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## Women and alcohol: a phenomenological exploration of women's decisions to engage with drug and alcohol services

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WOLLONGONG**



**WOMEN AND ALCOHOL: A PHENOMENOLOGICAL EXPLORATION  
OF WOMEN'S DECISIONS TO ENGAGE WITH  
DRUG AND ALCOHOL SERVICES**

**Renee Michelle Brighton**

**This thesis is submitted in fulfilment of the requirements  
for the award of the Degree:**

**Doctor of Philosophy**

**University of Wollongong**

**School of Nursing**

**February 2016**

## **Abstract**

The aim of this study was to explore the meaning that women who live with alcohol-use disorders attributed to their decisions to engage with drug and alcohol services. Women, alcohol and alcohol-use disorders are under-researched topics when compared to the abundance of studies on male alcohol consumption and its related harms. In particular, there is nearly silence on the discourse about the lived experience of women who consume harmful levels of alcohol and live with alcohol-use disorders (AUDs).

In order to understand and interpret the essence of meaning behind the reasons why the 15 women participants made their decisions to engage with services, a phenomenological approach was used. More specifically, van Manen's (1997) methodological framework provided a structure and a guide to the phenomenological enquiry into the lifeworld's of the women participants.

The research study was designed in a way so as to answer the question: 'what does it 'mean' for a woman with an alcohol-use disorder to engage with services'. So as to encourage the women to share their stories and uncover meanings in their experiences, semi-structured, one-on-one interviews were the methods used to collect the data. NVivo 10TM data analysis software was used to capture the interview transcripts and to analyse and explore the 15 texts. van Manen's (1997) method for isolating thematic statements formed the basis of this analysis.

Within the women's story-telling, an exploration of the essential, unified themes were uncovered and portrayed. These themes, which follow, centre on the women discovering their 'Dislike for Alcohol', 'Overcoming Barriers' to service engagement, prevailing over a 'Sense of Enforcement' to engage with services and bouncing back from reaching 'Rock Bottom'. Deeply embedded within the scenes in the women's story-telling was the essence of their experiences – the meaning that each woman ascribed to her decision to engage with services. This essence was found to be the woman arriving at her 'conceptualisation of the need for change' in terms of her service-seeking behaviours.

Implications for researchers and drug and alcohol service providers' explore the subjective views of women with AUDs. In particular the unique, contextual factors that characterise a woman's lifeworld in terms of her developing and living with an AUD should be understood and privileged.

## **Declaration of Originality**

I, **Renee Michelle Brighton**, declare that this thesis submitted in fulfilment of the requirements for the award of Doctor of Philosophy, at the University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Signed by Renee Michelle Brighton

On the 30th October, 2015

## **Dedication**

This thesis is lovingly dedicated to the memory of my mother, Margaret, who left us too soon. My mother instilled in me strong principles of social justice and the need to create a 'rightness' in this world, which formed the foundations for my work as a nurse and subsequently fuelled my desire to undertake this research. I did it Mum!

*Although you're gone,  
I'm not alone,  
and never shall I be.  
For the precious memories of the bond we shared,  
will never depart from me.*



## **Acknowledgements**

This thesis is the end of my journey in obtaining my PhD. I have not journeyed in a vacuum; this thesis has been completed with the encouragement of many people. The support of friends and colleagues has made this whole endeavour possible, and I am truly grateful to all who journeyed with me.

This work would not be possible without the loving support my husband, John, and my two daughters, Bethany and Violet. Thank you for putting up with all my absences and my obsession with the need to 'write, write, write'! You have all contributed to the completion of this work, especially you John, with your unwavering belief in me that I could do this.

I would like to express my utmost gratitude for the support given to me by my principal supervisor, Lorna Moxham. Her dedication and enthusiasm for qualitative research is unsurpassed, and her vast knowledge and perceptive insight is truly inspiring. Lorna's unconditional faith in me served as a driving force for the completion of this work. I would also like to gratefully acknowledge my co-supervisor, Victoria Traynor, for her advice, mentorship, great enthusiasm, and for simply believing in me. I simply could not have wished for a better supervisory team! I have learned so much from these two amazing women.

I gratefully acknowledge Janette Curtis for the woman who first planted the 'research' seed in my mind and started me on the path to completing this work. Thank you for inspiring me Janette to achieve something I always deemed an impossible 'pipe dream'.

I would like to convey my appreciation of the 'behind the scenes' work of my mother-in-law and father-in-law, Wilma and Russ. The child minding, help with school projects and countless other things you have done was truly remarkable and so very much appreciated.

I appreciatively acknowledge the encouragement of my colleagues in the School of Nursing, University of Wollongong. I would especially like to thank the Head of School, Angela Brown, for her support and consideration of the time I needed to work on this PhD.

I cannot finish without acknowledging and conveying my upmost thanks the 15 women who invited me into their lives and shared their stories with me. Whilst I cannot acknowledge you publically by name, it was an honour and a privilege to have been entrusted to hear and retell your moving stories.

## **Publications and Presentations Arising from this Research**

### ***Manuscripts***

Brighton, R., Moxham, L., & Traynor, V. (2015). Women, alcohol and alcohol-use disorders: Time to understand the 'lived experience'? *Journal of Addictions Nursing* (accepted for publication January 2016), submitted 27<sup>th</sup> October 2015.

Brighton, R., Moxham, L., & Traynor, V. (2015). Women and alcohol-related harms. *Australian Nursing and Midwifery Journal*, 22(10), 52-52.

Brighton, R., Traynor, V., Moxham, L., & Curtis, J. (2013). The needs of women with alcohol-related brain injury (ARBI): a review of the international literature. *Drugs and Alcohol Today*, 13(3), 205-214.

Brighton, R.M., Moxham, L., & Traynor, V. (2012). Support and services for people with alcohol-related brain injury. *Australian Nursing Journal*, 20(3), 36-37.

### ***Presentations***

Brighton, R., Moxham, L. & Traynor, V. (2015). Giving women a voice – narratives on accessing (or not) drug and alcohol services. *Alcohol, Other Drugs, Behavioural Addictions: Prevention, Treatment and Recovery: ADDICTION 2015 Australia: The Australian & New Zealand ADDICTION*.

Brighton, R. (2015). Women, alcohol and alcohol-use disorders: A phenomenological study. *Seminar, School of Nursing Research School, University of Wollongong*.

Brighton, R. (2014). Time to understand the lived experience? Women, alcohol and alcohol-use disorders. *Seminar, South Coast Private Hospital (Evolution Health), Wollongong NSW*.

Brighton, R.M., Moxham, L. & Traynor, V. (2013). Falling between the 'service cracks': women living with Alcohol-Related Brain Injury (ARBI). *1st Australasian Mental Health and Addiction Nursing Conference (pp. 1-1). New Zealand: NZCMHN and DANA*.

Brighton, R.M., Curtis, J. & Traynor, V. (2012). Understanding the lived experience of alcohol-related dementia. *Creating Synergy 2012, Wollongong*.

Brighton, R.M., Curtis, J. & Traynor, V. (2011). Explaining social exclusion in women with alcohol-related dementia: a literature review. *DANA Conference - Exploring the Frontiers of Drug and Alcohol Nursing Melbourne: Drug & Alcohol Nurses of Australasia*.

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## Glossary of Key Terms

ACROYNM	TERM	DEFINITION
AA	Alcoholics Anonymous	An international organisation that offers self-help groups and emotional support encased within a model of abstinence for people with alcohol-use disorders.
ABS	Australian Bureau of Statistics	Statistical agency of the Australian government. Provides national statistics on a range of economic, environmental and health issues.
AIHW	Australian Institute of Health and Welfare	National government agency that provides Australian information and statistics.
APA	American Psychiatric Association	The main professional organisation of psychiatrists and trainee psychiatrists in the United States.
AUD	Alcohol-use Disorder	A problematic pattern of alcohol use leading to clinically significant impairment or distress, as diagnosed by criterion in the DSM-5 by the APA.
BAC	Blood Alcohol Concentration	The concentration of alcohol in a person's bloodstream, expressed as a percentage.
DSM-5	Diagnostic and Statistical Manual (5 <sup>th</sup> edition) of the APA	The standard classification of mental disorders used by mental health professionals in the United States and many other countries throughout the world.
Harm minimisation	Harm minimisation	The official Australian policy concept underpinning national and state public health strategies. Harm Minimisation is consistent with a comprehensive approach to reducing alcohol and drug-related harm, and incorporates supply reduction, demand reduction and harm reduction strategies.
HREC	Human Research Ethics Committee	Institutional committee that reviews the ethics of research proposals.
ICD	International Classification of Diseases	The standard diagnostic tool for epidemiology, health management and clinical purposes, created by the World Health Organization. The ICD-10 is the version currently in use within Australia.
NHMRC	National Health and Medical Research Council	Australia's leading expert body promoting the development and maintenance of public and individual health standards.
NIAAA	National Institute on Alcohol Abuse and Alcoholism	Part of the National Institutes of Health in the United States, supports and conducts biomedical and behavioural research on the causes, consequences, treatment, and prevention of alcohol-related problems.
NSW	New South Wales	The state of Australia where the research was conducted.

NVivo 10TM	NVivo	Qualitative data management software distributed by QSR International.
Primary health care settings	Primary health care settings	Clinical or medical services which are often the first point of contact for the person experiencing/at risk from a health-related condition. Primary health care encompasses primary care, disease prevention, health promotion, population health and community development.
Standard drink	Standard alcoholic drink	Alcoholic drink that contains 10 grams of alcohol (Australian measurement).
UOW	University of Wollongong	Institution supporting this research.
WHO	World Health Organization	A specialised agency of the United Nations (UN) that is concerned with international public health.



## **Conventions used throughout this Thesis**

The following conventions are used throughout the thesis:

- P = participant
- *italic text* for quotations from participant interviews
- ‘single quotation marks’ for added emphasis

Cognisant of my desire to be person-centred, I have used the terms ‘woman and women’ when discussing the participants who were part of this study. ‘Person first’ descriptors are also used and include ‘individual’, ‘person’ and ‘person/people with the lived experience’.

Throughout this thesis, the researcher is referred to in the first person. The use of ‘I’ is made when the worldview of the researcher is presented.

# CHAPTER ONE

## Research Outline

This thesis documents the exploration of the *meaning* women who experience alcohol-use disorders (AUDs) attribute to their decision to engage with drug and alcohol services. This study was undertaken with the intention of privileging women with alcohol-use disorders with a voice, as their stories have, for the large part, remained untold. Knowledge on the lived experiences of women with AUDs in relation to service engagement is important, as women are less likely than men with AUDs to engage with services (Small, Curran & Booth 2010; Grosso et al. 2013). This is despite the fact that women with AUDs, when compared to men, are at greater risk of physiological and psychological health problems (Foster et al. 2014; Dawson et al. 2010).

The impetus for this study came about when I was working as a registered nurse (RN) for a publically funded drug and alcohol service. The lives of women experiencing AUDs shocked and astounded me; the abuse and violence they had endured, the hurdles they had overcome to attend their appointments, the strength they found when contemplating leaving their children for their admission period. I found myself wanting to know more, to do more. Why did some women engage with services when others did not? Why did more men than women with AUDs contact services? What could services do to improve engagement rates by women? Importantly, how could I, as a clinician, do more for these women?

When I was given the opportunity to choose a research topic, this was the first one that came to mind. In my quest to examine this topic, I wanted to explore the lived experiences of women with AUDs and to document their largely untold stories. In addition, I wanted to highlight the gender differences between women and men in relation to alcohol consumption and the development of an AUD. Significantly, I wanted to ask women with AUDs what is was that led to their decisions to engage with services, the *meaning* behind their decisions, so there was the possibility of this information being used to develop women-orientated services.

One of the first steps in the research process was to undertake a comprehensive exploration of the literature specific to women, alcohol and alcohol-use disorders. The topic of women and alcohol in general was found to be a grossly under-researched area. A small number of studies had examined alcohol-use disorders from the perspectives of women, although very few of these had focused on service engagement. The following highlights the key findings from the literature:

- Globally, alcohol remains one of the most commonly and widely used psychoactive, dependence-producing substances. The harmful use of alcohol ranked amongst the top five risk factors for disease, disability and death throughout the world (World Health Organization [WHO] 2014; Lim et al. 2012).
- Alcohol was found to be responsible for a considerable burden of death, disease and injury in Australia (National Health & Medical Research Council of Australia [NHMRC] 2009; Tobin, Moodie & Livingstone 2011). In Australia, alcohol was second only to tobacco in terms of drug-related deaths and hospitalisations (NHMRC 2009).
- Alcohol-use disorders were identified to be alcohol-related psychiatric disorders characterised by a cluster of behavioural and physical symptoms (American Psychiatric Association [APA] 2014). AUDs remained the most prominent neuropsychiatric conditions arising from alcohol consumption (WHO 2014). AUDs were found to be common disorders that were of worldwide widespread concern (APA 2014; Lenaerts et al. 2014). AUDs affected 3.6 percent of the global population aged 15 to 64 years (Roercke & Rehm 2013). Despite this, it was found that only a small proportion of people with AUDs engaged with drug and alcohol services (Korcha et al. 2014; Polcin et al. 2012).
- Women, alcohol consumption and alcohol-use disorders are under-researched areas (Bravo et al. 2013; Evans & Levin 2011), despite the fact that women were found to be more physiologically, psychologically and socially vulnerable to the toxic effects of alcohol than men (Al-Otaiba et al. 2012; Becker & Hu 2008). Women experience a 'telescope effect', where they progress more rapidly than men from minimal alcohol consumption levels to harmful levels; leading to the development of alcohol-use disorders (Kay et al. 2010; Greenfield et al. 2007).

- The findings of research examining alcohol consumption undertaken with male participants have been typically applied to women who consume alcohol (Moos & Moos 2006). Only limited information was available in relation to the long-term outcomes of women who consume harmful levels of alcohol (Monras 2010).
- The lack of women-targeted research has led to the development of male-dominated services for women with AUDs and there exists a paucity in programs designed for women's needs (Al-Otaiba et al. 2012; Cadiz et al. 2005). It was found women with AUDs experience more shame, stigma and societal rebuke than men with AUDs, resulting in women being less likely to engage with services (Small, Curran & Booth 2010; Grosso et al. 2013).
- Women with AUDs had frequently led traumatised lives (Bennett & O'Brien 2007) and faced additional barriers when contemplating engaging with services, such as childcare issues and opposition from family members (Greenfield & Grella 2009). These and other barriers also resulted in women with AUDs being less likely than men to seek help from services (Grosso et al. 2013; Greenfield et al. 2007).
- Despite the fact that women with AUDs may have valuable information regarding their experiences and reasons for services engagement, their views had only been very minimally explored in the literature (Vandermause & Wood 2009). Their voice is largely silent.

Therefore, notwithstanding the fact that alcohol-related harm globally was of considerable concern to the World Health Organization (2014) and other prominent healthcare agencies, there remained a paucity in research exploring women and alcohol consumption. In particular, there was a significant gap in research exploring the topic of women and alcohol-use disorders, specifically that which looked at service engagement. Given this gap, I wanted to add to the body of knowledge in this area and as the reader progresses through this thesis, they will see that this has been achieved.

In order to better explore this topic, I needed to choose a methodological approach that enabled an in-depth exploration of this meaning. It was a priority for me to utilise a methodology that resonated with my quest to ensure opportunity for the women's lived experiences to be documented and acknowledged.

Thus, I employed a phenomenological methodology, as phenomenology is a qualitative method of inquiry where researchers explore the 'deeper meaning' of individual lived experience and meaning (Lopez & Willis 2004). More specifically, utilising a 'hermeneutic' phenomenological approach ensured that my own perspective was not excluded (bracketed) from the research (Laverty 2003).

I felt this was of upmost importance, as, given my background as a drug and alcohol nurse who had cared for women experiencing AUDs, I believed that my experiences would not only enhance the study but in all honesty, how could I 'erase' such experiences? By applying a hermeneutic phenomenological approach, I was provided with the opportunity to use my own experiences to guide the research questions and fuse my own beliefs and experiences with those of the participants (Heidegger 1962).

After I had collected my data, via in-depth individual interviews, the method of analysis employed in this thesis was based upon that proposed by van Manen (1990; 1997). This resulted in the identification and interpretation of an overarching essence of meaning, which was interpreted as being how each woman 'conceptualised her need for change' in relation to her decisions to engage with services.

This essence resulted from the exploration of the themes – scenes – which captured the essential story-telling of the 15 women participants. These scenes were representative of the lifeworlds of the women who unselfishly shared their stories with me. Each woman's experience intertwined to make the phenomenon not a set of segmented experiences, but rather a holistic experience overall. Captured within the women's story-telling was their unique meaning(s) of why they made the decision to engage with services.

### **Research purpose and aim**

The purpose of this research was to make a contribution to the body of knowledge where there was a significant gap in the literature.

The aim of this research was to explore the *meaning* that women with alcohol-use disorders attributed to their decisions to engage with drug and alcohol services.

## **Research question**

The research question that guided this study was:

*What does it mean for women with alcohol-use disorders when making decisions to engage with drug and alcohol services?*

## **Rationale for the study**

This study was undertaken with the intention of providing a voice to women with alcohol-use disorders. This is because their lived experiences and insights, with very few exceptions, have not been adequately explored in the literature, nor are they the focus of clinical practices. To design services that are person centred and in this regard, women-orientated, it is critical to ask the women what led to them contacting services, what prompted their decisions to engage. Therefore, it was expected that the findings of this research would contribute to the identified significant gap in the literature. To that end, this thesis presents findings that explored the meaning that women with alcohol-use disorders attributed to their decisions to engage with services, as told by the women themselves.

## **Organisation of the thesis**

This thesis is presented in six chapters. This current chapter (*Chapter One*) presents a brief introduction, purpose and aim of the study. It also outlines the approach used to structure the thesis.

*Chapter Two* presents a background to the study by exploring the literature on this topic. The chapter places the research into context. Due to the length of the chapter, it has been divided into three sections. Section one documents a general overview of alcohol use in society at an international and national level, including alcohol-related harms. Section two looks specifically at alcohol-use disorders, including diagnostic criteria, causes and origins and service delivery options. Section three explores alcohol use and the development of alcohol-use disorders as experienced by women.

*Chapter Three* outlines the design of the research, describing the qualitative phenomenological methodology and the phenomenological research methods. It includes an explanation of the ethical considerations, demographic information on the research participants and the manner in which they were recruited. Also included are the approaches used to both collect and analyse the data.

*Chapter Four* details the findings of this research. It begins by describing the essence of meaning which is how each woman 'conceptualised her need for change' in relation to her decisions to engage with services. The scenes and elements from the women's story-telling are then described with the support of direct quotes from the interview transcripts.

*Chapter Five* is the discussion chapter, which builds on the information presented in the findings. The information presented in the background chapter is integrated within chapter five as it is compared to the interpretation of the findings. A deep engagement with the literature as well as an examination of theoretical positioning is offered. The essence of meaning that evolved from the scenes and elements is further explored, also with the use of direct quotes from participating women.

*Chapter Six* provides a summary of the purpose and aims of this research. It highlights the study's contribution to knowledge and the implications that this study holds for women with alcohol-use disorders. Other implications for future research and service delivery and policy development are also discussed. Limitations of the study are documented and the chapter concludes with a final reflection.

### **Style and language**

The experience of people with alcohol-use disorders is not well understood, as a large percentage of individuals who live with these disorders never receive help from services (Cohen et al. 2007; Finney, Wilbourne & Moos 2007). This is particularly true of women who experience AUDs (Greenfield et al. 2007; Hunter, Jason & Keys 2013). There is, therefore, the need to privilege women experiencing alcohol-use disorders with a voice, as their voices have been silent for far too long in the literature and in current clinical practices.

Phenomenological research aims to provide evocative descriptions so that the reader will feel and understand the participants' lived experiences (van Manen 1997). For these reasons, I have used the voices of the women participants in the form of direct quotes. In this study, every effort has been made to present each woman's experience from her own perspective whilst also maintaining confidentiality.

The use of hermeneutic phenomenology enables the exploration of participants' experiences with further abstraction and interpretation by the researcher, based on the researcher's theoretical and personal knowledge (Ajjawai & Higgs 2007). van Manen (1990, p. 32) reminds us that phenomenology 'requires of the researcher that he or she stands in the fullness of life, in the midst of the world of living relations and shared situations'. In acknowledgement of this, I have used the first person when referring to myself in this thesis so as to further elucidate how I positioned myself as researcher within the text.

This chapter provided an introduction to, and an outline of, the organisation of the thesis. The next chapter, Chapter Two, will offer a background and in-depth explanation about the impact of alcohol on a global, national, societal and individual level, information which evolved from a comprehensive exploration of the literature specific to these topics. Also provided is an overview of the harms that result from the consumption of alcohol, including the development of alcohol-use disorders. There is also a specific section focused on the experiences of women with alcohol-use disorders.



## **CHAPTER TWO**

### **Background and Context to the Study**

#### **Introduction**

This chapter has been structured to provide a background and in-depth explanation about the impact of alcohol on a global, national, societal and individual level. The significance of alcohol and global public health is explored, as well as the harm that results from intoxication and harmful alcohol consumption. An overview of alcohol-use disorders is provided, with a specific section focused on the experiences of women with alcohol-use disorders, including health service engagement.

A comprehensive review of the literature on alcohol-use disorders was undertaken to better understand the significance of alcohol-use disorders for women. However, the topic of women and alcohol in general was found to be an under-researched area. A small number of studies, which examined alcohol-use disorders from the perspectives of women, were found, but of these, very few considered women's service engagement.

The paucity in the literature, in particular the silence of women's voices, highlighted the contribution to be made by this research. This study, which examined the meaning that women with alcohol-use disorders attributed to their decisions to engage with services, will significantly add to the body of knowledge in this area.

## ***Section one: Alcohol and Society, an Overview***

### **The rise of alcohol consumption**

**Inscription on an ancient Egyptian tomb (circa 2800 B.C.)**

*'His earthly abode was torn and broken by beer.  
His spirit escaped before it was called by God'.*

(Hajar 2000, p. 341)

From the earliest times, ethanol (C<sub>6</sub>H<sub>5</sub>OH), commonly referred to as alcohol, has been used as an intoxicating agent (Chastain 2006). Indeed, alcohol has been used an integral part of many cultures for thousands of years (McGovern 2009). Preceding the modern era (prior to the sixteenth century) fermented alcoholic beverages were consumed in most tribal and village societies with the exception of Australia, Oceania and North America (World Health Organization [WHO] 2014). Remnants of 9000 year-old pottery containing residues of alcohol found in northern China demonstrates that Neolithic people consumed alcoholic beverages (McGovern 2009).

Consumption throughout history has been affirmed and so have adverse health effects. Ancient Greek and Egyptian texts depicted by hieroglyphs and documented on clay tablets recorded the social and health problems associated with the use of alcohol (Room et al. 2002). Ancient Babylonians worshipped a wine goddess and the famous Code of Hammurabi, the Babylonian law code of ancient Mesopotamia, devoted attention to alcohol. Early texts do not hesitate in describing the joys of drunkenness, although ancient sources also warned of the dangers of excess drinking (McGovern 2009).

During the industrialisation period, from mid 1750s to early 1900s, the production of alcohol changed with European colonial expansion to include new beverages developed from innovative ways of distilling and brewing alcohol (Jernigan 2000). As transportation improved, alcoholic beverages became a powerful commodity and influenced patterns of drinking. This changed the cultural position of alcohol, almost everywhere, as it became a household commodity available in all seasons of the year (Room, Barbor & Rehm 2005).

Over time, alcohol was used in many societies and for many purposes. One of the main reasons people consumed alcohol was because of its resulting euphoria. After alcohol is ingested, it enters the bloodstream, crosses the brain-barrier and interacts with several neuronal pathways and cerebral structures in the Central Nervous System (CNS) (Chastain 2006). Alcohol is considered a psychoactive drug because it has complex interactions with a range of neurotransmitters and receptors in the CNS, producing pleasurable effects and mood-changing properties when consumed in moderation (Dasgupta 2011).

More specifically, alcohol is believed to activate the pleasure and reward pathways in the brain by triggering the neurotransmitters dopamine and serotonin (Paton 2005). Alcohol also reduces the excitatory neurotransmitter systems, which stimulate the brain, in addition to increasing the inhibitory ones that sedate CNS activity (Dasgupta 2011). Alcohol is therefore classified in the 'CNS depressant' class of drugs, as it depresses the function of normal CNS responses and slows down brain activity.

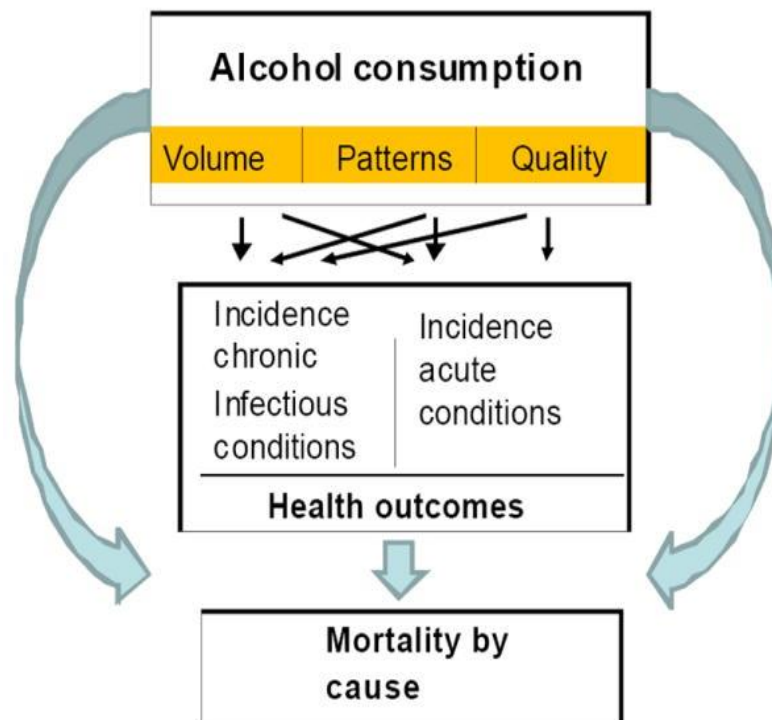
Apart from the physical properties, the consumption of alcohol has always carried a wide variety of symbolic meanings, positive and negative (WHO 2007). Drinking alcohol was, and still is, seen as a token of inclusion, or less commonly exclusion, from a social group, a symbol of celebration or a sacramental act. In most societies, drinking alcohol was, and continues to be, a social undertaking, embedded in a context of values, attitudes and other norms (Chrzan 2013). As described by Lyvers and Webb (2010), social motives were significant predictors of the levels of alcohol consumption. Regardless of how important the biochemical and physiological factors are, it is these values and norms that have an enormous influence over the levels of alcohol consumed in society today (Chrzan 2013).

### **Alcohol and global public health**

Alcohol remains one of the most commonly and widely used psychoactive, dependence-producing substances globally, second only to tobacco (WHO 2014; NHMRC 2009). The excessive use of alcohol ranks among the top five risk factors for disease, disability and death throughout the world (WHO 2014; Lim et al. 2012). Alcohol is the leading contributor to premature death and disability worldwide in people aged between 15 and 59 years (WHO 2014).

Alcohol is associated with more than 200 diseases, injuries and health conditions (WHO 2014). According to the latest Global Status Report on Alcohol and Health by the WHO (2014, p. 2), the net effect of harmful alcohol use is approximately 3.3 million deaths each year, accounting for 5.9 percent of all deaths worldwide, with 5.1 percent of the global burden of disease attributable to alcohol consumption.

The ‘harmful use’ of alcohol is defined by the World Health Organization (WHO 2014, p. 2) as being ‘drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large’. Although there are regional and national differences in levels, patterns and contexts of alcohol consumption, current trends suggest availability and levels of alcohol use will continue to rise. Alcohol contributes to health inequalities on a global level. Three related dimensions of drinking determine ‘alcohol-related harm’: (1) the volume of alcohol consumed, (2) the pattern of drinking, and (3) the quality of the alcohol consumed (WHO 2010; Rehm, Kanteres & Lachenmeier 2010). These interrelated factors result in alcohol-related harm and mortality (Figure 1).



(Rehm et al. 2012)

**Figure 1. Causal model of alcohol-related harm**

With regard to dimension one, the volume of alcohol consumed, little systematic work was undertaken prior to the mid-1990s to describe the overall dose-response relationship between the consumption of alcohol and the risk of disease (National Health, Medical and Research Council [NHMRC] 2009). Alcohol epidemiology is challenging because it can include alcohol use and alcohol-use disorders, as well as countless medical, social, legal and economic consequences (Gunzerath et al. 2010).

Several studies (Laatikainen, Manninen & McBride 2003; Corrao et al. 2004; Rothman & Greenland 2005) have combined data from large-scale international epidemiological studies in an attempt to determine the overall impact of mortality and morbidity from alcohol-related diseases and conditions. For most chronic diseases and injuries causally impacted by alcohol, there was a dose-response relationship (Rothman & Greenland 2005; Dasgupta 2011). The traditional volume in alcohol epidemiology reporting is generally operationalised as the total absolute alcohol consumed over a time period, such as one year (Rehm et al. 2010). As the average volume of alcohol consumption increases, the lifetime risk of illness and death from alcohol-related diseases also increases.

For example, for both genders, the lifetime risk of death from alcohol-related disease more than triples when consumption of alcohol increases from two to three standard drinks (20 to 30 grams of alcohol - one standard drink contains 10 grams of alcohol) per day (NHMRC 2009). Drinking patterns, dimension two, have detrimental impacts on the health of individuals and result in increased levels of alcohol-related mortality. There are many ways that 'drinking patterns' are defined, such as drinking alcohol with meals, drinking on weekends only, or drinking more than a certain amount per session (Tolstrup, Jensen & Gronbaek 2006; Gronbaek 2009).

What is known is that studies measuring 'binge drinking' or 'heavy episodic drinking', most often defined as drinking five or more standard drinks (50 grams or more of alcohol) per session, found increased levels of ill health and disease in both women and men (Chavez et al. 2012; Naimi, Nelson & Brewer 2010; NHMRC 2009). In particular, binge patterns of drinking have been linked to physical injuries, both unintentional and intentional, as well as to increased risks of acute health problems such as heart attack and stroke (Roerecke & Rehm 2010; WHO 2014).

The quality of alcohol consumed, dimension three, has an impact on the incidence of alcohol-related harm. A key example is when homemade beverages are contaminated with methanol or other toxic substances such as disinfectants (Rehm, Kanteres & Lachenmeier 2010). Such alcohol is generally produced illegally, and there are no government controls over the ingredients, price and availability (Rehm et al. 2014), leading to increased alcohol-related harm from consumption of these toxic substances.

Alcohol is a major public health concern, although it has remained a low priority in public policy (WHO 2014). The use of alcohol results in a large disease, social and economic burden in societies across the globe (Rehm et al. 2014; Anderson, Chisholm & Fuhr 2009). Alcohol represents a paradox; it is the most favoured and accepted drug of choice but causes more harm than all of the illicit drugs combined (Collins & Lapsley 2008).

## **Alcohol-related harm**

### ***Health consequences***

As mentioned, an individual's pattern of drinking can have detrimental effects on their health. Patterns of drinking have been linked to disease, injuries and cardiovascular risk, mainly in terms of 'heavy' or 'harmful' drinking occasions, defined as 60 plus grams of pure alcohol on a single occasion (five or more standard drinks) in most countries (Rehm et al. 2010; Roerecke & Rehm 2010; WHO 2014). The increased risk of mortality from the consumption of alcohol generally lies in the range of 245 to 315 grams of pure alcohol per week in the majority of countries (Dawson 2011).

However, it must be noted that considerable debate exists on how to measure high-volume drinking (Glassman 2010; Bagnardi et al. 2008), with many disparities found in the literature. Low levels of alcohol consumption are also difficult to define, as 'low-risk drinking guidelines vary substantially across countries' (Dawson 2011, p. 149). For example, in the United Kingdom (U.K), low levels of alcohol consumption is considered to be drinking no more than three-to-four standard drinks per day for men and two-to-three for women (Department of Health 2015).

In the United States (U.S), according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA 2010), drinking up to one standard drink per day for women and up to two for men is considered 'moderate' drinking. However, the 'ambiguity involved in understandings of excess mean that there is no simple, uncomplicated extreme to which moderate drinking can be countertransposed' (Yeomans 2013, p. 60).

The Australian alcohol guidelines (NHMRC 2009) identified a lifetime mortality risk associated with different levels of drinking, as the lifetime risk of harm from drinking alcohol increases with the amount consumed. The NHMRC (2009) asserted that for healthy men and women, drinking no more than two standard drinks on any day reduced the risk of harm from alcohol-related injury or disease. The World Health Organization (WHO 2014) recommends that women and men drink no more than two standard drinks (20 grams of ethanol) per day, which is considered 'low level'.

The relationship between alcohol and health is complex and multi-dimensional. At low consumption levels, alcohol has been found to have some benefits to health. Such positives include a lower risk of cardiovascular disease resulting from the cardio-protective effects of some alcoholic beverages, such as red wine (Gronbaek 2009). On the other hand, low-to-moderate alcohol use has also been associated with a significant increased risk of cancers of the upper respiratory and gastrointestinal tracts, as well as of female breast cancer (Poli et al. 2013). This again illustrates the paradoxical nature of alcohol. Low-to-moderate consumption may appear beneficial to some body systems but detrimental to others.

There is also considerable variability in biological responses to alcohol. These are determined by individual variations such as genetic predisposition, gender, body mass index (BMI), social context and experiences of drinking, nutrition and metabolism (Quinn & Fromme 2011). Age is also a significant determinant of health risks related to alcohol, as harm from alcohol-related diseases manifests more in older people (Poli et al. 2013). This is why, in Australia, the National Health and Medical Research Council (NHMRC 2009, p. 20) determined 'there is no amount of alcohol that can be safe for everyone'.

It has long been known that an increase in alcohol consumption levels is responsible for increased rates of disease and death (Room, Babor & Rehm 2005; Gronbaek 2009). The cumulative effects from alcohol, defined by the NHMRC (2009) as the effects from many drinking occasions over time, also lead to mortality and morbidity. Reasons why are complex. After alcohol is consumed, approximately 20 percent of it is rapidly absorbed into the bloodstream from the gastrointestinal tract, where it diffuses to almost every biological tissue in the body (Dasgupta 2011).

Alcohol generally starts to affect the brain within five minutes of being consumed and the Blood Alcohol Content (BAC) reaches its peak approximately 30-45 minutes after the consumption of one standard drink (10 grams of alcohol) (NHRMC 2009). Cell membranes are highly permeable to alcohol, as it is a water-soluble molecule. Alcohol itself is not toxic to cells, but the breakdown product acetaldehyde, together with the process of alcohol metabolism by the liver, can result in direct injury to cell structures (Chase et al. 2009).

It takes approximately one hour for the body to clear one standard drink, although the rate of metabolism is dependent on the size of the person's liver, their body mass and composition, as well as their tolerance to alcohol (Edenburg 2007). The cumulative effects of alcohol and the toxic pathways of alcohol metabolism have numerous detrimental consequences that contribute to tissue and organ damage and disease.

### ***Cardiovascular disease and stroke***

The WHO (2014) identified that the highest number of alcohol-attributable deaths worldwide is from cardiovascular disease. The cumulative effects of regular alcohol use are an established risk factor for high blood pressure (hypertension) and the formation of atherosclerosis plaque (hardening of the internal walls of the arteries) (Carnevale & Nocella 2012). Even a moderate amount of alcohol can lead to a rise in homocysteine, an amino acid, which causes the blood to clot and leads to the formation of atherosclerosis (Carnevale & Nocella 2012). Blood clots and atherosclerosis are major risk factors for cardiovascular diseases, such as ischemic heart disease and cardiomyopathy, as well as for myocardial infarction (heart attack) (Roerecke & Rehm 2010). Hypertension and the build-up of plaque in the vessels are also key risk factors for stroke.



The toxicity of ethanol and its primary metabolite substance acetaldehyde on the heart are thought to be another principal mechanism involved in the development of cardiovascular disease (Beyer 2004), although the exact processes of this are not well understood. A meta-analysis of 17 international observational studies examining the causes of mortality from alcohol consumption, confirmed that alcohol has detrimental effects on heart function, and harmful alcohol use is linked to a two-fold risk of developing cardiovascular disease and stroke when compared to the general population (Roerecke & Rehm 2013).

### ***Liver and gastrointestinal damage and disease***

Given that the liver is the primary organ involved in the metabolism of alcohol, moderate levels of alcohol even for only a couple of days can produce fatty liver changes, which generally reverse after abstinence from alcohol. Drinking heavily for longer periods can cause alcohol-related liver injuries and diseases, such as alcohol-related hepatitis, hepatic fibrosis and cirrhosis of the liver (Dasgupta 2011). Liver diseases resulting from alcohol use are the most prevalent types of liver diseases in the western world (Poli et al. 2013). Alcohol-attributable liver diseases are a major factor in the global burden of disease (Rehm & Shield 2013).

Other gastrointestinal problems include acute and chronic pancreatitis (Irving, Samokhvalov & Rehm 2009), with higher alcohol levels creating an exponential increase in risk. Gastritis, gastrointestinal bleeding, and ulcers in the stomach and duodenum are all causally related to alcohol consumption (American Psychiatric Association [APA] 2014). Alcohol can also interfere with the absorption of vitamins and minerals, in particular the B-group of vitamins that are water soluble and easily destroyed by alcohol, resulting in malnutrition (Irving, Samokhvalov & Rehm 2009).

### ***Carcinomas***

Ethanol alcohol has been identified as carcinogenic for the following cancer categories: cancer of the oral cavity, pharynx, larynx, oesophagus, colon and rectum, liver and female breast (International Agency for Research on Cancer [IARC] 2010). The molecular and biochemical mechanism by which alcohol leads to the development of cancers is not fully understood. What is known, is the higher the consumption, the greater the risk.

However, consumption as low as one drink per day significantly increases the risk for some cancers, such as female breast cancer (Seitz et al. 2012; Nelson et al. 2013). While the role of alcohol in breast cancer has been suspected for some time, a meta-analysis of international cohort and case-control studies on alcohol intake and the risk of breast cancer found a linear 12 percent increased risk of some types of breast cancer per 10 grams of daily alcohol (Suzuki et al. 2008).

### ***Alcohol-Related Brain Injury (ARBI)***

Alcohol consumption at higher levels can result in irreversible changes to the structure of the brain and impairment in cognitive function, resulting in Alcohol Related Brain Injury (ARBI) (Brighton et al. 2013). Younger people aged in their teens and early 20s who consume harmful levels of alcohol are at significant risk of negative changes to brain structure, such as smaller pre-frontal cortices and white matter volumes, as their brains are still maturing (De Bellis et al. 2005).

The reasons for these injuries are varied and poorly understood, but are known to be related to the neurotoxicity of alcohol, as well as metabolite and vitamin deficiencies, particularly B vitamins such as thiamine, seen in those who drink (Montoya 2013). Individuals who drink at high levels also have an increased risk of dementia (Gilchrist & Morrison 2005). One devastating type of ARBI is alcohol-induced persisting amnesic disorder, or Wernicke-Korsakoff syndrome, where the ability to encode new memory is severely affected (APA 2013), resulting in long-term cognitive damage and death if left untreated.

### ***Psychological disorders***

The use of alcohol is associated with a high prevalence of psychological disorders, in particular mood disorders. There has been extensive research undertaken on alcohol use and anxiety, but this is complex given that people with social phobias are more comfortable in social situations when they have consumed alcohol (Thomas et al. 2003; Bolton, Robinson & Sareen 2009). Despite this, there is evidence to show that the repeated use of alcohol to alleviate stress and anxiety may actually increase a person's anxiety levels and lead to a dependence on alcohol (Gorka et al. 2014).

The exact nature of the relationship between alcohol and depression is also unclear, as it is somewhat difficult to establish which disorder precedes the other. For example, a meta-analysis by Sullivan, Fiellin and O'Connor (2005) of 35 international epidemiological studies on alcohol and depression found that problems with alcohol were more common in people diagnosed with depression than those in the general population.

Individuals experiencing depression often use alcohol to ease their symptoms (Boschloo et al. 2012), and there is a reported two-to-four fold increased risk of experiencing depression for populations at risk of alcohol-related harm than the general population (Hasin & Katz 2007). The ambiguity may in part be due to symptoms associated with high-risk alcohol use and depression sharing similar behavioural, neurochemical and pathophysiological changes (Hauser, Getachew & Tizabi 2011). Whichever way the disorders manifest, it has been identified that there is a high prevalence of depressive and anxiety disorders in people with moderate-to-high alcohol use (Boschloo et al. 2012; Boden & Fergusson 2011).

### ***Injuries, intentional and unintentional***

Alcohol-related harm also includes injuries that occurred when people were intoxicated. Injuries result from impaired judgement, motor coordination, alertness and reaction time (Friedman 2012). This impairment is dependent upon the person's blood alcohol concentration (BAC) but does show an exponential dose-response relationship (Taylor, Irving & Rehm 2010). People who are intoxicated are more likely to be impulsive, less averse to taking risks and have poor judgement and decision-making abilities (Friedman 2012).

There are two classifications of injuries: intentional and unintentional. Intentional injuries relate to self-harm attempts and suicide, as well as deliberate acts of violence against others (WHO 2007). Alcohol increases impulsiveness and risk-taking behaviour, and thus a strong correlation exists between suicide and alcohol. Alcohol use is a causal factor in at least one-quarter of all Australian suicide deaths (Begg et al. 2007), and there are approximately 2,500 suicide deaths in Australia each year (Australian Bureau of Statistics [ABS] 2014).

Unintentional injuries are caused by road traffic accidents, drowning, burns, poisoning and falls (WHO 2007). Even for people who consume two standard drinks, the odds of injury are almost double for most types of injury (Taylor, Irving & Rehm 2010). According to the WHO (2014), injuries, mostly unintentional, are second only to cardiovascular disease when it comes to the number of alcohol-attributable deaths globally.

### ***Social consequences***

Repetitive, excessive alcohol use can result in social problems and social exclusion. Significant disruptions to family life, homelessness, unemployment, financial difficulties and criminal convictions are all attributable to alcohol use (Pratten 2009; Casswell & Thamarangsi 2009). Another major social issue is related to people driving under the influence of alcohol, as this remains a causative factor in a large percentage of motor vehicle accidents in western societies (Graffigna, Gambetti & Bosio 2011; WHO 2014).

Marginalisation can be a direct result of harmful alcohol consumption. Research has demonstrated that people who consumed alcohol at harmful levels were at risk of homelessness (Johnson & Chamberlain 2008; Thompson et al. 2010). Reasons for this, among others, were the breakdown in marriage or relationships from harmful alcohol use, as well as diminished financial reserves because of the costs of alcohol (Beaumont 2011). As well as being a risk factor for homelessness, harmful alcohol use is common in people who find themselves homeless – people who may not have consumed alcohol to excess before they were homeless (Collins et al. 2014).

People who consume harmful amounts of alcohol have been shown to have diminished access to good healthcare (WHO 2014). Studies on health services demonstrate that the care given to the person who drinks is likely to be inferior, especially if the person is seen as destitute or impoverished (Santana 2002; Mitchell, Malone & Doebbeling 2009). Even when the person is not homeless, stigmatising attitudes from healthcare professionals towards those with alcohol use continues to exist. Healthcare staff often have negative attitudes and a lower regard towards people who consume excessive amounts of alcohol (Gilchrist et al. 2011), which can result in marginalisation and a lack of access to quality care.

Societal stigma toward people engaging in harmful alcohol use is also high. Studies consistently show that people who consume harmful levels of alcohol provoke more social rejection and more negative emotions than those with other mental health disorders (Schomerus et al. 2011; Angermeyer et al. 2011). The origins of this stems from the attribution of responsibility and self-infliction explanations of alcohol consumption, so called 'attribution theory' (Lincoln et al. 2008). This theory proposes that there is an association between the notion that a condition is 'controllable' and the attribution of responsibility for the condition (that the alcohol-related problems are only the person's fault). Lower levels of support for the person can then result, as people believe that the disorder is self-inflicted and thus it is up to the person to help her or himself.

It is claimed that alcohol consumption diminishes empathy (Gizewski et al. 2013), and has a negative impact on the person's ability to solve social problems (Thoma, Freidmann & Suchan 2013). This can result in the person who is consuming harmful levels of alcohol being perceived as a social burden on the people around them, as well as on the healthcare system (Tamutiene 2014). The intensity of this is mediated by the degree of damage to the person's social relations with others, such as family members, employers, colleagues, friends and the public (Room et al. 2010). Harmful alcohol consumption and the resulting lack of empathy also impacts on the person's ability to form social relationships.

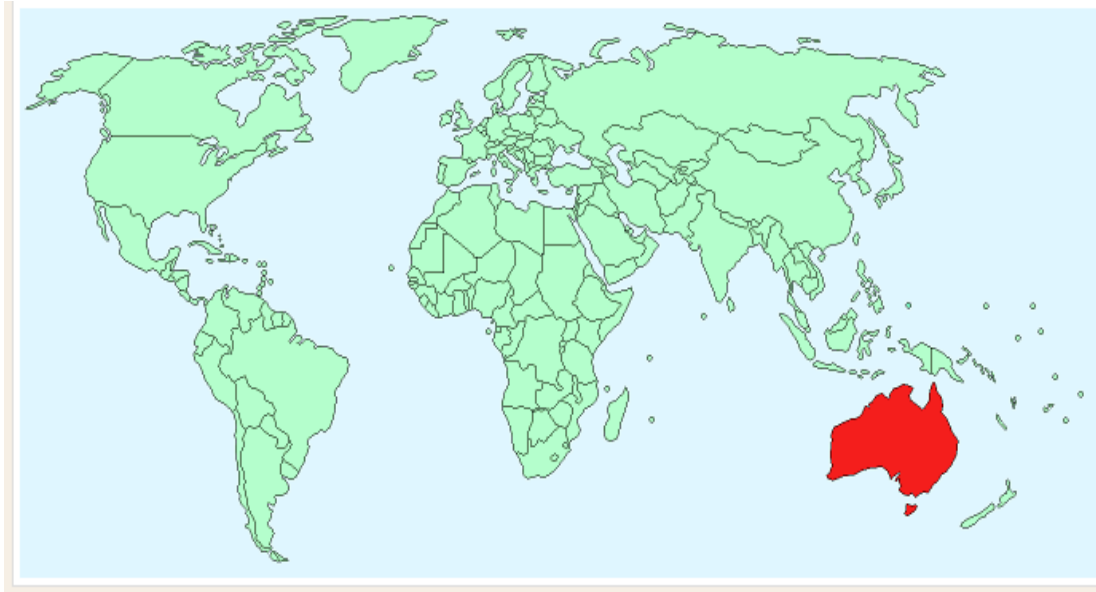
Some of the most severe consequences of harmful alcohol consumption are experienced by the people in the most immediate environment to the person drinking, usually children or partners (Berends, Ferris & Laslett 2014). Even when only one parent is drinking to excess and the other takes care of the child social risk is unavoidable, as harmful alcohol consumption has an impact on the family and may contribute to the relationship becoming dysfunctional (Schroeder, Kelley & Fals-Stewart 2006). In a review of the literature undertaken in the United States (U.S.) exploring the links between alcohol consumption, intimate partner violence, and the effects on children, it was suggested that home environments where one or both parents consumed excessive alcohol are 'often marked by high levels of violence and general intraparental conflict' (Klostermann & Kelley 2009, p. 3162).

Excessive alcohol use has been documented as a risk factor for many types of aggressive and violent behaviours (Foran & O’Leary 2008; Livingston 2011). Alcohol-related violence is an immense social consequence of drinking. People under the influence of alcohol commit violent acts or find themselves the victims of such acts (McMurrin 2012). During violent interactions, such as assaults that occur in public, not only does alcohol enhance and trigger aggressive and violent behaviours, it can also reduce the likelihood of bystanders intervening to help the victim (Bye 2007). Consistently, it is reported that almost half of all victims of violence reported that perpetrators were under the influence of alcohol (Motluk 2004; Livingston 2011).

Alcohol is also highly correlated with intimate partner violence, with research demonstrating that the use of alcohol, when compared to no alcohol, significantly increased the severity of injuries experienced by the victim, usually a woman (Oberleitner, Mandel & Easton 2013; Klostermann & Fals-Stewart 2006). In a narrative review on the biological and psychological explanations for intimate partner violence by Ali and Naylor (2013), violent male partners who assaulted their female partners were reported to have drunk at excessive levels when compared to non-violent controls and the general population.

The above discussion illustrates that alcohol-related social consequences are not restricted to the person drinking, as families and the wider community also experience negative outcomes. Alcohol is responsible for a considerable burden of death, disease and injury. The impact of alcohol, however, goes beyond injuries and diseases to a range of social consequences, which remain of significant concern.

## Alcohol and Australia



(wpmap.org)

### *Setting the context*

#### Convict Rum Song (circa early 1800s)

*Cut yer name across me backbone  
Stretch me skin across yer drum  
Iron me up on Pinchgut Island  
From now to Kingdom Come.  
I'll eat yer Norfolk Dumpling  
Like a juicy Spanish plum,  
Even dance the Newgate Hornpipe  
If ye'll only gimme Rum!*

(convictcreations.com)

It is important to note that this section of the thesis contains information on events that occurred during and after the European colonisation of Australia and only examines facets of alcohol consumption by non-Indigenous Australian people. This is because, prior to European colonisation (1788), no evidence has been found to show that Aboriginal and Torres Strait Islander peoples (Indigenous Australians) consumed alcohol (WHO 2014). The history regarding the introduction to, and current use of, alcohol by Aboriginal and Torres Strait Islander communities, whilst extremely significant, is beyond the scope of this thesis.

The image of the hard drinking Australian person has historical roots that date back to European colonisation. It has even been argued that 'drinking forms part of the romantic Australian legend' (Midford 2005, p. 892). At the time of colonisation, beginning with the first white settlers in 1788, it was the custom in Europe to drink excessively, a trait which was carried to Australia by the new settlers, many of them convicts (Dunstan 1974). At the very beginning of European settlement, as a predominantly male penal colony, excessive drinking was a prominent feature in Australian society (Room 2010).

The new settlers to Australia were known to drink more alcohol compared to any other society in the world (Dunstan 1974). The trade in rum even formed an integral part of early Australian currency. The first hospital erected in Australia in Sydney 1816, was given the title 'the rum hospital' (later known as 'Sydney Hospital'). This title resulted from no direct government money from Treasury. Construction costs were covered by a rum monopoly of 60,000 gallons of rum as organised by Governor Macquarie and sold in the colony over a three-year period (Johnson 2000).

Although an integral part of early life in the colony, not everyone, viewed such excessive alcohol use in a positive light. Marcus Clarke, an author and poet, wrote of his fellow-colonists in the late 19<sup>th</sup> century that 'they are simply a nation of drunkards' (Kirkby 2003, p. 203). Similarly, English novelist Anthony Trollope, in his thoughts about the Australian colonists, wrote 'drunkenness was their one great fault' (Kirkby 2003, p. 203).

In the late 1800s, as Australia became an urbanised society, the temperance movement, a movement aimed at curbing the production, selling and consumption of alcohol, reached its most influential era, and, as a result, alcohol consumption levels decreased dramatically (Room 1988). The temperance movement in Australia had been operating in the colonies since the 1830s. After a number of Scottish and North American temperance missionaries visited Australia, the number of temperance members increased (Kirkby 1997).



Temperance as a social movement began to gather strength in Christian Protestant denominations, including the Church of England, and by mid 1870s temperance advocates were being elected to public office. From then on, it was a concerted campaign to convert the population to temperance principles (Kirkby 2003). These principles included teetotalism, but the real goal was the prohibition of alcohol. The movement then turned towards legislation and sought to influence liquor reform. Temperance was an attack on the 'evils' of drink but targeted the liquor trade rather than the 'victims' - the 'drunks who were to be 'saved' (Kirkby 1997, p. 94).

Temperance activism therefore became directed not only at the 'evil' drink, but also at political action. 'Each colony formed an Alliance to tie together all the various anti-drink forces for political action' (Dunstan 1974, p. 56). The eventual result became an attempt at alcohol Prohibition, which, like most countries where Prohibition was undertaken, failed at stopping the sale of alcohol altogether. In fact, alcohol was often purchased illegally and there was a trend of rapid consumption of high alcohol content beverages (Midford 2005). What did occur was a large reduction in the number of hotels ('pubs'); there were less than half the original number by the early 1900s due to the closure by governments of the venues deemed 'unnecessary' (Dunstan 1974).

Another visible restriction from the Prohibition period was the requirement of the six o'clock closure for all alcohol drinking establishments across Australia (Phillips 1980). This was adopted after the First World War, more than 30 years after the beginnings of temperance campaigning. The fallout was what eventually became known as the 'six o'clock swill' – the frantic hour between finishing work at five and the six o'clock pub closing hour (Luckins 2007).

This period in time resulted in a significant shift in drinking patterns. Old hotels with small bars, where people went to socialise and have a quiet drink, had to be renovated to make way for the crowds of men who made their way to the pubs after work each day for this hour of intense drinking. And it was only men, as 'respectable women' were excluded from public drinking places until the 1960s (Room 2010). As per a sign posted in a hotel from this time 'No kids, dogs or women in this bar' (Keesing 1982, p. 62).

This one-hour of excessive drinking was apparently a sight to be seen, as described by journalist John Larkin: ‘ankle deep at 5.30pm in a morass of cigarette butts decomposing in slopped grog, a howling thirsty mass crawling over each other demanding fifteen beers each to drink in the last, desperate guzzling minutes’ (Luckins 2007, p. 8). Men would order a staggering number of beers at one time and drink them in quick succession. Image 1 depicts a typical ‘6 o’clock swill’ weekday crowd.



(Inside Story 2014)

**Image 1: Drinkers at a Bondi pub, NSW Australia 1941**

The rapid consumption of alcohol seen every weekday afternoon throughout Australia led to persistent problems of alcohol-related violence - ‘pub brawls’ and public displays of extreme and often violent drunkenness (Luckins 2007). It also resulted in extremely intoxicated husbands going home and taking out the frustrations of their day on their wives and children. Getting drunk was what Australian men equated with the ‘good life’ (Kirkby 2003). It became a rite of passage for young men entering manhood to be taken to the pub everyday by their fathers to celebrate their coming of age (Luckins 2007).

Australian men drank, as stated by a young man at the time, 'with the sole idea of getting drunk...everybody got drunk, several would have chundered [vomited] and others flaked [passed] out' (Kirkby 2003, p. 205). Despite the problems seen with alcohol use back then, these heavy drinking traditions became enshrined rituals of male solidarity, which still continue to be seen today in some places. Once established, the early closing time endured for much longer than originally anticipated.

When the Melbourne Olympics in 1956 were held, some 30 years following the introduction of the six o'clock closure, such scenes as that depicted in Image 1, were still astonishing overseas visitors. One Olympic visitor from the United States declared, 'it is a most interesting sight, but no doubt distressing for the people of Melbourne' (Dunstan 1974, p. 111). Beer drinking, masculinity and Australian nationalism was at its height during the 1950s (Kirkby 2003).

There were concerns at the time from medical practitioners and their allies regarding the negative impact of high alcohol consumption levels. Alcohol-specific treatment systems began to appear (Room 2010). Alcoholics Anonymous (AA), a self-help group aimed at people who had the desire to stop consuming alcohol, which formed in Australia in 1945, flourished around this time (Leach & Norris 1977), and a new name and conceptualisation for inebriety was established - 'alcoholism' (Room 2010).

In 1956, the Foundation for Research and Treatment of Alcoholism was founded in NSW, soon followed by the other states and territories, which was run by a small group of ex-drinkers (Room 1988). In the early 1960s, specific state agencies for alcoholism emerged, and services shifted to be more in line with the medical or disease models of treatment of the time. Framing harmful alcohol use in terms of alcoholism had the effects of essentially splitting the population of drinkers in two. On one side, there were the 'alcoholics', people with an illness who could not control their drinking and needed treatment, and on the other there was rest of the population –the 'social' drinkers (Room 2010).

It was therefore considered pointless trying to use ‘controls’ as a way of reducing the availability of alcohol as a means to reduce harmful drinking, as ‘alcoholics’ would get their alcohol anyway. People (the ‘non-alcoholics’) were opposed to the mention of government controls; they had the right to take care of themselves and be left alone to enjoy their drinking (Room 2010). Despite all the evidence to show that restrictions and controls do work (Anderson, Chisholm & Fuhr 2009; Casswell & Thamarangsi 2009), these assumptions continue to be made to this day.

In 1966, six o’clock closure finally ended as the last states and territories amended their licensing laws. Even so, by the late 1960s, beer consumption had come to be identified with ‘being Australian’, due to the nature of Australian drinking practices and the unique place the pub played in Australian life (Kirkby 2003). This era also witnessed a clear level of coercion in the expectation that by drinking with mates, one endorsed Australian values – in other words, it was ‘un-Australian’ not to engage in heavy binge sessions with friends (Phillips 1980). Not surprisingly, the number of male ‘alcoholics’ (men with alcohol-use disorders) was deemed high at this time by world standards, it was calculated that one in every 20 males were alcohol dependent (Phillips 1980).

In the late 1960s, drink driving was recognised as a major contributor to traffic deaths and the first countermeasures, pioneered in the state of Victoria, to combat this, were introduced. This included introducing the use of the breathalyser to check Blood Alcohol Concentrations (BAC) levels in 1962, and setting the 0.05 percent blood alcohol level in 1965 (Room 2010). Random breath testing followed, first in Victoria in 1976 and across the rest of Australia by 1988. However, drink driving tended to be defined as a ‘policy area separate from alcoholism’ (Room 2010, p. 158). In saying this, it was thought that the criminalisation of drink driving was undertaken as a balancing measure to counteract the end of the 6 o’clock pub closure.

This era also revealed a change in Australian drinking culture, as women were now allowed to frequent the previously male dominated public drinking places. It was no longer acceptable for women to wait outside on the footpath while their husbands drank in the bar with their friends, nor were pubs the only place to drink, as licensing provisions were extended to restaurants and theatres (Kirkby 2006).

The growth of sports and other clubs also facilitated the transformation of drinking establishments (Room 2010). By the 1970s, the result was an enormous increase in the availability of alcohol. Although beer consumption continued to increase after licensing changes, moving Australia in 1970 to the fourth highest beer-drinking nation in the world, it slowed pace significantly when the laws governing closure were rescinded (Phillips 1980).

Wine consumption, in contrast, increased dramatically at this time, mainly due to the influence of the 'new Australians', people who emigrated from eastern and southern Europe (Kirkby 2006). More people, women and men, began to drink wine at home, with meals or to relax in the evenings. 'Cask' wine (an Australian invention of a cardboard box with a plastic liner containing several litres of wine) became available and sat conveniently on Australian kitchen counters and in refrigerators (Room 2010). Also common were the sweet, sparkling wines largely consumed by women, which were considered a female substitute for beer. Alcohol had begun to penetrate all parts of Australian life, and had reached 'epidemic proportions, the neglect of which would represent gross national responsibility' (NHMRC 1975, p. 2).

From the 1980s, the alcohol beverage industries, particularly the breweries, moved to identify themselves with Australian culture, such that they sponsored sports events and cultural activities (Baume 1985). Nearly every sporting event featured advertising and sponsorship from the main alcohol industries, in particular the beer industry, a tradition which continues to this day. To help combat the influence of alcohol advertising and other variables on drinking rates, in 1985 the first National Drug Strategy was launched, which monitored patterns of alcohol and other drug use in the Australian population (Blewett 2009).

The National Health Policy on Alcohol followed this in 1990, which had the objective of minimising the harms associated with the consumption of alcohol (Blewett 2009). The Australian government's response through the implementation of alcohol policies at this time was not a clear-cut commitment. The government stated: '...it is aware that implementation of any national strategy which involves reducing overall consumption of alcohol will also involve some curtailment of the rights and responsibilities of responsible consumers of alcohol' (Petersen 1987, p. 338).

The rights of 'responsible' consumers appeared to outweigh the prevention of the alcohol-related harm suffered by so many. This response may have, in part, been due to the fact that taxes on alcoholic beverages provided, and still do provide, significant contribution to total government revenue (Byrnes et al. 2010; Tobin, Moodie & Livingstone 2011; Room 1988). For example, in the 2007-2008 financial year period, the total taxation revenue collected from alcohol sales was equal to \$7426 million Australian dollars (Byrnes et al. 2010).

Over the last 20 years, there has been a gradual deregulation of liquor licensing in Australia, making it easier to obtain a license and to extend trading hours (Pennay, Lubman & Frei 2014). Alcohol manufactures increased their range of products, such as producing ready-to-drink alcoholic beverages or 'alcopops' targeting younger drinkers, particularly females (Jones & Reis 2011). Binge or heavy episodic drinking by younger Australians came to the forefront once again, and continues to be a problem in modern day Australian society (Jones & Magee 2014). Despite the challenges, Australia continued to adopt a range of policies to reduce the harms from the consumption of alcohol.

However, it was suggested that the most successful strategies and policies were not implemented or enforced as strongly as they could be for political and economic reasons (Pennay, Lubman & Frei 2014; Livingston, Laslett & Dietze 2008). There is evidence from other countries that some of the most effective policies and strategies at achieving a reduction in alcohol-related harm are the ones focused on restricting the availability of alcohol (Chikritzhs et al. 2007; Doran et al. 2010).

Reducing the number of alcohol outlets in the one area and imposing curfews on licensed premises can equate to a reduction of alcohol purchases and consumption (Livingston, Laslett & Dietze 2008). Raising the price of alcohol also results in reduced per capita consumption and a subsequent reduction in acute and chronic alcohol-related harms (Casswell & Thamarangsi 2009; Barbor et al. 2010). Despite the efficacy of these policies internationally, they are not proactively implemented in Australia.

This may be due to the fact that they are 'politically unpalatable' in a number of areas: drinkers and members of the community often oppose such restrictions, the alcohol industry is a strong lobby group with significant political sway and the government is accustomed to the tax revenue generated by alcohol (Pennay, Lubman & Frei 2014; Casswell & Thamarangsi 2009; Chalmers et al. 2013).

In Australia cheap wine and alcoholic cider attracts very little tax, and these inexpensive types of alcohol are favoured by those drinking at harmful levels (Chalmers et al. 2013). It would appear that the Australian government could curb per capita alcohol consumption and quite possibly reduce the harms associated with drinking by restricting the availability of alcohol and increasing the price (Pennay, Lubman & Frei 2014).

Evolving from its extensive alcohol-related history, Australian society continues to legitimise harmful alcohol behaviours (Livingston 2013). Many Australians accept drinking as an integral part of identity and culture. Currently, according to the WHO (2014), in higher-income countries such as Australia, there remains a greater alcohol-attributable disease burden when compared to lower-income countries.

Contemporary Australian beliefs about alcohol tend to grant it epic status; a rite of passage for youth and people display a general overall tolerance for drunken behaviours. The social acceptability and high availability of alcohol has led to a normalisation of high rates of drinking in Australian society (Pennay, Lubman & Frei 2014). This normalisation, especially in younger Australians, is thought to be largely associated with perceived approval from family and friends of 'drinking to get drunk' (Jones & Magee 2014).

Historical and cultural norms in this country when it comes to drinking have always exerted a powerful influence on individual behaviour, especially in youth. Alcohol is responsible for a considerable burden of death, disease and injury in Australia (NHMRC 2009; Tobin, Moodie & Livingstone 2010). Estimates indicate that alcohol-related harm costs the Australian community in excess of \$15 billion per year (NHMRC 2009). These figures (the latest available) were based on the year 2004-2005 and may not reflect the increased current expenditure and indeed be an underestimation (Room et al. 2010).

### ***Australians at risk***

According to the figures from the latest National Drug Strategy Household Survey Report (AIHW 2014, p. 31), one in five Australian people aged 14 years and over drank at levels that put them at risk of harm from alcohol-related disease or injury over their lifetime. More than 3.5 million Australians were at risk of alcohol-related disease or injury based on their lifetime patterns of drinking in 2013 and people aged 18 to 29 years were in the highest-risk age group (AIHW 2014). Young people have been shown to be at particularly high risk from memory loss, violence and unwanted sexual activity as a result of consuming alcohol (Midford et al. 2014).

Australian children under 18 years also had higher rates of alcohol consumption when compared to children in the U.S. (Toumborou et al. 2009), and children living in Europe (Jonkman et al. 2012). People living in areas deemed rural, remote or very remote were more likely to drink at levels that put them at risk of alcohol-related harm when compared to people residing in urban areas (AIHW 2014). Rural culture has been recognised as an important factor influencing the disproportionately high burden of alcohol-related harm experienced by rural Australians (Inder et al. 2012).

Alcohol consumption is highly valued in the Australian rural context and there is strong, normative pressure to participate in social drinking to gain a sense of belonging (Allan et al. 2012). In Australia, alcohol is second only to tobacco in terms of the preventable cause of drug-related deaths and hospitalisations (NHMRC 2009). The consumption of alcohol accounts for a large proportion of emergency department presentations (Coomber et al. 2013; Miller et al. 2011). On average, it is thought that one in four hospitalisations of young people aged 15 to 24 years occurred because of alcohol (AIHW 2014).

Gao, Ogeil and Lloyd (2014), in a recent report commissioned by the Victorian state government, closely examined national figures. The researchers analysed data on population, alcohol consumption and causes of death and hospitalisation to model the health impact of alcohol, based on its contribution to various diseases and injuries. The findings were startling and made news headlines across the country in July 2014. Gao, Ogeil and Lloyd (2014) found there were 5,554 deaths and 157,132 hospitalisations (Table 1) in Australia attributable directly to the consumption of alcohol. This equated to approximately 15 deaths and 430 hospitalisations per day, an increase of more than 62 percent in the last decade.



Table 1. Alcohol-attributable deaths and hospitalisations in Australia 2010

CONDITIONS	DEATHS (%)		HOSPITALISATIONS (%)	
	Men	Women	Men	Women
<b>Detrimental Effects</b>				
Cancers	861 (25%)	642 (31%)	5,175 (5%)	5,002 (9%)
Cardiovascular diseases	436 (13%)	708 (34%)	7,115 (7%)	3,558 (6%)
Digestive diseases	549 (16%)	237 (11%)	6,726 (7%)	2,970 (5%)
Infectious & parasitic diseases	123 (4%)	123 (6%)	4,990 (5%)	3,704 (7%)
Injuries	1,239 (36%)	256 (12%)	47,189 (47%)	17,779 (32%)
Neuropsychiatric diseases	258 (7%)	122 (6%)	30,231 (30%)	22,695 (41%)
<b>TOTAL</b>	<b>3,467 (100%)</b>	<b>2,087 (100%)</b>	<b>101,425 (100%)</b>	<b>55,707 (100%)</b>

(Gao, Ogeil & Lloyd 2014)

As indicated in Table 1, alcohol-attributable injuries resulted in the largest number of male deaths, and alcohol-related cardiovascular disease was ascribed to the highest number of female deaths (Gao, Ogeil & Lloyd 2014). The consumption of alcohol is also significantly linked to episodes of self-harm, with the incidence of self-harm episodes coupled with considerable alcohol consumption increasing over the past two decades in this country (O'Loughlin & Sherwood 2005). Costs to lost productivity due to absenteeism from work from alcohol use are also high in this country, estimated but probably conservatively, at \$3.5 billion per year (Manning, Smith & Mazerolle 2013).

It is not only the person consuming alcohol that is negatively affected by its use. In an Australian study that examined the views of 2649 people regarding the adverse impact of alcohol on people other than the drinker (Laslett et al. 2011), a total of 70 percent of participants reported being negatively affected by someone else's consumption of alcohol. This included physical and verbal abuse from an intoxicated person.

Recently, as highlighted extensively in the Australian media, an alarming incidence of ‘king hit’ or ‘one-punch’ cases, caused by a perpetrator knocking another to the ground with a single blow to the head, have been reported. Tragically a number of these cases, generally involving young men and stemming from alcohol-fuelled aggression and violence, have had fatal outcomes (Pilgrim, Gerostamoulos & Drummer 2013). In response to the increase in these cases, the New South Wales (NSW) State government introduced on the 30 January, 2014 a new ‘one-punch’ law, where an aggravated 25 year maximum and eight year minimum sentence is applied when the offender is intoxicated by alcohol or drugs (Quilter 2014). Image 2 reveals the faces of young Australian men tragically killed by alcohol-fuelled, one-punch attacks.



(The Age Victoria, 2<sup>nd</sup> December 2013)

**Image 2. Australian victims of alcohol-fuelled, one-punch attacks**

There is also a link to other types of violent acts and the consumption of alcohol. The most recent report on homicides in Australia indicated that alcohol consumption, either by the victim or the perpetrator, preceded nearly half of all homicide incidents (Chan & Payne 2013). Alcohol consumption in Australia is also associated with breakdown of the family unit resulting from intimate partner violence, child abuse and neglect (NHMRC 2009). The use of alcohol continues to affect a wide range of people, many innocent and some who put themselves and others at high risk of harm, trauma or even death.

### ***Australian NHMRC guidelines***

In an effort to decrease the high incidence of alcohol-related harm, the National Health and Medical Research Council (NHMRC, 2009) developed guidelines to help reduce the risks from drinking. 'Risk' in this sense is using the epidemiological definition of the term. A person's risk of experiencing an adverse health outcome is defined as 'the probability of the person developing that outcome in a specified time period' (NHMRC 2009, p. 33). The specified time period may be short, such as a few hours after drinking, or long, for example over a lifetime.

Lifetime risk is a commonly used standard for evaluating the risk associated with exposure to a specific substance or situation. The NHRMC (2009) decided on a lifetime risk of dying from alcohol-caused disease or injury of one in 100 (one death for every 100 people) as the source for guidance as to what could be seen as acceptable risk from drinking in the context of present-day Australian society. Table 2 identifies two of the guidelines, with further explanation to follow.

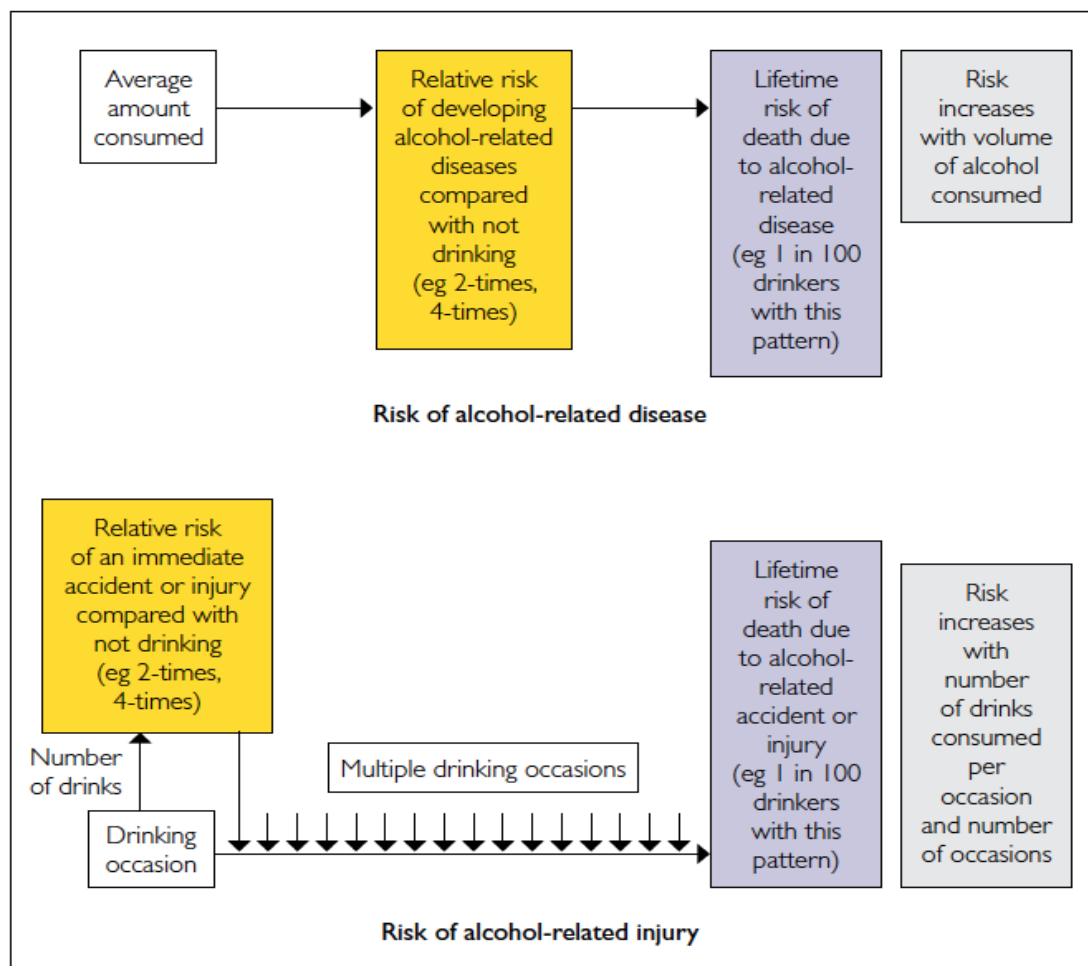
**Table 2. NHMRC Australian Guidelines to Reduce Health Risks from Alcohol**

<b>NHRMC Guidelines Alcohol</b>
<p><b><i>Guideline 1</i></b></p> <p>Reducing the risk of alcohol-related harm over a lifetime.</p> <p>The lifetime risk of harm from drinking alcohol increases with the amount consumed.</p> <p>For healthy men and women, drinking no more than 2 standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.</p>
<p><b><i>Guideline 2</i></b></p> <p>Reducing the risk of injury on a single drinking occasion of drinking.</p> <p>On a single occasion of drinking, the risk of alcohol-related injury increases with the amount of alcohol consumed.</p> <p>For healthy men and women, drinking no more than 4 standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.</p>

(NHMRC 2009)

It was established by the NHRMC (2009) that the lifetime risk of death from alcohol-related disease or injury remains below one in 100 if no more than two standard drinks are consumed on each drinking occasion for both women and men, even if the drinking is daily. The Australian standard drink contains ten grams of alcohol (equivalent to 12.5 grams of pure alcohol). Every drink above this level continues to increase the risk of both disease and injury.

When considering the number of drinks on a single drinking occasion, it is said that for healthy women and men, no more than four standard drinks reduces the risk of alcohol-related injury arising from that occasion (NHMRC 2009). Australians that choose to drink more than the guideline levels will, on average, increase their risk of harm to a level higher than that of a person who chooses not to drink or to drink at a lower level. Figure 2 illustrates this concept of risk.

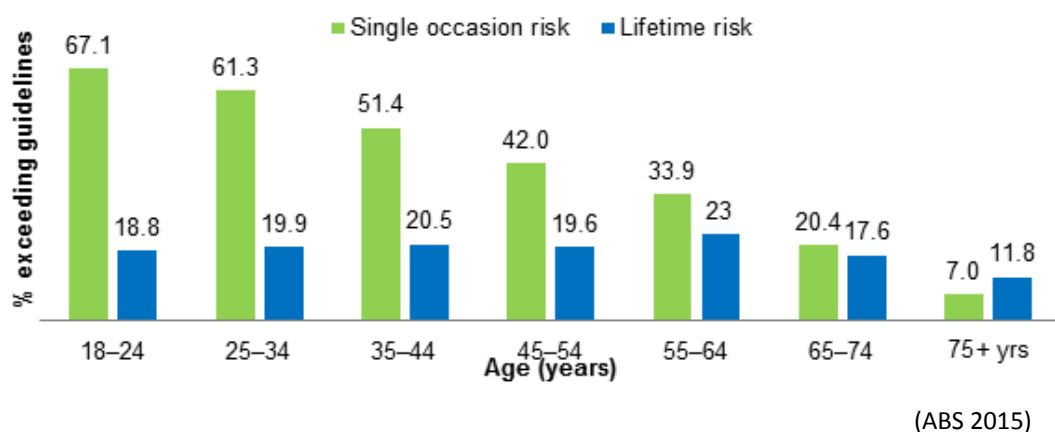


(NHMRC 2009)

Figure 2. Alcohol-related risks for different patterns of drinking

There is evidence to suggest that many Australian people are not aware of the NHMRC guidelines when it comes to their levels of risk with alcohol (Pennay, Lubman & Frei 2014; Livingston 2011). Even when people are aware, knowledge of this risk does not always translate into healthy drinking behaviours. In a survey of 1381 Australian people aged 16-29, using questions based on the NHMRC guidelines, 74 percent of participants had an accurate understanding of safe limits, 27 percent consumed alcohol at levels associated with long-term harm and 53 percent drank at levels that would cause harm or injury (Bowring et al. 2012).

Similarly, a survey of 774 Australian university students found 75 percent were aware of the guidelines but this knowledge was not associated with the reduced likelihood of harmful alcohol consumption (Reavley et al. 2011). Figure 3 outlines the proportion of Australian people (aged 18 years and older) that consumed alcohol in excess of the NHMRC guidelines in the 2013-2014 year period.



**Figure 3. Proportion of Australians who consumed in excess of NHMRC guidelines**

If the guidelines are to influence any major changes in how Australians perceive their alcohol behaviours, a more concerted public education campaign may be necessary. As people in the 18 to 29 years age group are more likely to experience harms from alcohol, campaigns aimed at younger Australians may help create greater awareness of the risks and their vulnerability (Rundle-Thiele et al. 2013). One type of harm experienced more commonly in Australia by people in the younger age categories is a group of conditions known as ‘alcohol-use disorders’ (AUDs). Due to the fact that these disorders result in more harm to the person than any other alcohol-related illness or disease, AUDs are discussed separately in Section 2 that follows.

## ***Section 2. Alcohol-use Disorders (AUDs)***

Significant national and global problems attributable directly to harmful alcohol-related behaviours are alcohol-use disorders (AUDs). These types of disorders, which result in higher rates of disability and social problems when compared to other chronic, alcohol-related illnesses, are the most prominent neuropsychiatric conditions resulting from alcohol consumption (WHO 2014). AUDs are common disorders that are of worldwide concern (APA 2013; Lenaerts 2014). AUDs affect 3.6 percent of the global population aged 15 to 64 years (Roercke & Rehm 2013).

As previously mentioned, there is a stronger likelihood that a younger person, when compared to an older person, lives with an AUD. The onset of AUDs is more likely to occur before age 30 (Grant et al. 2015; Kessler et al. 2005). In an Australian context, the latest report by the Australian Institute of Health and Welfare (AIHW, 2011) on the health and wellbeing of young Australians (12-24 years), identified that AUDs are the most common mental health disorder experienced by males, and second only to anxiety disorders in females. These disorders have been shown to have devastating consequences on an individual and societal level. As such, diagnostic criteria for alcohol-use disorders was developed to provide clear and descriptive categories in order for clinicians to identify and plan treatment for people who experience AUDs.

### ***Diagnostic criteria***

The fact that people can develop 'addiction' to alcohol has been known for some time. In the late 18<sup>th</sup> century, physician-scholar Rush began advocating for the 'disease model' of alcohol addiction (Keller & Doria 1991). Prior to this time, the excessive consumption of alcohol was viewed as moral degeneracy and a character flaw (Gunzerath et al. 2010). Swedish physician Huss coined the term 'alcoholism' in 1849 in his attempts to describe the disease model (Mann, Hermann & Heinz 2000).

Nevertheless, the 'moral weakness' explanation by some religious groups and endorsed by the temperance movement, where the use of alcohol was inherently addictive and people who drank were immoral and evil, still held sway during this time (Gunzerath et al. 2010). The Prohibition of alcohol sales in Australia, the U.S. and most European countries in the early 1900s resulted from temperance movements.

The failure of prohibition to stop alcohol consumption served to discredit the moral weakness theory and marked the beginning stage of the modern study of alcoholism as a disease (Mann, Hermann & Heinz 2000). Jellinek, a post-prohibition North American authority on alcoholism as a disease model, defined alcoholism as 'any use of alcoholic beverages that causes any damage to the individual, to society or both' (Gunzerath et al. 2010, p. 1). By the 1950s, major health organisations, such as the American Medical Association and the World Health Organization (WHO), began to address the healthcare consequences of alcoholism. They also examined and highlighted the discrimination against 'alcoholics' in healthcare settings (Gunzerath et al. 2010).

The American Psychiatric Association (APA) then joined these organisations in the late 1950s, and formally declared alcoholism as a psychiatric disorder. The work of Edwards, a North American physician and researcher who focused on the development of alcohol tolerance and the manifestation of withdrawal, was used by the WHO in the International Classification of Diseases (ICD) (Mann, Hermann & Heinz 2000). Edwards' work was also operationalised by the APA in an early version of the Diagnostic and Statistical Manual (DSM). The DSM is a standard classification system of mental health signs and symptoms which clinicians in the U.S. and throughout much of the world use to diagnose different mental health disorders.

The last three decades of the twenty-first century then witnessed a rapidly increasing knowledge base of the neurobiological correlates of alcohol use, such as the effects of alcohol on the Central Nervous System, as well as genetic susceptibilities (Mann, Hermann & Heinz 2000). Whilst AUDs were classified with mental health disorders, the service approaches for AUDs began to separate from the larger mental health systems, attributable to the pathophysiological understanding of addiction.

However, it was argued, and continues to be, that conceptualising excessive alcohol use as a chronic brain disease or disorder reduced the alcohol use to a problem (a disease), which only took into account harm caused to the individual (Cunningham & McCambridge 2012). Looking at excessive alcohol use through this medical lens, means that little or no attention is given to the contribution of social environments to the person's alcohol use. Nevertheless, in today's society, it is reported to be difficult to access appropriate mental health or substance use service without a clinical diagnosis and as a result, a diagnostic label is often applied (Jutel & Nettleton 2011).

Nowadays, the APA, in the 5<sup>th</sup> edition of the DSM (DSM-5) released in 2014, provides globally used criteria for diagnosing alcohol-use disorders. AUDs are categorised in the DSM-5 (APA 2014, p. 491), which is the latest version of this dynamic document, by the specifiers ‘mild’, ‘moderate’ or ‘severe’. There are 11 possible symptoms that are considered in order to apply a diagnosis of an AUD of which, two-to-three is necessary for the person to be diagnosed as experiencing a mild AUD. If an individual experiences four-to-five symptoms, they meet the criteria for a moderate AUD, and six or more symptoms signify a severe AUD. Table 3 outlines in more detail the DSM-5 criteria.

**Table 3. DSM-5 diagnostic criteria for alcohol-use disorders**

<b>DSM-5 Diagnostic Criteria</b>
<b><i>A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring with a 12-month period:</i></b>
<ul style="list-style-type: none"> <li>• Alcohol is often taken in larger amounts over a longer period than was intended.</li> </ul>
<ul style="list-style-type: none"> <li>• There is persistent desire or unsuccessful efforts to cut down or control alcohol use.</li> </ul>
<ul style="list-style-type: none"> <li>• A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.</li> </ul>
<ul style="list-style-type: none"> <li>• Craving, or strong desire or urge to use alcohol.</li> </ul>
<ul style="list-style-type: none"> <li>• Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.</li> </ul>
<ul style="list-style-type: none"> <li>• Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.</li> </ul>
<ul style="list-style-type: none"> <li>• Important social, occupational, or recreational activities are given up or reduced because of alcohol use.</li> </ul>
<ul style="list-style-type: none"> <li>• Recurrent alcohol use in situations in which it is physically hazardous.</li> </ul>
<ul style="list-style-type: none"> <li>• Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.</li> </ul>
<ul style="list-style-type: none"> <li>• Tolerance, as defined by either of the following:               <ul style="list-style-type: none"> <li>○ A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.</li> <li>○ A markedly diminished effect with continued use of the same amount of alcohol.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Withdrawal, as manifested by either of the following:               <ul style="list-style-type: none"> <li>○ The characteristic withdrawal syndrome for alcohol.</li> <li>○ Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms.</li> </ul> </li> </ul>
<p><i>Specify current severity:</i>            Mild: Presence of 2-3 symptoms.            Moderate: Presence of 4-5 symptoms.            Severe: Presence of 6 or more symptoms.</p>

(American Psychiatric Association [APA] 2014)



The other classification system used for diagnosing mental health disorders is the one developed by the WHO (2010) entitled the ‘International Standard Classification of Diseases, Injuries and Causes of Death, tenth edition’ (ICD-10). Both classification systems recognise that consuming alcohol can have serious consequences, negatively affecting an individual's psychological and physiological health and personal life.

The ICD-10 (WHO 2010, p. 69) describes ‘harmful use’ of a psychoactive substance, including alcohol, as being that which causes damage to the health of the person. This damage may be physical, for example liver disease, or mental, such as a depressive disorder, secondary to the excessive consumption of alcohol (WHO 2010). The ICD-10 (WHO 2010, p. 70) also describes a ‘dependence syndrome’ as one where the person has a ‘decreased capacity to control substance-taking behaviour in terms of onset, termination or level of use’, and a strong desire for the person to take the substance and evidence of tolerance to the psychoactive substance (WHO 2010). Table 4 provides the ICD-10 diagnostic criteria.

**Table 4. ICD-10 diagnostic guidelines for ‘Alcohol Dependence Syndrome’**

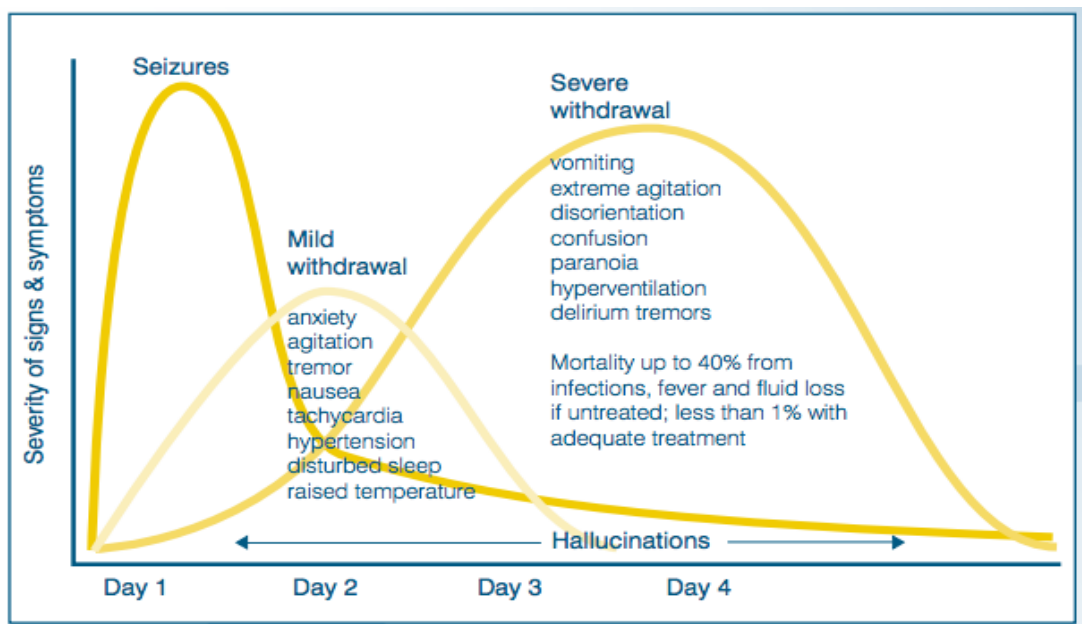
<b>ICD-10 Diagnostic Guidelines</b>
<b>A definite diagnosis of dependence should usually be made only if 3 or more of the following have been present together some time during the previous year:</b>
a. A strong desire or sense of compulsion to take the substance.
b. Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use.
c. A psychological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of avoiding withdrawal symptoms.
d. Evidence of tolerance, such that increased doses of the psychoactive substances are required in order to achieve effects originally produced at lower doses.
e. Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amounts of time necessary to obtain or take the substance or recover from its effects.
f. Persisting with substance use despite clear evidence or overly harmful consequences, such as harm to the liver through excessive drinking; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

(World Health Organization 2010)

## Alcohol withdrawal

Both diagnostic classification systems consider withdrawal as an essential feature of an alcohol-use disorder. Alcohol withdrawal is a common clinical condition that has a variety of complications and morbidities (Manasco et al. 2012). People who experience AUDs and wish to cease their alcohol use will experience some form of alcohol withdrawal, and this a key reason for people with AUDs to engage with services. Withdrawal from alcohol, when compared to withdrawal from other substances, is associated with the highest mortality rates (McKeon, Frye & Delanty 2008). Failure to adequately treat alcohol withdrawal can have fatal consequences.

Alcohol withdrawal manifests in physical signs, as well as psychological symptoms that contribute to distress and discomfort. This is due to Central Nervous System (CNS) responses following cessation of use after prolonged alcohol exposure. With the abrupt cessation of alcohol, the inhibitory effects of alcohol on the brain are withdrawn and an elevation in excitatory neuronal responses occurs (Manasco et al. 2012). Figure 4 depicts the progression of alcohol withdrawal, with further explanation on this to follow.



(NSW Ministry of Health 2007)

Figure 4. Progress of alcohol withdrawal

The more mild withdrawal symptoms include: tremors, anxiety and agitation, sweating and headache (McKeon, Frye & Delanty 2008). People in alcohol withdrawal also frequently experience an elevation in blood pressure (hypertension), a rapid heart rate (tachycardia) and a raised temperature resulting from the rise in excitatory CNS activity (Manasco et al. 2012). Less common, more significant symptoms of alcohol withdrawal are arrhythmias (abnormal heart rhythms), vomiting and dehydration. Hallucinations may also occur. These are usually tactile such as formication or the feeling of ants crawling on the skin; these hallucinations occur in approximately 30 percent of people with AUDs (Sarff & Gold 2010).

Mortality can result from the delirium tremens or DTs, which is delirium combined with autonomic hyperactivity and alcohol hallucinosis (Khan et al. 2008). The DTs, which occur in approximately five percent to 20 percent of people in withdrawal from considerable levels of alcohol use, manifests as tachycardia, hypertension, high fevers, dehydration, agitation and somatic disturbances (Hecksel et al. 2008). This condition carries a five percent mortality rate in people without co-occurring health conditions and up to a 25 percent mortality rate in those with concomitant complications (Manasco et al. 2012). As such, this is a condition that requires an elevated level of clinical management, usually in an intensive care unit.

Alcohol withdrawal seizures, which occur in approximately 10 percent of people with AUDs, can also be a life-threatening manifestation of withdrawal (Sarff & Gold 2010). The risk of seizure begins early in withdrawal, often within a few hours of ceasing alcohol use. Seizures are generally brief and tonic-clonic in nature, although some people have multiple seizures or sustained status epilepticus, which is a state of persistent seizure (McKeon, Frye & Delanty 2008). This can lead to serious health consequences and death, even with pharmacological and medical interventions.

Alcohol withdrawal symptoms generally begin six to 24 hours after the last drink, peak over 36 to 72 hours and subside after a few days (McKeon, Frye & Delanty 2008). As per the DSM-5 (APA 2013, p. 500), the essential feature of alcohol withdrawal is the 'presence of a characteristic withdrawal syndrome that develops within several hours to a few days after the cessation (or reduction in) heavy prolonged alcohol use'. As alcohol withdrawal can be a dangerous condition for people living with AUDs, appropriate and timely service approaches are necessary. This will be discussed further in the 'service model approaches' section below.

## **AUDs: causes and origins**

### ***Genetics***

It has been acknowledged for decades that alcohol-use disorders appear to be familial. This was, until recently, ascribed only to exposure to alcohol from a young age and an overall tolerance of harmful alcohol behaviours by family members (Kohnke 2008). It is now known that approximately 40-60 percent of the risk of AUDs is credited to genetic factors and the remainder to environmental factors (Kendler, Kuo & Kalsi 2006; Nurnberger & Bierut 2007). Large epidemiological studies, including adoptive studies, demonstrated that inheritance for AUDs is largely genetic and not just dependant on environmental association (Osby et al. 2010; Edenburg 2007). For example, gene forms associated with impulsivity, disinhibition and sensation seeking contribute to vulnerability to AUDs (Kendler, Kuo & Kalsi 2006).

Genetic studies have isolated the specific genes linked to AUDs across different ethnic groups, of which many are linked to the person inheriting variations of the genes that encode enzymes involved in the regulation of alcohol metabolism (Kohnke 2008). Biological offspring of people with AUDs are three-to-five times more likely to develop AUDs when compared to the children of people without alcohol-use disorders (Kohnke 2008). Recent advances in the understanding of genetic variations in people with AUDs can help identify children who may be at high risk of developing AUDs in the future.

### ***Environment***

There are also environmental aspects to the development of AUDs. Children exposed to a parent(s) or guardian who have an AUD may emulate and model their alcohol-related behaviours (Sher, Grekin & Williams 2005). This, however, remains controversial. Adoption studies have shown little evidence of behaviour modelling, as elevation in the rates of AUDs in children living with adoptive parents with AUDs was not established (Hopfer, Crowley & Hewitt 2003; von Borczyskowski, Vinnerljung & Hjern 2013). It is acknowledged that parents with AUDs may have poor family management practices, such as lax curfew times, family-related conflict and marital problems, which are strongly linked to higher rates of internalising and externalising problems in children (Sher, Grekin & Williams 2005). This can lead to the children experimenting at an early age with substance use, more commonly alcohol.

One of the most enduring environmental perspectives on the cause of AUDs is the relationship between alcohol use and the alleviation of negative affect (Sher, Grekin & Williams 2005), also known as 'self-medication' theory. The coping motivations to drink in reaction to anxiety, stress or depressed mood are strongly associated with the development of AUDs. Linked to this is the effect of exposure to significant, traumatic life events. Studies have found that stressful life events, such as the sudden death of a loved one or being the victim of a traumatic assault, are associated with increasing alcohol use and the subsequent development of AUDs (Anthenelli 2012; Blomeyer et al. 2011).

Peer influences on alcohol consumption in younger adults also strongly correlate to the development of AUDs. As drinking is considered a social activity for adolescents (they almost never drink by themselves), their willingness to drink is largely dependent on social consequences and the pressure from their friends (Teunissen et al. 2012). A report from the European School Survey Project on Alcohol and other Drugs (Hibell et al. 2011) carried out across 35 countries and involving 38,370 girls and boys aged 16 years, indicated that young people drink more with a clearer focus on 'drunkenness' than earlier generations. Heavy, episodic drinking to 'get drunk' was found to be common among the adolescents surveyed (Hibell et al. 2011).

This is significant, as teens who consume harmful levels of alcohol are more likely to experience AUDs later in life when compared to their peers who did not drink until they reached an older age (Hingson, Heeren & Winter 2006; Toumbourou et al. 2009). Consequently, permissive views on excessive alcohol use from peers, as well as an earlier age of first use; are risk factors to the adolescent experiencing an AUD.

Once people pass adolescence, they may still not be immune to the peer influences involved in alcohol consumption. Longitudinal studies in population-based samples have shown individual heterogeneity in patterns of drinking behaviours, including levels of alcohol use that result in AUDs, in people aged 20 years and above (Rosenquist et al. 2010; Jacob et al. 2009; Jackson & Sher 2005). Across all age groups, social networks influence the amount of alcohol an individual consumes, which can be in a positive, supportive way, but is more likely to be in a manner that contributes to high drinking levels (Astudillo et al. 2013).

Older adults are also at risk of social network pressures to drink. Moos et al. (2010), in a longitudinal study examining the drinking behaviours of 719 people aged 55-65 years at baseline (between 1986-1988) and then again 10 and 20 years later, found that social network factors enhance the chances of the person engaging in high levels of alcohol consumption. Older adults who had more money, who were socially active and whose friends approved of excessive drinking (more than three drinks per day or 14 per week) were more likely to drink excessively and develop an AUD (Moos et al. 2010). Peer and social network pressures to consume higher levels of alcohol therefore result in vulnerability to the development of AUDs across the lifespan.

### ***Brain changes***

Structural brain changes from the use of alcohol also contribute to the progression of AUDs. The cumulative effects from alcohol use induce neurodegeneration and frontal lobe dysfunction (Crews & Boettiger 2009). As the frontal lobe of the brain is involved in judgement, impulsivity and goal-directed activity (Bonelli & Cummings 2007), these changes are likely to contribute to an individual's consumption of alcohol despite their knowledge that problems occur as a result of their drinking (Crews & Nixon 2009). Therefore, AUDs do not have one single cause; rather, they are the result of a complex group of genetic, psychological and environmental factors.

## **Clinical diagnosis**

### ***Biomarkers of AUDs***

As the toxic metabolites of alcohol affect nearly every bodily organ, there are methods of measuring the damage to the body caused from alcohol. The term 'biomarker' refers to a broad subcategory of clinical signs, objective indications of medical states observed from outside the person (Strimbu & Tavel 2010). Although not as sensitive as personalised screening questionnaires, there are blood tests that can determine the damage resulting from excessive alcohol use.

One such test is the measurement of the mean volume in red blood cells (mean corpuscular volume or MCV), as the volume increases after prolonged alcohol use (Shuckit 2009). Another common biomarker measured in suspected cases of AUDs are liver function tests that look for a rise in liver enzymes, which are indicative of liver damage from alcohol metabolism processes (Gao & Bataller 2011). The measures of biomarkers do not necessarily establish a diagnosis, but can be useful in highlighting to the person the adverse health impacts from drinking.

### ***Screening for AUDs***

The social and health implications from AUDs, such as those discussed, can be reduced by preventative measures, including the early identification of AUDs and the delivery of early, appropriate interventions. Alcohol screening is used to assess a person's drinking pattern, to distinguish if alcohol is harming their health or is likely to cause harm in the future. Screening in this sense refers to a tool, usually a brief questionnaire, which detects people who have, or who are at high risk of developing a disorder in a population of interest, for example, primary care (Pilowsky & Wu 2012). Screening does not establish a diagnosis; instead it identifies people most at risk of experiencing alcohol-use disorders currently or in the near future.

One such screening tool is the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 2001), first developed by the WHO in 1982. AUDIT was used to screen alcohol consumption levels, to help clinicians identify people who would benefit from reducing or ceasing their alcohol use. The development of the AUDIT was due to the fact that a large percentage of people who experienced AUDs remained undiagnosed (Babor et al. 2001).

People with AUDs were presenting to healthcare services with symptoms or health issues related to their disorder, but these were not clinically attributed to their AUD. The original AUDIT consisted of 10 questions that addressed the extent of alcohol use, its negative consequences, as well as evidence that others had noticed about the respondent's drinking (Freedly & Ryan 2011). Total scores range from 0 to 40, with scores equal to or above eight indicating increased drinking behaviours.

A WHO study (Saunders et al. 1993) established that among people engaging in regular, excessive alcohol use, 92 percent had an AUDIT score of eight or more and 94 percent of people without excessive alcohol use had a score of less than eight. It was suggested from this and other similar studies that the AUDIT was a valid instrument with high sensitivity and specificity. There is now an abbreviated version of the AUDIT available, the AUDIT-C. This consists of items one-three of the original AUDIT, and is used in many primary health care settings (Pilowsky & Wu 2012).

Another commonly used screening tool for AUDs used in Australia and throughout the world is CAGE. CAGE, an acronym of its four questions, remains one of the most popular validated screening tools used by primary health care providers (Skogen et al. 2011). CAGE asks respondents four straightforward questions: (1) “Have you ever felt you had to **C**ut down on your drinking” (2) “Have people **A**nnoyed you by criticising your drinking?” (3) “Have you ever felt bad or **G**uilty about your drinking” (4) “Have you ever had a drink in the morning to steady your nerves or get rid of a hangover (**E**ye opener)?” (Pilowsky & Wu 2012). Two positive responses suggest that the person’s drinking levels warrant further investigation.

A third screening tool for AUDs is SBIRT (Screening, Brief Intervention, Referral and Treatment). The core components of SBIRT are: (1) regular and universal screening for substance use in a clinical setting; (2) systematic use of validated screening instruments and assessment approaches; (3) consideration of harmful substance use as a continuum instead of ‘dependent versus not dependent’ judgement; (4) use of person-centred change talk (including assessment of readiness); and (5) assurance that seamless transitions occur for the person between primary care and speciality drug and alcohol care settings (Muench et al. 2015; Gordon & Alford 2012). The use of SBIRT has been associated with long-term reductions in both alcohol use and the utilisation of health care by those with harmful alcohol use and AUDs (Pringle et al. 2012). The ‘brief intervention’ component of SBIRT used as part of service delivery (directly after screening) is described in more detail below in the ‘models of service delivery’ section (page 50).



Despite the availability of validated screening tools such as those elucidated above, screening for AUDs in healthcare settings such as emergency departments (ED), which see an over-representation of people with alcohol-related trauma and disease, remains lacking. As identified by Forsythe and Lee (2012, p. 171), in an international systematic review on research which had explored the implementation of alcohol screening in EDs, 'there has been a very slow uptake of alcohol screening as part of the routine ED care with barriers such as staff attitudes...'

Similarly, a recent Australian study by Browne et al. (2013), where registered nurses at a trauma service were asked to use a 'stepped-down' two-item screening approach over a four-month period, found only a 49 percent compliance rate with the use of this protocol despite extensive education and training on its use. Importantly, the key findings highlighted the urgent need for this screening, as Browne et al. (2013, p. 115) ascertained nearly two-thirds of patients ( $n=729$ ) assessed met the DSM criteria for problematic drinking and nearly one-third met criteria for an alcohol-use disorder. Consequently, screening for alcohol use disorders in acute health care areas is of extreme importance.

Apart from staff attitudes to using screening tools, another barrier found was that associated with organisational issues. Johnson et al. (2011), in their synthesis of 47 qualitative studies on screening for alcohol-use disorders, found that a lack of managerial support, a lack of training regarding use of the tools and workload issues, impeded significantly on healthcare staff's use of screening instruments. Some clinicians also find drinking a difficult topic to raise with people in their care, as they may have limited knowledge on alcohol in terms of measures and guidelines (Kaner et al. 2007).

Despite the fact that many clinicians feel uncomfortable discussing alcohol for fear of alienating people, people receiving healthcare generally find it acceptable to be asked about alcohol use and associate this with higher quality care (Saitz et al. 2013). Therefore, whilst it has been recognised that screening for AUDs can be an effective and efficient way to reduce alcohol-related harm, a significant number of people with these disorders who find themselves in healthcare settings remain unscreened, and therefore undiagnosed and as a consequence, without the support of specialised staff or services.

## Models of service delivery

Accessing specialised services for AUDs increases the likelihood of success in terms of the person reducing or ceasing their levels of alcohol consumption (Dawson, Goldstein & Grant 2007; Finney, Wilbourne & Moos 2007). If a person is screened for and diagnosed with an AUD, there are a number of service options available in Australia. It must be highlighted that these services are not like services for other health conditions, particularly physical ones, which aim to ‘cure’ people. The emphasis instead is on a harm minimisation approach (Table 5), to reduce the harms associated with the person’s use of alcohol on the individual, their family and the community and thus improve quality of life (Commonwealth of Australia 2011).

**Table 5. The three pillars of harm minimisation**

<b>Demand Reduction</b>	<b>Supply Reduction</b>	<b>Harm Reduction</b>
Strategies and actions which prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs	Strategies that control, manage and/or regulate the availability of legal drugs, including alcohol	Strategies and actions that primarily reduce the adverse health, social and economic consequences of the use of drugs and alcohol
Strategies that reduce the misuse of alcohol and the use of tobacco and other drugs in the community	Strategies and actions which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs	
Support people to recover from dependence and reintegrate with the community		

(Commonwealth of Australia 2011)

The types of approaches offered are dependent upon a number of factors. These include: the amount of alcohol the person is consuming, the presence or absence of co-occurring health conditions, the degree of social support the person has, and their willingness to engage with the recommended approach (Albanese 2012; Saitz 2013). Alcohol continues to be the most common drug in Australia leading people to seek specialist services.

Nationally, in the year 2013-2014, alcohol accounted for 57 percent of all specialist drug and alcohol service delivery episodes (AIHW 2015). Types of services available to the person with an AUD include: brief intervention and motivational interviewing, withdrawal management (formally ‘detoxification’), rehabilitation, and specific services designed to prevent relapse (such as individual counselling or group programs). Figure 5 outlines the stages of service provision in more detail.

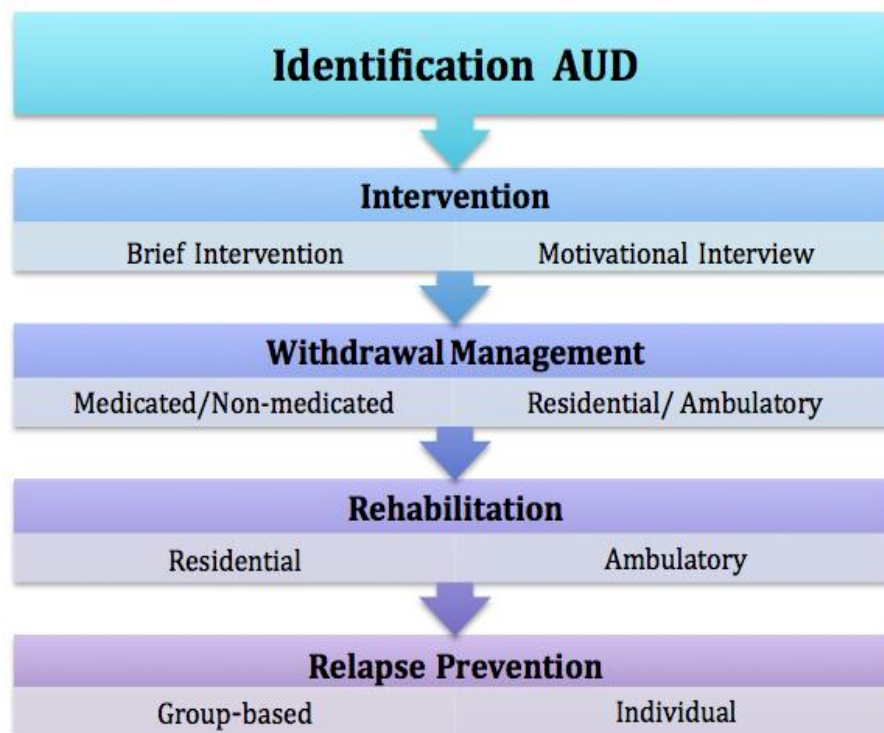


Figure 5. Services for people with alcohol-use disorders

***Brief Intervention (BI) and Motivational Interviewing (MI)***

Brief intervention for AUDs is designed to help people reduce alcohol use, facilitate behaviour change and motivate people to achieve non-harmful levels of alcohol use (McCambridge & Cunningham 2013; Anderson, Chisholm & Fuhr 2009). It can take as little as five to ten minutes to administer a brief intervention, and it can be implemented in all healthcare settings (Mulia et al. 2011). Brief intervention is considered a first-line approach, as it was designed to be implemented directly after screening when harmful alcohol use was first detected.

Brief intervention (BI) is an umbrella term for two main types of interventions: (1) brief advice that generally involves persuading the person to drink less, and (2) adaptations of motivational interviewing (MI) (McCambridge & Rollnick 2014). Whilst the relative effectiveness of brief advice in comparison to MI interventions is largely unknown, it is thought that MI interventions add more benefit to alcohol outcomes (Rubak et al. 2005; Bertholet et al. 2014). Brief advice may not be enough to elicit therapeutic change, although it may stimulate a small amount of useful thinking (McCambridge & Rollnick 2014).

On the other hand, brief motivational interventions are considered one of the few useful and cost effective strategies when it comes to reducing alcohol consumption (Barbor et al. 2010). MI-based brief interventions are based on Miller and Rollnick's (2002) MI techniques, which are person-centred, directive methods for navigating resistance and resolving ambivalence that impedes a change in behaviour. MI conceptualises motivation for change as a natural human condition, rather than a pathological problem (Miller & Rollnick 2002).

MI focuses on person-centred, motivational processes within the person to facilitate change. Key principles of MI include: expressing empathy, developing discrepancy between the person's goals and the current problem behaviour, avoiding argument, rolling with resistance and supporting self-efficacy for change (Miller & Rollnick 2002). Technical aspects of MI include: focussing on person-centred counselling, determining internal motivation to change using reflective listening and decreasing the person's resistance to change (Miller & Rollnick 2002). These strategies help position the person who wants to change their health behaviour in the 'expert' role. Rollnick et al. (1992) originally developed a MI model of brief intervention to be used by clinicians to assist people who wished to change their substance use behaviours elucidate their readiness to change, depicted in Table 6.

**Table 6. Readiness to change questionnaire**

Readiness to Change Questionnaire					
	<i>Strongly disagree</i>	<i>Disagree</i>	<i>Unsure</i>	<i>Agree</i>	<i>Strongly agree</i>
1. I don't think I drink too much.	1	2	3	4	5
2. I am trying to drink less than I used too.	1	2	3	4	5
3. I enjoy my drinking, but sometimes I worry that I drink too much.	1	2	3	4	5
4. Sometimes I think I should cut down on my drinking.	1	2	3	4	5
5. It is a waste of time thinking about my drinking.	1	2	3	4	5
6. I have just recently changed my drinking habits.	1	2	3	4	5
7. Anyone can talk about wanting to do something about drinking, but I am actually doing something about it.	1	2	3	4	5
8. I am at the stage where I should think about drinking less alcohol.	1	2	3	4	5
9. My drinking is a problem sometimes.	1	2	3	4	5
10. There is no need for me to think about changing my drinking.	1	2	3	4	5
11. I am changing my drinking habits right now.	1	2	3	4	5
12. Drinking less alcohol would be pointless for me.	1	2	3	4	5

(Rollnick et al. 1992)

Due to time and resource constraints, many researchers and clinicians now use condensed versions of this and other brief intervention models for people with substance use, including AUDs (McCambridge & Strang 2003). Some common aspects of the newer models include: an exploration of the use of alcohol and related harmful behaviours, an introduction of behaviour change perspectives, with discussions taking place in a non-judgemental, empathic and collaborative manner (Gaume et al. 2011; Kaner et al. 2009).

The efficacy of brief intervention can be difficult to determine due to the diversity in models, as well as clinician competence and the degree that the person is ready to engage. However, a primary meta-analysis of 22 international RCTs on the effectiveness of brief intervention found that overall, compared to a control intervention, brief intervention did reduce the quantity of alcohol consumed by people with AUDs in the primary care setting (Kaner et al. 2009).

Despite the possibility of success, many clinicians may avoid opportunities to initiate brief intervention strategies. According to the WHO (2014), only nine percent of countries globally implement brief intervention strategies for people with alcohol use. Physicians and other health workers, including nurses, may feel reluctant to use brief intervention strategies (Groves et al. 2010).

Reasons stated for this reluctance included: a lack of time, inadequate training on how to use the interventions, fear of antagonising the person, concerns about their own drinking behaviours, a perceived incompatibility of alcohol counselling techniques in primary care and the overarching belief that people with AUDs do not respond to interventions (Barbor et al. 2001; Nilsen 2010). Similar to low rates of screening, clinician uptake of brief intervention is said to be limited on a global scale (Wilson, Heather & Kaner 2011; Groves et al. 2010). Even if brief interventions are proven effective, they provide no benefits to people with AUDs unless they are routinely delivered.

### ***Withdrawal management programs***

People with AUDs who engage with specialist services frequently enlist the help of withdrawal management programs to assist them reduce or cease their use of alcohol. The primary goal of withdrawal management in Australia is to achieve the person's goals in relation to their alcohol use in a safe and meaningful manner (Frei et al. 2012).

Withdrawal management should not be seen as a stand-alone intervention, but a transitional first step toward the person's goal, be it abstinence from alcohol or a reduction in levels (Haber et al. 2009). A realistic expectation for the person following the withdrawal period is important, as withdrawal management alone has been shown to have little impact on long-term alcohol use (Carlson et al. 2012).

As mentioned, alcohol withdrawal and related symptoms can be very serious if the person does not receive appropriate care and support. The levels of alcohol consumed and the predicted significance of withdrawal symptoms determines if the person with an AUD receives care in either an ambulatory setting, in a community-based residential setting or as an inpatient in hospital (Carlson et al. 2012).

Concurrent psychiatric symptomatology, a history of complicated withdrawal including seizures or the DTs, and the person's social support and home situation also determines the service setting (Albanese 2012). People with a history of complicated withdrawal and poor social support will generally require residential or inpatient service options (Bonnet et al. 2010). Table 7 outlines the Australian Department of Health and Ageing's admission criteria for different settings.

**Table 7. Admission criteria for different withdrawal settings**

	<b>Ambulatory</b>	<b>Community, Residential</b>	<b>Inpatient: Centre Hospital</b>
<b>Predicated alcohol withdrawal severity</b>	Mild-moderate	Moderate-severe	Moderate-severe
<b>Likelihood of severe withdrawal complications</b>	No	Withdrawal complications (seizures, hallucinations)	Withdrawal complications (delirium, unclear cause of seizure)
<b>Medical or psychiatric comorbidities</b>	Minor comorbidity	Minor comorbidity	Significant comorbidity
<b>Other substance use</b>	No heavy drug use	Heavy or unstable use of other drugs	-
<b>Social environment</b>	Alcohol-free 'home'  Daily monitoring by reliable, supportive people  Good access to health care services	Unsupportive home environment	-
<b>Previous attempts</b>	-	Repeated unsuccessful attempts at ambulatory withdrawal	-

(Haber et al. 2009)

Within an ambulatory setting, the withdrawal occurs in the person's home environment. The management of the withdrawal may be undertaken by a specialist drug and alcohol service, a GP, a nurse practitioner or other medical professional (Haber et al. 2009). Regular monitoring of the person generally occurs daily during the first three to four days.

If the person is at risk of significant withdrawal symptoms, Diazepam, which belongs to the sedative-hypnotic benzodiazepine group of drugs, is generally the medication of choice and prescribed in low doses (Bonnet et al. 2010). This is because medications like Diazepam are CNS depressants and function as a replacement for alcohol in terms of reducing the excitatory actions of the CNS (Khan et al. 2008). The symptoms associated with alcohol withdrawal are thus minimised or diminished with the pharmacological actions of the Diazepam.

If the person with an AUD requires a community-based, residential service, there are specialist withdrawal programs run purely for people wanting to be admitted for the withdrawal period (generally five to seven days). These programs provide a range of specialist medical, nursing and support services for managing the withdrawal and can help facilitate post-withdrawal service options (Haber et al. 2009). There are approximately 140 services in Australia that offer residential withdrawal management, the majority of which are located in or around major cities (AIHW 2015). In the year 2013-2014, 19 percent of Australian people with AUDs who accessed specialist drug and alcohol services engaged in residential withdrawal management programs (AIHW 2015).

However, people with a significant medical or psychiatric history, such as delirium or reoccurring conditions that feature psychosis, may require an admission to a hospital for the withdrawal period. Many hospitals throughout Australia now have the support of consult liaison services. These services entail specialist drug and alcohol or mental health nurses and addiction medicine specialists assisting staff in the care of the person who has been admitted to hospital for any health problem, be it related to their alcohol use or not (Frei et al. 2012). A number of privately funded mental health hospitals also run withdrawal management programs across the country. As indicated above when discussing withdrawal in ambulatory settings, medications such as Diazepam for symptom relief are also generally administered as part of the programs.

Withdrawal management is considered the beginning stage of the person's journey to reduce or cease their alcohol use (after brief intervention), and as such, the service provider (ambulatory or residential) works with the person to optimise their motivation to change behaviours (Albanese 2012). Therefore, motivational interviewing techniques play a key role in withdrawal management programs. Educational support and the beginning of relapse prevention planning should also take place at the withdrawal stage (Fiellin, Reid & O'Connor 2000), for both the individual with an AUD and their support person.



### ***Rehabilitation***

After the person with an AUD has undertaken the alcohol withdrawal stage, they may wish to engage with rehabilitation services. In Australia, rehabilitation from problem alcohol use can be delivered in a residential setting or by a community-based program (AIHW 2015). These are generally long-term programs where people live or work with others who have the lived experience of an AUD (Haber et al. 2009). Programs can be anywhere from one to 12 months (or more), with the aim of helping people build the skills and attitudes to make positive, long-term changes in relation to their alcohol use. The majority are run by non-government, not-for-profit organisations, and incorporate self-help programs into their service structure such as AA (Haber et al. 2009).

### ***Relapse prevention***

Counselling programs run by nurses, psychologists, social or welfare workers and other specialist drug and alcohol staff are some of the most commonly used services by people with substance-use disorders, including AUDs (AIHW 2015). These programs often include cognitive behaviour therapies (CBT) and motivational interviewing as part of their structure (Haber et al. 2009). They are designed to help prevent relapse to harmful drinking behaviours.

Participation in a self-help group, such as Alcoholic Anonymous (AA), provides the person with an AUD to meet and be supported by others who have had similar experiences in order to help them adhere to their goals in relation to stopping their alcohol use. AA works on the same principles, the 12-steps, worldwide (Mueller et al. 2007). These 12-steps include the belief in a higher power, such as a God, which aids the person in their recovery from an AUD. AA is an abstinence-based program, with the philosophy 'once an alcoholic, always an alcoholic' (Kelly, Magill & Stout 2009).

Another type of self-help group is Self-Management and Recovery Training (SMART Recovery), an international non-profit organisation offering mutual aid groups for people who are considering abstinence or who are abstinent (Horvath & Yeterian 2012). SMART Recovery offers a substantially different format than that of 12-step programs, incorporating self-empowerment and CBT elements into the programs. SMART Recovery groups also run in government-funded specialist drug and alcohol programs, where staff are trained on the use of these techniques (Haber et al. 2009).

## **Barriers to service delivery**

Despite the availability of the services mentioned, an overwhelming number of people living with AUDs never access any type of specialised program. It is well recognised there remains a large service delivery gap, with only eight to 40 percent of all people living with AUDs engaging with specialist services (Cohen et al. 2007; Hasin et al. 2007; van Amsterdam & van der Brink 2013). Reasons as to why remain elusive, as very few studies have examined barriers to services for people with AUDs (Mojtabai & Crum 2013; Vandermause & Wood 2009) and even less examining the lived experience of a person with an AUD. This research, which aims to explore the meaning that women with AUDs attributed to their decisions to engage with drug and alcohol services, contributes to this knowledge gap.

### ***Person-related barriers***

What is currently known, is that a large majority of people living with AUDs do not recognise the need for specialised services (Saunders, Zygowicz & D'Angelo 2006; Rapp et al. 2008). For example, in a secondary data analysis of two separate national U.S. surveys on substance-related conditions and health, Edlund, Booth and Feldman (2009) identified that of the 10,314 people with established AUDs; fewer than one in nine perceived the need for service engagement. Stecker, McGovern and Herr (2012, p. 162) suggest that '...by far, the most frequently endorsed barriers [to services] involve not believing that the problem was serious enough for treatment ...believing the problem would get better on its own'.

People have also been shown to rationalise that the symptoms or social issues related to their AUD resulted from other factors, such as low socioeconomic status or poor diet, or that they minimised the negative impact that alcohol was having on their lives (Saunders, Zygowicz & D'Angelo 2006). Since it is difficult to admit to having 'problems' with a substance that so many others enjoy and purportedly do not have 'problems' with, people with AUDs may find their harmful alcohol use and related symptoms a very difficult subject to raise. This issue of keeping hidden high alcohol intake levels can be even more acute in younger people aged 18-25 (Kavanagh & Proctor 2011), especially given the peer pressure to engage in heavy episodic drinking. Efforts to increase the levels of perceived need for service engagement in people living with AUDs, and more robust efforts to undertake research in this area, appear to be warranted.

Stigma was also shown to be another barrier to the person accessing services. Public stigma or fear of the reactions from loved ones, friends or colleagues about their alcohol use has been demonstrated to stop people with AUDs from accessing help (Gray 2010; Room et al. 2010). Prejudice, stereotyping, and discrimination, such as being thought of as dangerous, unpredictable, hopeless or worthless, are strongly associated with a person with an AUD hiding their disorder and being unwilling to engage with services (Keyes et al. 2010). Concerns about privacy, fear of embarrassment and being afraid of the negative attitudes of others are cited reasons for the person with an AUD not seeking help (Fortney et al. 2004; Schomerus et al. 2011).

Blame from others for their predicament is said to lie at the heart of this stigmatisation (Livingston et al. 2012). In a study by Keyes et al. (2010), which examined data from an epidemiological survey on the perceptions of alcohol involving 34,653 adults in the U.S., perceived stigma was highly associated with the decreased likelihood of service engagement. Individuals with AUDs who perceived high stigma in the community were found to be less likely to have accessed services and the likelihood of engagement decreased in a stepwise fashion with increasing stigma perception (Keyes et al. 2010).

It is not just people external to the person with an AUD who may have stigmatising attitudes; it is also the person themselves. Self-stigma, where one internalises prevalent negative views about 'some like her or him' and incorporates these negative views into one's sense of self, is also common in people with AUDs (Schomerus et al. 2011). The person may feel worthless, 'just a drunk', or that the alcohol use is 'all their fault', so they should not bother seeking help.

Self-stigma also leads to low self-efficacy, low self-esteem and low-self-worth, all of which are immense barriers to the person engaging with services (Fortney et al. 2004). The person may also want to avoid relating to difficult or painful thoughts and feelings about their alcohol use and the negative factors that have resulted from this (such as violence or money issues), so they reduce, evade or deny their experience of the disorder altogether (Schmader, Johns & Forbes 2008). In both public stigma and self-stigma, it is therefore the *behaviour* (the harmful drinking) resulting from their disorder wherein the problem lies, and not the *individual*. Efforts to create understanding of the processes involved, such as the social and pathophysiological aspects, in relation to AUDs may thereby assist in reducing the levels of stigma.

### ***Service-related barriers***

Stigma does not only occur in the general public. Healthcare staff have been shown to have stigmatising attitudes towards people with an AUD (Gray 2010; Berends 2010). Such attitudes also hinder the person from engaging with services. It is thought that current clinical management of AUDs is usually in stark contrast to the concepts of person-centred care (Bradley & Kivlahan 2014). van Boekel et al. (2013), in their review of 28 international research publications examining primary healthcare staff's attitudes towards people with substance-use disorders (including AUDs), found that staff generally held a negative attitude toward people with AUDs. Staff distinguished violence, manipulation and poor motivation as impeding factors to the way in which they delivered healthcare services to people with AUDs (van Boekel et al. 2013).

The negative attitudes of staff can have a damaging impact on the person with an AUD in relation to coming to terms with their disorder and accessing specialised care. Due to perceived poor treatment by staff, a person's fear of rejection or experiencing discriminatory behaviours by healthcare professionals can be a barrier to engagement (Gray 2010; Sterling, Chi & Hinman 2011). For people who live in rural areas of Australia, not only is it difficult to access specialised services because of a lack of available programs (Livingston, Lassetz & Dietz 2008), it has also been shown that rural people with AUDs are more at risk of stigmatising behaviours from healthcare workers than those living in metropolitan areas (Booth & McLaughlin 2000; Berends 2010).

This is important to note, as hospitalisations because of an alcohol-related disease are generally much higher in rural areas than metropolitan ones, due to the elevated rates of alcohol consumption by rural people (Miller et al. 2011). In 2013-2014, harmful levels of alcohol consumption were higher in Australian areas deemed remote or very remote (approximately 35 percent of the populations) when compared to those of people residing in major cities (approximately 30 percent of the populations) (AIHW 2015). It was also proposed that no matter what location people live in, current service and care options for people living with AUDs were inadequate (Saitz et al. 2013; Giesbrecht 2010). Care for people with AUDs is said to be based on practices with little or no evidence of proven efficacy (Corte & Stein 2007; Martin & Rehm 2012).

Research on the effectiveness of services is still in its infancy and additional work is needed to enhance outcomes for the person (Hodge 2011). Despite there being evidence of effective interventions helping the person with an AUD achieve their goals, 'it is unlikely that treatment consistently provides such benefits because different treatment approaches do not work equally well' (Martin & Rehm 2012, p. 350). There are gaps between what is known to be effective and what is currently practiced. When care is provided, it has been shown to rely heavily on acute, medical-model approaches providing medicalised pharmacological treatments only, such as in withdrawal management, but without proactive efforts to ensure continuity of care (Raistrick, Heather & Godfrey 2006; Corte & Stein 2007).

There is also a reported lack of integrated care for people living with AUDs. Clinical treatments, substance use programs and mental health care are often provided separately, in very disparate health care settings (Lash et al. 2011; McKay 2009). This is despite the fact 'it is widely recognised that the majority of patients with alcohol use problems also suffer from co-occurring mental health and medical problems' (Sterling, Chi & Hinman 2011, p. 338). People with multiple conditions being treated for something other than their AUD are often reported as not receiving interventions targeting their use of alcohol (Martin & Rehm 2012). As found in Lenaerts et al.'s (2014) recent systematic review aimed at identifying existing researched continuing care interventions for people with AUDs internationally, there remains no single active intervention that fully meets all care requirements of continuous integrated care for the person living with an AUD.

However, integrated care of the person with an AUD is another area that is poorly researched (Martin & Rehm 2012), and more evidence may be required before services can be designed to suit the specific needs of the person. The person with the AUD also needs to be asked what it is *they* want. To date, there has been very minimal research done *with* people experiencing AUDs, as opposed to *on* people with AUDs, in relation to their service needs (Tucker, Foushee & Simpson 2009). This is particularly true if the person living with an AUD is a woman, as services for AUDs are often perceived by women as male-orientated (Grosso et al. 2013). The needs of women with alcohol-use disorders are very separate and diverse to that of men, as such and given this research is about women with AUDs, the discussion in the next section is specifically dedicated to women, alcohol and AUDS.

### ***Section 3: Women, Alcohol and AUDs***

The topic of women and alcohol, when compared to the plethora of studies examining male drinking and related harms, has been an extremely under-researched area. The findings of research with male participants involving alcohol consumption have been typically applied to women who consume alcohol (Moos & Moos 2006; Monras 2010). It has only been in the last couple of decades that the influence of gender on drinking patterns and alcohol-related harms has attracted researchers' attention (Mancinelli, Binetti & Ceccanti 2007; Evans & Levin 2011).

With respect to long-term outcomes, only limited information is currently available specific to women and the consumption of alcohol and its related harms (Bravo et al. 2013; Monras 2010). Historically, when the medicalised treatments of 'alcoholism' began in Australia and many parts of the world in the late 1950s and early 1960s, the harmful consumption of alcohol was seen only as a 'male problem' (Room 2010). At this time, there were a lot more men who consumed excessive alcohol when compared to women.

However, the disparities that once existed between men and women's rates of alcohol consumption are thought to be narrowing (Keyes, Grant & Hasin 2008; NHRMC 2009), and women's drinking patterns have now become similar to men's. The resulting impact from the male-dominated alcohol program paradigm continues to resonate today, as there is a paucity in the number of specialist alcohol programs targeting women's needs (Al-Otaiba et al. 2012, McCrady et al. 2011). 'Treatment is still based on traditional modes that disregard feminist theory and ideals' (Lafave, Desportes & McBride 2009, p. 52).

Women-centred services and care is needed given that, when compared to men, it has been shown that women face a heightened vulnerability to the adverse physiological, psychological and social impacts of alcohol (McCrady et al. 2011; NHRMC 2009; WHO 2014). This vulnerability, according to the World Health Organization (2014, p. 8), 'is a major public health concern because alcohol use amongst women has been steadily increasing in line with economic development and changing gender roles'.

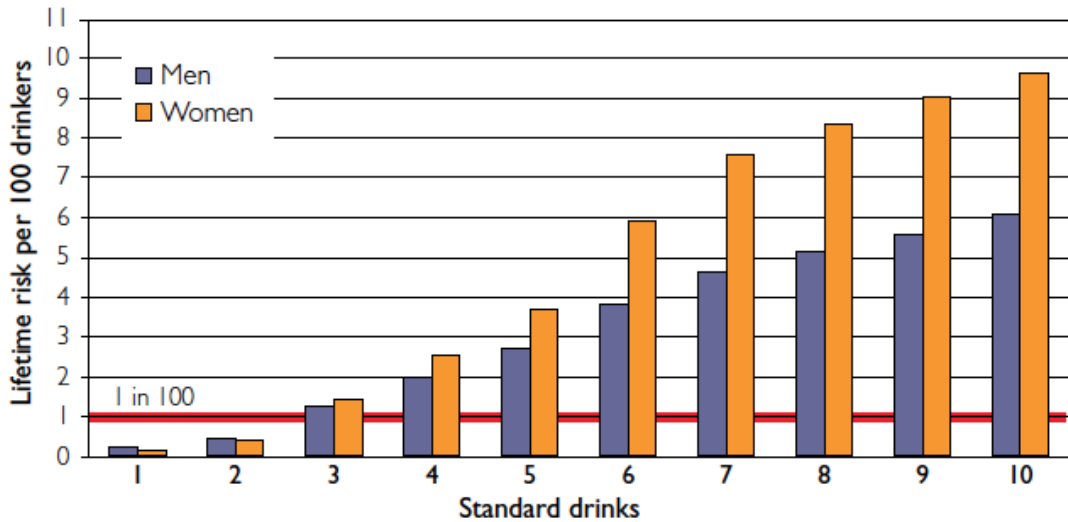
## **Biological variations in women**

Women, when compared to men, are considered more vulnerable to the toxic effects of alcohol and physiological and psychological alcohol-related harms (Alfonso-Loeches; Pascual & Guerri 2013; Al-Otaiba et al. 2012). Women consistently drink less than men but despite less volume, experience more alcohol-related harms than men. Women generally metabolise alcohol more slowly than men, as they tend to have smaller sized livers and a lower concentration of liver enzymes to break down the alcohol molecules (Saitz 2013).

Due to alcohol being a water-soluble molecule, and the fact that women on average have less body water content than men, a woman has less water available to dissolve alcohol, even at equivalent doses for both genders (Dasgupta 2011). This results in women having higher blood alcohol concentration (BAC) levels than men, even with corresponding alcohol dose levels. This increased bioavailability of alcohol has been shown to lead to gender differences in women's susceptibility and progression to alcohol-related diseases and harm, including AUDs (Nolen-Hoeksema 2004).

Women are thought to develop alcohol-related health conditions after fewer years of drinking than men (Alfonso-Loeches, Pascual & Guerri 2013; Bravo et al. 2013). Women are also more sensitive to the effects of alcohol, and may experience alcohol-related disease at lower levels of consumption than men. Studies have revealed that women reach equivalent (Hustad & Carey 2005), or even higher Blood Alcohol Concentrations (Kyrpi, Langley & Stephenson 2005), even when they have consumed less alcohol than men.

At higher levels of consumption, the risk of alcohol-related diseases increases more quickly for a woman. As demonstrated in Figure 6, in Australia, the lifetime risk of death from an alcohol-related disease is about 0.4 in 100 for people who consume two standard drinks per day. Above this level, the risk of experiencing an alcohol-related disease over a lifetime increases much more sharply for women than it does for men (NHMRC 2009).



(Rehm, Room & Taylor 2008)

Figure 6. Lifetime risk of death from alcohol-related disease per 100 drinkers

## Women and alcohol-attributable harms

### *Physiological*

Women experience more adverse physiological health consequences from alcohol consumption than men and over a shorter period of time (Becker & Hu 2008; Caetano et al. 2006). One example is cardiovascular disease. Alcohol-attributable cardiovascular diseases, as mentioned earlier in this chapter in the section on Australia and alcohol, are the alcohol-related conditions that result in the highest number of female deaths in the nation (Gao, Ogeil & Lloyd 2014). Similarly, on a global scale, cardiovascular disease from harmful alcohol use resulted in higher overall levels of mortality for women than men in the year 2012 (WHO 2014).

The association between alcohol and the heart is complex. Large statistical population studies have demonstrated a J-shaped dose-effect curve, with moderate alcohol use reducing cardiovascular disease, whereas excessive or heavy episodic drinking has the opposite effect (Di Castelnuovo et al. 2006; Costanzo et al. 2010). Low-to-moderate rates of alcohol use (two-to-four standard drinks per day) are thought to have cardio-protective effects that lower risk of cardiovascular disease in some people (Agarwal 2002), although once again very few of these studies have reported specifically on women's drinking (Wilsnack, Wilsnack & Kantor 2013). There is also literature to suggest that cardio-protective effects of alcohol exclude women who have not undergone menopause (Walker et al. 2013).



What is known is that women have been shown to have a more heightened sensitivity to the toxic myocardial effects of alcohol than men (Awtry & Philippides 2010; Mukamal et al. 2005). Harmful alcohol consumption (six or more standard drinks per day) can significantly increase blood pressure in women, even in those without a previous diagnosis of hypertension or other type of cardiac condition (Sesso et al. 2008). Women are generally more susceptible than men to alcohol-induced cardiomyopathy (damage to heart muscle) due to the gender differences in alcohol metabolism and absorption rates (Walker et al. 2013).

Another condition women have been shown to develop more quickly than men is alcohol-related liver disease. Women are generally more susceptible to the toxic effects of alcohol on the liver, which can lead to liver injury and disease, namely cirrhosis (Forrest & Reid 2011; Dasgupta 2011). Women who consume harmful levels of alcohol are thought to be at greater risk than men of developing liver disease, even when drinking less over a shorter period of time (Paton 2000; Testino et al. 2014).

There are also known gender differences in the neurotoxicity of alcohol. It is thought that women's brains are more vulnerable to alcohol-induced damage when compared to men, even when the woman has a shorter drinking history (Sharrett-Field et al. 2013). For example, Mann et al.'s (2005) German case-control study (76 cases, 82 healthy controls) using neuro-imaging to identify Alcohol Related Brain Injury (ARBI) differences in women and men, found that not only did the women in the study group develop significant brain volume reductions from their excessive alcohol use when compared to the control group, they also developed these in considerably less time than the male control group.

There also appears to be a relationship between alcohol intake and female breast cancer. Alcohol is now the dietary factor most consistently associated with breast cancer in women (Berstad et al. 2007; WHO 2014). In a meta-analysis of European and U.S. epidemiological data, it was proposed that heavy alcohol consumption, defined as three or more drinks per day, was associated with a 40-50 percent increased risk of breast cancer (Seitz et al. 2012).

However, even drinking one drink per day was thought to increase a woman's risk of breast cancer by four percent (Seitz et al. 2012). Therefore, whilst light-to-moderate use of alcohol possibly could have some health benefits for women, there may be an increased risk of breast cancer from just one drink per day. Harmful, excessive alcohol use, however, is known to be associated with poor health and increased mortality in women.

Alcohol use by pregnant women is another area that has attracted a lot of attention in terms of research and public health campaigns. Whilst some alcohol-related guidelines allow for occasional drinking of low-to-moderate amounts, most countries have modified their recommendations in line with abstinence during pregnancy (WHO 2014). The effects of harmful levels of alcohol consumption on the fetus are well-documented (Henderson, Kesmodel & Gray 2007; Anderson et al. 2012), with heavy drinking in pregnancy being associated with the substantial risk of physical and psychological fetal harm (Popova et al. 2012; Stade et al. 2009). However, whilst an important issue, the focus of this study is not on pregnancy and alcohol use, as this constitutes a different research topic.

### ***Psychological***

Not only does alcohol have negative physical effects, there are also links between women's drinking and mental health disorders. Compared to men, women with harmful alcohol use are thought to be significantly more likely to have co-occurring mental health disorders (Epstein & Menges 2012; Greenfield et al. 2010). Evidence suggests that women who engage in harmful alcohol use are at higher risk of developing depression when compared to men (Kessler et al. 2005; Blanco et al. 2010). Women are more likely than men to drink to relieve a negative affect (Lau-Barraco, Skewes & Stasiewicz 2009) and women who drink excessively are also thought to meet criteria for lifetime comorbid anxiety disorders, more so than men with harmful alcohol use (Kessler et al. 2005).

Women who experience Post-Traumatic Stress Disorder (PTSD) are thought to use more 'maladaptive' coping strategies, such as excessive alcohol use, when compared to men with the same disorder (Olf et al. 2007). Alternatively, when compared to men, women who engage in heavy episodic and harmful use of alcohol may be at greater risk of experiencing traumatic life events, particularly rape and sexual assault, and develop PTSD as a result (Abbey et al. 2004).

### ***Social***

Research literature alludes to the notion that women reported drinking excessive alcohol in public in an attempt to 'challenge' traditional gender roles (Peralta 2008; Gill et al. 2007; Griffin et al. 2012). Alcohol was seen as a 'license' to break social norms expected of women in relation to alcohol, to challenge the symbolic masculinity that alcohol represented (Griffin et al. 2012).

The public consumption of alcohol has historically been an important aspect of men's dominance over public space and places of drinking. When women were 'allowed' to drink in pubs, this was seen as a threat to the sanctity of this institution (Day, Gough & McFadden 2004). For a long time, women who entered these domains were thought to be either unfeminine or sexually available (Plant 1997). This continues to resonate today, as women's drinking, particularly when excessive, is still thought by many to be immoral, unrespectable and associated with sexual promiscuity (Rolfe, Orford & Dalton 2009), and as such, has been largely viewed as a taboo subject.

Women who drink are more likely than women who do not drink to experience familial conflict and be victims of intimate partner violence (IPV) (Walitzer & Dearing 2006). In a meta-analysis of 55 international studies specific to women and intimate partner violence, a clear positive association between alcohol use by the women victims of intimate partner physical or sexual violence was demonstrated (Devries et al. 2014). Women engage in harmful drinking to cope with the violence. As shown in La Flair et al.'s (2012) U.S. study, which examined data collected from 11,782 women who completed the National Epidemiologic Survey of Alcohol and Related Consequences (NESARC), women in the general population with a recent history of IPV were more likely to drink at harmful levels than non-abused women.

Women may thus consume harmful levels of alcohol to cope with the traumatic consequences of abuse (Kaysen et al. 2007). Conversely, a woman's harmful consumption of alcohol may lead to abuse from their partners, as they are seen as a 'deserving' victim because they have been drinking (Golinelli, Longshore & Wenzel 2009). Harmful alcohol use can thereby be both a cause and a consequence of experiencing intimate partner violence. Early life stress and trauma, particularly childhood sexual assault, is also more frequently experienced by girls than boys, and is associated with a high risk of substance use disorders later in life, including AUDs (Sarin & Nolen-Hoeksema 2010).

In a recent study by Smith, Smith and Grekin (2014), 395 women aged 17-23 years were surveyed on childhood sexual assault and their use of alcohol (22.5 percent reported a history of childhood sexual assault). This research identified a direct relationship between childhood assault, unresolved distress and alcohol used to release 'tension'. Another finding was that the women who had experienced childhood assault and who drank to excess deliberately consumed alcohol in this way, so as to lead to adverse consequences, such as high-risk sexual behaviours (Smith, Smith & Grekin 2014). It also appears that when compared to men, women who drink to excess are more likely to have a partner who consumes more alcohol than they do (Mustonen 2000).

Compared to men's motives, women's motives to drink are thought to be more strongly influenced by their partner's drinking patterns (Payne et al. 2009). It is postulated that women drink in response to, or to match the use of their partner, particularly if the partner is male. For example, in a large Australian twin study (Grant et al. 2007) involving 5,974 participants, 13 percent of women who were using alcohol to excess reported that their male partners also had excessive alcohol use, as opposed to three percent of men who drank excessively and had female partners that did the same.

The discussion presented above demonstrates the clear and consistent gender differences in the consequences of alcohol consumption. Women have been shown to be uniquely burdened by multiple psychosocial issues and vulnerabilities that can contribute to harmful alcohol use and the development of AUDs.

## **Women and AUDs**

**'Alcoholism'**  
**by**  
**Melisa Karpic (2009)**

*Pray daily now for the death of this beast  
in the beginning it was my comfort and friend  
underneath the mask a demon of lies  
I am now a skeleton  
of the woman I was then  
peace being my only goal  
way back when I started to drink  
worse than drugs  
o this alcohol  
dying slowly day by day  
week by week.*

(poetrysoup.com)

There is a body of research that discusses a phenomenon called the ‘telescope effect’, where women progress more rapidly than men from minimal alcohol consumption levels to harmful alcohol levels and the subsequent development of AUDs (Kay et al. 2010; Greenfield et al. 2010; Hernandez-Avila, Rounsaville & Kranzler 2004; Bravo et al. 2013). For example, in an analysis of international retrospective reports of over 2000 people with AUDs, Johnston et al. (2005) found a faster progression in women from the initiation of regular alcohol use to harmful use and the development of AUDs when compared to the male participants.

This is thought to be due principally to biological differences in the metabolism of alcohol, as well as to a greater sensitivity to alcohol (Diehl et al. 2007). Women who experience AUDs may do so along a ‘unique etiological pathway’ (Foster et al. 2014, p. 322), and tend to be at risk of greater impairment in functioning than men with AUDs (Dawson et al. 2010). Despite this evidence base, it is surprising that only modest attention has been given to the study of women with AUDs as a separate population from men (Nolen-Hoeksema 2004; Foster et al. 2014).

Very little is known about the risk factors for, and consequences of, AUDs for women. ‘Many women with serious [alcohol] problems are unseen, misunderstood, misdiagnosed or simply ignored’ (Vandermause & Wood 2009, p. 728). As such, the literature is almost silent on the topic of women and alcohol-use disorders despite an extensive search. Males have been the focus of most studies on AUDs, or, if women were included, the gender of the participants was not reported on separately. As a result, established theories, norms and practices related to harmful alcohol use and AUDs experienced by women are thought to be predominately male-orientated (Moos, Moos & Timko 2006). It is time then to make women’s experiences and voices audible.

Women with AUDs have been shown to face more societal rebuke and chastisement than their male counterparts (Nolen-Hoeksema 2004; Vandermause & Wood 2009). Women are often expected to conform to a specific role in society - they are often the caregivers, the nurturers, the homemakers (Thurang & Bengtsson 2014), and when they divert from this normative path (such as when they experience an AUD) they are judged to have ‘deserted’ their responsibilities (Angove & Fothergill 2003).

Women with AUDs have been shown to experience significantly more guilt and shame over their drinking than men with AUDs (Small, Curran & Booth 2010; Thurang & Bengtsson 2014). Women have been reported to believe that there are more social sanctions against harmful alcohol use for them, than there are for men (Nolen-Hoeksema & Hilt 2006). This results in women with AUDs being less likely to engage in health seeking behaviour such as accessing services.

### **Service approaches for women with AUDs**

Types of services for women with AUDs are the same as the ones discussed earlier in this chapter in the AUDs 'models of service delivery' section (page 43). Discourse undertaken previously illustrated that despite the fact that women may experience a faster transition to the development of an AUD, women are less likely than men to receive the help of services (Greenfield et al. 2007, Grosso et al. 2013). As mentioned, low rates of screening for AUDs in primary care have been identified, and women are thought to be at even higher risk than men not to be screened (Vandermause & Wood 2009), despite the fact that they generally experience significantly more alcohol-related harm.

Regardless of the fact that many women with AUDs experienced significant trauma and abuse in their lives that has occurred often at the hands of men (Bennett & O'Brien 2007; Roche et al. 2007), the usual service approach to AUDs delivers care to both women and men simultaneously (Tang et al. 2012). Although somewhat limited within the literature, there was recognition of the need for gender-specific and gender-responsive programs, due to the fact that the care needs of women can be very distinct from that of men's (Tang et al. 2012; Messina, Wish & Nemes 2000; Grosso et al. 2013).

A study of 180 U.S. women with AUDs about their motivators for seeking help from services (Grosso et al. 2013) found that women have a different set of internal motivators to men for seeking help. These motivators, including worries about progression of their AUD and health problems, as well as concerns about family, were associated with 'worse drinking and retention outcomes' and early exit from the programs (Grosso et al. 2013).

It is thought, however, that a large majority of specialised programs for AUDs were originally designed with male participants in mind and do not take into account women's motivators for engagement (Vandermause & Wood 2009). This is made all the more significant when considering that women who do engage in services generally have a greater chance of reducing alcohol-related harms when compared to their male counterparts (Dawson et al. 2010; Hernandez-Avila, Rounsaville & Kranzler 2004).

Women with AUDs experience a different set of barriers to engaging with services than men. These include experiencing more opposition and less support from family and friends when planning contact with specialist services (Small, Curran & Booth 2010; Grosso et al. 2013). Further to this and as discussed previously, societal stigma and discrimination also present significant barriers (Hser et al. 2003; Bradley & Berger 2013).

The stigma toward people with AUDs is particularly strong for women and the questions over their fitness as mothers and caregivers, accompanied by social and familial ostracism, are often cited reasons for not engaging with specialist services for help (Greenfield & Grella 2009; Brienza & Stein 2002). Women with young children have been shown to have concerns over asking for help, in case this will lead to the children being removed from their care (Brienza & Stein 2002; Hser et al. 2003).

Self-stigma experienced by women with AUDs is high and leads to secrecy about drinking and a delay in seeking help (Jakobsson, Hensing & Spak 2005). Other barriers faced were reported to include: lack of services for women with small children, childcare issues if they need residential services, economic barriers due to unemployment and the costs of the programs as most are not government funded, as well as co-occurring mental health issues that resulted in difficulty in obtaining care for both disorders (Greenfield et al. 2010; Pelissier & Jones 2005).

As mentioned, a woman who drinks at harmful levels has a higher possibility of having a partner who also drinks, and, because of perceived threats to their own drinking, the partners may not be supportive of the woman's decision to engage with care (Brienza & Stein 2002). Often the partner not only discourages the woman from entering programs, but may also threaten violence or to leave the relationship if the woman chooses to engage with services (Nowotny & Graves 2013; Green 2006).

Gender is therefore, an important variable to consider when planning appropriate services for people with AUDs. However, regardless of the fact that women with known AUDs may have valuable information regarding the experience of their disorder and reasons for service engagement, their views have only very minimally been explored in the literature (Vandermause & Wood 2009). This highlights the need for research to bridge this gap, to create understanding of what it means for a woman with an alcohol-use disorder to engage with health services. This research will therefore go some way to filling this void and contribute to this gap in knowledge.

The next chapter (Chapter Three) will describe in detail the design that was used to fulfil the aims of the research and the specific approach used to answer the research question. It will include the methodology and methods used to explore the meaning that women with alcohol-use disorders attributed to their decisions to engage with services.



## **CHAPTER THREE**

### **Research Design**

#### **Introduction**

This chapter introduces the methodology and methods used to explore the meaning that women with alcohol-use disorders attributed to their decisions to engage with services. It examines the philosophical underpinnings that led to the adoption of the hermeneutic phenomenological approach of van Manen (1990). In order to understand and interpret the essence of meaning behind the reasons why the 15 women participants made their decisions to engage with services, a phenomenological approach was used. Phenomenology is recognised as a research paradigm that seeks to uncover embodied, experiential meanings and rich descriptions of phenomena.

Two prominent leaders in phenomenology, Husserl (descriptivist) and Heidegger (interpretivist) are discussed so as to express the different theoretical phenomenological perspectives. A description of the phenomenological research methods used in the study is also provided, including ethical considerations, recruitment details, data collection and analytic processes. The chapter concludes with an explanation of the trustworthiness of the data using Guba and Lincoln's (1989) evaluative criteria.

#### **Research aim**

The aim of this research was to explore the meaning that women living with alcohol-use disorders (AUDs) attributed to their decisions to engage with drug and alcohol services.

#### **Methodology**

##### ***Qualitative research***

I chose to use an approach within the qualitative paradigm to frame this research. This is because qualitative research is concerned with understanding the complex and subjective meanings that emerge for different individuals and groups in particular social contexts and over time (Schneider et al. 2007). Qualitative research methods are especially useful in discovering the meaning that individuals give to the events they experience (Bogdan & Biklen 2003; Denzin & Lincoln 2000), as per the aims of this research.

Qualitative researchers are always aware of the perspectives and voices of the participants. Qualitative research often expresses what the person themselves has been unable to say (Morse 2012). Research within the qualitative paradigm 'humanises' healthcare (Denzin & Lincoln 2000), as it provides a social justice agenda to the provision of healthcare. The identification of hidden phenomena that comes from qualitative methods adds an important dimension to health research.

Laverty (2003) compares quantitative research; that which emphasises prediction, control and measurement, with qualitative research; that which emphasises discovery, description and meaning. Complex behaviour is not well captured by quantitative methods. Historically, research topics that could not be explained objectively held no place in the domains of science (Streubert & Carpenter 2011). In more recent times however there has been a move to include not only the traditional quantitative methods needed to provide such objectivity, but also a more humanistic approach.

Those who engage in this form of inquiry support a way of exploring research that honours an inductive style, a focus on meaning, and the importance of representing the complexity of a situation (Creswell 2015). Therefore, exploring the meaning that women with alcohol-use disorders attributed to their decisions to engage with services lent itself well to a qualitative paradigm, as the goal of qualitative research is to understand natural phenomena while emphasising the meaning, experiences and subjective views of participants.

### ***Phenomenological inquiry***

Phenomenology is a qualitative method of inquiry where researchers investigate the deeper meaning of individual lived experience and meaning. I employed a phenomenological methodology to explore the meaning that women with AUDs attributed to their decisions to engage with drug and alcohol services. 'Phenomenology is both a philosophy and an approach to enquiry that seeks truth and logic through critical and intuitive thinking about human existence' (Omery 1983, p. 59).

The development of the phenomenological movement attempted to clarify a way of viewing human beings and their lives in a manner that identified the essential uniqueness of the human world. Phenomenologists want to know what the experience was like to live, what it meant to the person, and not just the individual's reaction to the experience (Munhall 2007). The phenomenological attitude solicits the adoption of a different point of view, one that is more radical and comprehensive than any other (Sokolowski 2000). Lopez and Willis (2004, p. 726) remind us that:

Phenomenology offers nurse scholars and clinicians an approach to inquiry that has a good fit with nursing philosophy and nursing art: understanding unique individuals and their meanings and interactions with others and the environment.

Thus, phenomenology is, in its simplest form, a way to explore the profound *meaning* of another's human experience, therefore theorising 'what it is like' to experience a phenomenon, as was the goal of this research.

### ***Phenomenology as a philosophy***

In the late nineteenth century, phenomenology emerged as a reaction against the then scientific (positivist) view of philosophy and psychology (Hammond, Howarth & Keat 1991). As such, phenomenology did not endorse Descartes' dualism of the mind and body. Descartes maintained that real objects can exist independently of our consciousness. This dualistic perspective perceived subjective experiences as appearances and therefore privileged science over experiences.

For phenomenologists, the separation between appearances and reality or objects and the external world was untenable because experience is always 'of' something (Hammond, Howarth & Keat 1991). Phenomenology as a philosophy recognises that consciousness is consciousness of something (Merleau-Ponty 1962), that is, reality consists of objects and events (phenomena) as they are perceived or understood by human consciousness. Consciousness must be directed towards an object, it does not exist as a solo entity (Bourgeois 2002).

From this perspective, consciousness or experience is seen as fundamentally intentional, as it refers to or is directed at objects. It is the study and exploration of phenomena (what presents itself to us in conscious experience) as a means to grasp the absolute, logical, ontological and metaphysical 'spirit' that is behind phenomena (Omery 1983). As highlighted by Wertz (2005, p.175):

Phenomenology is a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy over the known.

The philosophy developed through two main schools in Germany (Göttingen and Munich), and eventually into France and then worldwide (Embree 2001). This development initiated a number of different phenomenological schools of thought; dependent upon the world-view one follows. Phenomenology attempted to unite philosophy, science and the life-world, and attach importance to rich contextualised descriptions, based on lived experience.

The phenomenological tradition, akin to any other philosophical tradition, spans many different perspectives and viewpoints. As it has unfolded throughout the past one hundred years, what has remained central is that phenomenology as a philosophical perspective has thrown light on previously ignored phenomena of the human experience. It has reformulated philosophical questions and penetrated thought in almost all fields of scholarship (Tymieniecka 2003).

### ***Phenomenology and research***

Phenomenology as a research methodology is essentially the study of lived experience or the life-world (van Manen 1997). Phenomenology rejects the concept of objective research. The emphasis instead is on the world as lived by an individual, not the world or reality as something separate from the individual. It is the lived experience that gives meaning to each individual's perception of a particular phenomenon and thus presents to the individual what is true or real in her or his life (Giorgi 2000).

As a methodology, the use of phenomenology enables the researcher to access meaning, where understanding the participants meaning is more important than unbiased data or mere facts, where lived experiences and realities are sought as the ultimate goal. There are many variations of phenomenological research methods, although phenomenological researchers generally agree that the central concern is to return to embodied, experiential meanings (Finlay 2009). This is owing to the fact that the epistemology of phenomenology focuses on revealing meaning rather than on arguing a point or developing abstract theory (Flood 2010).

Meanings are constructed by people as they engage with the world they are interpreting. Individuals are embodied in their worlds, and this is why their visions of reality are so meaningful and revealing of the reality that researchers intend to explore. The researcher's task is to analyse the intentional experiences of consciousness to perceive how a phenomenon is given meaning and to arrive at its essence (Sadala & Adorno Rde 2002). Thus, phenomenology practiced within a human science perspective can result in valuable, insightful knowledge about individual lived experience.

### ***Descriptive phenomenology***

Phenomenology as currently debated was formally introduced to twentieth-century thinking through the seminal works of the philosopher Edmund Husserl in the early nineteen-hundreds. Though important precursors of phenomenology can be found in the work of Immanuel Kant, Georg Wilhelm Friedrich Hegel and Ernst Mach, phenomenology, as a new way of theorising philosophy, was first proposed to the world of research by Husserl (Moran 2000). Conversely, Laverty (2003) contended that the structuring of phenomenology as a philosophy was arguably attributed to Franz Brentano (Husserl's teacher). Equally the practice of phenomenology can be traced further and goes back to the 'wisdom' traditions such as Buddhism and Hinduism (Smith, Jarman & Osborn 1999).

Nevertheless, Husserl's work '*Logical Investigations*' has most often been considered the first true phenomenological work (Finlay 2009). Husserl's philosophical ideas played a part in the departure of positivism; a philosophy of science based on the view that information is always derived from logical and mathematical treatments and reports of sensory experiences, and brought inspiration to the methodology of social science.

According to Thompson, Locander and Pollio (1990), Husserlian phenomenology began as a search for the philosophical foundations of logic and evolved into a study of the logical structures of consciousness. This is because Husserl was concerned with the essence of consciousness, emphasising the description of the person's lived experiences that were free from interpretation (Schultz & Cobb-Stevens 2004). However, the term 'essence' should not be mystified; it must be understood as a 'linguistic construction', a description of a phenomenon (van Manen 1990, p. 39).

Husserl therefore described phenomenology as a science that investigates essences, and, moreover, as a science that dealt exclusively with essences and essential relations. Husserl's central insight was that consciousness was the condition of all human experience. He believed that the essence of phenomena could be seen and clearly felt, free from the clutter absorbed by the ego. His dictum was '*Zu den Sachen selbst*' - to the facts themselves (Cohen & Omery 1994). Husserl sought to explain how to overcome personal biases, biases which stand in the way of achieving the state of pure consciousness. Husserl's insights launched a new philosophy and a new approach to scientific inquiry.

'Descriptive' phenomenology, attributed to Husserl, is where every day conscious experiences are described, while preconceived opinions are set aside or bracketed (Giorgi 2000). Husserl attempted to make phenomenology a rigorous science within the tradition of its time and used the concept of bracketing to maintain objectivity. He called this an *epoche*, or phenomenological reduction (Cohen & Omery 1994).

Bracketing involves putting aside what the researcher already knows about the experience being investigated and approaching the data with no preconceptions about the phenomenon. Bracketing remains an important aspect of phenomenology within phenomenological healthcare research today. Husserl saw this method as a way of reaching true meaning through penetrating deeper and deeper into reality.

The aim of phenomenological reduction is to isolate the pure phenomenon from what the researcher already knows about the phenomena, which is only possible when the researcher remains void of any preconceptions (Streubert & Carpenter 2011). Researchers are encouraged to 'bracket' their own assumptions pertaining to the phenomenon in question by refraining from positing a static sense of objective reality for oneself and the participants whose experiences are being explored (Giorgi 2000). Therefore, Husserl argued, if the description of lived experience was to be considered scientific and generalisable, strict adherence to the principles of descriptive phenomenology had to be employed and commonalities were to be identified among research participants.

Descriptive phenomenology calls on researchers to set aside preconceptions through procedures involved in bracketing. The ultimate test of the quality of a descriptive phenomenological investigation of caring, healing, or wholeness would be testimony from the participants themselves that the investigator's universal description of the phenomenon captured their personal experiences (Tymieniecka 2003). The researcher would believe that it was possible to suspend personal opinion, to arrive at a single, essential and descriptive presentation of the phenomena.

### ***Hermeneutic (interpretative) phenomenology***

While Husserl focused on understanding beings or scientific phenomena, his former student and then colleague Martin Heidegger focused on '*Dasein*'; translated as 'the mode of being human' or 'the situated meaning of a human in the world' (Lavery 2003, p. 72). Heidegger (1962) claimed that phenomenology should make known what is hidden in everyday human experience, the existential experience.

Heidegger sought to answer the question of the meaning of being. According to Heidegger (1962), the pre-understanding that came from a person's history, background and culture was a structure for being. Pre-understanding was not something a person could step outside of or put aside, as it was understood as already being with us in the world. Australian nursing scholar Koch (1995, p. 831) explained in the following passage how Heidegger's notions of history and culture mesh to provide the human being with pre-understandings about the experience of phenomena:

Human beings always come to a situation with a story or a pre-understanding and are brought into focus in order to be understood. Pre-understanding is a structure of 'being-in-the world'. It is not something that we can eliminate, or bracket, it is already with us in the world. This is one of the most difficult notions to grasp, but unless one does, the nature of interpretation posited by Heidegger will not be understood.

Heidegger (1962) suggested that human beings are thrown into the world, but the world existed long before the person was placed into it. When we are born, we are placed into a world of other people, who teach us their language, laws, morals, social structures and our possibilities for being within human society.

The world is not just the person's physical environment that they found themselves in, as the world consisted of human structures and human given meanings before they were born. However, the world to the person's experience has always been, the person takes the world for granted and is therefore unable to see how it influences their understanding. The person is thus shaped and formed by their world.

This contrasts to what Husserl philosophised -acts of attending, perceiving, recalling, and thinking about the world, and humans being understood primarily as 'knowers' (Morse & Field 1996). With descriptive, Husserl-inspired phenomenology, researchers aim to reveal essential general meanings of a phenomenon. They stay close to what is given to them, to what the person under investigation 'knows' (Finlay 2009). Husserl therefore acknowledged that people could only be certain about how things appear in their consciousness – the only certainty in the world was derived from the immediate experience as experienced through a person's consciousness.

Conversely, Heidegger (1962) proposed that consciousness is not separate from the world of human existence - he argued that one could not begin an analysis of the self (and therefore other people) from an isolated 'I' of pure consciousness. Bracketing and removing oneself from a phenomenon could not succeed if the self is involved in the world, and this involvement is part of conscious experience and knowing.

Humans are already caught up in a world which they find themselves thrown, which reveals itself in moods, the overall nature which was encapsulated by Heidegger's notion of *In-der-Welt-sein* or 'being in the world' (Moran 2000, p. 13). In his own application of phenomenology, Heidegger profoundly altered Husserl's. Heidegger transformed philosophy at the time with his radical articulation of the notion of being-in-the-world.

The focus of Heidegger's (Mackey 2005) hermeneutic inquiry was therefore on what humans 'experience' rather than what they consciously 'know'. Hermeneutics, the word, was derived from the Greek word *hermeneuin*, 'to interpret' (Walsh 1996). For Heidegger, interpretation was a further development of understanding: 'In interpretation, understanding does not become something different. It becomes itself' (Heidegger 1962, p. 188).



In contrast to Husserl's descriptive phenomenology, Heideggerian hermeneutic or interpretative phenomenology rejected the idea that one can completely suspend one's presuppositions, prejudices or preconceived ideas by simply 'being-in-the-world' (Todres & Wheeler 2001). Heidegger believed that life experiences were tied to individual knowledge where meaning was co-developed through one's humanness, combined life experiences, background, and ultimately the world in which one lives (Byrne 2001).

Hermeneutics therefore went beyond description of core concepts and essences to look for meanings embodied in common practices. Herein lays a pivotal difference between descriptive and interpretative phenomenology. For Husserl, context was of peripheral importance, for Heidegger, context was of central concern (Wojnar & Swanson 2007).

Interpretative phenomenology emphasised that individuals cannot abstract themselves from various contexts that influenced their choices and gave meaning to lived experience. The researcher is considered inseparable from assumptions and preconceptions about the phenomenon of study; instead of bracketing and setting aside such biases, they are explicated and integrated into the research findings. Hermeneutics goes beyond mere descriptions of core concepts and essences to look for meaning embedded in everyday life practices.

### ***Interpretive phenomenology and ontology***

Heidegger's (1962) view of the person differed from that of Husserl, mainly in the way Heidegger conceptualised the person not as a separate subject living apart from the other things that make up the world. Hermeneutics, as put by Koch (1995), is grounded in interpretive paradigm, which reflects distinct assumptions related to the nature of reality (ontology), how one comes to know that reality (epistemology) and how one gains access to what can be known about that reality (methodology). An individual is not an isolated entity in this world; an individual lives in social systems and interconnects with other entities. 'Dasein' did not simply mean human existence, it is an ontological term which described the way in which humans are and understand themselves rather than what they are (Large 2008).

Heidegger (1996) viewed the person as an integral part of that world, one that could not be separated and taken out of the context of their world. 'Being is only in the understanding of those entities to whose Being something like an understanding of Being belongs' (Heidegger 1996, p. 116). One is immersed in and absorbing from the world, so one will not be able to notice everything that one is gaining from the world. It is important for an individual to be understood by one's fellow beings – only in their own being can they gain an understanding of the other.

Heidegger also insisted that any interpretation is only valid when background is taken into account (Lavery 2003). This not only facilitates the researcher's deeper understanding of the other's experience, but also facilitates more accurate interpretation of context and meaning. For Heidegger (1962), phenomenology was subservient for what he called 'fundamental ontology', which centred on the question of being.

Heidegger raised to an ontological level the essential role of humans as 'questioning' beings (Lavery 2003). Heidegger (1962) asserted that our pre-ontological understanding of being, in relation to the entities we engage with and respond to, cannot be detached or isolated from these very entities. Ontology addresses questions about existence. As human beings, we cannot escape from our being-in-the-world as we are thrown into and placed in time and space (Heidegger 1993).

This means placing our ontological views into the context of specific fields of interest. To gain access to people's lived experiences; firstly, we consider the life world of the researcher; as she also shares conditions similar to other human beings. From this it follows that research within a life world approach entails interrelating with and, to some extent, sharing other people's life worlds (Heidegger 1962). By conversing with people, listening to their narratives, observing their use of tools and the environment and so on, we gain access to other's life world phenomena.

### ***Rationale for choice of methodology***

Essentially, in interpretative phenomenology, the phenomenological researcher becomes an interpreter of interpreters. The aim of interpretive phenomenology is to seek explicit and universal meanings, to describe and give structure to a given phenomenon. The researcher analyses and interprets lived experiences to find essential themes and the themes taken together allow meaning of the experience to emerge as a whole (van Manen 1990). A Heideggerian, interpretative phenomenological framework was considered the best fit with the conceptualisation of this research – an understanding of the meaning women living with alcohol-use disorders attribute to their decisions to engage with drug and alcohol services.

Hermeneutical phenomenology as a philosophy of actions has the potential to not only radicalise thought but make a difference in the world (van Manen 1997), in the case of this thesis by giving voice to the women who may feel silenced as a result of living with an addiction. I believe, as Heidegger (1962) did, that it was impossible to bracket my own life experiences, values and assumptions – a conviction that my own life world would enhance the study as the research process unfolded; a precept held in high regard within the hermeneutic approach.

With this, I sought to solely understand the participants' contextual experiences, but did not believe it was possible to fully suspend my preconceptions about women's experiences of alcohol-use disorders given my professional expertise, experience and role as a former nurse manager of a drug and alcohol service. I acknowledge these preconceptions and make them explicit so that the readers of this research can understand the conceptualised constructions regarding the interpretations of the data.

With this type of framework, the researcher may also use their own experiences to guide the research questions (Moustakas 1994). I personally believe that it would have been difficult for me 'bracket out' my interpretation of the phenomenon. As such, I chose to follow the ideas of Heidegger (1962) and fuse the horizon of my beliefs and experiences with that of the participants.

Within this approach, I also wanted to emphasise the uniqueness and diversity of the participants who took part in the research, rather than find common essences. An interpretative foundation enhances the view where researcher and the researched meet on equal ground, they engage with one another as co-creators of the research and the knowledge. Understanding is looked upon as a fusion of two perspectives, that of the participant's involvement with the phenomenon, and that of the interpreting researcher (Bentz & Shapiro 1998). What is sought is an understanding as opposed to facts, in this case, an understanding of the meaning that a woman living with an AUD attributed to her decision to engage with a service.

### ***Role of the researcher***

Hermeneutic phenomenology recognises the influence of the researcher. When operating from a phenomenological paradigm, subjectivity from the researcher is acknowledged as unavoidable and in fact the basis for truth (Moustakas 1994). It is therefore necessary that the researcher critically reflect on themselves as the person conducting the research. This is known as 'reflexivity', which Guba and Lincoln (1989) deem necessary when considering the research process and how the findings are represented.

It is crucial that interpretative phenomenologists undergo a process of reflexivity to provide a credible and plausible explanation of participants' accounts and avoid assumptions (Clancy 2013). Berndtsson et al. (2007) reminds us that the openness towards the participant displayed by the researcher when using an interpretative paradigm represents an inherently reflexive attitude.

Heidegger's (1962) being-in-the-world provides further support - through making myself aware of my own feelings about my expectations of the research, I fully appreciated the nature of my investigation and its relationship to myself both personally and professionally. Interpretative phenomenology recognises the significance of the researcher's presuppositions, in which the self and other and the relationship between them are explicitly examined as part of the research study. As such, I acknowledge that the lens through which I viewed my inquiry was coloured because of my professional background.

This is not to say that the use of a phenomenological paradigm is not without its challenges. In van Manen's (2006, p. 720) words, 'phenomenological method, in particular, is challenging, because it can be argued that its method of inquiry constantly has to be invented anew'. This type of research cannot be reduced to a general set of strategies or research techniques. The essences of some experiences may also be hidden from view by everyday meanings. According to Bourgeois (2002), the signs used to relate experiences are already diluted by the person's exterior and interior filters. The very act of asking questions alters the participants' state of awareness and therefore their views on reality. The person may not have reflected on the phenomena in the same way as that suggested by the researcher.

Despite these warnings, van Manen (1990, p. 27) considered that this was the point of hermeneutic inquiry, when the 'description is an adequate elucidation of some aspect of the life world'. The final elucidation should resonate with our own experiences, or experiences we could have. The researcher should honour the human experience in all forms, unconditionally and with imagination (Anderson 1998). With our understanding of what it is to be human, we base our constructions of reality on our own experiences. As Heidegger (1996) pointed out, it is perhaps impossible to separate oneself from one's past understandings and experiences; an individual's realities are inherently influenced by the world in which they live.

Thus, the researcher needs to be aware that the use of phenomenology requires sensitive interpretative skills. Geanellos (2000, p. 113) suggests that 'the art of interpretation is always bounded by the separate, intersecting horizons of researchers and participants'. Our understanding of 'otherness' comes from the process of making ourselves more transparent, so as we can untangle this fusion of horizons. A richness of meanings is elucidated when we recognise that none of us really have privileged access to another's reality of lived experience, what we offer as phenomenologists is one version, an interpretation.

All interpretations are subject to continual revision. It is about having a sense of what the world feels like from another's perspective, about using their words (and what is *not* said), in an attempt to enter their world and reside with another being for a short time. It is to immerse ourselves, as put by Merleau-Ponty (1964, p. 97), 'to the extent that I understand, I no longer know who is speaking and who is listening'.

### ***van Manen's approach to phenomenological research***

Phenomenological researchers can choose from a diversity of approaches. Just as there are many variants of phenomenological philosophy (Moran 2000), there are many ways in which it has been operationalised empirically in research. Max van Manen (1990) began promoting the use of phenomenological qualitative methods in educational and human science research in the 1980s. van Manen (1990) developed his interest in the human sciences and phenomenology through his studies into pedagogy in the Netherlands before becoming a Canadian citizen in 1973.

According to van Manen (1990), phenomenology differs from almost every other science in that it attempts to gain insightful descriptions of the way we experience the world reflectively, without taxonomising, classifying or abstracting from it. As the term 'science' is derived from 'scientia', meaning 'to know', phenomenology, according to van Manen (1997), can be deemed in a broad sense to be a 'scientific' process. This is because phenomenology is systematic, explicit, self-critical and intersubjective in its research endeavours.

I chose to use van Manen's methodical structure to base this research on, as he provided a very sophisticated and comprehensive framework that incorporated hermeneutic phenomenological reflection and hermeneutic phenomenological writing which resonated with me. This resonance largely occurred after reading van Manen's (2007, p. 11) description of phenomenology as 'a project that is driven by fascination; being swept up in a spell of wonder, a fascination with meaning'.

van Manen's (1997) approach to interpretive phenomenological research incorporated the researcher acknowledging her previous experiences, knowledge and beliefs, and how these may influence the researcher in all phases of data collection, analysis and interpretation. van Manen (1997) considered hermeneutic phenomenology to be the construction of an interpreted understanding of an aspect of a human life-world. For van Manen, interpretative phenomenology was a marriage between hermeneutics, phenomenology and semiotics. Where phenomenology defines a person's orientation to the lived experience, semiotics defines the linguistic approach to research, and hermeneutics describes how a researcher 'interprets the 'texts' of life' (van Manen 1990, p. 4).

van Manen posited six dynamically interconnected activities, a methodical structure for hermeneutical phenomenological research. By presenting six distinct activities or steps, the intention is not to provide a detailed step-by-step procedure that a researcher should adhere to. In fact, van Manen (1990, p. 34) clearly advised against this strategy by stating that 'although a certain order is implied in the methodological presentation this does not mean that one must proceed by executing and completing each step'. It may be that some activities are undertaken simultaneously whilst others intermittently.

I chose van Manen's (1990) six-step structure as it is designed to reach deeply into the inner person involved within a human experience, to bring out and describe the meanings and structures within that lived experience; in my case, to find out the meaning behind what prompted the woman to seek help for her alcohol-use disorder. The six steps provided a framework for the research method as a whole, as the steps were seen as sufficiently broad enough to allow flexibility in emphasising and minimising one step or another, dependent on the emerging data (van Manen 1997). An explanation of the six steps is provided below, as is the table summarising the steps undertaken in this study.

### *Step 1: 'Turning to the Nature of Lived Experience'*

The first of the six steps involved me being committed and interested in the specific phenomena, or, in van Manen's (1990, p. 31) words, 'turning to the nature of lived experience'. This implied that the researcher set out to explore and eventually describe some element of human experience that interested them. The overall aim is to textually model the essence of a lived experience. There is a realisation that the experience can never be explored whilst it is being lived, it has to involve reflection on an experience that was past (Sokolowski 2000). However, we can only do this if we can keep ourselves open in such a way that we stay truly interested, 'to interrogate something from the heart of our existence' (van Manen 1990, p. 43).

In keeping with this, my original area of interest was an exploration of why women who live with alcohol-use disorders do not engage with the services set up to help them. When working as a nurse, it became apparent to me that while many women experienced the negative effects from overusing alcohol, they did not engage with services nearly as much as their male counterparts.

After reading more on phenomenology, in particular the works of Heidegger and van Manen, I realised that the 'essence' of what I was seeking could not be explained by asking, "why didn't you engage?". Instead what was required was an explanation of "why did you engage?". Practices could not be potentially changed or recommendations could not be made unless we knew more about women's reasons *for* engagement, rather than their reasons for not. It also explores women's strengths rather than focus on barriers.

According to van Manen (1990), this identification process is followed by the formal development of a phenomenological question. The question must clearly define the topic being explored. Once defined, the researcher lives the question as if becoming the question. According to van Manen (1990, p. 42), an important reminder for all phenomenological researchers is to be constantly mindful of one's original question and 'thus be steadfastly orientated to the lived experience that makes it possible to ask the "what is it like" question in the first place'.

The focus of this research was on women with alcohol-use disorders, more specifically, the meaning that these women attributed to their reasons for engagement with drug and alcohol services – what it was that prompted them to engage in the first place. To fully explore this meaning, it was important for me to comprehend the experience of an alcohol-use disorder, not in 'real life' terms, but with recognition of the knowledge I gained from my prior experience of working directly with women who experienced these disorders. This, as suggested by van Manen (1990), is because any attempt to ignore or bury prior knowledge will inevitably result in that knowledge edging in to the researcher's reflective processes.

### ***Step 2: 'Investigate the Experience as Lived'***

The second step involved investigating the lived experience as opposed to a theoretical presentation of the experience. For van Manen (1990), this centred on a broad search for resources that may help with revealing the nature of the experience. van Manen (1990, p. 54) pointed out that my own (as researcher) life experiences 'are immediately accessible to me in a way that no one else's is'. This does not mean that the researcher should include an autobiographical account when presenting other's lived experience phenomena.



It is the extent that the researcher is aware of the structure of their own experience of the phenomena, so as to provide the researcher with clues for orientating them to the phenomena. Thus, the experience of my clinical background as a drug and alcohol nurse helped to orientate me to the phenomenon, ensuring that the phenomenological descriptions had a universal, intersubjective character (van Manen 1990, p. 58).

Another important place to look for information was with an exploration of personal descriptions of the experience, as was undertaken in this study via in-depth one-to-one interviews with participants. van Manen (1990, p. 62) asserts, 'the point of phenomenological research is to 'borrow' other people's experiences and their reflections on their experiences...'

In the interviews, I gathered information and discussed the meaning of the phenomenon - the meaning the women attributed to their engagement. The essence was to ensure that the process remained focused on revealing something about the nature of the phenomena in question (van Manen 1990). With this, Kvale (1994) cautioned that the researcher should pay attention to not only the words, but what is also between the words. More detail on the specific interviewing processes is discussed below in the methods section.

### ***Step 3: 'Reflect on the Essential Themes which Characterise the Phenomenon'***

The third step is centred on hermeneutic phenomenological reflection. A reflective process helps the researcher to make explicit the structure and meaning of the lived experience, to gain insight into the essence of the phenomenon (van Manen 1990). With this, the researcher conducts thematic analysis or the formulation of a thematic sense or meaning. The aim is to organise and order the research as distinct from following strict rules (van Manen 1990). Themes are a focus of meaning; they are simplifications, descriptions of aspects of the phenomenon. Themes in a phenomenological sense are concerned with exploring meaningful structures as opposed to repetitive concepts (Barnes 2003).

In the final analysis, the researcher ‘composes linguistic transformations’ (van Manen 1990, p. 96), as to create a process of explicating the phenomenon. In staying true to this, I studied the interview transcripts to determine the incidental and essential themes. As put by van Manen (1990, p. 106), not all meanings we encounter in reflecting on a certain phenomenon are unique to that phenomenon or experience – themes that appear to be essential meanings are often historically shaped or determined. To this end, I used the ‘method of free imagination variation’ (van Manen 1990, p. 107); to determine whether the theme is question belonged to the phenomena of meaning attributed by the women participants on their engagement. More detail on the analysis is forthcoming in the methods section.

#### *Step 4: ‘Describe the Phenomenon in the Art of Writing and Rewriting’*

van Manen (1990) explicitly elucidated that the creation of the phenomenological text is the object of the research process. The act of writing itself formalised thought and allows for deeper reflection on the phenomena. The act of writing brings forth the structures of the lived experience. At its core, van Manen (1990) considered the process of writing and rewriting the most important skill possessed by the phenomenological researcher.

Writing, in the phenomenological sense, is considered as two distinct levels, the practical and the reflective. The practical centres on method, technique, form and style, while the reflective entails issues such as metaphysics, truth, limits of language, interpretation and the phenomenological meaning (van Manen 1990). As the cycles of writing and rewriting continued throughout this research process, there was constant revising and refining of thought.

The researcher may also use anecdotes or stories to highlight a point that may be difficult for the researcher to explain, as has been done in the chapter documenting the findings of this research. Anecdotes may serve to express what was not written or what could be ‘generally acknowledged truths’ (van Manen 1990, p. 120). Through the entire process of writing, the intention was always to make visible the feelings, thoughts and attitudes of the women participants, staying true to the aim of phenomenological research.

### ***Step 5: 'Maintain a Strong and Oriented Relationship to the Phenomenon'***

During step five, the researcher must strive to remain focused on the research question. 'To establish a strong relation with a certain question, phenomenon, or notion, the researcher cannot afford to adopt an attitude of so called scientific disinterestness' (van Manen 1997, p. 33). During the sometimes laborious task of interview transcription and analysis, my genuine interest in the phenomena helped me to progress towards the timely completion of the study. However, it was often too easy to become immersed in the participant stories, to become distracted from the study as a whole.

Thus, it was necessary to establish systems so as to maintain my orientation to the phenomenon, such as a reflective journal and frequent contact with my research supervisors, in an effort to uphold my concentration on the task at hand. This also helped me become more aware of the difference between my own preconceived notions and the thoughts of the participants. The ongoing process of reflexive writing was necessary to assist me to maintain a conscious awareness of my pre-understandings of the phenomenon and how the memories of such experiences could possibly influence the research process (van Manen 1990).

### ***Step 6: 'Balance the Research Context by Considering the Parts and the Whole'***

In the last step, van Manen (1990) suggested that both the parts and the whole should be balanced. This type of research can have 'transformative effect' on the researcher herself, as it is a time of deep learning, heightened perceptiveness and increased thoughtfulness (van Manen 1990, p. 163). Despite the positive aspects of this personal transformation, I had to ensure that I allowed the text to speak in the 'hope that the reader will be affected by it' (van Manen 1997, p. 364).

Thus, the final phenomenological text needed to be concretely part of the life world of participants, be vivid and evocative, and develop intensity and thickness in the descriptions and discussions. To do this, I took van Manen's (1997) advice and stepped out of studying the parts, the analysed interview transcripts, the resulting themes and so on, and looked at the whole – at how each of the parts contributed to the whole. I constantly measured the overall study design against the significance that the parts played in the total textual structure (van Manen 1990).

With this, no one meaning or theme stayed static or fixed, as I attempted to uncover the experience, I found that creative visualisation was helpful – to ‘see’ how the whole was constituted by the parts and vice versa. The researcher is also advised to consider their ethical responsibilities, not just to their participants, but also to themselves. The nature of phenomenological research can have certain effects on participants, such as anxiety, discomfort and self-doubt (Wolgemunth et al. 2015). Ethical considerations for this study are described in the methods section.

Therefore, the purpose of these six steps was to assist the research process in order to gain a deeper understanding of the nature of meaning of our everyday experiences. This process was a constant flow for me as I carried out the study, all of the six steps flowed one into the other and, at times, spiralled backwards. With reflection, there were times where I also carried out the steps simultaneously. In the quest to apply the appropriate phenomenological depth, there was no beginning or end, no top or bottom to this circular process. Table 8 summarises the stages followed in the study of the meaning the women participants attributed to their decision to engage with services.

**Table 8. van Manen's six steps and the role of the researcher**

Steps	Role of the Researcher
<b>Step 1.</b> <b>Turning to the nature of lived experience</b>	Research question: <i>What does it mean for women with alcohol-use disorders to engage with drug and alcohol services?</i> The question is one of particular interest to the researcher – the intent was to give a rich description and evoke new and deeper understanding of the phenomenon of meaning that women with AUDs attribute to their engagement with services.
<b>Step 2.</b> <b>Investigate the experience as lived</b>	Individual, semi-structured, in-depth interviews occurred in this study. These served the dual purpose of collecting data to discover a rich, deep understanding of the phenomenon in question, thus creating a dialogue between the researcher and the participants about the meaning of their experiences.
<b>Step 3.</b> <b>Reflect on the essential themes which characterise the phenomenon</b>	Capturing the essence of the phenomena – the researcher reflected on the themes identified from the interviews and strived to capture the essential meaning or essence that women attribute to their reasons for engagement.
<b>Step 4.</b> <b>Describe the phenomenon in the art of writing and rewriting</b>	Through the process of writing and rewriting, the intention of the researcher in this study was to make visible the feelings, thoughts and attitudes of participants.
<b>Step 5.</b> <b>Maintain a strong and oriented relationship to the phenomenon</b>	The researcher strived to remain focussed on the research question at hand. Genuine interest from the researcher helped her persist through the intense time demands of transcribing, interpreting, reinterpreting and analysing data, and helped to avoid ‘wishy-washy speculations’.
<b>Step 6.</b> <b>Balance the research context by considering the parts and the whole</b>	The researcher constantly reminded herself what she was focussing on, thus finding the balance between what the participants were revealing and keeping true to the research question.

(van Manen 1997)

## **Phenomenological research methods**

In this section, the research methods used in the study are presented. Phenomenological methods need to be consistent with the aims of phenomenological research and ensure that they enable an investigation of what the researcher has set out to investigate (Moran 2000). Whilst there are no fixed signposts or a prescription of methods in phenomenological research, a process must be in place to check the resonance of the interpretation (van Manen 1990).

The question should have both social meaning and personal significance, both of which are demonstrated in this research study. Ethical principles of human science research should be taken into account, and participants should be fully informed and respected in their privacy. With this in mind, included below is information on the process of gaining ethical approval, the recruitment of participants and the way in which the data was collected and analysed. van Manen's (1997) suggested framework for hermeneutic phenomenological isolation of thematic statements was used to structure the discussion on data analysis.

### ***Ethical considerations***

Ethical approval to conduct the research was obtained from the Human Research Ethics Committee (HREC) at the University of Wollongong; New South Wales, Australia (refer Appendices B, C & D). Ethical approval was also obtained from the health service organisation for the area in which the research was conducted; the Illawarra Shoalhaven Local Health District (Appendix E).

The participants were provided with a plain language information sheet (Appendix F) outlining the research, which included the contact details of the research supervisors and the Research Services Office. The participants were informed about the purposes, benefits and potential risks of the study. The data collected was kept confidential, real names were not used and any identifying details were removed. Pseudonyms have been used throughout the reporting of the study.

One concern raised by the HREC was the potential vulnerability of the research participants, specifically how the benefits to participants' would outweigh the risks. There is a growing body of literature that would argue that it is unethical not to research vulnerable populations because, by excluding potential participants from research endeavours, researchers are depriving these individuals of the benefits to be gained from research (Alexander 2010; Juritzen, Grimen & Heggen 2011; Welch et al. 2015).

In fact, the autonomy of an entire group of people may be unnecessarily compromised by this very notion of exclusion (Welch et al. 2015). It was made clear to participants from the very start that involvement in the study would not change their experiences of services as they currently stand. However, the benefits to participants in having their stories heard and having a 'voice' can be considered cathartic, particularly for disadvantaged groups of people (McGrath 2003).

As was also highlighted in the background chapter (Chapter Two), very little research has been done with women with AUDs in relation to exploring their engagement with drug and alcohol services. As the information sought was of a personal nature, the main risk identified was the possibility of participant distress, in recalling an unpleasant event, for example. It was made clear that participant welfare would take precedent over the research.

Every effort was made to ensure that the participants were not put at risk of emotional harm and they were assured that they could cease the interview at any time. As a registered nurse with mental health training, I am skilled in monitoring and assessing individual distress responses and therefore was competent to recognise and respond to any distress that may have been exhibited by the women participants and refer them to professional help accordingly. A large number of participants did disclose matters which had distressed them deeply, such as experiences of intimate partner violence and social isolation. Although tears were shed on occasions, none of the participants were so distressed so as to be in need of professional counselling.

### ***Research participants***

The selection of participants was the initial step in the data gathering process. The purpose of phenomenological research is to describe the fundamental structure of an experience, not the statistical characteristics of the individuals under study. Therefore, participants are not chosen randomly in order to achieve statistical generalisation, but are chosen purposively – selected due to their experience with a given phenomenon (Dale 1996; Lavery 2003).

According to Hycner (1999, p. 156) ‘the phenomenon dictates the method (not vice-versa) including even the type of participants’. Purposive sampling was therefore appropriate to determine the primary participants: the sample was based on the purpose of the study, that is, those who have had experiences relating to the phenomenon to be researched (Lavery 2003). Purposive sampling is a strategy in which the researcher selects participants who will yield information necessary for the needs of the study (Polit & Beck 2006). Consequently, it was necessary to conduct the research with a purposive sample of women who had the experience of living with alcohol-use disorders and who could therefore speak on the meaning of their reasons for engagement with drug and alcohol services.

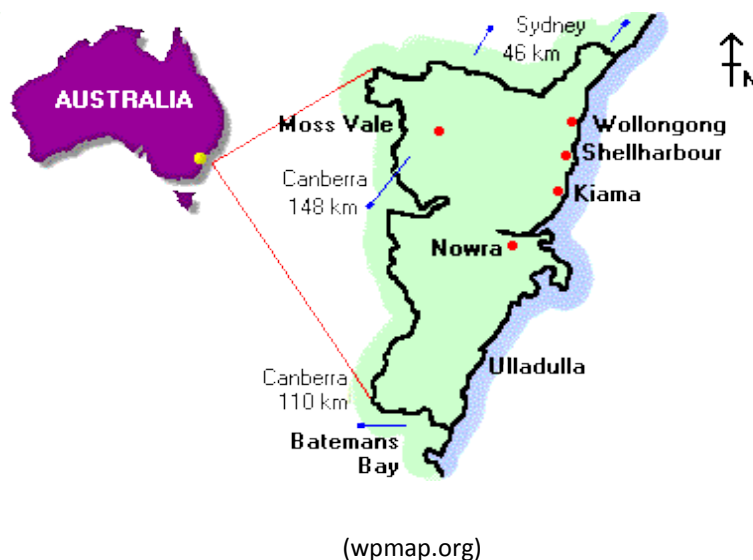
### ***Participant recruitment***

The women in the study were members of the population from which the sample was drawn, as the sample was purposive (Polgar & Thomas 2008). With a phenomenological study, when it comes to recruiting the participants, the question the researcher has to ask themselves is: ‘do you have the experience that I am looking for?’ (Englander 2012). The task is therefore finding and selecting participants who reported having a specific experience of the phenomenon. As such, a random sampling method, where each member of a population group has an equal chance of selection (Polgar & Thomas 2008), would not be appropriate.

With a random sample, the researcher would be trying to determine if the participant belonged to the population they were studying. However, the participant in a phenomenological study *has* to have belonged to the population – has to have had the lived experience of the phenomenon. The phenomenon has to have a deep connection with the participants’ history and culture (McManus Holroyd 2007).

A non-randomised, convenience sample, where I purposively selected the participant group and the settings from where the participants were drawn, was therefore used to gain insights into the phenomenon I explored (Onwuegbuzie & Collins 2007). The sample size was not pre-determined. Smaller sample sizes are recommended for phenomenological research studies, as the aim is to provide detailed, in-depth accounts of participants' lived experience. As stated by Morse (2000, p. 4), 'the greater the amount of usable data obtained from each (as number of interviews and so forth), the fewer the number of participants'.

Three to 10 participants is typical of phenomenological research (Creswell 2015). The actual sample size was dependent upon the number of interviews required to allow me to arrive at a point when no new information came forth in the data collection process (Morse 2012). In the end, 15 interviews took place. This number of participants enabled a significant generation of data so as to construe themes and concepts for this research. To gain access to potential participants, the participant information sheet (refer Appendix E) was circulated at two services in the Illawarra region (Image 3) which ran drug and alcohol programs. Interested women then contacted me by phone and an interview was organised at a time, date and place convenient to the participant (cafes, restaurants and the participant's place of residence).



**Image 3. The Illawarra region**



### ***Selection criteria***

The selection criteria for this study was specific to women aged 18 and over who lived with an alcohol-use disorder and who were, or had, engaged with a drug and alcohol service.

### ***Interviews***

In phenomenological research, the interview itself is not simply about collecting data. Deeper than mere simple communication between two people, the interview is a conversation that creates a therapeutic alliance between participant and researcher (van Manen 1997). To help develop this therapeutic alliance, a semi-structured interviewing process was used in this research. In hermeneutic phenomenology, one-on-one, semi-structured interviewing are well-supported methods to use for data collection (Crotty 1996; Dowling 2007) as these types of interviews serve very specific purposes.

Firstly, they are used as a means for exploring and gathering narratives (or stories) of lived experiences and second, they are a vehicle by which to develop a conversational relationship with the participant about the meaning of an experience (Moustakas 1994). This may be achieved through reflection with the participant on the topic at hand (van Manen 1997).

These types of interviews allow participants to share their stories in their own words. Interviews provide narrative access to the person's particular experience, capture the temporal progression of situations and elicit stories in everyday language (Moustakas 1994). It was important to encourage the women participants to share their stories and to uncover meanings in their experiences.

A 'grand tour' question (Brenner 2006) that asked "what did it mean for you to seek treatment?" was used to open the interview. This type of opening question asks the participant to provide a broad description about the topic under investigation. This broad question positioned the phenomenon of interest being introduced early, with the use of subsequent open-ended questions, which allowed the participants to choose the dimensions of the questions that they are going to answer. This is of particular importance, as it enabled probing by the researcher and facilitated revealing aspects of the questions that were relevant to the participants (Morse & Field 1996).

Equally, I tried very hard to ensure that I listened reflectively and with integrity and respect (van Manen 1990). I treated the women with unconditional positive regard. Other open-ended questions were used as a guide, not to direct participant responses, but to enable the woman to express her beliefs, understandings, experiences and opinions (Byrne 2001). Participants were encouraged to elaborate on their responses and to further expand and clarify as needed. This fostered flexibility in gathering information from the participants.

I personally undertook all 15 interviews, which assisted me to gain a sense of the whole experience for each participant. Prior to the commencement of the interviews, the purpose and objectives of the study were clearly explained to all participants and each participant was asked to verbalise their consent for the interview on the tape. All the women were reminded that they could withdraw from the study at any point in time without repercussion. My past experiences and beliefs, and particularly my own orientation as a drug and alcohol nurse, formed part of the context of the interview.

However, I was mindful of not imposing any personal assumptions or vocalising any leading statements during the interviews, although there was a time during the first interview when I was tempted to interrupt and offer clinical advice. Once the interview was completed, I left pamphlets for the participants' that contained clinical information to assist them with their journey, which they could accept or reject as desired.

The use of a journal assisted me in the process of reflection and interpretation and helped give thought to my own experiences as a novice researcher (Moran 2000). The use of a journal also helped me remain reflexive, as I used this journal as a stimulus to deepen my understanding of the research processes. Drawing on excerpts from the journal helped me to make links between the literature on methodology, decisions I made during the research processes and my evolving understanding of qualitative, phenomenological research. The interview data was collected via a digital audio recorder. The interviews lasted 1.5 hours on average, with the shortest being 50 minutes and the longest 2.5 hours.

## Demographics

Table 9 provides the personal characteristics of the 15 participating women.

**Table 9. Participant characteristics**

<b>Participant Characteristics</b>			
<b>Participant</b>	<b>Age Range</b>	<b>Alcohol History</b>	<b>Service Engagement History</b>
Participant 1	40-50	First drink age 12, 21 years harmful drinking, had ceased alcohol use at time of interview	4 episodes of engagement within a 2-year period, the last 18 months prior to interview
Participant 2	20-30	First drink age 11, 12 years harmful drinking, had not ceased alcohol at time of interview	At least 7 episodes of engagement over a 5-year period, engaged with a service at time of interview
Participant 3	40-50	First drink age 12, 16 years harmful drinking, had not ceased alcohol at time of interview	At least 11 episodes of engagement over a period of 9 years, engaged with a service at time of interview
Participant 4	40-50	First drink age 13, 30 plus years harmful drinking, had not ceased alcohol at time of interview	At least 9 episodes engagement over a period of 18 plus years, engaged with a service at time of interview
Participant 5	50-60	First drink age 9, 40 plus years harmful drinking, had ceased alcohol at time of interview	At least 12 engagement episodes over a period of 15 plus years, the last one 2 years prior to interview
Participant 6	50-60	First drink age 14, 25 plus years harmful drinking, had not ceased alcohol at time of interview	2 episodes of engagement within a 18-year period, engaged with a service at time of interview
Participant 7	30-40	First drink age 11, 17 years harmful drinking, had ceased alcohol at time of interview	3 episodes of engagement within a 1-year period, engaged with a service at time of interview
Participant 8	30-40	First drink age 12, 14 plus years harmful drinking, had ceased alcohol at time of interview	4 episodes of engagement over a 3-year period, engaged with a service at time of interview
Participant 9	30-40	First drink age 13, 10 plus years harmful drinking, had ceased alcohol at time of interview	1 episode of engagement (in progress at time of interview)
Participant 10	40-50	First drink age 15, 8 years harmful drinking, had ceased alcohol at time of interview	2 episodes of engagement over a 1-year period, engaged with a service at time of interview
Participant 11	30-40	First drink age 10, 14 years harmful drinking, had not ceased alcohol at time of interview	4 episodes of engagement within a 3-year period, engaged with a service at time of interview
Participant 12	40-50	First drink age 11, 23 plus years harmful drinking, had not ceased alcohol at time of interview	13 plus episodes of engagement over a 8-year period, engaged with a service at time of interview
Participant 13	50-60	First drink age 11, 35 plus years harmful drinking, had not ceased alcohol at time of interview	14 episodes of engagement over a 14-year period, last episode 1.5 years prior to interview
Participant 14	20-30	First drink age 10, 5 years harmful drinking, had ceased alcohol at time of interview	2 episodes of engagement over a 6-month period, engaged with a service at time of interview
Participant 15	40-50	First drink age 19, 7 years harmful drinking, had ceased alcohol at time of interview	2 episodes of engagement over a 3-month period, engaged with a service at time of interview

### ***Data collection***

I conducted all 15 interviews in-person. The interviews were undertaken at a location chosen by the participant. Twelve were conducted in a coffee shop, and the other three were undertaken in the women's homes at their request. All interviews were audio-recorded to enable verbatim transcripts to be created. I also took notes when undertaking the interviews, recording such things as my own beliefs, the responses and emotional state of the participants and my immediate thoughts of the interview.

When listening and re-listening to each tape and reading and re-reading each transcript, I made notes in a reflective journal about my questioning techniques, verbal and non-verbal responses, as well as my personal thoughts, feelings and ideas regarding the participants' stories and words. I kept this journal as part of my audit trail for the study, which helped facilitate a reflexive approach (Krefting 1991).

While these observations were not data in the formal sense, they were of extreme value in the process of interpretation and analysis of the participant data. These notes were invaluable as a reminder of my earlier thought processes, initial impressions of concepts (van Manen 1997), and as a cue to the continued evolution of thought involved in producing this thesis.

Each of the transcripts was analysed manually. Key words and phrases were highlighted and cut and pasted into Microsoft Word documents. This initial coding process involved extracting and tabulating words and statements from participants into sections, which were grouped, firstly under key words, then concepts, followed by sub-themes and finally themes. van Manen (1990, p. 90) describes themes as:

The stars that make up the universes of meaning we live through. By the light of these themes can we navigate and explore such universes. Themes have phenomenological power when they allow us to proceed with phenomenological descriptions.

A theme suggests van Manen (1990), is something that appears often in the text and is understood as a structure of experience. Therefore, the themes that were derived represented an element of the lived experience of the phenomenon. It was decided that theme saturation (Morse 2000) had occurred once the fifteenth interview had been transcribed and coded, as a clearer understanding of the experience would not have been found through further discussion with participants.

Bazeley and Jackson (2013) describes how coding typically moves through two main stages: an initial stage of identification and labelling and a final stage of refining and interpreting to develop analytic clusters or categories. The analytic work lay in establishing and linking the concepts and sub-themes, and the coding was a process that enabled me to identify meaningful data and the set the stage for interpretation (van Manen 1990).

### ***Structural data analysis***

In keeping with the methodology adopted in this research, the data analysis methods were developed from phenomenological and hermeneutic principles. The typical features of phenomenological analysis involves a researcher adopting a phenomenological attitude, reading the 'whole' data for meaning and working closely with the detail, in order to transform the everyday into disciplinary language and seek the essential structure of an experience (Cohen, Zane & Steeves 2000; Giorgi 2000). Throughout all stages of data analysis, there was ongoing interpretation of the research text and the phenomenon of meaning attributed by the women in relation to their decisions to engage with drug and alcohol services.

Thematic analysis is one of the most familiar approaches used to explore qualitative data. van Manen (1997) was a primary source of guidance for the thematic data analysis undertaken in this study. In van Manen's approach to thematic analysis, the researcher is concerned with discovering the phenomenological themes that make up the experiential structure of a lived phenomenon. Metaphorically, van Manen (1997, p. 90) compared phenomenological themes to '... knots in the web of our experiences, around which certain lived experiences are spun and thus lived as meaningful wholes'. The collection of themes then leads to a rich description of the phenomenon.

Thematic analysis evolves through an examination of the transcripts in whole and in their parts. Benner (1994, p. 116) described this movement between the examination of the whole transcript and its parts as forcing the interpreter to 'shift from understanding and imagining dwelling in the world of the participant to distancing and questions the participant's world as other'. Through a process of interpreting the emerging themes, I attempted to define the *essence* or a more enlightened, deeper understanding of the meaning of the phenomenon as the research outcome. Thus, I anticipated that a new, deeper, understanding of the woman's experience would come about.

Although van Manen (1997) claimed that thematic analysis should not be a rule-bound process, he did give insight into how best to identify themes through a list of techniques. The researcher is guided to engage in the activity of thematic analysis as a means of uncovering or isolating thematic aspects of lived-experience descriptions. van Manen (1997) maintained that themes can be isolated in several ways and offered three reading approaches for isolating thematic statements. These are: (1) the holistic reading approach, (2) the selective or highlighting approach and (3) the detailed or line-by-line analysis (van Manen 1997, pp. 92-93). Table 10 provides a summary of the approaches, followed by a more in-depth explanation on their application in this research.

**Table 10. van Manen's 'Three approaches for isolating thematic statements'**

<b>Approach</b>	<b>Question to Consider</b>	<b>Action</b>
<b>1. Holistic Reading</b>	'What phrase may capture the fundamental meaning or main significance of the text as a whole?'	The researcher attempts to express the fundamental meaning with the use of a phrase
<b>2. Selective or highlighting</b>	After reading the text several times, the researcher considers the following question: 'What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?'	The statements once identified are highlighted or underlined
<b>3. Detailed or line-by-line analysis</b>	'What does this sentence or sentence cluster reveal about the phenomenon or experience being described?'	The researcher documents what is revealed

(van Manen 1997, pp. 92-93)

### **1. The Holistic Approach**

In this phase, van Manen (1997) asks the researcher to consider the phrase that may capture the fundamental meaning or main significance of the text as a whole. With this, I ensured that the transcripts were transcribed as close as possible to the time of the interview so as to minimise the length of time between interview and interpretation of the content. After transcription, I began by reading each interview in its entirety several times. It was difficult at first to find the phrase that captured each participant's meaning of engagement with services, partly due to the extent of the interview content (especially the ones that lasted over 2 hours). However, this phase did help yield a sense of the experience as a whole for each of the participants.

## ***2. The Selective or Highlighting Approach***

The second approach asks the researcher to look at which statements were the most revealing about the phenomenon in question (van Manen 1997). The researcher looks for specific phrases that stand out and are essential to capture the experience or phenomenon. In this study, each of the statements that appeared to be thematic of the experience were highlighted, copied and tabulated.

## ***3. The Detailed Reading Approach***

In the third approach, van Manen (1997, p. 93) proposed that the researcher look at each sentence or group of sentences while asking: 'what does this sentence, or sentence cluster, reveal about the phenomenon or experience being described'. This amounted to reading and re-reading each transcript and identifying key words and concepts that appeared in certain sentences or groups of sentences. These were then condensed and compared across all texts. Common themes and variations then became a coding guide.

### ***Reflecting, writing and re-writing***

Phenomenology always requires thoughtful reflection in order for the researcher to come into a more direct state of contact with the phenomenon (van Manen 1990). As I read each text and worked my way through each of the three reading approaches, I spent time reflecting on the emerging picture of the meaning that the women participants attributed to their decisions to engage with drug and alcohol services. This analysis was supplemented by the journal-styled, reflexive observations documented during data collection and when completing the analytic processes.

van Manen (1990) advocates writing is not a process that characterises the final stage of research, but instead is an essential part of hermeneutic phenomenological investigation. Consequently, the analysis involved a constant writing and re-writing of reflections on the parts and the whole. Each analysis of the participant interviews, together with my reflections, was written and re-written several times. As such, the themes were derived in a way of creating structure and making sense of the phenomenon rather than as a result of coding.

### ***Trustworthiness of the data***

Establishing trustworthiness is the foundation of sound qualitative research (Koch 2006). 'Too frequently is qualitative research evaluated against criteria appropriate to quantitative research' (Krefting 1991, p. 214). The goal of quantitative research, informed by the positivist worldview, is finding the epistemological single truth that lies in an objective real world (Thorne 2000). In contrast, the goal of interpretive phenomenology is increased understanding of the multiple interpretations of the meaning of human experience (van Manen 1997; Crist & Tanner 2003). As Lopez and Willis (2004, p. 730) point out, 'there is no one true meaning'.

Unlike quantitative research, where the researcher's personal experiences do not influence the data in anyway, the premise of phenomenology is to understand human behaviour that cannot be explained through detached experimentation. Phenomenology is about personal, human experiences, it is understood that the researched and the researcher approach the phenomenon with a unique dialogue and a certain connectedness (Finlay 2009).

Thus, terms like 'rigour', 'reliability' and 'validity' do not fit the details of qualitative, phenomenological research. In their seminal exposition of the parallel perspective, Lincoln and Guba (1985) argued that conventional, quantitative rigour-related criteria, such as reliability and validity, were incompatible with the axioms and procedures of qualitative research. Sandelowski (1986) proposed that the parallel to reliability and validity is confirmability, which is an expression of the neutrality of the researcher and a way to guarantee her freedom from bias.

However, interpretative phenomenologists are not neutral or value-free. Instead, as identified earlier, the researcher's biases and assumptions are clarified and become an integral part of the study findings (Koch 1995; Morse 2012). Interviewer subjectivity is firmly viewed as a necessary and unavoidable component of Heideggerian phenomenological interviewing; compatible with the central tenets of Heidegger's philosophy. The researcher makes herself visible and audible, as I have done in this thesis.



Qualitative researchers who have rejected the use of quantitative terminology have developed an equivalent language to express similar concepts (Sandelowski 1986). Nurse qualitative researchers have generally adopted the criteria developed by Guba and Lincoln (1989). Guba and Lincoln (1989, p. 290) coined the term 'trustworthiness', the aim of which is to support the argument that the inquiry's findings were 'worth paying attention to'. Trustworthiness, according to Guba and Lincoln (1989), encompasses several constructs including: credibility, dependability and transferability.

### ***Credibility***

Guba and Lincoln (1989) suggested that credibility replace internal validity. Credibility, to Guba and Lincoln (1989), meant recognisable and faithful descriptions of human experience - whether something is worthy of belief. Sandelowski (1986, p. 32) asserts that:

A qualitative study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognise those descriptions or interpretations as their own. A study is also credible when other people can recognise the experience when confronted with it after having only read about it in a study.

In an attempt to interpret the experience from the viewpoint of the participants, my focus was on describing the phenomena of meaning from the women as it was presented to me, rather than forcing themes or concepts on to it. To help with this, I checked and rechecked the written observations I made during the interviews and measured these, as well as my thoughts and observations from my reflective journal, against the participant stories at every phase in the analysis.

The constant reflecting back and clarification process throughout each interview and when reviewing the transcripts helped me to understand the participant's meaning, rather than ascribe mine. I reviewed each theme thoroughly and did not allow these to be finalised until I was convinced by re-reading, checking and re-checking that each one was a faithful representation of my perception of the truth in the text (van Manen 1990). Further to this, peer-debriefing with my research supervisors was used on a regular basis to ensure that my conceptual interpretation of the interview data was believable and congruent (Merriam 1998).

My commitment to a hermeneutic phenomenological approach also assisted with the credibility of the study, as I remained faithful and orientated to the essence of the phenomenon throughout the whole research journey. The situation of the participant quotes and stories in the findings chapter also increased the credibility of this research, as it allowed the perspectives of the participants to emerge and be as clear as possible, thus helping to substantiate my interpretation of the data.

### ***Dependability***

This aspect of research refers to the manner in which the research is explicit in its steps and transparent in its journey towards explicating the phenomenon in question (Guba & Lincoln 1989). In this study, this journey is overt; from my initial proposal through to the final presentation of this thesis. Dependability can be demonstrated through an audit trail (Koch 2006), where others can examine the researcher's documentation of data, methods, decisions and the end product. Audit trails document the course of development of the completed analysis. In communicating an audit trail, the researcher makes explicit her theoretical, methodological and analytic choices (Koch 1995), the final products of which were presented earlier in this chapter.

The use of the reflective journal, which logged all research activities including the data collection and analytic procedures undertaken in addition to my reflections on the research experience, helped me better assess whether the study's findings were grounded in the data and the inferences I made were logical. Hence, as researcher, the audit trail required clarification and self-reflection on my part (Akkerman et al. 2008). Maggs-Rapport (2001) suggested that dependability is when the methodological approach is suitable for the research question.

In line with this, I have maintained a stated orientation towards the phenomenon and sought a methodology most applicable which embraced both the intention of the research along with my epistemological and ontological stance (Laverty 2003). I have clearly articulated that the underpinning methodology for this study was hermeneutic, interpretive-style phenomenology and this was reflected both in the title of the research and in its aims. I engaged in acquainting myself with the philosophy of Heidegger and that of the many scholars who have informed contemporary phenomenology. This was done in order to make sense of how this approach would best bring to the fore what I was seeking in my research question.

I also collected data in a manner apropos to the interpretivist paradigm, enabling a conversational interview to evolve into further possibilities for knowing, rather than a 'guided tour' of the topics I wished to discover and reveal (Smythe et al. 2008). I became immersed in van Manen's (1990) methodical structure, where I would view the text in its whole before looking for emergent meanings. I remained cognisant of the fact that when 'doing' phenomenology the 'things themselves' would appear with careful consideration of how I worked with the data; how I was able to 'dwell' patiently with the data and allow meanings to be revealed without force or 'pushing these forward' (Smythe et al. 2008, p. 1396).

Understanding my pre-assumptions and foreknowing kept me attuned to how I interpreted the data. Maintaining a focus within the hermeneutic paradigm provided an avenue to ensure that I gave thought to my own experiences and assumptions and how these may influence the research process (van Manen 1990). The interpretive process continued until I reached sensible meanings of the experience for the women participants, free from inner contradictions (Kvale 1994). After all, I had the responsibility as a phenomenological researcher to tell the participant stories as close to the experience as possible.

### ***Transferability***

Guba and Lincoln (1989) suggested transferability or fittingness should replace external validity or generalisation. In the words of Morse (1994, p. 106), transferability referred to whether the 'findings from one study can be transferred to another similar context or situation and still preserve the particularised meanings'. In the main, phenomenological research is not considered to be generalisable or transferable, nor does it strive to be.

The fittingness of the research lies in the power of the phenomenological text to elicit recognition of the individual experience (van Manen 1990). It is important in the presentation of the research not to imply that the findings can be generalised to other populations or settings. Instead of broad generalisations, Guba and Lincoln (1989) proposed the findings from qualitative studies be recognisable and faithful descriptions of human experience. In keeping with this, by making prominent in this text the rich descriptions of the woman's meaning on their decisions to engage with a service, foundational knowledge about whether a transfer of the findings can be made to other populations is possible.

The methods by which I assured these rich descriptions were described in detail earlier in this chapter -the recruitment processes, the use of purposeful sampling strategies, the employment of open-ended, semi-structured interview. A key point made by Lincoln and Guba (1989, p. 298) was that 'if there is to be transferability, the burden of proof lies less with the original investigator than with the person seeking to make an application elsewhere'. The reader of this research therefore must determine if they wish to transfer the results and conclusions to their own research or clinical practices.

Nevertheless, whilst I did not aim for transferability, I feel that the findings of this study will shed some light on the phenomenon of what is behind the decisions of women with alcohol-use disorders in relation to engaging with services. This may help provide valuable insight for drug and alcohol service provision and the structuring of targeted gender-specific programs. It may also help inform the development of health professional education and training programs within the context of women and alcohol-use disorders.

### **Chapter summary**

In this chapter, the research methodology and methods used to explore the meaning that women with alcohol-use disorders attributed to their decisions to engage with services were discussed. The discourse above demonstrated that van Manen's (1990) approach to phenomenology fitted the aims of this research. This is because, in elucidating the interrelationship between phenomenology, hermeneutics and practice, van Manen (1990) offered a process of textual reflection that helped me remain focused on the uniqueness of the participants' experiences and the clarification of their lived meaning.

The use of van Manen's thematic approach to data analysis also helped provide phenomenological structure to the analytic processes. The chapter concluded with the criteria necessary to ensure trustworthiness within this study was specified, defined and applied. The findings from the use of the outlined methodology and methods will be presented next in Chapter Four.

# CHAPTER FOUR

## Findings

### Introduction

This chapter presents the key findings from the phenomenological analysis using van Manen's (1997) isolating thematic statements framework. The thematic analysis resulted in a discovery of *meaning* that the 15 women attributed to their decisions to engage with services. This chapter presents what was found while a deeper exploration, and discussion central to the meaning in connection with the women's stories are presented in Chapter Five. For van Manen (1997), one of the primary purposes or outcomes of hermeneutic phenomenology is the telling of a story. In this telling of the story, the goal remains to 'uncover' and describe the phenomenon which is being examined (Hein & Austin 2001).

Within this discovery, four scenes are explored that were representative of the themes of the original story-telling by the 15 women participants. I have entitled these: 'Disliking Alcohol', 'Overcoming Barriers', 'Sense of Enforcement' and 'Rock Bottom'. These scenes are representative of the lifeworlds of the 15 women who unselfishly shared their stories with me and thus provided the readers of this research with the opportunity to be part of their deeply personal experiences. Each scene is further divided into elements so as to enhance the understanding of each scene. In order to privilege the voices of the women participants, specific words and phrases from the interviews are utilised and are presented in italics.

The scenes and elements were uncovered through a systematised and deep reflection on each participant's experience of what it meant for them to engage with services, as per step three of van Manen's (1997) framework. After intensely reading and re-reading the transcripts a number of times, as per stages one and two of the thematic analysis framework, the scenes and elements presented themselves to me and helped open up a 'deepened and more reflective' grasp of the phenomenon (van Manen 1997, p. 86). Although the scenes are interwoven as the participants moved through different phases of their stories, I have presented them separately in this chapter to enhance clarity.

However, it is imperative to mention that life experiences cannot be so easily compartmentalised. What was real for each woman was shaped in the moment and was different for each, and, while individual, these unique stories also contained shared, collective understandings. van Manen (1997) maintained that there is a relationship between each theme, which is exemplary and temporary, and the essence of a phenomenon which each theme points to - a theme fixes our attention on the phenomenon.

Each woman's experiences intertwined to make the phenomenon not a set of segmented and compartmentalised experiences, but rather a fluid and holistic experience overall. The phenomenological experience as a whole in the case of this research, the *essence of meaning*, was interpreted as each woman *conceptualising the need for change* in relation to her decision to seek the help of services for her alcohol-use disorder. An in-depth discussion on this essence will be elucidated in the discussion chapter (Chapter Five). Figure 7 provides a visual representation of each scene, its related elements and the overarching essence of meaning.

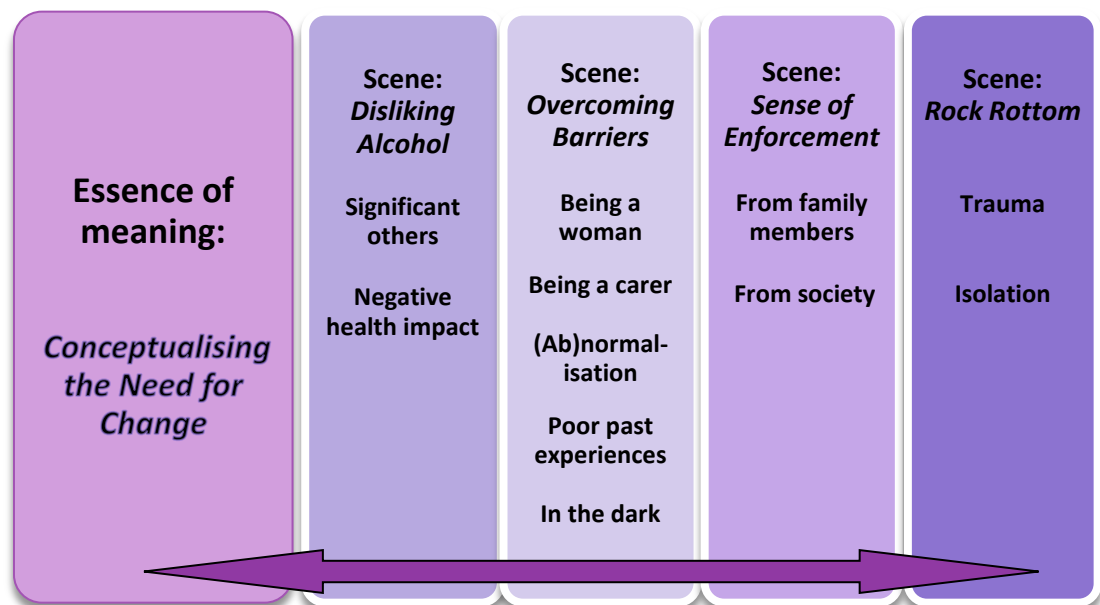


Figure 7. Visual representation of scenes, elements and essence of meaning

## Scene: *Disliking alcohol*

The first scene, 'Disliking Alcohol', refers to the participants deciding to engage with services only after they became aware of the negative impact that alcohol was having on their lives (participants 1, 3, 5, 6, 7, 8, 10, 11, 12, 13, 15). The notion of 'Disliking Alcohol' emerged from the woman's realisation regarding the negative consequences of excessive drinking. There were two key elements associated with this scene: 'significant others' and 'negative health impacts'.

### *Significant others*

Nine participants (participants 2, 5, 7, 8, 9, 10, 11, 12, 15) described significant others in their lives as being the predominant motivating factor for creating awareness of their unhealthy alcohol use. This awareness contributed to the participants' decisions to engage with services. The participants expressed this dislike of alcohol in terms of the negative effects they perceived it was having on their loved ones. Participant 10 discussed the '*huge impact*' that drinking all day had on her partner and family and how she arrived at '*make or break*' stage because of this.

Similarly, participant 15 conversed in depth about how she came to the realisation that alcohol had caused a rift in her family, about how she attributed the '*breakdown in relationships*' and '*neglecting*' her family, to her need to engage with services to help her cease drinking. Participant 12 discussed how she came to realise that her use of alcohol had '*torn her family apart*' and how she wanted to get help so she could '*fix her relationships with her family*'.

*My son, because of my drinking he does not let me see my grandchildren because he says he does not want his kids to see their grandmother drunk and falling and do stupid things. So I want to fix that and I just want to get better. (P12)*

Five participants thought awareness of the impact alcohol was having on their loved ones took a while for them to realise and it was only after extensive drinking histories and numerous attempts with services did they come to this realisation. Participant 8, who had three previous attempts with services to try and cease her alcohol use before the current attempt at time of interview, felt it took until this final attempt before she:

*...started to see where my alcohol and the abuse of what I was doing...impacted on [the family] relationships'. It was a contributing factor in the breakdown of my marriage. (P8)*

Participants often expressed how their partners or other family members had to be explicit in letting them know how they felt about their excessive alcohol use. Participant 5 described how her partner stated *'I can't take this anymore'*, which was the turning point for her in her realisation that she loathed what alcohol was doing to her relationship. Participant 11 explained how it took for her grown son to say *'mum, you really are drinking too much, you need to get help'*, before she realised how much she *'hated'* drinking and felt the need to engage with services.

*I've got two beautiful grandkids, two beautiful children, it's killing them and me, I hate it [alcohol], I know I needed to give it away. (P11)*

Seven participants had young children in the home leading up to their decisions to engage with services. Five of these women mentioned they had not been *'the best mothers'* because of their drinking, and coming to this realisation, whilst *'difficult'*, influenced their decisions to access services. Participants 2, 5 and 8 expressed fears of losing custody of their children. They described how this insight emerged only after they became aware of the negative impact that their drinking was having on their children.

The women also discussed the significance of their children's needs and future happiness in relation to their decisions to stop drinking and engage with services. Participants 9 and 10 talked about not wanting their children to be negatively influenced by their excessive drinking in relation to role modelling and suggested that they used this as their motivation to contact services.

*The children will notice that there is wine in the house every night and I can become a bit forgetful sometimes but not to the point of neglect. I am not saying I am neglectful, I am just saying I could be a better parent if I didn't drink, I could be a better role model. (P9)*

*It was having a huge impact on the kids; I was a terrible role model. I was doing dangerous, I was drink-driving. I was doing really dangerous things. I don't want them to grow up with a mum like that. (P10)*

There were also fears raised by participants that they would not be around to care for their children. These fears were as a consequence of awareness of the negative health problems associated with their alcohol use.



Participant 7, who had two young children at the time of interview, was worried that her children would be left without their mother because of the health effects from drinking. She became aware of the negative aspects of her drinking, and, as a result, made the decision to engage with services:

*I wanted to get help for myself....but I want to be alive for my kids. My kids are my life, they need me. I carried them around for 9 months. I'm their mother. They need me. That's the reason... (P7)*

A number of participants also discussed the negative health impacts of drinking as reasons why they developed a strong dislike for alcohol, which is the next element to be discussed.

### ***Negative health impacts***

Participants 1, 3, 4, 5, 6, 7, 11, 14 and 15 described the negative impact alcohol was having on their health as contributing to their awareness of their dislike of alcohol and the need to engage with services. The harmful health impact of excessive alcohol use over the years was a common thread throughout all 15 participant stories.

When it came to their decision to engage with services, participants 6, 11 and 15 discussed being '*concerned for their health*' and '*scared of dying*' if they did not do something about their drinking and get help. Participant 15 experienced hypertension from her alcohol use and was concerned that she was a '*heart attack waiting to happen*'.

Participant 11, five months before the interview, had surgery to remove an alcohol-related tumor from her liver, but started drinking again four weeks after the surgery. It took further complications from the surgery for her to come to the realisation that she '*hated drinking*' and needed to contact services in order to be alcohol-free. She mentioned this '*being her last chance*'- this was '*break or make*'. Participant 5 discussed at length the physical impact of alcohol and her need to get help to stop drinking. An excerpt is provided below:

*I was sick of being sick. My teeth were rotten...I've got no teeth whatsoever because of the poison that was going through my body. That's when I was drinking all the time so I was feeling good, but then it just became too much and I knew I need to get help. (P5)*

Participants 1, 3, 4 and 14, as reasons to stop drinking and contact services, described their perception of the negative impact that alcohol was having on their mental health conditions. 'Self-medication' for the negative symptoms of mental illness was mentioned several times throughout these women's stories.

One of the participants, who said she also experienced a mental illness, felt she was *'getting to the stage where I was suicidal'* before she came to the realisation that she disliked what alcohol was doing to her, and she needed to access services to help her cease alcohol use.

*I've been suicidal for years but I had my child and I couldn't do it to him. I'd just lay on the couch in a drunk coma and sleep for nearly 24 hours a day. I would get up in the morning and get him ready for school and then get up in the afternoon and make him dinner, the rest of the time I was passed out. I then realised I really needed help, I hated what it [the alcohol] was doing to me. (P3)*

Participant 1 talked about her diagnosis of mental illness and how she *'just wanted to be numb'*. She said she used alcohol to achieve this. She secluded herself from her friends and family for around 10 years before making the decision to engage with services to help cease her use of alcohol. Participant 12 talked about constantly experiencing alcohol-related blackouts, seizures and falls when she was intoxicated or in alcohol withdrawal. She described getting to the stage where her *'husband would come home from work and I am lying on the bed passed out with a bucket besides me... that's no way to live'*.

### **Scene summary**

Although the participants in the scene 'Disliking Alcohol' talked about elements of significant others or their health as contributing factors, they all described their decisions to engage with services as being based on the awareness they had *'come to'* about the negative impact of their alcohol use. The participants used language like *'being over it'* (P 8; P 10; P 12; P 15) in terms of disliking their drinking and the effects this was having on their relationships and their health. They also articulated wanting *'the life they had before'* (P 7; P 9) alcohol took over their lives. Participants were *'conceptualising the need for change'* with their awareness of their unhealthy alcohol use and the impact this had or was having on their loved ones and on their own physical and mental health.

## **Scene: Overcoming Barriers**

It was revealed in the participants story-telling that all 15 women had to overcome significant barriers when they arrived at their decisions to engage with services. The scene entitled 'Overcoming Barriers' contained five elements. These are: 'being a woman', 'being a carer', '(ab)normalisation', 'poor past experiences' and 'in the dark'.

## **Being a woman**

Nine participants described overcoming obstacles specific to their gender as influencing their decisions to engage with services. The participants spoke of *'being embarrassed'*. This was discussed in relation to having *'something'* that society thinks only men experience, and having different *'stressors'* to men, which impacted on decisions to contact services.

*People don't associate alcohol with worlds that can become so devastated because it is not out there. Like I said, people think that some guy sitting on a seat drinking from a flask of wine is an alcoholic, but they don't think that some woman that can go to work every day, drop the kids off at day-care or school, and pick them up and come home and drink herself to oblivion every day is an alcoholic because she is working and she is functioning. (P8)*

Participant 10 thought that men may not understand when a woman uses alcohol to cope with her home life or stress from the children:

*... being judged by men - like, you stay home all day and look after the kids, how hard can it be? (P10)*

Participant 3 felt she had to *'put herself first'* when deciding to get help, as women tend to *'put everyone's needs before their own'*. Similarly participant 4 talked about how she came to the realisation that she needed to put herself first and contacted services, but only after she could organise her mother to take care of her 15-year-old child:

*You need the free time to get through your recovery. Yes, it's hard because your children should come first and you tend to come second and so does your right to recovery. (P4)*

Participant 1 discussed the *'stigmatisation'* of women who drink and how overcoming this helped make her stronger.

*I'm just learning that there's more stigma for women than I thought there was because I've got a bubbly personality and optimistic and sometimes I live in the clouds. And I'm finding that I'm now more open with my alcoholism, and I'm finding it's good to now think that I can deal with people judging me. (P1)*

Similarly, participant 13 felt that as a woman, she *'faced many more difficulties'* and *'self-stigma'* than men when it came to arriving at the decision to get help, but came to the realisation that this was their problem and not hers.

*For a woman, it's stigmatising and not socially acceptable to be drinking that much but I think this needs to be addressed more than the problems with the alcohol. (P10)*

There was also the threat of violence and actual physical harm when participants contemplated engaging with services and mentioned this to their partners. Participants 4 and 5 spoke about being ‘bashed’ and assaulted by their male partners when they made up their mind to contact services. This was viewed as a result of their partners’ own drinking and related ‘insecurities’ about their own use of alcohol. However, both women found the strength to engage with services despite this abuse – they came to the realisation that it was not ‘their fault’ but their partner’s.

*I first got hit when I was about 17 and then when I was about 22, 23, it was really bad, alcohol fuelled rage from both of us really. The next relationship, it got abusive as well, he didn’t want me to leave, to go in to [service name]. (P4)*

*I got bashed all the time, but I sometimes gave as good as I got. He never wanted me to go in to [service name], but one day I just snuck out and did it anyway, best thing I ever did. (P5)*

Partner drinking was described as being a barrier for many of the women, even without violence, as partners were not supportive of the women when they decided to engage with services. Participant 8 thought her relationship ‘interfered’ with her initial decision to access services because of her partner’s drinking:

*He didn’t want to want me to be an alcoholic...but he would say how he would miss the fact that we could drink together. (P8)*

Six participants described these types of ‘enabling’ behaviours from their partners as being significant barriers. They talked about how they had to prevail over these attitudes before they arrived at their decisions to seek help.

A lack of gender-specific services was also discussed as a barrier for the participants. Participants 1, 2, 5, 7, 8 and 9 expressed concerns over the fact that there were not enough ‘women only’ services, which they had tried to source because of their histories of trauma and significant intimate partner violence. This impeded on these women contacting services in a timelier manner.

*I definitely say women only. I think that it should be done so I, me personally, because I can sometimes be scared of men that drink. I didn’t want to come in cause of the men, you know. I think, yeah, I think that they should do it separately. (P2)*

*...definitely woman to woman not a man to a woman, ‘cause a man might feel overbearing to a girl. You know? I feel intimidated by men. They can be too overbearing. I didn’t want to go back as I knew it was all men that worked there. (P5)*

## **Being a carer**

Participants with caring responsibilities for others cited this as being an immense barrier they had to overcome to reach their decision to engage with services. Participants 8, 9 and 10 discussed how they *'put off'* their decisions to access help. This was as a result of having no one to care for their children if they wanted to undertake a residential program. The participants described feeling *'guilty'* for wanting to access services, as they did not want to *'burden'* other people with caring for their children.

*They offered me in-patient but I did not want to go and leave the kids. And I guess that is the thing, my alcohol has always been my issue and I guess it has interfered with the kids enough that I have always tried, even though my recovery and dealing with that tried to make their life be as normal as possible, and at that point in time I did not want to go and put myself into a clinic somewhere and have the kids left sort of spread and scattered everywhere to deal with it and no know what was going on. I feel guilty enough. (P8)*

Participant 9 kept her excessive drinking hidden for a long time before making her decision to access services. She talked about how she felt *'it is not really a good look to be a mother who is an alcoholic as well'*.

*...the main thing with women is the shame; because we aren't suppose to be like this. We are supposed to be the carers...we are supposed to be the nurturers and we are failing our duty doing that, drinking. (P13)*

Participants with caring responsibilities for their partners also found this a barrier when making the decision to engage with services. Participant 7, who provided care her husband who required ongoing intense medical intervention, discussed how she was the *'rock'* of the family and needed to *'get herself well'* but how difficult this was because *'alcohol has been her best friend for a while now'*. This same participant described her excessive drinking as her means of being able to *'cope'*.

*I would start drinking once I got home from picking the kids up, making sure there was no after school activities that I needed to take them to, so I would start drinking when I knew I did not need to go out of the house. However, there were times when my husband required an ambulance and instead of calling the ambulance I possibly could have been the one to either escort him or possibly drive him to the hospital but I could not do it because I was over the limit. That's when I knew I needed help. (P7)*

Similarly, participant 6 also provided care for her partner who had experienced a number of cardio vascular conditions. Both women felt they gained strength from the realisation they would be able to provide better care for their partner's when they made the decision to engage with services.

*...my husband's - he's a type 1 diabetic, he had three heart attacks, he went in and had a triple bypass, then he had a stroke. I drank to cope with all this. I need to get well so I can help him get well, this helps me get through. (P6)*

Throughout the interviews, the women in the study brought up multiple times and for varying reasons that they used alcohol to 'cope'. Many spoke of the 'normal' way in which alcohol is used as a coping mechanism in contemporary society, which is the next element to be discussed.

### ***(Ab)normalisation***

The 'normalisation' of alcohol as part of upbringing and the way in which society positively views alcohol was mentioned as significantly contributing to participants drinking. This 'normalisation' was concomitantly also considered as a barrier to participants decisions to engage with services. This element has been entitled '(ab)normalisation', as the participants did not feel these influences were in anyway 'normal' or 'conventional'.

Eleven participants described the difficulties they experienced of growing up in households where one or both parents drank excessively. This led to participants believing that being reliant on alcohol was what happened at home.

*'I thought everyone grew up that way, with that much alcohol'. (P2)*

Participants described how they started drinking at a young age because of the availability of alcohol in the household. Participant 3 remembers '*being drunk at nine*' years of age because there was '*alcohol everywhere*'. Participant 12 described how she used to '*sneak*' her parents alcohol from a very young age.

Participant 8 discussed how her father was a '*heavy drinker*' and how she had heard about the '*genetic component*' of alcohol-use disorders. This participant also described how her siblings also drank to excess. The women talked about alcohol as always being '*part of my life*' (P4; P7) and how this way of living was a considerable hurdle to overcome when they thought about engaging with services.

*I come from a background with one side of the family that are drinkers and so those patterns and those belief patterns are being put in, this makes it hard to realise that alcohol is a problem. (P1)*

Participants of this research also described how 'Overcoming Barriers' from their upbringing was 'cathartic' in some ways. They related this in terms of 'dealing with their demons'. Participants who had children in their home also discussed how they did not want their children to feel the same way that they had growing up (P7; P9; P11; P12). This resulted in them thinking more positively about their decisions to engage with services and more determined to stop drinking.

*I don't want her [daughter] to start hitting the grog and saying "well, mum did it". You know. Cause that's what my attitude was. I said "well, mum did it so why can't I". Because we are the person they look up to. (P7)*

The 'normalisation' of alcohol in terms of how it is viewed positively by society was also mentioned as a barrier to making the decision to engage with services. 'In Australia, it is socially acceptable to drink' (P7). Participant 8 described the numbers of women who drink alcohol daily as 'an epidemic', because women think alcohol is 'OK, it is safe, it amazes me when you talk to people how many drink everyday'.

Eight participants discussed how 'accessible' alcohol was. They described how their local shopping centres had at least three or four 'bottle shops'. Participants 6, 7, 9, 10, 11 and 12 talked about how inexpensive alcohol was and how they would find themselves buying more than they had originally anticipated.

*I am just going to get one bottle of wine, and it's there, four for \$20, so I might as well get four'. (P12)*

*I can go down and get a box of clean skin [brand name] chardonnay for \$18. That's like, we're talking \$2 something a bottle so even if we don't have money you can, it's - and it's so, everywhere you go. [Name of town] mall's not that big...but you can't go into a shopping centre or go anywhere without alcohol. (P6)*

*And there was nothing wrong with me walking into the same bottle shop every day. "Hi, how are you going"? Whereas now I look back and think "surely he must have thought you old drunk". But it was all on for a chat and it got to a stage where I found bottles of wine that were \$2.99 at [name of alcohol franchise]. So it wasn't as though I was breaking the bank, so I could justify that to myself because a coffee would have cost me more than that bottle of wine. So I could get two of those for \$6.00. (P10)*

Participant 9 expressed disappointment about the *'lack of functions that were alcohol-free'*. She suggested that *'the consumption of alcohol in our society was just so accepted'*. Participants described *'inexpensiveness'* and *'availability of alcohol'* as being a barrier to stopping drinking and engaging with services, as well as created difficulties for them once they had made the decision to engage. This is illustrated by participant 6 saying *'you can't go anywhere without seeing it [alcohol]'*.

Participants described how they had to be *'strong'* to overcome the influence and acceptability of alcohol that is *'everywhere'*.

*'I bought [husband's name] beer the other day and did not even think about buying wine and I just feel really good about that. I'm getting stronger; you have to be because alcohol is everywhere'. (P11)*

Participating women also raised issues about the advertising of alcohol and how this *'bombardment'* was a barrier when making the decision to engage with services. Participant 1 eloquently articulated this when she said the *'beer economy ad'* was damaging for children and teens, and how *'the salience of advertising can be in your head...'*, making it difficult for people to realise they have a *'problem'* with alcohol. Similarly, participant 14, the youngest participant at 23 years of age, spoke at length of excessive alcohol use being *'the norm'* amongst young people and how advertising contributes to this. This participant said:

*...if only kids knew alcohol is not necessary, it's not safe, it not just like drinking water. It is a drug. Kids see ads for it everywhere...' (P14)*

The lack of clear warnings about the health risks of excessive alcohol use was also raised. Participant 6 and 7 spoke at length on how there are advertisements that caution the dangers of smoking on cigarette packets and television, but there was nothing similar for alcohol.

*If you're a smoker you can't turn around without something telling you that - like put the thing on the packets of cigarettes... the advertisements and that. If there were things on there like that showing you what could happen to you if you keep drinking, then you'd be more aware. (P6)*

*Oh look you have got cigarettes packets that have got people's lips falling off, and babies dead because of all this stuff, but there is nothing to show that alcohol can damage you. You know, you buy a bottle of wine; it doesn't have anything bad on it. You know, there is no warning on there that this can give you liver failure or... There has to be something done and make society aware of how dangerous it is. Dangerous and addictive it is. Because, it is. Clearly. (P7)*



This social acceptability of alcohol was said to have been partly responsible for participants relapsing back to previous levels of alcohol use once they had completed programs in the past. As stated by participant 14, *'everything revolves around alcohol; it's hard to stay straight'*. Many also spoke of the difficulties they faced when they thought about re-engaging with services, as discussed in the next element.

### ***Poor past experiences***

The participants having experienced *'poor'* services in the past influenced them making the decisions to engage with services. 14 of the 15 women had engaged with services more than once. Seven participants described negative experiences with self-help groups. Participants 1, 5 and 12 felt these groups were just *'full of old, drunk men'*, and did not benefit from them at all.

The participants also talked about being *'sick of hearing the same stories'* all the time. Participants 6, 7 and 14 discussed how groups they attended had included people with other substance-use disorders, such as methamphetamines, and how they felt they *'could not relate'* to these people. Participant 10 found the philosophy of the self-help group that she attended *'too regimented'* and *'too intense'*.

*I did not find it positive and it was just a room full of 'I've been sober for so long' and telling the same story. (P10)*

Participants talked about how they found the people in the groups were there for reasons *'imposed'* on them, which they felt were other than stopping or reducing their alcohol use. They gave examples such as *'court orders'* or because of *'DOCS'* to illustrate what they meant. DOCS is what was known as the Department of Community Services (now the Department of Family and Community Services), which is a Government service that aims, among many other things, to protect children from abuse. Participants described these people as *'not motivated'* to change behaviours, which the women in this study raised as a barrier to them going back to these types of services.

*I think most of them were there because they had to be because you either - DOCS were involved or something - and so I don't think they were there because they really wanted to be. You'd go round and have your little say and usually it would be oh I only drank twice last week and I went a day without this and I thought that wasn't for me. I thought I really need to give up; I don't need to be thinking oh one day here, one day there... (P6)*

Being disillusioned with services was not limited to self-help groups. Participants 2, 11 and 15 spoke at length of the poor treatment they felt they received when in rehabilitation units.

*Rehab, you know you have to do you know wake up at this time, be here at this time, you know lunch, eat, you know they tell you when you can eat, they tell you when you can shower, they tell you when you can do everything (emphasis) and it's like what? I'm not a very, you know I don't really like rules and I don't like being told what to do and if I get told what to do I do the opposite because I don't want to do what you tell me to do. (P2)*

*At the other rehabs, they treat you like a criminal, it's like you're in jail, like you're doing something wrong...they lock you in...they take your phone charger. I came out of there angry and cranky. (P11)*

*Because I don't think they [the rehab staff] gave me skills on how to...I knew what the purpose was, but they were really huge groups there and each group they made you go and introduce yourself and say "I am an alcoholic"... they would put the spotlight on you and when you are relatively new, it is all too much. (P15)*

The need for women-only services was reiterated. This issue was discussed in terms of how, if gender-specific services had been available to them, this would have motivated them to engage at an earlier stage in their drinking histories. The majority of participants (all but participant 15) spoke of being victims of assault and intimate partner violence, and thus felt women's-only services would have been of benefit and more appropriate. Many participants did not want to go back into the same service because of the risks of violence. The fact that men with alcohol and other substance-use disorders accessed the same services as women was seen as a deterrent for participants 1, 2, 5, 7, 9 and 14.

*I've been hit in the past with guns and stuff like that, I find men can be intimidating that way especially if they swear it just triggers off that street light, I don't want to go somewhere where there's men drinkers. (P1)*

These women in particular described how they needed to feel 'safe' when thinking of engaging in services. They also talked about how they had felt 'unsafe' when they had engaged with services in the past, particularly when they were contemplating residential services.

*When you have a history of trauma. Like more of a trauma enforced care also about how to cope. Like without kids...with your husband...we are the one who have to do everything and we're the role models and all that sort of stuff. That is what I was thinking about like a women's service that would incorporate that. It can't have men, as we need to feel safe. Some places don't make you feel safe. (P7)*

However, many women in the study discussed the fact that when they first thought about accessing services, they found it difficult to find program-specific information. They were left 'in the dark', which is to be explored further in the next element.

## ***In the dark***

Seven participants discussed their lack of awareness of, or being '*in the dark*' about, available services as being a barrier they had to overcome before they could make the decision to engage with a program.

*I didn't have a clue about going to services, they weren't presented for me. (P1)*

Participants 3 and 4 raised that they had '*to do all the legwork*' themselves when it came to learning about available programs. Participants 5 and 13 described how they had to find out about programs from others who had been through them. They felt that they could not find this information any other way.

*I didn't know about certain things because people never, like the knowledge, how could I say, not the knowledge, there was nothing out there to let you know about these services, only people that had been there. (P5)*

*I heard about it [the rehab] through the grape vine, you have to find out 'bout these things only through people who've done them before, it's the only way. Where else do you look? (P13)*

Participant 6 recounted how her General Practitioner (GP) did not know enough about services available for her. She described how she felt this was not good enough and how she felt let down, especially when he told her that she only had three months left to live if she did not stop drinking because of the alcohol-related damage to her liver.

Participant 7 spoke about how she went to her GP to find out more about services and how she told the GP she was drinking 'a bottle of wine a day. She said it was incredible when, her GP replied '*that's nothing, I drink that a night*' and did not provide any information. She explained in the interview that she '*kept on wanting to let people know*' of her unhealthy alcohol use, but '*no-one would listen*'. These experiences with seeking help and not getting it from their GP made both of these women all the more determined to find the service that would best help them. On the other hand, it could delay or deter help-seeking behaviour.

### **Scene summary**

Participants spoke at length and at times emotionally when telling their stories of the barriers they had to overcome once they had made up their minds to access services. The participants spoke of *'being judged'* (P9; P10; P11) and *'feeling guilty'* (P7; P8; P9; P13; P15) because of their gender and needing to put their children first, especially when they were aware of the impact their alcohol use was having on their children (P8; P9; P10; P13).

The women in this study also described growing up with parents, in particular fathers, who were poor role models regarding alcohol behaviours (P2; P3; P4; P5; P7; P8; P12; P14), and how the influence of alcohol is difficult to escape from, in Australian society. When speaking of these barriers, however, experiences were not always portrayed in a negative light. Participants spoke of how overcoming these barriers had made them *'stronger'* and more *'determined to change'* in relation to their unhealthy alcohol use. Therefore, once they made up their minds and *'conceptualised the need for change'*, they talked about finding the strength to overcome these gender-specific barriers.

### **Scene: Sense of Enforcement**

When listening, reflecting on and interpreting the participant's story-telling, the scene of a *'Sense of Enforcement'* became apparent regarding the way in which 11 of the women arrived at their decisions to engage with services. There were two elements to this enforcement, that from family members or friends and that from society.

#### ***From family members/friends***

Eight participants spoke of how they felt *'forced'* from family members or close friends to engage with services, but how this coercion turned into a positive experience for them once they obtained the help they needed. Participant 1 explained how her friend and flat mate had threatened to evict her if she did not *'do something'* about her drinking. She did do something, and described how this was a very successful program for her.

*I was sleeping, I was coming to uni once a week, and I was sleeping til four in the afternoon and staying up at night drinking bourbon and other drinks, and my friend, my flat mate, said to me they don't want to see me in my 40s and waste my life away. He thought I was going to die unless I got help, but I couldn't really see it at that stage. He threatened to kick me out, thought this was the only way I would see sense. So I went to a residential community and this made me realise I did have an alcohol problem. (P1)*

Participant 11 spoke of how her ex-husband and grown son had contacted her GP, as they were *'concerned'* about the amount she was drinking. This culminated with her GP *'having a word with me about drinking'* when she next had an appointment with him. Participant 11 also mentioned that she felt *'forced into rehab'* this time by her family and by her GP, but that this did not work as she was *'at the point where I didn't want to do it'*. She then turned this around when she next made the decision to engage by realising that she *'needed to do this myself'*.

Participants 3, 4, 5, 6, 9 and 12 had similar stories, in that the first couple of attempts at using services to stop drinking did not work because they had been *'forced'*, but they all turned used these experiences and *'grew from them'* (P9) in relation to the time they made the decision to engage on their own.

*...my life was unmanageable and I had friends and family who were making me to go to rehab. Telling me I had a problem and it just didn't click. After a few times, it clicked, I'm 100% now. (P3)*

### ***From society***

Five participants voiced opinions about societal pressures related to their decisions to engage with services, even when they may not have been ready to attempt the programs. Participant 2, who lost her baby very late in her pregnancy, spoke of *'others'* (staff at other health services) making decisions for her in terms of programs *'she should attend'* for her alcohol use following the period after the stillbirth where she *'lost the plot'*. It was after this tragic event that she turned to alcohol to cope. She then found the program to be of benefit, and realised after she was *'clean'* the impact the alcohol was having on her health and on her partner.

*I just wanted anything and everything to wipe that all out of my head I 'spose.... just to lose you know, not feel pretty much and that's where it ended up. They [the midwifery team] came and saw me a bit after, they said they had a duty of care, they rang up and booked me in, probably the best thing they could have done. (P2)*

Participant 6 described how she felt *'pressured'* to engage with services from the employment agency that was helping her find work, as well as from her medical practitioners, even when she felt she was not ready to do so.

*I lost my job a few years ago; I was in a well-paid role. I had a nervous breakdown after. They [the employment agency] told me to sort myself out; they could smell the alcohol on me I suppose. They were really hard; don't they know it's a disease? They wouldn't treat someone with diabetes or cancer that way. (P6)*

Participant 7 discussed how the first time she accessed services was after the health staff caring for her partner told her she needed to stop drinking so she could be a *'better carer'*. She talked about how she was *'not committed'* to the program at the time, and that she just wanted to *'reduce'* her alcohol intake. She described how she realised the need to be abstinent when she last accessed services:

*'I'm 100% into it this time. I wasn't anywhere near 100% last time. I don't think I was being true to myself, I felt pressured'. (P7)*

Similarly, participant 15, when discussing her first attempt at engaging with services, described feeling *'pressure'* from her medical practitioner and grief counsellor (she had lost her partner some years prior to the interview). This pressure was in relation to contacting and engaging with a residential program. However, she was not *'motivated'* when taking part in the program and *'did not get any benefit from [program name]'*. She talked about *'turning this around'* when last accessing services, and came to the realisation that *'I had to do this for myself'*.

Participant 8 also spoke about the first time she accessed services, which was when she was living in accommodation supported by a well-known charity. She spoke about how the people running the charity *'watched my behaviour, watched my drinking'* and told her she had to either move out or *'sort my drinking out'*. These people contacted the *'detox unit'*, packed her bags and physically took her to the service.

Participant 8 said she was thinking *'OK, I'll go and do this, and I will come back and have somewhere to live'*. She discussed how despite this, she did not access the service thinking she could do it by herself. She said that she thought *'OK, let's sort this thing out'* in terms of her drinking. Her last attempt at engagement, however, was different, as this time she was not coerced and thought to herself *'this is just about me'*. This time, she said, *'there were no outside pressures'*.

### **Scene summary**

The 'Sense of Enforcement' felt by these women described above from family, friends and other members of society, resulted in a lack of personal commitment by participants to the programs. The 'Sense of Enforcement' that the women described, resulted in them feeling 'hassled' and 'coerced' to engage, even when they were 'not ready' to commit to the programs. All eleven women consequently found it difficult to 'conceptualise the need for change' when they had felt forced into engaging with services. However, all participants who spoke of feeling forced came to the realisation they needed to engage for themselves, something that occurred without the influence of others.

### **Scene: Rock Bottom**

The final scene to be discussed is entitled 'Rock Bottom'. This term refers to the low point the twelve participants felt they had reached when they realised they needed help with their drinking and engaged with services. There are two elements as part of this scene: 'trauma' and 'isolation'.

### **Trauma**

Seven women spoke of traumatic circumstances leading up to, and influencing, their decisions to contact services. Participant 2 discussed how her children were removed from her care, due to her and the children's father's alcohol use and the violent interactions between them. She described this as the lowest period in her life and that is when she made the decision to contact services so she could get help to stop drinking.

*That's why my children were removed from my care. It was the violence. And then to deal with all that I was drinking and I was doing all that stuff so then that contributed to that you know, like but, yeah my children's father was extremely like, like DOCS became involved because he threw me out of a second story window. Yeah I'm lucky to kind of be sitting here today you know because there was some pretty close calls I think. I was at the lowest point, you can't get much lower. I needed help. (P2)*

Similarly, participant 3 described having experienced 'a lot of domestic violence', and how she reached an 'all-time low' before she made her decision to engage with services. Being the victims of intimate partner violence and trauma and feeling 'low', 'worthless' and 'useless' because of this was also raised by participants 4, 6, 8 and 9 as being key reasons for their decisions to engage with services.

The experience of trauma growing up was reported by six participants as contributing to them reaching 'Rock Bottom'. Participant 14 recalled never getting over being '*sexually abused as a child and raped at the age of 18*' as influencing the amount of alcohol she consumed and reaching the low point in her life just prior to contacting services. Similarly, participant 7 discussed being assaulted and how her mother did not believe her about the assaults. This she said led to '*unresolved grief*', uncontrollable alcohol use and suicide attempts; all behaviours she exhibited before she made the decision to engage with services.

*I drank so I didn't suicide. Yeah, I drank so I didn't suicide or self-harm. I had a shit mum. I had a shit childhood. I was raped between the ages eight and nine. I disclosed to my mum at 15 and she did not believe me. She let the person back in the house. (P7)*

Participants 5, 8, 12 and 13 pointed out that they had never reconciled growing up with '*dysfunctional*' and '*abusive*' families, which led to their 'Rock Bottom' and the realisation they needed to engage with services in order to stop drinking.

*My mother was an alcoholic and she was a very aggressive alcoholic, like I got knives thrown at me, frypans full of food. She was very aggressive. She tried to commit suicide numerous times when I was just there. She would lock herself in the bathroom and take a bottle of pills and I would have to go running to neighbours to knock in the door. It was a nightmare, and I still have nightmares. It's hard getting over growing up like that. (P12)*

Other traumatic circumstances that led to the participants' decisions to engage with services related to the loss of loved ones. Participant 13 talked about the sudden death of her sibling and how she '*hit the bottle to deal with my grief*'. She then felt the need to change her thinking and access services to help '*get my life back on track*'. Participant 15 discussed in depth the sudden loss of her partner in a motor vehicle accident and how this led to her feeling like she '*wanted to die too*'. She described reaching '*a very low point in my life*' before coming to realise that she needed to access services and stop drinking.

*I lost my husband in a car accident. It was not his fault and I have been struggling to deal with the loss ever since. So that has been five years now. I was not a drinker previously, so that would make me forget everything and I would be tired and go to bed and be able to sleep. And over the course that one drink led to two and then a bottle of wine and basically I realised I had a problem. But I didn't care; I didn't want to go on without him. (P15)*

Participant 15 also discussed how her harmful alcohol use led to her experiencing high blood pressure and putting on '*40 kilos in the five years*'. Her health concerns also resulted in her reaching 'Rock Bottom', and then she came to the realisation that she '*didn't want my family to have to bury me as well*'.



## **Isolation**

Six participants discussed how they were isolated and 'lost everything' because of their drinking. This they said is when they reached out to services for help.

*I was isolated and the drink came before everything. Anything at all. I wouldn't talk to my husband, I wouldn't go out. I didn't want to leave the house, and all I would leave for was to get alcohol. I realised I needed help. (P11)*

Participant 5 discussed how she got to the point where she was isolated, she had lost all of her friends and had no money, as she spent it all on alcohol and even resorted to 'stealing to support myself'. She described having to 'get to this point' before she fully appreciated the need to access services to help her stop drinking and get her 'life back on track'.

*How could I afford to drink every day, pay my rent, buy food, do my electricity bills and I always done it and never ever had to, I did do, steal some things from shops and that and was a bit of a fence, used to fence a bit but nothing too big. It was just little stuff but that was the only thing that I could do to get me through my alcohol habit. I was by myself, nobody cared. (P5)*

Participant 8 talked about feeling very low when her relationship with her partner and children deteriorated and she became isolated.

*I was fairly low at that point. I guess there was a great fear that the relationship that I was in at the time, which at the time meant the world to me. I saw that I was going to lose that, and for me that was a pretty big turning point. Also, I guess, I could feel that I was losing respect and I was losing connection with my two oldest kids. That was a really hard point for me to get to. I was at that point where, 'OK, there need to be more'. (P8)*

Participant 9 discussed the time she spent drinking everyday while her children were at school after she had left her husband because of the abuse she suffered at his hands.

*I felt so alone, so isolated, nobody understood the reasons why I drank, all my friends had jobs, partners, and I had nothing. I needed to turn this around, that's why I rang [service name]. (P9)*

## **Scene summary**

Each of the participants identified an event or events that led them to reach a 'Rock Bottom' point in their lives. Some described this period in terms of 'suffering', (P 1, P 9), feeling very 'depressed' (P 2; P 3; P 7, P 14) and 'losing respect' for self (P 8; P 13). The result was the women taking stock of, and making an effort to improve their lives with the help of services. The participants therefore hit 'Rock Bottom' before they 'conceptualised the need for change' in relation to engaging with services to attain help to stop drinking.

## **Chapter summary**

This chapter presented the findings that arose after using van Manen's isolating thematic statements framework for data analysis. The four scenes from each participant's story-telling: 'Disliking Alcohol', 'Overcoming Barriers', 'Sense of Enforcement' and 'Rock Bottom', revealed the essence behind her decision to engage with services. The scenes and elements were illustrated using the women's own words and phrases, as well as the interpretative efforts of myself as researcher.

What was presented was the lived experience of *meaning* that each woman *conceptualised* in relation to her decisions to engage with services so as to *change* her drinking behaviours. The significance of the essence of this meaning, how each woman 'conceptualised the need for change', will now be explored within the context of existing literature and in terms of a theoretical framework in Chapter Five.

# CHAPTER FIVE

## Discussion

### Introduction

This chapter theorises the meanings of the findings presented in Chapter Four. The aim of this phenomenological research study was to explore the meaning that women who live with alcohol-use disorders (AUDs) attribute to their decisions to engage with services. The use of van Manen's (1997) methodological structure offered a process of textual reflection that helped me remain focused on the uniqueness of the experiences of the participants and the elucidation of their lived meaning.

For the participants, the harmful use of alcohol and the experience of an alcohol-use disorder, as well as the meaning that the women attributed to their decisions to engage with services, presented as a series of experiences, had a profound impact on each woman. The lifeworlds of the women in this study portrayed this meaning in a different dimension (van Manen 1997).

This deeply personal and complex phenomenon could not be encapsulated in one singular experience, such as through the stigmatising attitudes of others (Jakobsson, Hensing & Spak 2005) or the victimisation experienced by participants (Tang et al. 2012). Rather, the story-telling by the women, presented in this thesis is a collection of a whole of their personal experiences, and offers new insights into the lived experience of women with AUDs and the gendered meaning behind their decisions to engage with services.

The insights that were gained, as explored in Chapter Four, were grouped into four scenes which were used to represent the story-telling of the participants: 'Disliking Alcohol', 'Overcoming Barriers', 'Sense of Enforcement' and 'Rock Bottom'. Scenes such as these are threads of meaning that portray essential fragments of the lived experience of individuals (Lindseth & Norberg 2004). Each scene was further divided into elements to enhance the understanding of each scene.

To make explicit, through a hermeneutic process the significance that the participants attributed to their decisions to engage with services, interpretation and transformation of the personal story-telling by the women was needed. This created deeper understanding about the essence of meaning for each participant. van Manen (1997, p. 39) reminds us:

...the term essence may be understood as a linguistic construction, a description of a phenomenon . . . so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way.

The term essence can thus be seen as the characteristics or the unique dimensions of a phenomenon. In this case, the fluid collection of emotions, thoughts and feelings that the women shared with me that became the meaning attributed by them regarding their decision to engage with services. The essence of meaning in this study, that which embodied the experiences of participants, was how each woman 'conceptualised her need for change' in relation to her decisions to engage with services.

Despite existing theories and scientific perspectives that have attempted to explain the experience of alcohol-use disorders, the decisions of people/ individuals as to why they do (or do not) engage in specialist programs remains a subjective human experience. One that is wholly lived by the person engaged in the experience. Nonetheless, as described in Chapter Two, only a very small percentage of individuals with AUDs actually engage with specialist services (Korcha et al. 2014; Polcin et al. 2012).

People with AUDs are generally less likely to perceive the need for service engagement when compared to those with other substance-use disorders (Hedden & Gfroerer 2011). This is due to the respective legal and illegal status of alcohol and drugs, as, unlike illicit drug use, the use of alcohol is sanctioned as socially normative and therefore the perception that excessive use requires the help of services is less likely to occur (Grella et al. 2009). Regardless of the low levels of engagement and despite individuals needing to do so, there is minimal research about the subjective reasons for this, particularly when it comes to the views of women with AUDs (Vandermause & Wood 2009).

The lack of perceived need for service engagement continues to be an immense barrier to individuals with an AUD receiving appropriate services (Oleski et al. 2010). This is particularly true when the person with an AUD is a woman. Relatively few studies have explored the motivations of women about their decisions to engage with services (Grosso et al. 2013; Greenfield et al. 2010). In my desire to contribute to knowledge and help fill the gap in this understanding, the essence of meaning that evolved from the scenes and elements, which in themselves grew from the participants unique story-telling, will be further explored in this chapter.

In order to more completely emphasise this essence of meaning, each of the four scenes will be revisited within the context of existing literature and with the use of direct quotes from the women participants. This is because, when performing a hermeneutic interpretation, 'we do not force the literature's perspective on the interview text, but let the chosen literature illuminate the interview texts and interview text illuminate the chosen literature' (Lindseth & Norberg 2004, p. 151).

## ***Scene: Disliking Alcohol***

The first scene, 'Disliking Alcohol', consisted of two elements: 'significant others' and 'negative health impacts'. 'Disliking Alcohol' captures the stories of participants making their decisions to engage with services only after they became aware of their dislike of alcohol. This dislike centred on the negative impact that their alcohol consumption had on the relationships with the significant people in their lives. It also centred on the participants own health and well-being.

### ***Significant others***

The women in the study expressed their dislike of alcohol in terms of the damaging impact of their alcohol consumption on others, particularly the relationships with their partners and children. Within relationships where one partner has an AUD, there is a direct association with lower levels of marital satisfaction, higher levels of verbal and physical aggression, and, when the couple have children, increased levels of psychological problems in children (Foran & O'Leary 2008; Schroeder, Kelley & Fals-Stewart 2006).

People with AUDs are likely to develop relationship problems due to the strain that harmful alcohol use places on their ability to function inside and outside of their relationships (Leonard & Eiden 2007). The experience of alcohol-use disorders damages social relationships, leading to social isolation (Testa & Smith 2009). Indeed, women, more so than men, are uniquely burdened by multiple issues and vulnerabilities that impact on their decisions to engage with services, including fractured support networks resulting from their years of harmful alcohol use (Cadiz et al. 2005).

There are also gender differences in the period between the onset of an alcohol-use disorder and the onset of interpersonal difficulties and adverse social consequences, with this course evolving at a faster rate for women (Diehl et al. 2007; Green 2006). Participants spoke of their growing dislike of what alcohol was doing, or had done, to their relationships - how it had resulted in a *'breakdown in relationships'*. They spoke about their lack of support networks, resulting from the years of drinking, and the fact this had *'caused rifts'* in their relationships, resulting in *'lost friendships'*.

*I was fairly low at that point [when P6 contacted services]. I saw I was losing my partner, my friends, and, for me, that was a pretty big turning point. I was at the point where, "OK, there needs to be more than this". I needed to hate alcohol. (P6)*

Participants also spoke of the negative impact their alcohol use had on their children. They lamented the fact that they were *'poor role models'*. The experience of AUDs for those with children in the home may be more uniquely complex for women. This is because women, more so than men, tend to believe that their harmful consumption of alcohol has a more damaging impact on their children, and they may lose custody of their children if they do not cease this use (Grosso et al. 2013). Conversely, some women may be less motivated to seek the help of services because of fear that their children will be removed from their care and that they will not be able to regain custody (Wilke, Kamata & Cash 2005).

*As a woman, it's a scary thought to put up your hand and say, 'yep, I've got an alcohol problem'. Does this mean my kids could be taken away and does this mean because I'm trying to do the right thing and access services, does this jeopardise the safety of my kids and their well-being...? (P7)*

As discussed in Chapter Two, women who drink to excess are more likely to have a partner who consumes even more alcohol than they do (Mustonen 2000; Nolen-Hoeksema & Hilt 2006). Women's motives to consume alcohol are also strongly influenced by their partner's alcohol consumption habits (Payne et al. 2009).

*When I first met my boyfriend, I didn't drink all that much but he drank heaps and wanted me to drink with him. It started from there; he would get angry if I didn't get pissed with him every night. I hated it, I wanted to stop, it got to the point where I was vomiting blood, but I didn't want to face that anger. (P2)*

Women with AUDs are also more likely than men to consume alcohol in response to negative emotions and stressful situations, such as when in conflict with their partners (Greenfield et al. 2010). Matwin and Chang (2011), when examining the value of a Readiness to Change (RTC) questionnaire with 499 U.S. women with AUDs, found that women drink in response to stressful situations and negative emotions. As such, this impacts on their motivation to reduce their alcohol consumption, regardless of their readiness to change. The findings of the above study suggest that women with relationship problems experience diminished incentive to cease alcohol consumption and engage with help.

In line with this, the women in this study described conflict and relationship problems as impacting on their decisions to contact services. Participants explained that their problems with alcohol were less of a priority when there was conflict in the home, particularly when children were involved. They mentioned needing to 'sort out' and 'fix' these problems before they could contemplate and commit to services for help with their own alcohol-use disorders.

However, in order to 'conceptualise their need for change', women with AUDs, generally more so than men, need the support of their social networks and close relationships (Davis & Jason 2005). The factors associated with a women's decision to seek help for her AUD include the perceived support from her partner and an overall satisfaction in her relationships with her significant others (Eubanks Fleming & Cordova 2012; Homish & Leonard 2007). How does a woman gain support for her own AUD when her partner is likely to consume more alcohol than she does?

The need for support is particularly true of women who want to achieve abstinence from drinking. Increased levels of social support are thought to be directly and positively correlated with a woman obtaining and maintaining abstinence (Mohr et al. 2001; Davis & Jason 2005; Moos, Moos & Timko 2006). Indeed, the women in this study spoke of the changes that occurred when they received support and encouragement from their loved ones and social networks.

*I now have wonderful support...while I'm surrounded by people I love, it is OK, I think I can do this, I can get better, I don't want to drink again. When I didn't have that, it was hard; I couldn't bring myself to care. (P15)*

*I was one hundred percent this time. I had help, that was the big difference. I had people who cared; they encouraged me to pick up that phone. It makes all the difference. (P5)*

### ***Negative health impacts***

The negative impacts of alcohol on their health were other key incentives influencing the development of motivation for abstinence by the participants, as well as for their dislike for alcohol and their decisions to contact services. The perceived severity of health problems related to harmful alcohol consumption as reasons to seek services has been explored minimally in the literature, and within this void there remains an underrepresentation of women in this research (Tucker, Foushee & Simpson 2009; Foster et al. 2014).

Chapter Two described in detail how women are more vulnerable than men to the toxic effects of alcohol after fewer years of excessive alcohol consumption, known as the 'telescoping effect' (Alfonso-Loeches, Pascual & Guerri 2013; Bravo et al. 2013; Greenfield et al. 2010). In comparison to men, women with AUDs experience a faster progression to alcohol-related negative health impacts, as well as an earlier onset of adverse consequences of alcohol consumption, such as brain damage and liver disease (Mann et al. 2005). From the commonly cited reasons for individuals not seeking services, such as feeling as if they could deal with their harmful alcohol use on their own or thinking that their 'problem' would just go away (Cohen et al. 2007), it is thought that most individuals wait until their alcohol-use disorder becomes severe before seeking help (Mowbray 2014).



As mentioned in Chapter Two, when an alcohol-use disorder is severe, there is likely to be more significant and chronic health problems caused by the toxic effects of the high levels of alcohol being consumed (Gronbaek 2009; NHMRC 2009). Women with AUDs have been found to delay seeking the help of services more so than men with AUDs. This is due, in part, to the stigmatising attitudes of others and the internalised feelings of shame and failure (Rolfe, Orford & Dalton 2009). The latter, known as self-stigma, is discussed in greater detail later in the chapter.

Therefore, when the woman enters a specialist program, she is likely to be experiencing acute and significant health impacts resulting from her harmful alcohol consumption (Angrove & Fothergill 2003; Grosso et al. 2013). Accordingly, a number of participants in this study cited the negative impacts of alcohol on their health as reasons for their 'conceptualisation of their need for change' - for developing a dislike for alcohol and for making the decision to contact services.

*But the stupid thing is the power that alcohol had over me. I knew the tumour was caused from alcohol and because it grew so big the alcohol actually accelerated the growth of the tumour and it was like the size of a tennis ball so they had to cut out part of my liver to get rid of the tumour and it was about four week after the operation I started drinking again and worse than ever, even though I hated it, what it was doing. I'm talking three bottles of wine, six-pack of beer and the doctor said to me if I continue to keep drinking, "you will be dead within six months". So, this really is my last chance. (P11)*

Several of the women mentioned cognitive damage from drinking, 'being very forgetful', 'not remembering large chunks' of their past and problems with 'short-term memory loss'. Others discussed high blood pressure and heart problems, weight gain, seizures and regular episodes of vomiting.

*I was drinking a cask of wine a day like you know and that's really bad you know. After two or three drinks I'd be vomiting blood. (P2)*

Participants, as being a reason for 'Disliking Alcohol' and for wanting to change behaviours and initiate contact with services, described co-occurring mental health disorders. It has been established that women with AUDs are generally more at risk of experiencing mental health problems when compared to men with AUDs (Moos, Moos & Timko 2006; Small, Curran & Booth 2010; Lau-Barraco, Skewes & Stasiewicz 2009).

Mental health disorders and AUDs are common co-occurring disorders (Dawson et al. 2010; Bolton, Robinson & Sareen 2009). In terms of suicidality, consuming excessive alcohol may lead to thoughts of suicide through disinhibition, impulsiveness and impaired judgement, but these patterns of consumption may also ease the distress associated with alcohol-use disorders, as well as the actual act of suicide (Pompili et al. 2011).

However, because of the stigma that surrounds women's experiences of AUDs, women with alcohol-use disorders often feel more willing to present to their physicians with symptoms related to their mental illness, rather than for their AUD, which results in the under-treatment of their AUD (Brienza & Stein 2002; Small, Curran & Booth 2009). Over time, the discrepancy about how the person with an AUD is behaving and how she would like to behave can also lead to depression (Hayes et al. 2006). Payne et al. (2009) described depression as one of the most frequent reasons given by women with AUDs for seeking help from a medical specialist, rather than for the AUD itself. The following quote by Participant 9 illustrates this:

*I've got depression... I've just started in the last few months seeing a psychologist seeing if it is going to help me mostly to get to the bottom of why I drink and built up the self-esteem and self-worth and that, to carry on without alcohol. I didn't want to come out and tell him I drink off the bat, you know, so I told him about the other stuff first, the depression, and then the drinking came out. (P9)*

Participants expressed how they used alcohol to 'self-medicate' the effects of their mental illness. They described drinking to 'feel numb' or to 'block out the bad thoughts'. Alcohol is described in the literature as being routinely used as a coping mechanism by women for symptoms of depression, anxiety and post-traumatic stress disorder (PTSD), as well as for tension and loss (Rolfe, Orford & Dalton 2009; Sarin & Nolen-Hoeksema 2010). In this instance, the moment participants 'conceptualised the need for change' was when they came to the realisation that alcohol was in fact contributing to their symptoms of mental illness. They thus needed to obtain help to stop drinking and to find alternative ways to cope with their symptoms.

*I suffer anxiety, which is why I drank. Taking alcohol stopped my heart beating out of my chest. That's pretty much the reason, coping mechanisms and anxiety. I now realise that it didn't help at all, made it worse, made my life shit. Took too long though, years and years, lost years of my life. I hate what it's done, what it's taken from me, from my family. I should've realised sooner that there were other ways to deal with it, the anxiety. (P7)*

However, as noted, there may be competing problems, other complicating issues and challenges, which can interfere with the person's alcohol-related change processes (DiClemente 2003). Conflict and relationship problems, child protection issues, the use of alcohol to mask symptoms of mental illness were all described by participants as being reasons '*to drink*', as well as being reasons to '*give up drinking*' with the help of services. Concerns about health are a frequently cited reason for the person with an AUD wanting to engage with services (Proude et al. 2006), and, in many cases, the decision to engage may be influenced more by the accumulation of health problems than by the specific substance-use disorder (Keaney et al. 2011).

Women-specific research, however, on the topic of illness recognition by those with AUDs and motivation for service engagement is very minimal (Greenfield et al. 2010; Jakobsson, Hensing & Spak 2005). Grosso et al. (2013), in their U.S. study examining 180 women's motivators for seeking services for help with their alcohol-use disorders, did find that negative impact of alcohol on their health was of significant concern upon service entry for 43.3 percent of participants. It has been suggested that alcohol-related health factors have a stronger and clearer impact on a person's readiness to change their alcohol-related behaviours than do other predisposing characteristics (Rapp et al. 2008; Apodaca & Schermer 2003; Orford et al. 2008).

Notwithstanding the desire, sustaining this illness-related motivation whilst engaged with services may be difficult, as people who cite this as a reason for engagement tend not to complete the program (O'Toole et al. 2006). It is, however, thought that those who use alcohol-focussed services tend to have serious psychiatric and physical health problems (Cohen et al. 2007), although understanding the influences of health on help-seeking for AUDs '*lags behind population need*' (Tucker & Simpson 2011, p. 375). It is important to highlight that the process of change is active and ongoing, spurred by activities and the lived experiences of the person in their everyday environment (DiClemente 2007).

Throughout the interviews, the women spoke of their lifeworlds in terms of their experiences of AUDs, which, for most, spanned quite a large number of years. The participants spoke of their experiences as they reflected on them. As they considered the reasons for their decisions to engage with services, they discovered how each part mirrored the whole experience and the whole experience was more than just each part joined together (van Manen 1997).

Reflection brought a reinterpretation of the past and a fresh interpretation of the present, resulting in a transformative change of the self (DiClemente 2007). Developing a dislike for alcohol, or even 'hatred' as mentioned by a number of participants, created an environment conducive to change, which was therefore key to the women's decisions to engage with services.

Participants spoke of being '*over it*', '*hating what it has done*', in terms of the damage that alcohol had caused to their relationships with others as well as to their own health. The participants' construction of their dislike for alcohol and their realisation as to the impact it was having on their significant others and their health thus related to their '*conceptualisation of the need for change*' in their alcohol-related behaviours and decisions to engage with services (Figure 8).

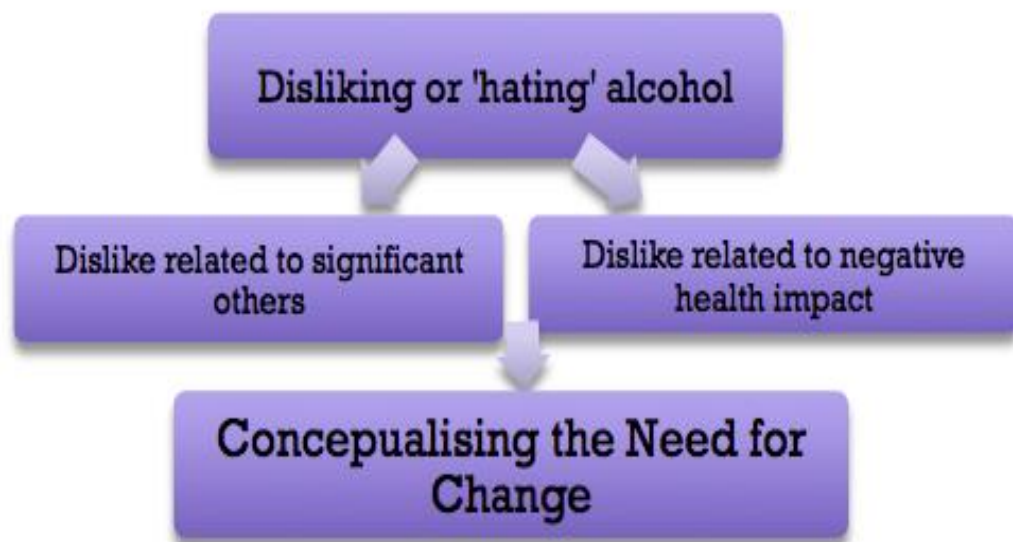


Figure 8. Representation of the 'Disliking Alcohol' scene

## Scene: *Overcoming Barriers*

Before the participants arrived at their decisions to engage with services, all 15 women described having to first overcome significant barriers. The term 'barriers' refers to reasons why people with healthcare conditions do not utilise specialist services or do not modify their targeted behaviours (Schober & Annis 1996). Women with AUDs, when compared to their male counterparts, face significantly more barriers when seeking the help of services (Greenfield et al. 2010; Green 2006; Small, Curran & Booth 2010). This scene of 'Overcoming Barriers' contained five elements: 'being a woman', 'being a carer', '(ab)normalisation', 'poor past experiences' and 'in the dark'.

### ***Being a woman***

The findings illustrated that the experiences of AUDs among the participants and reasons for their engagement with services were uniquely different from that of men, in that being-in-the-world is contextually different from their male counterparts. Women with AUDs often experience more feelings of guilt, embarrassment and shame than men in similar situations, and these feelings are generally more compounded (Thurang & Bengtsson 2014; Angrove & Fothergill 2003). Guilt and feelings of shame may lead to the woman denying her AUD or avoiding service engagement (Jakobsson, Hensing & Spak 2005).

*I am trying, but it is still hard and that is another thing too, as women, we are always worried about other people and then we aren't putting ourselves first. We then feel guilty if we want to put ourselves first, and ashamed, it's the shame thing you know. (P13)*

*We feel the guilt and shame and it stops up from getting help. We put other people first and we have got an excuse but it's ourselves a lot of the time -what we think people are going to say. (P5)*

Participants also spoke of the '*stigmatising attitudes*' of others as hindering their decisions to engage with services. Stigma refers to a social process where a perceived aspect, in this case the excessive use of alcohol, marks an individual to be socially sanctioned and devalued (Luoma et al. 2010). The stigma attached to women who live with AUDs, which merges with negative images of women's femineity (Greenfield & Grella 2009), is often cited as being a barrier for women seeking the help of services.

Stigma related to AUDs also decreases problem recognition, which is a necessary prerequisite to seeking help (Rothman & Salovey 2007). While men also experience the stigmatisation associated with AUDs, it takes on an additional layer for women; due to the way the excessive consumption of alcohol by women is negatively positioned in society (Rolfe, Orford & Dalton 2009; Mansson & Bogren 2014).

Women with AUDs have reported perceiving greater social stigma than men with similar disorders (LaFave, Desportes & McBride 2009). The perception of stigma and being 'judged' led to participants hiding their drinking from others. It also detrimentally affected their ability to engage with services, as they did not want to 'draw attention' to themselves and their disorder.

*I think the women just face more difficulties, different difficulties than what men do when it comes to getting help. There is much more stigma for women. We don't fit in to what people think a woman should act like, people think alcoholism is a man's disease, but I know a lot of women who suffer in silence because of this stigma. (P1)*

Against this backdrop of shame and stigma, participants lamented how their experiences of AUDs were constructed around feelings of marginalisation, disempowerment and low self-esteem. It has been found that women with AUDs learn that it is not safe to feel good about themselves, or have been taught through family and cultural socialisation that there is 'no good in them' (LaFave, Desportes & McBride 2009, p. 62).

Women with AUDs, when compared to men, are also more likely to have a lifetime history of sexual or physical abuse (Small, Curran & Booth 2010; Salter & Breckenridge 2014), which results in the women feeling disempowered and having low self-worth.

*I had low self-esteem, before that growing up, I was teased and abused and yeah later on when there was the violence that's when I really lost all self-esteem and drank to erase it all. I didn't want to know what I was doing was wrong, I had no insight. (P14)*

It was difficult for some women to overcome the barriers associated with being a woman with an AUD, and this had to occur before participants 'conceptualised the need for change' and contacted services. Many of the women in this study spoke of 'suffering' for years before making the decision to contact services, mainly because of the stigma and the poor attitudes from friends, family and society. That women with AUDs seek the help of services, even though it is difficult for them, is a 'poignant example of their need' (Vandermause & Wood 2009, p. 733).

Stigma may also increase feelings of shame (Cadiz et al. 2005), and lead to self-stigma. Self-stigma refers to the self-devaluation and fear of enacted stigma resulting from personal identification with a stigmatised group (Luoma et al. 2010), in this case women with alcohol-use disorders. Self-stigma may threaten the sense of control and self-esteem of an individual with an AUD, and strongly interfere with their prospect of a decision to engage with a specialised alcohol and other drug services (Saunders, Zygowicz & D'Angelo 2006).

*A lot of people talk about societal stigma but also about self-stigma. We do it to ourselves too. We feel the guilt and it stops up from getting help. We put other people first and we have got an excuse but it is ourselves a lot of the time. What we think people are going to say. (P13)*

Enabling behaviours from partners in relation to the use of alcohol also made it difficult for the women to 'conceptualise the need for change' and engage with services. The women spoke of their partner's drinking as being a barrier when they were contemplating engaging with a specialised program. Participants' described their partner's buying drinks for them or drinking in front of them when they were considering or going through the motions of abstinence.

*I hang around a lot of enablers now. Like my boyfriend now and my boyfriend before was in the same habit so if I was starting to get stressed out I know the first thing to do was to pass me a glass of alcohol and I would be happier, friendlier less stressed. (P9)*

Chapter Two elucidated how women with AUDs are more likely than men to be adversely affected by their partner's alcohol use, and the partner may even threaten violence if the woman chooses to engage with services (Nowotny & Graves 2013; Green 2006). Perpetrator control, where the partner uses their power and brute force to 'control' the movements of the woman, is seen in relationships where the woman experiences an AUD (Galvani 2006). Dialogue from six of the participants contributes to this discourse; their being-in-the-world was controlled by their male partners to the extent where they felt they had no control. This is illustrated by Participant 5:

*The only thing that has stopped me is my man. He's made me not go [to rehabilitation]. He said if I went, he would come and drag me out of that place. He's bashed me so I couldn't go. He controlled me for so long, I couldn't buy food, clothes or anything for the house without his permission. The only thing I could buy was grog (P5)*

LaFave, Desportes and McBride (2009, p. 59) describe how it is important to ‘recognise the degree to which women have been controlled by others in their lives to understand fully the profound significance of their awareness of their choices and willingness to embrace responsibility’. The women in this study needed to first come to terms with and manage their partner’s controlling and violent behaviours before they could ‘conceptualise their need for change’ in relation to their decisions to engage with services.

*It was pretty bad. That’s why my children were removed from my care. It had to do with the alcohol, but it was also the violence. And then to deal with all that I was drinking and I was doing all that stuff so then that contributed to that you know, like but, yeah my children’s father was extremely like, like DOCS became involved because he threw me out of a second story window. I finally turned the corner one day and thought ‘enough’. I had to get out and get myself sober, but I had to get away from him first. (P2)*

Participants who had numerous service engagement experiences also described feeling ‘intimidated’ and ‘frightened’ by male service users and the male-orientated structuring of the programs, due to the trauma and violence that the women had experienced throughout their lives. A perceived lack of women-only services was mentioned as a barrier to the participants making the decision to engage with services. A range of barriers to change are associated with being a woman with an alcohol-use disorder (Figure 9).

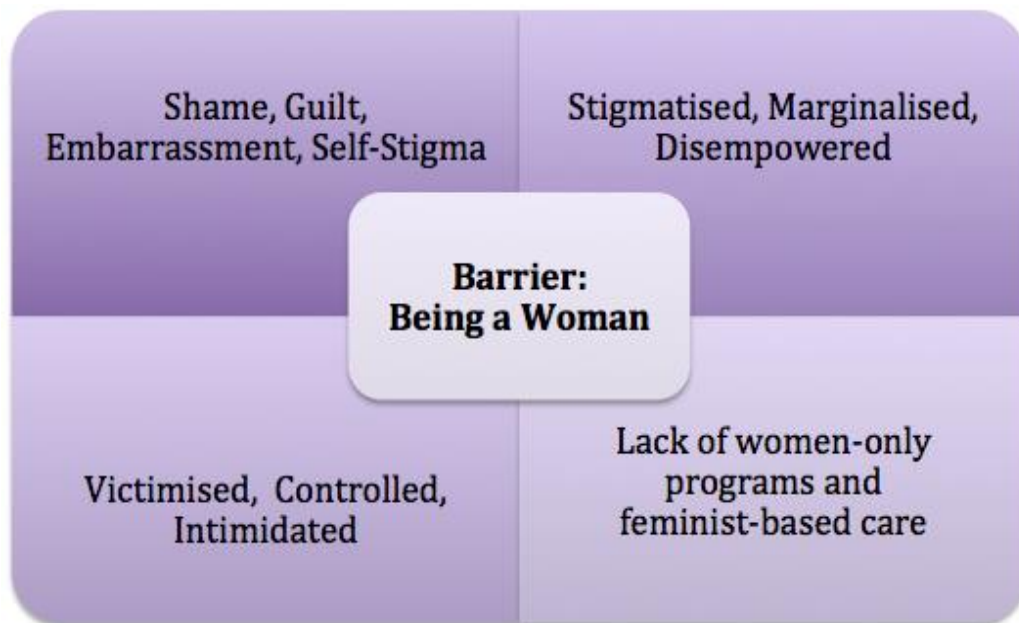


Figure 9. Barriers to change - being a Woman with an alcohol-use disorder



Women with AUDs often feel intimidated by male-dominated service settings due to life experiences involving childhood abuse, maltreatment and long-term interpersonal violence (Cadiz et al. 2005). This created a barrier for the participants contemplating re-engagement with programs. 'Few programs adopt feminist approaches to treatment that may prioritise relationships and values of caring over considerations of strict autonomy and a legalistic sense of accountability' (Geppert & Bogenschutz 2009, p. 292).

Despite the fact, due to the lack of women-only programs, that the majority of women with AUDs will access mixed gendered programs, evidence suggests that women-only programs have enhanced retention rates and better outcomes (Greenfield & Grella 2009; Claus et al. 2007). The complex patterns of alcohol consumption associated with women with AUDs, as well as their problems with interdependence and social isolation, supports the need for gender-specific programs to address these issues (Green 2006; Geppert & Bogenschutz 2009).

*A place where females could go. When it's mixed with the males, I feel scared. So if there was a female environment, yeah, it's just different genders have different ways of coping, when the men get angry, I get intimidated. We have different way of expressing our emotions, so if it's females only it would take away that confusion and I'd feel more comfortable. (P14)*

When participants did overcome the barriers associated with being a woman and 'conceptualised the need for change', they spoke of needing to 'put yourself first'. The ambivalence many participants felt in relation to change and contemplating engagement with services, resulting from stigma, shame, low self-esteem, violent relationships and feeling intimidated by mixed gender services, was resolved after the women decided to 'take responsibility' for their future, a future without alcohol.

*I think right now the difference for me is this time around is it is about me, there is not relationship issues, there is no outside interference, there is nobody sitting back saying, you know [participant name], it would be nice to have a drink. This is just about me... (P8)*

*I jut couldn't take no more. I wanted to do this for me. I got to the point where he had no power over me any more, I was just numb. I thought, it doesn't matter what he does, I can't hurt any more. So I just left and went to rehab. Just like that. I did it for me. (P12)*

## ***Being a carer***

Being a woman also meant being a mother for many of the participants. This, however, created an additional and complex barrier to decisions by the women to engage with services. Motherhood is often equated with the essence of womanhood (McQuillan et al. 2008). The norms, values, ideas and images about the 'ideal' mother figure, which have been developed and perpetuated by society 'establish ideals about good and bad mothers and mothering' and 'constitute the discourse of motherhood' (Robson 2005, p. 219).

Motherhood and alcohol-use disorders are believed to be incompatible according to conventional perspectives (Lee & Zerai 2010). This was highlighted by Participant 13 below. In a society where identity is linked to practices and patterns of alcohol consumption, the 'flawed consumption' (Bauman 2007, p. 52) practices of women with AUDs deem their capacity for motherhood as questionable by society.

*But the guilt thing is the main thing with women and the shame and you know, because we are not supposed to be like that. We are supposed to be the carers. Not supposed to be the one that goes to work and then goes out and has a few drinks to relax. We are supposed to be the nurturers and we are failing our duty doing that, drinking. Setting a bad example.*  
(P13)

Women are under immense pressure to perform the role of the ideal mother, which is characterised by an unwavering commitment to their children – 'selflessness, compassion and nurturing', all of which are suggested to be 'natural qualities in women' (Kilty & Dej 2012, p. 19). A hierarchy has been created by society to clearly differentiate between 'good' and 'bad' mothers, and women rank themselves using self-surveillance techniques, enabling them to identify how they could or should be a 'good' or 'better' mother to their children (Milligan et al. 2010).

This motherhood hierarchy is complicated when women experience substance-use disorders, such as AUDs. There exists a dominant, negative and stigmatising discourse directed toward women who use substances, including those who engage in the harmful consumption of alcohol (Kilty & Dej 2012). Women with AUDs and other substance use disorders are seen as incapable of raising their children, as they put their 'compulsion' to use their substance of choice over their mothering role, despite evidence to suggest that these women can parent successfully (Milligan et al. 2010; Smith 2006).

There has been found to be a negative construct centred on the concept of neglect by health workers and society in terms of women with AUDs and motherhood, one which is applied collectively and often without evidence (Kilty & Dej 2012). It is thought however, that if AUDs and other substance-use disorders were understood as health problems with multiple causes, rather than as problems of social deviance that need to be 'risk-managed', women with substance use who have children would be empowered to make the decisions to seek the support of services (Reid, Greaves & Poole 2008).

Nevertheless, women with AUDs must continually re-define what it means to be a 'good' mother in light of their harmful consumption of alcohol and the negative and stigmatising views of society (Milligan et al. 2010). Being a mother with an AUD, according to Reid, Greaves and Poole (2008, p. 211), involves the 'challenges of negotiating the prevailing attitudes, practices and stigmas of being a substance-using mother while trying to do the right thing for her children'. As such, participants with children in this study spoke of how they grappled with the barriers associated with the ideologies of motherhood and role modelling, as opposed to making the decisions to change and obtain help for their AUD.

*And with the kids especially. I wasn't belting the crap out of them but I would be yelling at them and that, and then I wonder why they yell. Or they are yelling because I yell? They are following what I do. Not good role modelling. You know, they are beautiful kids and they have got so much future and I chose to have those kids. I had to make the decision to put my needs first, but did this mean I was abandoning them? (P7)*

Women with substance-use disorders, including alcohol-related ones, will often make the decision to engage with a specialised service with 'an awareness of the impact of substance abuse' on their children (Wilke, Kamata & Cash 2005, p. 1315). This awareness can result in women with AUDs developing enhanced maternal identity, as they not only become more responsive to their children's needs, but also are motivated to overcome the barriers they face when parenting and separating their own needs from their children's (Wong 2006).

Overcoming the barriers to their 'conceptualisation of the need for change' as experienced by the women in this study who had children involved prevailing over significant, gendered stereotypical roles as governed by society.

*This time I don't know if it was just the stage of life I was at but I knew that drinking was a problem and that I couldn't socially drink. I went in with that mind-set and it was more my choice as opposed to, if I don't go in... I will not see my kids, things like that. OK, I need to get my act together. I knew it was affecting my kids; I had to weigh up leaving them or staying and doing more damage. It's always a choice when you're a mum with kids.... (P10)*

The actual service approach can also be a barrier for women with children, as the traditional structured and rigid programs which target the needs of men are often not suitable for parenting women (Niccols et al. 2012; LaFave, Desportes & McBride 2009). A U.S. quasi-experimental retrospective study explored outcomes for 747 parenting women with substance-use disorders in a specialised women-only service, and compared these outcomes to those of 823 parenting women in a mixed-gendered service (Claus et al. 2007). The results were that the women in the specialised service were more likely to complete the program, have longer stays and engage with post-care options.

However, there are a lack of targeted women-only programs (Greenfield et al. 2010; Grella et al. 2009), and, as such, the women in this study expressed dissatisfaction over there being very few specialised services which addressed their complex needs of being a woman with an AUD who cared for their children. Caring responsibilities by the women in this study were not limited to children, as a number of participants provided care for their ill partners and/or aged parents. No matter whom the care was provided for, participants described having to overcome the requirement to put *'others before their own needs'*.

*As a woman, it is a scary thought to put your hand up and say, "yep, I have got an alcohol problem". Does this mean that my kids could be taken away and does this mean because I am trying to do the right thing and access services, does that jeopardise the safety of my kids and the well-being of them being in my home. If I said "yeah, I've got a problem", where am I meant to put my kids? I wouldn't be able to see them for weeks if I went inpatient. There's nothing out there if you've got kids... (P8)*

Women have been socialised to put their own needs after those of their loved ones, and strongly believe that looking after their own needs is *'selfish'* (LaFave, Desportes & McBride 2009, p. 62). This created an additional barrier to the decision-making of the participants about their engagement with services, one which they had to overcome in order to *'conceptualise their need for change'*. This was exemplified by Participant 13.

*It is still hard and that is another thing too, as women, we are always worried about other people and we aren't putting ourselves first. We aren't. We are taking care of everybody else making sure everybody else is all right. Making sure everybody else is well cared for and all their emotional problems are met and our worries are different to men...I needed to find a reason to put myself first, which is pretty stupid when you think about how sick I was... (P13)*

The barriers associated with being a carer featured prominently throughout the storytelling of the participants. The challenges of negotiating the prevailing negative attitudes and stigmas associated with being a mother who has an AUD in a society which does not value them or provide much in the way of assistance created distress for many of the participants. Failing to live up to the ideals and roles that society assigns in terms of femininity and motherhood, results in severe social stigma for women with AUDs (Niccols et al. 2012).

However, motherhood and caring responsibilities, despite the harmful consumption of alcohol and the experience of an AUD, emerges as a deep-seated part of a woman's life (Litzke 2005). One which is an integral component of their identity. This is regardless of that fact that women with AUDs, as mentioned by participants in this study, struggle with social isolation, intergenerational patterns of alcohol and other substance use, mental illness and a history of physical and sexual abuse (Niccols et al. 2012).

Women with AUDs are some of the most vulnerable individuals in our society (Grosso et al. 2013; Corte, Rongmuang & Stein 2010), and continue to experience marginalisation, stigma and discrimination. The battles they faced, for many of the women participants, left them feeling as if society had let them down; as they '*fell between the cracks*' when it came to obtaining the help and support that they needed.

*Because, at the end of the day, I chose alcohol as a way to get through a really difficult time for me... It's unfair in a way, I feel let down as I needed help but nobody would give me the time of day. I had to struggle by myself; I was up shit creek but who cared? Where was the help for me, for my kids? (P8)*

van Manen (1997, p. 89) reminds us that 'some battles are victorious, some leave permanent scars, and others end in irredeemable loss'. The women in this study, whilst victorious when they 'conceptualised their need for change', displayed their deeply embedded scars when relaying their personal stories. This was particularly evident when these stories involved children. The women had to endure many losses in their battles; losses which continue to resonate in their everyday lives and the relationships with their loved ones.

Overcoming the barriers associated with being a woman and a carer denotes that the woman living with an AUD must have hope. For Heidegger (1962, p. 362), hope – the expectation of future good, is found in ‘having been’ - grown from one’s past experiences, hurts, difficulties and setbacks. Hope is related to the past just as it is to the present, as well as to the opening of one’s eyes to one’s position in being-in-the-world, to Daesin (Heidegger 1962). The foundation for the ‘conceptualisation of the need for change’ was the women’s hope for a better future with their children and families, as ‘to hope is to believe in possibilities’ (van Manen 1997, p. 95).

### ***(Ab)normalisation***

Other barriers women in this study had to endure and overcome in making their decisions to change and engage with services were related to the ‘normalisation’ of alcohol in society. This scene was entitled ‘(A)bnormalisation’, as these experiences were anything but normal for the women participants. All but two of the participants were brought up in households where being reliant on alcohol was considered ‘normal’.

As discussed in Chapter Two, the environment in which the person grows up can play a significant role in the onset of an AUD (Sher, Grekin & Williams 2005). As such, exposure to harmful levels of alcohol use when growing up, served as a salient risk factor for the development of AUDs. Paternal excessive alcohol consumption was a particularly common thread in the women’s story-telling, with nine participants discussing their fathers’ regular harmful consumption of alcohol.

It has been suggested that paternal alcohol-use disorders are linked to the increased likelihood of daughters, but not sons, also developing an AUD (Coffelt et al. 2006). However, findings of other research specific to parent gender and risks of offspring developing AUDs were inconclusive (Braitman et al. 2009; Weitzman & Wechsler 2000). No matter if it was their mother or father (or both) who consumed alcohol at harmful levels, the exposure to alcohol from a young age made it difficult for participants to think about a life which did not ‘revolve around’ alcohol.

*There's a lot alcoholism in my family. My mother was an alcoholic, a very aggressive alcoholic. My father liked a drink. My uncle died at 48. He was a full-blown alcoholic. I learnt to use alcohol to numb everything; it's what my family did... (P12)*

*I think, in a lot of homes, not only with those with alcoholic parents such as mine that alcohol, well in society alcohol is sold everywhere today, but if kids knew it is just not the norm. It is becoming such a norm. If kids knew alcohol is not necessary or it is not just like water. It is a drug. (P14)*

Children of a parent or parents with AUDs have been found to show higher rates of harmful alcohol consumption in adolescence and early adulthood, and consume alcohol at an earlier age, when compared to their peers (Hussong, Bauer & Chassin 2008; Wong 2006). Emotional adjustment problems, poor self-esteem, insecurity and an 'instability of self-concept' is experienced by the children of parents with AUDs (Polak, Puttler & Ligen 2012, p. 832).

'The impact of growing up in an alcoholic home environment often goes beyond the childhood years with some of these children carrying the legacy of social and emotional adjustment problems into adulthood' (Hall & Webster 2007, p. 425). Participants in this research echoed this, having to overcome barriers related to an early drinking age, as well as '*poor self-esteem*', '*poor coping mechanisms*' and using alcohol to '*self-medicate*' their life and social '*problems*'.

*I really started drinking when I was 13 years old, it was the norm in my family, a way of coping, that's how you deal with any situation whether it be a problem or whether it be anxiety...I come from a background with one side of the family that are drinkers and so those patterns and those belief patterns are being put in... this makes it hard to realise that alcohol is a problem. (P1)*

For participants, the way in which alcohol consumption is normalised by society compounded their need to consume alcohol to excess. Fishbein and Azjen (2010) indicated that an individual's behavioural intention is strongly impacted by social norms that advise permissible behaviour. The so-called '*cultures of intoxication*' (Hutton, Wright & Saunders 2013, p. 452) have led to shifts in the alcohol consumption practices of women, particularly younger women (McEwan, Campbell & Swain 2010).

It was suggested McRobbie (2009, p. 83) that younger women may feel that gender equality can be achieved with such behaviours as excessive drinking, without, however, 'relinquishing their own desirability to men'.

*I thought it was normal. I thought I'd been drinking, I probably drank about three times a week but I'd drink up to like sixteen cans in one sitting. It was just a normal part of my life. We all did it, us girls together - the start of everything really. (P11)*

There exists a 'wider cultural ambivalence' about women's drinking, where women need to protect against a stigmatised identity, that of an 'unrespectable or irresponsible woman, addict or more generally a woman out of control' (Rolfe, Orford & Dalton 2009, p. 333). This results in femininity being fraught with contradictions and tensions when it comes to alcohol (Griffin et al. 2012), and highlights the complex relationship that exists between women and alcohol. This complex relationship, with excessive alcohol consumption being considered unsuited to femininity, as well as the stigma related to women with AUDs, may lead to secrecy about drinking and a delay in seeking help (Jakobsson, Hensing & Spak 2005).

*People don't associate alcohol with worlds that can become so devastated because it's not out there. People think that some guy sitting on a seat drinking from a flask of wine is an alcoholic, but they don't think that some woman that can go to work every day, drop the kids off at day-care or school, and pick them up and come home and drink herself to oblivion every day is an alcoholic because she is working and she is functioning. She doesn't even see it herself, because who tells her? She is by herself, hiding it. (P8)*

This complexity and emotional straight jacket is further enhanced by the way in which alcohol is viewed by society. Alcohol is an expected and often key component of any normal social gathering and plays an integral part in women's social lives (Rúdólfssdóttir & Morgan 2009). Although the focus of many studies on culture, socialisation and alcohol has predominantly been on male drinking (Moos & Moos 2006; Bravo et al. 2013), 'alcohol is an important part of women's social worlds...the increasing consumption of alcohol by women in western counties is of great concern' (Killingsworth 2006, pp. 358-359). As such, women participants spoke of having to overcome difficulties when socialising and contemplating abstinence or when they were abstinent:

*I don't like going to parties or anything like that yet, especially family ones where everyone knows about my problem, because I feel everybody is watching me and everybody is drinking, and I am the only one sitting there with a can of coke. I have been to a couple of ones where the table has been set up and then wherever there is going to be a wine glass and then you see where I sit then the wine glass is taken away. You know you feel awkward. (P12)*



Participants, as being a barrier when contemplating service engagement, also described the ease of access to outlets that sell alcohol. Alcohol is widely available in Australia and the number of licensed restaurants, bars, bottle shops and nightclubs continues to increase every year (Pennay, Lubman & Frei 2014). Participating women also spoke of the low price of alcohol, how 'cheap' it was and how 'buying in bulk' saved them even more money. To help combat this, it is thought that the Australian 'government can curb per capita alcohol consumption and reduce harmful drinking by increasing the price of alcohol' (Chalmers et al. 2013, p. 517).

However, due to the way in which alcohol consumption is normalised in Australia, the Australian public is not supportive of policy, which seeks to control the consumption of alcohol using price, and tax increases (Tobin, Moodie & Livingstone 2011; Chalmers et al. 2013; Fogarty & Chapman 2013). Public concerns have also been expressed, as 'moderate drinkers of moderate means' may be unfairly penalised (Ludbrook et al. 2012, p. 51).

Despite the fact, as discussed in detail earlier, alcohol consumption can result in significant health problems (particularly for women), another consequence of the '(ab)normalisation' of alcohol is that alcohol-related health risks are understated or not mentioned at all in the media and when alcohol is advertised (Measham 2006).

When public health campaigns addressing alcohol-related harms are run, the competing messages associated with the 'social norms' of consuming alcohol and the accessibility of alcohol result in such campaigns not leading to sustained changes in behaviour (Anderson, Chisholm & Fuhr 2009, p. 2237). Participants mentioned the lack of health warning information in alcohol outlets, doctor's surgeries or on product labelling regarding health-related harms attributable to alcohol:

*You go into doctor's surgeries or anywhere you'll see lots of things about quit smoking and why you should quit smoking and things like that. Do you see any pamphlets - I looked - there's no pamphlets about alcohol, there's no information, there's no ads on TV. Even the cigarette packets now where they've got all these horrible images, alcohol there's nothing to deter you really. (P6)*

For women who consume alcohol to excess and are at risk of an AUD, or for those who have such a disorder, a suggested way forward to create awareness of the harms associated with alcohol may be for public health campaigns to address the differences in the drinking practices of women and men (Jayne et al. 2012). Women's consumption of alcohol and the associated problems and harms have been minimised or ignored in the media and by public health campaigns, making it difficult for women with AUDs to conceptualise the need for services (Bloomfield, Gmel & Wilsnack 2006).

Hutton, Wright and Saunders (2013, p. 476) declared that campaigns needed to take into consideration modern day feminist activism: 'there is a need to move away from campaigns that base themselves on conservative ideals of femininity and respectability...' Accordingly, participating women spoke of the need for society, in particular women, to become more aware of the dangers associated with alcohol - the harms that can result from excessive and regular alcohol consumption.

*You know, this is an epidemic, where there are so many girls out there, whether it is that they are 38, 39 like myself, or whether they are in their 20s, and they drink every day. There's no information, they don't know that they're doing wrong, how can they know when there's no info? People don't associate alcohol with worlds that can become so devastated because it's not out there. (P8)*

The barriers associated with the normalisation of alcohol in society were therefore significant for the women in this study. To 'conceptualise the need for change' in relation to their decisions to engage with services meant the prospect of giving up alcohol in a society where it is perceived as an integral part of life. DiClemente (2005, p. 8) acknowledges that the 'internal or external environment that surrounds the targeted health behaviour change makes a significant contribution to understanding the process of change'.

The environment in which the change occurs can therefore not be ignored and, if the person undertaking the change ignores it, the change has a high chance of not being successful (DiClemente 2003). Importantly, a lack of confidence about change in relation to the person's ability to resist the temptation of alcohol likely contributes to ambivalence about change and influences their decisions on whether or not to engage with services (Bandura 2004).

As such, women participants who had maintained change in relation to their alcohol use with the help of services spoke of their indecisiveness when first contemplating abstinence from alcohol, due to societal and familial pressures and the wider social acceptance of alcohol. Women described the '*social pressures*' to consume alcohol, the fact that alcohol is '*legal*', '*cheap*', '*accessible*' and '*everywhere*', which created '*difficulties*' and '*triggers*' when first '*conceptualising the need for changing*' behaviours. Overcoming these barriers was '*life changing*' for many participants, but it took '*commitment*' to '*resist*' alcohol.

'Commitment to change seems to be related not only to admission of problem but also to temptation to drink and confidence to abstain, which needs to be addressed before individuals begin to take responsibility...'*'* (DiClemente, Doyle & Donovan 2009, p. 889). The context to change is therefore larger than the alcohol-related behaviours, as the context can facilitate or complicate the process of change for the woman living with an alcohol-use disorder. Figure 10, which emerged from the data analysis, illustrates this concept.

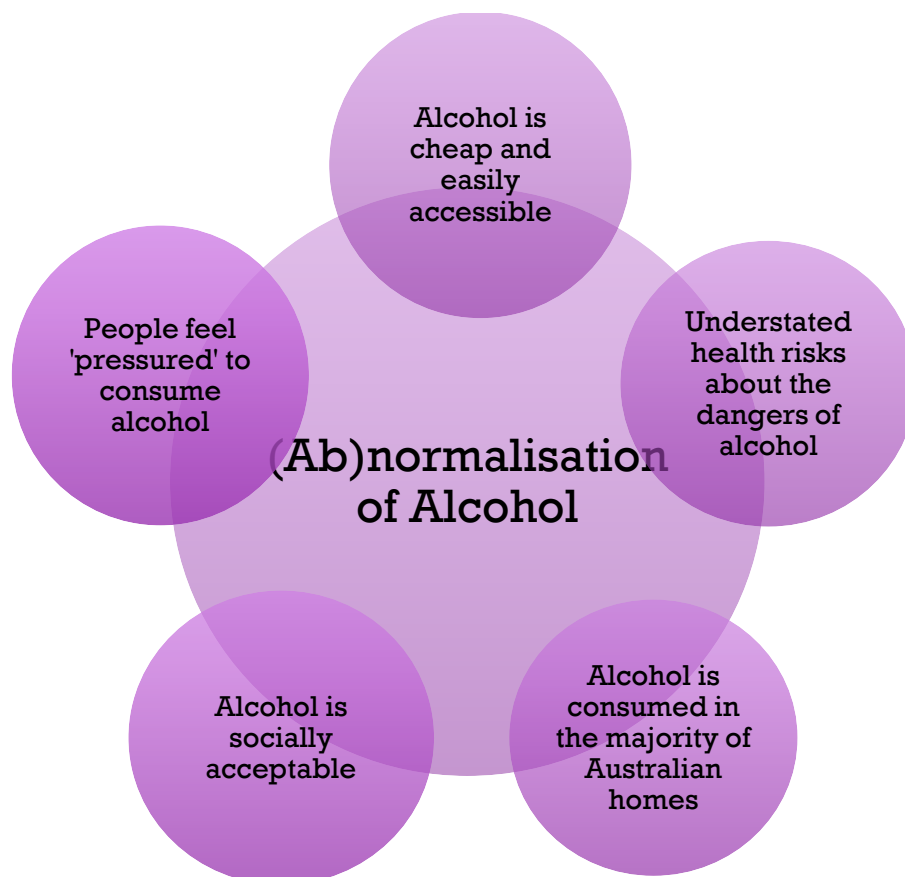


Figure 10. The context of the '(Ab)normalisation of alcohol'

## **Poor past experiences**

Another barrier to change that participating women had to overcome was highlighted in the findings as being their '*poor past experiences*' of services. All but one participant had engaged with services multiple times over their life-course for help with their alcohol-use disorder. Participants discussed in their story-telling, barriers related to self-help groups - these services being too '*regimented*', '*intense*', '*religious*' and '*male dominated*', with the other people attending the service being '*negative*' and '*repetitive*' when disclosing their experiences.

*I did not find it positive and it was just a room full of 'I've been sober for so long' and telling the same story. (P10)*

*I found the [service] too regimented, things like that. Like alcohol is the devil and all that kind of stuff. And it is not. My husband can drink and there is not a problem. My sisters can drink and there is not a problem. So alcohol is not the devil. Your choices in the end ruin your life. (P2)*

As research on participation in self-help groups has relied mainly on samples of men, despite the fact that large numbers of women participate in such groups (Moos, Moos & Timko 2006), very little information exists regarding outcomes for women with AUDs who engage with self-help groups. Mixed-gendered research found that sustained self-help meeting attendance was associated with better outcomes for the person with an AUD (Moos & Moos 2006; Witbrodt et al. 2007). The characteristics of people, such as those with high motivation for abstinence and enhanced social support, are also indicated in successful self-help group outcomes (Staines et al. 2003; Laudet, Morgen & White 2006).

Nevertheless, throughout all 15 interviews, only one participant in this study discussed that a self-help group had assisted her in her change processes. There are also critics of self-help groups, in particular Alcoholics Anonymous (AA), who have argued that AA is a cult that relies on the Christian God as the mechanism for change (Ferri, Amato & Davoli 2006). High dropout rates following initial engagement with AA have also been established (Kelly & Moos 2003, Tonigan, Bogenschutz & Miller 2006). LaFave, Desportes and McBride (2009, p. 52) posited that despite the recognition that women with AUDs differ from men in relation to their service needs from programs, the male-orientated directives given from AA are '*disempowering and thus not at all consistent with feminist theory*'.

Nevertheless, studies examining the efficacy of self-help groups such as AA are hard to come by, due to self-help organisations being indifferent to research, as well as the fact that group members' may be utilising multiple interventions for their AUDs (Vaillant 2005; Kelly, Magill & Stout 2009). It is an area that requires further research. A number of participants also spoke unfavourably of residential programs, in particular rehabilitation services. They felt as if they had been treated like a 'criminal', 'locked up', and 'punished' as they could not contact their children or other family members or take in certain personal effects (such as a hair dryer or phone charger).

They also spoke of deficient treatment by staff, the 'poor staff attitudes' and feeling 'victimised'. Admission to the programs mentioned by the women, which were all undertaken in privately-run, non-government facilities, also meant being admitted to a locked facility, where leaving through the front door also meant instant dismissal from the program.

*I find that at the other rehabs, they treat you like you are a criminal; it is like you are in jail, like you are doing something wrong. Where this place [service at time of interview] is for, they understand that you are sick and they treat you like a human being and don't lock you in here or lock you in there. (P3)*

As with self-help groups, research regarding the experiences of people, in particular women, in terms of their experiences of residential services is limited (Pulford, Adams & Sheridan 2011; Coulson et al. 2009). Minimal attention has been given to how program organisation may contribute to a person's subjective experience (Broome et al. 2007). When research is undertaken, there is difficulty trying to measure the success of rehabilitation programs, as program completion does not necessarily relate to the person's rehabilitative success, just as non-completion does not mean that the person has not changed her alcohol-related behaviours (Scalise, Berkel & Whitlock 2010).

With respect to retention in services, there is evidence that the person's expectations, whether positive or negative, regarding the planned service predicts their adherence to the structure of the program and their length of stay (Nock, Ferriter & Holmberg 2006; Tran & Bhar 2014). When the person with an AUD is more positive about their expectations of the service, they report greater and more durable benefits than those with more negative expectations (Greenberg, Constantino & Bruce 2006).

Negative past experiences with services therefore play a significant role in shaping future service engagement and expectations (Tran & Bhar 2014). As such, Cacciola, Dugosh and Camilleri (2009, p. 318) suggested that the history and experiences of a woman with an AUD of program engagement had 'prognostic value' and definitely warranted consideration when helping planning and structuring person-centred services.

Participating women in this research who expressed poor experiences of a self-help or residential program had not re-engaged with that same program at time of interview. A number of participants described that their poor experiences meant that they '*blocked*' or '*obstructed*' further attempts at service engagement. This contributed to their lack of motivation to change their alcohol-related behaviours and a delay in seeking help.

There is a growing consensus that motivation to change involves multiple constructs, such as intentions, beliefs, commitment, efficacy and self-regulation (Ajzen 2002; Miller 2006; Miller & Rollnick 2002). Therefore, if the person with an AUD has the belief that the type of program offered will not result in positive change, their motivation and efficacy to change will be negatively affected (Miller & Rollnick 2002).

Having positive expectations of the service before entering the program correlates to people with AUDs being much more ready to change their alcohol consumption behaviours, as well as leading to greater levels of self-efficacy and a determination to remain abstinent (DiClemente, Doyle & Donovan 2009). In regards to AUDs, self-efficacy refers to the 'belief in one's ability to resist alcohol in various high-risk situations, and robustly predicts substance use problems and treatment outcomes' (Oser et al. 2010, p. 367).

Participation in gender-responsive services empowers women with AUDs to be more autonomous and make more positive choices (LaFave, Desportes & McBride 2009). Service-related factors from past attempts at engagement therefore can be a barrier to change for the women with an AUD. On the other hand, if these factors are evaluated as favourable, they can be empowering for the woman in relation to her 'conceptualisation of her need for change' and her engagement with an appropriate service to help her succeed in her alcohol-related goals.

### ***In the dark***

The final element in the 'Overcoming Barriers' scene was entitled 'in the dark'. Women in this study spoke of '*not knowing*' what was '*out there*' in terms of services for help with their AUD. A lack of information about service options – 'their availability and likelihood of success', is a barrier to the woman with an AUD obtaining appropriate help (Green 2006, p. 58). That said, very few studies have explored whether women and men differ in their knowledge in these areas. People with AUDs often have to rely on 'word of mouth' communication from others who had accessed specialist services, as 'drug and alcohol services have poor visibility' (Berends & Lubman 2013, p. 340).

*I didn't know about certain things because people never, like the knowledge, how could I say, there was nothing out there to let you know about these services, only people that had been there. (P5)*

The discussion in Chapter Four, findings, highlighted how there is a lack of integration of alcohol-related care and screening in primary health care environments (Tsai et al. 2010; Nilsen 2010). Women with AUDs are more likely than men to seek help in non-alcohol specific settings (Greenfield et al. 2007), such as by consulting with their General Practitioner (GP). However, GPs who have concerns over alienating their patients or those who believe the patient lacks interest in discussing alcohol consumption have been found to avoid the subject or not address it adequately (Saitz et al. 2013; Nesvåg & Meland 2015).

This was particularly true if the patient was a woman, as AUDs experienced by women were found to be recognised significantly less frequently than men in primary health care environments (Vandermause 2007; Green 2006). Negative attitudes towards women with substance-use disorders such as AUDs may contribute to avoidance by health care providers in terms of screening and education (Goodman & Wolff 2013).

Also inherent in the literature was the fact that GPs and other primary healthcare providers may lack sufficient knowledge on alcohol-related conditions such as AUDs (D'Amico et al. 2005; Nilsen 2010). As such, participating women in this research spoke of their GPs '*not knowing*' or '*not having enough information*' about available services, or how to provide care to someone experiencing an AUD.

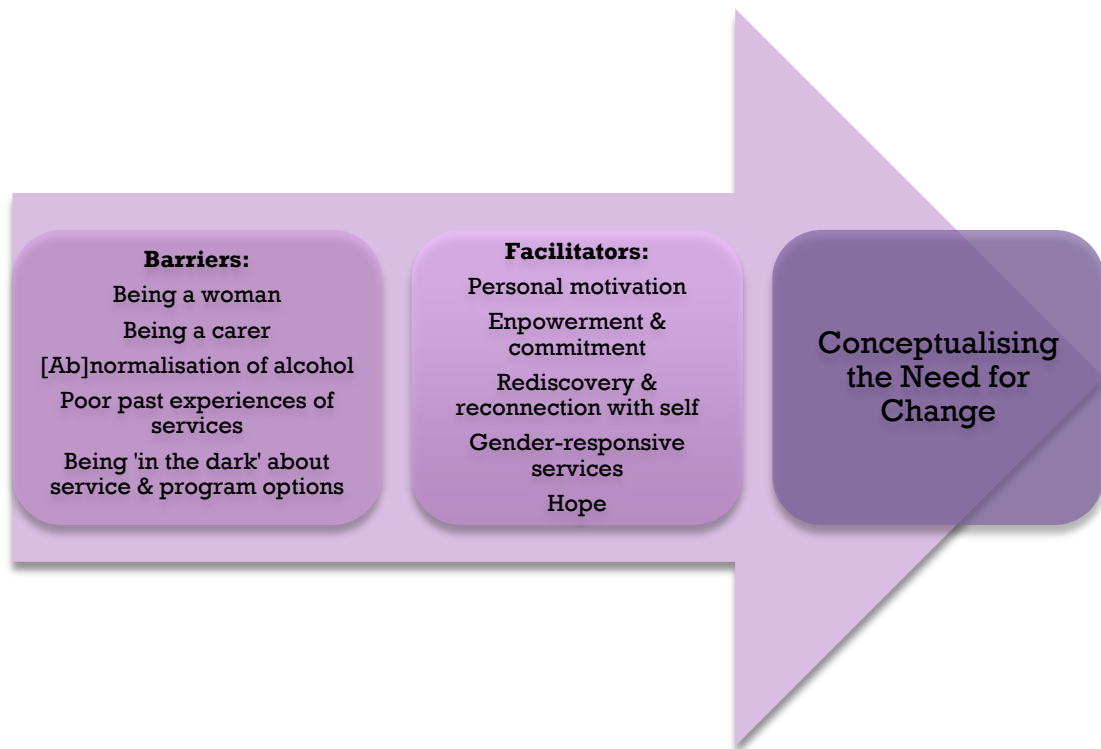
*Just not knowing about the services, now knowing. Even my doctor didn't have enough information; he said to me "you've just got to stop drinking". It wasn't until I went in to drug and alcohol and they contacted him and said "it's too dangerous for her to just stop, it's just too dangerous" and even he didn't know that. There's just not enough information out there. (P6)*

'If appropriate diagnostic, preventative, or therapeutic interactions take place in this [primary health care] setting, perhaps harmful consequences to women and society could be minimised or eliminated' (Vandermause & Wood 2009, p. 728). 'Consciousness-raising' with the help of health care providers, which refers to the level of awareness as to the origins, consequences and service possibilities for behaviours such as harmful alcohol consumption (Berre et al. 2012, p. 1547), assists people in their 'conceptualisation of their need for changing' their behaviours. However, consciousness-raising with the support of health care providers may not be enough to help the woman with an AUD achieve intentional behaviour change (DiClemente 2005). As an example, many people are made aware of the harms associated with tobacco use but are not deterred from smoking.

To help the woman with an AUD come 'out of the dark' in terms of 'conceptualising her need to change' her alcohol-related behaviours, not only does advice and education on the management of the disorder need to be given, but the woman's awareness of her personal motivations for change need to come to the fore (DiClemente 2005). Participating women in this study spoke of realisation of change as being when they '*came to terms*' with '*the dangers*' and '*damage*' resulting from their alcohol consumption was when they became '*motivated*' to '*get sober*' and engage with services. Although significant delays in help-seeking for some participants occurred because of the lack of information available on service options and management of their AUDs, when this information was ultimately communicated in a supportive and motivational way (thus helping them to 'conceptualise their need for change'), the women overcame this barrier.

Prevailing over their lack of awareness of appropriate service options was therefore significant to the women in this study, as was overcoming the barriers to being a woman, a carer, the normalisation of alcohol consumption in our society and the her poor past experiences of services. It became clear when actively listening to the story-telling from each of the participants that they had the innate drive to find meaning in their lives (Lavery 2003), when working to overcome these barriers and change their alcohol-related behaviours. The women overcame a range of barriers as they 'conceptualised their need for change' (Figure 11).





**Figure 11. Barriers and facilitators to change**

As I became immersed in their life-worlds, the struggle that the women went through on a daily basis to triumph over the barriers to change, were clearly evident. The participants' 'conceptualisation of their need for change' and the pathways to their decisions to engage with services were marred by their attributions of being an '*alcoholic woman*', an '*inadequate*' mother, partner or family member, as well as the negative gendered stereotypes as governed by society. However, having the '*strength*' to overcome these barriers was viewed by participants as '*empowering*' and '*life-changing*'.

In the face of the social and societal adversities that women with AUDs experience and have to overcome (Aston 2009), participants spoke of '*rediscovering*' or '*reconnecting*' with their identity. The path to and away from the harmful use of alcohol has often been described as a 'transformation or change in identity and developing a new sense of self' (Shinebourne & Smith 2009, p. 162). van Manen (1998, p. 23) reminds us that, 'we must constantly be reflectively engaged in how to live in contextually appropriate relations with the body...acknowledge the ultimately mysterious nature of our embodied being so that a possible inspired body relation may be brought into view'.

## **Scene: Sense of Enforcement**

When listening to the story-telling by the women, those who had felt '*forced*' into their decisions to engage with services found it difficult to 'conceptualise their need for change' and thus transform their lives. It is thought that pressure to engage with services and reduce or cease alcohol consumption is not positively associated with alcohol-related behaviour change in the person with an AUD (Matzger, Kaskutas & Weisner 2005; Weisner et al. 2003; DiClemente 2005). Participants felt this '*sense of enforcement*' from family members and from society.

### ***From family members***

Feeling '*forced*', '*pressured*', '*hassled*' and '*coerced*' from family members to cease alcohol consumption and engage with services was a common thread in the participants story-telling. All but one of the participating women had undertaken multiple attempts at changing her alcohol-related behaviours with the help of services. When they spoke of their change attempt histories, the women mentioned how feeling this pressure from family '*did not work*', as they were '*unmotivated*' at that time, to change. With this, participants revealed how they had '*learned*' from their previous attempts when they had felt pressured, how this had made them '*stronger*' and '*more determined*' to change.

*Every other admission had been like I have been forced into it. Whereas this time it was totally my decision. I'm not saying the others were a waste of time, but I wasn't committed. I'm 100% now. (P12)*

*I realise now my life was unmanageable. I had friends and family who were supporting me to go rehab, telling me I had a problem, but it just didn't click the first time, or the second or third. Took a while. (P4)*

Motivation and readiness for change are crucial concepts that represent complex, dynamic elements that extend throughout the process of modifying alcohol consumption behaviours (Miller 2006). Motivation is considered 'crucial to the therapeutic process' (Wolfe et al. 2013, p. 2188); yet numerous attempts to change may be required before the person makes the shift from contemplating change to successfully actioning it (Prochaska, DiClemente & Norcross 1992). It has been suggested that motivated people with substance-use disorders have significantly better outcomes post service engagement than those not motivated to engage (Longshore & Teruya 2006).

Motivation to change is thereby thought to be an integral part of initial service engagement, retention in services, positive alcohol use outcomes and long-term maintenance of therapeutic gains, such as abstinence from alcohol (Cahill et al. 2003; Klag, O'Callaghan & Creed 2005). A person's recognition of the consequences of their harmful alcohol consumption can influence their motivation and degree of readiness to change their behaviours (DiClemente 2005).

As with anything that involves change, people who are resistant to change do not like being told what to do, as they may have fears or insecurities about the possibility of changing their behaviours (Stoddard Dare & Derigne 2010). Due to the fact that services are intended for those with high internal motivation, those who are highly motivated at the initial time of engagement often have better outcomes (Pollini et al. 2006). Therefore, if the woman with an alcohol-use disorder is 'unmotivated' to engage or only engaging with services because she feels 'forced' into this by her family or friends, she will likely have reduced levels of commitment to the program and changing her alcohol-related behaviours (Wolfe et al. 2013).

Conversely, there were two participants in this research who thought that the coercion they felt from family members was beneficial to their change processes, as this helped them to realise that they had a 'problem' and 'needed help'. Orford et al. (2006, p. 174) discussed how '...words such as 'coercion' or 'pressure' do not do justice to the complexity of family influence'. This influence can lead to awareness in the person with an AUD as to the damaging effects their drinking is having on their family and their relationships. The person may be then more motivated to engage with services, as highlighted by Participant 13:

*He [partner] brought it to my attention and he is not one to say stuff and I thought, well if [partner's name] is saying that there is something really wrong. I took that on board and thought, yes I do need help and, with the kids going, I do need help and so I sought help.*  
(P13)

Motivation and coercion to change is a complex phenomenon, as coercion may, for some, play a role in motivating the person to engage with services and achieve successful change outcomes and, for others, it may be a barrier to engagement and program adherence (Wolfe et al. 2013; Klag, O'Callaghan & Creed 2005). There is no single common change trajectory representative of the personal varied journeys through which people progress as they move into and out of episodes of substance use (DiClemente 2007).

## ***From society***

Participants in this research also discussed the pressures to engage with services they felt from members of professional networks, such as from their employers, medical practitioners and staff at welfare support programs. They felt '*pressured*', '*pushed*' and '*forced*' to engage with services, as their harmful consumption of alcohol meant they were perceived as '*difficult*' and '*too complicated*' by others in society.

In literature, which examines substance-use disorders and behavioural change, social pressures have been identified as an external force which is a significant contributor to help-seeking and service engagement (Polcin & Beattie 2007; Polcin, Galloway & Greenfield 2006; Wild, Cunningham & Ryan 2006). Social pressures for the person with a substance-use disorder are defined as 'confrontation from members of one's social environment regarding the negative aspects of one's substance use and the need for treatment' (Goodman, Peterson-Badali & Henderson 2011, p. 661).

*My doctor scared the life out of me, more or less said, it's this or - you go one way, keep drinking and you're going to die. He really put the pressure on. I had no idea I could die before this. He picked up the phone and handed it to me so I could talk to [service name]. I was in shock; I wasn't ready for this. (P11)*

Along with participating women who felt pressure from family to engage with services, participants who experienced societal pressures eventually came to the realisation that they needed to '*do this for themselves*'. They did this to be '*accepted*' and '*acknowledged*' by society in a non-judgemental way, and not be defined by their harmful alcohol consumption and experience of an alcohol-use disorder.

As such, therapeutic modalities 'must look beyond the goal of simply getting the individual sober and instead focus on the development of self-efficacy, self-determination, shame reduction and an improved dialogical self' (Gubi & Marsden-Hughes 2013, p. 208). Feeling a sense of enforcement from family and society for participating women was therefore multifaceted in terms of their 'conceptualisation of the need for change' – for some it helped, but for many it hindered.

Experiencing an alcohol-use disorder was a subjective, life-changing experience for participants, grasped as meaningful in terms of their being-in-the-world, their identity, feeling 'normal', their sense of belonging, their escape from reality or pain (Laudet, Morgen & White 2006). All participants reported reaching a 'turning point' (Best et al. 2011, p. 295) in their alcohol-related being, one which triggered a decision to change and seek help. Conceptualising the need for changing from this alcohol-dependant world was driven by the complex interactions of many factors involving family, the environment and society, and, as such, the experience was diverse for each of the participants (Figure 12).

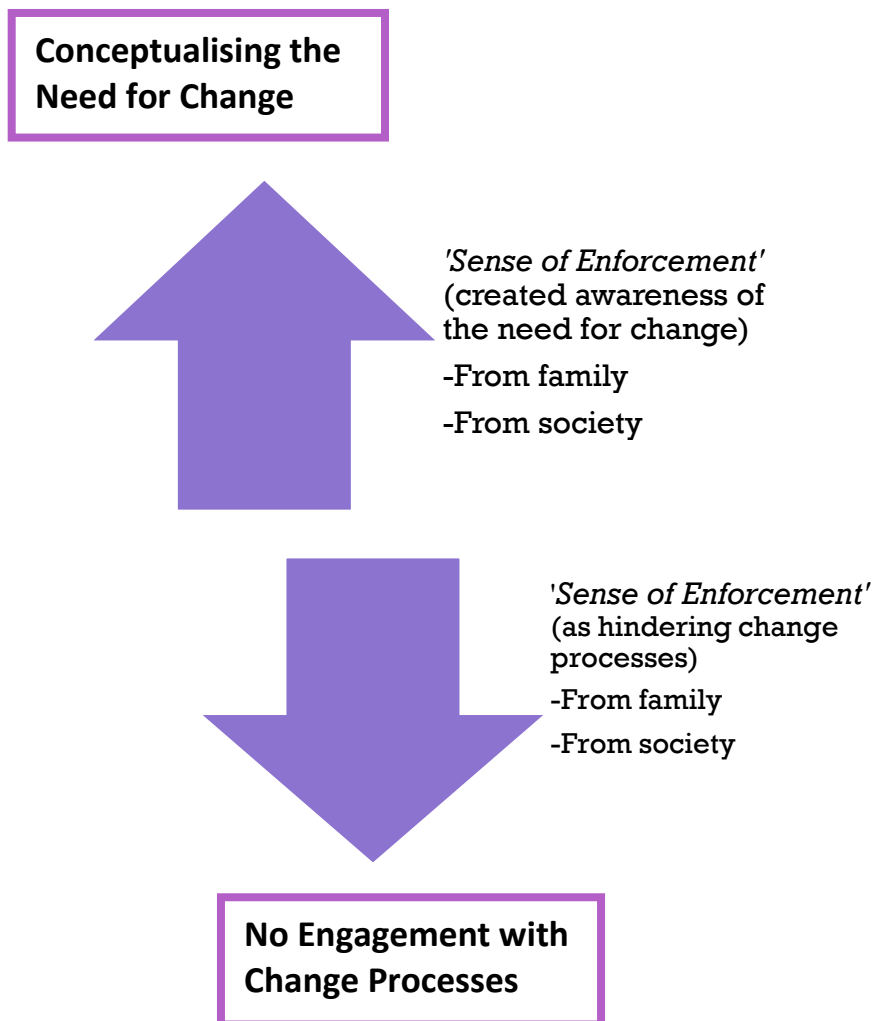


Figure 12. 'Sense of Enforcement' depiction

## Scene: *Rock Bottom*

For participants, 'conceptualising the need for changing' their alcohol-related behaviours by making the decisions to engage with services meant that they had to first hit their 'Rock Bottom'. Traditional views of why people changed their alcohol-related behaviours were centred on the fact that people had to reach the lowest point in their lives before they could become 'motivated' to change (DiClemente, Doyle & Donovan 2009, p, 879).

As per the Alcoholics Anonymous (1976) paradigm, a person must 'hit bottom' before being able to acknowledge the existence of their addiction. While distinctive to the particularities of their own life situations, throughout the women's storytelling there were experiences of hitting 'rock bottom'. They described this 'Rock Bottom' as being due to the elements of the 'trauma' they had lived through, as well as their experiences of 'isolation'.

### ***Trauma***

Participating women spoke of the significant traumatic experiences that had occurred throughout their life-courses. Chapter Two, which includes a section specific to women's development of AUDs, explained this, as it was established that consuming excessive alcohol is a way for women to escape the memories, or current experiences, of trauma, violence and adverse events (Gutierrez & Puymbroeck 2006; Min, Tracy & Park 2014; Salter & Breckenridge 2014).

For the women in this study, these experiences included: childhood sexual and physical assault, childhood neglect, intimate partner violence, adult victimisation and sexual assault and the deaths of loved ones. The women spoke of how their traumatic experiences had resulted in them reaching the '*lowest of the low*' point in their lives and how consuming alcohol helped them '*forget*'.

*I was sexually abused as a child and raped at the age of eighteen, so my alcoholism.... I did not start drinking until I was 17 and then partly it just became fun, then it became boredom, then it became burying the trauma. (P14)*

*There was so much family violence growing up, dad would hit mum when he was drunk, mum would hit dad when she was drunk. I started drinking to cope and then never really stopped. My partner then started hitting me...just a cycle really. I was so low. (P9)*

A U.S. study by Sacks, McKendrick and Banks (2008), which examined the impact of childhood abuse on the functioning and 12-month outcomes of 146 women with substance-use disorders (including AUDs), found that 69 percent of participants reported some form of childhood abuse and 89 percent reported being abused during their lifetime. Similarly, twelve women in this study discussed their experiences of childhood sexual abuse, while all 15 women had been victims of some form of assault or violent act in their lifetimes.

Compared to their peers who were not abused, women who reported childhood abuse also described a more disrupted family background, under-education, unemployment and problems with psychosocial functioning (Sacks, McKendrick & Banks 2008). Gutierres and Puymbroeck (2006, p. 503), in their international literature review on studies examining childhood and adult violence experienced by women with substance-use disorders, proposed that two possible paths emerge that 'lead women who have experienced abuse to later substance misuse'. The first direct path is that women who have gone through, or who are going through, traumatic experiences and sexual abuse are at increased risk of substance-use disorders.

The second, more indirect, path is that sexual abuse may lead to the woman experiencing low self-esteem, fear, anxiety, guilt, depression, as well as feelings of hopelessness and vulnerability, which, in turn, instigates the development of a substance-use disorder (Gutierres & Puymbroeck 2006). The consumption of alcohol may then be used to 'self-medicate' so as to avoid the experience of trauma-related symptoms, or to lessen the impact of the violent episodes and abuse (Wu et al. 2010).

When discussing the trauma they had experienced, their 'Rock Bottom' centred on reaching the '*low point*' in their lives where the memories or experiences of the trauma or traumas, and their alcohol consumption to alleviate these experiences, was at its all-time worst. It has also been suggested that trauma and abuse rarely occur as isolated incidents, but can be components of a pattern of recurrent traumatic life experiences that begin in childhood (Sacks, McKendrick & Banks 2006; Guardia et al. 2013; Potthast, Neuner & Catani 2014).

Childhood sexual abuse has been associated with emotional symptoms and re-victimisation in adulthood (Lake et al. 2015). Participating women in this study also spoke of the frequent, abusive and violent episodes that had occurred throughout their lives, as highlighted by participant 3:

*I've had a lot of domestic violence... just not being able to cope. I just go from one bad relationship to another. My life started shit, childhood abuse and all that, and then the abuse just continued and continued. (P3)*

Many participants described how they were victims of intimate partner violence from their male partners. The women spoke of being 'bashed', 'abused', 'slapped' and 'attacked' by their past or current partners, particularly when they were both under the influence of alcohol. The women referred to this as 'domestic violence' or 'alcohol-related violence'.

A considerable number of women survivors of intimate partner violence have substance-use disorders, including AUDs (Bennett & O'Brien 2007; Roche et al. 2007). There is though a significant knowledge gap that exists as to the exact relationship between women's substance use and victimisation (Fowler 2007; Macy et al. 2009). Research indicates that intimate partner violence victimisation increases the likelihood of excessive alcohol consumption (Abramsky et al. 2011; Hill et al. 2009), while other studies have found that the harmful consumption of alcohol by women increases her risk of becoming the victim of such violence (Walitzer & Dearing 2006; Devries et al. 2014).

Whichever the way this relationship occurred, the lives of the women in this study were cycling between their harmful consumption of alcohol and periods of sometimes-lengthy victimisation. The participants discussed the violence they had experienced in terms of the 'struggle' they had to go through to overcome this 'Rock Bottom' period to 'find the strength' to make the decisions to engage with services. 'The view that 'hitting bottom' is the key motivation for change seems consistent with how consequences and dependence symptoms influence readiness' (DiClemente, Doyle & Donovan 2009, p. 888).

*I feel like, this will sound funny, I feel like I have grown up. It is like I am over it. Yep, like I am over it. Over the struggle, over the excuses to drink, over having to re-live the abuse time and time again. Yeah, I hit rock bottom, but now I'm on my way back. (P10)*

*I needed to claw my way back up from the bottom. I found it's much easier to go down than to get back up! I couldn't get any lower, so thought the only way was up from here, I had to get my act together and stop drinking. I needed help and I got it. (P2)*



Women who engage with services for their AUD, compared to men, tend to experience greater psychological distress from exposure to past and current violence and trauma (Hankin, Kassel & Abela 2005; Cohen & Hien 2014). Thus, it is important for services to assist the women to cope with the trauma-related symptoms and to develop effective supports (Tracy et al. 2012). 'There is increasing recognition that trauma-informed care should be part of all substance abuse treatment programs...' (Capezza & Najavits 2012, p. 63).

However, by the time a woman with an AUD engages with a service, their needs will likely go far beyond what is offered by the usual service approaches, which are, as mentioned above, typically based on a 'male model of substance misuse' (Gutierrez & Puybroeck 2006, p. 506). Trauma histories also make certain service approaches or mixed-gendered programs less desirable for women (Greenfield et al. 2010), thereby creating additional barriers to the possibility of change.

### ***Isolation***

Familial and societal ostracism is also experienced by women with AUDs (LaFave, Desportes & McBride 2009; Greenfield et al. 2007), which was another factor in the journey to 'Rock Bottom' for participants. Participating women spoke of the fact that their family members, friends and colleagues had ceased contact with them because of their excessive alcohol consumption and the symptoms related to their AUD.

Negative interpersonal relations are also associated with the ostracised person's psychological difficulties and poor physical health (Smart Richman & Leary 2009), which were factors in the women reaching their 'Rock Bottom'. Other participants spoke of difficulties forming relationships because of the years of abuse they had experienced. Participants who shared their stories in this research spoke of '*being excluded*' and feeling '*abandoned*' by their family and society.

*I was isolated and the drink came before anything. Anything at all. Nobody would talk to me, I was a leper. My family didn't talk to me for over five bloody years. (P9)*

*I was alone, nobody wanted to know me. I was a drunk. I had nothing. There's only one way you can go when you have nothing. I suppose you could choose not to go on, which I thought about, after all the shit I went through when I was young – the abuse, you know. But then I decided I'd show everyone who abandoned me that I could get better. And I am, no thanks to them. (P3)*

Experiences of trauma, in particular childhood physical and sexual abuse, affects the woman's development processes and connections, and results in disruption in family attachments, as well as places the woman at high risk of developing a substance-use disorder (Cadiz et al. 2005). Social isolation and reduced closeness with family members can be a consequence of compromised attachment related to previous abuse by close network members (Pearlman & Courtois 2005).

Trauma in childhood and adulthood also pose challenges and complications to the development of personal networks for women with AUDs (Min, Tracy & Park 2014). Women with AUDs and other substance-use disorders who have experienced significant traumas find it difficult to form healthy and secure relationships with others, leading to isolation and loneliness (Min et al. 2013). It was also suggested that peer victimisation – physical and verbal bullying, as well as relational bullying (one damaging another's friendship or relationship), was part of the lives of women with alcohol-use disorders (Topper & Conrod 2011; Crothers et al. 2012).

The stigma and social disapproval directed towards women with alcohol-use disorders can also lead to their experiences of societal isolation and ostracism (Kandell 2010). 'A stigmatised identity has been characterised as 'socially devalued' and is often associated with negative stereotypes and beliefs' (Talley & Littlefield 2014, p. 569). The gendered societal contradictions around excessive alcohol consumption by women (Hutton, Wright & Saunders 2013), contributes to the marginalisation of women with AUDs. As well, their feelings of shame and the self-stigma they experience lead to women with AUDs isolating themselves from their families and society (Rolfe, Orford & Dalton 2009).

Because of the poor treatment they received from their families and communities, women in this study spoke of feeling '*like scum*', '*the lowest person*', as they were '*rejected by society*'. However, reaching 'Rock Bottom' because of the barriers of stigma and familial ostracism for some participants triggered their 'conceptualisation of their need for change' and to engage with services. Problematic life events such as these have been shown to promote thoughts of help-seeking and service engagement in those with AUDs (Orford et al. 2008).

Hitting 'Rock Bottom' was conceptualised by participants as having diverse origins, although the experiences they spoke of in terms of feeling abused, secluded and abandoned by family and society held many similarities.

*I was fairly low at that point. I guess there was a great fear that the relationship I was in at the time, which at the time meant the world to me. I saw that I was going to lose that, and for me that was a pretty big turning point. I had already lost the respect of the rest of my family; I was kicked out of the family, an alcoholic, a nobody. That was a really hard point for me to get to. I then was at that point where, 'OK, there need to be more'. (P8)*

As found in Matzger, Kaskutas and Weisner's (2005, p. 1637) analysis on 'reasons for drinking less', in a sample of 659 people (239 who had not engaged with services and 420 who had), logistic regression analysis predicting sustained remission from harmful alcohol consumption showed the odds of remitting from alcohol were highest in those who identified as 'hitting rock bottom'. Concurrently, Field et al. (2007, p. 77) posited that 'patients [people with substance-use disorders] are more likely to seek treatment and take steps toward lasting change if they have experienced significant negative consequences or emotional distress as a result of their substance use'.

For women in this study, reaching 'Rock Bottom' was when new possibilities came to light that focussed their attentions on seeking help – their 'conceptualisation of their need for change' was directly influenced by their experiences of '*losing everything*'. All the women who spoke of their 'Rock Bottom' made the conscious choice to '*fight back*', and acknowledged that this choice would require instituting change at a deep level in their lives (Figure 13).

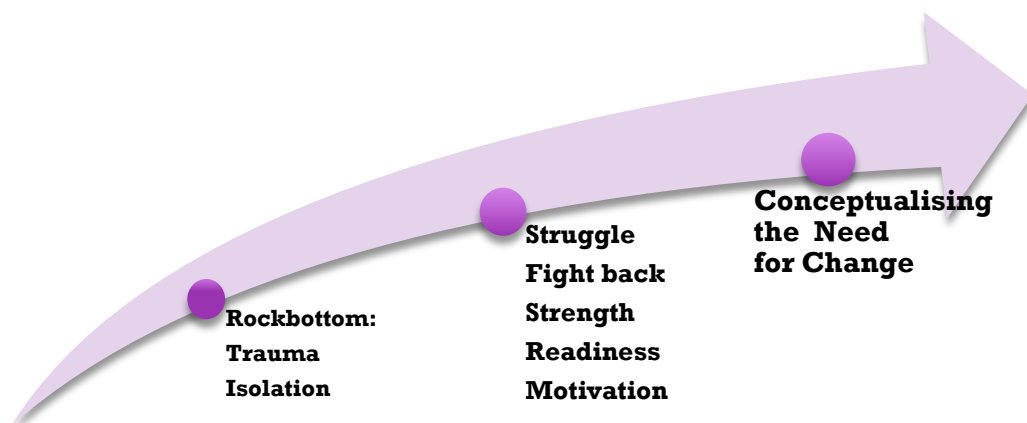


Figure 13. The 'Rock Bottom' scene

## Essesence of Meaning: 'Conceptualising the Need for Change'

*'Epiphany' by S.P. Fulkerson*

*I'm finding that the light  
is more mysterious  
than the dark  
that though I'd always found  
comfort in the shadows  
there really wasn't  
all that much  
to see  
that blind groping  
was sufficient  
to find the bottle  
and let loose  
the spirits  
of desolation and madness  
so they may  
feast on my fears  
and twist  
my liver dry  
set fire to my belly  
and dance my bones  
to splinters  
and ash*

*But then there was light  
and the phoenix emerged  
and the demons slunk back  
and the light  
healed all  
that was rent  
and sundered  
and I saw the world  
once again  
but with new eyes, wide eyes  
eyes with a light  
of their own  
and the will  
to see*

(allpoetry.com)

The poem on the previous page by Fulkerson highlights that, although difficult, change is possible when the person with an alcohol-use disorder finds the courage to fight back. Cunningham (2007, p. 74) paraphrases Descartes when he says that to 'create is to be' which, in the most basic sense, entails having the courage to be ourselves and create ourselves as we project into the future. The women in this study demonstrated immense courage time and time again as they deconstructed their views of themselves as 'addicts', 'alcoholics' and 'victims' and conceptualised instead their 'rights' to change and thus created a new reality of what it is to 'be'. I felt an immense privilege to witness this as they spoke to me.

McIntosh and McKeganey (2001, p. 1503) suggest that 'the key to the recovery process lies in the individual coming to an understanding that her damaged sense of self has to be restored together with an awakening of the individual's old identity and/or the establishment of a new one'. The concept of change and making the decision to engage with services therefore went beyond just ceasing alcohol - it sent its tentacles into all components of the women's lives, where her relationships with herself and society were redefined, and her life experiences were validated and recognised (DiClemente 2005). There was a common set of key scenes from the women's story-telling that helped them 'conceptualise their need for change' and thus create their new identity (Figure 14).

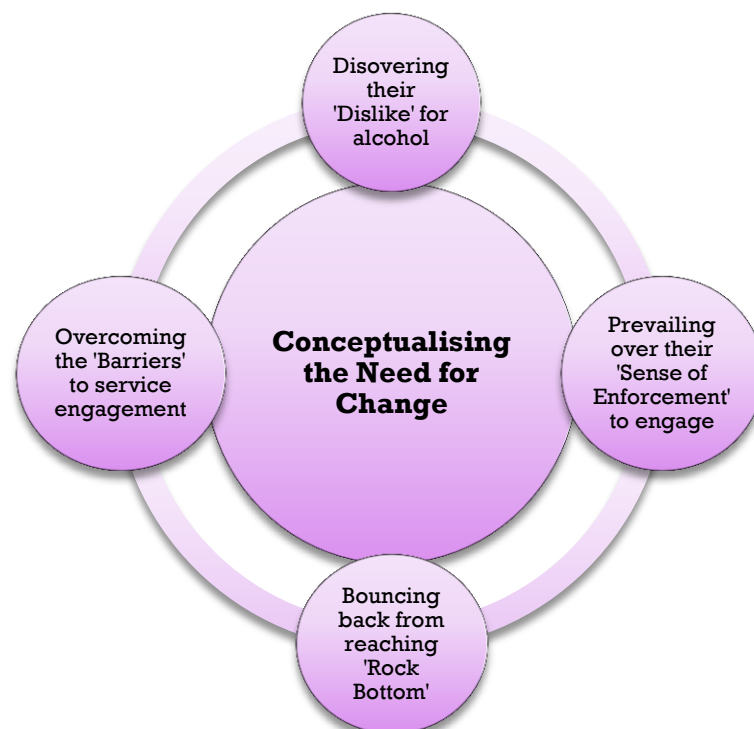


Figure 14. Scenes that resulted in the 'Conceptualisation of the Need for Change'

Behaviour is a direct consequence between what we believe and how we feel – if we want to change behaviours, it is necessary to ‘change the underlying beliefs and feelings related to that behaviour’ (Bundy 2004, p. 43). Miller and Rollnick (2002) contend that most people who seek help already perceive a discrepancy between motivations to change; yet they are ambivalent, caught in an approach-avoidance conflict. This ambivalence was captured in each participant’s story-telling, in her knowledge that her consumption of alcohol was damaging to both herself and others, but ceasing this would lay bare her pain, her trauma, the damage in her life.

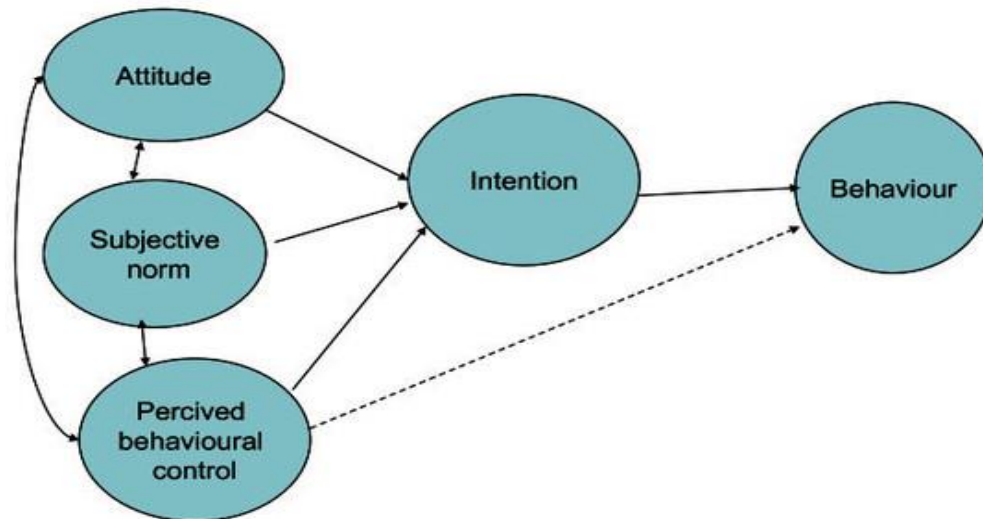
### **Health behaviour change theory**

The women’s story-telling revealed that the ‘conceptualisation of the need for change’ was directly related to each woman’s motivation to change her alcohol-related behaviours and engage with services. The ‘motivation’ to change behaviour is a key component to a number of health behaviour change theories. These theories can be divided into two main groups: continuum models and stage-based models (Weinstein, Rothman & Sutton 1998).

Continuum models attempt to identify predictors for behaviour or behaviour change, such as the individual’s intentions or attitudes (Lippke & Ziegelmann 2008). These variables place the individual along a continuum of behaviour likelihood, which is dependent upon the level of variables considered. If one or more of these determinants are strengthened, the likelihood of behaviour change is also increased (Lippke & Ziegelmann 2008). Interventions designed to promote health behaviour change, based on a continuum model, focus on increasing all the associated variables in all individuals (Sutton 2008).

One such continuum model is the Theory of Planned Behaviour Change (TPB) (Ajzen 1991). TPB postulates that human behaviour is predicted through cognitive self-regulation, rather than an individual’s disposition, such as their general social attitudes or personality traits. The TPB proposes that an individual’s decision to perform a behaviour is directed by their beliefs about the outcomes and evaluations of the behaviours (behavioural beliefs or attitude) and their beliefs about the normative expectations of others and their motivation to comply with those beliefs (normative beliefs).

An individual's belief about the presence of factors that facilitate or discourage performance of the behaviour and the perceived power of these factors (their perceived behavioural control) also forms part of this theory (Ajzen 2002). These three independent variables are thought to mediate the prediction of behavioural intentions (Figure 15).



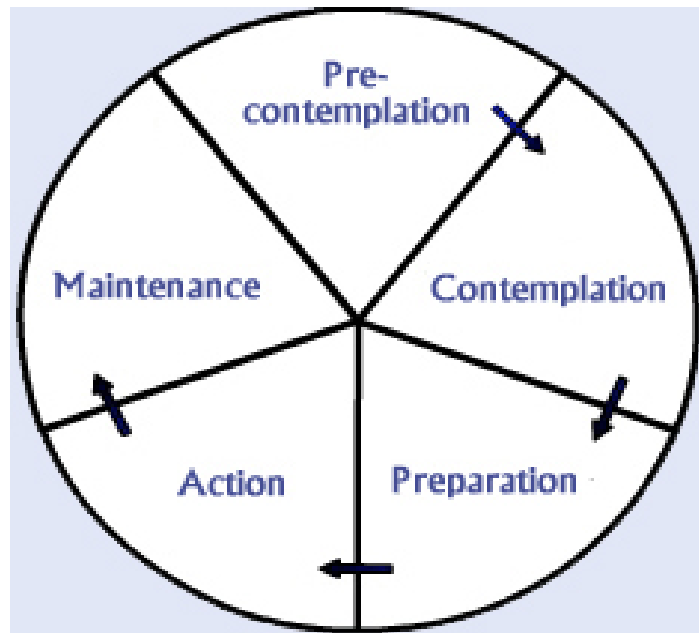
**Figure 15. Theory of Planned Behaviour, adapted from Ajzen (1991)**

Conversely, stage-based models of health behaviour change, presuppose that behaviour change takes place in several distinct stages. Specific social-cognitive variables are more important than others, and are dependent upon the stage of change the person belongs to (Weinstein & Rothman 2005). Treatments or interventions are matched to the stage-specific needs of the individual (Weinstein, Rothman & Sutton 1998).

The idea that individuals pass through an ordered set of different stages on their way to adopting new health behaviours is a theme of many change processes (Brug et al. 2005). It is also highly attractive for practical applications, as specific, targeted intervention components for individuals in different stages are suggested to be more effective than the 'one size fits all' measures akin to the continuum models (Prochaska et al. 2004).

One stage-based model that has been used in the substance use intervention fields is the Transtheoretical Model of Intentional Behaviour Change, which was first developed by Prochaska and DiClemente (1982). The Transtheoretical Model or TTM incorporates elements of various theories of therapy, learning and behaviour change (DiClemente 2007).

The TTM consists of four constructs: stages of change, processes of change, decisional balance and temptation (Prochaska & DiClemente 1982). The stage dimension (stages of change) is central to this model. The stages of change are temporal, motivational aspects of an individual's behaviour change (Prochaska & DiClemente 1982). Change is viewed as a progression, a circular process, through the five stages. The stages are: precontemplation, contemplation, preparation, action and maintenance (Figure 16).



**Figure 16. Stages of Change, adapted from Prochaska & DiClemente (1984)**

Prochaska and DiClemente (1984) describe that individuals in the pre-contemplation stage often deny or minimise they have a problematic health behaviour and are not yet ready to make changes in their lives. Those in the contemplation stage recognise that they have a problem and are willing to make changes but are not totally committed to doing so.

Individuals in the preparation stage begin to prepare by committing to make change and set up the necessary steps to move forward. Those in the action stage make overt behavioural changes. Lastly, the maintenance stage is reserved for those who have made the appropriate changes and are attempting to manage those new behaviours. Individuals are described as differing along two dimensions in each of these five stages, behaviourally and attitudinally (Prochaska & DiClemente 1984).



Motivation is viewed as an important component throughout the entire process of change. Prochaska and DiClemente (1984) caution that although no behavioural changes occur between the pre-contemplation and contemplation stages, awareness develops as to the individual's personal problems, which can leave the individual at risk of developing low self-esteem and feelings associated with a loss of control over their lives. They realise that they have to give up the thing that they deem most important and may fear that they cannot overcome their problematic behaviour and thus lose hope.

As a consequence, individuals in the early stages of change may have increased levels of defensiveness and a distinct lack of self-efficacy, may take action just to please others and rarely demonstrate true commitment to making change (Prochaska & DiClemente 1984). Adapted from Bandura's (1997) work, the notion of self-efficacy in this model represents an individual's confidence in performing the behaviour change (DiClemente 2003). Correspondingly, the histories of suffering as experienced by the women in this study meant that purposeful behaviour change and movement from the pre-contemplation to contemplation and preparation stages was hard to achieve.

The efforts to change – to cease consuming alcohol and engage with services, required the women to forgo her established coping strategies, which were centred on consuming alcohol, whilst simultaneously adopting new strategies (LaFave, Desportes & McBride 2009). For participating women, engagement with services and the change in their alcohol-related behaviours entailed a purposeful re-engagement with the world after many years of isolation, self-depreciation and marginalisation.

Prochaska and DiClemente (1984) posit that concern, interest and vision are thought to help move individuals from contemplation to preparation, but only if the costs do not outweigh the benefits. For the women in this study, the stigma of experiencing an AUD and needing help was often an oft-cited reason for not contacting services sooner. The experience of stigma and shame outweighed the potential benefits of becoming alcohol free. It was only when they found the strength to overcome this and other barriers did the women decide to take action and contact services. Finding meaning in the struggle between the costs and the benefits of change in itself produced motivation and maintenance.

The previous discussion has elucidated that the participants' 'conceptualisation of their need for change' and their decisions to contact services did not occur in isolation. Instead, their personal transformations were greatly influenced by their situational world, their social and professional networks and their home environments (DiClemente, Doyle & Donovan 2009). These environments themselves also created barriers and facilitators to each woman 'conceptualising her need for change'. As discussed, this conceptualisation was often related to the negative life events that the women had lived through. The strategy of shifting perspectives when examining self and others enabled the women to think critically about their own sense of identity and how they wanted to change their alcohol-related behaviours.

Motivations alluded to in their story-telling for service engagement was inferred to be complex phenomena influenced by their social context, as well as by the gendered conceptions, norms and social sanctions regarding the consumption of alcohol by women (Nolen-Hoeksema & Hilt 2006). For each woman, it was revealed that 'conceptualising her need for change' was directly related to her personal motivation to change (DiClemente 2003). This was shown to be vitally important in terms of her reasons for service engagement. Each woman reached a 'critical juncture or turning point of readiness' (Aston 2009, p. 623), which helped motivate her to change her alcohol related behaviours and engage with services.

The women's perspectives regarding the successful and not-so-successful elements of their change attempts, what helped and what hindered, have the potential to influence thinking about self-efficacy and other cognitive processes critical to change processes (Begun, Berger & Salm Ward 2011). Health professionals are in a position to help the woman with an AUD achieve her transformative change. To do this 'health professionals should realise that the context complements and complicates change...' (DiClemente 2005, p, 10). It was identified by the women in this study, as well suggested in the literature, that services for AUDs do not always recognise peoples' individual needs, in particular the needs of women and mothers with complex relational histories and trauma (Salter & Breckenridge 2014; Capezza & Najavits, 2012).

According to van Manen (1998, p. 23), when looking at the illness-to-health continuum, health care professionals should be involved in helping people who are 'out of step with the body' to recover a 'liveable relation' with her 'psycho-physical being'. The health professional can bring about 'reflective awareness of what modalities of body experience are disturbed and what may be done to develop meaningful, worthwhile and liveable relations between the lived body, between the embodied being and the world' (van Manen 1998, pp. 23-24).

To help create this awareness, it is important for the health professional to work with the woman to uncover the essence of *meaning* behind her decision to change, the intrinsic qualities that brought her to this stage in her lifeworld. Helping her to draw on her already present strengths, those that enabled her to survive her traumatic life, and which facilitated her conceptualising her need for service engagement would appear to lay a logical and meaningful foundation to her successful change.

### **Chapter summary**

This chapter built on the findings of this study by providing an in-depth exploration of the main scenes and elements that evolved from the women's story-telling. It described in detail the inter relationships between concepts and how 'conceptualising the need for change', as identified in this study, speaks to the theories within the literature regarding behaviour change.

The next chapter, Chapter Six, will provide a conclusion summarising these findings, as well as outline the recommendations for future studies and programs which provide services for women with alcohol-use disorders. Chapter Six will also provide the limitations to this study and deliver a final reflection.

## CHAPTER SIX

### **Conclusion, Implications and Future Directions**

The aim of this phenomenological study was to explore the meaning that women who live with alcohol-use disorders (AUDs) attributed to their decision to engage with services. The use of van Manen's (1997) methodological approach provided a structure and a guide to the phenomenological enquiry into the lifeworlds of the women participants. The research study was designed in a way so as to answer the question: *'what does it 'mean' for a woman with an alcohol-use disorder to engage with services?'*

This PhD study was undertaken for a number of reasons, the not least of which was with the intention of providing a voice to women with alcohol-use disorders. This is because their lived experiences and insights, with very few exceptions, have not been adequately explored in the literature, nor are they the focus of clinical practices. This silence is despite the fact that 'gaining a better understanding of the mechanisms involved in individuals recognising their alcohol-use disorders and deciding to change, is a high priority' (Oser et al. 2010, p. 367).

The background to this study, elucidated in Chapter Two, was discussed within the context of existing literature. A detailed overview as to the research methods was provided in Chapter Three. By exploring the story-telling of participants, new insights into the women-centric meaning behind decisions to engage with services was presented in the findings chapter (Chapter Four).

In Chapter Five, the discussion chapter, the scenes and elements to this story-telling were further explored, incorporating the perspectives of existing literature and linking the essence of meaning, 'conceptualising the need for change' to existing behaviour change theories. Thus, 'conceptualising the need for change' became nested within an established philosophical and conceptual framework.

This final Chapter (Six) concludes the thesis and provides a summary on how this research contributes to new knowledge. Also provided is a section on implications and future directions, highlighting the implications for women with AUDs, as established in the background chapter (Chapter Two) and in the findings of this research (Chapter Four). The titles of the scenes and elements that evolved from the women's story-telling are provided in quotation marks to explicate the link to the implications. Also provided are the implications related to service delivery and policy development. Further, a description of study limitations and a final reflection complete the chapter.

### **Summary**

My time with the women participants was deeply moving and extremely enriching. I have attempted to 'transform lived experience into textual expression of its essence' (van Manen 1997, p. 36), so that the reader will gain understanding and appreciation of each woman's journey to reach her decision to engage with services, as well as the transformative change that the women in this study assumed.

With this, however, it is important to heed van Manen's (2007, p. 16) words when he states: 'the richness and depth of lived experience can never be fully appreciated, because it is situated within the totality of life rather than a de-contextualised, isolated experience'. Nevertheless, the aim of the researcher and writer of phenomenology is to reveal human meaning and bring the phenomenon to light (Sokolowski 2000). van Manen (1997, p. 70) asserted that story-telling enables us to experience life situations and events 'that we would not normally experience'.

The women in this study spoke of their experiences as they so generously exposed them. As the women reflected on their lifeworlds, they pondered, discovered and verbalised how each part affected their whole experience of living with an alcohol-use disorder. They contemplated this in terms of their decisions for contacting and engaging with services. As such, I adopted the same techniques of looking at how the sum of the experience informed the whole for the women in this study, and reflectively how the whole informed each woman's individual aspects of the experience (Omery 1983).

By becoming deeply immersed in each woman's lifeworld, the phenomenological process enabled me to seek out and reflect on 'the essential themes which characterise the phenomenon' for each woman (van Manen 1997, p. 30). Subsequently, this absorbing process led me to recognise the fundamental unifying themes related to each woman's decision/s to engage with services.

Thus, within the women's story-telling, an exploration of the essential, unified scenes were uncovered and portrayed. They were found to centre on the women discovering their 'Dislike for Alcohol'; 'Overcoming Barriers' to service engagement; prevailing over a 'Sense of Enforcement' to engage with services; and bouncing back from reaching 'Rock Bottom'.

According to van Manen (1997, p. 97), 'phenomenology attempts to systematically develop a certain narrative that explicates themes while remaining true to the universal quality or essence of a certain type of experience'. Deeply embedded within the scenes in the women's story-telling was the essence of their experiences – the meaning that each woman ascribed to her decision to engage with services. This essence was found to be the woman arriving at her '*conceptualisation of the need for change*'. This was the foundation in terms of her service-seeking behaviours.

The research exposed many facets to the women in this study conceptualising their need for change. Trauma and suffering were common threads throughout the women's story-telling. So too were gendered concepts related to stigma and marginalisation, and the norms and social sanctions regarding the consumption of alcohol and the experience of AUDs by women.

DiClemente (2007) proposed that there is no single, common developmental trajectory representative of the diverse personal journeys through which people move into and out of when it came to the harmful consumption of alcohol. This is why it is imperative to ask the woman what it was that motivated her to arrive at her decision to engage with services – what it was that led to her conceptualisation of her need for change. Does it not make sense to ask the service 'users'?

Unlike the literature cited in the background and discussion chapters, this study aimed to elucidate firsthand the essential phenomena, the essence of meaning, as it was perceived directly by participants in terms of their decisions to engage with services. I endeavoured to add to the body of knowledge regarding the lived experience of alcohol-use disorders by women by asking them to explicate the meaning behind why they had decided to engage with services. I wanted to privilege their voices and give integrity to their lifeworlds.

### **Contribution to knowledge**

This study brought the views of women living with an alcohol-use disorder to the forefront. It did this in terms of their everyday life experiences, so as to capture the meaning of why they made the decision to engage with services. Despite evidence that women with AUDs have valuable information and insights regarding their experiences and their reasons for service engagement, their views have only very minimally been explored and are largely inaudible in the literature (Vandermause & Wood 2009).

Given that, as reported throughout this research, only a very small proportion of people living with AUDs actually engage with services (Korcha et al. 2014; Polcin et al. 2012), it is important to understand the reasons behind why women *do* seek help. Therefore, I assert the following essential differences between this study and the existing literature as cited in previous chapters. These assertions justify my claim that this study has added to the body of knowledge in the area of alcohol-use disorders as experienced by women. This assertion is emphasised by the following findings:

1. Women in this study sought help from services only after they became aware of their dislike of what alcohol was doing to their relationships with their significant others, as well as the negative impact it was having on their own health.
2. Before they arrived at their decisions to engage, the women had to overcome significant barriers associated with their gender, being a carer, the normalisation of alcohol in our society, their poor past experiences of services, the lack of women-centric services and their lack of awareness regarding available services.

3. The women who felt forced into contacting services by their family members or friends, or from society, found it difficult to change their alcohol-related behaviours and engage with services.
4. Reaching 'Rock Bottom', or the lowest point in their lives, which centred on traumatic experiences and feelings of isolation, is when the women chose to '*fight back*' and regain control of their lives by engaging with services and ceasing their consumption of alcohol.
5. 'Conceptualising the need for change' for the women was directly related to their personal willingness to change. This decision to engage, however, went beyond just contacting a service and ceasing alcohol. This decision impacted on all parts of the woman's life and redefined her relationships with herself and with society. To make the decision to contact services involved a purposeful reengagement with the world after many years of isolation, trauma and marginalisation.

## **Implications and future directions**

### ***Implications for women with alcohol-use disorders***

Given the focus of this research, it is appropriate to first discuss the implications that this study holds for women with AUD. Each woman who participated described in some way that they felt '*unburdened*', '*relieved*' that someone had '*listened*' to their life stories, how '*cathartic*' and '*therapeutic*' this was, and, importantly, how it felt '*safe*' to do so.

The women spoke of how this was the first time they felt they had been given the opportunity to really tell their stories and verbalise the contributing factors that had led to their harmful consumption of alcohol and their resulting AUD. To help reiterate the significance of their contributions, a summary of the findings from this study was sent to each participant (Appendix A).



The women who were abstinent from alcohol at the time of interview also discussed how the interview affirmed their decisions to cease drinking and continue their engagement with services. For the women, being provided with a voice was therefore seen as a positive, a time where they could share their life-stories without fear of reprisal or retribution. For me as the researcher, it was a privilege and humbling. The intention of the interviews was not to be purposively cathartic, nor were they meant to be life changing.

However, story-telling enabled the women to openly express their feelings in a safe environment. It even brought to light an explicit awareness of feelings that had not been previously acknowledged, which was described by participants as '*healing*'. 'Healing after painful experiences can begin when our voices and stories are listened to and heard' (East et al. 2010, p. 17). New perspectives can be gained through the telling of personal stories to an interested and attentive listener (Murray 2003). Intentional behaviour change can be a cumulative, often agonisingly slow process, one which involves multiple successes and disappointments over time (DiClemente 2007; Glanz, Rimer & Su 2005).

To have someone listen to her journey, her fears, her struggles, her disappointments and her successes, a journey which had spanned years if not decades for most of the women, may therefore contribute to the woman with an AUD further 'conceptualising her need for change'. This is because reflection and the personal desire for positive change often accompany story-telling and dialogue (Cowling 2005). Summarising and organising the experience through lifeworld story-telling may also help participants to understand the experience better, and 'to store it and move beyond it' (Holloway & Freshwater 2007, p. 707).

As a result, in terms of future directions, there is a need for researchers and service providers to pay close attention to women with AUDs in relation to the descriptions of their experiences, languaged within their own narratives. Acknowledgment of divergent voices that merit being heard and recognised will empower women with alcohol-use disorders to validate and redefine their life experiences. Such an approach may help them recognise and draw upon their already present, but at times unknown, strengths.

### ***Implications for future research***

1. Future research could be approached in a manner that includes a life-course, story-telling framework, privileging women with time to tell their stories and make sense of their disorders within their particular social and environmental contexts. This is because, as alluded to earlier, the opportunity to express their views as a marginalised group and being listened to in this way was considered by participants in this research to be *cathartic* and *healing*. Services for those with AUDs cannot be legitimised without the input of consumers (Bryant et al. 2008) and, for such a marginalised group; in-depth interviews may be the best way forward to gain real insights missed to date.
2. As this research has established, the gender of the person with an alcohol-use disorder, 'being a woman', has the potential to affect several critical stages along the pathway to engaging with services. Due to the paucity of research exploring women and alcohol-use disorders, little is known about these critical stages in terms of a woman's subjective experience when it comes to reasons why she decided to, or decided not to, engage with services. Evidence presented in this research identified that whilst the topic is under-researched, epidemiological and population studies, as well as reviews of established literature, found significant gender differences in the experience of alcohol-use disorders. The use of epidemiological research could also help inform policy and practices in relation to the provision of services for women with alcohol and other drug-use disorders who make the decision to seek help.

In spite of this, much remains unexplored about the unique contextual factors that characterise a woman's lifeworld in terms of her developing and experiencing an AUD. Research that focuses on the subjective experiences of women with AUDs and how certain factors throughout their life-courses led to the development of their disorder may provide insight and greater understanding as to the developmental nature of AUDs. This type of research may also elucidate ways that alcohol-use disorders could be halted or prevented at certain points in a woman's lifeworld.

3. As part of this exploration of engagement, the woman's expectations of the service could be examined. As found, the woman's past involvement with services, 'Poor past experiences', was a significant predictor of her expectations of, and engagement with, future services. Future research could focus on developing an 'expectations checklist', which would more closely 'align' the woman with an AUD to the service most appropriate for her. As part of this, the degree to which the woman's 'conceptualisation of her need to change' would also be assessed. This is important, as matching people to services based on their motivation to change can help them obtain more benefits from the program (Giovazolias & Davis 2005).
  
4. Embedded in the findings of this research were the unique contextual factors that characterised the women's lifeworlds. Nearly all participants had been exposed to alcohol at a young age, '(Ab)normalisation', which was found to be a main contributing factor to the development of their alcohol-use disorder. All participants had lived through some form of trauma and violence, directly related to 'Being a woman'.

Thus, exploring the meaning and reasons behind their consumption of alcohol may increase understanding of hindrances or facilitators to service engagement. Research investigating reasons for the harmful consumption of alcohol leading to the development of the AUD could achieve this, particularly studies that centre on the women's upbringing and experiences of maltreatment, trauma and violence. The development of programs designed to prevent child abuse or neglect before it occurs, as well as the provision of appropriate trauma support and services when trauma does take place, could prevent the development of AUDs in women in the first place (Potthast, Neuner & Catani 2014).

5. Whilst this study explored the views of women only, future research could focus on the views of alcohol and other drug professionals and mental health clinicians on facilitators and barriers to service engagement by those with alcohol-use disorders. This may help create awareness on factors that impede women's service use, as well as factors that facilitate appropriate access to services.

### ***Implications for service delivery and policy development***

1. This research identified that women were underrepresented in programs targeting AUDs. It was also revealed there is a faster progression of alcohol-related harms and the development of AUDs in woman who consume excessive alcohol, when compared to men. Women experience more alcohol-related harms, 'Negative health impacts', in terms of physiological, psychological and social issues. There are more complexities for women, 'Being a carer', 'Sense of enforcement', 'Isolation', in terms of accessing appropriate services.

The reasons for this underrepresentation need to be the focus of drug and alcohol service planning, policy and staff training. All participating women spoke about the need for a *safe* and *women-friendly* place when discussing services, the lack of which was found to be a major barrier to engagement. Participants spoke of what constituted women-centric services, the main commonality being the need for women-only services that incorporated childcare facilities.

2. The 'conceptualisation of the woman's need for change' was identified as linked to her self-efficacy and readiness to transform her life. Clinicians who work with women with AUDs should be wholly responsive to the woman's motivation to change by being aware of, and using, health behaviour change theory that highlights the processes of change, such as the Transtheoretical model (Prochaska & DiClemente 1982). Actively listening to the woman's stories would assist with this, understanding her needs and appreciating the reasons as to why she consumes/d harmful amounts of alcohol and developed an AUD, such as her experiences of 'Trauma' and 'Isolation'. This may help her draw on her strengths and to 'Overcome barriers' to service engagement.

3. The inclusion of consumers in planning and policy development has been widely and successfully promoted by mental health services in Western countries for more than two decades (Hungerford & Fox 2014). Consumer participation is vital to improve the responsiveness and quality of services (Muir-Cochrane, O'Brien & Ward 2012). Consumer-centred and led approaches to mental health care are important components to Australian government policies and initiatives. However, progress in relation to consumer involvement in drug and alcohol service planning and approaches is considered to be slow (Patterson et al. 2009).

Given the increasing success of consumer inclusion by mental health services, the involvement of women with AUDs in service planning and delivery may help achieve gender-orientated services, as well as an increase in the numbers of women who engage with such services. Given that the women in this study identified their story-telling as being '*cathartic*' and '*therapeutic*', it may be implied that the sharing of stories in a consumer-led manner be a way to overcome the lack of consumer involvement in services. Within drug and alcohol services, a peer worker-led workforce would also be of great value.

4. The findings of this research highlighted that 'trauma' and 'isolation' was part of the women's lives and key reasons as to the development of their alcohol-use disorders. It is therefore imperative that services use a trauma-informed framework when working with women who experience AUDs. According to Covington (2008), trauma-informed care principles include:
  - taking the trauma into account;
  - avoiding triggering traumatic reactions or re-traumatising the woman;
  - staff adjusting their behaviours so as to support the woman's coping capacity;
  - enabling the woman to manage their trauma successfully so that she may achieve the full benefits from services.

5. Another key finding from this research was the lack of awareness the women possessed regarding the harms related to excessive alcohol consumption. Participants described the lack of advertising and media campaigns designed to draw attention to these harms. To help avoid the development of AUDs and other alcohol-related harms, a public policy strategy could include governments conducting media campaigns that centre on changing the way Australian people think about alcohol. These campaigns could incorporate the health and social effects of harmful alcohol consumption, similar to the campaigns targeting the use of tobacco products or the 'drink driving' campaigns that one observes on Australian television.

## **Limitations**

As with all research, this study also holds certain limitations. With the assistance of my research supervisors, I carefully considered how I could account for these limitations and reduce their impact on my study. In undertaking this research, I have conscientiously adhered to van Manen's (1997) phenomenological framework to the best of my ability. As such, I subscribe to his view that 'every interpretation can be called into question; every enquiry can begin anew; every hermeneutic phenomenological conversation is unending' (van Manen 1997, p. xv).

Although questions open up possibilities of meaning, questions can limit the boundaries of the topic being explored (Schmidt 2005). In other words, by virtue of asking one question or pursuing one line of enquiry, the researcher does not ask another question or engage in a diverse, but fundamental, topic of discussion. There was also the risk with phenomenological research that during the interviews and analysis of the texts, the questions may be too leading or too narrow in focus, or the researcher may impose her own perspectives, theoretical or otherwise, thus limiting the boundaries of what is being explored (Moustakas 1994). Interviewing participants can also generate different interpretations due to varying degrees of ease the participants have with the researcher, the sense of rapport, each person's mood, the time of day and the setting (van Manen 1997).

Through ongoing journaling and consultation with my supervisors, I engaged in continuous reflection to monitor the processes involved with conducting and analysing the interviews. In terms of my own subjective being-in-the world, I was also aware of the need to remain self-critical in relation to the influence I may have exerted when collecting the data and analysing the results. I debriefed regularly and often. It is, however, unrealistic to expect that all of these concerns can be overcome. As phenomenological researchers, we can plan for the limitations in our research, but we can really only know phenomenology by doing it (Merleau-Ponty 1962).

Part of our growth and evolution as phenomenological researchers' lies in our insecurities and doubts, such as when we question our abilities to ask the 'right' questions. For phenomenological researchers, 'doubt releases us from the harness of our convictions and the dogma of our truths...doubt creates the opportunity for deeper understanding through reflective enquiry' (Conklin 2014, p. 126). Emphasis on human experiences overrules exactness but instead pursues the uniqueness of a given phenomenon (Wojnar & Swanson 2007).

With this deeper understanding, I always endeavoured to communicate the women's stories by using their voices, their perspectives, their lived experiences and their understandings. The need to privilege the women with a voice and appreciate the essence of their lifeworlds in terms of their decisions to engage with services was paramount given that the worlds of women with AUDs are so seldom explored or articulated. This silence, dictated the methods used in this research. As the findings represent my account and interpretation of the data (Higgs, Horsfall & Grace 2009), I also acknowledge there may be other interpretations that are equally as valid.

It is also important to concede that in my attempt to uncover the essence of meaning behind the participants' decisions to engage with services, I am aware that this study can only be considered a fractional elucidation of the multifaceted journey that women with AUDs experience when 'conceptualising their need for change'. As articulated by van Manen (1990), the results of hermeneutic phenomenological research make no claims as to the generalisability of the knowledge produced. In fact, 'the tendency to generalise may prevent us from developing understandings that remain focused in the uniqueness of human experience' (van Manen 1990, p. 22).

The subjective and personal views of the women in this study are unique to them and are therefore not necessarily identical to other women's perceptions of this profound and complex phenomenon. The value of the findings of hermeneutic research lies in its ability to evoke the lived reality of the phenomena under investigation (van Manen 1990). As such, this study has produced a rich understanding of women's experiences of alcohol-use disorders and the essence of meaning behind their decisions to engage with services.

### **Final reflection**

It was both a privilege and, at times, a painful encounter to be with the women who participated in this study whilst they shared their lifeworld experiences with me. There were times when I felt helpless, as I was not in my usual nursing role as advocate, helper and advice-giver. However, feeling free from the constraints of being in a clinical role in a clinical setting, such as when working within time restrictions to an agenda that requires answers to predetermined questions, created for me feelings of interconnection between the women and I. With phenomenological research, 'we can allow the research to be about self and others, truly valuing what other people say and experience...we can use our ability to reflect, contemplate and value our own personal experiences and the insights that rise within us' (Schmidt 2005, p. 123).

van Manen (1990) advised that phenomenological studies often have a transformative effect on the researcher as well as the participant. I remembered what it was like to truly 'be' with another, when they were suffering, when celebrating their successes, to be able to take the time to listen, to share, to reflect. Moustakas (1994) recommended phenomenological researchers should endeavour to set aside presuppositions and look at events and people with fresh eyes, to see them as they are, open, and as they present themselves.

To do this, we must first know who we are and let go that which we think we know. Research can be a personally rewarding experience, one which reaffirms what it is to be human, for both the researched and the researcher (Schmidt 2005). Through my engagement with research processes, I learned a great deal about what life is like for women who live with alcohol-use disorders, but I also learned a great deal about myself as a clinician, a researcher and, most importantly, as a person, a woman.



As I now reflect on my own journey, I find not only did I come to a much-enhanced understanding of the women's essence of meaning; I came to know my own self as well. An advantage of phenomenology is the opportunity for the researcher to gain insight into the self; 'awareness of one's own intuitive caring nature empowers one to respond with increased understanding when encountering the phenomenon in the future' (Pallikkathayil & Morgan 1991, p. 198). Engaging with the participants during the research processes enabled me to reflect on my own experiences of working as an alcohol and other drug clinician.

I have come to the realisation that life-story; lived experience narratives hold immense value for women with alcohol-use disorders and for clinicians alike. This had previously gone unnoticed by me as an important aspect in the therapeutic relationship in terms of gaining an enhanced understanding of the woman and her experience of her disorder. Only by going on a journey together will the clinician gain answers to previously unasked questions in terms of the woman's concealed lifeworld and her 'conceptualisation of her need for change'.

This hidden world may unlock many unanswered questions for both the woman and the clinician, as well as provide a voice to the marginalised, stigmatised and victimised group that are women who live with alcohol-use disorders.

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## Summary of Results for Participants

### ‘Exploring Women’s Engagement with Drug and Alcohol Services’

Renee Brighton

Thank you again for giving me your time so generously. I have now finished summarising my study and I wanted to tell you what I found out:

- This research study was designed in a way so as to answer the question: ‘what does it mean’ for a woman with an alcohol-use disorder to engage with services’.
- The topics of women, alcohol and alcohol-use disorders were found to be under-researched. In particular, there is very limited information about the lived experience of women who experience alcohol-use disorders (AUDs).
- Within each woman’s story-telling during the interviews, common themes were found. These centred on participants’ discovering their ‘Dislike for Alcohol’, ‘Overcoming Barriers’ to service engagement, prevailing over a ‘Sense of Enforcement’ to engage with services and bouncing back from reaching ‘Rock Bottom’.
- Deeply embedded within your story-telling was the essence of your experiences – the ‘meaning’ that you spoke of when making the decision to engage with services. This essence was found to be your ‘conceptualisation of the need for change’ in terms of seeking the help of services. That is, coming to a point when you decided – “that’s it, I need to change”.
- Implications for researchers and drug and alcohol services were around the need for further research that incorporated the views of women with AUDs. I particularly recommended that the lived experience of women be understood when services, policies etc. were being constructed. The lived experience is valuable and people who have lived experience should be part of the solution.

The thesis can be accessed through digital thesis on-line if you would like to read it in its entirety.

I would like to once again take this opportunity to thank you for the invaluable contributions you made to this study and wish for you, health and happiness.

*Renee Brighton*  
Ph. 02 4221 3614, email: [reeneb@uow.edu.au](mailto:reeneb@uow.edu.au)

Summary of Results: Participants

## APPENDIX B. ETHICS APPROVAL HREC (INITIAL)



### APPROVAL – ISLHD AUTHORISATION

In reply please quote HE12/470  
Further Enquiries Ph: 4221 3386

18 April 2013

Ms Renee Brighton  
School of Nursing, Midwifery & Indigenous Health  
University of Wollongong NSW 2522

Dear Ms Brighton,

Thank you for your correspondence received on 14 January 2013 and subsequent information received 18 April 2013 responding to the HREC review of the application below. I am pleased to advise that the application has been approved:

**Ethics Number:** HE12/470  
**AU RED Number:** HREC/12/WGONG/137  
**Project Title:** Women with Alcohol-Related Brain Injury (ARBI): Exploring their engagement with Drug and Alcohol Services  
**Name of Researchers:** Ms Renee Brighton, Professor Lorna Moxham, A/Prof Victoria Traynor

Sites/CIs reviewed:

Site	Principal Investigator for site
Illawarra Drug and Alcohol Service	Renee Brighton
Wollongong University	Renee Brighton

**Documents Reviewed/Approved:**

1. Initial Application
2. Additional information dated 13 January 2013
3. Consent Form v. 1 dated 26/11/2012
4. Participant Information Sheet v. 3 dated 3/4/2013 received 18/4/2013
5. Example Interview Prompt Questions v. 1 dated 29/11/12 received 18/4/2013

**Approval Date:** 17 January 2013  
**Expiry Date:** 16 January 2014

The University of Wollongong/ISLHD Humanities, Social Science and Behavioural HREC is constituted and functions in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research*. The HREC has reviewed the research proposal for compliance with the *National Statement* and approval of this project is conditional upon your continuing compliance with this document.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at

Ethics Unit, Research Services Office  
University of Wollongong NSW 2522 Australia  
Telephone (02) 4221 3386 Facsimile (02) 4221 4338  
Email: [rso-ethics@uow.edu.au](mailto:rso-ethics@uow.edu.au) Web: [www.uow.edu.au](http://www.uow.edu.au)

## APPENDIX C: ETHICS (RENEWAL) APPROVAL



### RENEWAL APPROVAL – ISLHD

In reply please quote: HE12/470

Further Enquiries Ph: 4221 3386

3 February 2014

Ms Renee Brighton  
School of Nursing, Midwifery & Indigenous Health  
University of Wollongong

Dear Ms Brighton

Thank you for submitting the progress report. I am pleased to advise that renewal of the following Human Research Ethics application has been approved.

Ethics Number: HE12/470  
Project Title: Women and Alcohol: A phenomenological exploration of women's engagement with Drug and Alcohol Services  
Name of Researchers: Ms Renee Brighton, Professor Lorna Moxham, A/Prof Victoria Traynor  
AuRed Number: HREC/12/WGONG/137  
Approval Date: 17 January 2014  
Expiry Date: 16 January 2015

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to expiry date.

This certificate relates to the research protocol submitted in your original application and all approved amendments to date. Please remember that in addition to completing an annual report the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project.

A copy of this advice has been forwarded to the ISLHD for their records.

Yours sincerely

Professor Kathleen Clapham  
Chair, Social Sciences  
Human Research Ethics Committee

Ethics Unit, Research Services Office University of  
Wollongong NSW 2522 Australia Telephone (02) 4221  
3386 Facsimile (02) 4221 4338  
Email: [rso-ethics@uow.edu.au](mailto:rso-ethics@uow.edu.au) Web: [www.uow.edu.au](http://www.uow.edu.au)

APPENDIX D: ETHICS APPROVAL ILLAWARRA/SHOALHAVEN LOCAL HEALTH DISTRICT



**Health**  
Illawarra Shoalhaven  
Local Health District

**Research Directorate**  
Telephone: 02 4253 4800  
Facsimile: 02 4253 4803

**TRIM NO: DT13/21737**  
**Ref: HE12/470**  
**APPROVAL**

Ms Renee Brighton  
School of Nursing, Midwifery & Indigenous Health  
Building 41, Room 212  
University of Wollongong  
WOLLONGONG NSW 2522

Dear Ms Brighton

**HREC project number: HE12/470**  
**Project title: Women with Alcohol-Related Brain Injury (ARBI): Exploring their engagement with Drug and Alcohol Services**

Thank you for submitting an Access Request Form application for authorisation of the above project. I am pleased to inform you that authorisation has been granted for this study to take place at the following site:

- Illawarra Drug and Alcohol Services – Illawarra Local Health District

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;
2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer.

Yours faithfully

**KRISTY VARDANEGA**  
Research Governance Officer

22 April 2013

c.c.: Mr David Reid, Director – Drug and Alcohol Service

**Research Directorate**  
Level 8, Block C, Wollongong Hospital  
(LMB 8808, SCMC NSW 2521)

## APPENDIX E: PARTICIPANT INFORMATION SHEET



### Participant Information Sheet Exploring Women's Engagement with Drug and Alcohol Services

Renee Brighton (MNSurs(MndiHlth), RN, BN, Cert IV Training & Assessment, PhD Candidate)

This research is being conducted within Doctoral (PhD) research program by Renee Brighton. Professor Loma Moxham and Associate Professor Victoria Traynor (School of Nursing & Midwifery, University of Wollongong) are supervising this research.

The overall aim of this project is to understand the reasons why women seek help from drug and alcohol services.

This project will involve interviewing you to find out why you sought help from drug and alcohol services. The interview will last for about an hour and will be audio taped. The interview will be at a time and place that is convenient to you.

Some examples of the questions you may be asked include:

- Please tell me why you decided to go to a service to get help?
- What types of things could encourage you to seek help?
- What types of things could get/have gotten in your way of seeking help?

You will not be identified in any way as result of your participation in this research. Only the researchers listed above will have access to the information you provide, except as required by law. All information will be stored securely.

Participation in this research is voluntary. If you do decide to be involved, you will be asked to sign a consent form. If you consent to take part and change your mind later on, you are free to withdraw from the project at any stage. Your decision to withdraw from the project will not in any way affect your future relationship with the University of Wollongong.

If you would like further information about this study, please contact Renee Brighton on 02 4221 3614 or [reeneeb@uow.edu.au](mailto:reeneeb@uow.edu.au). Any questions regarding the way that the research is conducted can be directed to the Secretary of the University of Wollongong, Human Research Ethics Committee on 02 4221 4457.

Thank you for considering taking part in this study.

Renee Brighton  
Ph. 02 4221 3614, email: [reeneeb@uow.edu.au](mailto:reeneeb@uow.edu.au)

Participant Information Sheet Version 3 03/04/2013