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Grief and Loss Issues and Women's Drinking Patterns

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GRIEF AND LOSS ISSUES AND WOMEN'S DRINKING PATTERNS

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This project is dedicated to my mother
Florence May Moran
(1903-1958)
who gave me the skills
to live, to love, and to survive
without her presence.

It is the image in the mind that links
us to our lost treasures;
but it is the loss that shapes the image,
gathers the flowers,
weaves the garland

--Colette, *My Mother's House*

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Grief and Loss and Women's Drinking Patterns

by

Joyce Moran Halstrom

GRIEF AND LOSS ISSUES AND WOMEN'S DRINKING PATTERNS

A QUALITATIVE STUDY

JOYCE MORAN HALSTROM

MAY 12, 1998

This exploratory, qualitative study was undertaken to explore the relationship of grief and loss and women's drinking patterns. The literature review focused on major contributors of grief work, theoretical frameworks of the grieving process, and an overview of alcoholism in women. Ten women who were recovering from alcoholism in a half-way house were interviewed using open-ended, semi-structured questions. The interviews focused on the respondents' drinking patterns, their grief and loss issues, and the treatment of those issues in their chemical dependency treatment program. Implications for social work practice is included. Results indicate the importance of prevention, intervention, and education of women regarding the relationship of grief and loss and women's alcoholism and illustrate the theme of circularity that emerged in this study.

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CHAPTER ONE

INTRODUCTION

Few national prevention efforts have been focused on reaching women regarding alcohol and drugs and their impact on the lives of women. Even fewer have linked alcohol problems with grief and loss issues such as domestic violence, sexual abuse, incest, underemployment, poverty, marital difficulties, death of a significant person, developmental changes, and other dramatic losses (Roth, 1991).

That people drink alcohol to regulate the quality of their lives and emotional experiences is widely accepted. Both anecdotal and scientific evidence tell us that alcohol is used as a coping mechanism (Allan & Cooke, 1985; Gomberg, 1996; Kauffman & Dore, 1995; Martin & Privette, 1989; Nelson-Zluppko, Kauffman & Dore, 1995; Rando, 1994). However, while most alcoholism treatment programs teach skills for coping with feelings, few, it appears, attempt to help women process their grief and loss issues inherent in the problem (S. Fuchs-Hoeschen, personal communication, December 10, 1997).

Background of the Problem

The use, misuse, and abuse of alcohol is one of the major health problems in the United States and ranks as the third most prevalent public health problem today. The problems associated with alcohol are not just limited to health but lead to familial, vocational, social, and legal problems (Pattison & Kauffman, 1982).

Local and National Data on Prevalence of Alcoholism

Misuse of alcohol is a serious problem in many rural counties (one in which county this project was proposed). Population comparisons of at-risk drinking are higher in this rural county than the rest of Minnesota and United States. The Board of Health (1995) cited that, during the Community Health Assessment recently compiled for the county in which this study was proposed, misuse of drugs and alcohol ranked first and second in the survey in the category of "Serious Problems Needs More Attention."

A report released by the Minnesota Department of Human Services Chemical Dependency Division (1994) stated that the county alone spends $250,000 per year on this population. In 1993, 486 clients were admitted to the tri-county area detoxification center for a total of 1,111 days. Admissions to chemical dependency treatment programs in the county for 1993 were 4.42 per 1,000.

Women and Alcoholism

Nearly 6 million women in the United States are either abusers of alcohol or are alcoholics (Blume, 1988; Roth, 1991). Moreover, during the last 10 years, there has been a considerable increase in the numbers of women appearing for treatment (Blume, 1988).

Over 70% of women in treatment for alcoholism are survivors of incest, rape, or other sexual abuse, and the rate of alcoholism among battered women is 160 times greater than in non-battered women (Roth, 1991). In 74% of battered women cases, alcoholism emerges after the onset of abuse (Banks, 1989). Lesbians have higher rates of alcohol and drug problems than other women (Morales & Graves, 1983). The reported rate of alcohol abuse among lesbians is estimated to be as high as 30% to 35% (Glaus,

1989; Hall, 1990; Saunders & Valente, 1987). The trauma of the coming out process and the subsequent alienation one experiences from others have been viewed as factors in alcohol and drug abuse. Saunders and Valente (1987) acknowledged that alcohol use is one way that lesbian women cope with the "hatred, fear, and isolation they feel from society at large" (p. 7).

Copeland and Hall (1992) reported that 86% of women who enter treatment have experienced sexual or physical abuse at some point in their lifetime. In a study of 117 women volunteers from Alcoholics Anonymous, Kovach (1986) discovered that 29 of those women had suffered the experience of incest in childhood.

Women in these situations are grieving. They are grieving the loss of their dreams, their innocence, their integrity, and their honor. In contrast to the somewhat large body of literature that deals with the alcoholic personality, there is little written about the coping styles of alcoholics. In fact, the use of alcohol itself has been considered a popular vehicle for coping with life stress (Conte, Plutchik, Picarad, Galanter, & Jacoby, 1991).

Some of our understanding of women and alcoholism comes from a nationwide study by Wilsnack and Beckman (1984). Wilsnack and Beckman collected information from over 900 women drinkers. Their study revealed that the characteristics of women with the highest rate of alcohol problems varied according to age. Risk factors for women in the youngest group (21-34) were never having married, childless, and not employed full-time. These, it was conjectured, were young women who had not yet taken on expected adult roles. Among women aged 35-49, those who were divorced or separated, unemployed, or with children no longer living with them, had higher rates. These were women who had taken on adult roles and lost some

of them. The age group that showed the most alcohol problems were those women aged 50-64 who were married, not employed outside the home, and had children no longer living with them. These women revealed traits similar to the "empty nest" syndrome characteristic of women who had lost significant roles in their lives. Though this important study appears to clarify the relationship of alcohol problems to transitions and losses in women's' lives, additional research is needed to discover if those transitions led up to the alcoholism.

Gearhart et al. (1991), Gomberg (1996), Plant (1980), and Weathers (1995) reported that women drink in response to stress in their environment. Blume (1988) and Wilsnack, Klassen, Schur, and Wilsnack (1991) concurred and added that women in treatment for alcoholism are more likely than men to relate the onset of pathological drinking to a stressful event. They are also more likely to be depressed, have symptoms of anxiety, and suffer from low self-esteem. Wilsnack et al. (1991) suggested that the three primary types of stressful life events that are associated with substance abuse are: biological events unique to women, psychosocial changes such as marriage and divorce, and problems such as death, retirement, health problems, and marital difficulties.

Women are more likely than men to use drugs to numb their anger because anger is generally seen as "taboo" for women and they learn it is better to take a tranquilizer, eat a piece of cake, or drink, than to express their anger (Jacobson, 1982). A study done by Conte et al. (1991) found that different coping styles were found between groups of non-alcoholics and alcoholics. Unlike the nonalcoholics, alcoholics, as a group, tended to cope

by avoidance, engaging in indirect problem-solving behavior (such as drinking) to reduce their tensions.

Alcohol as a treatment for grief relieves some of the pain of loss. It helps the griever to distance and deny, facilitates sleep, and may help the griever talk about the loss. Unfortunately all of these effects of alcohol encourage the griever to rely on it to cope, thus increasing their risk for dependency on it (Parkes & Weiss, 1983). The child who suffers the loss of her mother through death often turns to alcohol and drugs in adult life in an attempt to fill the empty space, to mother herself, to suppress feelings of grief or loneliness, and to get the nurturing she feels she lost or never had (Estes, 1990).

Unresolved grief has been found to be a factor in the development or perpetuation of a wide range of psychological problems including depression and addiction to alcohol (Matsakis, 1992). Seeking euphoria and using alcohol to cope with life's problems are commonly cited reasons for initial and repetitive use among alcohol abusers in treatment. Further, reliance on alcohol to cope may lead to further deterioration in adaptive coping (Cooper, 1995).

A thorough understanding of the grieving process is key to helping women reach recovery. Treatment, to be effective, must consist of helping women work through their losses by working through the grief process. It is in the repetitive telling of their story that grievers work through the stages or the phases of the grieving process (Rando, 1984). Obershaw (1992), in his book Cry Until You Laugh , reminds us that:

> If we don't learn to recognize the losses in our lives, learn to identify the feelings that result from those losses, and learn to work through the

> grief that results, it isn't long before the losses, and the grief build up to the point of overwhelming us. When we are overwhelmed, all we know is that we want out. We want to quit. We just want the pain and hurt to stop. And we will do whatever it takes to make the pain stop. (p. 71)

It is this very work of recognizing our losses and working through the accompanying grief, that could serve to promote recovery from alcoholism and decrease recidivism among women alcoholics (S. Fuchs-Hoeschen, MSW, personal communication, January 3, 1998).

Purpose of Proposed Research and Significance to Social Work.

The first and ultimate purpose of this research is to explore the impact of grief and loss on women's drinking patterns. The researcher's cumulative personal and professional experiences in grief and loss provided the impetus for this study. Ten years of working in a hospice program as a social worker and grief counselor, combined with 2 years of chemical dependency counseling in an alcoholism treatment program, gave birth to this study. Personally, the researcher was a bereaved adolescent whose mother died when the researcher was 17, followed 1 1/2 years later by the death of her father. As a current social worker and chemical dependency counselor in a rural high school, the researcher is concerned with prevention of alcohol and drug use, for which this research is of particular significance.

Finally, the Council on Social Work Education (CSWE) does not currently provide curriculum content specific to grief and loss (CSWE, 1994). Peyton (1980) found that studies indicate social workers as a group are deficient in the making of early diagnosis and interventions of alcoholic clients. Further, where alcohol abuse was suspected, social workers did not make appropriate referrals. Rando (1992) believes that the mental health

profession is also deficient in the knowledge of grief, loss and bereavement and because of that, often promote the myths of grieving pervasive to our society. Those myths include the myth there is a predictable and orderly progression to the experience of grieving and that the goal of a griever should be to "get over it" (Wolfelt, 1989).

This research may provide impetus to include curriculum on grief and loss and alcoholism for social workers and mental health professionals, and it may fill a gap in the literature on the relationship of these two powerful issues.

Research Questions

The research questions studied were:

1. What is the impact of grief and loss issues on women's drinking patterns?
2. How are women's grief and loss issues dealt with in their chemical dependency treatment program?

Summary

This chapter has outlined the prevalence of grief and loss issues in women who enter treatment for alcoholism. This study will address those issues and demonstrate the need for a greater understanding of the process necessary for the resolution of grief and loss. Chapter 2 will discuss a review of the literature on grief and loss and includes a historical perspective and theoretical and conceptual frameworks of grief. Chapter 3 explains the methodology used for this research study. Chapter 4 presents the results of this study, including summary tables of the findings. Lastly, Chapter 5 will discuss the findings in relation to the framework used and the literature reviewed. Limitations of this study, implications for social work practice, policy development, and future research recommendations are included.

CHAPTER TWO

LITERATURE REVIEW

The field of bereavement has grown considerably since Kubler-Ross (1969) dared to focus on a once taboo subject, death and dying. As she helped conceptualize the needs of both the dying and the bereaved, she gave the helping professional "tools" for working with the grieving population. We have only recently become aware that there are losses other than death that require the help, the understanding, and the use of those tools. Victims of battering, rape and incest, along with illnesses like stroke, HIV, and alcoholism share the same dynamics as those who are surviving the loss of employment, health, and body parts, and are but a few of the losses that require the process of grieving.

Due to cultural and personal reasons that preclude grieving, many people suffering from a loss are prevented from experiencing feelings that accompany loss in order to ensure a healthy resolution of the trauma. Increasingly, unresolved grief is being recognized as a precursor to a wide range of physical, mental, and emotional disorders and diseases (Simos, 1979).

In this chapter, definitions of terms, major contributors to grief work, and theoretical frameworks of grief will be presented.

Definitions of Terms

Bereavement--"Bereave" and "rob" are derived from the same root, which implies deprivation of something valued (Rando, 1993).

Grief--the emotion felt when experiencing loss (Wolfelt, 1988).

Grieving--the full range of coping responses to significant losses (Wolfelt, 1988).

Mourning--the outward expression of grief influenced by societies and cultures that tell us how to behave in response to loss through death (Wolfelt, 1988).

Contributors of Grief Work: A Historical Perspective

An earlier modern contributor on grief and loss was Sigmund Freud (1917), with his paper on "Mourning and Melancholia." He described mourning as:

> the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, and so on . . . It is also well worth notice that, although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (pp. 243-244)

Freud (1917) reinforced a well-known belief that normal grief is a by-product of any loss and is not necessarily confined only to losses involving a death. Freud's departures from a normal attitude toward life are consistent with characteristics generally associated with grief of a crucial and profound loss and include a decreased interest in life and the world, loss of ability to love, and a loss of interest in activities that do not involve connections with the loss.

In 1944, a landmark study by Lindemann, another important contributor to the field of grief and loss, followed a famous fire at the Coconut Grove in Boston. One of the most important conclusions from his study was that grief is not only natural to the human condition but also a necessary reaction

following a significant loss (Rando, 1984; Simos, 1979; Wolfelt, 1988). Lindemann (1944), although trained in the psychoanalytic perspective, made a major contribution in the area of physiological nature of bereavement. Like Freud, Lindemann was interested in learning to distinguish between normal grief and pathological grief. He was the first bereavement researcher to discuss the somatic characteristics of grief that include choking, shortness of breath, tightness in the throat, an empty feeling in the stomach, lack of muscular strength, and intense distress (McNeil, 1995).

Another aspect of Lindemann's work was the operationalization of three tasks necessary for the completion of grief work: (a) emancipation from the deceased, (b) readjustment to the environment in which the deceased is missing, and (c) the establishment of new relationships. Lindemann (1944) and Freud (1917) are the two most frequently quoted early modern theoreticians in the field of bereavement (McNeil, 1995).

Bowlby's (1969) attachment theory plays a major role for bereavement researchers in explaining the reactions of most people to major loss. Based on observations of animal behavior after separation and loss, it views the behavior of grieving that is seen in a child's crying when a parent disappears as an aggressive instinct that is designed to retrieve the "attachment object" on whom safety and affection depend at any cost. According to Bowlby's theory, the intense feelings of grief are beyond conscious control and are triggered by the threat of serious loss.

Bowlby (1969) and later Parkes (1974) presented their theories of the grief process and both endorsed the following phases of the grief process:

1. Numbing lasting from hours to weeks following a loss.

2. Yearning and searching with strong urges to find, recover, and reunite with the lost person.
3. Disorganization and despair characterized by surrendering the search.
4. Reorganization and establishment of new ties to others, return of appetite, and interests of daily living.

No study of grief and loss is complete without including the work of theorist Kubler-Ross (1969). Kubler-Ross pioneered the movement on grief and loss more than 20 years ago when she observed that the journey of death and dying took its victims down an emotional path that knew no boundaries of race, religion, and gender. Understanding this dynamic, she believed, was a key to helping people through the difficult process of coping with both their own death and the loss of their loved ones (Kubler-Ross, 1969). After Kubler-Ross' dissemination of her research, other people began to build on her ideas creating a new school of thought called thanatology. Thanatology comes from the Greek *thantos* , which means "death." However, it is not as much about the study of death itself as it is about the human reaction to death.

Theoretical and Conceptual Frameworks of Grief

This study will focus primarily on the theories of Attig (1996), Kubler-Ross (1969), and Worden (1991) and their application to the field of grief and loss and social work.

Kubler-Ross (1969) outlined five stages that accompany a person's realization that they are dying:

- Denial
- Anger

- Bargaining
- Depression
- Acceptance

These stages have been used to identify grief of the survivor as well as the deceased. They also have implications for other important losses including, but not limited to body parts, employment, health, miscarriage, divorce, and abductions. In the treatment of alcoholism, they have been used to help identify dynamics associated with the loss of freedom to drink. Initially, Kubler-Ross' (1969) stages were thought to occur in the given order. It is more acceptable today to understand these stages in terms of being circular rather than linear. One does not pass from one stage to the next in orderly fashion, but rather presence in those stages are random and circular, continuing for some, throughout the life cycle and most certainly appearing at different mileposts throughout life (Sr. J. Iten, personal communication, August 15, 1997).

Worden (1991) identified and organized his theory by tasks, rather than stages. Here, too, it is important to recognize that one does not progress neatly from one task to the next . Frequently, tasks need to be repeated at different developmental stages in the life of the griever. The task theories identify grieving as something that we do. Rather than remaining passive, the griever actively engages the challenges of letting go, seeks ways to make sense of a new reality, and searches for new meaning in life. Worden's (1991) tasks are:

1. <u>Acknowledging the reality of the loss.</u> This means care must be taken to avoid denying the loss and accepting the reality that loss has truly happened.

2. Experiencing and working through the emotional chaos. To accomplish this task, it is essential to find expression for all of the attending emotions as opposed to the suppression of them.
3. Adjusting to the environment where the deceased is missing. This task challenges the griever to define new life patterns.
4. Loosening ties to the deceased. The withdrawal of emotional energy from the grieving process and reinvesting it in relationships defines this fourth task.

Worden's (1991) tasks provide opportunity for growth on a cognitive, behavioral, and feeling level. The task of acknowledging the reality that loss has happened challenges the intellect and spirit as attempts are made to take in the loss and information surrounding it. It is the opposite of denial. Funerals, wakes, and other cultural practices provide meaningful ways of helping grievers accomplish this task.

Working through the emotional chaos is related to the emotional and psychological facets of coping and efforts to process the feelings. Healthy grieving allows for expression, rather than suppression of all feelings associated with the loss.

Adjusting to the environment entails dealing with behavioral coping and exploring the world with a new definition of self in the context of the loss. Widows and widowers who have been married for many years find this task especially difficult as they face new social status as a single people. Grievers over the loss of limbs or body parts are also challenged here as are alcoholics with a new descriptor of "sober" after treatment.

Finally, loosening ties deals with social coping, preparing for new relationships, and relegating that which was lost to the past to make way for

the present and the future. This task involves a "letting go" process which for some, depending on the severity of loss, may take years to reconcile.

Attig (1996) offered his belief that grieving is a process of "relearning the world" (p. 11). His view is that bereavement disrupts our learned behavior and our way of relating to the world around us, forcing us to learn new ways in the following areas of our lives. His tasks involve the following:

1. Relearning physical surroundings. This entails coping with special places of the deceased such as their bedroom, play area, or office. It involves sorting contents of a dresser or closet, perhaps a wallet. It also challenges families to adjust to a missing place at the dinner table. For others, this loss may mean the griever's need for a geographic move such as daycare, college, new employment, rehabilitation, or, in some cases, a new home (Attig, 1996).
2. Relearning relationships with fellow survivors. Attig (1996) tells us that this task may involve the difficulty many bereaved parents have in taking care of surviving children. The role of a son-in-law when the daughter in a family dies is a question that begs to be answered during bereavement. Each family member, then, is forced to learn new behaviors with one another. Friendships and acquaintances become transformed through the loss, many avoiding the bereaved for fear of saying the wrong thing. Families are forced to make new and different alliances. In the case of the recovering alcoholic, it involves relearning friendships as a sober person. For a newly divorced victim of domestic violence it may mean establishing new and

different relationships with the children in the context of a single parent.

3. Relearning places in space and time. Holidays, birthdays, anniversaries, etc., challenge survivors. Relearning on these occasions include deciding whether or not to celebrate. Maintaining or not maintaining traditions becomes a monumental task and with it, stress and utilization of energy. It is within this task that we come to live life differently without our loved one in the picture. This is especially difficult the first year following a loss (Attig, 1996).

4. Relearning spiritual places in the world. The bereaved often feel victimized by death. They frequently see no end to the pain in their future and feel out of control and helpless. Many feel abandoned by God and seek to recover a sense of safety and security with an intense wish to stop feeling fearful, anxious and vulnerable. The victim of rape who grieves the loss of her innocence, the newly diagnosed cancer patient, paraplegic, or person suffering from a traumatic brain injury, feels the same sense of being out of control and helpless. Interestingly enough, a symptom of the disease of alcoholism is "loss of control," and the 1st of 12 steps to recovery for the alcoholic is admission that life has become unmanageable. (Anonymous, 1952)

Attig (1996) believes that his theory of grieving as relearning fosters respect for individuality because it emphasizes the grieving process is, and needs to be, accomplished in a unique way by each individual.

Attig (1996), Bowlby (1961), Freud (1917), Kubler-Ross (1969), Lindemann (1944), Parkes (1964, 1970, 1972), and Rando (1993) acknowledged that grief and loss challenge us psychologically, behaviorally, physically, socially, intellectually, and spiritually. There is also agreement in the field of theorists that feelings frequently felt during a time of grief and loss are: sadness, guilt, loneliness, rejection, abandonment, relief, numbness, anger, shock, yearning, anxiety, and fatigue.

Cognitively, grief is felt through disorientation, preoccupation, confusion, and disbelief. Behaviorally, grieving people may respond with sleeplessness, pacing, crying, hyperactivity, angry outbursts, appetite disturbances, wearing clothing of the deceased, sleeping in their bed or bedroom, and, in many cases, accelerated drug use such as caffeine, alcohol, and tobacco products.

Grieving people are all too vulnerable to well meaning people who, not wanting to see them saddened, offer alcohol or medication, "Here take this and you will feel better," they are often told. It is not just by chance that alcohol use and abuse become problems for many grieving people since alcohol is the most common form of self-medication during any bereavement. Many subcultures indeed condone and encourage the use of alcohol during times of loss. However, because alcohol can be psychologically as well as physically addicting, patterns easily develop with resulting addiction. Increased alcohol also leads to additional depression with its accompanied sleeping and eating disturbances (Wolfelt, 1988). Wolfelt acknowledged "when alcohol or other drugs take on a abuse or dependence pattern within a mourner, these problems must be addressed before grief reconciliation can occur" (p. 137).

Normal Grief

Normal grief is comprised of the following characteristics that seem to be generally common in people following a loss (Attig, 1996; Lindemann, 1944; Rando, 1984; Simos, 1979; Staudacher, 1987; Worden, 1982). Sadness is the most common feeling which may or may not be manifested by crying and because of its universality, needs no further explanation. Anger appears to have its roots in the belief that someone is to blame for the loss and is a common and normal response in grief. The anger and blame is frequently directed toward the lost person or object but is also directed at God, the physician, family members, society, etc. If anger is not acknowledged it can lead to complicated grieving (Rando, 1984).

Guilt and self-reproach are common experiences of survivors. Guilt usually occurs over something that happened or something that did not happen at the time of the loss. "I wish I would have . . . " are words frequently heard from someone experiencing a loss (Sr. J. Iten, personal communication, August 15, 1997).

Anxiety can range from a slight case of insecurity to strong panic attacks. It usually results from fear that it will be impossible to continue with life after loss occurs. Lewis (1961) described his anxiety after the death of his wife with the words:

> No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restless, the yawning. I keep on swallowing. At other times it feels like being mildly drunk, or concussed. There is sort of an invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps, hard to want to take it in. It is so uninteresting yet I

want the others to be about me. I dread the moments when the house is empty. If only they would talk to one another and not to me. (p. 7)

Loneliness is reported more frequently by widows and widowers and those experiencing the death of a close relationship. Young widows left with small children frequently report the feeling of helplessness which is generally reported in the early stages of grief. Feelings of shock occur most often in cases of sudden death as in the case of accidents, illness, or murders.

Yearning for that which is lost is what the British call "pining." Parkes (1972) tells us this is a common experience which, when it begins to diminish, can serve as a benchmark that mourning is coming to an end.

Many people feel relief when death comes after a long and lingering illness. Children who have been physically or sexually abused often report relief when the abusing parent dies (Sr. J. Iten, personal communication, August 15, 1997). Numbness is described as the absence of feeling, is normal in the beginning states of grief, and is generally seen as a protective factor for overwhelming feelings.

Worden (1982) mentioned the importance of understanding and acknowledging normal signs of grieving so as not to pathologize behavior, feelings, or cognition that are considered normal. While the feelings and behaviors described above are normal responses to grief, existence of them over a long period of time or an absence of them, could lead to abnormal grief.

Abnormal Grief

Worden (1982) acknowledged that abnormal grief has been given many labels from complicated, pathological, unresolved, and exaggerated grief. The newest volume of the Diagnostic and Statistical Manual (1994) of

the American Psychiatric Association (DSM -V) lists bereavement as a "condition that may be a focus of clinical attention" (p. 299.). Whatever one chooses to call it, whether it is abnormal or pathological etc., Horowitz, Wilner, Marmar, and Krupnick (1980) described it best when they stated it is:

> The intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behavior, or remains interminably in the state of grief without progression of the mourning process towards completion . . . It involves processes that do not move progressively toward assimilation or accommodation but, instead, lead to stereotyped repetitions or extensive interruptions of healing. (p. 1157)

This grief is characterized by an absence of feeling in which the death or loss is denied or the griever remains in shock (Rando, 1984).

Variations of Grief

Grief is a highly unique and individual process (Doka, 1993; Parkes, 1975). No two people experience or cope with loss and grief with the same intensity, in the same manner, or in the same time frame. Grief responses are affected by the result of many factors which include the type of death, history of losses, nature of the attachment, type of death, and other dynamics (Rando, 1984). The following are descriptive forms of unresolved grief:

Delayed grief. Because the griever has pressing responsibilities or is unable to handle the intensity of the loss, grief may be delayed for many years. It is sometimes initiated later by another loss, at which time the griever may enter beginning stages of the grief process (Rando, 1984; Worden, 1982).

Conflicted grief. This type of grief is frequently associated with an ambivalent relationship with the deceased. Feelings of intense anger or intense guilt are triggers for this type of response (Rando, 1984).

Chronic grief. Prolonged, excessive, and chronic grief never quite comes to a satisfactory conclusion. It is sometimes found in extremely dependent relationships when the griever fails to exhibit any process in the continuum toward resolution (Rando, 1984; Worden, 1982).

Unanticipated grief. Sudden loss that is extremely disruptive falls into this category. Grievers are unable to grasp the full implications of the loss and are left feeling bewildered and depressed to the point of being unable to function. Parents experiencing the death of a child, suicide, and murder are examples (Rando, 1984).

Disenfranchised grief. Disenfranchised grief is grief that does not allow survivors the usual means of social support and bereavement. This loss of support often forces the survivor to grieve silently and alone, creating a situation that puts the griever at high risk for complicated grief. Perhaps not as stigmatizing as disenfranchised grief of AIDS related deaths or suicide, the loss of a lover in an extramarital relationship whether heterosexual or homosexual, are examples of disenfranchisement. Finally, there is confusion in our society on the grieving process after the death of an infant or a miscarriage. A common assumption is that the grief should not be as severe because the parents did not have adequate time to "bond" with the child. This attitude ignores the possibility that attachment may begin early in the pregnancy, and places the parents in a situation where their grief is disenfranchised.

Masked grief reactions. Grief that is left unexpressed and finds its expression in medical symptoms similar to that which the deceased displayed or in other forms of psychosomatic complaints come under this heading. It could also result in acting out of some kind or maladaptive behavior (Worden, 1982).

The description of physical symptoms given us by Rando (1993) of complicated mourning, are amazingly close to the DSM IV (American Psychiatric Association, 1994) description of post-traumatic stress syndrome (PTSD). Those symptoms include: difficulty falling asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, and an exaggerated startle response. Further, PTSD causes "clinically significant distress or impairment in social, occupational, or other important areas of function." (American Psychiatric Association, 1994, p. 211.). Cook (1992) added that PTSD is characterized by guilt, depression, and grief and that "the core of this response is often unresolved grief" (p. 25).

A large scale study of homicide's effects on family survivors, led to the discovery that one fourth of those survivors developed full-blown PTSD. About half developed several symptoms of PTSD, and 5% were still suffering from the disorder more than 10 years after the murder. Twenty-two percent were still experiencing one or more of its symptoms. Because the relatives of murder victims are left not only with their tragic loss but also the loss of faith in society, the legal system, old friends, and their belief in God, their grief has the propensity to become very complicated (Schlosser, 1997).

Grief as a universal experience appears to be widely accepted. Stroebe and Stroebe (1987) asked, "Is grief universal?" To answer the question, they reviewed the cross-cultural literature and concluded that there

is no simple answer. They examined factors such as grief symptoms, duration of grief, and crying. In Western and non-Western cultures, they did not find an absence of crying but rather variations in the timing of the crying as well as places where the crying was acceptable. Duration of grief was limited in some cultures; in others there were restrictions placed on the amount of time given to resolute the grief process. Variations of grieving may also be influenced by religion.

In Judaism, the grief process is done in a precise manner that differs from most Christian denominations (Moss, 1979). In Judaism, *shiva* ,the first 7 days after burial, is marked by customs by which the mourner breaks their ties with the living. This is accomplished by several customs which include: (a) no cutting of hair, (b) no washing or anointing of self, (c) no washing of clothing, (d) no marital relations, (e) no wearing of shoes, (f) no going to work or conducting business, (g) no scripture reading except biblical books such as Job and Lamentations, (h) no greetings of hello or well-being, and (i) no sitting on sofas or beds. These customs of mourning do have exceptions, based on specific circumstances and also whether the mourning occurs on Sabbath or a holiday. This mourning practice is considered very helpful because it brings the mourner to the first task of grieving which is to acknowledge that loss has truly happened. The mourner is then forced to face the fact of the other's death directly and realistically.

Grieving is not simple. When people grieve they experience loss at least three levels (Matsakis, 1992). The first level is grief over people, objects, or emotional, spiritual, or physical aspects of the self. For example, the griever may have lost a friend or spouse, a business, an organ or body part, or an intellectual or physical ability. The loss also could have been as serious

as a cherished value such as sobriety, or belief in the integrity of certain people.

The second level of loss, according to Matsakis (1992), involves grieving the acknowledgment of powerlessness. Some of the sadness of grieving comes from knowing that no matter what you do, you cannot replace what has been lost. No matter how smart, successful, or rich you are, you cannot resurrect dead people, restore your faith in people, grow another body part, or recover the years lost to drinking.

The third loss involves grieving mortality. The fact that we will all die is the ultimate expression of powerlessness. At the same time people are grieving a specific loss, they are also, consciously or unconsciously, grieving their own mortality. Thus the awareness of one's own death that comes with grieving another's is one of the dynamics that makes grief work hard to do (Matsakis, 1992).

Summary

Because there is a wide range of beliefs and cultural practices surrounding grief and loss, it is vital that social workers educate themselves about the cultural and religious practices appropriate to the people they serve. The literature is clear, however, that there is a wide need for social work and mental health education in grieving as a universal process. Cultural influences are important factors in the study of grief models. Much of the research to date has been done by anthropologists and there seems to be a real need for further research on bereavement by social scientists (McNeil, 1995).

That women come to treatment for alcoholism with a history of losses that are similar and yet different is well documented in the literature. Sexual

abuse, domestic violence, bereavement, and divorce are but a few of the many grief and loss issues that women struggle with and, in many cases, cope with through the use of alcohol. While there is a great deal of documentation in the literature pertaining to both women's alcoholism and grief and loss issues, there is little on the relationship of these two powerful forces in the lives of women. One study, however, (Zisook & Lyons, 1989) found that among 1,000 consecutive outpatients seen at a university-run psychiatric clinic, 430 (43%) had experienced the death of a first degree relative at some time in their lives. Of those who responded to a questionnaire item asking whether they were still having difficulty dealing with the loss, 211 patients had evidence of unresolved grief. This unresolved grief was associated with past histories of depression, suicide attempts, and alcohol abuse. While the Zisook and Lyons (1989) study suggested a relationship between unresolved grief and alcohol abuse, the nature of the relationship remains unclear. For example the relationship between the two may or may not be one of cause and effect.

Martin and Privette (1989) believe in the importance of having a grief and loss component in an alcohol treatment program. Using Worden (1982, 1991) and Kubler-Ross' (1969) theoretical models of grief and loss, they designed a psycho educational, experiential group for members of an alcohol treatment program that addressed issues of grief and loss. The week-long group loss and grief component was facilitated by two therapists in a 28-day residential alcohol and drug abuse treatment program. The goals of the project were to assist clients in identifying loss, recognizing their reactions and coping mechanisms, understanding the process and tasks of grieving, and mourning their losses. This model was designed specifically for

treatment because of their belief that "people who abuse any substance may be doing so to deny loss" (Martin & Privette, 1989, p. 51). Second, addicted individuals often suffer losses because of their loyalty to the addictive substance, the giving up of which signified another loss and disappointment (Martin & Privette, 1989).

This study attempts to fill a gap in the literature on the relationship of alcoholism and grief in women. The next chapter discusses the methodology of this study.

CHAPTER THREE

METHODOLOGY

In this chapter, the methodology used to conduct the research is discussed. The literature review indicated that while it is widely believed that grief and loss issues are prevalent among alcoholic women, few have established a relationship between them. Fewer yet were found to discuss the need for a theoretically constructed component of the process of grieving for women in treatment. This chapter contains the research questions, research design, information on data collection, instrumentation, data analysis, definitions of key terms, and finally, the protection of human subjects.

Research Questions

The following research questions were studied:

1. What is the impact of grief and loss on women's drinking patterns?
2. How are women's grief and loss issues dealt with in their treatment for alcoholism?

Design

Because the literature indicates that women generally become alcoholic in response to trauma in their lives, this research attempted to raise awareness of the process needed to resolute grief and loss issues associated with that trauma. In addition, it attempted to ascertain whether grief and loss was an antecedent to women's alcoholism. Finally, it attempted to discover if alcoholism treatment adequately addressed grief and loss issues.

The study used primarily qualitative data gathered from in-depth interviews, supported by quantitative data to answer the research questions.

The researcher used two self-administered questionnaires selected because they offered privacy to participants, thereby encouraging uninhibited responses and avoiding interview bias.

Key Terms and Definitions

In order to address the research questions, terms need to be consistent and measurable definitions. The key terms applied in this research were: alcoholism, alcoholism treatment, bereavement, grief and loss, and women.

Definition of Terms

Chemical Dependency (CD) Counselors--People who are certified to provide counseling services for the treatment of alcoholism and other forms of chemical dependency (Institute for Chemical Dependency Professionals, 1996).

Psychologist--Any person who is licensed to practice psychology in the state of Minnesota.

Social worker--Any person with a BSW or MSW from an accredited school of social work, or a license to practice social work in the state of Minnesota.

Grief--The emotion felt when experiencing a loss (Wolfelt, 1988).

Bereavement--The state or a condition caused by loss (Wolfelt, 1988).

Grieving--The full range of coping responses to significant loss (Wolfelt, 1988).

Mourning--Refers to the way our society or culture tells us to behave in response to loss through death (Wolfelt, 1988).

Alcoholism--A primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease often is progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial (Sullivan, 1995).

Patients--Patients are defined for the purpose of this study to be women with a diagnosis of alcoholism and current residents of the half-way house.

Study Population

The unit of analysis was women who were current residents of a half-way house for women and were recovering from their alcoholism. The women were in varying stages of their aftercare treatment, and had completed primary treatment from a variety of settings and cities.

Sampling Procedures

Non-probability sampling procedures were utilized by reliance on available subjects. All women who were current residents of the half-way house, recovering from alcoholism, and had grief and loss issues, were invited by posted flyers to participate in the study. A copy of the flyer and invitations can be found in Appendixes D and E. A $5 honorarium was offered to compensate the women for their time, and used as an incentive to encourage the women to join the study. The first 10 women to sign up were the designated participants (N=10).

Location of the Study

The study was conducted at a 20 bed half-way house for women in rural Minnesota. Residents of the rural community have lived in the area of the half-way house for an average of 21 years. Average two-adult household income is $41,684 and the average wage is $10.71 per hour. Of the population, 98.5% were white and predominately of the Roman Catholic faith (Chamber of Commerce, 1993).

Measurement

Demographic data was collected for each individual in the sample. These data included discrete and continuous variables. Ratio measures included age, income, family size, etc., and nominal data such as education. An alcohol questionnaire, designed by the researcher, included nominal data and ratio measurements. The data on treatment characteristics included both ratio and nominal measures. A standardized Grief Experience Inventory (GEI) was used and participants were given a choice of the death version or the non-death version. The GEI consists of 135 statements found to be frequently associated with grief and bereavement. The questions for both versions are printed in a booklet and the responses were recorded on a separate answer sheet. The 135 GEI items yield scores on 12 scales, including three validity scales and nine clinical scales. In addition, there are six research scales that can be scored. GEI protocols were scored by hand utilizing the response sheets and scoring stencils available from the publisher. The GEI scales are expressed as percentiles.

Validity

To increase face validity and enhance the effectiveness of the questionnaires, the open-ended questions were pretested by a recovering,

female alcoholic with an MSW degree. The goal was to complete the interview in less than 1 hour. The pretest indicated that probes were necessary for the interview portion. The interview was then modified and the use of probes were included but limited to: (a) elaboration, (b) detail, and (c) clarification. Total time was 45 minutes. From pretest results, editing the alcohol questionnaire and clarifying the time necessary for completion of all questions increased face validity. The directness, depth, and detail of the qualitative portion of the study gave it validity stronger in scope than quantitative measurements (Rubin & Babbie, 1997).

Reliability

The sample was kept small enough to permit the researcher to report accurate description replete with rich detail. The researcher, due to the qualitative nature of the study, was able to make detailed observations and provide quotations that are geared toward giving the reader a deeper understanding of the subjects. Qualitative studies, due to their nature, "leave less concern about whether one particular measure is really measuring what it is intended to measure, than quantitative ones" (Rubin & Babbie, 1997, p. 186).

The reliability of the GEI scales has been studied in several samples. The internal consistency or homogeneity of the scales was indicated by the values of coefficient alpha (Cronbach, 1951). The reliability data suggested that the GEI scales were suitable for research use (Sanders, Mauger, & Strong, 1985).

Data Collection

The first 10 women to respond to counselor and bulletin announcements were contacted to be participants. Dates and times were

scheduled at their convenience. Interviews were conducted at the half-way house in one of the administrative offices and were audio-taped following the completion of the three instruments: the demographic form, the alcohol questionnaire and their choice of the death or loss version of the GEI. Following the signing of an informed consent (See Appendix F) and the completion of the questionnaires, the women participated in a 1-hour, standardized, open-ended interview. Transcribing of the material was done by this researcher.

Standardized open-ended questions were used for the interviewing process. These questions can be found in Appendix K. Demographic data was collected for each individual in the sample. The data was collected as part of the informed consent and can be found in Appendix H.

Data Analysis

The data was analyzed using both qualitative and quantitative methods. For the open-ended questions, the data was organized into categories, themes, ideas, and patterns. This information is reported by the use of tables, graphs, and charts. Quantitative data is presented both in frequencies and percentages. The GEI was scored by hand using the scoring stencils provided with the instrument. Other data was tabulated by hand due to the small sample size.

Protection of Human Subjects

In order to prevent harm to or violation of rights of any of the individuals participating in this study, the research was approved by Augsburg College Institutional Review Board, #97-29-03, and the Hospital's Ethics Committee.

Confidentiality was assured to all participants. The records of this study will be kept private. In the final report of findings, information that could

make it possible to identify any subject was not included. First names only were used to record data. Interviews were tape recorded for ease in handling the material which were kept in a locked drawer in the researcher's home. Tapes and raw data will be destroyed by the researcher in July of 1998.

Participation in this study was completely voluntary. Consent forms were signed by all participants and the investigator. Following the informed consent, the women participated in a 1-hour, standardized, open-ended interview.

Summary

This chapter discussed the methodology employed in this study and included: research design, key terms and definitions, study site, sampling procedures, data collection, data analysis, reliability and validity factors, and pre-test results. In addition, protection of human subjects and study sample were described. In the next chapter, the results of this study are presented.

CHAPTER FOUR

RESULTS

In Chapter Three, a theoretical framework of grief and loss was developed utilizing the work of Attig (1996), Kubler-Ross (1969), and Worden (1991). Research questions were developed from these theoretical frameworks and from other variables in the literature. In this chapter, the results of this study will be presented as they relate to each research question.

Ten of 10 scheduled interviews were completed. The 10 women interviewed ranged in age from 17 to 47 (See Table 4.1). All were Caucasian. Two of the respondents had not completed high school, while four had some post-secondary. Three of the women were divorced while seven were single. Only one respondent was employed and that was on a part-time basis, while the remaining nine were unemployed. Most (90%) earned less than $10,000 per year. All respondents resided within the state of Minnesota and represented seven different counties. In terms of distance from the half-way house, the respondents came from counties that were as far as 40 miles to the east, 50 miles to the west, 140 miles to the north, and 52 miles to the south.

Of the 10 women, all identified themselves as alcoholics. Three of the women had a dual-diagnosis (bulimia, post-traumatic stress disorder and depression). Three had cross addictions (cocaine, crack, and ephedrine). One woman had a diagnosis of severe and chronic cirrhosis of the liver.

Table 4.1

Women's Demographic Characteristics (N=10)

	N	%
Age (M=29.4)		
17-25	3	30
26-32	3	30
33-47	4	40
Ethnicity		
White	10	100
Education		
(mean 12th grade)		
grade 8-10	2	20
High school graduate	4	40
Some college	4	40
Marital Status		
Single	7	70
Divorced	3	30
Employment Status		
Unemployed	9	90
Employed FT	0	0
Employed PT	1	
Annual Income		
Less than 10,000	9	90
10,001 - 15,000	1	10

Research Question 1

What is the impact of grief and loss on women's drinking patterns? The impact of grief and loss on women's drinking patterns is presented in the order of the interviews.

A 33-year-old respondent stated that her drinking pattern changed when she was in her early 20s. She reported that she felt lost, alone, and confused at the time. This was also the age when she lost custody of her first child. Though she reported that her losses came about because of her drinking, she also identified a powerful loss issue at about the same time that she began drinking:

> I started drinking when I was 12-years-old and I was alone and didn't like school. Something inside of me was broken and I didn't know what it was. I was lost inside-so I lost myself in use. I have been in treatment a total of 10 times since the age 15, and the longest time I have been sober has been four years. The loss I am grieving is the loss of four years of sobriety. I have had plenty of losses though. I have had the loss of my daughter's father, he left me, my grandfather died, and I have been involved in many abusive relationships. I am also bulimic. I lost custody of my daughter when she was 4-years-old.

The major loss identified for this respondent was her sobriety. It was that loss that impacted on her drinking pattern.

The 35-year-old mother of four, who began drinking at age 12, did not signify a change in drinking patterns, but reported that she was beaten from age 4 to age 7 by her step-dad and watched him beat her mother. He left the home when she was age 7. She reported that because of her use, she has lost custody of her children, lost her home, and lost her reputation:

> I have no recollection of my childhood before the age of five except for the whippings. The whippings started at about age 4. They ended when my stepfather left when I was about 7. I have been having flashbacks about things now. I am dealing with the fact that my mother didn't protect me from those beatings. She let me get beat up so she wouldn't have to be. Growing up, and until now, I have had no dreams for life. Now I am starting to dream since I have been here in the half-way house. I need to get in touch with why I am so angry.

The losses this respondent identified also included early childhood abuse as a contributor to her drinking pattern.

The third respondent, who was age 36 and began drinking at age 13, reported that her loss occurred at age 35 when her 17-year-old daughter committed suicide. She believes that her drinking was the cause of her daughter's problems. She was in treatment twice before the suicide and stated that she had been through treatment twice since the suicide:

> I drank the whole time I was in treatment the first time. My 17 year old daughter committed suicide while I was in treatment the second time. After her funeral (I was in treatment at the time and out on a pass), I got drunk and violent and was arrested. When I went to court for that, the judge ordered me to grief counseling and back to treatment. I have been in treatment twice since her death. After my daughter died the worst had happened and it didn't matter any more what else happened to me. I just drank more and didn't care about the outcome.

The loss experienced by this respondent shows a clear connection to her consistent drinking pattern.

The oldest respondent, a 47-year-old woman, stated on the questionnaire that her drinking pattern changed at age 28 when her marriage began to fail:

> The loss I identify with is the loss of my health. I needed to go to treatment for medical reasons. I have severe cirrhosis of the liver from my alcohol use and nearly died in treatment where I was for 4 months. I was in bed and used a wheel chair for mobility for one month. I fought very hard to live during that time and I don't know if I will recover. It depends on whether or not my liver will reheal. I was down to 82 pounds from 117 pounds. My drinking caused my health problems.

Marital problems were directly linked to the respondent's change in her drinking pattern, and ultimately led to her loss of health and diagnosis of chronic cirrhosis of the liver.

The youngest respondent was age 17. She reported that her drinking began at age 13. She was grieving the death of her infant:

> My drinking patterns never really changed because I fell into drinking and using right away. Then I started mixing my alcohol with crack or cocaine. I came into treatment after my baby died. He was born and lived two months. He was born addicted to crack and died from a collapsed lung and a defective heart. I was using crack while I was pregnant and I was also being physically beaten.

This respondent was being physically beaten and continued to drink to forget, despite the fact that she was pregnant. Her grief and loss issues helped to maintain her drinking pattern and crack addiction.

Two of the women lost custody of their children as a result of their drinking. One stated that she started drinking at age 3. She was currently

age 29, single, had four children and four DWI's. She stated that her drinking pattern changed by age 11:

> My children have all been in foster home placement for a long time. My loss is the loss of years with my children. The first time they were gone for 1 year when I went for treatment. This time they have been gone for 7 months and I know I will get them back.

This respondent was offered alcohol by her family at an early age, signifying neglect and abuse. The neglect and abuse ultimately resulted in establishing her drinking problem, which in turn led to further losses.

The other woman stated that she started drinking at age 15 and her drinking pattern changed when she lost her children. The loss happened 1 year ago. She was age 25, and the single mother of four children:

> When I lost my kids I didn't care anymore about anything. One month after I lost custody of my children my best friend committed suicide. I suffer from post traumatic stress syndrome (PTSD).

This respondent had been a victim of domestic violence which was an antecedent to the change in her drinking pattern. It was that change that led to her losing custody of her children.

A 21-year-old single woman was the next respondent, the mother of a small child and obviously pregnant. She reported that her drug use started with crank at age 19 but that she used alcohol two to three times weekly as well. She stated that her drinking pattern changed in August of 1997 when she lost her job, her home, and custody of her daughter:

> My greatest loss was the loss of connection with healthy adults while I was growing up. I felt like everything was falling apart and getting high was how I dealt with it because there was so much going wrong that I

had to use more to feel better. My parents used while I was growing up and divorced when I was age 6. Everyone in my close life was a user. I didn't have connections with any healthy adults in my life.

In this case, the respondent grew up with drinking parents who were also divorced. That factor, as well as being totally surrounded by adults who spent most of their time drinking, led to her misuse of alcohol and drugs and ultimately created additional losses.

A 29-year-old respondent stated that she started drinking at age 18 after her father died. She has had four DWI's. Her oldest son is in foster care:

If I really think about it, I think that my issues are less about my dad dying and more about the abuse. He was very abusive to me.

This respondent's abusive father was a strong factor in her misuse of alcohol and led to complicated grief which further impacted her drinking.

The last woman interviewed had been drinking for the past 4 years having started at age 18. She stated that her drinking pattern changed when she started using ephedrine. She was pregnant at age 18 and had an abortion at age 19. She did not feel that the abortion was a grief and loss issue for her:

My loss is the rape that happened to me while I was drunk and in a blackout. The rape happened when I was age 21. I also had an abortion at age 19 but the rape thing is the worst.

It is clear that the trauma suffered by this respondent, as a result of the rape, changed her drinking pattern resulting in many legal entanglements.

Grief Experience Inventories

The GEI inventory (both the death version and the non-death version) is scored by transferring the respondents raw score from the bottom of the

answer sheet to the corresponding marks at the bottom of the profile (See Table 4.2) (Sanders, Mauger, & Strong, 1985). The profile is designed in such a way that by plotting the raw scores on the appropriate grid, one automatically obtains a percentile. Norms on the profile are based on a total of 693 respondents. The GEI scales are expressed as percentiles with a mean of 50 and a standard deviation of 10. The larger the percentile, the greater the intensity of the behavior measured by the scale. Any score above the 50th percentile is an indicator of the respondent having the symptom present. The profile is divided into two parts: (a) the validity scales, and (b) the bereavement scales.

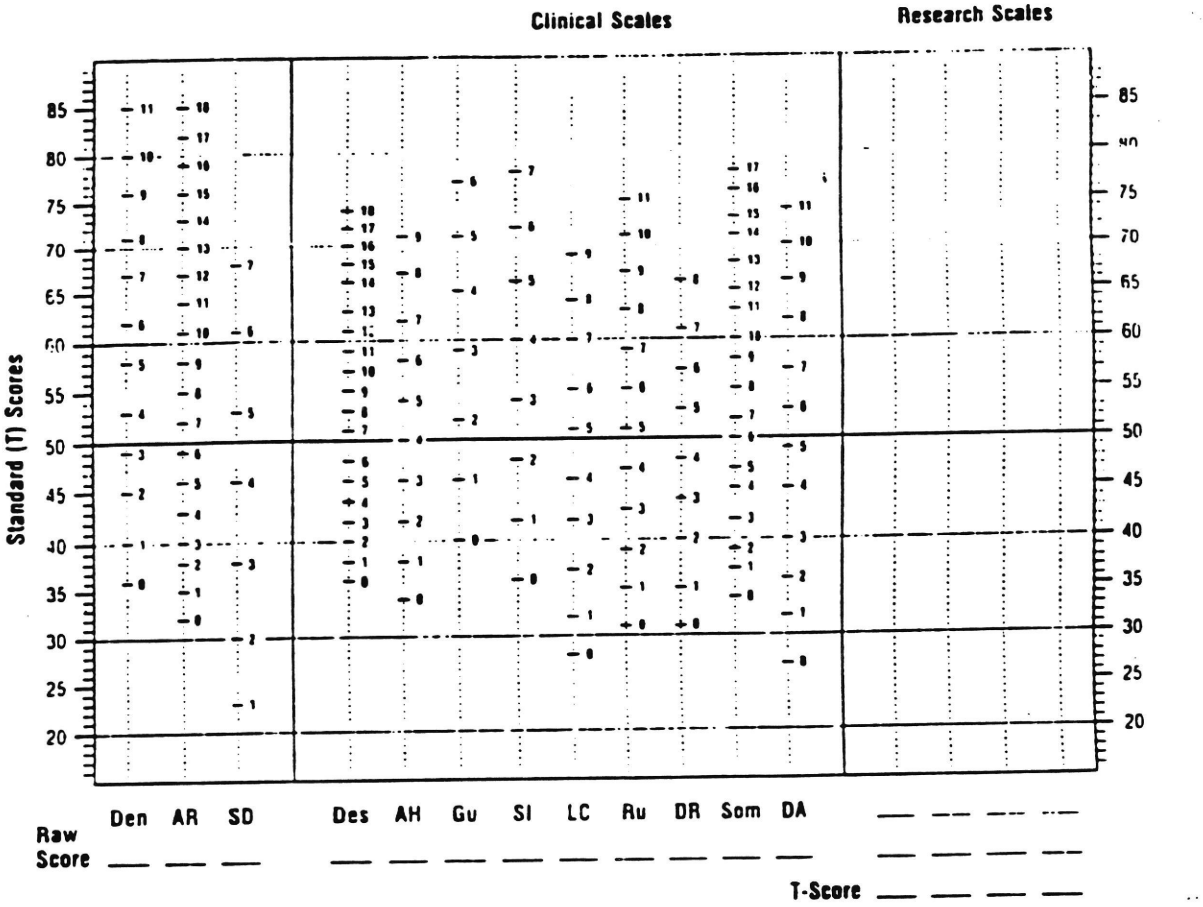
Validity Scales

The validity scales include Denial (DEN), Atypical Responses (AR), and Social Desirability (SD). Because the respondent's attitude toward the inventory affects scores on the bereavement scales, the validity scales indicate whether a profile is interpretable. Profiles with scores above a percentile of 70 are not interpretable (Sanders et al., 1985).

A high score on the AR scale indicates a tendency to endorse items which less than 25% of the normative sample endorsed. Such items were selected according to the frequency of endorsement and cover a variety of content areas. A person answering an item according to the following examples would obtain a high score on that particular scale, or in this case, on the AR scale. Examples on the AR scale are, "I have feelings of guilt because I was spared and the deceased was taken" (True); "Aches and pains seldom bother me" (False). This scale was developed to detect an unusual response set. People with high scores on the AR scale have responded to GEI items in an unusual manner. The inventory's authors (Sanders et al.,

Table 4.2

GEI Inventory



1985) believe that high scores on this scale may be due to the following reasons:

1. The person is overwhelmed by feelings and too upset and confused to closely attend to the items on the test.
2. The person has a reading problem and can't understand the test items.
3. The person has a visual problem and can't see well enough to make out all of the words.
4. The person is unable to understand the nature of the test due to:
   a. mental subnormality
   b. advanced age
   c. physical debility, senility, cerebrovascular accident
   d. lack of previous experience with psychological tests
   e. effects of sedatives or other psychoactive drugs
5. The person lost their place on the answer sheet
6. The person is motivated to present themselves as experiencing an extreme type of bereavement. (p. 8)

Profiles with AR percentiles greater than 70 occur in only 1% of the cases and those profiles, according to the authors, should be interpreted with caution. Three of the 10 women in this study had scores higher than 75 on the AR scale.

The Social Desirability (SD) scale demonstrates a tendency to respond in a socially desirable or acceptable manner. This tendency has been conceptualized as a "facade effect" or an attempt to put up a good front of which the participant is largely unaware (Edwards, 1957). There may be pressure for the bereaved person to bias their response in a socially

desirable direction in attempt to put up a good front. Evidence has shown that the strength of the socially desirable response set is related to the need for self-protection, avoidance of criticism, social conformity, and general approval. Persons answering the same as the following examples, would score high on the SD scale for that particular item. Examples of items are: "I felt a strong necessity for maintaining the morale of others after the death" (True), and "It helps me to comfort others" (True) (Sanders et al., 1985).

Bereavement Scales

According to GEI authors (Sanders et al., 1985), the Despair scale (DES) is the longest and most reliable of the bereavement scales. It measures the respondent's mood, feelings of hopelessness, worthlessness, and low self-esteem. Some representative items are: "Small problems see overwhelming" (True), "I seem to have lost my self-confidence" (True), "Life has lost its meaning for me" (True). Again, persons responding to the items in the same manner as the above example would obtain a high score high on that particular item. The DES scale measures the most pervasive psychological expression of grief. A high score on this scale would indicate that the respondent is preoccupied, turned inward, and dysphoric. Feelings present include depression, anxiety, fear, anger, and hopelessness (Sanders et al., 1985).

The scale that indicates a respondent's irritation, anger, and feelings of injustice, is the Anger/Hostility Scale (AH). Items include: "I find that I am often irritated by others" (True), and "The actions of some people make me resentful" (True). Individuals responding in this manner would score high on this scale and would be more likely to be restless, agitated, and angry. They are likely to lose their temper over small matters and utilize projection as a

defense mechanism and place blame for their feelings on others or on external circumstances. They feel unfairly treated by the world and motivated to strike back (Sanders et al., 1985).

The Guilt Scale (GU) is an expression of feeling responsible for the loss or in some way to blame. Examples are: "I sometimes feel guilty at being able to enjoy myself" (True), and "I feel that I did all that I could have done for the deceased" (False).

Social Isolation (SI) are behaviors of withdrawal from social contacts and responsibilities. Such people withdraw not only by their own choosing, but by their feelings of isolation by others. Samples of items are: "I feel cut off and isolated" (True), and "It is not difficult to maintain social relationships with friends" (False). Respondents who score high on these scales not only feel like withdrawing but fear being hurt in interpersonal relationships (Sanders et al., 1985).

Loss of Control (LC) indicates a person's inability to control overt emotional experiences. Many of these items deal with crying and are: "I cry easily" (True), "Sometimes I have a strong desire to scream" (True), and, "I showed little emotion at the funeral" (False) (Sanders et al., 1985).

Rumination (RU) measures the amount of time spent with thoughts or preoccupation with the loss. RU items include: "I yearn for the deceased" (True), and "I sometimes talk with the picture of the deceased" (True) (Sanders et al., 1985).

Depersonalization (DR) measures the numbness, shock, and confusion of grief. Sample items are: "Concentrating upon things is difficult" (True), and "I have feelings that I am watching myself go through the motions

of living" (True). Some of the items on this scale seem to be related to disassociative or psychotic states (Sanders et al., 1985).

The Somatization (SOM) scale looks at the extent of somatic problems which are occurring. Examples of SOM items are: "I experienced a dryness of the mouth and throat" (True), and "I feel tenseness in my neck and shoulders" (True) (Sanders et al., 1985).

Finally, the Death Anxiety scale (DA) measures the intensity of one's personal death awareness. Examples of these items include: "I would not feel uneasy visiting someone who is dying" (False), and "The idea of dying holds no fears for me" (False). This scale is more highly affected by social desirability than the other GEI scales and has a higher correlation with the Denial scale than any other GEI scale (Sanders et al., 1985).

As stated, the despair scale is the longest and most reliable of the bereavement scales. The respondent with the highest score on this scale, 66 percentile, identified her loss as a loss of self as a child (See Table 4.3 for a summary table of the GEI). She also began drinking the earliest, age 12, of all the respondents. The second highest score was from the youngest respondent (age 17) whose child died from crack withdrawal with a percentile score was 53. She was the second youngest of the group when she began drinking (age 13). Tying her score was a mother who lost custody of her children. She too began drinking at age 13. The woman with the lowest percentile score, 36, was a woman who had been raped one year before she began treatment.

Nine out of the 10 respondents were drinking to forget their troubles, as noted on Number 8 of the alcohol questionnaire (See Appendix I).

Table 4.3

Grief Experience Inventory Scales (in percentiles)

Respondent	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
DEN	53	36	49	62	40	36	40	36	36	0
AR	70	82	67	58	52	70	90	67	58	76
SD	60	46	53	53	53	61	38	61	38	30
Clinical Scales										
DES	66	46	51	46	53	44	74	51	53	36
AH	62	54	62	50	50	62	67	62	58	58
GU	71	77	51	65	59	40	72	46	71	78
SI	78	67	66	42	48	72	79	73	48	60
LC	64	56	51	60	51	55	69	46	47	42
RU	71	71	55	63	59	67	59	59	52	47
DR	56	44	56	53	61	57	57	53	58	67
SOM	55	65	61	52	56	52	83	58	50	60
DA	49	45	62	45	53	49	57	55	53	62

Key

DEN = Denial	AH = Anger/Hostility	RU = Rumination
AR = Atypical Response	GU = Guilt	DR = Depersonalization
SD = Social Desirability	SI = Social Isolation	SOM = Somatization
DES = Despair	LC = Loss of Control	DA = Death Anxiety

Research Question 2

How are women's grief and loss issues dealt with in their chemical dependency treatment program? Treatment is defined as chemical dependency treatment in a medical facility, using the medical model, and the Alcoholics' Anonymous 12-step program of recovery. Seventy percent of the women acknowledged that their loss issues were dealt with in treatment while 30% stated they were not.

Two of the 10 women interviewed had just experienced their first treatment and both expressed relief at having dealt with their losses:

> I did a lot of journaling in treatment and then I talked with my friend who committed suicide as though he was really there, and that helped a lot. The more I talked the better I felt. I was also referred to a psychologist and I am still talking about those issues. I also learned that I could have done something different so as not to lose custody of my children, but I could do nothing to stop the suicide. It was helpful to acknowledge the loss and be able to hear that I can change what has happened to me and be a better parent because of what has happened. Treatment also helped me learn how to pick the good out. My goals and objectives were to journal, to talk, and to write letters to my parents about what it was like growing up. I am still in a numbing phase because I have just discovered that the lack of healthy parenting as a child is an issue for me.

One woman who had been through treatment the most often, 10 times since age 15, stated that her grief and loss issues were not dealt with in any of her treatment programs.

They dealt with basic treatment issues each time. Nothing special, they just dealt with alcoholism. They need to take more time! I needed more individual time!

Another, after being in treatment four times:

I have been in treatment twice since my daughter's death. In treatment I talked about her death a little bit when it came up but it was never really dealt with. They said I could talk about it if I wanted to but I don't think they got it at all. I mean, those counselors didn't know what to do with me in treatment! When I refused to write my own obituary they didn't understand how difficult that would be since I had just written my daughter's.

The remaining four respondents all went through treatment twice. Of the four women, two of them stated that the loss was not dealt with the first time because it had not yet happened but acknowledged that their losses were dealt with the second time:

The rape didn't happen yet my first time in treatment. The second time it was up to me to talk about it and I did a little bit. They suggested that I see a counselor for my eating disorder though, and seemed to focus on that.

I wrote letters and I talked a lot about the death. I met with a chaplain and did a lot of crying. I also spent time with myself just meditating.

Finally, of the remaining women who had been through treatment twice, one did not deal with it the first time and the other dealt with it both times:

I didn't deal with it the first time. No, not really. They did want me to see a counselor but I didn't. The second time I talked about it in my

autobiography but didn't do much processing in detail. Actually I think my issues are more about the abuse I suffered from my dad more than his death. Part of my treatment plan dealt with the abuse but not the death. My counselor recommended after my first treatment that I see a counselor and I hadn't done that until now. Yesterday was my second time seeing a counselor. It went well.

I dealt with this issue both times. This last time I underwent a spiritual transformation when I was in treatment with just women. They really made me take responsibility for losing custody of my children. All along I blamed it on bad luck! I had to go to anger management classes. My peers gave me good feedback. I did the basic step work and was told to slow down, learn to take it easy, and find leisure activities to enjoy. It was a spiritual experience.

Many of the women in this sample identified feelings of satisfaction regarding their treatment experience, while others expressed frustration. Those that expressed frustration seemed to have an awareness of what they needed from treatment professionals in order to process their grief, yet stated that the counselors either "didn't get it," or, "didn't have time to deal with it in treatment." All of the respondents acknowledged an awareness of the grief group that met every Friday morning at the half-way house, and all of the respondents either planned on attending the grief group, or were already involved in it.

Of the 10 women studied, 70% of the women had been physically abused. Ten percent had been sexually abused, and 80% were experiencing legal problems at the time of the interviews.

Believing that drinking caused their losses held true for 100% of the respondents. However, the interviews revealed that though these women believed their drinking caused their losses, it was also true that many of their losses were antecedents to their drinking.

As stated previously, the authors of the GEI (Sanders et al., 1985) believe respondents with scores higher than 70 on the validity scale AR should be interpreted cautiously as such profiles occur in only 1% of the cases. It appears significant that this small study yielded three scores over 70. Those scores were: 76, 82, and 90. The clinical scales, therefore, of these women, were not included in the final analysis of data that looked at the presence of themes in the qualitative portion of this study. It should be noted, however, that were some commonalties of the three respondents with high scores on the AR scale. The women were all: (a) victims of domestic violence; and (b) they each had a significant diagnosis alongside their alcoholism. Two were cross-addicted (marijuana and ephedrine) and the third had a diagnosis of PTSD.

Themes

One major theme throughout this study was one of circularity. All of the women in this study had unresolved grief issues because of powerful and traumatic losses. The losses, and accompanying grief, either led to a change in their drinking patterns or exaggerated their drinking patterns. This in turn converted their drinking patterns into full blown, diagnosable alcoholism, which resulted in further grief and loss issues. Completing the cycle is the need for abstinence and a lifestyle free of mood modifying substances. This new lifestyle, while important and necessary, brings with it additional losses. The most significant of those losses is the attempt to sever the ties to the

addictive substance. This loss is substantial because of the loss of comfort that the drug alcohol provides, the loss of drinking friendships, the loss of the social environment of bars and saloons, and the loss of a predictable lifestyle of using. Following treatment, the alcoholic is faced with a new grief and loss issue called sobriety, thus completing one cycle and beginning another of grief and loss of alcohol. That loss in turn will ultimately lead to either recovery or recidivism.

The respondent who scored the highest on the GEI clinical scales, (endorsing the most items with scores over the 60th percentile on six separate scales) was Respondent 1 (See Table 4.4). The second highest score was Respondent 3 who endorsed four items over 60 on four separate scales. Those respondents shared the following commonalties:

1. They began drinking the earliest of most respondents (ages 12 and 13). Only one other woman reported drinking earlier than 12 years of age and she stated she drank as early as age 3. However, it appears that the respondent was reporting the age of her first drink, rather than the age at which she began drinking.
2. They were the only respondents who answered "no" to Item 6 on the Alcohol Questionnaire, "Did you ever drink socially?"
3. They had been in treatment the most often (10 and 4 times)
4. They were the only respondents who reported that their losses were not dealt with in treatment.

Table 4.4

Women Who Scored Highest (over 60%) on the GEI Clinical Scales (in percentiles)

Respondent 1	Percentile	Respondent 3	Percentile
DES	66	AH	62
AH	62	SI	66
GU	71	SOM	61
SI	78	DA	62
LC	64		
RU	71		

Finally, both of these women's losses centered around the death of a child. Respondent 1 stated initially that her loss was the loss of sobriety. In the interview, however, she spoke extensively about her loss of self.

> I started drinking when I was age 12 and I was alone a lot and didn't like school. Something inside of me was broken and I didn't know what it was so I lost myself in use. I drank myself to death and I died.

Respondent 3 stated that her 17-year-old daughter died as a result of her (respondent's) drinking. "The worst had happened and it didn't matter what else happened to me so I drank more and didn't care about the outcome."

Other themes were: (a) 90% of the women endorsed drinking to "forget my troubles" (See Table 4.5), (b) 70% of the women had been physically abused, (c) 80% of the respondents were experiencing legal troubles, and (d) believing that drinking caused their losses held true for 100% of the respondents.

Table 4.5

Effects Respondents Like From Alcohol

Forgetting My Troubles	Drinking to a Blackout	Passing Out	Getting Drunk	Getting High	Having a Relaxed Feeling	Other
9	0	0	3	3	3	4

Other categories endorsed were: happy feeling, loosing inhibitions, feeling good about myself, and being more sociable.

Summary

This chapter presented results as they relate to the research question. It includes the presence of themes and patterns. The last chapter includes a discussion of the results, limitations of the study, and implications for social work practice and future research.

CHAPTER FIVE

DISCUSSION

A review of the literature for this study revealed that little attention has been given to the presence of grief as an active component to alcoholism. Belwood (1975) reported that 20% of the alcoholic population in his study began heavy drinking in response to a significant loss. Kellerman (1980) tells us that alcoholism produces losses for the alcoholic and that it is a progressive illness which brings on greater losses as the person continues to drink over the years. The alcoholic's relationship to alcohol is the same as that of any relationship to a close friend in that it has an emotional component. As one respondent in this study reported, " I have to give up my lover vodka." The importance of grieving the loss of alcohol is validated by the literature on pathological grief (Denny & Lee 1984; Friedman, 1984; Goldberg, 1985). Pathological grief reactions are know to occur most frequently when the relationship with the object or person lost is ambivalent, where the loss creates feelings of guilt, and where the world that is left behind changes as a result of the loss (Goldberg, 1985). This appears to be an accurate description of the relationship between the alcoholic and the alcohol.

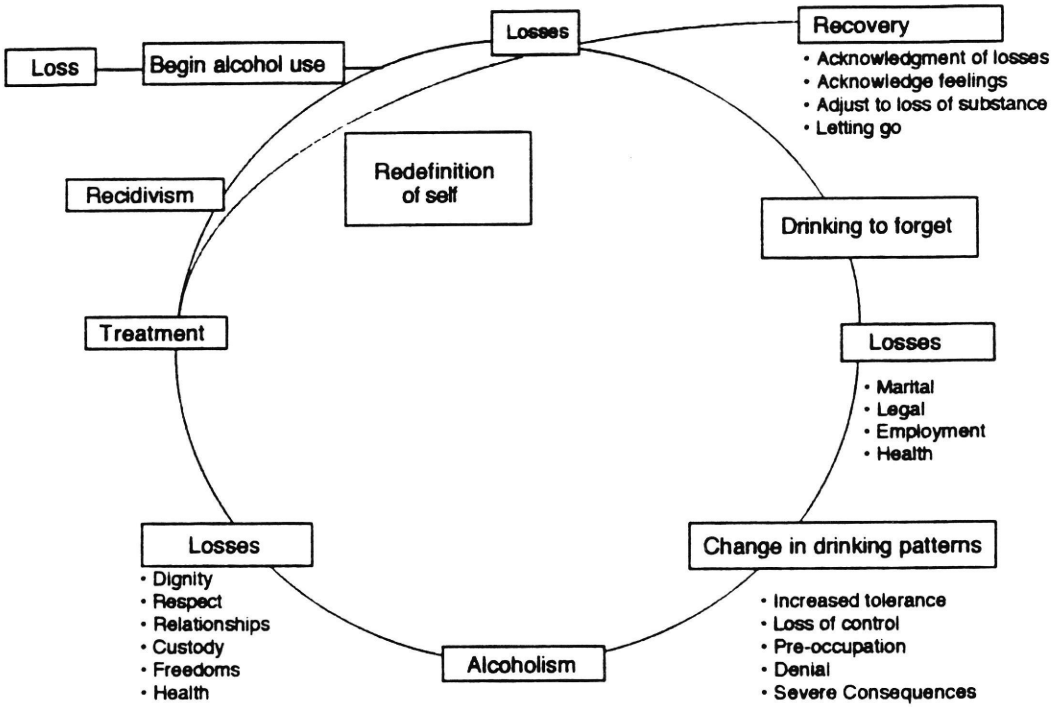
Themes

Forgetting. In this study, 90% of the respondents reported "forgetting my troubles" as the effect they liked the best from alcohol. Beckman (1980) acknowledged that the few studies that have examined antecedents to women's drinking have reported that women are likely to drink to forget. Drinking over the course of many years often becomes the alcoholic's way of coping and forgetting about troubles (Friedman, 1984; Goldberg, 1985). Both quantitative and qualitative findings are consistent with the

review of the literature indicating that alcohol is used as a coping mechanism (Allan & Cooke, 1985; Gomberg, 1996; Martin & Privette, 1989; Nelson-Zluppko et al., 1995; Rando, 1984).

Circularity. Circularity (See Figure 5.1) was a recurring theme identified in this study. As stated previously, women often drink in response to a traumatic loss or stressors in their lives (Blume, 1988; Gearhart et al., 1991; Gomberg, 1996; Plant, 1980; Weathers, 1995; Wilsnack et al., 1991). All of the respondents interviewed in this study believed that their drinking caused their problems, but also acknowledged serious and powerful events that happened in their lives before their drinking patterns changed. The losses and accompanied grief of the respondents either led to a change in their drinking patterns or exaggerated their drinking patterns. This in turn converted their drinking patterns into full blown, diagnosable alcoholism, which resulted in further grief and loss issues. Completing the cycle is the need for abstinence and a lifestyle free of mood modifying substances. That lifestyle, while important, healthy, and necessary, brings with it the loss of ties to the addictive substance. It is considered a significant loss because the alcoholic has to deal with the loss of drinking friendships, loss of the social environment of bars and parties, the loss of a predictable lifestyle etc. Following treatment, the alcoholic is faced with a new grief and loss issue called sobriety, thus completing one cycle and beginning another. That loss in turn ultimately leads to either recovery from addiction or recidivism.

Figure 5.1. Circularity



In order to recover, the alcoholic must resolve the losses identified as either antecedents or consequences, and accomplish the tasks of grieving as defined by Worden's (1991) model of grief resolution:

1. Acknowledging the reality of the loss. This means accepting the reality of the loss of alcohol, and acknowledging that the relationship with alcohol can not be retrieved (Worden, 1982).
2. Experiencing and working through the emotional chaos involves identifying and discussing the feelings inherent in the loss. Often the feelings are sad, angry, or embarrassed ones due to the damage of relationships, legal entanglements, and wrongs that have been committed. Frequently there is guilt for not living up to the image the alcoholic had of themselves (Kurtz, 1982).
3. Adjusting to the environment where the deceased is missing. With this task, relationships are examined and redefined as the search for new identity and new meanings in life begins. The grieving entails not only the loss of person or thing, but the life lived with that relationship. The alcoholic in treatment is in search of the self, trying to answer the question, "who am I now in the context of this loss?" In an attempt to redefine themselves, the alcoholic has to decide how they want to walk in the world.
4. Loosening ties to the deceased involves withdrawing energy from the grieving process and reinvesting it in the self and in relationships. Marris (1974) stated that "the fundamental crisis of bereavement arises not from the loss of others but the loss of self" (p. 33). The task in recovery then becomes finding the lost self, the self that was lost to the ravages of alcoholism. One

respondent described her drinking by saying, "I lost myself in my use." A grieving survivor from Vietnam stated that when her loved one died, "a part of me died too" (Horacek, 1995, p. 23). Making restitution and seeking forgiveness from others and from the self is also inherent in this task (Kaczkowski & Zygmond, 1991). Finally, alcoholism counselors need to be able to empathize with an individual's losses and especially the loss of alcohol since the loss of this primary love object is nearly as painful as losing a close friend or family member.

Physical abuse. Roth (1991) reported that the rate of battered women appearing for treatment is 160 times greater than in non-battered women. In 74% of battered women, alcoholism emerges after the onset of abuse (Banks, 1989). Seventy percent of the women who participated in this study stated they were battered women. For several, it was the impetus to seek treatment.

Age factor. The two women who scored in the highest percentile of the GEI were women who began drinking before the age of 14. They had also been in treatment the most often of the respondents (10 and 4 times), and reported that their losses were not dealt with in treatment. A new report issued by the National Institute on Alcohol Abuse (1998) stated that the younger the age of drinking onset, the greater the chance that an individual at some point in life will develop a clinically defined alcohol disorder. Young people who began drinking before the age of 15 were four times more likely to develop alcoholism than those who began drinking at age 21. The risk that a person would develop alcohol abuse (a maladaptive drinking pattern that repeatedly causes life problems) was more than doubled for persons who

began drinking before age 15 compared with those who began drinking at age 21.

Children. Eighty percent of the respondents identified losses around a child. They either lost custody, experienced a death, or identified the loss as that of their own "inner child."

Strengths and Limitations of the Study

The strength of the study is based in its qualitative design with a strong quantitative component. The qualitative portion offers depth of information. The use of a standardized Grief Experience Inventory adds to the reliability and validity of the respondents' information reported during the in-depth interview.

Limitations include the difficulties in generalizing results to a large population. The small population of women (N=10) residents in a half-way house is a limitation. And finally, there are serious methodological difficulties in determining the relationship between stressful life events and drinking patterns (Sullivan, 1996). Despite these limitations, several findings have implications for policy and practice.

Issues for Treatment

For addicted people, the necessity for grief work is of critical importance. Not only can unresolved grief provide a reason to begin, continue, or return to drinking, it can also delay completion of the tasks necessary for grief work to be accomplished (Denny & Lee, 1984; Goldberg, 1985). People who are abusing a substance may be doing so to deny a loss. This was indicated by the respondents in this study who stated that they drank to forget (90%). Members of alcohol treatment groups are attempting to sever their ties to an addictive substance, teaching them how to work through the

tasks of grieving would not only equip them with important skills to resolute their own issues, it would enable them to help others resolute theirs as well. For successful treatment of alcoholism to take place, it appears essential that grieving women understand the grieving process, be given an opportunity to work through their issues in the safe and protected environment of treatment, and to learn alternatives to alcohol for coping with stress. To facilitate this growth, helping professionals need to be aware of the process needed for healthy resolution of grief work.

Issues for Prevention

Because the study population was young when they began their use of alcohol, prevention efforts aimed at delaying the onset of alcohol use in young people must continue. It has been shown that teaching young people to "just say no" is not enough (Jones, Corbin, Sheehy, & Bruce, 1995). They need to develop conflict resolution skills, identify ways to get "high" naturally, and learn healthy and constructive ways to deal with their grief and loss issues and the feelings that accompany those issues.

Recovery from alcoholism is a challenging and difficult process. Looking beyond the prevention and cessation of drug use, women must be given the hope of a better life through the development of skills that will increase their chances of living a full and productive life. Programs that offer services to women must address not only the addiction, but also the development of basic coping skills in the areas of parenting, conflict resolution, assertiveness, decision making, vocational and financial planning, therapeutic relationships, and the healthy resolution of grief and loss. These issues should be vital components of battered women shelters, rape crisis center, half way houses, mental health units, and treatment programs.

Social Work Implications

Magura (1994) stated that social workers are not well represented in substance abuse programs. This is of particular interest when you consider the problems of the client populations and the program functions that are generally performed in treatment. Alcohol and drug dependent clients have multiple emotional, family, and interpersonal problems and, as we learned in this study, grief and loss issues. Any one of them could be a causal factor of alcoholism or a consequence. Assessment and diagnostic skills are an important component for case management or the implementation of a care plan and social workers are highly trained in those areas. It is very likely that social workers could lend more efficacy to treatment programs.

New models of treatment are emerging (Magura, 1994) that require professionals educated in theories of human behavior. Social workers could serve a very useful role in the implementation of these developing models, and in the development of new models to improve treatment. Equipped with the knowledge of grief resolution, social workers could write curriculum for treatment programs that would include these vital components.

As advocates, social workers need to become engaged on community, state, and national levels to establish policies that would eliminate youth access to alcohol. Child care policies need to reflect services needed to allow women to seek and remain in treatment, and they also need to include services aimed at prevention work with children of substance-abusing women.

Finally, because most substance abuse treatment is publicly funded, social workers need to network with public funding agencies who have a major influence on the types of staff hired by these programs. Perhaps this

study will interest some practitioners in the work of chemical dependency, where their commitment and skills are so vitally needed.

Future Studies

Future research could include a longitudinal study of alcoholic women to study their patterns of grief resolutions. A more detailed quantitative questionnaire could be used for that study that might ask questions such as:

- At what age did you start using regularly?
- At what age did your loss happen?
- Did you use more following the loss?
- Did you talk with anyone about your loss:

Clearly there is a need for more studies on this group of women and all women who are experiencing the ravages of alcoholism.

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APPENDIX A

AUGSBURG INSTITUTIONAL REVIEW BOARD LETTER

AUGSBURG

C•O•L•L•E•G•E

To: Joyce Halstrom
30314 Lilac Road
St. Joseph, MN 56374

From Professor Michael Schock
Institutional Review Board
Augsburg College
Minneapolis

January 5, 1998

Dear Joyce Halstrom,

Augsburg College Institutional Review Board (IRB)has considered your proposal for research, "Grief and loss issues and women's drinking patterns". You have been approved of your research as proposed. Your IRB approval number is 97-29-03. Please use this number on your consent forms or letters and all other official documentation related to this research.

As a reminder, this IRB number must go on all participant related material. We hope that your research proves to be an exciting discovery for social workers in the field of chemical dependency work.

cc. Maria Dinis

APPENDIX B

HOSPITAL INSTITUTIONAL REVIEW BOARD LETTER

January 2, 1998

Dr. Maria Dinis, Advisor
Augsburg College
Department of Social Work
2211 Riverside Avenue
Minneapolis, MN 55454

Dear Dr. Dinis:

In accordance with the Food and Drug Administration (FDA) and Federal Regulations, this letter serves as official approval from the Saint Cloud Hospital Institutional Review Board (IRB) for the protocol entitled "Grief and Loss Issues and Women's Drinking Patterns" as submitted by Joyce Halstrom.

This protocol has been approved as of December 17, 1997. Progress made on this protocol will be reported at the annual review in December, 1998. At that time, we would ask you to submit a progress report and also a copy of the consent form in use at the time of the annual review. In addition, we would remind you that any treatment related death or serious adverse event should be reported to the chairperson of the IRB, in writing, within ten days of the occurrence.

Thank you for your cooperation with these requests. We look forward to working with you in the future.

Sincerely,

Linda Chmielewski
Chairperson
Institutional Review Board

bla

APPENDIX C

COPYRIGHT PERMISSION LETTER

THE CENTER FOR THE STUDY OF
SEPARATION AND LOSS
P.O. BOX 2087
BLOWING ROCK, NC 28605
704/295-9501

Joyce Holstrom
30314 Lilac Rd.
St. Joseph, Minnesota
56374

Dear Joyce:

I am happy to give you my permission to use the GEI Profile in your thesis in explaining your results of your study.

My very best wishes in receiving your degree.

Most sincerely,

Catherine M. Sanders

Catherine M. Sanders, Ph.D.
Director

APPENDIX D

RECRUITMENT SCRIPT TO BE READ BY STAFF TO WOMEN IN THE HALF WAY HOUSE.

IRB 97-29-03

You are invited to participate in a research project by and for women on grief and loss issues and women's drinking patterns. Any current resident who is recovering from alcoholism and has grief and loss issues, is welcome to be a part of this study. The research is being conducted by Joyce Halstrom, a chemical dependency counselor. Your participation is voluntary. The first 10 women to sign up will be the participants. The next 10 women to sign up will be on a reserve list. The sign-up sheet is posted on the bulletin boards. Participation in this study will not affect your treatment stay, your relationship with your counselor, or any current or future relationship with Augsburg College.

APPENDIX E

ATTENTION ALL WOMEN WHO ARE RECOVERING FROM CHEMICAL DEPENDENCY

YOU ARE INVITED TO PARTICIPATE IN A RESEARCH PROJECT BY AND FOR WOMEN ON:

Grief and Loss Issues and Women's Drinking Patterns
IRB 97-29-03

The research is being conducted by Joyce Halstrom. Joyce is a certified chemical dependency counselor, licensed social worker, and a graduate student at Augsburg College. This project is for her master's thesis.

Your participation is totally voluntary. The first 10 women to sign up will be the participants. Ten additional women will be on the reserve list. Participation includes a one hour interview with Joyce at which time she will ask each of you questions about your grief and loss issues, your drinking patterns and your treatment. What do you get out of it? You get a chance to be a significant part of research on this important topic. Confidentiality will be strictly maintained. Your name will not be used. Interviews will be scheduled at your convenience.

You will be given a $5.00 honorarium following the interview to compensate you for your time.

APPENDIX F

INFORMED CONSENT
IRB 97-29-03

Grief and Loss Issues and Women's Drinking Patterns

You are invited to be involved in a research study that will explore grief and loss issues have and women's drinking patterns. Grief and loss are defined as loss such as: death of a significant person in your life, loss of job, loss of health, physical abuse, sexual abuse, etc.

The study is being conducted by:

Joyce Halstrom	Certified Chemical Dependency Counselor Licensed Social Worker Master of Social Work student, Augsburg

Background Information
The purpose of this study is to gather information from women in an aftercare halfway house to learn about their drinking patterns and their grief and loss issues. The information will provide data for my thesis.

Procedures
If you agree to be in this study, I will ask you, through a private interview, to complete a demographic form that asks questions about age, marital status, etc. Then I will ask you to complete two questionnaires and meet with me personally to answer some questions about your treatment experience. The interview will be about one hour, and will be tape-recorded for ease in handling the material. Notes will be taken.

Risks and Benefits of Being in the Study
The study has the following risks: Discussion of your personal experiences with grief and loss may elicit many different emotions. Participants will be encouraged to attend the grief and loss group that meets at the halfway house every Friday morning for two hours and is facilitated by Sister Joan.
Benefit to participant: Upon completion of the interview, you will be given a $5.00 honorarium to compensate you for your time. If either of us decide to terminate the interview process, you will still receive the $5.00.

Confidentiality
The records of this study will be kept private. No names will be used. I will not include, in my thesis, any information that might make it possible to identify you. Research notes and the audio tape will be kept in a locked file in my home. After the researcher records the information, the tape will be erased or discarded. Raw data will be destroyed by June 30, 1998.

Voluntary Nature of the Study

The researcher conducting this study is Joyce Halstrom, a certified chemical dependency counselor and licensed social worker. You may ask any questions you have, either now or later, by contacting me, Joyce Halstrom, at my work telephone, 320-256-4224 or at home 320-363-4155. You may also contact my thesis advisor: Maria Dinis, at Augsburg College, 612-330-1704. Your decision to participate or not participate will not affect your treatment stay, your treatment outcomes, your relationship with your counselor, or any present or future contact you may have with Augsburg College.

YOU WILL BE GIVEN A COPY OF THIS FORM FOR YOUR RECORDS.

Statement of Consent

I have read the above information. I have asked questions and have received answers. I hereby consent to participate in the study.

_____

Signature Date

_____

Signature of Researcher Date

I agree to be audio taped.

_____

Signature Date

_____

Signature of Researcher Date

APPENDIX G

SCRIPT
IRB 97-29-03

To be read by the researcher to the respondents before interview and questionnaires begin

THIS RESEARCH IS BEING DONE AS PART OF MY GRADUATE PROGRAM AT AUGSBURG COLLEGE. THE TITLE OF MY PROJECT IS, "GRIEF AND LOSS ISSUES AND WOMEN'S DRINKING PATTERNS." I WILL EXPLAIN THE CONSENT PROCESS TO YOU AND IF YOU AGREE TO BE IN THE STUDY, I WILL ASK YOU TO SIGN THE CONSENT FORM. AFTER YOU HAVE SIGNED THE FORM, I WILL HAVE YOU FILL OUT A FORM ABOUT YOUR AGE, EMPLOYMENT, ETC. YOU WILL THEN FILL OUT A QUESTIONNAIRE ON YOUR ALCOHOL USE AND A QUESTIONNAIRE ON THE LOSS THAT YOU IDENTIFY WITH. IF YOU PREFER, I CAN READ THE QUESTIONNAIRES TO YOU. FOLLOWING THAT, I WILL INTERVIEW YOU TO ASK YOU SEVERAL QUESTIONS. EVERYTHING YOU SAY WILL REMAIN PRIVATE AND CONFIDENTIAL. THE ENTIRE PROCESS SHOULD NOT TAKE LONGER THAN ONE HOUR. THE INTERVIEW WILL BE TAPE RECORDED. I WILL BE THE ONLY PERSON TO LISTEN TO THE TAPE. YOUR NAME WILL NOT BE USED IN ANY WRITTEN MATERIAL AND YOU WILL NOT BE IDENTIFIED IN ANY WAY. IF AT ANY TIME YOU FEEL UNCOMFORTABLE ANSWERING ANY OF THE QUESTIONS, PLEASE LET ME KNOW.

PARTICIPATION IN THIS STUDY IS STRICTLY VOLUNTARY AND THERE ARE NO CONSEQUENCES FOR TERMINATING THE INTERVIEW SHOULD EITHER OF US DECIDE TO DO SO. IF I CHOOSE TO TERMINATE THE INTERVIEW, FOR ANY REASON, I WILL TELL YOU. IF YOU AND I AGREE TO TERMINATE THE INTERVIEW BEFORE ITS COMPLETION, YOU WILL STILL RECEIVE THE $5.00 HONORARIUM, GIVEN TO YOU TO COMPENSATE YOU FOR YOUR TIME. IF THE QUESTIONS BRING UP STRONG EMOTIONS THAT YOU FEEL NEED TO BE DISCUSSED FURTHER, YOU WILL BE ENCOURAGED TO PROCESS THOSE FEELINGS WITH YOUR COUNSELOR. YOU ARE ALSO ENCOURAGED TO ATTEND THE GRIEF AND LOSS SUPPORT GROUP THAT IS HELD AT THIS FACILITY EVERY FRIDAY MORNING WITH SISTER JOAN. FOLLOWING THAT IF YOU FEEL YOU NEED ADDITIONAL TIME, REFERRAL TO AN OUTSIDE AGENCY OR PROFESSIONAL CAN BE MADE. PAYMENT FOR SUCH REFERRALS WILL BE EITHER SELF-PAY OR, DEPENDING UPON YOUR COVERAGE, PAID BY YOUR HEALTH INSURANCE.

APPENDIX H

DEMOGRAPHICS
IRB 97-29-03

1. How old are you? _____

3. What is your county of residence?_____State of residence_____

4. What is the highest grade you completed? (Circle one)

A. Grade School:		0	2	3	4	5	6	7	8
B. High School:	1	2	3	4	9	10	11	12	
C. College:	1	2	3	4					
D. Postgraduate:	1	2	3+						
E. Other		(SPECIFY)_____							

5. Employment: Check the answer that best describes your work situation at this time.

A. Employed full-time (35+ hours) If so, check and skip to question 5A___
B. Employed part-time (less than 35 hours) If so, check and skip to question 5A___
C. Unemployed and looking for work___
D. Unemployed and not looking for work___
E. Unable to work___
F. Retired___
G. Homemaker___
H. Student___
I. Other___

5A. If employed, what is your job title?_____

6. What is your marital status?

A. Single___
B. Married___If married, how many years married?____
B1. If married, how many times married_____
C. Separated___If so, how long have you been separated?_____
D. Divorced___ If so, how long have you been divorced?_____
E. Widowed___ If so, how long have you been widowed?_____
F. If not married do you live with a significant other? _____
F1. How long have you lived together? _____

7. How many children do you have?_____How many step children do you have?_____

8. What is your ethnicity? Check all that apply.

A. Asian, Asian-American___Pacific Islander
B. African American___
C. Hispanic____
D. American, Indian___
F. Caucasian___
G. Other (please describe)_____

9. What is your yearly salary?

A. less than $10,000 yearly ____
B. $10,001 - $15,000 yearly_____
C. $15.001 - $20,000 yearly_____
D. $20,001 - $30,000 yearly_____
E. $30,001 + yearly _____

APPENDIX I

ALCOHOL QUESTIONNAIRE

IRB 97-29-03

1. How often did you drink prior to treatment?

   a. every day___
   b. 2-3 times a week___
   c. once or twice a month_____
   d. once or twice a year___
   e. other
   _____

2. When did you have your last drink?

   a. today___
   b. yesterday___
   c. last week___
   d. between 6 months and one year ago___
   e. more than one year ago___
   f. other (please describe)
   _____

3. What did you drink? (Check all that apply)

   a. beer____
   b. mixed drinks___
   c. wine___
   d. I substituted_____for alcohol.
   e. other (please descrribe._____

4. At what age did you take your first drink?_____

5. Why did you take your first drink? (Check all that apply.)

   a. to get drunk or high___
   b. to give me courage___
   c. curiosity___
   d. family offered it___
   e. friends encouraged you___
   f. other (please describe)_____

6. Did you ever drink socially? Yes___ No___ If no go to #7

   a. If yes, what does drinking socially mean to you? By that I mean how much did you drink when you drank socially?_____

   b. When did your drinking pattern change_____

c. What do you think/believe happened to cause the change in your drinking patterns? Please explain

_____
_____
_____

7. How much did you drink when you did drink?

a. 12 or more drinks___
b. 6-12 drinks___
d. 3-6 drinks___
d. 2 drinks___
e. 1 drink___
f. until drunk or high___

8. What effect did you like the best from alcohol? (Check all that apply.)

a. forgetting my troubles when I drink___
b. drinking to a blackout___
c. passing out___
d. getting drunk___
e. getting slightly high___
f. having a relaxed feeling___
g. other (please describe)_____

9. What is the biggest impact drinking has had on your life? (Check all that apply)
a. resulted in an accident, injury, domestic violence, or arrest_____
b. gotten me into trouble (please describe type of trouble)_____
_____
c. damaged one or some of my relationships_____
d. interfered with my work_____
e. other (please describe)_____

10. How did you feel about your drinking? (Check all that apply.)

a. I often felt guilty about my drinking___
b. I needed help to control myself___
c. I could control it but I was easily influenced by others___
d. I could set limits and control myself___
e. other (please describe)_____

11. I have completed treatment_____ times. My treatment was in_____

12. I started treatment but didn't complete it _____times.

13. If in treatment more than once, how long were you sober in between?_____

14. How do you believe others see / saw your drinking patterns? (Check all that apply.)

a. my friends and family told me they would drink too if they were me___
b. I came to treatment because of an intervention___
c. my friends and family told me to get help for my drinking ___
d. when I drank I neglected my friends and family___
e. as a normal drinker___
f. other (please describe) ___

APPENDIX J

INTERVIEWER SCRIPT
IRB 97-29-03

The following script will be used by the interviewer to determine which of the grief and loss inventories to use with each participant.

Interviewer:

"When your drinking became a problem for you, can you identify a significant loss, a loss through death, or both? By significant loss I mean, for example, a loss other than death. It could be the loss experienced through divorce or separation, the loss of employment, health, or body parts. It could also mean the loss experienced through such things as rape, battering, incest, or sexual abuse.

Interviewer:

"Is it a significant loss, a death loss, or both?"

(Interviewer circles the appropriate response.)

Significant loss Death loss Both significant and death loss

Interviewer Instructions:

If significant loss, give the loss version of the Grief Experience Inventory.

If death loss, give the death version of the Grief Experience Inventory.

If both significant loss and death loss, give both versions of Grief Experience Inventory.

APPENDIX K

INTERVIEW QUESTIONS

To be asked by the researcher

IRB 97-29-03

1. Were any of your grief and loss issues dealt with in treatment? If so, how did you process those issues? If not, why not?

2. Did the goals and objectives of your treatment plan deal with your grief and loss issues? If so, what were they? If not, why not?