dependence research and founded the National Institute of Alcohol Abuse and Alcoholism (van Wormer, 1995). While the disease concept decreases the need for blame, shame, stigma and the low self-esteem the label "substance dependent" can cause, Burman (1994) argues that the sick role weakens women's sense of personal power and control over their lives. It remains, in her view, a useful model, but one which is incomplete for substance dependent women.

Psychological Model

Psychological models stress the importance of identifying underlying conflicts that motivate misuse of chemicals, such as self-medicating emotional pain caused by childhood experiences or other mental disorders. Stressors, as well as learning dysfunctional skills in relating and coping with others may contribute to the need to escape through chemical misuse (Kissin, 1977; Lindstrom, 1992; Nunes-Dinis, 1996; Siegler et al., 1968). Approaches used include psychoanalytic, reality therapy, behavioral and gestalt techniques, cognitive restructuring, and social learning (Nunes-Dinis, 1996; Siegler et al., 1968; Siegler & Osmond, 1968). Specifically, group and family approaches will be discussed in a later section of this chapter.

Sociocultural and Psychosocial Models

Sociocultural and psychosocial models focus not only on the individual, but also on the individual's social and cultural environment, including the family. The feminist perspective states that, "The development of substance dependence

can be related to the isolating and oppressive conditions engendered by societal values which promote competition and conquest over others, as well as conformity and perfectionism" (Van Den Bergh, 1991, p. 34). Kasl (1992) believes capitalism leads to substance dependence because people are treated like objects that need things to make them feel lovable and powerful. Patriarchy encourages compartmentalization, anhedonia and a blame the victim orientation. According to Kasl (1992) and Van Den Bergh (1991), mood altering substances are used to remain loyal to the system despite inner conflicts. Therefore, a model addressing the environmental component is essential to understanding substance dependence, in Kasl's (1992) view. The psychosocial model recognizes growth on a continuum which includes changes in multiple contributing agents, personal, familial, environmental, and the interaction among these (Rhodes & Johnson, 1994).

Alcoholics Anonymous (AA), begun in 1935, is considered under sociocultural and psychosocial models, as classified by the Institute of Medicine report (IOM 1990; Nunes-Dinis, 1996). AA members acknowledged that alcoholics experienced a loss of control over alcohol and provided a supportive, spiritual program, the Twelve Steps to help members stay sober. AA was originally established for men and is nonhierarchical, emphasizing peer support. AA groups are widely available, free, and focus on making concrete changes (Kasl, 1992). While Burman (1994) acknowledges that reliance on a group and on a Higher Power, as emphasized in AA, is important, she states that women also need to find power within to deal with their substance dependence. AA is grounded in patriarchal thinking that may, instead, promote female dependence (Nelson-Zlupko, Kauffman & Dore, 1995).

Integrative Model

An integration of the models discussed previously is common in the treatment of chemical dependency (Brower et al., 1989; Nunes-Dinis, 1996) and can be classified as a biopsychosocial model. The biopsychosocial model integrates the biological, psychological and sociological approaches. This approach combines interventions to address the medical needs of the substance dependent person, the psychological factors premorbid to the substance dependence and arising from it as well as the substance dependent person's isolation, social conditions and social needs.

Therapies

From the psychological model, various therapies have been developed. Group and family approaches based on a number of different theories are commonly used with substance dependent people.

Group Approaches

Substance dependence treatment and therapies most often take place in a group setting. The recovery rate for individuals in group psychotherapy is two to three times higher than for those in individual therapy (Flores, 1988), although this rate may not be maintained long term. Group therapy is also less expensive than individual therapy. The strong denial and delusion system present in the substance dependent person makes getting a reliable history from the active substance dependent person in insight oriented, psychodynamic individual therapy difficult in the absence of corroboration (Flores, 1988; Galanter, 1999). AA members recount stories of wasted years in psychotherapy during which time they continued to drink and deteriorate (Galanter, 1999). Individual therapy is effective once recovery has been established to assist recovering substance dependent people to address related issues impacting their lives, such as low

self-esteem, abuse issues and relationship issues (Nelson-Zlupko, Kauffman & Dore, 1995). Consultation with a psychiatrist is often recommended in conjunction with group therapy if medications such as antidepressants, anticraving drugs or disulfirim (Antabuse) are indicated (Egan, 1994).

Group therapy has the advantage over individual therapy of offering a support system with common concerns to confront denial, shame and stigma (Flores, 1988). Shame and guilt are common in female alcoholics both before and after the progression of the disease is diagnosable (Clemmons, 1979; Finkelstein et al., 1981; Gomberg, 1987; Rolls, 1995). Members of groups have more people to feel accountable to which can increase motivation to remain sober in early recovery.

Treatment groups offer a facilitator, counselor or therapist who guides communication and helps with interpretations of experiences as well as providing education for group members on substance dependence and relapse issues. Cognitive behavioral techniques such as Ellis' Rational Emotive Therapy and Gorski's relapse prevention skill building are used to teach coping techniques and challenge negative self-talk (Egan, 1994). Therapies based on social learning theory are also prevalent, especially in relapse prevention (Gorski & Miller, 1986). As discussed previously, gender specific groups and psychosocial models, which place substance dependent people in their environment and consider the stressors in that environment contributing to chemical misuse, are well suited to women (Burman, 1994; Nunes-Dinis & Barth, 1993; Rhodes & Johnson, 1994; van Wormer, 1995).

Self-help groups such as AA, NA (Narcotics Anonymous), and CA (Cocaine Anonymous) for substance dependent people and Al-Anon for family members have been effective not only in offering support to members, but also in

sharing common concerns and providing others to identify with, all of which Flores (1988) states are powerful curative forces. The more sobriety and stability in life an AA member obtains, the more respect that individual has in the fellowship. The phenomenological approach AA takes in having members retell their stories of descent into active substance dependence and their road to sobriety offers newcomers a way to relate and examine their own use and helps those with months and years of sobriety to stay connected with the consequences of their use to avoid overconfidence which can lead back to chemical use (Flores 1988). The concepts of interdependence and mutual sharing common in AA are familiar to women, who routinely come together to talk about personal issues (Kasl, 1992).

Women for Sobriety (WFS) was introduced in 1975 by Jean Kirkpatrick for women to attend in place of or as an adjunct to AA. WFS has four major themes: no drinking, positive thinking, believing in one's competence, and spriritual and emotional growth. Members are discouraged from labeling themselves as alcoholics or addicts and do not tell stories from their using days. Meetings are less directive than AA meetings. The Twelve Steps are replaced by Thirteen Statements of Acceptance that affirm women's competence (Davis & DiNitto, 1998).

Family Approaches

Family involvement, which had been discouraged by professionals, has come to be recognized as an important component of the treatment of substance dependence (Garrett et al., 1999; van Wormer, 1995). A shift has occurred from blaming the family for the chemical misuse (Wegscheider-Cruse, 1981) to enlisting family as allies to the substance dependent person in maintaining sobriety (Galanter, 1999). Professionals recognize that the whole family can be affected by a member's substance dependence and that family and

significant others can facilitate the recovery process or undo progress made by clients (Gomberg, 1987; Rolls, 1995; Sylvia & Leipman, 1991). Some barriers that exist in treatment for families have been: lack of family systems training for substance dependence counselors, agency procedures, and concerns with confidentiality (Garrett et al., 1999). A number of approaches involving family have been developed for or adapted to deal with substance dependence.

The intervention technique developed by Vernon Johnson at the Johnson Institute in Minneapolis prepared the substance dependent person's family to confront the substance dependent person with evidence of the problem. The goal was to break through the substance dependent person's denial and delusion. The substance dependent person is given an ultimatum of agreeing to immediate entry into a treatment program or accepting consequences, agreed upon before the intervention, such as loss of financial support (Johnson, 1986). Concerned persons in the substance dependent person's life can be important factors in motivating the substance dependent person to seek treatment (Edwards & Steinglass, 1995; Galanter, 1999; Johnson, 1986). Garrett et al. (1999) state that: "involving the family and having a social support system can be highly effective in achieving this goal [of helping the substance dependent person accept and continue treatment]" (p. 364). Family is used to intervene in the destructive cycle of substance dependence and is sometimes the best chance for leverage in getting the substance dependent person to address the substance dependence. Garrett et al. (1999) has developed a protocol, as well, to assist therapists in taking family calls for assistance and engaging their support to encourage the substance dependent person to begin treatment.

Family systems approaches, view substance dependence as the result of ineffective family communication and functioning and as a way to maintain

homeostasis in the system. The goal is not to "fix" the identified patient, the substance dependent person, but rather to address relationship dynamics, communication and pathological processes within the family system (Keller, Galanter, & Weinberg, 1997). Family passes on cultural values, some of which can result in substance dependence (Kasl, 1992). Therefore, the family and the substance dependent person are involved in therapy to address these values and restructure their family so, hopefully, the substance dependence becomes unnecessary (van Wormer, 1995).

Network therapy is an approach in which specific family members and support people are brought into the treatment of the substance dependent person for support and to promote attitude change (Keller, Galanter, & Weinberg, 1997). Network therapy is abstinence-based and strives to aid the substance dependent person in preventing relapse and developing a drug free lifestyle (Galanter, 1999). A combination of meetings between the substance dependent person and the network as well as individual sessions between the substance dependent person and therapist are used. An understanding is established at the beginning that any drug related behavior will be reported to the therapist immediately. Issues between network members and the substance dependent person are not addressed. The focus is kept on having everyone work together to deal with the substance dependence to achieve the goal of establishing and maintaining abstinence through behavioral changes (Keller, Galanter, & Weinberg, 1997). Involving family has the advantages of loyalty and built-in accountability for the substance dependent person. Most substance dependent people are in regular contact with family members (Garrett et al., 1999). This approach can be used by private practitioners as well as by substance dependence counselors. Studies

have shown outcomes for substance dependent people involved in network therapy to be comparable to other behavioral treatment approaches (Keller & Galanter, 1998).

Project MATCH (Matching Alcoholism Treatments to Client Heterogeneity), an NIAAA funded research study, applied three treatment approaches to male and female subjects and found no gender related outcome differences. Gerald Connor, Ph.D., Project MATCH chairperson, notes, however, that other client-treatment matching effects may have clinical importance (NIAAA news release, 1996). There is, for example, evidence that women in gender specific groups where women were viewed wholistically did have significantly better outcomes than women in nongender specific groups (Davis & DiNitto, 1998). A study by the Committee of the Institute of Medicine Division of Mental Health and Behavioral Medicine (1990) concludes that while no single treatment approach has been found effective for all individuals with alcohol and drug problems, treating comorbid life problems and matching clients to specific treatments based on a variety of variables, including personality factors, severity of misuse, and drinking antecedents has the potential to significantly improve outcomes. Additional factors that affect treatment outcomes include therapist characteristics and an interaction among treatment process factors, posttreatment adjustment factors, characteristics of those seeking treatment and characteristics of their problems.

Those treated for alcohol and drug problems "achieve a continuum of outcomes with respect to drinking behavior and alcohol problems and follow different courses of outcomes" (IOM, 1990, p. 148). When chemical misuse is stopped or incidences of misuse significantly reduced for an extended period of

time, improvement in other life areas usually also occurs (IOM, 1990). Thomas Babor, Ph.D., principal investigator for Project MATCH Coordinating Center, states that all of the Project MATCH treatments (Twelve Step facilitation therapy, cognitive-behavioral therapy and motivation enhancement therapy) are associated with positive change. NIAAA Director Enoch Gordis, M.D. says research must now focus on the complex biochemical mechanisms of alcoholism and combine behavioral treatment with pharmocological treatment (NIAAA news release, 1996).

Application of Theoretical Framework to Study

The framework described in the previous section is used to aid understanding of the participants' experiences at different stages of their recovery processes. Because each of the participants have completed a treatment program which included the availability of a family program, the theories described provide a context for their experiences. The models described outline a framework through which to view the various explanations attributed to their substance dependence by the participants and those around them. This framework is not described to explain the participants' experiences, since explanation is not the goal of hermeneutics, as is discussed in Chapter 4. Rather, it is provided to give a background of meaning derived from the culture and history of substance dependence and substance dependence treatment in which to place the participants' experiences.

The theoretical framework gives this background of meaning by describing views of chemical misuse and misusers. These views are held by both lay and professional persons in society as well as by theorists seeking to explain and treat chemical misuse. Chemically dependent people involved in treatment programs have experienced clinical interventions evolving from this framework.

Summary

This chapter introduced the theoretical framework used in this study. This framework included treatment models and theories used in the conceptualization and treatment of substance dependence. In the next chapter, the methodology of the study is presented.

CHAPTER FOUR

METHODOLOGY

Introduction

In this chapter, the methodology used to carry out this study is discussed. Chapter 3 examined a variety of theories and treatment models used to study substance dependence and recovery. This research study looks at two women who are substance dependent and have completed treatment programs and examines their stories of their experiences with substance dependence, treatment, recovery and family support, or lack thereof, throughout their processes. This research study uses the hermeneutic method to identify and interpret themes that stand out in those experiences. This method examines the complexities and subtleties of everyday experiences (Baker et al., 1998). The purpose of this study, as stated in Chapter 1, is to use the hermeneutic method to capture the experiences with family support for two substance dependent women. This chapter contains the research question; interview questions, philosophical background of the method used, design, participants, criteria for determining quality research, data collection, data analysis, and finally the protection of human subjects.

Research and Interview Questions

The research question was "How does family support impact the experience of substance dependent women?" The research question was operationalized with the following interview questions that were asked of the participants.

1. Tell me what family support means to you.

2. Based on your definition, tell me about your experience with family support before treatment.

3. Based on your definition, tell me about your experience with family support during treatment.

4. Based on your definition, tell me about your experience with family support after treatment.

5. Tell me how family support, or lack of family support, affected your ability to decide to come to treatment.

6. Tell me how your family support, or lack of family support, affected your ability to decide to stay in treatment.

7. Tell me how your family support, or lack of family support, affected you after treatment.

8. Tell me what your recovery program consists of for you.

9. Tell me overall, how did family support help or hinder you to work your recovery program?

Philosophical Background

This study employed hermeneutic methodology. Hermeneutics is a type of qualitative research that is naturalistic. Goals are to study people from their own perspective to better understand the world, the self, and others and to uncover similarities and differences in lived experiences (Benner, 1994). A goal is not just to acquire new knowledge, but to hear and interpret how another understands her/his experience (Koch, 1995).

For Martin Heidegger (1889-1976), hermeneutic phenomenology was a way to interpret the "being of human beings" (Plager, 1994, p.65). Hermeneutics filled in the gaps of understanding left by empirical science (Plager, 1994). While empirical science saw the research subject as separate from the world, this

philosophy saw humans as part of a world of shared background and familiarity (see Endnotes). The world for Heidegger was not impersonal and objective, but rather was personal and part of the self (MacLeod, 1996).

Hermeneutic interpretation seeks to hear and understand the voices of the subjects, called participants. The focus is on understanding rather than explaining and, therefore, shows a respect for the social and cultural nature of being human (Benner, 1994). Hermeneutics makes clearer the world of the participants and openly states meanings, practices, habits, concerns and skills that have been taken for granted (Benner, 1994). Shared meanings from being in the world can become so familiar that we lose sight of the significance of understanding these lived experiences (Plager, 1994). Describing common practices and shared meanings is intended to reveal, enhance or extend understanding of a human experience on its own level (Fitzpatrick, 1997). "Understanding" in hermeneutics means the "power to grasp one's own possibilities for being within the context of one's world" (MacLeod, 1996, p.140).

In Heidegger's hermeneutics, the researcher has a circular relationship with the experience studied. The participants and researcher engage in the process together and are affected by the interaction. The experience is shaped by and shapes researchers who bring with them their own background and experiences that must be made explicit. The background of this researcher was discussed in Chapter 1. The experience makes the researcher's preunderstanding visible and challenges it (Benner, 1994).

Interpretation to Heidegger is in a fore-having, which is the background of meaning and experience we have from our culture and history. Therefore, interpretation starts with a meaning and understanding (MacLeod, 1996). A

hermeneutic principle is that through interpretation, the being comes to the foreground (MacLeod, 1996). Patterns emerging from interpretation express the relationship of themes and are the highest level of hermeneutical analysis (Fitzpatrick, 1997).

Relation to the Current Study

The hermeneutic method is applicable to the current study because it allows participants to define their own experiences. Women have not had a voice in much of the research done on substance dependence and treatment, even though their experiences are quantitatively and qualitatively different from men's (Davis & DiNitto, 1996; Kane-Cavaiola & Rullo-Cooney, 1991; Underhill & Finnegan, 1996). This study examined the lived experiences of two women from their own perspective in order to broaden understanding of these experiences. The hermeneutic method was chosen to allow the participants maximum freedom in defining their experiences.

Data collection was done through 60-90 minute taped interviews. The interviews allowed the participants to tell their stories with a minimum of structure so that these stories can be examined in-depth to discover their richness, and the similarities and differences between them.

Design

A semi-structured interview format was used in this research. The nine questions stated earlier were asked of the participants who were interviewed separately. The interviews provided a large amount of detailed information regarding the participants' experiences. A strength of this research study was the richness and depth in these detailed stories. Through these stories, a better understanding can be gained of events and their significance for the individuals involved, which can broaden options and understanding toward others (Plager,

1994). Hermeneutic phenomenology is well suited to answering "what" and "how" questions concerning human issues (Plager, 1994).

Because of the small number of participants and the concentration on their personal experiences, this study lacks generalizibility. Understanding rather than prediction is a goal of hermeneutic phenomenology, however.

After the transcribed stories were interpreted by my advisor and myself, the participants were sent the interpretations for their input so they could confirm, extend and/or challenge the analyses. The participants clarified their experiences and added information through written comments on the interpretations.

Participants

This study sought to understand the lived experiences of two substance dependent women with family support by eliciting information about these experiences in depth. As stated above, the term "participants" is used in hermeneutic investigation rather than "subjects" because human beings are not to be seen as objects to be studied but rather as individuals to be understood (Plager, 1994). Requirements for participation were that the participants needed to have been diagnosed as substance dependent and to have completed a treatment program at least two years ago. Referrals were sought through coworkers. A $10 honorarium was given to the participants after the interview by way of a compensation for the time the participants volunteered to be involved in the study. The first two women to respond by contacting the researcher were designated as participants and interviews were set up in the respective homes of the participants at a time convenient to them.

Criteria for Determining Quality Research

Benner (1994) states that the researcher's views need to be challenged, extended, or turned around or the quality of their account is questioned. Van

Manen (1990) lists six activities of research that are interrelated in interpretive research. These are: 1. studying a phenomenon that commits us to the world; 2. investigating experience as it is lived rather than as it is conceptualized; 3. reflecting essential themes characterizing the phenomenon; 4. describing the phenomenon; 5. maintaining a learning orientation to the phenomenon; and 6. balancing the research by considering parts and wholes (van Manen, 1990, pp. 30-31).

Madison (1988) lists nine principles for evaluation appropriate to phenomenological hermeneutics. These are: coherence, presenting a unified picture; comprehensiveness, wholeness in context; penetration, resolution; thoroughness, addressing research question; appropriateness, questions addressed are raised by the text itself; contextuality, preservation of the historical and contextual text; agreement, interpretation agrees with what text says; suggestiveness, text stimulates further research; and potential, future events illuminated by insights gained from the text.

Patton (1990) discusses the use of triangulation as a technique to enhance qualitative analyses. This involves, "checking findings against other sources and perspectives." (p. 470), such as having more than one person interpret the data in this study.

Interpretive research takes the stance that prediction is not possible in human science because humans are self-defining. Lincoln (1995) discusses emerging criteria for qualitative and interpretive research, since criteria for quantitative scientific research, such as objectivity, does not apply. Lincoln's (1995) criteria are used in this study because of their clarity. Among the criteria

are, according to Lincoln (1995):

Positionality-The position of the researcher is made clear with researcher objectivity being a barrier to quality in interpretive research. My background in relation to this study was discussed in Chapter 1. I identified for the reader that I have both professional and family experience with substance dependence so my position was made clear.

Community as arbiter of quality-Knowledge gleaned from interpretive research is meant to benefit the community of which it is a part, making the research a community endeavor before it is an academic one. This research study was done to serve the research community, the social work community, and the community of substance dependent women.

Voice-Benner (1994) says that interpretive research should allow the participants to speak in their own voice with limited structuring. Lincoln (1995) says that giving voice to those silenced is especially important for interpretive research as is seeking to change conditions contributing to that silencing. Giving the participants a platform from which to tell of their experiences was a way to overcome the silence of substance dependent women. They spoke to me while I actively listened. Excerpts from their texts have been used so they have been able to speak through this study to a wider community. Their experiences have provided me with insight to use in my profession.

Critical subjectivity-Self-awareness is increased by revealing subtle differences, relationships and contradictions in the story that can lead to personal and social transformation. As stated, researcher objectivity is a barrier in interpretive research but researcher biases must be made explicit to the reader. During the interviews, I had difficulty not falling into a clinical style of interviewing designed for diagnosing. Instead, I had to remind myself of my role

as a researcher which was not to lead the participants in any one direction. Because of the unfamiliarity of this role, I was quite self-conscious of my interviewing techniques which was uncomfortable.

Because I work professionally with this population, I had experience with different forms of support my clients have had, some similar to and some different from those of the participants. I found it difficult at times to refrain from generalizing their experiences so I could stay focused on the uniqueness of their perceptions.

Reciprocity-This concept is central to interpretive research. The researcher is part of what is being studied and is in relation to the participant. The participant is in relation with the researcher and others and these relationships are part of the study. It was exciting to me to be able to link literature in the field with the participants' experiences. Because I generally work with substance dependent people who are either still misusing their chemicals or who are newly sober, and generally in distress and in need of intervention, it was enlightening to listen to women who have been in long term recovery. While I learn from all my clients, I was keenly aware of the participants' roles as teachers. As I gave them the opportunity to share their experiences, they gave me information valuable in my professional work.

Sacredness or spirituality-Respect is shown for what nourishes and sustains us and involves a deep concern for human dignity, justice, and respect among persons, as well as a deep appreciation for being human. Both participants mentioned spirituality in their interviews, although they viewed spirituality in different ways. I have had a deep respect for this population, which greatly influenced my choice of topic. I also found myself respecting the participants not just as members of the population of recovering women, but as individuals who

had created unique ways to grow and live in the face of their substance dependence.

Sharing the perquisites of privilege-Lincoln's (1995) final criteria involves acknowledging the debt owed by researchers to participants and the truth that researchers reap benefits from producing research that are not shared with or by the participants. I have shared my interpretations with the participants. It is my hope that through this study, readers will gain a new respect for the obstacles faced by substance dependent people. I have gained knowledge and respect that I will use as a practitioner.

Data Collection

The first two women who responded by contacting the researcher were designated as participants in the study. A mutually agreeable time and place to meet was established between each participant and the researcher. The interviews were done at the respective homes of the participants. The consent form was reviewed and signed and the semi-structured interviews were conducted. The participants gave permission to have the interviews audiotaped for purposes of transcription.

Data Analysis

The transcribed interviews were read to identify themes that stood out in the women's stories regarding their experience with family support. Discussion among my thesis advisor and myself regarding the themes within the transcribed narratives took place. This review process reduces the chance of including unwarranted interpretations not supported by the text. Heidegger cautioned against interpretations that lose their context and temporality as this can cause a shift from truth to untruth. Therefore, the researcher must take care not to bias

the interpretation away from the participants' experiences and toward the researcher's (Plager, 1994).

According to MacLeod (1996), the principles of the hermeneutic interpretation process include: the ability of the researcher to recognize her/his influence on the text while still hearing the voice in the text; engaging in the hermeneutic circle, meaning understanding the parts in order to understand the whole while having the meaning of the parts enriched by the overall whole which prevents a linear view; engaging in systematic analysis of evolving themes; keeping in mind the goals of understanding the human beings in front of the text and identifying human context rather than universals. MacLeod (1996) declares that "within hermeneutic interpretation, there is never a final or absolute interpretation" (p. 150). Rather, an interpretation is sought which makes the most sense in the present place and time.

Widera-Wysoczanska (1999) presents a seven-step analysis process that was used with each individual transcript in this study. The steps are as follows:

Step one: Open-minded reading of the transcripts. This involved immersing myself in the participants' experiences by multiple readings of the transcripts for understanding.

Step two: Looking for themes. Additional readings during which important themes were marked were then done.

Step three: Discovering key words. Key words and phrases that seemed essential for understanding the participants' experiences were also marked.

Step four: Looking for unity of meanings. The key words that represented an idea were marked and lifted from the text for further analysis in which attention was given to each word.

Step five: Creating units of meaning. These words and ideas were grouped together with similar words and ideas from the same transcript. This placed them in a new context and allowed similarities and differences in the meanings to be discovered and connections and contradictions to the segments to be sought in the text.

Step six: Forming a personal picture of the support experience. The segments were then combined to create a complete picture of the participants' experiences with support.

Step seven: Forming a personal model of the support experience. Main themes and subthemes were sought and arranged into coherent patterns for presentation.

Interpreted themes were sent to the participants once for their corrections, validations and expansions and were then supported by text excerpts and extended by published literature findings. In hermeneutical analysis, patterns are the highest level. A pattern is discerned during the interpretive process and is, "constitutive, present in all interviews and expresses the relationship of the themes" (Fitzpatrick, 1997, p. 4).

Protection of Human Subjects

This study was approved by the Augsburg College Institutional Review Board, #99-56-3 (Appendix E). Participation in this study was completely voluntary and the participants signed informed consent forms. The participants were informed of potential risks involved in the research such as bringing up sensitive emotions from discussing these experiences and were given resource lists that included a crisis number if they felt they needed support. Participants were told that the information they would share would be confidential but not anonymous due to the small sample size of the study. The interviews were

audiotaped to insure accuracy of the information but the names of participants, family members, and treatment facilities changed in the transcribed texts were identified by numbered codes only. The audiotapes and other identifying material were kept in a locked safe in the researcher's home and will be destroyed by January 1, 2001. The participants were informed that the transcripts would be shared with the researcher's thesis advisor.

Summary

This chapter discussed the methodology of this study. The research and interview questions, design, participants, data collection and analysis were stated. In addition, the philosophical background of the methodology and criteria for determining quality research were presented. Actions to protect the human subjects were also included. The following chapter presents the results and discusses the findings of this study.

CHAPTER FIVE

FINDINGS AND DISCUSSION

Introduction

This chapter begins with a brief description of the participants. Their perceptions of themselves became altered when they identified themselves as chemically dependent. Changes also occurred in their perceptions of others in their world which lead to a change in their definition of family and of support. While both participants experience the significance of these changing perceptions in unique ways, this study sought to uncover shared meanings and common themes in their experiences and to provide an interpretation of them. It should be noted, however, that this interpretation is only one way of understanding the significance of this life event. Evolving and deepening interpretations will continue to be made by the participants as they reflect upon their experiences. As stated in Chapter 4, no final or absolute interpretation exists, but one is sought that makes the most sense at the present time (MacLeod, 1996). Reference to the literature on family roles, substance dependence and spirituality is used to support and extend the interpretation.

Participants

The first participant, Kathy, is a Caucasian upper middle class female in her fifties. Kathy is an alcoholic who has been in recovery for twenty years. She sought treatment for her alcoholism in her thirties while she was married to her first husband, the father of her three adult children. She has remarried and is a homemaker.

The second participant, Lauren, is a Caucasian middle class female also in her fifties. Lauren is an alcoholic who has been in recovery for eighteen years.

She has two adult children and works full-time outside the home. She divorced shortly after treatment and has not remarried.

An Experience of Connection

These substance dependent women made various connections within and outside of their families that changed as they attempted sobriety and then lived a recovery lifestyle. When actively misusing chemicals, both women pulled away from human connections to "create isolation in our addiction." This isolation both resulted from and caused distance between them and their families. They reached a "moment of clarity" when the consequences of their use became apparent to them and they then chose to make connections that could support their journeys from active chemical misuse to sobriety and recovery. Without these connections, recovery was perceived as impossible. Kathy believes strongly in the necessity of connecting with others and shares that message. She says, "I constantly tell people...you can't do recovery by yourself. [T]here's not much recovery going on if you're trying to do it alone...people need to connect with other people." For both participants, isolation became identified with their past active misuse behaviors and recovery with thoughtful connections and growth.

Having connections with other human beings can be an experience that is taken for granted as one moves through one's life. For these participants, recovery required them to reevaluate past connections, to consciously choose people with whom to make meaningful connections and then to put effort into maintaining those connections. Connecting is a theme that was common to both participants' experiences with family support in their chemical dependency and recoveries.

The process of connection involved a pattern of stages that was fluid rather than linear and consisted of disconnection, connection, and reconnection.

Disconnection from the original family (parents, siblings and spouses) occurred during active chemical misuse and continued in a more conscious manner after sobriety was achieved. This disconnection, although painful, allowed for connection with an expanded family including professionals and peers. The development of a sense of identity, self-worth and spirituality was facilitated by the connections made with these people. Discovery of self and spirituality created the opportunity to reconnect with the original family in new ways as recovering women.

Disconnection from Family

Both participants describe conditional connection with their families of origin prior to entering treatment. Kathy's father was alcoholic and her mother was emotionally distant. Kathy experienced her connection with them as an affiliation rather than as love or support.

> So when I look back I have this image that my family--we had designated chairs and as long--and they had our little names on them. I picture little director chairs. And as long as we're willing to sit in the chair as it was when we were little, when I was little and when my brother was little, that there would be some kind of affiliation. Um, I never considered it particularly love or support, but affiliation with the family.

Kathy's experience with her family emphasized role fulfillment over personal growth. She could maintain affiliation with them only if she performed as expected. Rigid roles are considered common in alcoholic families (Black, 1981; van Wormer, 1995; Wegscheider-Cruse, 1981). These roles ensure a place for each member, maintain the unhealthy system and provide payoffs for the family at a price to the individual. Kathy identified her role in her family as that of

scapegoat, a role which focuses negative attention on the individual while taking the focus off of the alcoholic. A price paid to maintain this role is often the development of substance dependence in the scapegoat herself (Black, 1981; Wegscheider-Cruse, 1981).

As her own substance dependence developed and progressed, Kathy "drank like my dad because I identified a lot with him." However, she found that her drinking was viewed differently and less tolerantly by her family than was her father's drinking. Her experience extends understanding of Fillmore's (1984) description of women's drinking being more morally unacceptable than men's.

> They knew that I was drinking a lot. They considered it a moral issue for me. If I'd just get a grip on myself that I would, I could quit drinking, um, despite the fact my dad had drank nightly all his life, it was okay for him but it wasn't okay for me. And they had no desire to participate in any kind of pre- or post-treatment, actually, therapy with me.

Rather than recognize similarities between Kathy's and her father's behavior, her family chose to focus only on *her* drinking. She found these divergent responses confusing and concluded that something was wrong with her. Confusion can develop when one's internal experience fails to match with other family members' behavior (Wegscheider-Cruse, 1981). Later in therapy she understood this conclusion that she was inadequate to have contributed to her feelings of shame.

Lauren also internalized shameful feelings that she states contributed to her disconnecting from family because, "this history of expecting to be judged or scolded-or causing my parents to be disappointed in me-stopped me from going to them when I was involved in anything I was already ashamed of." Lauren talks

about her learned responses to her parents' judgments and how they became a part of her perception of herself.

> I do remember being spanked very often, and scolded, and moralized to. In response, I either responded with belligerence or succumbed to guilt and shame. As I grew older, this pattern continued, although I finally internalized most of the shaking fingers and scoldings along the way...Um (pause) well, I think there would have been family support available but I didn't avail myself of it. Um, I stayed pretty, uh, I hid, you know I hid emotionally and I, and I uh, tried as much as I could to hide as much as I was drinking.

Gomberg and Schilit (1985) state that both the alcoholic woman and her family are responsible for this mutual disconnection. As the substance dependence progresses, the dependent woman is increasingly rejected by family because of her drinking behavior. She responds by disconnecting further by her choice to continue drinking and acting out. Emotional distance and cut-off is a common reaction to anxiety and tension in families (Bowen, 1974).

Lauren married an alcoholic and they drank together until she reached a point of, "personal desperation" and entered treatment. She describes her young children as being happy to have her go to treatment and stop drinking, but receiving no support from her actively alcoholic husband.

> I got nothing from my husband. My children were very supportive... My 10 year old, my ten year old was um, had been becoming concerned about how much drinking was going on in the house and he was very happy to see me stop it. And, um, they went to family week and we, even after their

> father dropped out, they continued to go and, um, that was pretty important. I mean, they were pretty distressed, too, um by the time the divorce was happening, that followed family week...Um, in my immediate family I was married and, uh, there was like, there was no support. He's active, actively drinking also and terrified in treatment. In fact, walked out during family week, which precipitated our divorce actually.

Lauren gives voice to women's issues addressed in Chapter 2. These issues were: 1) alcoholic women are often married to men with problematic drinking behavior (Gomberg, 1991); 2) a higher proportion of husbands leave their alcoholic wives early in the women's sobriety than women leave alcoholic husbands (Rolls, 1995); and 3) women are more likely to be supported by their children than by their spouses in treatment (Davis & DiNitto, 1996).

Kathy had been physically abused by her husband and his telling her he was having an affair had been a catalyst for her to enter inpatient treatment. During a visit, he not only told her that he planned to divorce her, but wished her dead, out of existence.

> We were outside [at the treatment center], walking, below zero weather and he said to me several times, "I wish I could find a way so that you would be dead." So, as far as he's concerned, um, obviously that's not supportive, he, and he said he really wished I wouldn't sober up. And in fact I probably couldn't and wouldn't and he was going to buy a townhouse near our house, and I could live there and then he and his girlfriend would live in our house with our children.

To Kathy, divorce and death were perceived as equally terrifying because "he allowed me to exist." Without her identity as a wife "there really wasn't anything inside." Substance dependent women often are overresponsible in their families, and their guilt and shame contribute to them concentrating on their families' needs rather than their own (Nelson-Zlupko, Kauffman & Dore, 1995; Rhodes & Johnson, 1994).

Because Kathy's family disconnected from her while she was in treatment, she was able to connect with others who would become significant in her recovery and to disconnect from the caretaking role she had played in her family. Literature shows family support to be an important ingredient of treatment (Edwards & Steinglass, 1995; Garrett et al., 1999; Galanter, 1999). For women, however, the conclusions are mixed. Studies report family and friend support to be a precursor of positive recovery outcomes for women (Gordon & Zrull, 1991; Rice & Longabough, 1996) and yet also report lower rates of substance misuse after treatment in women who separated or divorced during the course of one study (Wilsnack et al., year unknown). The exact nature of the support, and more importantly, how that support is perceived seem to have been factors for the women in this study.

Both women experienced their spouses' withdrawal as "a very hard time" but decided they "had to be responsible." In time, Kathy felt gratitude for this lack of support because she credits it with leading her to treatment.

> It was the *lack* of family support that got me to treatment...Um, so in many ways, you know, I thank my husband for being such an abusive son of a bitch (chuckles). Because it really was his lack of care that got me into treatment. Because I just didn't know what else to do about it. And, um, my parents' lack of concern

> for me that, the three of them, it was the people I depended on the most, um, I really didn't, didn't have any support from. So in some respects, I can actually thank their insanity for helping me to treatment because my insanity was too severe to have me thinking clearly at this point.

Kathy's explanation of her family's lack of support may challenge social work and alcohol and drug treatment interventions aimed at connecting clients and family, a common social work and treatment goal. If these interventions are done without understanding the family's story, they could interfere with rather than promote recovery. Negative interactions with family can lead to relapse (Hawkins & Catalano, 1985).

An alternate view of families that maintain or allow distance may be that they are supportive in a paradoxical sense because recovering substance misusers may then seek out other supports. Excluding family members from participation in treatment, as in the past (Galanter, 1999; Garret et al., 1999), is an extreme and unwarranted reaction to some members' behaviors. However, assessment of the family system and the members making up that system could occur prior to involvement in family programs and be beneficial to both the substance user and family members. Modifications of family programs to include those more representative of other non-family support systems useful to women may facilitate important connections.

Connection with Expanded Family

Both participants found a need to look beyond their families of origin and marriages for support in recovery. When family is unavailable or unwilling to be supportive, Davis and DiNitto (1996) state that it is important for women to use

alternative supports, including professionals. The connections made early in treatment were experienced intuitively as being vital. Kathy's reaction to those she met at the treatment center extends understanding of the impact of the realization of the need for alternative support. She found a new chance to connect and believed the care she felt from strangers would help her discover a new way of life.

> I totally, totally felt as though I had a new lease on life. A new chance to be different. A new chance to, to um find some peace and some happiness, some connection. But I knew somewhere inside it wasn't going to be with my family...The only way I'm going to stay alive is if I stay with people other than my family. If I didn't have a family in the sense of, of, um, people that care for me, I had never had that, that sense in my life. And I knew that these strangers in treatment cared more about me than my husband and my parents.

Treatment professionals took on a special significance, having power to validate her existence. They became surrogate parental figures, facilitating the disconnection from family roles. On the advice of her therapist, Kathy did not have a relationship with her parents for five years because she, "couldn't go visit them in [State] and be the adult recovering woman I wanted to be." A process of redefining family was begun as caring connections were experienced. Professionals, such as the therapist, "became part of my family, probably the person who single handedly was the most responsible for the changes that went on in those early years of my recovery and for helping to keep me alive."

Alcoholics Anonymous (AA) was recommended by the treatment counselors as an important way of maintaining and extending the support the

women had received in their treatment programs. A relationship with AA was begun to "learn about how to do recovery" and to overcome the loneliness they felt as they disconnected from the chemical and from family.

> I remember walking in the meeting. It was cold, scary; I had no idea what to expect. I had my sunglasses on to hide from, from all the people at AA... it came my turn to talk and I burst into tears and everybody sat there patiently and waited...I did that for months. Months! And no one ever said, well, come on, quit crying...Talk about family, they're part of my family. So, um, the switch becomes my family of origin becomes less important...A bunch of drunks, total strangers, that I felt more connection as I said earlier, affiliation and affection with and for and from than I had in 35 years of people that I had lived with and loved and thought loved me.

Definitions of family continued to expand, now including " people that had something to do with recovery" and who connected in nonjudgmental ways.

Kathy has maintained a relationship with AA to the present time because she views the people in the meetings as family. Lauren left AA and found the sense of connection she sought in a Gestalt therapy group. Fleischman (1989) states that membership in a group, identifying with members and being identified by them, fills a critical need we all have for a network of human contact. Both Lauren and Kathy experienced the shared meanings within these group connections. As Kathy explains:

> But those early couple of years without the support of a group of people who I knew would be there when I wanted, ten in the morning or eight at night, or, or at the other end of my

telephone, um, I would not have, I would not have stayed alive.

The availability of group members virtually at any time who "took the time to talk" challenged beliefs that no one "would bother with me." Instead, peer availability and support connected these women to a sense of their own worth. Lauren and Kathy experienced the diminished sense of self-worth and poor self concept common to alcoholics (Booth et al., 1992; Gordon & Zrull, 1991). The nonjudgmental connections made with peers in the groups they attended allowed them to experience themselves as worthy human beings and to heal their shame which had blocked their spirituality (Flores, 1988; Fromm, 1995). As self-identity and self-worth were internalized, a network of connections was created where the participants contributed as well as received support. The participants not only maintained the networks they had begun in their treatment programs, but also added to them, an important contributor to continued recovery and growth (Gordon & Zrull, 1991). Lauren talks about how these connections enhanced all of her relationships.

> But I have that kind of intimacy with those friends and that is really important to feel, to be able to say anything. Um, and then other friendships kind of blossomed after I learned how to do that kind of talk...and I've learned about boundaries in there. But all my, I think all my relationships are better...and I think they're more fulfilling for other people because I can give and take, where I was pretty closed before.

Group membership and nonjudgmental peers helped the women to learn and to practice social skills related to maintaining relationships, such as respecting boundaries and taking risks to share honestly. They were then able to apply these skills to others and enhance existing and new relationships.

As mentioned, Lauren chose to leave AA to participate in other therapy groups she felt better served her needs. Her dissatisfaction with AA centered on the concept of a Higher Power referred to in the Twelve Steps. It is not uncommon for women who have felt powerless to resist following the suggestion in the Twelve Steps of turning their life over to a Higher Power (Burman, 1994; Nelson-Zlupko, Kauffman & Dore, 1995). Lauren felt her independence and control were limited by the concepts AA taught.

> [I]t wasn't solving my, my fundamental loneliness to continue to, to continue to be in AA. And I found out that I had a whole other bunch of personal growth room that I wasn't, that I didn't think I was ever going to get to um, through AA...I mean a great deal of recovery that you can do through AA, there's a, there's a lid on how far you can go...there's this mystique that you can, that only another drunk will understand you. And so long as there's that mystique... you're always impaired. And those two are really very limiting concepts to me...then the real big change was when I started Gestalt therapy training. Um, and I, um, uh, found, found those real strong connections, that real intimacy that I was missing.

Kasl (1992) and Burman (1994) support the need women have for concepts that are empowering and agree that women need to develop resources beyond AA to support their growth in recovery. Kathy, also, looked beyond AA for connection.

> As I have become a more healthy woman and a more spiritual human being, I have found that I have to, I can seek other, I had sought out other people who are spiritual human beings and aren't necessarily in 12-step programs or aren't necessarily

> in a therapy group or at a church, but that are just the, the people that are trying to live the same kind of life I am. And I seem to, well, we seem to attract each other.

Ravndal and Vaglum (1994) found that substance dependent women who established trusting relationships with other women were able to break destructive patterns of relationships. Kathy and Lauren found that they experienced satisfying connections in treatment, in AA, and with peers and were able to have the types of relationships that nurtured them. This lead to the ability to challenge their limiting perceptions of themselves and to experience self acceptance.

Connection with Self/Spirituality

The participants entered treatment defining themselves in terms of the roles they played in their families. Fromm (1995) states that when a person's value depends on the approval of others, that person's self-esteem is uncertain. S/he, then, has no sense of identity, just a spiritual void. Kathy explains what this experience was like for her.

> I had zero sense of identity in treatment...I was 23 when I married...when he left me, my identity left... I think this is very typical of sick addicts, my whole sense of who I was, was external...My way of being in the world was totally about other people and about my alcohol. And that wasn't something that happened in my marriage that was something that happened on the day I was born, that I had no identity. And that was um, very difficult, that learning to fill up that spiritual void...I was without the two things I had depended on all my life, my husband or my father, and my booze.

Kathy states that, "I don't think it's an accident that we call alcohol 'spirits.'" Royce (1989) supports this by suggesting that substance dependent people may be unconsciously trying to fill their spiritual needs by using mood altering chemicals. Breaking the connection to alcohol and drugs leaves a void which leads to a sense of loss and grief that "are active components in alcoholism" (van Wormer, 1995, p. 6).

Kasl (1992) feels women in American culture are programmed to tie their identity to men which may contribute to the emptiness and anxiety Kathy described. This programming may contribute to the formation of substance dependence and increase the obstacles to getting and remaining sober for women (Davis & DiNitto, 1996). Lauren and Kathy, however, experienced the anxiety and emptiness they felt as a motivation to get help. Their reaction may reveal the often unconscious knowledge individuals have that breaking the connection with chemicals is the first step to constructing a higher sense of self (Carroll, 1987).

In treatment and beyond, the participants made connections between their feelings of shame, their chemical misuse and their isolation. Isolation was described as "a hole in my soul." A connection with spirituality was made that helped them to experience themselves as worthy human beings. Through spirituality comes a knowing of the truth about ourselves, which gives us the ultimate context to understand who we are and to know our intrinsic value. To achieve mental health, we must integrate innate spiritual patterns into our lives (Legere, 1984). Spirituality continues to be experienced as an essential ingredient in the participants' recoveries and to their ability to connect in a healthy manner with others. Lauren states:

> Um, and I, even though I never, um, bought into a lot of the western religious overtones of AA, I really bought the importance

> of spiritual growth, however it's defined and um, um being open and let yourself depend on others. And um, so that became a very important part of my personal recovery work was to do that. And, um, it still is.

Substance dependence is often viewed as a spiritual as well as a physical, emotional, and social illness (Carroll, 1993; Royce, 1989, van Wormer, 1995). Recovery, then, includes the achievement of spiritual health and serenity (van Wormer, 1995). Attention to spirituality, which is often neglected in treatment programs, can be achieved in a variety of ways, as witnessed by the participants' experiences. Some of these ways are through the Twelve Steps, religious affiliation, and a sense of harmony with nature and the universe. Spiritual health helps individuals to attain a higher degree of consciousness that contributes greatly to a sense of well-being, connectedness and wholeness. A sense of meaning and comfort comes through the spiritual dimension of the self and provides an effective way of coping with stress (van Wormer, 1995).

Once able to connect with spirituality, Kathy discusses being free to be herself in relationships rather than having to conform to a role. She had moved physically away from her family early in her recovery on the advice of her therapist. Now she was able to break away from her emotional need to try to please her family by her performance and integrate her "insides" and "outsides."

> [O]ne of the unspoken family rules was outward appearances are the most important and we don't want to talk about...anything that goes on inside...And so that was really a turning point for me, when I was willing to break away from the family value...and it does matter to me that my insides and my outsides match.

Kathy's experience enhances our understanding of substance dependent families' covert rules (Black, 1981; van Wormer, 1995; Wegscheider-Cruse, 1981). Black (1981) lists these rules as: 1) do not talk; 2) do not trust; 3) do not feel. Wegscheider-Cruse (1981) includes versions of these three rules among others. These rules protect the family dysfunction by isolating family members from outside help and from each other. No one in the family names the reality of what is going on within the family and instead stays loyal to a projected image. Genuine feelings get repressed and family members identify with less painful false feelings. While true feelings are intuitively acknowledged, the false feelings are expressed. Confusion arises due to the incongruency between portrayed and actual realities and leads to mistrust within the family and within the self (Wegscheider-Cruse, 1981).

Kathy described integrating true feelings and behavior as "a turning point" which can be interpreted as her ability to disobey the family rules in order to be true to her own perception of reality. She then experienced congruency in her feelings and experiences which allowed her to form healthy relationships. She could be herself in these relationships, allowing emotional growth. Bowen (1974) refers to this emotional maturity as differentiation of self. In Bowen's (1974) view, a well-differentiated person has less intense togetherness needs and more intellectual rather than emotional responses to stressors than a less well-differentiated person. He viewed togetherness and individuality as competing forces and believed healthy relationships were possible when individuals were more autonomous and less emotionally reactive.

Knudson-Martin (1994) challenges Bowen's divergent view of togetherness and individuality which she states conceptualizes well-differentiated individuals according to a male standard. She offers an expanded model based on

Bowen's theory that more accurately reflects women's experiences with connection in relationships. Female differentiation in Knudson-Martin's (1994) model is the ability to "hear and trust one's own voice at the same time one attends to the voices of others" (p. 40). The ability to think and to feel are equally valued. Women grow by discovering themselves while at the same time developing and maintaining relationships. Togetherness and individuality can each facilitate the development of the other instead of following Bowen's linear model. The participants experienced the cyclical and facilitative nature of connections with self and others in the various forms described in this chapter.

Reconnection with Family

The participants had discovered who they were outside of their families of origin and marriages and had established what Wegscheider-Cruse (1981) calls a family of choice made up of caring and supportive individuals. Both women then sought to complete the circle of connections by reconnecting with their original families. Lauren's family of origin and her children are important parts of her life.

> My family is very important to me. My relationship with my grown-up children is very important to me and I, I look to them, my children who are part of my social life and I look to my family members for part of my social life. And an important part, I was in [City] last weekend being with my family. And it was wonderful. And, um, they have, so they do, they have a tremendous amount to do with my emotional well being. My emotional well being has a lot to do with how easy my sobriety is coming.

Wegscheider-Cruse (1981) calls this reconnection a family reconstruction. Reconstruction is made possible when the experience with family is reframed or perceived in new ways. This reframing develops from the connections made with the self and with the family of choice. The participants live the experience of reconstruction that calls for, as Lauren has found, acceptance of family members' limitations and imperfections.

> [Mother] is not someone from whom I seek support for my emotional problems or difficult times, but she offers it and lets me know she loves me and is proud of me for all that I have accomplished in my recovery...So I feel close to my mother but she is 82 and more in need of my support and friendship than I am of hers. I am glad to give it and mostly enjoy being with her.

Lauren is able to give her mother support even though she does not turn to her mother for support. She appreciates her mother's efforts but uses her own network to meet her needs.

Reconstruction can occur even when the family members do not make changes. Kathy talks about letting go of anger and blame toward her family which in turn helped her to feel good about herself. When her father died, Kathy was with him, which was mutually gratifying. She reconnected with her mother who "has made her choices about not being different in her life." She can reconnect now without losing herself because she, like Lauren, has others in her life who can meet her needs.

> I did connect with my parents again when I could go to [State] and I could be an adult recovering woman and take my recovery

> stuff with me and leave my addiction and my codependency behind. And that was very hard the first time I did that, but it was very meaningful for me. And I actually have some affection for [Mother] in a way I didn't for many, many years because of what I didn't get. I don't need that any more because I've gotten it in other ways in my adult life, in my recovery adult life. Um, so it's nice for me that I could do that...Um, so I feel good that I can kind of overcome some of my prejudice and anger about my family.

Reconstruction occurs when responsibility for one's own actions, reactions and decisions is taken and the focus is on the self rather than on others. Wegscheider-Cruse (1981) states that when reconstruction is done, a spiritual transformation is possible. The individual moves from fear to trust, self-pity to gratitude, resentment to acceptance, and dishonesty to honesty. A cycle is created in which connecting with spirituality allows reconnection with family. In turn, this allows for a greater spiritual connection and an openness and acceptance that had been impossible, but is now possible, as long as the focus is kept on "me, not them, in the present, not the past or future." Lauren experiences the rewards of reconnecting with her family in this new way.

> These new relationships with my family since my sobriety have been among the most important rewards that have come to me. I had to open up enough to let it happen. I am the one who changed; they were always there.

Because a network of connections has been created by the participants, they are less dependent upon any one individual. Connections and disconnections become fluid and can be seen as valuable growth experiences. Without the fear

of disconnecting, freedom to connect is experienced. Kathy talks about being able to let go of relationships that she has outgrown. Her experience can be interpreted as enabling her to run from relationships. In the context of her story, I have interpreted her comments to mean she is no longer dependent on people and relationships to define her, and therefore, is free to disconnect if she or another feels this is necessary.

> I truly believe that part of my spiritual journey is that I am no longer afraid to let go of relationships. I believe that people come in and out of my life as I come in and out of theirs for certain reasons. And that when we learn those lessons than we're able to move on. So I don't try to hold on to a relationship that doesn't seem best for both of us any more. And I don't feel angry about it when a friend leaves or when, I, hopefully they don't feel angry when I leave. And that really frees me up to have always room for new things in my life and new people in my life.

An integration of families produced a mutual support system developed over years representing different stages of the participants' journeys. In Chapter 2, a definition of family was given that was inclusive of a broad range of support people who come together out of affection and responsibility (Brooks & Rice, 1997). Kathy gives voice to what family means to her and extends our understanding of "family."

> You know, when things are tough I want to isolate, but I don't much do that anymore. So I'm so, I'm so grateful for all the family. I really don't have any regrets about my family. I'm grateful for all the families I've had, especially grateful

> today for the numerous different people who I consider family. My family of origin and my husbands and my kids and my step-kids and grandchildren. People I've worked with. People I have as friends. People that I've done therapy with...I'll say that my definition of family has grown so and it encompasses all those people now in my life that care about me and I care about them and we have things in common.

Carroll (1987) describes the "journey home" as follows: 1) becoming disillusioned with one's reality and one's roles; 2) stopping attempts to change others; 3) perceiving reality in a new way; and 4) allowing a new reality to develop from one's greater understanding of oneself and the world. These participants have lived and continue to live the experience of this journey home from their active chemical use to recovery. They have traveled on their journey by disconnecting from some relationships, creating and maintaining new connections, and reconnecting in new ways that have both impacted and been impacted by their recoveries.

Summary

This chapter presented excerpts from the transcribed text from Kathy's and Lauren's interviews in relation to the theme of connecting. It presented a discussion of the excerpts in relation to the literature on spirituality, family roles, and substance dependence. The next chapter discusses implications of the findings of this study.

CHAPTER SIX

IMPLICATIONS

Introduction

This chapter will discuss the contributions, strengths and limitations of the study. Implications for social work practice and policy will be presented as well as direction for future research.

Contributions of the Study

The participants in this study were well "storied," sharing information and experiences freely with few prompts. The study's design allowed this information to be shared in depth from which detailed descriptions of the experience were able to be developed. Women's unique experiences with chemical misuse and recovery as well as the impact support systems have on them have not received sufficient attention. This study contributed to a deeper understanding of these experiences. It allowed these stories to be viewed as part of women's gender and role experiences. These women were able to define and explore the meaning these experiences had for them.

Strengths and Limitations of the Study

Because the participants each had several decades of recovery, the progression of their experiences was able to be placed in a wide context allowing them to compare early experiences with those that came later. This study could be strengthened by including stories of participants with varying lengths of sobriety and with diverse ethnic backgrounds.

The participants' clarification and expansion on my interpretation allowed them to be part of the process of interpretation. It also gave them time to reflect on their stories which in turn led to additional details of their experiences. The

first interview was done in person with both participants, which was one participant's preferred mode of expression. The second interview was done in writing by mail without the researcher present. Writing was one participant's strength. She felt she expressed herself better in writing than in a face-to-face interview. Using two different interview techniques allowed each participant a chance to express herself in a manner most comfortable for her.

During the interviews, I found it difficult to maintain a hermeneutic approach and avoid a clinical approach. There were points during the interviews when I wanted to probe further to elicit more information. I was reluctant to do so, however, because I was unsure of how to use the probes in this context. As an example, I would have liked to have known if a relapse occurred and, if so, how family members reacted. This reflects the limitation of being a novice researcher lacking experience with hermeneutic interviewing in which each interview informs the next.

Finally, only the researcher's interpretation was used. Interpretations may have been enriched by more viewpoints, such as those of a hermeneutic research team.

Implications for Social Work Practice and Policy

Hermeneutic studies are not designed to be generalizable. This study, however, does have implications for social work practice and policy involving substance dependent people, their support systems, including family members and treatment.

Listening is an important skill for clinicians. During the interviewing and interpretation processes involved in this study, I found my listening skills were challenged. Continuing to hear and stay true to the participants' voices while reading and interpreting the transcripts was especially challenging but critical

(Plager, 1994). I have been trained to search for criteria to diagnose and then provide or refer to interventions that move clients beyond their present reality to a more workable one for them. It was tempting to use my past experience and knowledge of "similar cases" to assume an understanding of the participants' stories. While the hermeneutic researcher influences the text, s/he must hear clearly the voice in the text (MacLeod, 1996). This required me to stay fully present and self-aware during the interviews and the interpretive process.

Because of this awareness during the interpretive process and having to return to the transcripts to check my understanding of the participants' words, I found myself able to move beyond the urge to explain and solve. I was then able to listen and understand from a new perspective and in a deeper way. This ability is invaluable to my clinical work because it affirms the necessity to view each client as unique and to hear her story with a goal to first understand and empathize. Only then can I support and assist that client's journey to find her own answers. The participants in this study grew when they connected with others who let them be themselves and who allowed them to walk their path at their own speed. Their peers were willing to share with the participants pieces of their own experience and knowledge and walk with them. My clinical work, then, has grown beyond finding the answers for my clients to helping them see their reality clearly enough so they can find their own. I will do this by listening carefully and intensely and then together we will search for the shared meanings that will enhance their journey.

I have found objectivity to be a limitation in working with clients. Conducting this research has confirmed for me that while I must stay grounded in my own context, I am more effective when I involve myself in the worlds of my clients.

Listening is not only for individuals but also for institutions. Many treatment centers provide programming that is cost efficient and convenient for the center without taking into account individual needs. Individualized treatment plans are often precluded due to funding restrictions. Therefore, each person must fit into the agency's program rather than the agency creating an individualized and specific plan to meet the needs of the particular client (Nunes-Dinis, 1993; Smith, 1986). Research by Prochaska, DiClemente and Norcross (1992) indicates that clients cycle through stages of change (precontemplation, contemplation, preparation, action, and maintenance), arriving in treatment at different stages. These authors emphasize a need to assess the stage the client is at in order to increase the chances of clients making lasting changes. Interventions can then be tailored to the particular client and particular stage. If programs address the needs of clients at only one stage, they "are likely to underserve, misserve, or not serve the majority of their target population." (Prochaska, DiClemente & Norcross, 1992, p. 1105).

Substance dependence is considered a disease that involves isolation (Gorski & Miller, 1988; Johnson, 1986). While the substance dependent individual is not necessarily isolated physically, the relationship with the chemical becomes primary to the dependent individual. This relationship most often is maintained at the expense of meaningful connections with other people (Johnson, 1986). Connection with supportive people, as indicated in this study and in the literature, is an important factor in recovery.

Because connection is important, identifying and mobilizing effective support is an important role for the practitioner and for policy makers who deal with substance dependence. Connections with professionals were shown to be important to the participants in this study. Policies of treatment centers and

funding agencies ought to be reviewed to better meet individuals' needs for support.

Heidegger considered the world to be a part of the self (MacLeod, 1996). Individuals both construct and are constructed by their worlds (Koch, 1995). The importance of Heideggerian philosophy in regard to treatment center policies becomes apparent when the goal of treatment is examined. This goal is to move substance dependent people from the world of chemical misuse and all that entails to another world consisting of sobriety and recovery. Policies of treatment programs are influenced by managed care mandates for brief therapy types of interventions and limited stays. Changes that occur within these limitations are generally short term and can disappear over time (IOM, 1990; Prochaska, DiClemente & Norcross, 1992). Clients are members of the culture of chemically dependent people and must reidentify with a new culture of sobriety to maintain long term recovery. This entails change in belief systems and major life adaptations that take time to develop (Prochaska, DiClemente & Norcross, 1992). Punitive policies interfere with the reidentification process by limiting the number of treatments in which an individual can participate. In addition, chemically dependent people often cannot reenter a treatment program for additional support unless they reach the end of the relapse process and return to chemical use.

While the initial phase of chemical dependency programming can be intensive and brief, long-term supportive programming that could include home visits is needed as a follow-up. Ongoing scheduled meetings with professionals in both group and individual contexts may result in an increase in the number of those who attain long term recovery by supporting their gradual adjustment to a new world.

The literature indicates that family support is an important variable affecting the ability of individuals to attain sobriety and remain in recovery (Galanter, 1999; Garrett et al., 1999). The experience of these participants, however, indicates that the benefit of family support is dependent upon the functioning level of the family system. Families can indeed contribute to the sobriety of that member, but families can also be quite destructive in their dealings with the substance user (Davis & DiNitto, 1996; Nelson-Zlupko, Kauffman & Dore, 1995). The literature also indicates that families can be part of an environment that increases the difficulties faced by chemically dependent people, especially women (Rhodes & Johnson, 1994; Underhill & Finnegan, 1996). Therefore, assessment of both the substance user and the family is beneficial. Separate services could be provided to each party before bringing them together for family treatment when it is determined by another independent professional assessment that this would be appropriate for all concerned.

The multiple needs of families could be met by providing assessment for both mental health disorders and substance dependence prior to attending the family program. If additional services were determined to be beneficial for the family member before s/he attended family programming, those services could be provided by the treatment center or referral could be made to an appropriate site. If family could receive services prior to attending family programming with the chemically dependent person, then both the family and the substance user might have a better chance to resolve their often long-term conflicts. Otherwise, it is possible for the family, substance user, and the treatment counselor to become enmeshed in a triad and a dynamic that often results in an impasse for all parties concerned. The woman and her family may be experiencing different realities in group and at home which are not expressed in the treatment setting. The

counselor responds to what s/he observes being presented in the treatment session without addressing the often unknown reality that both the woman and the family may be experiencing outside of the therapeutic environment. Interventions, then, may be ineffective because they are based on roles being played by the clients and families rather than on their lived reality (Marilyn Schaefer, personal communication, May 15, 2000).

Finally, chemical dependency continues to be stigmatized (Fillmore, 1984; Rhodes & Johnson, 1994). It is hoped that through sharing the in-depth experiences of two chemically dependent women with various types of support, including professional support, that practitioners will examine their own biases in this area to make their work with this population more effective.

Future Research Studies

This study has discussed the importance of connections for these substance dependent women. Connection with spirituality was a theme for both participants. Future research is needed to investigate the meaning spirituality has for recovering substance dependent people, especially those who have maintained sobriety for long periods of time. Questions that are raised by this spiritual connection are: 1) how is spirituality experienced by family members of substance dependent people?; 2) does spiritual growth occur for them and, if so, is it important in their own recovery?; and 3) how does the family members' spirituality, growth and recovery affect their support of the substance dependent person.

Having investigated substance dependent women's experience with family support, qualitative research could be conducted on the experience of family members with their substance dependent family members. This type of research

would point to the impact those with chemical dependency have on other non-chemically dependent or former chemical misusing family members.

Support systems are important for chemically dependent people attempting sobriety. Further research is needed beyond referrals to Alcoholics Anonymous or Alanon to discover ways that facilitate helpful connections in this population. This research could include an examination of the benefits and costs of disconnecting from various types of family members and what factors facilitate reconnection. Research with larger numbers of chemically dependent women could enrich and broaden understanding of their experiences with various support systems.

Finally, this study has raised questions regarding the intensity of nonsupportive and sabotaging behaviors found in some spouses and partners of chemically dependent women. Future research studies into the dynamics of these relationships and their impact on women attempting sobriety could provide insight into treatment issues and solutions.

ENDNOTES

Terms important in Heidegger's philosophy and hermeneutics are defined in this section.

Background-Background is handed down to an individual at birth. It is the culture that individual is born into as well as their way of viewing and understanding the world and cannot be made completely explicit. Background determines what the individual will understand as real (Koch, 1995).

Clearing-Heidegger believed the body is irrevocably connected to the world (Benner, 1994). The shared background that makes it possible to have shared as well as individual interpretations of the world is referred to as the clearing and allows humans to understand what it means to be human and allows the interpretation of human activities (Plager, 1994).

Co-constitution-This is the relationship between an individual and her/his world. According to Heidegger, an individual cannot be separated from her/his world because "from the beginning the person is amongst it all, being in it, coping with it" (Koch, 1995, p. 831). Individuals both construct their world and are constructed by it (Koch, 1995).

Fore-conception-This is the anticipated sense of what interpretations will reveal and is shaped by our background practices (Fitzpatrick, 1997).

Interpretation-Heidegger believes individuals are self-interpreting beings. Everything the individual encounters is filtered through that individual's background and experience (Koch, 1995).

Pre-understanding-Pre-understanding is a structure for individuals in the world and cannot be eliminated. It is the "meaning and organization of a culture which are already in the world before we understand" (Koch, 1995, p. 831). Whenever an individual encounters a new situation in her/his life, that individual's pre-understanding is brought with her/him into that situation.

Note: Adapted from Yager, N.M. (1999). Grieving the loss of a partner: The ways of isolation: A hermeneutic experience. Unpublished master's thesis, Augsburg College, Minneapolis, MN.

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APPENDIX A

INTERVIEW QUESTIONS

To be asked by the researcher

IRB 99-56-3

1. Tell me what family support means to you.

2. Based on your definition, tell me about your experience with family support before you entered treatment.

3. Based on your definition, tell me about your experience with family support during treatment.

4. Based on your definition, tell me about your experience with family support after treatment.

5. Tell me how your family support, or lack of family support, affected your ability to decide to come to treatment.

6. Tell me how your family support, or lack of family support, affected your ability to decide to stay in treatment.

7. Tell me how your family support, or lack of family support, affected you after treatment.

8. Tell me what your recovery program consists of for you.

9. Tell me overall, how did family support help or hinder you to work your recovery program?

APPENDIX B

RECRUITMENT SCRIPT
IRB 99-56-3

Hello, my name is Christina Decker. _____ has told me that you might be interested in participating in my research study. What have you been told about it? Let me tell you more about this project. I am currently in my final year of a Master in Social Work program at Augsburg College. As part of our program requirements we work on a thesis, or research paper, in an area of interest to us. I have chosen the issue of family support in addiction; specifically what the experience of addicted women who have gone through treatment has been with family support. There is literature that discusses the importance of family support for influencing addicts to seek treatment, to remain in treatment, and to remain in recovery. I would like, however, to find out what your experience with family support has been, what stands out for you and what it has been like for you to have this experience.

What the process would entail is a 90-minute in-person interview in which I would ask you a few questions. I would like to audiotape the interviews for transcription purposes, but these audiotapes and papers would be destroyed when I am through with my thesis for confidentiality purposes. You will also be asked to read through an interpretation of your interview for accuracy.

This is completely voluntary. You will receive a gift, total value $10.00, as an honorarium whether or not you complete the interview. Indirect benefits include helping to improve the understanding of the researcher and social work practitioners about your experience and the ability for you to reflect on and share your experiences with family support. Is this something in which you would be interested in participating?

If yes, when is a good time for us to conduct the interview?
If no, thank you for your time.

APPENDIX C

Confidentiality Form

IRB 99-56-3

This research study includes sensitive and confidential information about individuals. This information is shared with you confidentially for the purpose of being transcribed. By signing this form you are agreeing to not reveal names, identifying information or any of the content of the interviews.

_____

Name of Transcriptionist

_____ _____

Signature Date

APPENDIX D

CONSENT FORM

A HERMENEUTIC STUDY OF ADDICTED WOMEN'S EXPERIENCE WITH FAMILY SUPPORT

IRB 99-56-3

You are invited to participate in a research study designed to look at the lived experience of addicted women with family support. Participation is completely voluntary. This study is being conducted by Christina Decker, an MSW student at Augsburg College, as part of the MSW thesis requirement.

What will happen during this study?
The study consists of one audiotaped interview lasting about 90 minutes. Interviews will be conducted by a Master of Social Work student who is working on her thesis. You will be asked to relate stories about your experience with family support prior to beginning treatment, during treatment, and after treatment. Once I have written an interpretation, I will contact you to review the written text. Changes may be made to that interpretation to reflect your comments.

Are there any risks?
It is possible that through the discussion and recollection of your story, painful memories or thoughts could occur. After the interview I will provide a referral for you to contact should the need arise.

Are there any benefits?
It is possible that you could experience some enhanced sense of well-being or sense of satisfaction as a result of telling your story. Also, participants will receive a personal gift worth $10 after the study as an honorarium.

When and where will the interview be done?
The interview will be scheduled at a time and place that are convenient for you. Interviews will be done in person.

Who will have access to the interview material?
The audiotaped interviews will be transcribed by a trained transcriptionist and then destroyed. The trained transcriptionist will be required to sign a confidentiality form to ensure your privacy. Any identifying information from the interview, including your name, will be removed or altered on the written transcript. The transcripts will be shared with the researcher's thesis advisor during the process of writing the thesis. Transcripts will be identified with

If you have any questions or concerns you may reach me at:

Christina Decker
Augsburg College, MSW student
Business Phone: 612-892-2115

Or if you need further information, you may contact my thesis advisor:

Maria Dinis, Ph.D.
c/o Augsburg College
Business Phone: 612-330-1704

APPENDIX E

AUGSBURG INSTITUTIONAL REVIEW BOARD LETTER

MEMO

October 14, 1999

TO: Ms. Christina Novak

FROM: Dr. Lucie Ferrell, IRB Chair

RE: Your IRB Application

Thank you for your prompt response to IRB concerns and questions regarding your study, "A Hermeneutic Study of Addicted Women's Experience with Family Support." You have met the conditions and are granted IRB approval, number 99-56-3. Please use this on all official correspondence and written materials relative to your study. One last stipulation, though, is that you may not use your home phone number as the contact number for potential participants. That is the policy of the IRB instituted in protection of the researcher.

Your research should prove most interesting and professionally valuable. We wish you every success.

LF:lmn

c: Dr. Maria Dinis