

**THE LIVED EXPERIENCE OF FEMALE ALCOHOL DEPENDENCE:
A HERMENEUTIC PHENOMENOLOGICAL APPROACH**

by

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ABSTRACT

The hermeneutic phenomenological study interprets the lived experience of female alcohol dependence. Literature reveals that past research into alcohol dependence has generally used male subjects that formed the standard for theories, and treatment, of alcohol dependence. Researchers realised that alcohol dependent women differ significantly from their male counterparts, leading to an increase in exploratory studies of female alcohol dependence. However, these studies only provided a description of the disorder. How female alcohol dependents experience their disorder and how it makes sense to them has been largely ignored. The philosophy of Martin Heidegger provided the framework for collection, analysis and interpretation of data. Analysis revealed four life-worlds: 'The Disheartened One', 'The Ambivalent Player', 'The Contemplator' and 'The Covert Chauvinist'. A lived experience typology of female alcohol dependence was proposed, namely 'The Condemned', 'The Utopian' and 'The Realist'. Implications of the findings on treatment and recommendations for future research are discussed.

KEYWORDS: alcoholism; alcohol dependence; female; hermeneutics; interpretation; life-world; lived experience; Martin Heidegger; phenomenology; qualitative; typology; women.

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CHAPTER 1: INTRODUCTION

“A tree is known by its fruit; alcoholism by its problems”

(Goodwin, 1981, p. 31)

1.1. Alcohol: the enduring enigma

Why do some people become dependent on alcohol while others do not? Why do individuals become dependent on alcohol, despite daily experiencing multiple negative consequences of such dependence? Why do they carry on drinking if, after the last binge episode, they swear they will never drink again? Why do some people rely on alcohol to help solve their problems? In order to understand why I ask these questions it is important to provide an overview of my experience with alcoholism and the reason it set the stage for this study.

My childhood fuelled an interest in alcoholism. This phenomenon has always fascinated me as, through my father's alcoholism, I experienced it on a daily basis. Over a period of 36 years I witnessed the ways in which this disorder affected every single component of my father's existence. He suffered daily. He lost his job, he lost his friends, he lost his wife and his child and ultimately he lost himself.

I struggled to understand how he could allow this to happen. How can someone carry on doing this to himself if he can clearly see what it does to him and to others? Throughout my adolescence and young adult life, I could never find an answer to this question. I was left with a great deal of resentment and anger towards my father.

These feelings grew as I experienced, on a few occasions, the effect that alcohol has on a person. I could never understand why people do this to themselves on a daily basis. Why do you want to feel like this every day of your life, even if you know what the consequences will be?

During my postgraduate study at the University of South Africa, a research project for the psychopathology course allowed me to investigate this mysterious phenomenon. Over a period of three months I attended Alcoholics Anonymous meetings and listened to the alcoholics' stories. It was an eye-opening experience for me as I realised that this could happen to anyone, irrespective of age and gender. What surprised me the most was that there appeared to be a hidden and invisible group of alcoholics, namely female alcoholics. They seldom surfaced at the Alcoholic Anonymous meetings. They rarely spoke about their ordeals and usually sat at the back of the room while the male alcoholics shared their stories. It occurred to me that they might be a misunderstood population and that we have a superficial understanding of female alcoholism. This realisation led to an extensive literature review, which confirmed that female alcoholics are misrepresented in treatment. The literature focuses on their immediate needs, and other facets of their lives are ignored. The literature review further revealed that female alcoholics face more ridicule and bias from society and health provider services than their male counterparts.

As a result I decided to go on a journey into the world of female alcoholism. I wanted to allow the female alcoholics to share their experience of alcoholism with me and ultimately to gain a better understanding of this hidden world in which they exist.

1.2. Background and rationale of this study

Alcoholism, also known as alcohol dependence and problem drinking, is a debilitating disease that affects every aspect of the alcoholic's existence. Over the past 60 years the definition of alcoholism has varied greatly (Vandermause, 2005). Some of these definitions have been complementary and others contradictory. It is difficult to pinpoint an exact definition of alcoholism, however most definitions include the criteria of a loss of control, psychological dependence, increased tolerance and withdrawal symptoms (Lazarus & Colman, 1995). Furthermore, literature shows that the term alcoholism often carries an element of confusion coupled with negative connotations (Vandermause, 2005). Also, the

term alcoholism is mostly associated with the now outdated and misleading disease model (Lazarus & Colman, 1995). Therefore, for the purpose of this study, the more appropriate terms ‘alcohol dependence’ and ‘alcohol dependent(s)’ will be used.

Historically male alcohol dependents have been the subjects of quantitative studies on alcohol dependence (Van der Walde, Urgenson, Weltz & Hanna, 2002; Wilke, 1994). This has not only formed the norm and standard for research on, and judging of, alcohol dependents’ behaviour, but also the development of alcohol dependence theories and treatment approaches. As a result alcohol dependence is seen as a man’s disease and unique behaviours and side effects exhibited or experienced by women alcohol dependents are defined as abnormal or deviant (Wilke, 1994). This results in personal differences and individuality being ignored (Ettore, 1997). Ettore (1997) indicates that there is a lack of research on the emotions, feelings and the lives of female alcohol dependents. Ettore (1997) also notes that it is important to link women’s use of alcohol to their experience of themselves in society.

1.3. Aims of this study

The aims of this study are twofold. Firstly, the study aims to fill the gap in literature concerning female alcohol dependence and to shed light on this misunderstood disorder. Unlike a disease or an illness where the focus is exclusively on bodily organs or infectious organisms, a mental disorder is less value-neutral as it includes the complex interaction of biological, social and psychological factors (www.thefreedictionary.com/disorder). Any deviant behaviour is seen as a symptom of a dysfunction in an individual (Kendell, 2002). The literature review indicates that focusing on describing the lived experiences of female alcohol dependence without interpreting these experiences would not address the gap in the literature. This study therefore aims to add another dimension to the literature on female alcohol dependence by portraying female alcohol dependence as more than just another statistic or case of deviant behaviour according to the DSM-IV-TR. Secondly, based on my experience of my father’s alcohol dependence, the study aims to provide answers to the

multitude of questions I have regarding this disorder. As a result, it is inevitable that my personal experience forms part of the research process. The study is guided by the following research question:

What is the lived experience of female alcohol dependence?

In general, this study provides a rich interpretation of the lived experience of female alcohol dependence within the female alcohol dependents' and my own contexts. In order to achieve these aims, and to study female alcohol dependence as a complex and contextual phenomenon, this study worked within the hermeneutic phenomenological approach to investigate, understand and interpret the lived experience of female alcohol dependence (Lopez & Willis, 2004). As the emphasis in hermeneutic phenomenology is on interpretation (Moules, 2002), it assists in discovering meaning, achieving understanding and making sense of that which is not yet understood (Addison, 1992; Wilson & Hutchinson, 1991). Ultimately, the focus of a hermeneutic inquiry is on what individuals experience rather than on what they consciously know (Lopez & Willis, 2004). Therefore, spending time with the research participants within a hermeneutic phenomenological framework allowed them to share their lived experience of alcohol dependence with me, while at the same time allowing me, with my own preconceived ideas, biases and emotions, to become part of the process.

1.4. Overview of chapters

The second chapter is dedicated to the theoretical background underlying this study. This chapter focuses on the difference between alcohol abuse and alcohol dependence, various definitions of alcohol dependence and how the definition of alcohol dependence has changed during the past few decades. The second chapter also looks at theories explaining the aetiology of alcohol dependence. The chapter concludes with a critical look at these theories. Chapter three provides an overview of how various studies, based on the theories discussed in chapter two, have researched alcohol dependence in the past. Once again, a critical overview

of these studies and the methodologies used within these studies is provided. The following chapter discusses the research design for the present study and the methodological framework from within which the data collection and data analysis took place. Chapter four indicates why the Heideggerian hermeneutic phenomenological framework is thought to be the most suitable framework from which to answer the research question. The strengths and limitations, the role of ethics together with the role of the researcher and the trustworthiness and dependability of this study are discussed. Chapter five provides an overview of the general findings in this study that concur with, or refute, existing literature and theories. Chapter six provides an in-depth discussion of the lived experience of female alcohol dependence. This chapter discusses the various life-worlds that revealed themselves through hermeneutic phenomenological analysis. The final chapter provides a discussion of the findings and recommendations for future research. In addition, based on the findings of this study, this chapter proposes a lived experience typology of female alcohol dependence. This typology allows the reader to see female alcohol dependence in a manner not offered by the existing literature.

CHAPTER 2: THEORETICAL BACKGROUND

*“First the man takes a drink, then the drink takes a drink, then the drink
takes the man”*

(Goodwin, 1981, p. 61)

2.1. Introduction

Alcohol dependence is a chronic condition with disastrous effects (Klaich, 1996). It can lead to heart attacks, cirrhosis of the liver, high blood pressure, premature aging and stomach ulcers (Sue, Sue & Sue, 1994). It is a large factor in disruptions of family patterns and can lead to divorce, and it can also manifest in suicide attempts, car and industrial accidents, as well as crimes such as rape, murder, assault and spousal abuse (Sue et al., 1994).

Most people enjoy drinking at times. However, knowledge of the disastrous effects that alcohol dependence can have on an individual, makes it difficult to understand why some individuals drink more than they can handle. Looking back at the 19th century, we can see that alcohol dependence as an ailment came into its own more than 200 years ago. During the Industrial Revolution alcohol dependence grew to epidemic proportions, especially among the working class (Bauer, 1982). In contemporary society alcohol dependence remains an extremely common disorder (Hales & Hales, 1995).

2.2. Effects of alcohol consumption

It is important to begin by describing the positive effects of alcohol consumption in order to gain an understanding of why people drink. Barlow and Durand (2001) indicate that one of the main benefits of consuming alcohol is the resulting experience of euphoria. Alcohol helps individuals to relax through reducing their physiological arousal. Individuals also drink alcohol to calm down, to feel sociable with others, to ward off loneliness when alone and to cheer up (Hales & Hales, 1995).

Alcohol consumption, and more specifically alcohol dependence, also has numerous negative consequences. Following excessive alcohol consumption an individual will show a variety of side effects, such as slurred speech, a decreased ability to make judgments and to react, as well as impaired hearing and vision (Barlow & Durand, 2001; Coombs, 2004). Coombs (2004) mentions that an alcohol dependent person does not just exhibit these symptoms, but also experiences shame, guilt, humiliation and various types of family, financial and legal problems. Coombs (2004) further points out that alcohol dependents have an irresistible urge to drink alcohol repetitively and to perform ritualised acts, such as having a quick drink before leaving for the office in the mornings. These acts are intrusive and ego-dystonic, to such an extent that certain individuals often hear voices urging them to continue with the behaviour (Coombs, 2004).

According to Coombs (2004), three types of needs motivate alcohol dependent individuals to continue drinking, even though they are aware of the negative consequences. Firstly, the person experiences psychological rewards that are characterised by feelings of euphoria. The alcohol dependent will pursue the desired mood change regardless of the cost. Secondly, in having fun with others who consume alcohol the individual achieves recreational rewards. Lastly, individuals receive achievement rewards as alcohol allows them to feel better about their well-being and performance. Stewart (as cited in Bauer, 1982) states that individuals drink to dull problematic personal relations, to ease tension and anxiety, to ease boredom and fatigue and to release pent-up feelings.

2.3. Alcohol abuse and alcohol dependence

In order to gain an understanding of the various facets of alcohol dependence, it is important to look at the origin of the term. In the past studies have focused on different aspects of this phenomenon and there is no consensus on the definition of alcohol dependence (Barlow & Durand, 2001; Gregory, 1998). Some theorists identify alcohol dependence as a disease whilst others focus on the psychological and social aspects of alcohol dependence.

Flavin and Morse (1991) emphasise that at certain times one conception of alcohol dependence can be seen as more important and more popular than another conception as it is a reflection of the socio-political and scientific trends of contemporary societies. Flavin and Morse (1991) further indicate that research occasionally refutes a certain definition and gives way to another theoretical approach.

In order to arrive at a comprehensive understanding of alcohol dependence, it is important to look at the various definitions that have been prominent over the last few decades. These definitions also highlight the difference between alcohol abuse and alcohol dependence. Sue et al. (1994, p. 288) define alcohol abuse as a "... maladaptive pattern of alcohol use despite social, occupational, psychological, physical or safety problems". Alcohol dependence is defined as a maladaptive pattern of alcohol use characterised by a greater intake of alcohol than what was initially intended. Sue et al.'s (1994) definition of alcohol dependence includes unsuccessful attempts by individuals to control their use of alcohol despite experiencing problems caused by alcohol as well as the occurrence of tolerance and withdrawal. Hales and Hales (1995, p.212) define alcohol abuse as "... the continued use of alcohol despite awareness of social, occupational, psychological, or physical problems related to drinking and/or drinking in dangerous ways or situations". According to them alcohol dependence is defined as "... a chronic, progressive, potentially fatal disease characterised by physical dependence on alcohol, tolerance to its effects, and withdrawal symptoms when consumption is reduced or stopped" (Hales & Hales, 1995, p.211). Cavanaugh (1997, p.125) suggests that alcohol dependence is "... a more severe form of alcohol abuse characterised by drinking behaviour that becomes habitual and takes priority over other activities, increased tolerance of alcohol, repeated withdrawal symptoms which are relieved by further drinking, and awareness of feeling compelled to drink, and a reinstatement of this drinking pattern after abstinence".

From the above discussion, it is clear that definitions of alcohol dependence vary. The American Psychological Association's Diagnostic and Statistical Manual of mental disorders (DSM-IV-TR) provides the most accepted definitions for alcohol abuse and alcohol dependence. According to the DSM-IV-TR (Carr, 2006) alcohol abuse is diagnosed when one or more of the following criteria occur at any time during any twelve-month period:

- Recurrent alcohol abuse that results in a failure to fulfil major role obligations at work, home or school, such as missing work;
- Recurrent alcohol use in situations in which it is physically hazardous, such as before driving;
- Recurrent alcohol-related legal problems, such as drunk driving arrests;
- Continued alcohol use despite persistent or recurring social or interpersonal problems caused or exacerbated by alcohol, such as fighting while drunk; and
- No current or past alcohol dependence, as defined by the DSM-IV-TR.

The DSM-IV-TR diagnoses a person as alcohol dependent if the person shows three or more of the following criteria during any twelve-month period (Carr, 2006):

- Tolerance, as defined by either of the following
 - a need for markedly increased amounts of alcohol to achieve intoxication or desired effect, or
 - markedly diminished effect with continued drinking of the same amount of alcohol as in the past;
- Withdrawal, as manifested by either of the following
 - the characteristic withdrawal syndrome for alcohol, or
 - the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms;
- Alcohol is often taken in larger amounts or over a longer period than was intended;

- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use;
- A great deal of time is spent in activities to obtain alcohol, use alcohol, or recover from its effects;
- Important social, occupational or recreational activities are given up or reduced because of alcohol use;
- Alcohol use continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol (e.g. continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

What is important to note is that according to the DSM-IV-TR an individual can move from abuse to dependence. However, once a person is dependent on alcohol, they can no longer be described as abusing alcohol (alcohol dependence is an exclusionary criteria for alcohol abuse). Thus, according to this classification once a person is dependent on alcohol they will always remain dependent (Coombs, 2004).

The fact that dependence can be of a psychological and/or a physiological nature indicates the intensity of this disorder (Reber, 1995). Psychological dependence occurs when the alcohol dependent believes she needs alcohol in order to cope, whereas physiological dependence exists when physical changes cause tolerance and withdrawal. Tolerance develops when the alcohol dependent individual requires greater and greater amounts of alcohol in order to experience the same euphoric effect (Barlow & Durand, 2001). Barlow and Durand (2001) state that withdrawal occurs when the alcohol dependent physically responds in a negative manner when alcohol is no longer consumed. One of the most obvious signs of withdrawal is morning shaking, which is cured by having another drink (Goodwin, 2000). In extreme cases, the alcohol dependent individual can also experience hallucinations and convulsions, resembling the grand mal seizures of epileptics (Goodwin, 2000). It is important that withdrawal not be mistaken for delirium tremens, where the individual experiences

insomnia, agitation, hallucinations, illusions and memory disturbances (Goodwin, 2000). The effects of alcohol withdrawal are distressing but unlike delirium tremens, which is incurable, only last between two days and a week.

It is clear from the above discussion that there is no single and concise definition of alcohol dependence. However, there are several behavioural criteria such as loss of jobs and friends, blackouts, psychological dependence and increasing tolerance and withdrawal that must be considered to enable us to judge the severity of the problem (Lazarus & Colman, 1995).

2.4. Alcohol dependence and denial

According to Engs (1990) and Hales and Hales (1995), denial is the cornerstone of alcohol dependence. They indicate that alcohol dependents do not feel they have a problem with alcohol as they employ denial in order to convince others, and themselves, that they are not drinking too much (Coombs, 2004; Hales & Hales, 1995). It is common for alcohol dependents to manipulate their family, their friends and colleagues and to blame their relationships, financial or work problems for their drinking behaviour. Coombs (2004) cautions against using the word denial, as it is an emotionally laden term that may not reflect the true nature of the underlying problem. Coombs (2004) found that some alcohol dependent individuals do not even know that they are in denial and as a result cannot be classified as dishonest. Rather, an alcohol dependent individual may have difficulty with awareness and the ability to process new information. Consequently, it will appear as if the individual is in denial, when the person is in reality cognitively impaired (Coombs, 2004).

2.5. Jellinek's typology of alcohol dependence

E.M. Jellinek, a doctor from New England and a world-famous expert on alcohol dependence (Bauer, 1982), was the first to classify the drinking habits of alcohol dependents in 1942 (Clarke & Saunders, 1988). According to Jellinek (as cited in Clarke & Saunders,

1988) the alcohol dependent passes through a few phases on the way to becoming alcohol dependent. She moves from having the occasional drink to being a drinker experiencing a reward for having a drink and finally experiencing a loss of control. Jellinek identified this final phase of losing control as the critical symptom for diagnosing alcohol dependence (Aston, 2005). The following typology provides an overview of the different types of alcohol dependence as well as the variable roles alcohol plays in alcohol dependents' lives (Clarke & Saunders, 1988).

The first phase in Jellinek's typology is alpha alcohol dependence (Clarke & Saunders, 1988). An individual in this phase is a 'problem drinker' as she has a psychological dependence on alcohol. Although she can abstain from using alcohol she uses alcohol to combat daily emotional distress. While in this phase, it is possible for the person to progress to the more advanced stages of alcohol dependence discussed below.

In beta alcohol dependence (Clarke & Saunders, 1988) the focus is on physical damage, such as gastritis and cirrhosis, as a result of heavy drinking. The individual will show no signs of physiological and psychological dependence. Clarke and Saunders (1988) indicate that this type of alcohol dependence is very prevalent in societies that promote a heavy drinking culture combined with an unhealthy diet.

The third and most devastating phase is gamma alcohol dependence where the focus is on loss of control. The individual withdraws from social interaction and experiences physical deterioration. According to Bauer (1982) gamma alcohol dependents are those whose drinking is characterised by compulsiveness and lack of control; they are individuals who cannot drink moderately and are frequently drunk, disorganised and incapable. Jellinek (as cited in Clarke & Saunders, 1988) indicates that the alcohol dependent passes through four stages while in the gamma alcohol dependence phase:

- During the first few months, the pre-alcohol dependent will use alcohol to handle stressful situations. The individual will not appear to have a drinking problem and is seen by others as just another normal drinker. The pre-alcohol dependent can be entrenched in this stage for as long as two years;
- The second stage, known as the prodromal stage, has a sudden onset. Others see this person as a hard drinker. However, the individual does not make fellow drinkers suspicious of an underlying drinking disorder. It is common for an alcohol dependent in this stage to either drink alone before socialising or to gulp down drinks at other times. During this stage, which can last up to five years, it is common for the person to experience blackouts;
- Loss of control is the focus of the crucial stage. While in this stage, the individual is unable to stop drinking once she has consumed the first drink. The alcohol dependent person will become preoccupied with obtaining alcohol, to the detriment of her other responsibilities in life. Significant others in the alcohol dependent's life will notice that there is a problem as the alcohol dependent's social life, family life and occupation suffer on a daily basis. During this stage it is common for an alcohol dependent to be hospitalised on numerous occasions;
- The final stage of gamma alcohol dependence, namely the chronic stage, is characterised by the consumption of alcohol to relieve withdrawal symptoms. It is common for the alcohol dependent to lose control over every aspect of her life, to have a first drink very early in the morning and to become intoxicated on a daily basis. This excessive level of intoxication eventually leads to significant psychological and physical deterioration. Clarke and Saunders (1988) found that if an alcohol dependent during this stage does not follow a balanced diet, serious brain damage could follow.

The fourth phase in Jellinek's typology of alcohol dependence is delta alcohol dependence, which usually only develops very late in an individual's life (Bauer, 1982; Clarke & Saunders, 1988). During this phase, an individual is unable to abstain from consuming alcohol and will experience withdrawal symptoms with every attempt to do so. Physical and psychological dependence are present, as with gamma alcohol dependence, but the alcohol dependent does not suffer loss of control once she has had her first drink.

Clarke and Saunders (1988) point out that Jellinek does not see this typology as exhaustive, as many other additional classifications are possible. They also indicate that although Jellinek warns against a restricted focus on these classifications, this typology continues to provide a simple classification of the various types of alcohol dependence. Much of this typology is still used in the treatment of alcohol dependents (Clarke & Saunders, 1988).

2.6. Aetiology of alcohol dependence

Following the discussion on the various facets of alcohol dependence, it is necessary to look at the possible causes of this intricate disorder. Some theories are similar in their approach, some overlap in their assumptions and others contradict each other. It is essential to look at the somewhat controversial disease theory first as it has formed the foundation from which most theories of alcohol dependence have grown. This is followed by a discussion of the diverse array of theories related to alcohol dependence, explaining each theory's stance on the cause of alcohol dependence. The chapter concludes with a discussion of the bio-psycho-social theory, which provides a comprehensive approach to alcohol dependence.

2.6.1. The disease theory

The disease theory has formed the foundation of alcohol dependence literature, research and treatment in the past. However, during the past three decades conflicting evidence has made this theory much less influential (Clarke & Saunders, 1988).

During the 19th century it was believed that alcohol dependence was sinful and reflective of a spiritual deficit (Clarke & Saunders, 1988; Engs, 1990; Goodwin, 2000). It was also believed that alcohol dependence was a ‘constitutional weakness’ that ran in families and was passed on from one generation to the next (Lazarus & Colman, 1995). The turning point in the conceptualisation of disorder came in the 1800s when it was discovered that syphilis, once thought to be a psychological disorder, had a biological basis as it responded to medicinal treatment (Lazarus & Colman, 1995). This discovery filtered through to the approach to alcohol dependence.

Contrary to belief, the disease theory did not originate with Jellinek (Coombs, 2004; Klaich, 1996). Instead, it originated in the writings of Benjamin Rush and Thomas Trotter (Clarke & Saunders, 1998), which lifted alcohol dependence from a moral weakness to a disease (Goodwin, 2000). This new approach to alcohol dependence caused major conflict, especially between the medical profession and the church, as the alcohol dependent was now seen as not responsible for her immoral behaviour and was “... thus protected from moral condemnation and judgment” (Coombs, 2004, p.11). At that point, E.M. Jellinek, a respected scientist, announced in acceptable medical terms that alcohol dependence, like any other disease such as cancer or asthma, is indeed a disease (Aston, 2005; Coombs, 2004). Jellinek (as cited in Lazarus & Colman, 1995) aimed to legitimise the idea of alcohol dependence as a disease in order to combat the stigma and prejudice that alcohol dependents experienced. This paved the way for the emergence of the disease theory (Klaich, 1996).

The idea of alcohol dependence being a disease gained credibility in the 1930s and 1940s when Alcoholics Anonymous (AA), founded in 1935 by two alcohol dependents, experienced irrefutable success (Ward, 1983). This movement sees alcohol dependence as a disease of the body and the mind and views abstinence as the only way towards sobriety (Ward, 1983). Alcoholics Anonymous provided counselling and support to alcohol dependents, a population that had previously been ignored by society, and softened the

general harsh view of alcohol dependency (Ward, 1983). They also showed the world that alcohol dependents are normal people who can lead normal lives when they stay sober.

The disease theory has had major support in the past. However, various contemporary theories challenge the disease theory for several reasons. It is felt that the disease theory gives the alcohol dependent a good excuse for self-indulgence (Goodwin, 2000). Goodwin (2000) also points out that the disease theory associates alcohol with fun, although diseases are not normally associated with fun. Klaich (1996) illustrates that the disease theory of alcohol dependence has not been able to explain the aetiology of some of the variations of alcohol dependence in alcohol dependents. Lastly, and some might suggest most importantly, the disease theory does not account for the social, psychological and environmental context in which the alcohol dependent lives, hence reducing the focus of the theory to a singular cause for alcohol dependence (Klaich, 1996).

2.6.2. Psychodynamic theories

Psychodynamic theories date back to the 19th century and have had the most influence on professional approaches to alcohol dependence (Bauer, 1982). According to the psychodynamic theories, childhood traumas, such as sexual abuse and an overprotective mother, are the cause of alcohol dependence. The psychodynamic theories state that childhood traumas cause frustration during the oral stage of psychosexual development and an individual will respond to these traumatic events by developing an oral dependent personality that is a manifestation of latent homosexual tendencies (Bauer, 1982; Sue et al., 1994; Ward, 1983). Childhood traumas can cause the individual to repress the painful conflict of the dependence needs. The individual's behaviour symbolically reflects the unconscious conflicts expressed as hostility, anxiety and depression (Sue et al., 1994). The alcohol dependent turns to alcohol in an effort to release her inhibitions and allow the repressed conflicts to surface. It is through alcohol consumption that the alcohol dependent eventually obtains oral gratification and satisfies her dependence needs (Sue et al., 1994). According to Ward (1983)

and Lazarus and Colman (1995) the argument is that if the underlying personality dysfunction is resolved, the alcohol dependence will disappear.

The psychodynamic theories have evolved from Freud's theory on repressed feelings and instinctual drives (Levin, 1990). According to Freud (as cited in Levin, 1990, p. 99) "... it has occurred to me that masturbation is the one great habit that is a 'primary addiction' and that the other addictions, for example alcohol, morphine, etc., only enter into life as a substitute and replacement for it". He further explains this by referring to infantile masturbation (Levin, 1990). Freud sees infantile masturbation as guilt inducing, as parents often forbid it. A child experiences internal conflict as she wishes for instinctual gratification but at the same time also struggles with internalised prohibition. Consequently, the child cannot fight against the urge to masturbate but also experiences the guilt that accompanies such an act. This leads the child to experience less and less self-esteem. This anxiety is in turn soothed through masturbation. According to Freud (cited in Levin, 1990), this is the pattern of most dependence disorders. Levin (1990) illustrates that Freud's theory highlights the narcissistic nature of addiction, as during masturbation one's love object is oneself, without any other person being involved. Freud suggests that the same could be said of alcohol dependence, as the love object becomes alcohol itself without the presence of another party. The alcohol dependent experiences alcohol as an extension of the self (Levin, 1990). Freud's theory also emphasises the loss of self-esteem that narcissistic individuals experience when they give in to the urge to drink. In order to cope with this loss of self-esteem the alcohol dependent has to consume more alcohol in order to uplift her self-esteem. The result is a vicious addictive cycle (Levin, 1990).

Glover (as cited in Levin, 1990) states that aggression is the common trait in alcohol dependence. Specifically, the alcohol dependent uses oral rage and anal sadism to hurt significant others in her life. Abraham (as cited in Levin, 1990) focuses on repressed homosexual perversion as the alcohol dependent, through alcohol dependence, can express

hidden and mostly forbidden homosexual wishes. Knight (as cited in Levin, 1990) emphasises alcohol dependence's link to depression as the alcohol dependent turns their rage inward. Menninger (as cited in Levin, 1990) concurs with Knight, and points out that the focus of alcohol dependence is self-destruction. Menninger (as cited in Levin, 1990) states that the alcohol dependent turns her conflict against herself in order to punish the self for aggressive and hostile feelings, which are unacceptable to society and to the self. Also, through alcohol dependence the alcohol dependent can cope with the conflict between the hostile feelings and resentment towards these feelings.

The psychodynamic theories have had major impacts in the field of alcohol dependence. However, psychodynamic theory is limited because it does not allow for the input of other influences such as social, economic and cultural factors in the development of alcohol dependence. It is important to realise that these theories are retrospective in nature and focus on clinical studies rather than on empirical data (Sue et al., 1994).

2.6.3. Personality theories

During the 1960s and 70s researchers attempted to identify certain personality traits that could account for addiction to alcohol (Sue et al., 1994). However, contrary to commonly held beliefs, no single addictive personality (Coombs, 2004) or addictive profile (Klaich, 1996) has ever been found.

Stewart (as cited in Bauer, 1982) identifies six core attributes prevalent in the personality structure of alcohol dependents. Firstly, alcohol dependents are hypersensitive. This means that they are more susceptible to both physical and psychological stimuli than individuals who are not dependent on alcohol. Stewart (as cited in Bauer, 1982) also found that they are psychologically dependent, emotionally immature and have a lack of affective security; hence they have a great need to protect themselves. Thirdly, alcohol dependents are idealistic - they overestimate their own capabilities and also exercise debilitating self-abuse. Furthermore, due to a lack of primary security that allows the development of frustration

tolerance, alcohol dependents are impulsive and need instant gratification. Alcohol dependents are also perfectionists who are very critical of themselves; they conflict with authoritative figures and are disobedient towards authority figures. Lastly, Stewart (as cited in Bauer, 1982) found that alcohol dependents, based on their perfectionism, are wishful thinkers and have to escape into their own fantasy world in order to realise their dreams.

Hales and Hales (1995), rather than attempting to identify specific alcohol dependent personalities, distinguish between two types of alcohol dependents. Type 1 alcohol dependents develop problems with alcohol after the age of twenty-five. The alcohol dependent's heavy drinking is usually a response to setbacks, losses or other external circumstances. Type 1 alcohol dependents can usually abstain from alcohol consumption for long periods, and they often feel loss of control, guilt and fear about their alcohol dependence. Hales and Hales (1995) identify anxiousness, shyness, pessimism, sentimentality, emotional dependence, rigidity and a slow anger response as characteristics of Type 1 alcohol dependents. On the other hand, Type 2 alcohol dependents develop a problem with alcohol before the age of twenty-five (Hales & Hales, 1995). This type of alcohol dependence is limited to males, and the alcohol dependent is usually a close relative of an alcohol dependent man. They often suffer from poly-substance use, drink regardless of what is happening in their lives and have a history of conflict with the law. It is common for these individuals to not experience fear, guilt or loss of control over their drinking. They are impulsive, curious, quick-tempered and aggressive risk-takers who use alcohol to reinforce their feelings of euphoria. It is also common for Type 2 alcohol dependents to have antisocial personality disorder (Hales & Hales, 1995).

Barlow and Durand (2001), Bauer (1982) and Klaich (1996) state that one cannot assume the existence of an essentially homogenous population of alcohol dependents. They suggest that although certain psychological disorders are common amongst alcohol dependents – such as narcissistic, depressive, borderline and antisocial personality disorders,

as well as disorders in the schizophrenic spectrum – these disorders are also found in individuals who are not dependent on alcohol. Bauer (1982) indicates that although there is no single personality type for people with alcohol dependence four characteristics exist that distinguish alcohol dependents from individuals that do not have a problem with alcohol. Firstly, alcohol dependents do not have control over their drinking. In addition, they drink in order to get drunk. They also drink whether they want to or not. Lastly, once they start drinking they are more at risk of letting go of their inhibitions and expressing aspects of their personalities that under normal circumstances would be expressed differently.

According to Coombs (2004) many alcohol dependents experience difficulty identifying and regulating their emotions. He found that anger, sadness and grief, shame and guilt, regret and rumination are emotional predictors of developing alcohol dependence. Sue et al. (1994) confirm Coombs' (2004) findings by illustrating that certain characteristics, such as feelings of inadequacy, a need for power, emotional immaturity and a low frustration tolerance, may predispose individuals to use alcohol to deal with daily stressors.

Nathan (as cited in Sue et al., 1994) identifies two personality characteristics, namely antisocial behaviour and depression, which are associated with drinking problems. He found a strong relationship between childhood or adolescent history of antisocial behaviour and alcohol dependence. However, Nathan (as cited in Sue et al., 1994) also warns that to focus only on personality characteristics as causal factors in alcohol dependence would be too simplistic, as many alcohol dependents do not have any antisocial histories and many antisocial individuals do not drink excessively. He further indicates that depression may well be a consequence rather than an antecedent of alcohol abuse. It is also important to note that stress and traumatic experiences can trigger heavy drinking, even in those with no family predisposition to alcohol dependence. Hales and Hales (1995) mention that many people start drinking heavily as a way of coping with their psychological problems, rather than as a result of having an alcohol dependence personality.

It is clear that there is no conclusive evidence to indicate that certain characteristics are typical of an alcohol dependent and it is very unlikely that a single personality type (Lazarus & Colman, 1995) causes alcohol dependence.

2.6.4. Cognitive theories

The cognitive perspective postulates that an individual's interpretation of an event is of crucial importance. According to this perspective people "... are disturbed not by events, but by the views they take of them" (Sue et al., 1994, p.79). The cognitive theories of George Kelly, Albert Ellis and Aaron Beck assume that 'schema' – such as thoughts, self-evaluations and perceptions – determine the reactions and behaviour of people (Sue et al., 1994). According to their theories irrational and maladaptive assumptions, as well as thoughts or distortions in the actual thought process, could cause alcohol dependence. Ellis (as cited in Sue et al., 1994, p.80) suggests that "... irrational thought patterns that stem from the individual's belief system" produce alcohol dependence. These irrational thoughts develop in the individual's early childhood through the processes of conditioning, self-repetition and autosuggestion. According to Ellis (as cited in Sue et al., 1994) it is absolutist and dogmatic 'oughts', 'shoulds' and 'musts' that guide these thoughts. An example of such a 'must' is the idea that 'I must be loved by my mother and father'. He places special emphasis on the 'musts', which he also refers to as 'masturbating activities', as these unrealistic and irrational thoughts will create maladaptive and dysfunctional feelings and behaviours. It is thus possible for an individual to feel like a drink after a difficult day at the office, but more severe drinking will occur only if the person adds irrational thoughts, such as "I am a total failure" (Sue et al., 1994, p.80).

The cognitive theories also focus on distortions in the thought processes. According to Beck (as cited in Sue et al., 1994) six types of faulty thinking processes operate in alcohol dependence. 'Arbitrary inference' occurs when the individual draws conclusions about herself, or the world, without sufficient and relevant information. The individual also makes

use of 'selective abstraction'. This refers to a process where an individual draws a conclusion based on one incident without considering the larger picture. An alcohol dependent will also make use of 'over-generalisation' as she holds extreme beliefs about a single event and then generalises this inappropriately to other events. In addition, the alcohol dependent uses 'magnification' and 'exaggeration' as she overestimates the importance and significance of negative events. 'Personalisation' occurs when the alcohol dependent relates external events to the self when there is no basis for such a connection. Lastly, the alcohol dependent makes use of 'polarised thinking' to view the world in extremes, such as either very good or very bad. This 'polarised thinking' leads to irrational thinking and dysfunctional attitudes and beliefs (Sue et al., 1994).

The cognitive theories share many characteristics with the behavioural theories, such as their emphasis on learned cognitions and interaction with external events. However, cognitions are not observable and as a result cognitive theories reduce human behaviour to mere thoughts and beliefs (Sue et al., 1994). While focussing on irrational and maladaptive thoughts and assumptions, cognitive theories ignore the impact of socio-cultural factors in the development of alcohol dependence when there is evidence that other factors may also play a role.

2.6.5. Behavioural theories

In 1913 J.B. Watson (Sue et al., 1994) suggested that the behaviourist approach could be divided into the conditioning theories (operant and classical) and the social learning theories.

Classical conditioning, discovered by Ivan Pavlov, shows how associate learning explains the development and treatment, of abnormal behaviour (Sue et al., 1994; www.psychologistworld.com/behaviour/aversiontherapy.php). Aversive therapy, in operation since 1932, is designed to eliminate alcohol dependence by associating an aversive stimulus, such as nausea, with alcohol consumption. If the therapy worked, the patient would not have a compulsion to engage in alcohol dependent behaviour anymore.

According to the operant conditioning theories of Edward Thorndike and B.F. Skinner, alcohol dependence, just like any other behaviour, is subject to the laws of reinforcement (Barlow & Durand, 2001; Engs, 1990; Ward, 1983). Engs (1990) views alcohol dependence as a learned behaviour that is subject to change through relearning as well as positive and negative reinforcement. Positive reinforcement takes place when something pleasurable happens after the behaviour occurs. This makes repetition of the behaviour more likely (Barlow & Durand, 2001; Coombs, 2004). For instance, individuals who consume significant amounts of alcohol will experience euphoria and feel relaxed and joyful, and as a result will continue to consume alcohol in order to recapture the pleasure. Social encouragement and approval from peers could also serve as positive reinforcement (Ward, 1983). Negative reinforcement occurs when an activity removes an aversive consequence, therefore making repeated behaviour more likely. This is a very common scenario where individuals who are suffering from a hangover will continue drinking in order to 'cure' it (Barlow & Durand, 2001; Coombs, 2004). Individuals may also become dependent on alcohol to remove the stress and unpleasant feelings that go along with their life circumstances. Hull, Mowrer and Spence's tension-reduction theory supports this hypothesis (Blane & Leonard, 1987). They propose that the sedative effects of alcohol may reduce anxiety and this reduction in anxiety serves as the reinforcement that maintains the alcohol dependent's drinking patterns (Sue et al., 1994). Lazarus and Colman (1995) confirm that an alcohol dependent has learnt that she can reduce, or even avoid, painful withdrawal symptoms by maintaining her blood-alcohol concentrations at a particular level. As this level begins to drop, the alcohol dependent begins to feel the discomfort of withdrawal. As a result, she ingests more alcohol to avoid the symptoms. Lazarus and Colman's (1995) findings highlight why most alcohol dependents have their first drink early in the morning. Therefore, negative reinforcement increases the likelihood that the individual will continue her heavy drinking.

Research has produced conflicting findings and has found that the conditioning theories are too simplistic. A study by Rohsenow (as cited in Sue et al., 1994) found that drinking occurred for reasons related to attaining a positive affective state rather than for reasons related to avoiding a negative state of tension. Polivy, Schueneman and Carlson (as cited in Sue et al., 1994) found that individuals who consumed alcohol showed increased levels of anxiety, rather than decreased levels of anxiety. It is thus possible that alcohol can either increase or decrease anxiety.

Social learning theories take the conditioning theories a step further by emphasising the social context in which heavy drinking occurs (Engs, 1990). Engs (1990) indicates that causal factors include deficits in coping skills, peer pressure, modelling of heavy drinking, psychological dependence and expectancies about drinking. Bandura's observational learning theory, focusing on modelling of drinking behaviour, suggests that an individual can acquire new behaviour simply by observing others and imitating them at a later stage (Barlow & Durand, 2001). Bandura believed that observation and modelling could have four possible effects. Firstly, the individual can acquire new behaviour. Secondly, the model can elicit certain behaviour through providing cues to the individual to engage in those behaviours. It is also possible for the individual to exhibit previously inhibited behaviours. Lastly, the individual may inhibit certain behaviours through observing the negative consequences of the model's behaviour. Levin (1990) also focused on modelling and found that our culture, including the media and advertisements, provide numerous models for drinking. As a result, individuals model their behaviour in accordance with these portrayals. Levin (1990) found that one of the reasons why self-help groups, such as Alcoholics Anonymous, are so effective is that they provide models of sobriety. Tolman's expectancy theory postulates that individuals' expectancies play a role in their alcohol related behaviour (Reber, 1995; Sue et al., 1994). Reber (1995, p.267) defines expectancies as "... an internal state, an attitude or set of an organism that leads it to anticipate (or 'expect') a particular event". The expectancy

theory assumes that “... what is learned is a disposition to behave toward stimulus objects as though they were signs for other objects or events whose occurrence is contingent on the appropriate behaviour” (Reber, 1995, p.268). Reber (1995) proposes that reinforcement thus becomes confirmation of the behaviour. Barlow and Durand (2001) together with Blane and Leonard (1987) confirm that an individual’s expectations about the use of alcohol could develop before the person consumes her first drink. This could be due to the way a person sees her parents or friends using alcohol, or through the media and advertisements. Coombs (2004) found that individual beliefs about the outcomes of their behaviour, which Coombs (2004) refers to as self-fulfilling prophecies, are often related to their future behaviour. Coombs (2004) states that what individuals believe about the outcomes of using alcohol, their ability to cope in certain situations, or their ability to change their behaviour may be crucial factors in determining their future behaviours. Marlatt, Demming and Reid (as cited in Sue et al., 1994) provide evidence that learned expectations effect alcohol consumption. They challenge the notion that alcohol dependence is a disease. Their research found that subjects’ expectancy had a stronger effect on alcohol consumption and drinking behaviour than the actual content of their drinks. Marlatt et al. (as cited in Sue et al. 1994) also found that subjects who were given a tonic, but believed they were drinking alcohol, reported feeling ‘tipsy’ after a few drinks. This finding indicates the importance of expectancy on the maintenance of drinking behaviour (Goodwin, 2000). Goodwin (2000) found that the more dependent individuals are on alcohol the more expectations they have that alcohol will cause them to behave in a particular way, such as losing control and experiencing euphoria.

The discussion above indicates that expectancies, modelling and conditioning can predict future drinking behaviour and the development of alcohol dependence. It is important to remember that these factors alone cannot explain the development of alcohol dependence.

2.6.6. Family systems theory

Sullivan's family systems theory sees alcohol dependence as a family illness (Lazarus & Colman, 1995; Sue et al., 1994). This theory emphasises the alcohol dependent's dysfunctional family interpersonal relationships based on unhealthy and poor family communications (Bauer, 1982; Sue et al., 1994). Sue et al. (1994, p.87) state that: "... all members of a family are enmeshed in a network of interdependent roles, statures, values and norms". As a result, one member's behaviour will directly influence the other members' behaviour. Sue et al. (1994) illustrate that, according to the family systems theory, the attributes of the family rule personality development. Ward (1983) found a circular and mutually reinforcing relationship between the alcohol dependent and other family members. Each family member plays a role in sustaining and perpetuating the illness. Bauer (1982) suggests that as the alcohol dependent plays one role, the other family members play complementary roles, such as the 'martyred wife' or the 'neglected children'. Each of these roles serves to maintain the alcohol dependence. The family system has an inherent drive to maintain this *status quo* and changing the individual without addressing the family dynamics has a low chance of recovery for the alcohol dependent (Bauer, 1982).

Family systems theory places significant emphasis on the role of the family in causing and maintaining alcohol dependence. However, it does not give recognition to individual and social influences. Family systems theory also uses a culture-bound definition of the family and the assumptions of the theory make it difficult to study and quantify (Sue et al., 1994).

2.6.7. Transactional analysis theory

According to the transactional analysis theory of Eric Berne, alcohol dependence is a game rather than a disease. The focus is on interpersonal relationships rather than on individual factors (Ward, 1983). Berne (as cited in Ward, 1983) states that the alcohol dependent, like every other family member, begins her life with fundamental life scripts. These life scripts are dominant conceptions of the self. Social reinforcement from the alcohol

dependent's network of interpersonal relationships sustains these life scripts (Ward, 1983). It is also through participation in interpersonal transactions, specifically those that could be identified as games, that alcohol dependents validate and re-affirm their initial self-conceptions. For example, the alcohol dependent's script might be 'I am not worthy' and the result of this is that 'neither is anyone else' (Ward, 1983). The alcohol dependent uses this game in an attempt to expose and discredit others and attempt to entice them into one of the alcohol dependent's roles. Consequently, individuals play various roles, such as the 'Powerless Rescuer'. This role satisfies the alcohol dependent and keeps the game going. Ward (1983) further states that certain scripts or conceptions of the self are more likely to choose alcohol dependence as a game. An example of such a script might be: 'I will drink myself to death'. Despite this theory's focus on the importance of interpersonal relationships, it ignores the social, physiological and psychological contexts of alcohol dependence.

2.6.8. The role of genetics

For centuries it has been assumed that alcohol dependence runs in families (Goodwin, 2000). The heredity theory (Engs, 1990) postulates that genetics plays a significant role in the development of alcohol dependence. Goodwin (2000) found that having an alcohol dependent family member increases one's chances of becoming an alcohol dependent by a factor of four or five to one. Goodwin (2000) further states that the best way to distinguish between the influence of genetics and the impact of the environment in the development of alcohol dependence is to compare identical and fraternal twins. Identical twins share the same genes and therefore share characteristics controlled by these genes. Fraternal twins, on the other hand, share genes only to the extent that all siblings share genes (Goodwin, 2000). The assumption is that, given a genetic cause for alcohol dependence, identical twins would develop alcohol dependence to a greater extent than the fraternal twins. Goodwin (2000) found that identical twins more often had similar drinking patterns, alcohol-related problems and alcohol dependence than fraternal twins, emphasising the role of genetics. Another way to

determine the impact of genetics on alcohol dependence is to study adopted individuals who have alcohol dependent biological parent(s). According to Goodwin (2000) 18% of a group of Danish men who had been adopted, and who had not had contact with their biological parents since their adoption, developed alcohol dependence before the age of thirty. This rate was four times larger than that of a comparison group of adoptees, of the same age and sex, who did not have an alcohol dependent biological parent. Barlow and Durand (2001) also found that there is a strong genetic vulnerability to become alcohol dependant if one (or both) parents of an individual are alcohol dependents. They found that the presence of DRD2 on chromosome 11 interacting with other factors could possibly increase susceptibility to alcohol dependence. Coombs (2004) confirms that the risk of developing alcohol dependence seems to increase if dependence is present in the nuclear family. However, Coombs (2004) cautions that it must be borne in mind that other theories could also explain this link. These findings support the assumption of the heredity theory that genetics plays a significant role in the development of alcohol dependence. However, it is not possible to state that genetics is the only cause of alcohol dependence. Barlow and Durand (2001) suggest that a gene determines how a person will experience alcohol, which may or may not determine whether the person will abuse alcohol or even become dependent on it.

2.6.9. Socio-cultural explanations

Sociological theories focus on various social issues, such as the difference between social classes, the influence of belonging to ethnic and minority groups and the difference between cultures and religions as the causes of alcohol dependence. Dean (as cited in Barlow & Durand, 2001) suggests that drinking patterns are historical and arise within the context of the social and material conditions of a given epoch. In this light, Dean (as cited in Barlow & Durand, 2001) proposes that alcohol abuse and alcohol dependence are seen as deviant by the extent to which they exceed the established norms in a specific culture. What is seen as normal in one culture could be seen as abnormal in another culture (Barlow & Durand, 2001;

Ward, 1983). Culture also influences the way in which alcohol consumption manifests as well as tolerance towards alcohol abuse and alcohol dependence (Barlow & Durand, 2001; Sue et al., 1994). Goodwin (as cited in Sue et al., 1994) found that in France, famous for its wine-drinking culture, moderate alcohol intake throughout the day as well as drunkenness in general are more accepted than in other countries. In Italy drinking wine at mealtimes is acceptable, but becoming intoxicated is frowned upon (Sue et al., 1994).

Merten (as cited in Ward, 1983) proposes a more societal view of alcohol dependence. Each society has a set of common goals, such as material wealth (for example a luxury car) that everyone in that culture or society aspires to. Merten (as cited in Ward, 1983) states that even though everyone would like to have these possessions, not everyone has the same chance of obtaining them. This is especially true of racial and ethnic minorities. This inability to achieve material wealth creates a sense of hopelessness and helplessness and, as a result, individuals turn to consuming alcohol as a means to escape this 'unsatisfactory' life. Merten (as cited in Ward, 1983) also suggests that as the lower classes in society experience a greater degree of blocked opportunities this accounts for the disproportionate amount of alcohol consumption among lower socio-economic groups. Kanas (as cited in Sue et al., 1994) confirmed these findings and further found that even though alcohol consumption increases with increasing socio-economic status, alcohol dependency is more prevalent in the middle socio-economic class.

Laymen's theories, based on explanations of non-experts, also offer possible reasons why individuals develop alcohol dependence. According to the theory of impairment (Bauer, 1982) alcohol dependence does not occur for any specific reason. Alcohol dependents are seen as repulsive, irresponsible and comical. People do not want to socialise with alcohol dependents because there is no way to change their inherent drunk nature. The dry moral theory (Bauer, 1982) sees alcohol dependence as a moral problem that only occurs when drinking occurs. The theory states that if no alcohol is available there will be no alcohol

dependents. It sees alcohol as the culprit in determining alcohol dependence. In contrast to the theory of impairment, this theory holds the individual responsible for deciding whether to drink or abstain. The wet moral theory (Bauer, 1982) does not explain why individuals become alcohol dependent, but views alcohol dependents as individuals who do not obey the rules of society. Alcohol dependence is not viewed as a moral failure but as an unacceptable form of social drinking behaviour where the alcohol dependent ruins the enjoyment of good drinkers.

The laymen's theories are inept attitudes toward alcohol dependence. They are moralistic in nature and provide a standard to which all people need to conform. Alcohol dependents are seen as violating these standards through their immoral drinking patterns (Bauer, 1982). Bauer (1982) suggests that caution be used in accepting such moral judgements, as viewing alcohol dependents as weak and immoral leaves them with little chance of recovery.

The socio-cultural explanations indicate that social and cultural environments could play a role in the development of alcohol dependence. However, it is important to bear in mind individual psychological and physiological factors that impact on the development of alcohol dependence.

2.6.10. The biopsychosocial theory

The biopsychosocial theory of alcohol dependence, which is consistent with the biopsychosocial approach to health and illness, is the most comprehensive and holistic theory to date that addresses alcohol dependence. It moves away from a reductionist thinking towards a more integrative approach to alcohol dependence (Lazarus & Colman, 1995). The biopsychosocial theory incorporates the strengths of the older traditional theories while simultaneously focusing on the social and cultural environment of the alcohol dependent (Engs, 1990). The emphasis is thus on both internal (cognitive, psychological and physiological) and external (social, cultural and environmental) factors that cause alcohol

dependence (Aston, 2005; Barlow & Durand, 2001; Lazarus & Colman, 1995; Wallace, 1990). Thus, a person who is genetically vulnerable, when placed within a specific socio-cultural context, becomes susceptible to the development of alcohol dependence. The biopsychosocial theory provides an explanation for why some individuals become alcohol dependents whilst others develop other emotional and social problems when placed under similar social stressors (Engs, 1990).

Most theories rely on other theories to boost their own point of view (Bauer, 1982). However, none of these theories provide a complete explanation of the cause of alcohol dependence. On the other hand, the biopsychosocial theory has certain face validity and is a view acceptable to various disciplines that all claim that their field of interest provides the most credible causal explanation for alcohol dependence (Barlow & Durand, 2001). It seems that numerous contextual factors could play a role in the development of alcohol dependence, such as family upbringing, unemployment, adapting to technological change, effects of natural disasters such as earthquakes and floods, war as well as the experience of discrimination and prejudice. What is clear is that it is difficult to separate biological, psychological and socio-cultural factors when attempting to explain alcohol dependence. The biopsychosocial theory considers all these factors (Barlow & Durand, 2001; Hales & Hales, 1995).

2.7. Conclusion

The above discussion highlights the variety of definitions of alcohol dependence, including the most accepted definition provided by the DSM-IV-TR (Carr, 2006). The discussion indicates that alcohol use and alcohol dependence might have initial positive effects such as euphoria, but overall is characterised by a plethora of detrimental consequences. Not only are there physiological side effects, but also psychological and social consequences. The role of denial in alcohol dependence is also highlighted. The core of the chapter discusses the aetiology of alcohol dependence. According to the theories discussed

many factors such as heredity, personality, social as well as personal context play a role. The impact of inept attitudes toward alcohol dependence is also discussed. Incorporating each of these facets of alcohol dependence, the biopsychosocial theory provides the most comprehensive explanation of the factors that play a role in the development of alcohol dependence. Chapter three will discuss research findings based on the theories of alcohol dependence discussed in the second chapter. Research findings relevant to the lived experience of female alcohol dependence will also be provided.

CHAPTER 3: LITERATURE REVIEW

*“Not drunk is he who from floor
Can rise alone and still drink more,
But drunk is he, who prostrate lies,
Without the power to drink or rise”*

(Traditional Irish toast attributed to Thomas Love Peacock, in Edwards, 2004, p. 8)

3.1. Introduction

The following discussion provides an overview of the research findings on female alcohol dependence, based on the theories discussed in the previous chapter. The discussion first looks at studies that focus on the psychological aspects of alcohol dependence, followed by studies on the roles of heredity, socio-cultural aspects and the physiological consequences of alcohol dependence. Throughout the chapter emphasis is placed on the difference between female and male alcohol dependents, in order to establish the existence of female alcohol dependents as a separate population. The discussion on female alcohol dependents forms the core of this chapter. The chapter concludes with a discussion that explores the need for additional qualitative research on female alcohol dependence.

3.2. Psychological causes of alcohol dependence

An extensive literature search revealed that research on the psychological causes of female alcohol dependence has mainly focused on five areas. These areas are emotional, physical and sexual abuse, mental health problems, personality characteristics, the role of the family and social learning and cognition. Literature further indicated that these themes do not exist in isolation, but are in constant interaction with each other in the alcohol dependents' lives. Mello (as cited in Engs, 1990) states that, according to the 'Adam's Rib Syndrome', researchers frequently assume that women are identical to men and that any research findings

can be generalised to that population. The discussion below indicates that there are significant differences between female and male alcohol dependents, thus highlighting the need to approach female alcohol dependents as a separate population.

3.2.1. Childhood abuse

In contrast to male alcohol dependents' drinking behaviour, the drinking behaviour of female alcohol dependents' is frequently linked to childhood emotional, physical and especially sexual abuse (Green, Polen, Dickinson, Lynch & Bennett, 2002; Hser, Huang, Teruya & Anglin, 2003; Klaich, 1996; Nolen-Hoeksema & Hilt, 2006; Rice et al., 2001; Wilsnack, Vogeltanz, Klassen & Harris, 1997). Rice et al. (2001) found that 31% of alcohol dependent women, compared to only 6% of alcohol dependent men, have experienced emotional, physical or sexual abuse. In a study carried out by Homiller (as cited in Klaich, 1996) female alcohol dependents reported a higher incidence of deprivation and trauma during childhood, such as loss of a parent by divorce, desertion (such as attending boarding school) or death in comparison to individuals who are not alcohol dependent.

Although not all abused children become alcohol dependent, research indicates that childhood abuse is a key contributor to the development of female alcohol dependence. Fleming, Mullen, Sibthorpe, Attewell and Bammer (1988) caution that abuse should not be viewed as the sole causative factor in female alcohol dependence. They found that childhood abuse, especially sexual abuse, only becomes significant in predicting future alcohol dependence among women when seen in combination with such factors as having an uncaring, over-controlling and cold mother, having a mother with poor mental and physical health, having a partner who exercises problematic drinking, and believing that alcohol combats sexual inhibition.

Even though childhood abuse plays a significant role in the development of female alcohol dependence, it is important to focus on women's broader living contexts in order to achieve a comprehensive view of the impact of abuse on the development of this disorder.

3.2.2. Mental health

Existing literature indicates that alcohol dependent women have significantly greater mental health problems than their male counterparts. The most prevalent of these problems are depression, anxiety, low self-esteem, psychosexual dysfunctions, neuroticism and phobic disorders (Ambrogne, 2007; Edwards, Marshall & Cook, 2003; Skaff, Finney & Moos, 1999). Edwards et al. (2003), Klaich (1996) and Long and Mullen (1994) found that female alcohol dependents experience feelings of inadequacy, suicidal thoughts, feelings of loneliness, general sadness and fear of social isolation. However, Nolen-Hoeksema (2004) found that results comparing low self-esteem in female and male alcohol dependents are inconsistent. Nolen-Hoeksema and Hilt (2006) found that although there is a relationship between alcohol use and eating disorders (such as bulimia and anorexia nervosa) in both genders, this link is more common in women.

3.2.3. Personality

It seems likely that personality plays a smaller role in alcohol dependence than was originally theorised (Peele, 1990). However, some individuals do show more alcohol dependence characteristics than others. Miller (1991), investigating the role of personality and cognition in relapse and recovery in alcohol dependence, found that successful remitters are future goal-orientated and exhibit self-efficacy and frustration-tolerance, whereas relapsers are characterised by impulsivity, affective disorders, antisocial personality and poor cognitive flexibility. MacAndrew (as cited in Peele, 1990) found that alcohol dependents seek pleasure, are assertive and aggressive and ultimately resemble criminals and delinquents. Even though this study was conducted with alcohol dependent men, later research (MacAndrew, as cited in Peele, 1990) uncovered similar characteristics in female alcohol dependents. Various other studies have shown significant additional personality differences between female and male alcohol dependents. Wodarz et al. (2003) identified symptoms of affective and anxiety disorders amongst female alcohol dependents, whereas male alcohol

dependents tended to show symptoms of sociopathy. Research also indicates that female alcohol dependents are more submissive as children and rebellious as adults when compared to their male counterparts. Female alcohol dependents are also more likely to experience personality change when drinking (Goodwin, 2000; Hussong, Hicks, Levy & Curran as cited in Nolen-Hoeksema & Hilt 2006; Nolen-Hoeksema, 2004). Men have higher rates of impulsivity, conduct disorder, sensation-seeking behaviour, antisocial personality disorder or delinquent behavioural patterns and negative mood. Weijers et al. (2003) confirm that female subjects scored higher on neuroticism and harm-avoidance behaviour whereas male subjects scored higher on sensation and venture seeking behaviours. Males and females who are not alcohol dependent also scored differently on these measures. The only significant difference was the relationship between neuroticism and alcohol dependence in female subjects.

3.2.4. The role of the family

Fleming et al. (1988) indicate that a dysfunctional alcohol dependent family environment traps a child in an environment that may be devoid of care, safety and affection. This environment is also filled with fear, loneliness, confusion and distrust. This study found that there is a significant relationship between growing up in a violent environment and later alcohol abuse. Fleming et al. (1988) show that this type of environment predisposes a female child to low self-esteem, a sense of powerlessness and a tendency to be suspicious of others. The study did not report any other gender differences.

According to Finkelstein's Relational Model (Van der Walde et al., 2002), throughout their lifetime women develop and experience things in the context of relationships to others, especially in their family contexts. It is within this context of relationships to significant others that societal attitudes toward alcohol dependent women, as well as women's views of themselves, exist. Engs (1990) and Goodwin (2000) confirm that alcohol dependent women report dysfunctional environments in their childhood and adulthood more often than their male counterparts. Alcohol dependent woman are also more likely to have an alcohol

dependent parent, sibling or family member. Goodwin (2000) also suggests that female alcohol dependents are more likely to have relatives who are clinically depressed or who commit suicide.

3.2.5. Social learning and cognition

In the past the roles of expectancies, modelling and tension reduction have been extensively researched in the field of alcohol dependence. Looking at the role of expectancies, Klaich (1996) found significant differences between male and female alcohol dependents. Men appeared to anticipate positive emotional states when drinking, compared to women who expected drinking to reduce their negative states. Furthermore, the relationship between positive expectancies and alcohol use was much higher in men than in women (Armeli, Carney, Tennen, Affleck & O'Neil, 2000; Kushner, Sher, Wood & Wood, 1994; Long & Mullen, 1994; Nolen-Hoeksema, 2004). Goodwin (2000), studying this phenomenon from a different perspective, discovered that society's belief that women cannot hold their drink as well as men can cause women to expect that they will get intoxicated much faster than men. Fleming et al. (1988) caution that it is difficult to state whether these beliefs or expectancies are a function or cause of women's drinking behaviour.

Modelling also seems to play a significant role in the development of alcohol dependence behaviour. Various studies have shown that men get involved with heavy drinking by observing other men during their adolescent and young adult years, while women tend to learn their drinking behaviour from their husbands, partners or male friends during a later stage in their lives (Fleming et al., 1988; Goodwin, 2000; Long & Mullen, 1994; Raine, 2001). Advertising also seems to play a significant role in the development of alcohol dependence. Women are especially vulnerable to advertising as the media portrays female drinking as an attractive, desired and social pastime (McConville, 1991).

Alcohol's role as a tension reducer has been the focus of numerous studies on alcohol dependence and ties in with the roles of expectancies and reinforced behaviour in the development of alcohol dependence. According to Young and Herling (as cited in Barlow & Durand, 2001) the 'high' people experience when drinking alcohol serves as positive reinforcement to continue the drinking behaviour. Consuming alcohol can also provide negative reinforcement as it helps individuals escape from physical and emotional pain. This study did not consider gender differences. A recent hypothesis states that as women have entered the workforce over the past few decades, they have had to endure more stress and consequently drink more in order to relieve their newly found stressful lifestyles. However, research indicates that it is men, not women, who are more likely to drink excessively in order to cope with distress and relieve depression (Timko, Finney & Moos, 2005). Sutker, Allain, Brantley and Randall (1982) confirm that women expect alcohol to interfere with their ability to handle stressful situations; hence they avoid ingesting alcohol when they have to handle taxing situations. Skaff et al. (1999) confirm these findings. Their study found that men are more likely to resort to alcohol dependent drinking in response to stressful situations, whereas women are more likely to respond to these situations with depression. Skaff et al. (1999) further established that stressful relationship problems affect men's drinking behaviour significantly more than they affect women's drinking behaviour. In addition, the research showed that men resort to drinking alcohol when they are dealing with stressful situations, whereas women would rather avoid consuming alcohol in these situations. Women are more likely to develop psychological disorders than alcohol dependence as a consequence of stressful situations.

Looking at the coping styles of alcohol dependents, Walter et al. (2003) report that alcohol dependent men use a 'fight or flight' coping style, whereas alcohol dependent women use a 'tend and befriend' coping style. Barlow and Durand (2001), who focused on alcohol myopia, did not find any gender differences on this cognitive aspect, but they did establish

that alcohol dependents in general experience “... a state of short-sightedness in which superficially understood, immediate aspects of experience have a disproportionate influence on behaviour and emotion” (Barlow & Durand, 2001, p. 361).

3.2.6. Conclusion

It is evident from the above discussion that psychological factors play a significant role in the development of alcohol dependence in women. This plays a less important role in male alcohol dependence. It also shows that multiple factors contribute to the development of this disorder. Engs (1990) and Raine (2001) provide a comprehensive overview of the diverse risk factors that exist at various stages during an alcohol dependent woman's life, all of which can lead to the development of this disorder. During the early childhood years a poor relationship with the mother, lack of approval from either or both parents, loneliness, feelings of deprivation and a lack of social support are extremely prominent in the life histories of all women alcohol dependents. During the adolescent years critical risk factors include having alcohol dependent parents, experiencing parental disapproval and parents as well as children not adhering to traditional gender-specific norms and values. The most prominent adult risk factors are depression, the experience of violence and a traumatic life experience (such as divorce, gynaecological problems, 'empty nest syndrome', single parenthood and unemployment). Engs (1990) and Edwards et al. (2003) also found that depression, divorce, having a drinking partner, poor coping skills during stressful life events, working in a male-dominated environment and sexual dysfunctions were the most prominent psychological factors occurring in adulthood which contribute to female alcohol dependence.

3.3. The role of genetics in the development of alcohol dependence

Various studies have found that genetic factors play a significant role in the development of alcohol dependence in both men and women (Nolen-Hoeksema, 2004; Wodarz et al. 2003). McGue, Pickens and Svikis (1992) and Straussner (as cited in Klaich,

1996) found that genetic factors play a significantly bigger role than the environment in the development of alcohol dependence in men. However, these findings could not be confirmed for women. Prescott, Neale, Corey and Kendler (1997) and Wodarz et al. (2003) confirm that the role of genetics in the development of female alcohol dependence is not as significant as in male alcohol dependence. They further caution that these results are inconsistent and vary across studies.

3.4. Socio-cultural influences

Research confirms the influence of socio-cultural factors in the development of alcohol dependence (Barlow & Durand, 2001; Sue et al., 1994; Ward, 1983). Herd (1988), investigating the difference in drinking by black and white women, found that race, independent of other social factors, is the strongest predictor of being an abstainer, a drinker or a heavy drinker. Herd (1988) discovered that for White women being employed, single and of high income status predict drinking behaviour, while for black women drinking behaviour is predicted by age, income and employment. Peltzer (2009) however focussed on the multi-racial and multi-cultural South African context and found that overall the South African culture is characterised by weekend binge drinking. Wilsnack, Vogeltanz, Wilsnack and Harris (2000) in a cross-cultural study investigated the variability and/or consistency of gender differences in drinking behaviour. They discovered that gender roles could intensify biological differences in reactions to alcohol. Michalak, Trocki and Bond (2006) and Patock-Peckham, Hutchinson, Cheong and Nagoshi (1997) found that religion plays an important role in individual's drinking behaviour. Patock-Peckham et al. (1997) discovered that individuals with no religious affiliation exhibited higher frequency of drinking and consumption of larger quantities of alcohol. According to Michalak et al. (2006) religion variables play an important role in drinking behaviour, especially abstention. Austin, Chen and Grube (2006) and Bhana (2009), investigating the impact of the media on individuals' drinking behaviour, found that not only does the media have the tendency to foster positive attitudes to alcohol use as

fashionable and appealing, but also that the influence of the media is usually underestimated by typical exposure-and-effects analysis.

Mphi's (1994) study clearly illustrates the effect of social stigma and different socio-cultural views of female and male drinking behaviour, as well as the effect culture can have on an individual's drinking behaviour. Mphi's (1994) study investigated female alcohol dependence in Lesotho and focused specifically on the role of women and their drinking behaviour in that specific culture. The study found that even though women in Lesotho are the traditional brewers and sellers of homemade alcohol, they encounter immense social censure if they drink or abuse alcohol. Women have to terminate their marriages if they are found to have a drinking problem. In addition, the local community does not offer these women any assistance as they feel they bring shame to their husbands and the community. These women then have to return to their families of origin where they will be stigmatised as "... children born of an irresponsible woman" (Mphi, 1994, p. 946). This study clearly demonstrates the impact of societal gender roles on drinking behaviour. It further shows that while men are allowed, or even expected, to drink, women experience great social stigma if they abuse alcohol. At the same time women are expected to maintain their traditional role as the brewers of alcohol.

3.5. Physiological consequences of alcohol dependence

The discussion above clearly shows that alcohol dependence is a multifaceted disorder. In order to place this disorder in context it is important to look at the plethora of physiological consequences of alcohol dependence. Literature indicates that alcohol dependence is physiologically significantly more detrimental for women than for men (Goodwin, 2000). Firstly, women are not capable of handling the same volume of alcohol as men. They become intoxicated after having consumed less than half of the alcohol that male subjects consume (Goodwin, 2000; Greenfield, 2002; Turnbull & Gomberg, 1991). This difference in response to alcohol consumption is due to the lack of alcohol dehydrogenase (the enzyme in an

individual's stomach that breaks down alcohol) in women's stomachs (Long & Mullen, 1994; McConville, 1991; Turnbull & Gomberg, 1991; Walter et al. 2003). The shortage of this enzyme results in women passing concentrated alcohol into their small intestines. This results in women having higher blood alcohol levels than men who have consumed the same volume of alcohol. Secondly, it appears that alcohol dependence causes greater physical harm in alcohol dependent women than in alcohol dependent men. Various studies confirm that there is a higher incidence of breast cancer in female alcohol dependents (Goodwin, 2000; Long & Mullen, 1994; McConville, 1991; Tjønneland et al., 2007; Zhang et al., 2007). Liver disease, hypertension, heart damage, gastrointestinal haemorrhage and brain damage are all more common in female alcohol dependents (Goodwin, 2000; Greenfield, 2002; Klaich, 1996; McConville, 1991; Prescott et al., 1997; Tolstrup et al., 2006; Walter et al., 2003). Gynaecological and reproductive complications are also very common among female alcohol dependents. Alcohol dependent women may experience irregular menstrual cycles, which can often cease all together. They may also experience sexual dysfunction, pre-menstrual discomfort, infertility, miscarriage, fluctuating hormone levels and early menopause (Covington, as cited in Klaich, 1996; Long & Mullen, 1994; Prescott et al., 1997; Walter et al., 2003; Wilsnack, as cited in Klaich, 1996;). It is interesting to note that women become intoxicated far more quickly when they are premenstrual or ovulating (McConville, 1991).

During the past twenty years it has become evident that the development of alcohol dependence in women follows a telescoping path. Women's problem drinking, even though it tends to start at a slower rate and at a later stage than men's problem drinking, develops or telescopes at a faster rate than men's drinking. Women tend to experience the complications of their heavy drinking after fewer years of drinking (Goodwin, 2000; Klaich, 1996; Wodarz et al., 2003). This puts alcohol dependent women at a higher risk of developing physical complications than alcohol dependent men.

It is clear from the above discussion that female alcohol dependents are at high risk of developing organ damage and ultimately dying from physiological deterioration due to their heavy drinking (Greenfield, 2002; Prescott et al., 1997).

3.6. Female alcohol dependents: The invisible population

A review of literature and research in the field of alcohol dependence revealed that little research and attention has been given to female alcohol dependents as a separate population (Dodge & Potocky, 2000; Goodwin, 2000; Greenfield, 2002; Hein & Scheier, 1996; Long & Mullen, 1994; Nolen-Hoeksema, 2004; Prescott et al., 1997; Van der Walde et al., 2002; Walter et al., 2003; Wilke, 1994). Most studies on alcohol dependence have been conducted on male alcohol dependents (Van der Walde et al., 2002; Wilke, 1994). These studies established the norms and standards for research on, and judging of, alcohol dependents' behaviour. As a result, they shaped the development of alcohol dependence theories and treatment approaches (Padayachee, 1998; Raine, 2001). This has resulted in alcohol dependence being seen as a man's disease. Any behaviour displayed by alcohol dependent women that deviates from these norms is then defined as abnormal (Wilke, 1994).

Over the last two decades researchers have begun to realise that alcohol dependent women differ from alcohol dependent men (Raine, 2001). This realisation triggered a new wave of studies in which alcohol dependent women were studied as a separate population. However, most of these studies are of a quantitative nature and focus solely on the needs of alcohol dependent women in treatment, ignoring other aspects of this disorder (Smith, 1998).

There has been an increase in qualitative studies on female alcohol dependence during the past fifteen years. For example, Klaich (1996) studied the lived experiences of women alcohol dependents, using hermeneutic phenomenology to identify and describe supportive and non-supportive environmental factors in their lives. Nehls and Sallman (2005) conducted a descriptive phenomenological study with the aim of discovering and providing a narrative for the experiences of women living with physical and/or sexual abuse, substance use and

mental health problems. The study also looked at how women cope with their disorders. Boyd and Mackey (2000) used a descriptive grounded theory framework to describe the lived contextual experience of alcohol dependent women. These studies indicate that research has started approaching female alcohol dependents in a new way. Each of these studies has focused on a specific aspect of alcohol dependence and opened new alleys for further research. Yet, there appears to be a lack of qualitative studies of an interpretive rather than a descriptive nature. Van der Walde et al. (2002) suggest that additional qualitative research is needed in order to investigate the nature of female alcohol dependence. This research could influence the nature of women-only alcohol dependence treatment programs. Wilke (1994) supports this view and suggests that more qualitative research needs to be conducted in order to investigate how alcohol dependent women experience their disorder, how they become alcohol dependent and how they experience their recovery process. Wilke (1994) emphasises the need to investigate the meaning female alcohol dependents attach to their disorder, to understand the role of context in their lives and to allow the female alcohol dependent to be heard and to benefit from the process. According to Ettore (1997) alcohol dependent women experience a deep lack in their lives, and this has never been attended to or explained by research. For most alcohol dependent women, these issues are also hidden from themselves as they hide their drinking in order to avoid shame and guilt.

3.6.1. Increase in female alcohol dependence

In the Western world, alcohol dependence has increased drastically during the past two decades (Ely, Hardy, Longford & Wadsworth, 1999; Engs, 1990; Greenfield, 2002; Long & Mullen, 1994; McConville, 1991; Prescott et al., 1997; Redgrave, Swartz & Romanoski, 2003). Research reveals that alcohol related diseases are killing three times as many women as a quarter century ago (Drink's Deadly Toll, 2003; Mann, 2006; Nolen-Hoeksema, 2004; Parry, 1998; Parry, 2001). Parry (2001) found that white women in South Africa drink on

average significantly more than black women. However, Narcon (2005) reports that there are no racial differences amongst female alcohol dependents in South Africa.

The fact remains that there has been an alarming increase in alcohol abuse and dependence among females in South Africa. This may be due to the impact of industrialisation, which has changed women's traditional roles. Women now have more independence than ever before (Allamani, Voller, Kubicka & Bloomfield, 2000; Ames & Rebhurn, 1996; Long & Mullen, 1994). Consequently, women are now entering the job market at a higher rate than ever before. They also experience a rapid increase in their salaries and are exposed to images of alcohol consumption that portray it as an attractive and appealing social pastime. This increase in social equality leads to greater lifestyle freedom for women and increased access to, and affordability of, alcohol (Babcock, 1996; Barlow & Durand, 2001). The role of poverty on alcohol use has also been investigated. Khan, Murray and Barnes (2002) found that increased poverty causes increased alcohol use and alcohol problems. They also discovered that recent unemployment decreases alcohol use compared to longer unemployment that increases alcohol use.

Another alcohol related problem that has come to the fore during the past few decades is Foetal Alcohol Syndrome (Klaich, 1996). In 1973 two Seattle paediatricians, Jones and Smith (Goodwin, 2000) coined the term 'Foetal Alcohol Syndrome', more commonly known as FAS. The paediatricians found that pregnant women who drink heavily have a 50% chance of having a baby with abnormalities. The most common features of FAS are low birth weight, cognitive deficits, learning difficulties and general behaviour problems. Characteristic facial features, such as a thin upper lip, short nose, small head circumference, skin folds at the corners of the eyes, a low nasal bridge, a small midface, small eye openings and a groove between the nose and upper lip are also very widespread amongst individuals with FAS (Barlow & Durand, 2001). Awareness of FAS is not just limited to the psychological and medical community, but has become widespread in the general public as more evidence has

been found that pregnant women need to abstain from drinking in order to protect their unborn children (Goodwin, 2000; Prescott et al., 1997). As a result, women experience severe social sanctions for being intoxicated while pregnant (Klaich, 1996). Disturbingly, the prevalence of Foetal Alcohol Syndrome (FAS) in South Africa is increasing rapidly. In fact, research found that 122 out of every 1,000 Grade 1 pupils at a school in the Northern Cape have FAS (Foetal Alcohol, 2007; Louw, 2007; Visagie, 2006).

3.6.2. Social stigma and discrimination

Following the discussion on the increase in female alcohol dependence and the prevalence of Foetal Alcohol Syndrome, it is not surprising that society is harsh in its judgement of alcohol dependent women. They face more societal rebuke and chastisement than their male counterparts (Ettore, 1997; Nolen-Hoeksema, 2004; O'Connor, Berry, Inaba, Weiss & Morrison, 1994; Van der Walde et al., 2002). Gender, while shaping and influencing female and male roles on an economic, socio-cultural and political level, also creates inequalities between males and females (Raine, 2001). According to Raine (2001), gender influences cultural norms and values. It also creates expectations regarding correct behaviour and roles for men and women. Based on these prescribed rules, the social sanctions theory (Nolen-Hoeksema, 2004) states that while it is socially acceptable for men to consume alcohol, female alcohol consumption is discouraged. In addition, women are expected to conform to their prescribed gender roles and display traits such as nurturance, femininity and emotional expressiveness (Chassin, Tetzloff & Hershey, 1985; Landrine, Bardwell & Dean, 1988; White & Huselid, 1997). Alcohol dependent women are judged to have deserted their prescribed traditional roles of mother, wife, nurturer, general caretaker and sexual partner. They are also seen as being dangerous, sexually promiscuous, immoral, selfish, reckless and sometimes even hopeless (Bauer, 1982; Edwards et al., 2003; Ettore, 1997). Wilsnack (1996) confirms the hypothesis of the social sanctions theory. The research found that women attending a party felt that 50% of fellow party-goers would judge them if they got drunk, but

felt that only 30% of the party-goers would disapprove of a drunk man. Long and Mullen (1994) and Reed (1987) suggest that drunkenness in men is seen as an acceptable expression of camaraderie, whilst for women drinking is often a dirty secret that needs to be hidden from the world. Additionally, women experience a great discrepancy between their traditional feminine sex role identity, their attitudes toward marital and educational roles and their participation in male-valued activities (Anderson, Stevens & Pfof, 2001).

3.6.3. Drinking in isolation

Societal stigma and discrimination are the biggest barriers to care and treatment experienced by alcohol dependent women. These barriers cause them to experience shame and guilt about their drinking behaviour (Hser et al., 2003). Cook (1988) found that alcohol dependent women experience significantly more guilt and shame than alcohol dependent men. In contemporary society women experience constant pressure to drink, but at the same time they experience disapproval if they get drunk (McConville, 1991). Furthermore, a woman is often blamed for her alcohol dependent husband's behaviour, while men are seen as the victims of their alcohol dependent wives behaviour (Ettore, 1997). Therefore, alcohol dependent women often drink alone or with the companionship of only a few close friends. This reduces the likelihood that their problem will be uncovered by their partners and also helps them to avoid the moral sanctions of society (Edwards et al., 2003; Klaich, 1996; Long & Mullen, 1994).

3.6.4. Female alcohol dependence treatment

It comes as no surprise that the social stigma and discrimination experienced by alcohol dependent women affects the diagnosis and treatment of their disorder. Firstly, male physicians are often in denial about alcohol dependence in women simply because women, according to society's norms and values, should not be alcohol dependents (Bauer, 1982). Hence, they find it difficult to separate their personal image of womanhood from their

medical task of diagnosing and treating alcohol dependence among women (Bauer, 1982). Johnson (as cited in Padayachee, 1998) found that physicians view female alcohol dependents as having looser sexual morals, more psycho-sexual conflicts and more social difficulties than alcohol dependent men. Physicians and other health care workers also tend to see women's alcohol dependence as a mental health illness. As a result women are often treated at mental health facilities where they are given pills such as sedatives and tranquilisers, to quiet their nerves (Padayachee, 1998). It is common for these women to then develop a secondary addiction (Bauer, 1982; Edwards et al., 2003). Stereotypical attitudes are also apparent in the health care system. Alcohol dependent women found professionals to be ignorant and this resulted in their being a burden to the women (Padayachee, 1998).

The diagnosis of female alcohol dependence is problematic as the symptoms of female alcohol dependence are easily masked by other symptoms, such as gynaecological, psychological or cardiovascular problems not attributed to alcohol (Vandermause, 2005). Health care providers see female alcohol dependents as sicker and more difficult to treat than men (Wilke, 1994). Wilke (1994) suggests that the subordinate status of women should be acknowledged in order to provide meaningful information for accurate assessments and successful interventions.

Boyd (2004) and Green et al. (2002) report that women prefer having female counsellors as they found that many treatment services are sexist. Van der Walde et al. (2002) established that the cost of treatment, familial opposition, denial of alcohol dependence as well as inadequate diagnostic training of physicians are also common barriers faced by women in treatment. Furthermore, pregnant women are rarely taken in at treatment centres and their children are seldom allowed to join them. Similar findings by Cohen (2000) and Parks, Hesselbrock, Hesselbrock and Segal (2001) suggest that the provision of transportation and childcare are important needs in treatment for female alcohol dependents. These needs are often left unattended. They also found that female alcohol dependents experience pressure to

stay at home in order to look after their children at the expense of their health. Various other studies also emphasise the need to focus on the provision of mental and vocational services and the treatment of emotional, physical and sexual abuse. Ultimately, treatment programs should be designed specifically for alcohol dependent women to meet their specific situational demands and address the specific barriers they face (Ashley, Marsden & Brady, 2003; Redgrave et al., 2003).

The above discussion shows that the critical factors to successful alcohol dependence treatment differ for men and women. Women are more likely than men to experience circumstances and incidents that interfere with their ability to complete the treatment process (Green et al., 2002). Edwards et al. (2003) found that an early onset of alcohol dependence, multiple life problems, unemployment, a dysfunctional relationship with a significant other as well as few primary relationships prior to treatment were all factors predicting poor treatment outcomes for alcohol dependent women. Women entering treatment for alcohol dependence are also less likely to receive support from their partners and families than alcohol dependent men. Padayachee (1998) states that a drunken woman entering treatment for alcohol dependence is seen as being more offensive to society than a drunken man and is therefore scared to bring her private life into the treatment environment. Rice et al. (2001) suggest that the impact of violence on the alcohol dependent woman's life also needs to be investigated, and may ultimately have to be incorporated into treatment programs.

It is clear that alcohol dependent women experience immense social stigma and discrimination. Female alcohol dependents should therefore be treated in separate treatment programs in order to attend to their special needs. Physicians, therapists and other health care workers need to gain more knowledge about alcohol dependence and strive to change their negative attitudes and mindsets toward these women (Jarvis, 1992).

In addition, the increase in female alcohol dependence in South Africa is a grave dilemma that requires urgent attention. Alarming, there are no female-only treatment programs in South Africa (S. Hon, personal communication, February 28, 2006). It is important to realise that women, like men, contribute to the country economically, socio-culturally and politically. Hence, they also have the right to equal treatment to assist them in fighting their alcohol dependence.

3.7. Conclusion

The preceding discussion highlights the importance of psychological, biological, and socio-cultural aspects in the development of alcohol dependence. It also shows that female alcohol dependence is a complex phenomenon and that there is no single typical alcohol dependent woman (Klaich, 1996). A 75-year old widow abusing alcohol and prescription drugs has a very different living context than an unemployed 20-year old alcohol abuser who also uses cocaine and marijuana, or a black 35-year old divorced woman working fulltime to support her children while dealing with racism on a daily basis. The discussion also shows that research on alcohol dependent women, based as it is on traditional male-dominated scientific models of alcohol dependence, fails to consider the meaning and the role of context in the lives of alcohol dependent women. The discussion further indicates that there is a multifaceted circular interplay between the alcohol dependent and alcohol. There are numerous influences, including culture, life context and gender (Fleming et al., 1988; Klaich, 1996). Vandermause (2005) states that as the experiences of women have been less visible, the structure for understanding their experiences has not been traditionally defined. New insight into this disorder can be gained through using a different frame of language and questioning (Vandermause, 2005). The best way to achieve this and to understand the complexity of a person's lived experience is to allow that person to tell his or her story (Aston, 2005). Only then will it be possible to weave together pieces of the person's life story in order to provide abundant and concrete details of her life with addiction. It is also through

listening to the alcohol dependent women's stories, and reliving their experiences with them, that areas of their lives and disorder, which have not previously been researched, will become visible (Vandermause, 2005). It is therefore important to look further than the mere description of why female alcohol dependents drink and to investigate how they experience their problem and how this disorder makes sense to them. The following chapter provides an overview of the research design and methodology of this study and discusses why it is the most suited to investigate the lived experience of female alcohol dependence.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

*“The alcoholic thinks about alcohol from morning till night,
and at night, if not too drunk to dream, dreams about alcohol.*

When to have the first drink?”

(Goodwin, 1981, p. 34)

4.1. Introduction

The aims of the present study were twofold. Firstly, the study aimed to achieve an in-depth look at the lived experience of female alcohol dependence, to see how alcohol dependent women experience this disorder and how it makes sense to them. Secondly, this study allowed me to incorporate my lived experience of alcohol dependence into the research process, and ultimately find answers to my questions regarding this disorder. Due to my own involvement with this disorder, based on the lived experience of my father’s alcohol dependence, it is inevitable that my own perceptions and preconceived notions influenced the research process. The goal of this study was therefore not to establish any causality, but rather to explore the lived experiences of those who have this disorder as they naturally present themselves in the interviewing process.

Based on the above aims, the most appropriate methodology from which to conceive, analyse and present this study was judged to be Heideggerian hermeneutics. This approach is particularly useful in the study of complex and highly contextual phenomena, such as female alcohol dependence. Working within this framework allows the researcher to expound on the psychological and emotional facets while also incorporating any relevant cultural, social and physical features that manifest during the research process.

This hermeneutic phenomenological study, grounded in the philosophy of Heidegger, was used to investigate the following research question:

‘What is the lived experience of female alcohol dependence?’

This research question guided the research process and allowed me to obtain a resonant description of alcohol dependent women’s lived experiences of this disorder. It also allowed me to simultaneously incorporate my own interpretations in an ethical and compelling manner, thus ensuring a holistic and insightful understanding of the lived experience of female alcohol dependence (Neuman, 1997).

4.2. Research design

The interpretive approach assumes that “... people’s subjective experiences are real and should be taken seriously (ontology), that we can understand others’ experiences by interacting with them and listening to what they tell us (epistemology)” (Terre Blanche & Durrheim, 1999, p. 123) and that qualitative research techniques are best suited to achieve this. The goal of qualitative interpretive studies is to obtain a unique story of particular phenomena whilst keeping individuals’ subjective experiences intact as these events transpire in their natural setting (Hoepfl, 1997; Terre Blanche & Durrheim, 1999). Participants are encouraged to ‘tell it like it is’. The spoken (sometimes written) text is placed back into the context through ‘recontextualisation’ (Terre Blanche & Durrheim, 1999). This process is a back-and-forth movement between the strange and the familiar, as well as between parts of the study and the study as a whole. Consequently, the research question is reformulated time and again as new information comes to the fore. Hence, it is not possible to finalise any research strategies before data collection has begun (Hoepfl, 1997).

According to Terre Blanche and Durrheim (1999), there are numerous ways to collect and analyse qualitative interpretive information. Phenomenology, which is an umbrella term that incorporates various diverse philosophical schools, is one of these approaches. For the

purpose of this study, the discussion first focuses on namely descriptive (eidetic) phenomenology. This approach is then contrasted to interpretive (hermeneutic) phenomenology. The research approach and research findings of a study depend on which one of these approaches is used. An in-depth discussion on interpretive phenomenology – specifically Heideggerian hermeneutics – follows. Reasons are then provided as to why it was considered appropriate to use this approach as a framework for the present study.

4.3. Philosophical background

4.3.1. Phenomenology

Phenomenology is concerned with the world as it presents itself to us and “... seeks to understand the lived experience of individuals and their intentions within their ‘life-world’” (Crabtree & Miller, 1992, p. 24). When phenomenology was first used as a research methodology, it signified a major shift from empirical Cartesian positivism. Phenomenology distances itself from the natural sciences, which avoid incorporating human experience into their inquiries (Alvesson & Sköldberg, 2000). Phenomenology reproaches the purely scientific approach to research and views it as sterilising the life-world, maintaining that “... positivism, with its rational ‘scientistic’ analyses, had drained [the life-world] of all substance and colour, leaving behind mere abstract formal structures, castles in the air set free from their earthly moorings” (Alvesson & Sköldberg, 2000, p. 36). In contrast, phenomenology seeks to understand how individuals experience something, what is it like to feel a certain experience. This shift away from the scientific approach emphasises an understanding of phenomena as we encounter them in this world: our ‘lived experience’ of a phenomenon as “... integral, temporal elements of a dynamic situation” (Vandermause, 2005, p. 35).

4.3.2. Descriptive phenomenology

According to Edmund Husserl (1859-1938), one of the most prominent phenomenological philosophers of the twentieth century and seen by many as the founder of modern phenomenology, the natural sciences “... do not recognise [their] philosophical origins and [their] grounding in human subjectivity and that, through drawing a distinct line between human values and worldly facts, science ignores human existence, and consequently, becomes irrational” (Arfken, 2006, p. 14). Husserl, a transcendental phenomenologist, sees each individual as existing in a life-world where there are no theoretical concepts or scientific reflection (Arfken, 2006; Reber, 1995; Vandermause, 2005). Husserl focuses on the experience of happenings, events and occurrences through consciousness, where individuals, in their life-world, are free to engage in activities, enjoy their everyday lives and socialise with other individuals (Reber, 1995). Husserl states that this life-world forms our foundation for all our understandings, whether it is scientific in nature or part of our normal activities. He further notes that although this life-world consists of our knowledge of everyday activities, it is important to abandon this background knowledge in order to understand the essence of this life-world. He makes a clear distinction between “... the subject and the object-as-the-object-appears-through-consciousness”, in order to emphasise the abandonment of knowledge, sometimes also referred to as ‘bracketing’ or ‘reduction’ (Vandermause, 2005, p. 35).

Husserl’s methodology aims to allow us to perceive things as they appear to us, and to set aside, or bracket, the presuppositions and biases that we already have about these things (Willig, 2001). Willig (2001) indicates that, according to Husserl, in order to understand the life-world a researcher must not only let go of all existing knowledge, but must also refuse to accept or reject any hypothesis about this life-world. Hence, an individual has to detach herself from all opinions, whether they are commonsense or scientific evidence. For Husserl, this “... phenomenological reduction allows the researcher to grasp the organisation of what

we take for granted in our everyday practical experiences “ (Arfken, 2006, p. 18). However, some theorists see Husserl’s contribution to phenomenology as merely an extension of the Cartesian tradition of the natural sciences. From this viewpoint Husserl’s ideas are seen as positivistic, a consideration that caused a division in the field of phenomenology (Vandermause, 2005).

4.3.3. Interpretive phenomenology (hermeneutics)

Hermeneutics, which means to ‘interpret’, was conceived during the Renaissance as a way of interpreting biblical texts and ancient classics (Alvesson & Sköldberg, 2000). The term is derived from the Greek word ‘hermes’ (Wilson & Hutchinson, 1991). In Greek mythology Hermes was a messenger responsible for changing unknowable knowledge into something that humans could understand.

Hermeneutics aims to uncover reality, to discover meaning and to achieve understanding. In addition, hermeneutics aims to make sense of that which is not yet understood, and to provide a rich description of the meaning that individuals attach to their lived experiences within a meaningful social, cultural, political and historical context (Addison, 1992; Crabtree & Miller, 1992; Packer, 1985; Rapport, 2005; Wilson & Hutchinson, 1991). Phenomenology becomes hermeneutic when it is used in an interpretive, rather than a purely descriptive, manner (Moules, 2002; Rapport, 2005).

The idea of lived experience is very important within phenomenology. Rapport (2005) describes lived experience as an individual’s immediate and pre-reflective consciousness; the reality of lived experiences that belong to any one individual in any given context. Klauch (1996) views lived experience as individuals’ daily behaviours, meanings, accompanying thoughts and feelings originating from interaction with their environment. Furthermore, Dreyfus (as cited in Rapport, 2005) suggests that lived experience is embedded within the context of the lived life of each particular individual and forms the narrative of that life. The meaning a person gives to her life reveals how the life has been lived, is being lived and will

be lived in future. Dreyfus (as cited in Rapport, 2005) also postulates that severing an individual from her own personal meaning is inhumane as it ignores her will, the most important primary motivation to find meaning in life. Burch (2002) feels that lived experience originates in closeness or nearness to others and that through reflection on this experience the individual ascribes meaning to it. It is not correct to say that a lived experience is an individual's direct experience of something; rather, the individual is also her own lived experience.

Based on the above discussion, it is clear that an individual's context of lived experience plays a vital role in hermeneutics. Seidman (1998) stresses the importance of acknowledging context, as it results in participants' behaviour becoming meaningful and understandable. Incorporating an individual's context will help the researcher to interpret phenomena in a comprehensive manner, consequently producing a rich and insightful account of the lived experience of female alcohol dependence, rather than just providing a descriptive and accurate analysis (Hein & Austin, 2001). Addison (1992) also points out that while working within the hermeneutic approach, it is important to bear in mind that the meaning a person attributes to her life is constantly changing and evolving, and that the individual's context plays a major role in the formation of meaning.

Researcher subjectivity also plays an important role in hermeneutics. According to Vandermause (2005), researchers bring intact sociolinguistic and historical pre-understandings to a research project. Moules (2002) notes that a researcher cannot remove this subjectivity from the research process. Researchers should therefore make use of this subjectivity to see, understand and interpret what the participant says. Moules (2002) further notes the importance of declaring prejudices, even if only to ourselves, in order for the prejudices to form part of the research process.

The blending of the views, prejudices and attitudes of the participants and the researcher allows all these role-players to be involved in a ‘hermeneutic circle’ (Conroy, 2003). The role-players then build on their knowledge through constant reflection and interpretation and “...work together to bring life to the experience and phenomenon being explored” (Lavery, 2003, p. 21). Within the hermeneutic circle, parts of a conversation are understood from the whole, and the whole is understood from the parts (Alvesson & Sköldberg, 2000). Lavery (2003) further suggests that the participant and the researcher should use the hermeneutic circle, their imaginations, their idiolect and writing skills to accomplish their tasks. Conroy (2003) states that the hermeneutic circle also works outwards, and includes the interpretations of additional readers as they read the text and make their own contributions, based on their beliefs, assumptions and personal values. Furthermore, hermeneutics also incorporates empathy, as it is the responsibility of the researcher to put herself in the participants’ shoes so that the meaning of their acts emerges lucidly (Alvesson & Sköldberg, 2000).

The above discussion demonstrates that hermeneutics does not see truth as an objective reality. Rather, the researcher’s own values and experiences play a vital role in interpreting the lived experiences of the research participants (Addison, 1992).

a. Martin Heidegger’s hermeneutics

Heidegger’s philosophical hermeneutics formed the foundation for data collection and data analysis in the present study. Martin Heidegger (1889-1976), a student of Edmund Husserl, argued that “... all description is ultimately interpretation” (Klaich, 1996, p. 60). Heidegger extended and revised Husserl’s ideas. This revision led to a major shift from Husserlian transcendental phenomenology to philosophical hermeneutics, commonly known as the ‘Heideggerian turn’ (Vandermause, 2005). There are several differences between the two approaches. First, in contrast to Husserl’s epistemological questions of knowing, Heidegger focuses on ontological questions of experiencing: “... the attention to consciousness is pre-empted by an awareness of language, temporality and historicity as the

medium through which we came to be” (Vandermause, 2005, p. 36). Second, Heidegger does not keep Husserl’s clear distinction between subject and object and breaks away from Husserl’s transcendental concept of ‘bracketing’. The theory holds that “... subjectivity and objectivity should by no means be considered as radical and contradictory alternatives” (Stenner, 1998, p. 62). According to Heidegger, subjectivity and objectivity cannot be studied separately as human experience is already in the world and thus inseparable from the world. The subject-object distinction thus makes way for a more original unity (Alvesson & Sköldberg, 2000; Rapport, 2005).

Heidegger suggests that the hermeneutic method is the most suitable way to study human beings and human behaviour. The individual and her ‘lived experience’ in her ‘life-world’, as well as the relation the individual has to this world and experience, need to be studied because this is a precondition for understanding (Klaich, 1996; Lavery, 2003; Packer, 1985). Heidegger views knowledge as temporal and contextual, and truth as something that is hidden and fluid in nature. Truth can only come to the fore and become known as ‘truth’ through language, and through man as being (Steiner, 1989). He states that our understanding is constantly changing and that it is our pre-understandings that guide our behaviour (Klaich, 1996). Life is forever changing, revealing and concealing – Heidegger did not believe in the *a priori* existence of man (Fehér, 1994; Moules, 2002; Steiner, 1989; Vandermause, 2005). Instead, individuals are seen as interpretive, relational and meaning-seeking beings who are intertwined within the world they live in. This being-in-the-world is known as ‘Dasein’. Individuals are in constant interaction with each other through language, practice and culture (Lavery, 2003). In order to make sense of their existence, an individual “... achieves his existence through questioning...and it is this process which makes man deserving of question” (Seidman, 1991, p. 20). This concept is known as ‘Seinsverständnis’ and refers to the idea that only human beings themselves can question their being and give access to their thought processes and emotions. It is only through questioning that an individual’s existence becomes

meaningful (Steiner, 1989). Human beings must therefore pay attention to phenomena around them, and when they allow a situation to present itself to them, it will be recognised and ultimately lead to a questioning of their own being (Fehér, 1994; Vandermause, 2005).

Laverty (2003) notes that Heidegger places emphasis on 'situated freedom'. This means that individuals' subjectivity is closely linked to their social, political and cultural contexts. This situated freedom allows the individual to make choices freely but with the awareness that these choices are circumscribed by the specific conditions she lives in. Laverty (2003) notes that Heidegger's concept of situated freedom is in direct opposition to Husserl's concept of 'radical autonomy', which provides descriptive categories of the real world as found in the narratives of the participants. Laverty (2003) also suggests that a hermeneutic phenomenologist should focus on the meaning individuals attach to their being-in-the-world and how this influences the choices they make.

According to Heidegger, providing a description of what an individual subjectively experiences is not sufficient. It is important to allow the person to tell her story as it is experienced in order to interpret what she experiences every day (Klaich, 1996). It is through sharing our stories of our lived experiences that we communicate our pre-understandings to others (Wray, as cited in Klaich, 1996). Heidegger states that it is not possible for an individual to put her preconceptions, emotions and ideas aside in order to study phenomena. Therefore, 'co-constitutionality' is very important. This refers to a process wherein the meanings of researcher and participants are merged to interpret a phenomenon (Laverty, 2003). This stance clearly demonstrates Heidegger's opposition to physics and the scientific world. Individuals are inseparable from their life-world and therefore all actions in this life-world need to be interpreted.

From within this methodological framework it is therefore possible to generate new understandings through rigorous thinking, which allows particulars as well as new possibilities to rise to the surface. Within this framework a researcher must remain constantly

aware of known and unknown influences on thinking and understanding, as well as remaining aware that the self cannot be separated from these influences (Klaich, 1996).

4.3.4. Conclusion

Distinguishing between Husserl's transcendental phenomenology and Heidegger's philosophical hermeneutics has important implications for methodological application. Husserl's bracketing and epistemological approach to human experience assumes that a researcher must put aside all presuppositions, ideas, attitudes and biases in order to study phenomena (Vandermause, 2005). Heidegger, on the other hand, sees all these processes as being part of a misunderstood whole. It is thus clear that the way researchers "... approach, engage in, and interpret a project depends upon which tradition, the epistemological Husserlian or the ontological Heideggerian, provides the influence" (Vandermause, 2005, p. 38).

This study aimed to discover and obtain an in-depth narrative of the lived experience of female alcohol dependence. It sought understanding about what it means for alcohol dependent women to be in this experience; is sought to understand the *how* rather than the *why* of this phenomenon. Thus, working within the Heideggerian hermeneutic framework provided the best approach to addressing the research question.

4.4. Data collection and analysis

For the data collection and data analysis phases of this project, the guidelines proposed by Kvale (1996) provided the overall structure. These guidelines then divided the research process into seven stages. These stages were thematising, designing, interviewing, transcribing, analysing, verifying and reporting.

4.4.1. Thematising

The aim of this study was to uncover the lived experience of female alcohol dependence. Key questions included the following. How does alcohol dependence affect the way women feel about themselves? How do they make sense of their disorder? If they could tell a story about their lives of alcohol dependence, what would they tell? In order to achieve this aim, a Heideggerian hermeneutic phenomenological framework was used. This framework was the most appropriate way to answer the research question, which was: “What is the lived experience of female alcohol dependence?”

4.4.2. Design of the study

The qualitative, exploratory study was conducted from within an interpretive paradigm, which guided the conditions for collection and analysis of data. Working within this paradigm allowed the researcher to study female alcohol dependence as it unfolded in real-world situations. The experience was studied without manipulation, and the processes were viewed as parts of an interrelated whole (Terre Blanche & Durrheim, 1999).

Data was collected through in-depth, unstructured interviews. The interviews were audio-recorded, transcribed and later analysed in order to discover the meanings that the participants gave to their lives as female alcohol dependents. This unstructured approach was guided by the research question and allowed participants to talk freely about anything that they deemed relevant.

In order to gain access to potential research participants a letter of invitation (Appendix A), accompanied by a letter from the Ethics Committee at the University of South Africa as well as an example of the informed consent letter (Appendix B), was faxed or emailed to various state and private alcohol dependence rehabilitation centres in and around Johannesburg and Pretoria. This letter of invitation gave an overview of the background of this study, an overall description of the various aspects and stages of this study as well as the requirements for participation in the study. A case purposive sampling technique was used to

select participants. The psychologists or social workers at the rehabilitation centres selected participants based on various predetermined criteria (Seidman, 1991), these criteria are explained below. An important criterion was that the participants' primary reason for being in rehabilitation had to be alcohol dependence, although they could also have secondary dependencies on other substances. Participation in this study was voluntary and participants were selected based on their amenability toward participating in the research study and their willingness to tell their stories. The participants also had to be English or Afrikaans-speaking alcohol dependent females, who were older than 18 years of age. Participants had to be in rehabilitation for alcohol dependence at the time of the interviews. Participants had to be psychologically and physically able to participate in this study. In order to obtain a diverse sample of participants it was important that the participants were from various ethnic and cultural backgrounds.

Due to the nature of the research design, it was not possible to determine in advance the number of participants required. However, it was decided to invite a minimum of three participants from each rehabilitation centre. Recruitment of participants continued until no new information was yielded during the interviews (Guest, Bunce & Johnson, 2006; Seidman, 1991).

4.4.3. Interviewing

The aim of interpretive research is to interact with individuals in their natural, everyday settings and to get to know them fairly intimately, without engaging in a therapeutic relationship (Seidman, 1991; Terre Blanche & Durrheim, 1999). To achieve this, and to ensure that participants shared their feelings and experiences, data was collected through in-depth unstructured interviews. Interviews were conducted in English and Afrikaans. Questions were mostly of an open-ended and non-directive nature, focused or specific questions were sometimes used to encourage participants to elaborate on something they had mentioned (Willig, 2001). The open-ended nature of the questions allowed me to understand

the meaning and context of the participants' behaviour, as people's behaviour becomes meaningful and understandable when it is placed in the context of their lives and the lives of those around them (Seidman, 1991). Seidman (1991) states that, without context, there is little possibility of exploring the meaning of any experience "[E]very word that people use in telling their stories is a microcosm of their consciousness" (Seidman, 1991, p. 4).

Furthermore, working within the hermeneutic framework, I avoided asking leading questions. I explored and did not probe. Silence was tolerated. I avoided reinforcing the participants' responses and also asked questions when I did not understand what the participants were saying (Seidman, 1991).

The audio-recorded interviews took place in quiet and private rooms at the various rehabilitation centres. I met with each participant individually to discuss the various aspects of the study and to answer any questions relating to the study. The length of the interviews was also discussed with the participants prior to the interviews. It was noted that the length of the interview could vary from 60 to 90 minutes (Seidman, 1991).

I took notes during and after the interviews and captured verbal as well as non-verbal behaviour in order to enrich the data analysis. The participants were also provided with a diary to capture anything that they wanted to share, but did not mention during the interviews. I also kept a diary to record my own reflections after each interview. I maintained this diary throughout the duration of the study. Rapport (2005, p. 134) strongly recommends the use of a diary to assist in the self-reflection process and to "... focus the mind not only on the story being told, the semantic expression, but also on the emotive qualities of data collection, the mantic expression, which together offer a more holistic view of the lived experience".

The interviews were guided by Seidman's (1991) three interview series guidelines. During the first interview, the focus was on the focused life story of the participant, in order to establish the context of the participant's experience. At the beginning of the first interview the participant was informed about the purpose of the study and my own involvement with

alcohol dependence. I conveyed an equality of status by sharing personal information and allowing the participants to ask me questions (Klaich, 1996). I emphasised that the participants were not research subjects but rather experts on their own lived experiences of alcohol dependence.

Each initial interview opened with the following question: ‘If you had to tell me a story about your lived experience of alcohol dependence, what would you tell me?’ From that point forward the participants shared their early experiences as they saw fit. This included reconstructions of their childhood, their neighbours, their friends, schools they attended, career-related memories and, finally, their present circumstances.

The second interview focused on the details of their experience and allowed the participants to reconstruct these details in context. The focus during the second interview was on the details of experience, rather than on opinions. The participants were allowed to tell the story of their daily lives, starting from when they wake up to when they go to sleep.

The third and final interview allowed the participants to reflect on the meaning that they attach to the various aspects discussed in the first two interviews. During the final interview the following questions guided the conversation:

- Given what you have said about your life before you became alcohol dependent, and about where you are now, how do you understand alcohol dependence in your life?
- What sense does alcohol dependence make to you?
- Where do you see yourself in the future?

Vygotsky (as cited in Seidman, 1991) states that it is important that participants see how all the various factors in their lives interact to bring them to their current situation. Vygotsky (as cited in Seidman, 1991) also indicates that although participants only focus on the meaning and their understanding of these experiences during the third interview “... the very

process of putting experience into language is a meaning-making process” (p. 12). Seidman (1991) suggests that the three interviews should take place at least three days to one week apart, in order for participants and the researcher to have ample time to reflect on what transpired during the interviews.

An interview guide was not used during the interviews conducted for this study because the primary goal of the study was to allow the participants to tell their stories as they wished to tell them (Heliker, 1997). Arfken (2006) suggests that the following range of questions can be used during unstructured interviews:

- Concretising questions, such as ‘can you think about a time when that happened?’
- Elaborating questions, for example ‘can you say a little more about that?’
- Interpreting questions, for instance ‘I see, so you are saying that ...?’

The following questions, proposed by Vandermause (2005), guided the conversation during the interviews:

- Tell me more about ...
- That is interesting, isn’t it?
- What was that like for you?
- Anything else came up around that?
- Was there anything else going on?
- Can you think of a ‘for instance’?
- What else was happening that day?
- Anything more you remember?

- Others have told me about ... is this anything like your experience?
- What stands out for you about that situation?

Rapport (2005) suggests developing a conversational relationship with the participants. This allowed me to establish a trusting relationship with the participants. This relationship was achieved by means of appropriate prompting and interjection during the conversation. It was important that I exercise active listening techniques, to look, to question and to interpret, and relate to the participant by sharing my own thoughts during the conversation when the opportunity arose (Terre Blanche & Durrheim, 1999). Rapport (2005) refers to this as a fusion of horizons between the worldview of the participants and the researcher's own worldview. This blending of worldviews allowed for the elucidation of all the essential qualities of the phenomenon. I also surrendered to reciprocal question and answer dialogue during the interviews, in order to open myself up when participants asked questions, and to be sensitive to this spiral movement (Thompson, as cited in Vandermause, 2005). Terre Blanche and Durrheim (1999) emphasise that it is important to be close enough to the context to be familiar with it and recognise it as true, while at the same time keeping enough distance so that the phenomenon can be viewed in a new light.

4.4.4. Transcribing

Professionals transcribed the audio-recorded interviews verbatim for each participant. All the verbal and nonverbal signals, such as grammatical errors, pauses, telephone rings, laughs, sighs, outside noises, interruptions and any other sounds produced during the interviews were included in the transcripts in order to reflect the essence of each interview (Seidman, 1991).

4.4.5. Analysing

In this study, I was interested in the participants' lived experience of their disorder, rather than in establishing the objective nature of the world or finding out whether what happened to them concurs with an outside reality (Willig, 2001). Data analysis was therefore conducted from within a Heideggerian hermeneutic framework. This allowed unique and insightful information about the lived experience of female alcohol dependence to emerge. This assisted in understanding the participants' worlds more clearly. Analysing within this framework also allowed me to make my own history part of interpreting the participants' lived experiences. This fusion of horizons allowed all the essential qualities of the phenomenon to become known during the hermeneutic conversation, essentially revealing and constructing new meanings (Koch, as cited in Rapport, 2005).

There are no specific steps to follow when analysing data within a Heideggerian hermeneutic phenomenological framework. Thus, I made use of a combination of suggestions and frameworks proposed by various authors to guide me in the data analysis process.

a. General Orientation

Vandermause (2005) and Willig (2001) indicate that an analysis that uses a hermeneutic framework is constantly both phenomenological (as it represents the worldview of the participants) and interpretive (as it depends on a researcher's worldview). Therefore my interpretations and prejudices, as well as those of the participants, are subject to time, context, cultural and historical understanding, and are free to change at any given moment (Vandermause, 2005; Heliker, 1997). Willig (2001) additionally indicates that a researcher must first gain an understanding of how the participant views and experiences her world. The analysis should then capture the texture and quality of such individual experience. The phenomenological analysis thus produced will always be an interpretation of the participants' experiences.

Heliker (1997) acknowledges the importance of the participant's past, present and future, as well as various family patterns, when conducting data analysis. Heliker (1997) emphasises that it is important to obtain a comprehensive understanding of an individual's culture and language and to understand what matters for that unique person. Heliker (1997) also highlights the importance of personal meaning (for the participants and the researcher), which cannot be separated from the research process.

b. Steps to follow

Diekelmann (as cited in Heliker, 1997) proposes a general method for data analysis based on Heideggerian hermeneutic phenomenology. This method allows a researcher to move from one stage to the next, emphasising the hermeneutic circle. Firstly, in order to obtain an overall understanding of the story, each interview was examined as a whole. The interviews were then summarised and themes were identified. Interpretations, accompanied by excerpts from the transcripts, were used to support the analysis. During comparison, themes that cut across the participants' life-worlds and lived experiences were identified and documented. These patterns were then examined in order to find correspondence among the relational themes. In order to validate the interpretations in the final report, numerous excerpts from the verbatim data are included in the report.

Vandermause (2005) and Willig (2001) provide a comprehensive layout of the steps to follow during hermeneutic analysis. I first read and reread the transcribed texts and provided a summary of each interview. In the left margin of the text I noted my own wide-ranging and unfocused reflections, observations and thoughts. These notes included such things as observations on the language use of participants, questions that arose during the interviews and associations made during the interviews. In the right margin of the text I identified and labelled themes that characterised each section of the text. These themes, accompanied by psychological terminology, captured the essential quality of what was found in the text. The themes were then structured and put into context through clustering. Some of these clusters

were of a hierarchical nature, some overlapped, while others were natural clusters that shared similar meanings. For instance, ‘childhood memories’, ‘school days’ and ‘friendships during primary school’ could all form part of a ‘childhood’ cluster.

I constantly moved back and forth between the list of themes and the transcribed texts. I eventually generated a summary table of the structured themes, together with quotations that illustrated each theme. The focus at this point was on themes that captured something about the quality of the participants’ experience of alcohol dependence. Some of the themes produced during the second stage of analyses were not evident at this stage. It is important to note that my own interests and orientation towards this phenomenon influenced the clustering of these themes. The summary table also included keywords, subordinate theme labels, brief quotations and indications of where the references were found in the transcripts. This summary table was designed to reflect the meanings that structured the participants’ accounts and not my own expectations of how many clusters and themes there should have been. Finally, I identified patterns in the themes that cut across the participants’ interviews.

c. Facets of a hermeneutic analysis

Wilson and Hutchinson (1991) provide an overview of the different types of themes that comprise a hermeneutic analysis. Firstly, paradigm cases were identified. Wilson and Hutchinson (1991) state that paradigm cases involve cases that highlight the context, thereby keeping the person, the situation and their intentions intact. This information was not broken down into small units because this would have resulted in the loss of valuable information. Exemplars were then identified. These are shorter versions of paradigm cases that encompass all the interpretive and presentation strategies of the paradigm cases. However, exemplars also capture similar meanings in objectively different situations or contexts. Lastly, themes were highlighted. Wilson and Hutchinson (1991) indicate that themes form the last interpretive and presentation strategies in the analysis process. This phase involves the recognition of themes that appear in the texts. These themes are then combined with excerpts from the text that serve

as clear evidence for the existence of the theme. These three steps were essential in generating a deeper understanding of the lived experiences of female alcohol dependence through the blending of my own and the participants' worldviews. As the above discussion illustrates it is possible to use various guidelines to inform the data analysis process, despite a lack of clear steps to follow when conducting a hermeneutic analysis.

4.4.6. Verifying

One of the most difficult aspects of qualitative research involves demonstrating a study's trustworthiness and dependability. This is due to qualitative research's lack of scientific rigour (Crawford, Leyborne & Arnott, 2000). However, there are various ways to achieve trustworthiness and dependability within qualitative research. Including a 'decision trail' indicates the reasons for decisions regarding analysis and collection of data (Rapport, 2005). In this research study this is done through explicitly including the decisions and reasons underlying the theoretical and methodological choices made in the study. Moreover, the diary I kept reflected on my findings and conclusions, as well as any additional information that arose. I also frequently wrote, and rewrote, as new interpretations emerged. The diary was especially significant towards the end of the research process as its contents were added to the research findings in order to explore additional nuances. Van Manen (as cited in Rapport, 2005, p. 143) notes the importance of self-reflection as data collection is also dependent on the "... historical connection linking researcher interpretation to the participants' stories".

In order to gain a rich description of the lived experiences of female alcohol dependents the participants were quoted verbatim in paradigm cases, exemplars and themes. These paradigm cases, exemplars and themes are not intended to be generalised or to generate theory, rather they are used as vehicles to express my own interpretations (Wilson & Hutchinson, 1991). Wilson and Hutchinson (1991) indicate that these interpretations should be presented in this way in order to allow the reader an immersion or reliving of an

experience. The reader may then interpret and incorporate this experience into practice. As Rapport (2005) suggests, I also focused on the study as an integrated whole. No single aspect of the study was viewed as being more important than another aspect. Working within the three-interview series further enhanced the validity and trustworthiness of the study as it placed the participants' comments in context and allowed comparisons between these comments (Seidman, 1991). As the interviews were spaced between three days and a week apart, participants were allowed to reflect on the interviews and to insure the internal consistency of what was said (Seidman, 1991).

From the perspective of the hermeneutic framework it should be remembered that there is more than one valid interpretation of the lived experience of female alcohol dependence. Alternative interpretations are both possible and encouraged. The interpretation offered here is 'correct' only in as much as it reflects my own interpretation of the events at that given moment in time. Ultimately, it is the readers' interpretations that validate the research (Vandermause, 2005).

Each interview focused on investigating the lived experience of female alcohol dependence, and therefore produced rich information that would not have been obtainable through quantitative inquiry. As the goal of this study was to gain an understanding of the lived experience of female alcohol dependence, the findings produced a learning curve not just for the participants, but also for myself. It is important that the researcher learns from, and grows during, the research process (Seidman, 1991).

4.4.7. Reporting

At the end of the data collection and analysis phase, a final research report was generated. This research report contains the general findings, information on how the study has affected me personally, research suggestions on how the findings of this study can serve as a foundation for further research as well as how healthcare professionals can enhance their approach to alcohol dependent women.

4.5. Strengths and limitations

Working within the hermeneutic framework, specifically when conducting in-depth interviews, can be extraordinarily time consuming, emotionally taxing, labour intensive and expensive (Hoepfl, 1997; Seidman, 1991). Results apply only to the participants and generalisation thereof sacrifices understanding and individuality. The methodology chosen allowed the complexity and dynamics of the social and cultural contexts, as well as the way the participants and I experienced this phenomenon, to be taken into account (Hoepfl, 1997). The in-depth, unstructured interviews provided a rich hands-on description of this disorder. This ensured a compelling narrative of the lived experience of female alcohol dependence. It should also be borne in mind that even though the interviews took place in an uncontrolled environment, central tenets of the research framework were adhered to and this led to the generation of trustworthy research.

4.6. Ethics

The participants all signed informed consent forms before the first interviews (Appendix B). In this form the goals of the study and the participants' rights, including the right not to be harmed, during and after the study were explained. The form also explained that the interviews would be recorded, and that participants would be quoted directly in the final research report. The participants were informed that they have the right to full disclosure regarding any aspect of the research process (Mouton, 2001). The participants also had the right to review any material relating to them at any time during the study. They could ask questions at any point during the interviews. Participants could also withdraw from the study at any time without any negative effects resulting from this withdrawal. Pseudonyms were used during analysis to protect the participants' identities. Any identifying information was removed from all transcribed and analysed data (Fielden, 2003). Participants were also provided with my contact details if they needed clarification of any aspects of this study. Participants could also choose to receive a copy of the dissertation at the end of the study.

4.7. Conclusion

The above discussion focuses on the aims of the present study followed by a discussion on the chosen research design and methodology. The methodology adopted for the present study allows the researcher to address the research question in the most suited way. A background to Martin Heidegger's hermeneutic phenomenology provides an overview of the foundation for data collection and data analysis. This chapter highlights the various steps in the data collection and analysis phases and concludes with an overview of ethics and the strengths and limitations of working within the hermeneutic phenomenological framework. The next chapter provides a detailed description of the general findings in this study and examines the extent to which these findings concur with or refute existing literature.

CHAPTER 5: GENERAL FINDINGS

“One thing about alcohol: it works...much faster than a psychiatrist or a priest or the love of a husband or a wife. Those things...they all take time...but alcohol is always ready to work at once. Ten minutes..the little formless fears are gone or turned into harmless amusement”

(Goodwin, 1981, p. 88)

5.1. Introduction

This chapter aims to place the lived experience of female alcohol dependence, which will be discussed in chapter six, into perspective. An overview of the research participants as well as an outline of the research process is discussed. This is followed by a discussion of how the findings in this study concur with or disprove existing literature. The reader will note that due to the interactive relationship I had with the participants throughout the interview process, I have chosen to refer to them as co-researchers as I feel that this description better honours the nature of our relationships.

5.2. Overview of the research process

Nine co-researchers, recruited by social workers and psychologists, participated in this study. The ages of the co-researchers ranged from 18 years to mid-fifties. The majority of the co-researchers are Caucasian while one co-researcher is Coloured. All the co-researchers have children. Five co-researchers are divorced, one is single and three are married. Nearly all co-researchers have no tertiary education, other than one co-researcher who is a qualified nurse. One co-researcher is a nursery school teacher; another is a student while the remainder of the co-researchers are unemployed. Only seven of the co-researchers completed the study, two co-researchers left rehabilitation after the first interview. Although only seven out of the

nine co-researchers completed the study, all information collected during the interviews formed part of analysis.

The three-interview series guidelines proposed by Seidman (1991), guided the interviewing process. On average, the interviews lasted 90 minutes and were conducted in a comfortable and quiet environment at the rehabilitation centres at a day and time convenient for the co-researchers. Interviews were one week apart. This allowed the co-researchers and myself time to reflect on the experience. At the beginning of the first interview I shared with each co-researcher the history of my father's alcohol dependence. I decided to do this in order to explain to the co-researchers that I have been through the process now faced by their significant others. I also wanted the co-researchers to know that I am intimately aware of this disorder and its debilitating consequences. This revelation helped the co-researchers to feel more at ease to relate their experience of alcohol dependence to me.

The co-researchers were free to talk about their alcohol dependence in any way they saw fit. It was important that the co-researchers narrated their own experiences in their own words. This is because the meaning a person gives to her life ultimately reveals how her life has been lived, is lived and will be lived (Dreyfus, as cited in Rapport, 2005). Through reliving, discussing, questioning and re-questioning, the co-researchers and I embarked on a challenging journey together, with no mental itinerary and no preconceived ideas about where this journey was going to take us.

Following each interview, the content was transcribed verbatim. The information was then analysed in accordance with Heidegger's hermeneutic phenomenological framework (Crabtree & Miller, 1992). As this methodology has no precise analytical methods, various guidelines such as those suggested by Heliker (1997), Vandermause (2005), Willig (2001) and Wilson and Hutchinson (1991) were employed to give credibility to the analysis. Due to the nature of the methodology, analysis involved a constant back-and-forth movement between conversing with each co-researcher and interpreting the transcripts. The analysis of the rich

narratives eventually allowed us to journey to four separate destinies, each a life-world depicting a unique lived experience of female alcohol dependence.

Although the co-researchers showed an interest in the results of this study, final re-validation of my interpretations was not possible. Even though I did validate certain interpretations with the co-researchers through back-and-forth communication during the first two interviews, after the third interviews I was unable to communicate with the co-researchers due to either a changed telephone number or the co-researcher being unavailable. I was also contacted by a co-researcher's spouse who asked why she had to remain in contact with me. I was informed that he is not comfortable with her staying in touch with me, and as a result he strongly advised against it. I was given the impression that the co-researcher's spouse feared that additional sensitive issues relating to their personal life might be discussed, and he preferred that these issues remain hidden. After careful consideration of the implications of this state of affairs, as well as bearing in mind that the hermeneutic phenomenological framework allows multiple interpretations (Vandermause, 2005), I decided to continue with the analysis despite being unable to confirm my final interpretations with the co-researchers.

5.3. Theory and existing literature

5.3.1. DSM-IV-TR criteria

As expected, the co-researchers all met the DSM-IV-TR criteria for alcohol dependence (Carr, 2006). They had all made numerous unsuccessful attempts to cut down or control their alcohol abuse. The co-researchers also all had recurrent social and legal issues relating to their drinking behaviour. In addition, prior to the period of rehabilitation, the co-researchers failed to fulfil their major obligations and continued to use alcohol despite being aware of the adverse effects and the resulting social and interpersonal problems. Consequently, their pathological alcohol consumption led to the neglect of their social, occupational and recreational activities (Goodwin, 2000).

Another criterion, alcohol tolerance, was also evident among the co-researchers. They all found that they needed to consume larger quantities of alcohol over a longer period of time in order for the alcohol to have the desired effect (Goodwin, 2000).

... then I could already drink a bottle Malibu by myself. Then I started drinking it neat. Because you feel you just don't get the same buzz anymore. Have to make it stronger.

The co-researchers also mentioned that they have experienced a variety of withdrawal symptoms associated with their alcohol dependence. These symptoms ranged from morning shivers and nausea to headaches and anxiety.

... if not you know anxiety attacks, anger, shivers, heavy heavy ... the best advice is take another drink ... the more you drink the more you can handle, your body gets used to it.

I was too sick throughout the day to even think of cravings ... I had shakes and heart palpitations and nausea ... sometimes one hell of a headache ... I couldn't wait to get home and have my first drink at 5:30pm ... there were times that I was so sick that I couldn't drink but I did. I would get up and throw up, but that last bit of wine I had to drink because in my mind if I did not drink it then I will not be able to sleep tonight and there is no way that I cannot sleep, I have to sleep.

All the alcohol dependents displayed a considerable degree of denial (Coombs, 2004; Hales & Hales, 1995).

I have had no cravings, from day one to now. I am not even in the mood for it [alcohol]. I have not even thought about it. Honestly I have not even thought of alcohol since I entered rehabilitation.

Only one co-researcher indicated that she did not experience any withdrawal symptoms during rehabilitation. It is unusual for someone who is in rehabilitation for alcohol dependence to not experience withdrawal. It is possible that denial played a role in her not experiencing any symptoms. It must also be borne in mind that during rehabilitation the co-researchers received medication to minimise the symptoms of withdrawal.

5.3.2. Jellinek's typology of alcohol dependence

Looking at Jellinek's typology of alcohol dependence (Clarke & Saunders, 1988), it was clear that the co-researchers had all moved through the alpha and beta phases, expected of individuals who are in rehabilitation for alcohol dependence. The majority of the co-researchers find themselves at various stages of the most devastating phase of alcohol dependence, namely the gamma phase. One co-researcher, in the prodromal stage, experienced a loss of control, withdrawal from social interaction as well as physical deterioration due to her drinking behaviour (Clarke & Saunders, 1988). She describes herself as a hard drinker and had a sudden onset of alcohol dependence. She has the urge to have a few drinks on her own and experiences many blackouts.

Six of the co-researchers seemed to drift between the more advanced stages of the gamma phase namely the crucial stage and the chronic stage (Clarke & Saunders, 1988). They obtained alcohol at any cost and are unable to stop drinking once they have taken their first drink. The co-researchers lost control and ultimately consumed alcohol to relieve withdrawal symptoms. They also needed to have a drink first thing in the morning and are often intoxicated for most of the day.

*I have to drink half a jack to get up in the mornings and throughout the day I
drink to keep myself going...*

Two co-researchers appeared to be in the delta phase of alcohol dependence (Clarke & Saunders, 1988). They cannot abstain from alcohol, experience severe withdrawal symptoms when they attempt to do so and do not suffer loss of control after they have had their first drink.

The craving is unbearable. I mean I've experienced it very very bad. You can lose your mind. You don't want to you really don't want to ... I just had to have it to cope...

I could also drink nine quarts beer and then other people would look at me and think I am fine! I would never pass out.

The delta phase developed late in their lives after many years of drinking. Although they can consume alcohol without losing control they also need to consume alcohol in order to stay focused throughout the day.

5.3.3. Nature of drinking behaviour

The co-researchers consumed many different types of alcohol. The majority of the co-researchers indicated that they started drinking socially, initially drinking softer alcoholic beverages such as wine and beer and gradually beginning to drink spirits, rum and whisky. The co-researchers indicated that they had consumed alarmingly large quantities of alcohol in short periods of time.

You know, one month I must have spent – on our bar alone – I think R24,000 ... Just whisky. The other day I bought this papsak – you know, the soft bag of wine – and wine makes me very depressed. Whisky doesn't. But I really don't want to go back there, I really don't ... I used to drink 1 ½ litres a day of whisky. It was very bad. I never drank so badly.

I always started off with beer, because we stayed on a farm and it is freely available and cheap. Then I started off with Malibu and Coke. That is my luxury drink ... then I started drinking alone in my room. That was what I did the last time, but my father busted me. At that stage I was drinking a bottle by myself. I would have two or three mixed then I would have it neat. Because you then feel you do not get the same buzz anymore. Make it stronger. I would have a bottle by myself and think to myself 'what is wrong with the other people'?

Poly-substance use was prevalent amongst the co-researchers. Substances used included sleeping tablets and recreational drugs such as cocaine, cannabis and mandrax.

... dagga, ecstasy, mandrax. You know, I have tried everything except heroin ... I always looked for the hype ... I always look for something that would make me beat...

Yes, I am that type of person ... when my mom took alcohol away from me then I would go buy painkillers. Painkillers or sleeping tablets. Usually it was prescriptions tablets. If I had to go for an operation then I would abuse the tablets. I never used it as it was prescribed. I was very depressed and wanted to sleep all the time. And the alcohol made the depression worse. I just wanted to sleep and people had to leave me alone. Then I needed something to help me sleep. So I would use anything to make me sleep. If it was available I would use it. I would be fine for months and when I hit another dip I would look for tablets.

Only one co-researcher did not abuse other substances. She seemed to find alcohol more acceptable than other drugs. However, her family did abuse other drugs and this had led to her not wanting to experiment with other substances.

No I am totally against taking drugs. My brother uses drugs and my father uses drugs, and that really works on me. I cannot handle it. Even medication, If don't like it, pills and medicine ... for me it is something that could just get me drunk, I would use it.

One co-researcher indicated that she would go to any lengths to obtain the desired effect when alcohol was not available. She would drink Brasso, a metal polish, to achieve the high that alcohol could no longer provide. She appeared to view this as normal behaviour.

There are people in my mind if I'm not careful. I haven't had that for about 10 years now because I've been careful. So the last two years I've been drinking. I never drank like that before. Whisky. Before I used to drink spirits and Brasso ... through a rag. Don't you know it? You put it through a rag and you drink it.

The same co-researcher related that she experimented with various medications to counteract the effect of the Antabuse provided to them during rehabilitation. Antabuse is widely used in the treatment of alcohol dependence (Kinney & Leaton, 1982). Acetaldehyde, an intermediary product of alcohol metabolism, is normally present in the body in small amounts. However, when alcohol is taken after Antabuse medication (which blocks the enzyme necessary for the breakdown of acetaldehyde), it occurs in toxic amounts. The individual experiences adverse physical reactions such as vomiting, vertigo, breathing difficulty, tachycardia, general weakness and throbbing in the neck and head. The co-researcher was delighted to share her discovery that antihistamine counteracts the effects of Antabuse.

You must take the tablet [antihistamine] though because I drank three or four times on the Antabuse ... And then two hours after that I can drink ... I'm the first one to ever discover that and they asked me not to tell anyone else. Yes you just take the allergy tablet and it kills it. When I get home I will go straight to the clinic and get the Antabuse but I know the tablet to take that stops it and I'll drink on top of it and you get violently ill. It's an experience that you actually have to experience. You can die of a heart attack. You get high blood pressure and a rash. You want to get a knife and cut it open so you can just breathe. You suffocate to death actually. So I'll take the Antabuse then half an hour later I'll take the tablet to kill the Antabuse.

Physiological ailments, especially gynaecological problems, were common among the co-researchers. This is in accordance with the findings from previous research (Long & Mullen, 1994; Nolen-Hoeksema, 2004; Prescott et al., 1997). Liver disease, stomach ulcers, arthritis, disturbances in sleeping patterns, hallucinations and impaired memory were also prevalent amongst the co-researchers, a finding which is also supported by previous research (Goodwin, 2000; Greenfield, 2002; Klaich, 1996; Sue et al., 1994).

... sometimes for days on end I could not remember a thing I did. Even when I didn't drink, my memory was just a blank ... sometimes I couldn't remember what I did yesterday ... even though I did not drink. I couldn't remember what I wore, and I have always had a good memory ... the one day I was driving with my mother and I couldn't remember my pin number for my ATM card. I just couldn't.

I would say I get stuff like arthritis and alcohol, because it is so sour, made it much worse. I realised that sometimes I cannot even hold a pen. Then I realised it is all the acid ... My sleeping patterns also get worse when I drink. I

always woke up a lot. I also have many problems with my ovaries, but that is ok now ... I had cysts on my ovaries...

Not surprisingly, these ailments disappeared or improved radically once the co-researchers entered rehabilitation and halted their consumption of alcohol.

... but since I have stopped drinking my problems have disappeared. And I don't get sick that often anymore.

A few co-researchers indicated that they had ritualised drinking routines. During the interviews these co-researchers became upset when describing how people or external events interfered with their drinking routines. The co-researchers were very set in their ways and organised their daily existence around their drinking routines and drinking times.

... any painkiller you could get your hands on then you take it, go to the office and work the entire day ... I went in and worked, I never took lunch, rushed home, started dinner ... poured my glass of wine, chatted and watched TV with my son, had a bath, climbed into bed with my glass of wine right next to me, and exactly at a quarter past nine I would take my sleeping tablet and that was routine every single day. Monday to Friday. Go to work, get home, pour my glass of wine. Except for weekends. I couldn't wait to get home in the evenings to pour my first glass of wine. I got really upset if it was a quarter to six and I was not at home, because that interfered with my drinking time. Especially around five o'clock. I would buy whatever was needed for dinner, poured my glass of wine, took my shoes off, sit on the couch ... I did not swallow, I gulped it down. And as I drank it, it calmed me. I have so much stress at work. That is how my day started and how my day ended. Every single day.

Over Christmas we visited my in-laws. They asked us to stay over. But I wanted to return, I did not want to sleep there as it would interfere with my drinking time – I absolutely had a routine.

Only a few of the co-researchers experienced telescoping (Goodwin, 2000; Klaich, 1996; Wodarz et. al., 2003) as some of the co-researchers have been dependent on alcohol since adolescence and their drinking, as well as the accompanying complications, has remained constant. For some of the co-researchers alcohol dependence started during their late adult years and then telescoped at a rapid pace.

My daughters are 31, 27 and 23. My husband and I have been married for a while ... and we would open a bottle of wine and it would stand in the fridge for two or three weeks. But lately I started drinking a little bit more and more ... and when they found out that I have a drinking problem I started drinking behind their backs.

5.3.4. Disease theory and heredity

The disease theory states that alcohol dependence is a disease and should be treated as such (Aston, 2005; Coombs, 2004). However, based on the findings in this study, this appears to be a superficial view of this disorder. Although the co-researchers all exhibited physiological symptoms associated with alcohol dependence, it seems that these ailments are the consequence of their drinking rather than symptoms of alcohol dependence as a disease.

But I maintain that we also have a disease, is it a disease? Or is it a sin?

The conversations with the co-researchers indicated that their personality and morals played a significant role in the development of their disorder (Clarke & Saunders, 1988; Engs, 1990; Goodwin, 2000). All the co-researchers mentioned the idea of spiritual weakness. During rehabilitation they all become aware of a void in the spiritual or religious aspect of

their lives. However, it was also apparent though that this might be a transitory phase and would be likely to wane once the co-researchers leave rehabilitation.

It is also important to look at the role heredity plays in the development and maintenance of alcohol dependence. Existing literature indicates that heredity plays a significant role in the development of alcohol dependence (Nolen-Hoeksema, 2004; Wodarz et al., 2003) and this was confirmed in this study. All the co-researchers are children of alcohol dependent parents. However, even though heredity does play a role it is likely that a heredity predisposition to alcohol dependence interacts with modelling of alcohol dependent behaviour and socio-cultural influences.

Then you look for more and more of it. I believe it is heredity. All my family members are alcoholics. I am certain it is in our family.

... my father's family is very bad with drugs and alcohol and my mom's mom died of alcohol. So it is confusing people say it is a disease people say this you know?

During the research it became clear that the co-researchers experience pleasure when they consume alcohol. Goodwin (2000) indicates that individuals who suffer from a disease do not derive pleasure from the disease and do not look forward to the effects of the disease. Classifying alcohol dependence as a disease is therefore a very simplistic viewpoint. The co-researchers themselves also discussed the substantial influence of social, psychological and environmental influences in the development of their alcohol dependence, factors not acknowledged by the disease theory (Aston, 2005; Barlow & Durand, 2001; Engs, 1990; Lazarus & Colman, 1995; Wallace, 1990).

5.3.5. Laymen's theories

It is worth looking at the extent to which the findings in this study concur with laymen's theories (Bauer, 1982). Unlike the premise of the impairment theory, that alcohol dependents are seen as repulsive, irresponsible and comical drunks, the findings in this study do not portray that the co-researchers are repulsive. Although they were irresponsible in their drinking behaviour, each of the co-researchers is a unique person, with her own specific problems and emotions.

Yes another question is why me? And some people say why not you, are you better than the next person? That's not the answer I want.

The present study did not confirm the tenet of the dry moral theory that alcohol dependents are individuals who have a moral problem that only occurs when alcohol is available (Bauer, 1982). Although the co-researchers did display some level of moral weakness the simple removal of alcohol did not change their behaviour. Indeed, if alcohol was not available the co-researchers simply turned to other substances to satisfy their needs.

The findings in this study do not support the premise of the wet moral theory that alcohol dependents are individuals who do not obey society's rules. It shows the intricate role of personality, psychological, social, cultural and physiological factors in the development of the co-researchers' alcohol dependence (Bauer, 1982).

The present study shows that the laymen's theories are too simplistic. Female alcohol dependence is a rich and complex disorder that cannot be reduced to the result of a lack of moral values and positive characteristics.

5.3.6. Behavioural theories

This study clearly illustrates the role that positive and negative reinforcement, modelling, expectations and tension reduction play in the development of alcohol dependence (Barlow & Durand, 2001; Coombs, 2004). The co-researchers reported drinking to numb an

abundance of emotional pain, guilt, a hangover and physical pain. Some co-researchers drank out of boredom or loneliness and others drank to cope with stress, anger or frustration.

I had to drink a half a jack just to wake up ... I got up in the morning and realised I couldn't do without it ... I was never going to make it through the day [without it].

When I get up the first thing I do is drink pills for my headache, hangover I tell you. And then you lose your health, but I had to start my day with two pills ... any pills I could lay my hands on.

I drink when I am emotional. I drank when I was happy. I drank because I was sad or depressed.

Expectations played a large role in this study. The majority of the co-researchers indicated that they could taste the alcohol before they took the first sip. A few co-researchers also continued to experience the taste of alcohol while they were in rehabilitation.

I have always thought that I use alcohol as a mechanism to relax or to take the pain away ... I think about alcohol and I can taste it, really taste it.

I tell you beer does not make you drunk that fast. I started drinking wine just so I could get that nice feeling and then I would drink beer again. I drink wine just to you know relax a bit.

Many of the co-researchers had witnessed heavy drinking by a parent, spouse, partner or friend, indicating the significant impact of modelling on drinking behaviour.

And then my oldest brother ... my parents always said there is something wrong with him. So from the five children that are adopted [in our family] four are alcoholics! I have always felt that drinking is accepted, because everyone

around me was doing it! My father drinks every day ... my brother takes drugs occasionally. So I have always felt that, you know, my drinking is not that bad.

During this research it became clear that the co-researchers drank in response to stressful situations, refuting existing literature that women respond to stressful situations by developing depression and other psychological disorders (Skaff et al., 1999). However, it is possible that this stress was a symptom of an underlying depressed need.

I started drinking to deal with my stress, my marriage problems, anything that upset me ... I started drinking socially but over time started drinking to deal with my stress.

Then things started turning sour between my husband and I. Then his mother came to live with us. Not in the same house but right next to ours! She eats with us. She does everything with us.[My husband] then stopped giving me money. Its like: I need it because we don't have this and that. When he makes money he keeps it all to himself. Then I started hitting the street to go drinking, just to allow me to relax or feel better. Like when we disagree about something and he refuses to see my point then I will go out and drink. He will give money to his mother. I feel as if I am nothing in my house ... I do nothing more in the house. I don't care, I get up, get dressed and walk, even though I don't have money and go looking for alcohol. Just to get things off my mind.

One co-researcher mentioned how she relied heavily on 'Dutch Courage' when she had to cope with stressful issues. This made her feel socially acceptable and helped her to connect with others.

Terrible. Panic attacks. But I am going to try ... usually when I want to have a good talk I have Dutch Courage ... you have a good, strong whisky! You know, two strong whiskies and you've got Dutch Courage. We call it Dutch Courage – two strong whiskies and now I am ok. Now you must know I am saying to myself: ok, these two and it will do the thing. Half an hour later – another two whiskies, more Dutch Courage. Half an hour later – just another two whiskies. And another two. And then its another bottle. Its amazing to think that I've had all that alcohol and I am still alive. And I've hit the age of 52. How, I don't know I don't know. I don't know if I must be thankful for it or what.

All three motivations to drink, namely psychological rewards, recreational awards and achievements awards (Coombs, 2004) were present in this study. However many co-researchers preferred to drink in isolation. Overall reinforcement, modelling, expectancies and tension reduction appeared to play significant roles in the co-researchers' pathological drinking behaviour.

5.3.7. Family systems theory

Family systems theory postulates that alcohol dependence is a family illness and that the alcohol dependents' dysfunctional family relationships maintain the pathological behaviour (Bauer, 1982; Ward, 1983). This study found that the family dynamics could play an important role in the development and maintenance of a family member's alcohol dependence. Each of the co-researchers revealed that they come from, or are living in, a dysfunctional family. Although some of the families appeared to be more dysfunctional than others, each of the co-researchers had some measure of dysfunctional family dynamics.

The children started becoming scared of me [when I was drunk]. Just the mere fact that I was under the influence already made them scared of me. And that is not a nice feeling, when you have to hear that your children are scared of you. Because I know how I felt when my mother got drunk and came to me. I just wanted to be far away from her.

As far as I remember I think I was born in Pretoria. I stayed with my biological parents until I was six years old. I was adopted when I turned seven. There I have three brothers. My mother later remarried and I think I have three half-sisters. My father died when I was 14 years old. My mother died two years ago. My mother was also an alcoholic. My adopted parents always told me it is in my blood. That really frustrated me, 'its in your blood'. And in a way I always felt as if I had to prove to them that I am worthy to be their child. The social worker said the first seven years of your life is your forming years ... and for me there was not really any forming. There was only abuse. And then I was in a orphanage for 6 months and there I was also abused. Sexual abuse.

In keeping with the findings by Bauer (1982), it was found that some of the families are characterised by poor communication. This ranges from a total lack of communication (one co-researcher only speaks to her son a few times a year) to very rigid communication (where a perfect life is portrayed, and anything else is left unspoken).

My son started speaking to me as if I am an embarrassment. My son has seen me paralytic. He has no more respect for me. Why does he have to listen to me?

The findings in this study emphasise each family member's role in sustaining a family's status quo (Ward, 1983). I felt that the co-researchers' family members are afraid of looking at the dynamics of their families. Painful issues are avoided and the alcohol dependent behaviour displayed by the co-researchers is ignored. It appears that some family members avoid taking responsibility for their contribution to the problem. Furthermore, it appeared that the family members would rather let the alcohol dependent enter rehabilitation and deal with her problems on her own. Once rehabilitation is completed the alcohol dependent will return to her family life, which will continue as usual.

5.3.8. Transactional analysis theory

The transactional analysis theory of Eric Berne states that alcohol dependence should be viewed as a game rather than a disease. It is life scripts that form the dominant conceptions of the self and these scripts are maintained through social reinforcement (Ward, 1983).

My father is an alcoholic, he is still one. And he denies it all these years. You cannot even try and say something to him. That is where I learnt about alcohol, at home. At that time, I was young, it was a game to me and my mother did not drink ... they divorced when I was 15.

Most of the co-researchers had experienced this type of reinforcement. One co-researcher experienced turmoil from a very young age as she was transferred from one foster family to another. The only information she has always had about her biological parents was that her mother was alcohol dependent. She recalled her adoptive parents telling her that alcohol is in her blood and that she must be strong to make a success of her life. This script, that she is ultimately bound to be a failure, has formed the foundation of how she has approached life.

My mom was alcoholic. So it was in my house ... it is in my blood.

Another co-researcher clearly described pathological life scripts that form the basis of her existence. It is possible to speculate that these life scripts have played a significant role in the development of her alcohol dependence.

I screwed around heavy. I thought that having sex and drinking and smoking and laying around, was love. Because that's the only thing ... in the mean time it was a stuff up. I was getting beaten up. I thought that was love. And the more violent you abuse me the more I think it is love.

The premises of transactional analysis theory rang especially true for one of the co-researchers in this study. From a very young age she was constantly told how worthless and stupid she is and that she should have been a boy. In her adult life she constantly compares herself to her sister, who her father clearly appreciates more.

You know they told me I am stupid, some brain disease, dyslexia ... so there is something wrong with me ... My dad, you know, he always said I must have been his boy ... my father makes such a fuss over her [my sister] when she gets here.

Ward (1983) indicates that such scripts form early in life and guide subsequent drinking behaviour. In order to deal with these negative emotions, the co-researcher subconsciously discredits everyone else by making her scripts applicable to them.

I see this sister of mine every day of my life. She comes around half past six every morning to check on my dad to see if he's all right. That pisses me off, excuse my language. She is such a bitch ... You know I have a bad hangover and then I still have to see her! You know and I can't explain it to you, she's my biggest pain, you know she tries to control my life.

It is clear from the discussion above that life scripts, and the games people play, have an important role in the development and maintenance of alcohol dependence.

5.3.9. Psychodynamic theories

Although the numerous psychodynamic theories vary in their exact explanation, the general tenet is that childhood traumas cause alcohol dependence (Bauer, 1982; Sue et al., 1994; Ward, 1983). Analysis of the interviews revealed that all the co-researchers have experienced some type of abuse, whether sexual, emotional or physical, at some point in their lives. Most of their abuse occurred during childhood. The co-researchers appeared to exhibit an abundance of anxiety, anger and aggression towards others. This finding concurs with existing literature and indicates that childhood trauma is a key contributor in the development of alcohol dependence (Fleming et al., 1988; Glover, as cited in Levin, 1990).

I never had a very pleasant childhood, since the age of nine ... I was abused heavily by men.

The reason for my drinking ... hmmm ... I was raped. I kept it inside for 40 solid years. I was raped when I was 16. I kept it inside for 40 years ... you experience anger ... I was emotional, I cried, I was frustrated ... anxiety and depression.

The findings in this study do not support the viewpoint that alcohol dependence is the result of repressed unacceptable homosexual tendencies. One co-researcher is at ease with her sexuality and proudly identifies herself as lesbian. Her family supports her and her partner. The other respondents are in heterosexual relationships. No homosexual wishes came to the fore during this study. Furthermore, analysis revealed that the co-researchers turn their inner conflict against themselves. It was unclear whether this was due to hostile feelings unacceptable to society or due to feelings that they themselves refuse to confront.

My life is my life ... I am honest with my mother, my mother knows I am gay, I am lesbian, she accepts me that way. She accepts my girlfriend, actually they get on very, very well. I am glad they also accepted her. They are crazy about her

In accordance with current literature the study revealed that all the co-researchers have poor interpersonal skills. Most co-researchers also have poor relationships with their mothers.

I did not have a relationship with my mother ... they then told me she is not my mother ... and the reason I did not have a relationship with my mother was because of the man she married. He did not really like me and was very abusive towards her and that also kept me away from them ... I cannot talk to her about anything.

I was my dad's favourite ... not my mother's ... I was closer to my dad.

My mother and I do not get on. We will be civil with each other but that is where it ends. So my mother and I clash a bit. My mother doesn't really work with the emotional part of being.

The narratives in this study concur with the premise of Finkelstein's Relational Model that growing up in a dysfunctional environment leads to children developing a distorted sense of self (as cited in Van der Walde et al., 2002). The information that surfaced during the interviews strongly indicates that childhood traumas, whether they involved physical, sexual or emotional abuse or a poor relationship with the mother, played a significant role in the development of alcohol dependence among the co-researchers. However the findings do not necessarily support psychodynamic theory.

5.3.10. Personality theories

Personality theories postulate that certain personality traits account for alcohol dependence (Bauer, 1982; Coombs, 2004; Sue et al., 1994).

You forget about all your responsibilities ... you spend money, you spend money that it totally unnecessary ... spend on the kids, you spoil them and I know I am not suppose to do that ... I would buy them expensive clothing that I now know was unnecessary, at that stage I did not worry about it. So for the time that I did not spend with them I made up for it by spoiling them.

The present study does not support Hales and Hales' (1995) Type I alcohol dependence. As expected, some of the co-researchers in this study developed their alcohol dependence before the age of 25, mostly as a result of their traumatic childhoods as compared to a specific adulthood setback or loss. The co-researchers experience guilt, fear or loss of control regarding their alcohol dependence and some can abstain from alcohol for lengthy periods of time. However, other co-researchers have to consume alcohol on a continuous basis. Furthermore, as Hales and Hales (1995) and Wodarz et al. (2003) indicate, some of the co-researchers do appear to be anxious, shy, emotionally dependent and pessimistic. However, they did not present as sentimental. On the contrary, the co-researchers appeared to be emotionally absent with regard to anything that could have sentimental value.

The criteria for Hales and Hales' (1995) Type II alcohol dependence was found in the present study, refuting the tenet that it only occurs in males. Some of the co-researchers revealed that they developed alcohol dependence before the age of twenty-five. These co-researchers are close relatives of an alcohol dependent male and they consume alcohol to reinforce feelings of euphoria

I started drinking when I was thirteen ... my father dropped me at my mother's house and I didn't want to be there. So from thirteen [years] I was drunk. But think it was only naughtiness and my relationship with my mother was bad until today.

Man, it happened two weeks ago. I have high blood pressure, started getting blackouts and flickering till the point where I cannot see anything in front of me. Then I started taking alcohol with these tablets two weeks ago. Yes, it was bad. I also took sleeping tablets. I must have gotten up and fallen, I don't know what happened, I don't know anything. I am blank. The ambulance took me to the hospital and I have no idea how I got there. I am too scared to ask. I have not asked how I got home. I woke up in my own bed.

In addition, poly-substance use was common amongst the co-researchers. Many of the co-researchers also have a history of conflicts with the law.

[My husband] ... has had me locked up before. They will lock me up for an entire weekend. A few days.

The co-researchers in this study also exhibit an abundance of innate aggression and hostility towards others, something that is not found in Hales and Hales' (1995) Type 1 typology of alcohol dependence. The discussion above clearly indicates that the findings in this study do not concur with Hales and Hales' (1995) classification.

I always kept everything [emotions] in. Everything, pain, but when I drink, no it didn't come out, aggression did.

Weijers et al. (2003) found that female alcohol dependents seek sensation and exhibit adventure-seeking behaviours. The research question was not specifically designed to address this finding, but analysis did reveal that sensation seeking and adventure-seeking behaviours

were uncommon amongst the co-researchers. One co-researcher did indicate that she exhibited this type of behaviour only while intoxicated.

... we had a few glasses of wine then decided to go visit [friend] in Middleburg.

I do not know how we got there. I was very drunk. But I drove 200km. Can't believe they didn't catch me.

Coombs (2004) found that alcohol dependents have problems identifying and regulating their emotions. The alcohol dependent might be emotionally immature, have feelings of inadequacy, a need for power and low frustration tolerance. This inability to identify and regulate emotions appeared to be true for all the co-researchers in this study. This could be due to a lack of acceptance of the self accompanied by an overall sense of personal inadequacy. One co-researcher explained that she has had to hide her emotions and anger since childhood, as her father told her that it is not appropriate for her to cry or exhibit any emotions. This has caused her to mutilate herself as self-punishment for emotion. She was not hesitant to show me all her scars. I found it heartbreaking to see an individual who has never really felt any emotions other than hurt and pain. Overall her narrative is indicative of an emotionless existence and may indicate borderline personality disorder.

I just lay on my bed the other night ... and actually it is very strange ... I don't really cry. Not ever. Because my father told me that I am not suppose to cry ... last week Tuesday ... so I went to my room and I couldn't help it, I cried. But nobody – since the age of nine really – has ever wiped a tear off my face. I will always grab my pillow. And I went into my room, I closed the door and I was crying and I was thinking of how I used to drink and do I deserve all this punishment. And I wouldn't answer the door to anybody. And then the one care worker walked in and she wiped off a tear. I didn't like it [hugging by social worker] because I felt like a sissy because she caught me crying. And

she wiped off the tears and I thought: you know this is the first time in my life since nine... and then I was finished crying, I was extremely angry. Very angry. Then I went and cut myself because I cried ... and you mustn't cry because you are strong. It was a hell of a lot to hide. And I'm not really much of a talkative person because ... what's damaged is damaged. You can't undo it. You don't cry about it. What you do about it, I'd stopped it [self-mutilation] now for two years. I did for twenty-six years. You cut yourself or burn yourself with cigarettes. That was an answer to everything. I've been battling, five times I've nearly done it.

Nathan (as cited in Sue et al., 1994) identifies two personality characteristics associated with drinking behaviour, namely antisocial behaviour and depression. Despite not particularly investigating this association, all co-researchers did mention that they either suffer from depression or have received treatment for depression in the past. Unfortunately it could not be established if the depression is a cause or effect of alcohol dependence. Furthermore, there was no indication among the co-researchers of any anti-social behaviour.

Very depressed and very upset. Very, very, very. Really... very upset. I don't know, I am petrified as well

Eventually you cannot take it anymore, you cannot stand yourself as a human being anymore ... you get angry with yourself. Disappointed ... I could have been so much more in life.

It is disastrous, you cannot anymore. Everything in life is too much for you. Just to get up in the morning is too much for you, to get dressed is too much, to bath is too much, you are permanently under the influence.

The information from this study supports the research that indicates that alcohol dependence is not caused by a single personality type or trait (Barlow & Durand, 2001; Bauer, 1982; Klaich, 1996; Lazarus & Colman, 1995). It also refutes MacAndrew's findings (as cited in Peele, 1990) that alcohol dependents are aggressive, pleasure-seeking and assertive criminals and delinquents. However, the co-researchers did indicate that once they start drinking alcohol they express aspects of their personalities that, under normal and sober circumstances, would be expressed differently.

Maybe I want to discover cross addition. Because I feel I am an addictive person. They say you get your addicts and then you get your addictive personalities. And in everything I do I am addictive. You can tell me to go to gym and I will become addicted to it. I realised I have that personality.

5.3.11. Cognitive theories

Cognitive theories postulate that an individual's interpretation of an event is a critical factor in the development of alcohol dependence (Sue et al., 1994). Spending time with the co-researchers allowed me access to their schemas – their thoughts, self-evaluations and perceptions – and it was clear that their alcohol dependence, and more specifically their inability to remain sober, could possibly be caused by irrational and maladaptive assumptions and thoughts as well as distortions in their actual thought process.

This bad thing. I am not interested. Where is the garden? But help me out I don't know why after. I've had bad experiences in church, very bad.

Can you understand I cannot read well. I cannot understand well. I am a very soft-hearted, stupid woman.

I should have impressed my mother. I wanted to make my mother happier ... I feel like a failure. But it is not something I did consciously.

One co-researcher always believed that alcohol dependents are not psychologically stable and do not have settled lives. As she considers herself to be a together and settled individual, she struggles to understand how she became an alcohol dependent.

I cannot believe that I have become an alcoholic. I am so against it. My brothers drank, my mom and my sister. I didn't think that I would also end up there! I have everything I need in life, a good husband, a house, I have everything, so why did I become an alcoholic?

Dogmatic and rigid 'oughts', 'shoulds' and 'musts' also form a core of the co-researchers' schemas. Sue et al. (1994) found that individuals are not disturbed by actual events, but rather by the views they take of these events. For example, an event might trigger the belief that 'I am a failure'. This finding encapsulates the way the co-researchers appear to view their lives and society in general. They feel like victims trapped in their own worlds, they feel that they do not deserve what has happened to them.

I suppose I get what I deserve. But I have not asked to be an alcoholic. Why am I an alcoholic?

Beck (as cited in Sue et al., 1994) notes six types of faulty thinking processes that operate in alcohol dependents. Some of these thought processes were more common among the co-researchers, but all of them did occur to a greater or lesser degree. The co-researchers frequently made use of arbitrary inference to draw conclusions about themselves without sufficient and relevant information. They tend to draw these conclusions about themselves based on external events and the effects these events have on them. The process of selective abstraction, which refers to drawing a conclusion without considering the larger picture, was common among the co-researchers, especially among those co-researchers who had been

victims of rape. For example, one co-researcher blames herself for being in the wrong place at the wrong time.

You feel you are filthy, that it was your fault. Everyone always thinks it is their fault. You always think 'I should not have sat there'. How could I have been so stupid to walk with him and believe him?

The co-researchers seemed to over-generalise on two levels. Firstly the co-researchers felt that society treats them in a particular way. They often viewed themselves as fighting against society. One co-researcher over-generalised by assuming that alcohol dependence is a common occurrence for everyone. Despite my telling her on numerous occasions that I am not alcohol dependent, she continued to question me about my disorder.

How did you manage to stay sober? Do you have a relapse? Do you have cravings for drinking?

Beck (as cited in Sue et al., 1994) states that alcohol dependents use magnification and exaggeration to overestimate the importance and significance of negative life events. On the contrary, the co-researchers tended to minimise the importance and significance of negative events.

Thousands of women have been raped and it is not a big deal you know.

One of the co-researchers did seem to exaggerate her heavy daily workload. Her narrative indicated that most individuals would view this workload as normal. The co-researchers did not make use of personalisation, a thought process whereby external events are related to the self without basis (Sue et al., 1994). It is possible that the nature of the research question did not allow such thought patterns to surface. Lastly, the co-researchers tended to view the world in polarised extremes. For example, the world, people and social events are seen as either very good or very bad. The co-researchers also exhibit polarised

behaviour. This was especially evident in one co-researcher who sometimes exercises fanatically and at other times will not exercise at all. Another co-researcher emphasised that she does not make friends easily and is an introvert, while at the same time pointing out how outgoing she is.

I usually get up three or four in the morning to go to gym half past four in the morning. Come back again do my work then go back to gym and will jog and all that and I loved it, it was my lifestyle.

I don't make friends easily. No, I will introduce myself to new neighbours as soon as they move in.

I love taking chances but I hate changes.

As indicated by Beck (as cited in Sue et al., 1994) these patterns of pathological thinking may serve to protect the co-researchers from their troubled reality, but they may also have played a role in the development of their alcohol dependence.

5.3.12. Socio-cultural findings

The majority of the co-researchers are part of a heavy drinking culture and highlights the impact of socio-cultural factors in the development of alcohol dependence. In this culture drinking forms part of daily life and people are frowned on if they do not drink.

But then there are friends who will say 'we have to make a plan, we have to go drink'. We have to go to this place, there are guys and alcohol ... if you do not drink with your pals you are not their friend.

My biggest trigger is 'good times'. I grew up in a family where we always had good times drinking alcohol, we would socialise over a glass of wine, me and

mom and sisters whilst the men are out fishing, we would sit and chat over a glass of wine, this is how I associate alcohol. It was good times.

Merten (as cited in Ward, 1983) posits that individuals who strive towards material wealth end up becoming dependent on alcohol when they cannot realise their goals. This hypothesis was not confirmed during this study. None of the co-researchers mentioned the role of material wealth in their lives probably as it relates to their socio-economic status. Instead the inability to achieve personal goals such as happiness, inner control and stability played a major role in the development of the co-researchers' alcohol dependence. It appears that an individual's culture plays a stronger role in the development of alcohol dependence than not being able to achieve material wealth.

5.3.13. Biopsychosocial theory

The biopsychosocial theory hypothesises that a biological predisposition, psychological and social factors play a role in the development of alcohol dependence (Engs, 1990; Raine, 2001). The following summary provides an overview of existing literature as well as a discussion of the extent to which the findings in this study refute or concur with the tenets of the biopsychosocial theory.

- *Early childhood:* According to the biopsychosocial theory, a biological predisposition, lack of approval from parents combined with feelings of loneliness and social deprivation as well as a lack of social support are clear indicators of the possibility for the development of alcohol dependence in adulthood. The discussion above indicates that all of these factors were evident in the lives of the co-researchers in this study.
- *Adolescence:* The biopsychosocial theory further postulates that the presence of an alcohol dependent parent, as well as the experience of parental disapproval, are prominent factors in the development of alcohol dependence in adulthood. These factors were common amongst the co-researchers.

- *Adulthood:* During adulthood the experience of violence and a traumatic life experience in general seem to play a significant role in the development of alcohol dependence. All of the co-researchers had experienced traumatic events in their adult lives.

5.4. Conclusion

The preceding discussion and narratives clearly show that various factors play a role in the development of female alcohol dependence. A history of childhood abuse, the impact of watching a parent abuse alcohol, personality characteristics, the way in which an individual interprets an event and physiological vulnerability are all factors that can impact on the development of alcohol dependence. No one isolated factor can be highlighted as the cause of this disorder. As a result, the findings in this study support the biopsychosocial theory's premise that biological, psychological and social factors play a role in the development of female alcohol dependence (Lazarus & Coleman, 1995). When compared to other theories of the aetiology of female alcohol dependence, it is clear that the biopsychosocial theory provides the most comprehensive and integrated account of the causes of this disorder. Although the biopsychosocial theory provides a thorough explanation of the diverse causes of alcohol dependence, it does not explain how alcohol dependents experience alcohol dependence, which is the essence of the present study, and will be discussed in the next chapter.

CHAPTER 6: THE LIVED EXPERIENCE OF FEMALE ALCOHOL DEPENDENCE

“Live moderately because great pleasures rarely go unpunished”

(Puritan moral, Goodwin, 1981, p. 77)

6.1. Introduction

The overall objective of this study was to gain an in-depth understanding of the lived experience of female alcohol dependence. The focus was on the female alcohol dependents’ pre-understandings and pre-reflective experiences, rather than on what they consciously know. Heidegger’s hermeneutic phenomenology provided the overall framework for approach, interpretation and analysis (Crabtree & Miller, 1992). The research question ‘what is the lived experience of alcohol dependence?’ served as the departure point from which the interviews developed.

6.2. The lived experience of female alcohol dependence

Due to the hermeneutic nature of this study it was my responsibility to be empathetic, to put myself in the co-researchers’ shoes and allow the meaning of their lived experiences to emerge in a lucid manner. While I was spending time with the co-researchers, their lived experiences appeared to be highly elusive. Klaich (1996) states that it is our pre-understandings that guide our behaviour and that we are not explicitly aware of them but rather experience them. Through allowing ourselves to actively take part in the hermeneutic circle and to constantly reflect, interpret and work together, the co-researchers and I brought the lived experiences to life. Through reduction we re-achieved a direct and primitive contact with the co-researchers’ life-worlds as they are experienced. From within the hermeneutic phenomenological framework, analysis and interpretation revealed that the lived experience of female alcohol dependence is characterised by four life-worlds. These life-worlds can be identified as ‘The Disheartened One’, ‘The Ambivalent Player’, ‘The Contemplator’ and ‘The

Covert Chauvinist'. These four life-worlds were identified amongst all the co-researchers within their social, cultural and historical contexts. Each life-world encapsulates two extreme principles, each with their accompanying lived experiences. The first principle of each life-world has a negative undertone and is indicative of the lived experiences of female alcohol dependence prior to rehabilitation. The second principle of each life-world is more positive and is indicative of the ideal lived experiences of this disorder during and after rehabilitation. Ideally the co-researchers would move from the negative principle to the positive principle in each life-world. However, the reader must bear in mind that an alcohol dependent never fully recovers and therefore the co-researchers will always be at some unique position between the two principles of each life-world. Lived experience is fluid and ever changing. The lived experiences that correspond with each of the principles in a life-world are lived in the present, but could also have been experienced in the past. Thus, there is an abundance of overlapping as well as back-and-forth movements between the lived experiences within each life-world.

The following discussion of the lived experience of female alcohol dependence is based on my analysis and interpretation and aims to provide answers to my own questions about alcohol dependence. Why do alcohol dependents drink even though they are aware of the negative consequences? Why do they drink when they know the effect it has on their significant others? Why do alcohol dependents rely on alcohol to solve their problems? Why do they carry on drinking even though they have promised themselves that they will never drink again? These are just a few of the questions that the analysis below hopes to answer.

It is important to understand that the following discussion does not intend to generate theory or establish causality. Rather, it attempts to show that alcohol dependence is a multi-faceted and highly contextual disorder. The interpretation below is presented in a story-like format in order to capture the essence of the lived experience of female alcohol dependence. Throughout this chapter verbatim quotes are provided to substantiate my interpretations and

re-contextualise the findings by placing the language of the co-researchers in context (Terre Blanche & Durrheim, 1999).

6.2.1. The Disheartened One: Inner turmoil vs. Inner peace

The first life-world that presented itself was *The Disheartened One*. This life-world is characterised by an abundance of inner turmoil as well as a strong sense of inner peace.

a. Inner turmoil

Immersing myself in the life-world of the ‘disheartened one’ revealed a strong sense of negativity within this world. A constant sense of inner turmoil is present. At first it appeared that this turmoil is caused by current events, but spending quality time with the co-researchers made it clear that this inner conflict originated during their childhoods. This conflict appears to have been mentally pushed aside and has not been attended to since childhood.

All the co-researchers experience inner turmoil stemming from their histories of emotional, physical or sexual abuse. Some of the co-researchers experienced multiple types of abuse. The abuse that the co-researchers endured is a strong and constant presence in their immediate and pre-reflective consciousness. However, they are not aware of its continued impact. The co-researchers feel filthy and are repulsed by the self. This forms a significant core of their daily pre-reflective experience. They do not understand why they feel the way they do and try to find answers to questions that they do not know how to ask. Their will is a primary motivation to find meaning in their lives (Conroy, 2003; Lavery, 2003) and causes the co-researchers to continue searching for meaning. This is evident in the narrative below.

...dirty, who is going to want you? At fifteen you are not even a virgin anymore, something that you have been taught from a very young age is a wonderful thing for your wedding night is now stolen. Who will want you? No-one would want me now, you are damaged, damaged goods.

The co-researchers are looking for answers but at the same time they downplay events and abuse. Abuse was often portrayed as something that was almost normal and formed part of everyone's daily existence.

There is so much I don't want to talk about and there is so much I want to talk about. I learnt to deal with the part of my life being abused at nine years old. Being raped, I don't even think ... there are hundreds of thousands of millions of women that it happens to. It's just no big deal, I've dealt with it. I'm 52 years old and nobody's had answers to my questions. I've dealt with that part of my life. Its gone, its forgotten. I don't talk about it anymore. You can do nothing about it.

I was kind of raped by my brother ... at that stage I was just trying to keep the peace in the house for my brother and sister, they were much younger than me.

When the co-researchers talked about their distressing experiences, they reiterated various aspects of their lived experience within their life-worlds that are unclear to them. They seemed to be trying to convince themselves of why they are feeling the way they do, why they are thinking the way they do.

I kept it inside for 40 solid years. I was raped when I was 16. I kept it inside for 40 years.

One co-researcher shared intimate details of an unpleasant childhood with me. By allowing my lived experience to become part of her lived experience, I felt the emotional hurt and pain she endures daily. She was abused over a lengthy period of time during her childhood. It is not the actual abuse that hurts her the most, but the fact that her significant others let her down.

I was born in Alberton ... I didn't have childhood days. I had to work. I had to wash the dishes and set the table, because at 4 o'clock the day starts. My brothers had a great life. My mother loved the boys. I had to cook and on Fridays I had to iron all the washing. It was a lot of work. Eight o'clock at night then I had to wash the dishes. I didn't have to study. I didn't do homework. I was more in the office than on the playground because I had to work. Then my brothers would laugh. Then I had to carry the sweet potatoes and peel them. I didn't have a childhood. It was very difficult. My sister and I shared a bedroom. And if she did something wrong then my mother would shout at me ... yes, then I get blamed ... Yes. When I was in standard 5, (Inaudible). I worked every Friday afternoon and Saturday morning. Then I would take that money and I would get on the train. I would get to Germiston station and (Inaudible). I would then get back at 9 o'clock at night, then there's no one there to come and fetch me. It wasn't that far but it's dark ... I never played. When I listen to others talk about their childhood, playing in dollhouses and ... I just wish I had half of what they had ... I think I used the alcohol to forget ... It wasn't easy. My brothers abused me. They had sex with me. They hit me or tied me up. It was difficult to get up in the mornings.

All the co-researchers are haunted by demons from their past. Becoming part of this world allowed me to experience the deeply settled anger towards the self. They seek but cannot find answers and reasons for why the traumatic events occurred. They feel as if they should have prevented the abuse, yet they could not. As a result they continue to emotionally abuse themselves. The involvement of the co-researchers' significant others in their traumatic pasts leads to avoid confronting the events and finding answers to their questions. Instead they continue to live in their ideal world where there are no reminders of this hurtful past.

One of the co-researchers has made a conscious decision to confront her disturbing past and to give attention to the emotions she pushed aside many years ago. She tearfully shared her joy and relief at dealing with the memories of this painful past. Through allowing myself to become part of this process, I could relive with her the emotions and sense of relief she experienced, and continues to experience, realising that the traumatic event was not her fault.

Basically many spiritual and amazing things came out here yesterday. I was fifteen years old when I was raped ... It came out here for the first time, it is the first time ever that I told someone about it ... jeez man, and we laughed so much cause I then had to write a letter to the pig! Then my therapist said no, she is going to find me a piece of paper that I need to burn, I need to cut his penis off. I must, must burn him ... no ,then she said no, she is going to find me another piece of paper to draw on. Then she took a condom out. Yes, and there she was sitting with the condom in her hand. Then she said to me 'on no, you blow it up'. Then I had to draw a penis on the condom. You know, we were laughing so much. She said the brain takes it as a 'yes' or a 'true' because it is really what I want to do. I want to set him alight. I want him to burn ... You know he stabbed me with a screwdriver here and here ... Yes I was waiting for my sister, she was not at home and I didn't know what time she will be home so I waited for her. I sat on the steps ... it was a block of flats, and he then said to me he is the caretaker I must come with him and he will give me the key. Man I was fifteen years old. What do you know? He was about forty, thirty, thirty-five, I don't know. At that stage he was very strong. Yes then she gave me time to stab him and when I started with the scissors ... the whole piece of paper was full of cuts. And then we burnt him. We were both standing there waiting to see if the condom will pop. If I have to tell this to someone, no-one will believe me. There I was blowing up the condom, a nice big one! Then I stuck it to the

paper ... and it stood there erect on the paper. Then I burnt it and now I feel absolutely fantastic now. I feel fantastic, that is when I started down spiralling when I didn't share it with anyone.

It is possible that the other co-researchers' strong will to keep their 'ideal' worlds intact could hinder them in remaining sober once they leave rehabilitation. They have not reached a point where they can address their painful pasts.

As expected, depression occupies a significant part of the life-world as a 'disheartened one' (Coombs, 2004; Sue et al., 1994). Many of the co-researchers relate themselves to inanimate objects, a true reflection of their sense of self, their state of mind and how they distanced themselves from their emotions.

You end up becoming a dead piece of wood.

You have no feelings anymore. You are like a dead, blunt knife ... I didn't get excited about anything anymore.

It appears as if the years of alcohol dependence have thrown the co-researchers into a deep, dark and meaningless pit of nothingness that they cannot escape from. Alcohol provides relief, and the ability to forget this painful existence. I have never been depressed, yet experiencing a fraction of the emotions that the co-researchers deal with I truly sympathised with them. Also, feeling the strength of the negativity and how each of the emotions constantly pulls the co-researchers in different directions, I cannot help but wonder if they will ever be able to remain sober. They appear to reach out to alcohol at every hurdle in their lives and I do not know how they will be able to withstand their inner mayhem without alcohol.

So all this time I have been this little girl within myself ... and I have always felt I am the weak one and felt very small within myself.

Yes ... I am depressed and have been since I was seventeen years old. On and off with psychiatrists, psychologists ... took all kinds of pills ... you don't know how to handle it ... I don't have energy...

As a result of the inner turmoil and accompanying depression at the core of the co-researchers' existence within this life-world, I was not surprised to see the effects of low self-esteem and even self-loathing in the co-researchers' lives. This is clearly depicted in the narrative below. This particular co-researcher was extremely negative about herself and constantly degraded herself. She did not have any self-appreciation. During the interviews she elaborated on her lifetime experience of dyslexia and showed how a multitude of external and internal circumstances have caused her to abuse and become dependent on alcohol. Although she clearly knows the causes of her alcohol dependence, the story she told might have been that of a stranger, as she did not relate to it emotionally. Within her story telling the sense of distance was clear. She spoke about her ordeals without the embarrassment that would normally accompany a negative statement about the self. This could possibly be an indication of a defensive mechanism to protect herself against her painful past or to justify her alcohol habit. It was clear that this co-researcher has accepted her fate in life. This portrayal also seems to indicate an external locus of control. She presents herself as having no control over any events in her life. She has just accepted everything negative that everyone has ever told her about herself and has never made an effort to challenge this negativity and defend herself. It is likely that, given her low self-esteem, she does not have the emotional ability to do so.

... let me just explain to you before you go any further. I'm not a very bright person, so don't use very high English. Its going to be difficult for me to understand if you use high English. You have to come down to my level. I want to answer and know what I'm answering. Sorry ... I am dyslexic, and if I

read, I can't understand what I am reading. If you talk to me in high English or if you explain something to me, its quite difficult ... I ended up in a special school and there was no one to explain to me why. So I decided to go and find out. My one aunt took me to go and get tested ... he referred me to the mental health clinic sister. Now listen carefully. He referred me to the mental health clinic and ... a mentally retarded lady ... he said that I was mentally retarded and that I had brain damage and a mental illness ... and having this brain ... like they said. And I thought maybe I must try drinking. Then ... this is my fourth rehab. There are a lot of things that are disturbed in my life. My biggest problem is that I feel very humiliated and stupid and ashamed of myself because of my dyslexia. To be honest with you, it is embarrassing ... and you know the strangest thing is when I drink heavy, I wake up in the morning, I think: Wow. I go to the bath or the shower and I wash. I am trying to wash it off. But I am just explaining, the choice and the decision is now in the dumb blonde's hands.

As with all the other co-researchers, her language use consisted of numerous repetitions and reiterations. This might be because she needed to prove her feelings to herself.

It really is. I want to be clever. I am stupid. I'm dumb and I'm on chronic medication. I was a total loser. I don't really have a life. I am very angry with myself because I hate myself. I have no respect, no love, no nothing. Nothing. Nothing ... I call myself very stupid because of the life I had. I am very stupid and very low class and very dumb.

Along with depression, the mention of attempted suicide was common among the co-researchers. These women seemed to have a preoccupation with suicide. This was not surprising given their descriptions of existence as a deep dark void. One co-researcher

described her attempted suicide and her disappointment when she did not succeed. Spending time with the co-researchers made it clear that they were unable to handle life and the accompanying emotions, thoughts, feelings and behaviour relating to low self-esteem. It was not clear whether this low self-esteem is a cause or an effect of their alcohol dependence. It appeared to be a combination of both, resulting in a vicious cycle from which the co-researchers cannot escape. They would rather end their existence than confront this cycle.

... and then later I was so bad I couldn't speak, because my mind was totally messed up. I was taking medication now ... and I drank for three weeks. I did not eat, I just drank ... I tried to drink myself to death. I really did. And it didn't work. I really did. I thought: now I have to go. And I didn't ... to be honest, life is too difficult, its extremely difficult ... I tried to drink myself to death for three times. And I have never been successful.

Even though all the co-researchers have attempted suicide, it was interesting to note that one co-researcher related that as soon as she made an attempt to end her life, she ran outside looking for help. By placing my life-world in the midst of their life-worlds, it occurred to me that, in their innermost existence, the co-researchers could be looking for attention through their suicide attempt. This is not something that they are consciously aware of; it is an experience rather than an awareness of their motives. It is possible that their alcohol dependence could also be a way for the co-researchers to obtain the world's attention and hopefully gain assistance in solving their issues.

I just deteriorated after the drinking ... eventually I was so depressed that I couldn't think with a clear mind. All I ever thought about was to commit suicide, yes that is all I ever thought about ... eventually I took my husband's gun and shot myself whilst I was in the bath. I left a note for my husband, my

sisters and brothers, my mother. I climbed out of the bath to tell my father-in-law that I shot myself.

The co-researchers experience emotional turmoil on a daily basis. It also became clear that their will, their innate drive to find meaning in their lives (Conroy, 2003; Laverty, 2003) is powerless against their inner turmoil. The narrative below indicates the strength of these negative emotions and co-researchers' struggle to deal with them. Overall, the majority of the co-researchers confessed that they turn to alcohol when they cannot handle their own emotions. Most of the co-researchers struggle to handle their emotions. The co-researchers are unfamiliar with emotions and alcohol provides the co-researchers with temporary relief from these foreign emotions. At times the co-researchers are so far removed from their emotions, that their significant others know more about their emotions than they do. I found it difficult to relate to this behavior even though I experienced it with the co-researchers. This could be an indication of innate maladaptive defense mechanisms among the co-researchers.

Yes ... sometimes I became so aggressive ... but it happened mostly after my dad's death. From that point onwards, did I ... I know I started drinking because I felt a lot of aggression and I did not know how to handle it. And I also think it is because of these thoughts I have ... people can see when I want to commit suicide or if something is worrying me or if someone must stay out of my way. And my dad could see it so easily, he could see what is going on inside me ... you know now I can just snap so easily. Because I think over the years everything was so compressed, and I don't know what is going to happen the day I explode.

Reliving the experiences with the co-researchers I was amazed by the extent of one co-researcher's emotional turmoil. She appeared very confused during the interview and continuously changed topics. This seemed to be a reflection of disturbed cognition and the

fragmented lived experience of her disorder. She appeared confused but also sure of herself and jumped from one lived moment in her life-world to another without any of these experiences making any sense to her. Through the hermeneutic circle and constant questioning I attempted to understand her lived experience. However, I found it very difficult to relate to existence in this life-world. It appeared that as soon as one door opens to reveal the contents of the room it is closed and another door is opened, and as soon as we got to that door it is slammed in our faces. In essence, whenever this co-researcher and I had a chance to gain entry into a lived experience it became unavailable to us. She experiences this confusion and re-emergence of various aspects of her life-world on a daily basis without being consciously aware of it. There is thus an immense discrepancy between her daily existence, her consequent lived experience of alcohol dependence and her conscious awareness of what her being is all about. The co-researchers all experienced a certain degree of this discrepancy.

There is no more asking for advice. Look, I will ask you for advice, don't misunderstand, but the family side. I'm preparing myself. I'm very vulnerable. I have a Volkswagen Beetle for 28 years and this shit thing. I'm not interested. Where is the garden? But help me out I don't know why. I've had bad experiences in church, very bad. Where is the garden?

It became clear that underlying the emotional turmoil, depression and anger toward the self, the co-researchers experienced a multi-faceted sense of victimisation. A person feels victimised when they feel that they have been tricked, that someone or some act is exploiting them and treating them unfairly (Wehmeier, McIntosh & Turnbull, 2005). This was evident in the lived experiences of all the co-researchers, most especially in the narratives below.

I started this serious relationship with this guy and then I fell pregnant. And that is where the paw-paw hit the fan! We spoke about marriage but one day he said the baby is not his. That really got to me. I went through with the

pregnancy and put the child up for adoption. That was quite a depressing for me. Then I had a few drinks but I started isolating myself. And then things started getting better, and I went to England for two years. I was fine there and was standing on my own. I was doing ok and was carrying on with my life. Then I was raped on New Years Eve in London.

*I said it is about time, I am the baby, I cried with Auntie Margaret [therapist],
I just want to be the baby again.*

The majority of the co-researchers appear to lack insight regarding their lives in general. This is combined with an experience of victimisation and an external locus of control. Most of the co-researchers feel that people are holding them back and not allowing them to achieve their goals. I was initially irritated by the co-researchers' failure to take responsibility for their lives. Instead, they would sit back and wait for fate to intervene. However, reliving their lived experiences with them made me realise that this is the way they are, it is the way they think and the way they approach life.

You know I desperately needed a car. My dad said he will not allow it, because [due to my drinking] I am a high risk. So we had a lot of fights and I always felt that people are keeping me back.

Miller et al. (1993) found a link between victimisation and the development of women's alcohol-related behaviour. Furthermore Epstein, Saunders, Kilpatrick and Resnick (1998) indicate that women who have been exposed to some form of sexual abuse in their lives, are more likely to exhibit alcohol abuse than women who have not been exposed to such traumatic experiences. Not surprisingly the co-researchers experience symptoms characteristic of post-traumatic stress syndrome (PTSD). This syndrome affects cognitive processes and symptoms include feelings of helplessness, vulnerability, worthlessness and

being out of control (Ellis, Gordon, Neenan & Palmer, 2003). The co-researchers were not aware of these feelings. There is a discrepancy between what the co-researchers consciously know and are aware of, and what they experience. Their history of abuse and depression and their inability to deal with it creates a pathological way of relating to their feelings of being victims. Consequently, their world becomes meaningful to them in a distorted fashion.

I always had many friends at school. My best friend and I have been friends from Standard Four and we still spoke, but in a way ... With the first pregnancy did the friendship go down the drain. Then I started thinking that she mustn't tell me what to do. Then they said horrible things about my mother and she was never there for me and then I started back-tracking. Because I had to keep my mother happy, I had to keep my friend happy and no-one ever thought about how I felt at that stage. Then I started moving them out of my circle. We still talk but you can feel the bond is not there anymore. Then my dad asked me why I do not have friends anymore. You know if my friend was so drunk I would have picked her up and put her in her bed. That is the type of person I was. Then I realised I cannot trust anyone anymore, and I am not even going to try. They must be on their way. I am better off without them.

By allowing myself to experience the co-researchers' victimisation it became clear that not only do they feel like victims, but they are also grieving and this forms a significant part of the lived experience of female alcohol dependence. Grieving seems to set in after the co-researchers fail to reach a positive stance in their fight as victims. Grieving sets in when the co-researchers have given up hope of ever escaping their fate. The co-researchers grieve in a similar fashion to someone who grieves the loss of a significant other. Grieving is a reaction to loss, indicates some form of suffering and feelings of great sadness (Wehmeier et. al., 2005; <http://www.thefreedictionary.com/grieving>). This loss, experienced by each individual in a

unique fashion, could be a loss of sense of self, loss of a job or loss of trust and status. Loss formed part of each co-researcher's lived experience within this life-world. This loss took various forms depending on the co-researcher's own interpretation as well as the personality, culture, social and religious influences in the co-researcher's life.

According to Kübler-Ross (1969) the grief cycle consists of five stages. These stages are (a) denial, (b) anger, (c) bargaining, (d) depression and (e) acceptance. Kübler-Ross (1969) indicates that the grief-model can be applied to any individual who experiences some form of loss. Looking at the pre-reflective lived experiences of the co-researchers it is clear that this model can be applied to them. The co-researchers have all suffered loss at some stage in their lives and they have not grieved over these losses. Unfortunately, what the co-researchers experience and what they consciously know are not necessarily the same thing. As I spent time with these women I could feel them grieving, and yet they remained unaware of this process. It appears that they cannot relate to this world of grieving, and as a consequence cannot resolve their grief and pass back and forth between stages without ever dealing with the thoughts, feelings, emotions and behaviours that accompany each stage.

The co-researchers all experience denial, not just about their drinking behaviour but also about their self-worth, their emotions and the meanings they ascribe to these feelings. They also deny the significant impact of their traumatic experiences, such as sexual and emotional abuse. They are also in denial about the meaning of their true experiences. Secondly, as is evident in the previous discussion, anger forms a significant part of the co-researchers' lived experience of alcohol dependence. They experience anger towards themselves (e.g. blaming themselves for being raped), anger towards others (e.g. how could others allow them to be raped), anger towards God (e.g. how could God allow them to become alcohol dependent) and anger towards life in general (e.g. believing life has been unfair to them).

Eventually you cannot take it anymore. You cannot take yourself as a person anymore. You get angry with yourself. Disappointed ... I could have been so much more.

The co-researchers also constantly bargain with themselves (if they accomplish a certain goal, they will stop drinking) and with others (if their significant others do certain things for them they will stop drinking) regarding their alcohol dependence. However, most of the bargaining took place with the self.

And the last few weeks have I always felt: just give me another gap ... then I will show you.

As previously discussed, all co-researchers experience some degree of depression. This maintains a meaningless existence of confusion, hopelessness and despair.

I was basically always in bed ... I couldn't even get up to bath.

Lastly, the co-researchers have all reached a degree of acceptance of their drinking problem. For some this realisation made them enter rehabilitation, for others it is a part of their lived experience that is pushed aside and forgotten. Based on my lived experience intertwined with the experiences of the co-researchers', the narratives indicate that although the co-researchers continuously experience the five stages of Kübler-Ross' (1969) grief model, they have not dealt with the emotions in these stages, hence they move back and forth between the five stages. It is clear that their current lived experience of alcohol dependence includes a combination of all the emotions and behaviours that accompany each of the grieving stages. Each co-researcher, within her life-world of 'the disheartened one', cannot deal with her emotions and is confronted with a plethora of emotions on a daily basis. Each woman deals with this in her own unique way without ever finding any answers or solutions

to her inner turmoil. This inner turmoil is likely to play a significant role in their daily existence for the remainder of their lives.

b. Inner peace

The life-world of alcohol dependence as a 'disheartened one' is also characterised by a lived experience of inner peace. One source of this newfound inner peace was the experience of a 'wake-up call'. This made them realise that they have a drinking problem and need to attend to it. It made them grasp that they had been in denial about their alcohol dependence and urgently needed help. Once again, some co-researchers' conscious awareness of this wake-up call was more consistent with their life-world experiences than others. Some co-researchers had entered rehabilitation voluntarily based on this realisation, while others took this realisation and pushed it aside. They entered rehabilitation as a result of their significant others. However, all the co-researchers displayed severe feelings of guilt and disappointment, especially towards their spouses and children. It was only after these specific incidents, that they realised what they had been doing to their families. Even though they continue to be haunted by bad memories, they realised that in order for them to move forward and stay sober, they had to forget about the past and enter rehabilitation. To what extent these realisations will be implemented is uncertain at this stage. Denial is still present, and the co-researchers' strong will to remain in their ideal life-worlds may outweigh the impact of their wake-up call.

This one woman asked me one day if I want my children to see me drunk. And that changed my entire perspective. When she told me that, it opened up something inside of me ... I don't want my children to see me like that. I want them to be proud me.

You know, I lost my job too hey. So I am just thinking 'why the hell am I here, why do I do this? There is just no ... and I lay in the bed a lot of memories come back. I think of the hell of the last two years.

For most of the co-researchers' the wake-up call was quite severe, however, others experienced a more subtle wake-up call, as evident in the narrative below.

My daughter is very musical, just like me, but she has not developed that talent this year. I now know it is because of me. I was never there for her. I don't support her anymore. I don't give her what I used to give her.

Earlier literature indicates that alcohol dependents have a spiritual weakness (Clarke & Saunders, 1988; Engs, 1990; Goodwin, 2000). The co-researchers' wake-up call has helped them find a spiritual aspect to themselves that has never played an important role before. This has always existed in their life-worlds, but has been moved aside like most aspects of their lived experience that they refuse to confront. The co-researchers feel that in the past they have pushed God aside as alcohol took centre stage in their lives, but during rehabilitation they realised that the emptiness they felt was due to the absence of God in their lives. They realised the importance of having God in their lives in order to fight the urge to drink and that realisation in itself made them appear very hopeful. The co-researchers also mentioned that since they have discovered their spirituality they have realised that the problem lies with them. Once again, it is not clear to what extent this spiritual discovery will change the co-researchers' life-worlds and the accompanying perceptions, thoughts and emotions. However, the presence of this spiritual aspect could help them to make the right decisions and ultimately remain sober after rehabilitation.

It is not as if I am here to rehabilitate my alcohol abuse, it starts with myself. I realised that ... if I do not have God in my life, then no treatment and no medication will help me. If I do not have God in my life when I will not be able to do it [stay sober]. And that is the first step I need to take. I must ask God to be my Saviour. And when I did that I felt calm ... with God on my side I can do anything.

I know this is a chance the Lord gave me to start over again and I know that there is no way that I will manage to pull through this without God. When I let go of God's hand, I fell.

Another co-researcher mentioned that, even though she will face ridicule when she returns to the office, God now plays a major part in her self-confidence. God helps her to remain calm when facing others and ultimately helps to sustain her sobriety.

I am scared to go back to work. What will the people at the office think and what will they expect from me? Then I think 'no man, you will walk with God through this, you are not alone, why are you scared?' If they don't like you they don't like you ... but it is alright.

Only one co-researcher did not experience this newfound spirituality. She has a very pessimistic outlook on her future and her sobriety. She appeared to be scared of God and life in general. She refused to acknowledge the existence of God. God plays an important role in my life world and I thus found it difficult to relate to her life-world.

You know I was never religious because I was never brought up in a religious family ... Then I was locked up in Sterkfontein and they want to preach to me about the Lord, there's no such thing! Because why would God let all this happen to me? And why's all my sisters so perfect? I was scared of this God they were talking about.

Sharing the majority of the co-researchers' newfound spirituality allowed me to immerse myself even further into their life-worlds, to experience female alcohol dependence with them. The wake-up call and newly found spirituality has caused the co-researchers to question their lives and to reflect on their existence and their inner being. It is obvious that

the co-researchers' time in rehabilitation provided them with an opportunity to exercise introspection.

I can say that I am very disappointed in myself. And I don't want to go back to being that person. I do not want to be that person anymore.

Spending time in the co-researchers' life-worlds showed that prior to rehabilitation they were aware of themselves, but not of their own experiences. Their awareness of themselves and how they know themselves (drunk self), and their experience of their true selves (sober self), appeared to be two very different things. Allowing time for introspection and spirituality helped the co-researchers to become aware of their experiences, and to attempt to align that with what they know of themselves. This has forced the co-researchers to look in the mirror and see the stranger they have become.

How do I feel now? I feel much better about myself now. And there are many changes within myself. The person I am now, is the person I always wanted to be ... and I want to be better ... like, I want to drive my own car, I want to get a decent job, like office work. That is what I will have in life. Not a beautiful or big and expensive house, but a presentable house, a place to live in. I don't want anything shiny, I just want to carry on with my life.

The co-researchers realised that they do not know this stranger at all. They have always avoided getting to know themselves. However, the part of themselves that they have known - the drunken self - is the part that they have come to despise. They continue to experience an overwhelming sense of self-loathing (Sue et al, 1994) each time they think about this and they do not know how they allowed this to become part of their life-worlds. One co-researcher shared a very embarrassing experience of being a drunk.

Yes, my friend took a video of me one day I was drunk. I did not know about it. I look terrible when I drink. I swear I am ashamed of myself but when I drink my whole mood changes. At the beginning I am happy, then I get extremely jealous, then I get angry, then I start fighting. You know, I look for a fight. I will accuse someone, which is totally out of proportion, and you know when I am sober I will think that it was actually stupid, simple.

The co-researchers were embarrassed and humiliated by their drunken behaviour. Even though this behaviour was exhibited by the part of the self that they have known all this time, it still came as a surprise to them when they found out exactly how they behaved while being intoxicated. This caused more of the emotional turmoil, confusion and inner conflict that accompany the lived experience of this disorder. I felt that even if they remain sober for the rest of their lives, the legacy of these innermost conflicts would always remain with them.

And my dad one day told me that people get scared of me when I drink, cause I have that destructiveness in me that I ended up being scared of myself. Because I started imagining things and I always had that anger inside me that I brought out. Oh, I was quite a queen at knocking out windows!

I get aggressive, verbal, irate, I am hyper-critical, hyper-sensitive, hyper jealous, hyper everything, everything is hyper!

This awareness of their old drunken selves combined with an acquaintance with the new self, allows the co-researchers to experience a sense of inner peace. They can let go of this shameful past and start afresh. Only one co-researcher appeared to be at ease with her drunken self, the person she has known most of her life. She shared her experience of alcohol dependence with me, without showing any shame at her behaviour. On the contrary, she

appeared excited about relating her experience. She was the only co-researcher with whom I did not experience a sense of inner peace.

... then in that process, I lay in bed and I just stopped like that ... because the puking was quite awful actually. There is nothing in to come out ... and then I would take a few Grandpas which burns the hell out of your stomach. It eats your stomach away. Oh I am rotten with ulcers. One morning I realised there is a problem, no I cannot do without alcohol anymore. Now I had to drink half a bottle of jack to wake up and carry on drinking to help me through the day.

The majority of the co-researchers' experienced a newfound inner peace that made them realise that in the past they had stopped growing and were living in a fantasy world about themselves, their families and their surroundings. Now that they have been sober for a while they understand what it means to be realistic, to discover their hidden true selves and to enjoy the inner peace that has eluded them for so long.

I think I will be able to cope now. Last time I was on a high and thought 'I am going to conquer the world' ... this time I am more realistic and realise that if I do not attend my support group, if I do not do what Elim [rehabilitation centre] tells me to do once I am outside, I am going to relapse. I should have done it but never have.

I don't want this double life. I want to be who I am without the judgement. I am sort of discovering myself now, you know.

Along with this inner peace comes a sense of self-appreciation and self-respect. The co-researchers realised that they could also be respected by others and that they deserve respect. They want to prove to the world that they are worthy individuals who are capable of contributing to society. However, only a few of the co-researchers are willing to earn this

respect, most of the co-researchers want to demand it. This is another reminder of the many hurdles that an alcohol dependent faces when trying to remain sober.

Respect me for what I am. Don't try and make me into what I'm not. I'm tired of being a dumb blonde.

I need to prove to the world who I am and that I am worth it

Now I feel like a survivor. Because now I feel I can respect the word survivor because now I have been through it and I believe there is something in me that will make other people see that it can be done.

Through their ordeals some of the co-researchers have discovered their true selves. They can now look at themselves positively, believe in themselves and move forward. They are very slowly putting the pieces of their erratic and destructive lifestyles together and are slowly making way for a more positive and constructive view of themselves and life in general.

6.2.2. The Ambivalent Player: Loner vs. Team player

Apart from experiencing alcohol dependence as a 'disheartened one', the co-researchers also experience the disorder through the life-world of the 'ambivalent player'. The life-world of the 'ambivalent player' is characterised by experiences of being a loner, yet also being a team player.

... my subconscious told me not to drink again, not today, but tomorrow I would do it, tomorrow came and I would still feel bad about Friday night. Then I drank again the next Friday, spent the whole day in bed Saturday, Sunday stayed in bed, stopped going to church, my family life deteriorated, I stopped working in the garden, I stopped all my hobbies, slowly but surely I cut myself off from the rest of the world.

a. Loner

Becoming part of the 'ambivalent player' life-world clearly showed that the co-researchers do not know how to be emotionally close to other individuals. I realised early in the interviews that the co-researchers have always seen themselves as different to other people, yet they have been unaware of where this feeling comes from. Spending time with the co-researchers in this life-world made me experience a profusion of loneliness. I saw the extent to which they pre-reflectively experience being misfits in our society, an experience evident in various facets of their lives. The co-researchers appeared confused about their place in their own families and in society in general. Even though they played various roles, such as being a teacher or a mother, this was done against the backdrop of a pathological 'us-versus-them' worldview. This inequality is always experienced to their own detriment. The narratives indicate that this experience of being a loner has been present since the co-researchers' childhood and did not originate with the alcohol dependence. They have always felt that they have no significant role to play in life.

Life as a loner means being alone in all struggles, not just the struggle against alcohol abuse. It became apparent during the interviews that this pathological pre-conceived assumption originated during childhood. As I listened to their stories I realised that they instinctively feel that they cannot rely on anyone else, they cannot compete with anyone else and no-one understands them. Immersing myself in this life-world and experiencing this utter loneliness was a daunting experience. Although the extent of this loneliness might be exaggerated, it exists as reality to the alcohol dependents.

A long story, but I'll make it short, I went through many tests because my parents lied to me in the first place. And it affected me, after a while I realised something is wrong. So I spoke to my mom. And she would speak to my dad. 'No, you are just very slow'. I thought it was very strange ... 'You are just

slower than your sisters'. I realised, I was starting to deteriorate in my schoolwork. And I deteriorated with my body image as well.

I am totally different to the family. I really am. I am totally different. But ... there is nothing more I can say. It just makes me very, very scared ... there is nobody ... my family does not understand how we feel.

I was really like the outcast of the family. I always seem to hide myself away. I'm not a family person.

The fact that the majority of the co-researchers have been rejected by or have had to let go of significant others at very crucial points in their lives could be a reason for the development of this sense of being a loner. Letting go of significant others often occurred during childhood and took various forms. By immersing myself in the co-researchers' life-worlds, as well as drawing on my personal experience of my parents' divorce, I could identify with the void in their lives. I found it difficult to understand why the events had such a detrimental impact. I interpreted this as the result of irrational thinking, which has been present since childhood.

The impact of letting go of significant others is especially evident in the life-world of one co-researcher who had to let go of two children due to forced adoption. This resulted in a severe feeling of emotional emptiness. Her lack of choice in the matter has clearly contributed to her feeling that the world is against her and she has to fight her battles on her own. Her family expected her to get abortions and this created painful memories that have laid the foundation for her pathological perceptions of and approach to life. Her constant inner turmoil and attempts to make sense of her emotionally laden reality are evident in the narrative below.

Then I got home and all the time the only thing my mother could say to me was: when are you going to get the abortion? And that is what drove me crazy ... they should know at this stage how I work ... and I went through with the adoption ... the two sisters. At least they are together ... I sort of gave up. Everything was just too much for me quite frankly. Then I lost my mom ... I think losing my mom was ... I don't ... ya, I miss her love and attention ... my dad won't care about us. Whether we've got coffee or tea or water doesn't matter. So he has no sympathy with me whatsoever ... then I started drinking again ... I was really shattered. Because the guy I met ... we were engaged and he told me it is not his child and that I slept around. So he left me, and a year later he came back and said we must try and make it work again. I said no to him, emotional I had to go through everything on my own and you were not there for me. My parents were there but it was me who made the decision to put the baby up for adoption, to decide who the parents will be, and stuff like that. So it was a lot of responsibility that I had to take on myself. It sort of shattered me. And I felt bad that there are people out there who cannot have children, it is so unfair. And those who cannot look after their children, they get them by the dozen! At least I feel good that my children are in good hands ... So I think since I have been here I have dealt with it a lot, on many occasions. It is part of it. That is why I said I have always ... I drank emotionally. And that always made things worse. At school we always drank socially and I didn't cause any trouble. I was always just sick. But later, as soon as the problems got too bad, I drank more.

The other co-researchers' narratives were also full of evidence of loss. As I spent time with the co-researchers and began to see the world from their perspective I sensed an inability to deal with physical and emotional loss. All the co-researchers indicated that they had been

pushed to emotional breaking point as a result of loss, and had turned to alcohol to help them cope.

I got divorced and when I came back my mom was very ill. So we were looking after her. She died of emphysema that was the illness she died from. It was a very hard knock for me to lose my mother.

I sort of gave up. Everything was just too much for me quite frankly. I think losing my mom was ... I don't ... ya, I miss her love and attention ... my dad won't care about us. Whether we've got coffee or tea or water doesn't matter. So he has no sympathy with me whatsoever.

... then I got home and the thing my mother asked all the time is 'are you not going to get an abortion?' And that drove me insane. They should at that stage have known how my mind works. And I did go through with the pregnancies ... the two sisters, they are together now

As the co-researchers shared their experiences of being loners it became apparent that this inability to handle loss has left them with a vast amount of anger, not just towards their significant others but also towards life in general. Despite this constant anger, most of the co-researchers do not understand why they are so angry. This anger has filtered through to their relationships with their spouses, children, parents or siblings. They have a desperate need to be accepted by their significant others, yet they continually vent their anger at them. Consequently, fuelled by their 'us-versus-them' frame of mind, they experience being a burden in their significant others' lives. This vicious cycle of a need for attention inadvertently adds to their experience of being societal misfits.

I haven't ever done any damage to him, because he is fine. He is very well actually. He is fine ... He could have turned out to be a junkie, he could have turned out to be a proper junkie. But he is fine. He is very well off, my son. He is very smart ... And I've never seen him again. And he is now 27. But drinking ... casual. He told me ... he phoned me or I phoned him, I don't know. I phoned him the other day and he says to me ... to make a long story short: you deserve to be where you are. You got what you were looking for. I said to him: can't you say anything to lift my spirit up again? He said no. So I said: well count your words, count your words. Its not an easy place to be in. And I can't rely on anybody to hold my hand. I've got to face what is out there. They are tired of me, they are lightly gatvol. You know what gatvol is? ... Its not easy to be here. Its not a pleasure being here ... Very depressed, and very upset. Very, very, very. Really. Very depressed and very upset and hmm ... I don't know, petrified as well. I know I've got to go out, I've got to go ... I was married. I have a beautiful son ... I have a beautiful granddaughter. She's three years old. And I have a beautiful daughter-in-law who hates me loathes me to pieces. My son is very well off. Extremely very well off for his age and her age. And you know money talks and bullshit walks. Excuse the expression but I'm not very good with expressions. She's a dancing instructor on Razz-Ma-Tazz. She has 350 pupils. She's the third best dancing instructor in South Africa. And the money has gone to the head. She works bloody hard. But I'm an embarrassment and I don't live up to the standard, so I am an outcast. From here to the dining room where you were this morning? That's how far they stay from me. I have not seen my son for seven months. He phones me if he wants money.

This vicious cycle of a need for attention and affection appears to have a strong presence in the loner's life-world. The co-researchers seemed to be willing to try anything to fill this void in their lives. One co-researcher narrated the extent of her yearning for the attention that she has never received. She then turned to strangers to fill that void. There is a sense that she belongs with strangers, that she has a responsibility to listen to them, to be available for anyone who needs her. Her own family couldn't fulfil her needs and so she turned to strangers. Her frantic search for attention has led to numerous stays in rehabilitation. Spending time with her made me realise the pathological extent of her need, it seemed that she returns to rehabilitation mainly to receive attention. As she related her story it became obvious that things that I take for granted, like showing and receiving affection, are foreign to her.

My father and I never got on very well ... My father always called me his hippy-child, an inconsiderate stuck-up selfish bitch. Still today. Doesn't even have a good word ... Don't kick a dog that lies down ... Except this one kid I went to school with. She visits me once a month. She stays in Jo'burg. She phones me twice a week. Its the only support I've had. No-one else. You can choose your friends but you can't choose your family. They can go to hell!! ... But I feel uncomfortable in my son's house. So I say sweetie, I must go now. You know I used to feed hobos. Not with any funny stuff, no alcohol. But I got more attention out of those hobos, the three of them, Coloureds. And they are still there today. You know you can cook food in a tin pot. I ate with them. I got more respect and love out them. There was no sex or anything. We would just sit around this fire. And they would ask me about their problems. You know how interesting they are? They used to call me their girl. Here [rehabilitation] you feel needed. The women here are fantastic. They respect me and I don't know why. And a lot of them hug me and I thought this was very

strange. This is strange and they say they love me and they care for me ... And I feel better for it. I don't get it at home. On my 50th birthday my father just said 'happy birthday'. Not a hug, nothing. So I don't know what hugs and things mean ... I'm on my own.

Another strong feature of the life-world of the 'ambivalent player' is the absence of a network of friends. Although there is a need for friendships, engaging in friendships would require that the co-researchers were emotionally intimate with others, which would require that they expose themselves to other individuals. Their existence excludes almost everyone and everything except themselves. The co-researchers are aware of their lack of friends and seem to be content with this state. However, they are unaware of how they constantly block people's attention and do not allow people to become emotionally close.

And with work I don't really have time to visit friends. I need to leave at six in the mornings and then I have to open up, then it is a full day at the office and then I have to go home and cook. So there is no time to be social. And weekends revolve around my family.

The discussion above indicates that the co-researchers have an inability to be emotionally close to someone else. Although they experience a need for affection their inability to deal with affection ensures that they continue their lives as loners. As part of this life-world I felt that this pathological way of dealing with attention could become a major hurdle in their rehabilitation.

b. Team player

The life-world of female alcohol dependence as an ‘ambivalent player’ is also characterised by the experience of being a team player. This pre-reflective experience is evident in the co-researchers’ personal lives as well as in their lives with their significant others.

I have always seen myself as a pleaser. I must always please everyone to keep myself happy. I am tired of keeping everyone happy all the time ... I am so tired of pleasing everyone.

The majority of the co-researchers were forced to take on a carer role during childhood, mostly due to either the physical or emotional absence of a parent. This role has filtered through into their adult lives. Although society expects adults to take care of their children, the co-researchers seem to have taken this injunction to a pathological level. From an outsider’s perspective this lived experience seems negative, but from the co-researchers’ perspective it makes sense. They assumed the role of carer with good intentions, even though most of them were not allowed to choose the role.

... during that time I basically looked after my little brother. So he is my child. So I always tried to do the best for him. And they also hit him a lot. I always felt that it is so unfair, he is only a baby. And a social worker always came to visit and asked if he was ok and I said yes...

They have been conditioned to always put others first. The co-researchers require acknowledgement from others to allow them to feel a sense of belonging, as well as to experience happiness through the experience of being needed. The co-researchers are aware of their need to belong, but are unaware of the extent of this need. The way in which this position disadvantages them has only become clear to the co-researchers during their time in

rehabilitation. This can also be related to the co-researchers' inappropriate sense of victimisation.

Throughout my whole life I always looked after other people, always looked after other people's needs. I never looked after myself.

Sometimes I feel as if I give too much and get nothing in return. From everyone. Since I've been here I have received one phone call from my cousin ... and no-one remembers the times when I was there for them. I am one of those people, I never do things for myself. It is a problem for me, you yes you control me. I have always allowed people to walk over me. You allow people to do to you whatever they want to do to you. And now I don't feel like that anymore ... Now they must watch out for me!

I am forty one years old ... I grew up in a very dysfunctional home. My dad was also an alcoholic. My mom expected me to look after my father, she kinda dumped him on me since I was very young. When he threw up and did other stuff I was always the one to look after him, she hit the road.

Even though western society dictates caring as part of the role of a female, I felt an excessive need to care for others amongst one co-researcher. She did not take on a carer role during her childhood but this role manifested during her adult years. Even though she has two healthy adult children she continues to get up very early every morning to make them breakfast and lunch for work. She also supports them financially. She did not experience this as being to her own detriment.

Yes ... the youngest is still at home ... she is still at home because she brings her washing to me and comes for dinner every second night ... for instance, my adult children, I would wake them up and ask if I could make them coffee or

tea and breakfast, then they would place their orders, then I would go make them breakfast and take it to their rooms. I would also then pack them lunch boxes for work, everyone would get a nice sandwich and snacks, fruit and a Liquifruit. The people at the office are always amazed at the lunch boxes I pack for my children. My daughter still asks me for petrol money and even though I know I mustn't give it to her I give it to her. I am not lying to you, I have given her thousands of Rands, and bought her CDs every time she wants one. I realised now they are old enough to make their own sandwiches and I need time for myself. That time is now over, I am going to start building myself a nest-egg.

This need to care for others appears to be linked to the co-researchers' need for affection. One co-researcher in particular articulated this need very clearly. She identified strongly with the other patients in rehabilitation and got very emotional and upset when someone broke the dynamics of this social system. She believed that they all have problems, and therefore should all try to make it through the rehabilitation process. I had the impression that the absence of a sense of belonging in her life was reflected through her strong identification and association with the other women in rehabilitation. This is evident in the following narrative.

Yes, I hear that they are cheating and my blood boils. I got so upset that she wanted to give up, just so easily. Because it is difficult for all of us, if it is alcohol or painkillers or sleeping tablets, it is difficult. It was very difficult for all of us. Then I went to her and asked her if it is true and she said yes ... then I had a nice talk with her and told her that everything is falling apart, but so what, you have to pick it up and sort it out. It won't totally fall to pieces. Your mom is there, and that is how they manipulate her ... Her 14-year old son said

to her 'Mom don't you think you should rather stay and finish the course?' Exactly and then I said to her nicely that she has to finish the course, that she must contact people to sort stuff out for her, who will pay the phone bill and all the other accounts, just sort everything out, and if you still feel like that in two days then come back to me and I will convince you again. And this morning she stormed into my room, she is another person. I stay! I stay! I am going nowhere!

As a result of this strong urge to belong the co-researchers constantly set themselves up for failure, due to their unrealistic expectations about their own performance. It seems that the co-researchers' time in rehabilitation has helped them to realise that always putting others first may have a negative effect on their efforts to remain sober. Most co-researchers realised for the first time that they need to put themselves first and that they also deserve to be happy and respected. I was struck by the extent of the role played by this lack of self-interest. However, some co-researchers have started questioning their behaviour and are starting to re-discover themselves.

But yesterday I said to a friend: tell me now I have to stop thinking what other people think of me and start thinking what I want. She told me that and I just felt great the rest of the day. Then I decided: it is what I am doing for myself. No more for other people. And the biggest I am learning myself is to approach each day one day at a time. I don't want to worry about what is going to happen in two weeks' time when I leave this place. I want to worry about today and what I will do tomorrow.

Through introspection and becoming aware of experiences that have previously been foreign to them, the co-researchers have started feeling the need to salvage broken relationships. The majority of the co-researchers realise the importance of working on these

fragile relationships. They also realise that it is up to them to make the effort to make these relationships work.

I think I will start at home – the farm is very calm. And my mother ... because I am the only daughter. I want to be close with my mother. Because my mom and I were angry with each other for a very long time. So I think it is a relationship I need to start working on. Luckily my parents realise it is a long process and won't change overnight.

I am, I must admit. Oh jislaaik if you tell me not to do something, I will do it! I will do it! When I was so fat my mother used to moan: Stop eating so much, stop doing this, stop that. And I just thought: I will. Until I've made up my mind. Which is a shame, hey. Younger sister ... I should have hit her over the head! You know, really. Well she comes to the house every morning at half past 6. She's a beautiful girl, don't misunderstand me. She will help me, but with ... I don't know ... you know, I am a giving person. I must give, not to receive. I don't care about that. I really don't care. And she's always got some remark to make about somebody in our family. She thinks she is just ... you know ... no man, she's got this mansion of a house and just everything.

As I spent time in the life-world of the 'ambivalent player' I realised that although some of the co-researchers have a realistic perspective regarding saving their relationships others continue to blame their significant others for the broken relationships. This is indicative of their innate sense of victimisation and external locus of control.

6.2.3. The Contemplator: Lies and manipulation vs. Honesty

The third life-world that characterises the lived experience of female alcohol dependence is that of ‘the contemplator’. Spending time with the co-researchers revealed that lies and manipulation form the core of the lived experience of female alcohol dependence. Yet at the same time, honesty is also an integral part of this disorder.

a. Lies and manipulation

As I emerged myself in the co-researchers’ life-worlds I was struck by the prevalence of lies and manipulation within their lived experiences. The cognitive theories state that irrational and maladaptive assumptions and thoughts or distortions in the actual thought processes could cause alcohol dependence (Sue et al., 1994). The life-world of the contemplator illustrates the extent of the co-researchers’ distorted thought processes. Although the co-researchers are aware that they lie and manipulate, they are unaware of the extent of their lies. These lies are woven so deeply into the fabric of their life-worlds that they seem routine.

I expected the co-researchers to feel uneasy when talking about lying, but was instead amazed at the co-researchers’ boasts about their ability to lie. They were extremely excited to relate their stories and appeared proud of what they have accomplished. This was in stark contrast to the lack of excitement they demonstrated when discussing other aspects of their lives. I sensed that there were times when they wanted to reflect on their ability to lie and manipulate, but embarrassment, guilt and shame outweighed this reflection. The co-researchers lie and manipulate, but are convinced that others are unaware of their strategies. The co-researchers have mentally constructed an invisible wall around themselves, and they remain convinced that others cannot see through this wall. I realised that the co-researchers could also be lying to me and manipulating me, and I needed to constantly reflect on this possibility throughout my time with them.

And another thing we really spoke about, is that you become sly when you drink and it is the worst thing to do because when you drink behind everyone's backs ... eventually you are so drunk and no-one realised what is going on because you are not drinking. And that is bad. That is what us alcoholics do. It is the worst type of thinking. Rather drink in front of everyone where they can see what you are doing, but now you start acting simple and turn aggressive ... then you become angry if you cannot remember where you put the alcohol. You normally have these wonderful hiding places, it is really bad I tell you.

I wouldn't go to the extreme and sniff glue and stuff like that. But if there is no alternative to anything I like then I will drink anything with alcohol in it. You know shooters is really horrible for me, but if there is no alternative then I will drink it. I will drink it no matter how horrible it is. That is how I was. But I really looked after myself. I always took a bottle with me. One in the cupboard, one in the car ... I always hid one away from everyone else. If I finished both, yes, there was always back-up. Then I would say to my friend 'please just buy me a bottle vodka'. Then the bottle would still be half full and she would say 'jeez but you drink slowly'. Meantime it is already the third bottle! No I tell you, you became devious. At that stage I had those little brown bottles, medicine bottles, in my bathroom. My mom said I must mix brandy and camphor cream for my zits, but I kept it full of vodka. Then my ex-husband would look at the bottles and ask me 'what is this?'. Then I would make him smell the camphor bottle. You know, he is so stupid, he clicks nothing.

The co-researchers' lived experience involves manipulating and lying to others, but also lying to themselves. The same invisible mental wall that the co-researchers pre-reflectively use to block the outside world also blocks their own perceptions. In this way denial forms the

centre point in their life-world as a 'contemplator'. According to Morse and Flavin (as cited in Vandermause, 2005, p. 71) denial is "... the inability to accept the loss of control over drinking, the psychological dependency on the drug, and the eventual need to abstain". Existing literature shows that the alcohol dependent uses denial to convince others, and herself, that she does not have a drinking problem (Coombs, 2004; Hales & Hales, 1995). Furthermore, literature shows that alcohol dependent individuals manipulate their family, friends and colleagues and blame their relationships, financial or work problems for their drinking. The co-researchers' narratives are full of denial. Coombs (2004) has cautioned against the use of the word denial, as it is an emotionally laden term that may not reflect the true nature of the underlying problem. Some alcohol dependent individuals might not even know they are in denial and therefore cannot be classified as dishonest. Instead, an alcohol dependent individual might have difficulty with awareness and the ability to process new information. Consequently, although the individual appears to be in denial they may actually be cognitively impaired (Coombs, 2004). As I engaged with the co-researchers through the hermeneutic circle I sensed that the co-researchers were consciously aware of their denial and not cognitively impaired. I found that they live in constant denial, and use their lies and manipulation to refuse to acknowledge their own realities. This results in the realities within their life-worlds becoming increasingly dysfunctional.

As I allowed my life-world to become part of the co-researchers' life-worlds, I experienced the presence of two opposing forces, namely a 'rational-will' and an 'irrational-will' that both form part of the life-world of 'the contemplator'. The co-researchers' rational-will was the weaker of the two and this is the will that makes promises to the self as well to others. The irrational-will is much stronger than the rational-will and breaks these promises to satisfy their immediate needs. The co-researchers continue to make promises to their rational-will and then continue to fail themselves. They feel that they have let the rational-will down and as a consequence endure constant conflict between their two wills.

... but about that thing, you always try everything. I always said everything is fine. You know, everything was not fine for me, and I said it is. I believed myself. And I realised that I am a great manipulator, because sometimes you really need to cover good, so that people can't really see your true colours.

You know you lie to yourself – you know you make promises, but you also know you will break the promises. However, you convince yourself you will make up for it at a later stage and you think that is justified.

Williams (2000) indicates that denial occurs when individuals create and live in a fantasy of what they need to believe, rather than coping with their own reality. This was evident amongst all the co-researchers. Rehabilitation was a daunting experience, to the extent that they would have preferred to avoid it and rather continue abusing alcohol instead of being forced to face their demons from the past. It seems to me that it is not the absence of alcohol that they find daunting, but rather being forced to confront issues that they have never dealt with. The narrative below strongly demonstrates the influence of denial in the lived experience of female alcohol dependence. The co-researcher indicated that she is terrified of exiting rehabilitation. She develops numerous psychosomatic symptoms every time she nears her final day in rehabilitation. She is too scared to face up to her problems and dilemmas and instead finds ways to prolong her stay in rehabilitation. I experienced this as her rational-will momentarily taking over and allowing her to feel positive about life after rehabilitation, however this was soon replaced by the negativity and self-doubt of the irrational will. Her rational will seemed powerless against her irrational will. This could be a significant obstacle in this co-researcher's ability to remain sober.

I am very very itchy ... and then I struggle terribly – it feels like worms and its very very itchy ... I've got such headache. I've had it for about two weeks. I am petrified of going home ... maybe I shouldn't go out now, maybe I should

wait another week. I am nervous to leave this place. I have already extended a month. I've been in here since April. They've given me an extra month. And I really don't want to stay any longer. I am getting tired of this place. I don't want to go and I do want to go. I am very scared, very very scared. This is causing me crawling and itchiness and swollen head and anxiety. Its terrible ... panic attacks. But I am going to try. But I have maintained to myself – what has helped me a lot in this place is this cut [shows she self inflicted cuts and burns on her arms]. I want to cut myself and I think to myself: you can do it, you have to. Don't do it ... It's a scary situation, let me tell you. Coming here you don't know what to expect, you really don't know what to expect. I mean, you're petrified ... Its not easy. And then there are so many things you've got to do – control yourself in many, many ways. You can't even say what you want to say. You can think what you want to think, but you can't always say what you want to say. When I sit here and I listen to ... this one is much better than the previous one. In 2001 I was in Erika. The old place, I think I told you. And the amount of young girls ... so this is not so bad, these women are more ok here. But I don't know what to say, I really don't. Because they think it's easy doing this, hey. They really do. And it's very difficult because you are totally disorientated. If that is the right word I am using. You don't know what the hell is going on. Very, very scared. And now I don't know what is going on outside those walls. I don't want to hear motorcars, motorbikes and I am petrified of a telephone. And you are totally lost to the outside world, totally. When I came in on the Friday, I didn't know what was going on. I was petrified.

Spending time in the ‘contemplator’ life-world I sensed that the co-researchers’ lies and manipulations were related to a need to always be in control and remain in a safe position to continue their drinking behaviour. Through their lies they manage to exercise control, even if only over a very small part of their lives. These lies have destroyed their social relationships and have resulted in their alienation from family, surroundings and careers. This did not bother them at the time, but while in rehabilitation they have come to realise how isolated they have become.

... my subconscious told me not to drink again, not today, but tomorrow I would do it, tomorrow came and I would still feel bad about Friday night. Then I drank again the next Friday, spent the whole day in bed Saturday, Sunday stayed in bed, stopped going to church, my family life deteriorated, I stopped working in the garden, I stopped all my hobbies, slowly but surely I cut myself off from the rest of the world.

The narrative above indicates how entrenched lies as well as manipulation are in the life-world of female alcohol dependents. In essence, the co-researchers have become isolated and lonely due to their lies and constant manipulation. However, in order to remain in control and maintain the comfort of their life-world they, they continue to unconsciously lie and manipulate. As I spent time with the co-researchers I gained an understanding of this way of seeing the world.

b. Honesty

Despite the abundance of lies and manipulation that form the core of the life-world as a ‘contemplator’ this life-world is also characterised by a sense of honesty and openness. Rehabilitation forced the co-researchers to reflect on the lived meanings within their life-worlds and they came to understand that their lies and manipulation are stopping them from attaining normal, sober lives. This realisation has gradually filtered through to their conscious

awareness and through reflection they have come to understand that they need to be honest with themselves and need to acknowledge that they are the makers of their own destiny.

As I immersed myself in this life-world I realised that one of reasons the co-researchers' pre-consciousness has been opened is because of their exposure to taking responsibility for their own actions. This has been absent for most their lives. It was also obvious that some co-researchers experienced a greater sense of responsibility than others. However, all of the co-researchers started feeling worthy again, even if only temporarily, after they were given the psychological and social tools to take responsibility for their actions. Also, the majority of the co-researchers realised that this sense of responsibility will play a very important role in their sobriety.

You never really have any responsibility ... I used to be a reservist, then I never used to drink, because it was a lifestyle that kept me strong and I did something for someone.

My dad was here this morning and he said that he thinks I am ready to go on my own now. That was such a bonus for me. Cause I really want to get out of here, get my own place, start working and do my own thing.

This sense of responsibility is linked to a lot of confusion and anxiety. The co-researchers know that they are responsible for their own destiny, yet I felt that their denial and their strong irrational-will could prevent them from making the most of this opportunity. They are petrified of the world outside rehabilitation and experience extremely ambivalent emotions, feelings and thoughts regarding their entry into this world. Some co-researchers appeared to be more threatened by this than others. It was surprising to me that something that is taken for granted by most individuals is such an enormous burden in the co-researchers' lives. While sharing the co-researchers' experiences it occurred to me that the mental and

emotional challenges involved in crossing-over from rehabilitation to life thereafter might be too daunting for some of the co-researchers.

You are completely confused. You don't know where you belong.

I have to do it. I have to. Really I have to. The majority of people leaving aren't ready to go. We are all scared to leave. I mean, really we are. We are petrified to go. But I ask myself: what have I done to become this? I don't know. I really don't know. Yes I think we are all scared to go. You don't know how to relate to normal people. Because we are not normal. We've got this disease they say. And we're totally in routine here and we have to stick to all the do's and don'ts you know what I mean. And you find funny people out there. I am very scared of going out and I don't know how I am going to cope with normal life out there.

It was delight to see how some co-researchers were able to challenge this negative perception of life after rehabilitation after having spent a few days under supervision.

Because they tell us here [at rehabilitation] that the world is getting worse and worse. The bottle stores will not disappear. The drug dealers will not disappear. They will always be there and get worse and worse. So I see this as a new beginning from hereon. You know, I think those things that happened in the past ... it was my downfall. You always want to cling to the past. And I promised myself that the day I leave this place it all stays behind. So when I leave it is a new life.

Overall, the co-researchers viewed their experience in rehabilitation as largely positive. They consistently described it as the best thing that could have happened to them. During their time in rehabilitation they have learnt to face their pasts and deal with their emotions.

6.2.4. The Covert Chauvinist: Womanhood causes my problems vs. I appreciate being a woman

The life-world of ‘the covert chauvinist’ is filled with ambivalence about being a woman. The experience is split between feeling that womanhood is the root of all problems and the joyful experience of being a woman. Although all four life-worlds are characterised by lived experiences that the co-researchers are not overtly aware of, the life-world of the ‘covert chauvinist’ exists closer to the co-researchers’ conscious awareness than any of the other life-worlds.

a. Womanhood causes my problems

When I allowed myself to be immersed into the life-worlds of the co-researchers, I once again experienced the presence of distorted thought processes among the co-researchers. I was surprised by the overall pre-reflective experience that womanhood causes most of the co-researchers’ problems. This is indicative of their external locus of control and unvarying irrational thought processes. I continuously reminded myself that the co-researchers were exposed to some traumatic event during their childhoods. Since childhood they have experienced a negative gender-bias towards being female without being consciously aware of it. Some of the co-researchers indicated that the traumatic experiences would not have occurred had they been male. This gender-biased pre-reflective consciousness appears to have followed the co-researchers into their adulthood and is evident in various facets of their lives.

The co-researchers have all experienced the negative effects of society’s high expectations of them as women. In their life-worlds their immediate and constant experience is that they are unable to adhere to society’s stereotypical gender-roles. This is demonstrated in the narratives below.

... and a woman has to work all day, get tired and carry on as if she is not tired.

He [husband] sits in front of the TV, she has to make food, bath the kids, do general home work. If you don't do that you are a bad woman.

I get home and then I have to cook. So I don't have much time to socialise and have friends.

As the narratives unfolded it became clear that the co-researchers always put their significant others first. It is expected of them to always be available to everyone, to be emotionally strong, happy, energised and always be willing to provide a helping hand. They have to constantly juggle several tasks all the while remaining on their best behaviour and being frowned on when they get tired. I was struck by the negativity that surrounds the co-researchers' sense of womanhood, which ultimately leads them to experience themselves as being under constant pressure from society to conform to standards that they cannot meet. Further immersion in the life-worlds of the co-researchers made it clear that any time or effort spent on the self is experienced as selfish. This negativity left me feeling awkward at times as I fulfil similar roles in my life and I enjoy filling these roles. Through listening to their stories I realised that what they are experiencing is real to them, although it may seem irrational at points.

I decided, my children can stay with my parents, I just need to get on my feet again, I can now – that is maybe selfish ... but somewhere I need to become selfish to somewhere come right again because I feel I am worth it.

What also surfaced during the interviews was that the co-researchers experience a total lack of support from their spouses or partners and family members when they have to deal with personal issues. However, they are expected to be consistently supportive and available to others. This could be a reflection of the kind of individuals they chose as partners,

someone who can be blamed for their behaviour. The co-researchers perform so many womanly roles - mothers, housewives, carers and lovers – but do not receive any acknowledgement for their dedication. Although this was something that surfaced strongly during their interviews they did not seem to be consciously aware of it and therefore failed to understand the impact that it has on their lives. This is again reflective of an external locus of control among the co-researchers, as they blame others for their inability to deal with their inadequacies.

Yes, it is like that, think about dishing up for your husband. For your husband you will dish up the biggest lamb chop and you will take the small sinewy one.

I've never dropped my husband at any family function, holiday, birthday or Christmas function. So, everyone was surprised when I said I am going to rehabilitation.

Constant reflection and interpretation made it clear that the co-researchers have ceased to see themselves as self-sufficient, intellectual and worthy human beings. Klaich (1996, p.125) indicates that "... much of a woman's work goes invalidated and therefore unrecognised. When a women's work is unrecognised, part of the self is denied". The co-researchers' inability to cope with society's expectations leads them to feel that they are not recognised, and this could be one of the reasons why they turn to alcohol.

The co-researchers' pre-reflective experience of womanhood as the cause of most of their problems is also unknowingly reflected onto their significant others. This is evident in the following narrative. As I listened to the stories I realised that this is a deeply rooted problem and could seriously hinder the co-researchers' attempts to remain sober.

My daughter, she just wants to keep strange animals, like the tarantulas and iguanas. Why doesn't she just get married and have children?

As suggested by existing literature (Ettore, 1997; Nolen-Hoeksema, 2004; O'Connor et al., 1994; Van der Walde et al., 2002), the co-researchers experience immense social stigma and discrimination with regards to their drinking behaviour and are judged more harshly than men who consume and abuse alcohol. The co-researchers' gender-biased pre-reflective frame of mind also plays a role as they experience life as 'men versus women'. They try to find meaning in life and continue to look for smokescreens to justify their drinking behaviour.

Drunkenness looks ten times worse for a woman. You know, for a man it is okay, a man is allowable, he can get drunk and throw his name away ... everyone says he is just being a man, but a woman if you dance on a table you are a slut. So that stigma is there yes.

The co-researchers cannot explain why they drink and this results in a profusion of constant pre-reflective anger, irritation and frustration. This supports existing literature that suggests that women drink because of "... the direct expression of anger, especially at men" (Lerner, as cited in Klaich, 1996, p. 142). The co-researchers are unable to display these negative emotions as that would be a confirmation of their inability to fulfil society's feminine roles and would lead to them being seen as unmaternal, unfeminine and unladylike.

This negative life world is created by the co-researchers' strict adherence to extremely rigid thinking. They view the world as both 'us-versus-them' and 'men-versus-women', which means that they need to be the perfect woman and meet all of society's expectations. This could be due to the fact that they feel they have failed in every other aspect of their lives, and this is one part of their life-world as a covert chauvinist that they can control. The co-researchers are also looking to place blame for their alcohol dependence and society's prescribed gender-roles and expectations serve as a convenient target.

b. *I appreciate being a woman*

As with the other life-worlds, this life-world consists of a paradox. The co-researchers experience womanhood as being at the core of their predicament, yet at the same time they enjoy being women. In order to understand this paradox it must be borne in mind that lived experiences are hidden and fluid; within each life-world the lived experiences overlap and exist in parallel. A co-researcher is thus able to have a lived experience encompassing either principle at any given time and place without being explicitly aware of it.

Even though the co-researchers feel that their role as women causes most of their problems, their time in rehabilitation has made them realise that womanhood could also be an asset to them. It seems that the co-researchers are starting to reflect on their lives and are becoming aware of the pre-reflective gender-biased frame of mind that guides their general behaviour and negative approach to life. They are starting to see that they need to make a mental shift in order to remain sober. The co-researchers came to understand the importance of self-fulfilment, goal setting and achievement and going beyond societal expectations. Being in rehabilitation also made the co-researchers realise they have neglected themselves in the past, as individuals and as women.

I really neglected myself. I know that. I have so many hobbies that I want to start again, I am very good with my hands, needlework, artwork, batik, I make porcelain dolls. At home there is a room full of boxes with things left half-done ... when I get energy I will take it up again. I don't know if I will live long enough to do everything I want to do but I will start at point one and work my way down the list.

As the co-researchers' attitudes, views and prejudices blended with my own I realised that they had re-discovered what it was like to make an effort to feel good as women, to feel proud of themselves and place themselves in the centre of their own lives. Alcohol has

destroyed their positive sense of womanhood and disconnected them from their world and from their own individuality.

The co-researchers realised that one way to appreciate themselves as women and to achieve a sense of self-fulfilment would be through education. Most of the co-researchers mentioned that they want to enrol for courses to further their careers. It appeared to me that each co-researcher wants to be more than just another woman. They want to accomplish something separate from their roles as mothers, wives, carers and lovers.

During rehabilitation a few co-researchers discovered a previously hidden creative side. They enjoyed discovering their creative side as it made them feel happy and excited about themselves. Two of the co-researchers now offer make-up and hair services to other patients at rehabilitation. This was a watershed moment and clearly impacted positively on the co-researchers' self esteem. Other co-researchers proudly displayed their handicraft during the third interviews. I got the impression that prior to rehabilitation they had not felt capable of being creative or producing anything on their own. The tasks completed during rehabilitation, such as mosaic and pottery, made them realise they are indeed capable of being creative and most of the co-researchers were surprised by their own abilities. The co-researchers all mentioned that they will continue to be creative after rehabilitation and will utilise their newly acquired skills to make money for themselves.

6.3. Conclusion

The above discussion illustrates the rich and multifaceted lived experience of female alcohol dependence. Four life-worlds were identified. In the life-world of 'The Disheartened One' inner turmoil and inner peace characterise the lived experience of female alcohol dependence while in the life-world of 'The Ambivalent Player' experiences of being a loner as well as being a team player feature. 'The Contemplator' life-world is characterised by an abundance of lies and manipulation co-existing with honesty. 'The Covert Chauvinist' life-world is filled with ambivalence about being a woman.

The life-worlds are common among the co-researchers and depict what the co-researchers experience on a daily basis. Some experience each life-world with the associated lived experiences to a lesser degree than others nevertheless the four life-worlds are intricate to the lived experience of female alcohol dependence. In the last chapter the lived experience of female alcohol dependence, within my own life-world and interpretation, is placed into context. A typology of female alcohol dependence is proposed, followed by recommendations for future research.

CHAPTER 7: DISCUSSION AND RECOMMENDATIONS

“A drunkard is like a whisky bottle, all neck and belly and no head”

(Kinney & Leaton, 1982, p. 74)

7.1. Introduction

Within the hermeneutic circle the co-researchers and I went on a strenuous but invigorating journey together. Even though we had no mental itinerary we discovered four destinations that revealed life-worlds previously unknown to us. These life-worlds portrayed female alcohol dependence on a different dimension, not just as a reaction to modelling, expectancies or tension reduction (Armeli et al., 2000; Barlow & Durand, 2001), a result of genetics (Nolen-Hoeksema, 2004; Wodarz et al., 2003) or due to anxiety, low self-esteem or depression (Ambrogne, 2007; Edwards et al., 2003; Nolen-Hoeksema, 2004). Rather, the four life-worlds offer a new insight into female alcohol dependence as the co-researchers were allowed to ‘tell it like it is’ (Aston, 2005). Discovering the lived experience of female alcohol dependence also provided answers to my own previously unanswered questions regarding this disorder.

7.2. The lived experience of female alcohol dependence

Working within the hermeneutic circle, the co-researchers and I openly communicated our preconceived ideas, biases, emotions and attitudes. This allowed us to gradually immerse ourselves into each others’ being-in-the-world, our *Dasein* (Laverty, 2003). As a result, we discovered both conscious and unconscious experiences. We discovered the pre-reflective dimension that truly gives meaning to the co-researchers’ lives. The four life-worlds demonstrate that the lived experiences associated with each life-world are indeed highly elusive and fluid in nature. Some lived experiences had to be revisited more frequently than others in order to reach an understanding of them. Spending time in the life-worlds of the co-

researchers also showed how they constantly move between the lived experiences of a life-world, as well as between the different life-worlds. It appeared that the co-researchers could be present in one life-world, yet experience the underlying emotions, thoughts and feelings associated with another life-world.

7.2.1. The Disheartened One

The Disheartened One was the first life-world that the co-researchers and I found on our journey into the lived experience of female alcohol dependence. This life-world was exposed first because it forms the core life-world from which all other life-worlds and lived experiences originate. Without an understanding of this life-world it would be impossible to gain entry into the other life-worlds. The lived experiences of ‘the disheartened one’, namely inner turmoil and inner peace, form the foundation of the lived experiences in all the other life-worlds. Arriving in the life-world of ‘the disheartened one’, the first attributes I noticed were a sense of gloom, loneliness and despair. I immediately felt an immense dull emptiness, accompanied by a profusion of both negative and positive emotions. These emotions competed with each other and mentally pulled the co-researchers in various directions. It was difficult for me to imagine what it was like being part of this world on a daily basis. The pain and hurt that the co-researchers constantly experience was very foreign to me. Although these feelings are ever present in their existence, their strength does vary from day to day. What I did experience as real was the emptiness in the co-researchers’ eyes. This inner turmoil is the very first thing they experience when they wake up in the morning. The inner turmoil associated with the life-world appears to have exhausted the co-researchers. This inner turmoil is always present, although sometimes it is hidden and sometimes it is more obvious. The co-researchers do not have the resources to control this aspect of their lived experiences. The life-world of ‘the disheartened one’ is also characterised by the presence of inner peace. Inner peace is always hidden in the shadow of the co-researchers’ inner turmoil, but comes to the fore when the co-researchers attempt to find answers. This provides them with the

opportunity to become open to previously un-encountered experiences, experiences that could potentially fill their lives with joy and happiness. Yet, the power of their inner turmoil is of such magnitude that each attempt at discovering inner peace is overshadowed by the strength of their inner confusion. As a result, the co-researchers' inner peace fades into the background until another opportunity presents itself. As the co-researchers spend more time trying to find answers the lived experience associated with inner peace reveals itself to them. It was interesting to note that the co-researchers are the only inhabitants of the life-world of 'the disheartened one'. Although significant others may appear briefly in this world they are only reminders of a painful past. This world is something that the co-researchers must face by themselves. As the co-researchers deal with their alcohol dependence they will make numerous visits to this world in order for their life and their disorder to make sense to them. The lived experiences of this life-world are so intricately woven into the co-researchers' lived meanings that it seems impossible for them to ever leave this world behind. 'The disheartened one' life-world made me feel awkward as the lived experiences associated with this world are unfamiliar to me. This is a world to which I do not wish to return. I have always understood that alcohol dependents' lives differ from mine, but this experience within the life-world of 'the disheartened one' has shifted my stance with regards to this disorder. I now realise why I am able to drink in moderation and why I do not turn to alcohol to solve my problems. I realise the importance of my stable childhood and the presence of my supportive mother. Although it was not specifically tested in this study the co-researchers all seemed to have low emotional intelligence, characterised by an individual's inability to have empathy for other's feelings, understanding of their own feelings and regulation of emotions to improve their lives (Granacher, 1988). The co-researchers also tend to be loners and find handling relations with others problematic. This insight allowed me to appreciate just how different the co-researchers' lives are from my own.

7.2.2. The Ambivalent Player

The second life-world uncovered by this research was that of ‘the ambivalent player’, characterised by the lived experiences of being a loner as well as being a team player. This life-world co-exists with ‘the disheartened one’ and is also dark and gloomy. Unlike the depressed state that characterises ‘the disheartened one’ the life-world of ‘the ambivalent player’ is characterised by a forceful sense of abandonment. My first impression of this life-world was one of neglect and despair. The co-researchers seemed to experience life more as loners than as team players. I was struck by the sense of safety the co-researchers take from being loners, despite indicating in their narratives that they do not like being loners. I could sense that their true experience involves enjoyment of being alone as it allows them to exist in the world they have created for themselves. In this world they feel safe and secure and are not threatened by the demands of life. The co-researchers are thus the only inhabitants of this life-world. Yet at times the co-researchers need to become part of society, even if only to salvage broken relationships with their significant others, and this results in the lived experience of the team player. The experience of being a team player only emerges when the co-researchers feel the need to be a team player. The co-researchers subtly draw in individuals they deem relevant in fulfilling certain roles within their life-worlds. This was especially evident when the co-researchers made other individuals part of their life-worlds as they narrated their behaviour in relation to their alcohol consumption. Whenever they spoke about how much they used to drink or the behaviour they would exhibit while intoxicated, other people always seemed to form part of this world. It felt as if they pre-reflectively had to let go of their individuality whenever they had to take responsibility for their behaviour. This was probably due to an external locus of control and shame and guilt they experienced when relating their lives as alcohol dependents. It also occurred to me that the co-researchers would insert themselves into society as they deemed necessary. Spending time with the co-researchers in the life-world of ‘the ambivalent player’ revealed their strong sense of egotism

and insensitivity. Also, it seemed to me that if the co-researchers had a choice, they would rather be loners than team players. My experience of this world evoked many different emotions, ranging from confusion to awkwardness. However, the prominent experience for me was one of suspicion and I realised that it is important to maintain an emotional distance from the co-researchers.

7.2.3. The Contemplator

Co-existing with ‘the disheartened one’ and ‘the ambivalent player’ is the third life-world, that of ‘The Contemplator’. This life-world evaded the co-researchers and me for a long time and numerous attempts were needed before we gained entry. My first impression of this world was that it was sinister, characterised by a malevolent presence with the co-researcher as the only inhabitant. I immediately felt wary within this world, as it appeared that lies and manipulation are an integral part of the co-researchers’ lives. This is so deeply rooted in their life-worlds that it forms an integral part of being an alcohol dependent. There seemed to be an unspoken rule that this behaviour could be continued in order to sustain their drinking behaviour. As a result, it occurred to me that the co-researchers could have lied to and manipulated me throughout the interviewing process. I always kept this possibility in the back of my mind. However, I did feel that there were times, such as when the co-researchers relived their childhood traumas, that were real. I felt emotions and pain that could not have been faked. At times like these the co-researchers’ lived experience of ‘honesty’ came to the fore. As with the other life-worlds, this more positive lived experience seems to emerge when the co-researchers are looking for answers. It also appeared to occur when someone else trod on a sensitive part of their life-world that demanded answers. The co-researchers were unwilling to face the reality of their lies and manipulation unless someone else made them aware of these things. Also, spending time in this life-world showed that the co-researchers do not just pre-reflectively enjoy lying and manipulating, but rely heavily on it to keep them safe in the worlds they have created. I could sense that due to their lack of coping resources, the

co-researchers rely on their distortions of reality to justify their behaviour. This made me aware that their childhood recollections could also be exaggerated, although the experiences were very real to them. In essence I realised that, although these memories might be exaggerations, they form part of the co-researchers' lived experience of alcohol dependence. It was obvious that the co-researchers would have to continuously revisit this world on their road to recovery. Based on the nature of this world, I find it difficult to see how the co-researchers can turn their backs on their tactics of lies and manipulation, as these tactics have helped them to make sense of their lives. This world made me feel uneasy. I could not relate to being constantly immersed in a world of lies and manipulation purely to achieve self-interests.

7.2.4. The Covert Chauvinist

The last life-world that the co-researchers and I discovered was 'The Covert Chauvinist'. We were all surprised by the existence of this life-world, as well as its contents. This life-world is not characterised by negativity as the other worlds are, instead it is characterised by a masqueraded existence. I found that I could relate to the experience of womanhood as creating some problems, but had difficulty relating to the experience of womanhood as the cause of all problems. Within the life-world of 'the covert chauvinist' blame was placed on others for everything that had gone wrong in their lives as women. I was constantly surprised by the lack of responsibility that the co-researchers take for their own actions and their lives in general. In accordance with the life-world of 'the ambivalent player' it seems that the co-researchers use their womanhood to their advantage when it suits them, yet they blame their womanhood when things go wrong. What stood out the most was that, as with the other life-worlds, the co-researchers are unaware of these lived experiences and the way they impact on their thoughts and behaviours. In the life-world of 'the covert chauvinist' there are many inhabitants. Although the co-researchers are the main inhabitants, significant others, spouses and children play a significant part in this world. This highlights the co-

researchers' external locus of control; the significant others play a role only when the co-researchers deem it necessary. This world left me perturbed for a variety of reasons, especially when seen from a woman's point of view. Being part of this life-world indicated that the co-researchers do not take responsibility for their behaviour. Instead the co-researchers take womanhood – a part of life that should be natural and operate successfully – and make it responsible for their actions. The lived experiences associated with 'the covert chauvinist' drive the co-researchers' thoughts, emotions and behaviours in a way that is detrimental to the co-researchers' daily existence and sobriety.

7.2.5. Conclusion

My journey with the co-researchers into the lived experience of female alcohol dependence left me enriched. I have obtained an enhanced understanding of this disorder, which would have not been possible without spending time in the co-researchers' life-worlds. It made me realise that alcohol plays a significant role in the co-researchers' lives. Initially it seems that alcohol serves as a buffer against daily struggles and provides the co-researchers with momentary relief from a painful past. The findings in this study expanded on this view of the role of alcohol in the lives of female alcohol dependents. They showed that it is not alcohol itself that plays such an important role in the co-researchers' lives, instead alcohol is a medium through which the co-researchers connect with the lived experiences within their life-worlds. Alcohol provides a place where they can be on their own and deal with their turbulent existence. However, alcohol is also a medium that brings them back to reality and connects them with society and their significant others. If alcohol was taken out of their being-in-the-world, the co-researchers might lose their connection with reality and their life-worlds. In my interpretation only the few co-researchers who can find a substitute for alcohol as the link between their life-worlds and reality, stand a chance of truly recovering. The findings indicate that female alcohol dependence is more multi-faceted than what was assumed by the

literature presented. Yet this study only touched on the outer layer of this disorder and much remains to be discovered.

7.3. My own reflections

This wealth of information about female alcohol dependence made me look at the disorder from a different perspective. Most of all, it put me in a position to answer the questions I have always had about this disorder. I have always wanted to know why alcohol dependents drink and why they continue drinking even though they are aware of the negative consequences. The most obvious reason provided by these findings was that alcohol provides momentary sense of stability, something that is lacking in their lives. Closer investigation shows that the female alcohol dependents are unable to handle the abundance of lived experiences that accompany each life-world. Alcohol helps them to escape from a specific experience within a specific life-world, and allows the alcohol dependents to traverse to another less threatening life-world. The constant and eventful movements between the life-worlds, in the female alcohol dependents' attempt to escape the hurtful emotions and reminders of their painful past, does not allow them time to focus on the negative consequences of their drinking behaviour. Also, it appears that the individuals' irrational-will is much stronger than their rational-will, urging them to focus on their immediate relief rather than making long-term plans. This appeared to filter through to other aspects of female alcohol dependents' lives. The negative physical consequences that accompany alcohol dependence do not compare to the relief that alcohol provides.

It was also important to ascertain why some people become alcohol dependent and others do not. As I immersed myself in the life-worlds of the co-researchers, there seemed to be a multitude of reasons. It does seem that women who were abused as children are prone to develop alcohol dependence. Individuals without healthy coping resources, such as a supportive family, and individuals with an external locus of control are also vulnerable to developing alcohol dependence. Furthermore, the narratives further indicate that some

individuals might have coping skills and resources, but may be made vulnerable through a physiological predisposition. In addition, the findings show that individuals who had to take over a carer role during childhood as well as individuals who prefer to be loners run the risk of becoming alcohol dependents. The lived experience of female alcohol dependence thus showed that there could be many reasons why certain people become alcohol dependent and others do not. Perhaps some individuals do not have a multitude of negative lived experiences that make up the biggest part of their life-worlds. As a result they do not experience this inner turmoil and therefore have no need to escape. It could be that people who do not fall into the abyss of alcohol dependence experience a wealth of inner peace as compared to inner turmoil. Within this harmonious world they might have developed healthy ways of dealing with painful aspects from their past. They could have developed appropriate ways of dealing with hurt and loss and have learnt the importance of reflection in getting to know themselves and becoming self-actualised individuals. Alcohol dependents clearly lack all of these characteristics.

Based on the above discussion, it is important to also look at my relationship with my father. His alcohol dependence has caused us, as with the co-researchers in this study, to have a tarnished relationship. Only during the past few years have I made a conscious effort to get to know my father. We have spent so many years apart that the brief times we now spend together remain slightly superficial, as if we want to make the most of it and not spoil the moment. As a result, we have never really made time to get to know each other as people with backgrounds and pain. This has resulted in me forming an idea of what my father 'the alcohol dependent' is all about, without having any substantial information to support my beliefs. Unfortunately, this preconceived image of my father has guided my behaviour towards him from a very young age, something that I now regret following the findings in this study. Spending time with the co-researchers made me realise that there is more to my father than meets the eye. These things could be both negative and positive. He deserves another

chance from me. He has always appeared to be on his own and doing his own thing, and this study showed that alcohol dependents prefer to be left alone. I could never understand why my father appears happy in the absence of friends, but now this makes sense to me. Based on the findings in this study it occurred to me that my father must have a painful past, something that he has never shared with me. He always appears in high spirits yet I realise that this could be just a facade for when I visit. Lastly, on a few occasions I have experienced the way my father manipulated me in order to obtain alcohol. Based on the findings in this study, it does concern me that this forms such an integral part of his female counterparts' lives. As painful as it seems, I know that I need to be alert so that this does not happen again. Overall, I realised that I need to talk to my father and allow him to talk to me. He deserves to be heard and I will make a constant effort to become part of his life-world and experience his lived experience of alcohol dependence. Ultimately, we deserve a healthy relationship and immersing myself into my father's life-world, allowing me to experience his being-in-the-world, will assist us in achieving that objective.

7.4. Lived experience typology of female alcohol dependence

Based on the informative, enriching and revealing journey I enjoyed with the co-researchers, I have classified female alcohol dependents into various categories. Based on my interpretations, I propose the following typology for the lived experience of female alcohol dependence: The Condemned, The Utopian and The Realist. The reader must note that these classifications are not restricted and more research could provide additional qualifications. However, this typology is restricted to female alcohol dependents who participated in the present study.

7.4.1. The Condemned

A 'condemned' alcohol dependent has experienced inner turmoil since adolescence, or young adulthood, as a result of childhood trauma. As a result she has had an early onset of alcohol dependence. Furthermore, there is a vast discrepancy between her lived experiences and her conscious awareness of her disorder. Her *Dasein*, her being-in-the-world, is characterised by an abundance of inner turmoil resulting in negative and destructive lived experiences within her life-worlds. She is not interested in facing her own reality as an alcohol dependent as alcohol is the only thing that provides meaning in her life. She has accepted her fate, exhibits emotional numbness and resists any change to her life-world. 'The condemned' alcohol dependent is an extreme loner. There is no space for significant others in any part of their life-worlds and they defend these life-worlds at any cost. The 'condemned' alcohol dependent also makes use of excessive lying and manipulation to maintain her life-world as an alcohol dependent. Lying and manipulation are part of her daily life and form an integral part of her life-worlds. The 'condemned' does not blame her womanhood for her drinking behaviour. Instead she blames anything and everything that she encounters. In general, 'the condemned' has frequent rehabilitation admissions and usually enters rehabilitation due to law enforcement or concerned family members who registered on her behalf. Amongst all alcohol dependents 'the condemned' has the least chance of remaining sober.

7.4.2. The Utopian

As with 'the condemned' alcohol dependent, 'the utopian' has an early onset of alcohol dependence. She has experienced inner turmoil since adolescence or young adulthood. Her life-worlds are characterised by a discrepancy between her lived experiences and her conscious awareness of her disorder. However her *Dasein*, her being-in-the-world, is characterised by positive lived experiences within her life-worlds. Her behaviour, thoughts and emotions are guided by her idealistic lived experiences and often conflict with practical

considerations. She is unrealistically optimistic about her future and especially her own sobriety and does not fully comprehend the difficulty of remaining sober. She sees her alcohol dependence as a passing phase, and does not acknowledge that she will always remain an alcohol dependent. She has excellent ideas about the future and her own sobriety, but does not incorporate reality into the idealistic intricacies of her own life-worlds. 'The utopian' is a loner who lacks insight and projects herself to the world as a team player. Within her life-world her significant others play a significant role, however this role clashes with her ideal of the role that she feels they should play. She also makes use of excessive lying and manipulation to maintain her life-world. Unlike 'the condemned' lying and manipulation centre on her drinking behaviour. Furthermore, she blames a great deal of her problems, and reasons for drinking, on her role as a woman. Overall, 'the utopian' has frequent rehabilitation admissions and usually enters rehabilitation as a result of the encouragement of family members or friends. Due to the euphoric nature of her lived experiences within her life-worlds, 'the utopian' has little chance of remaining sober.

7.4.3. The Realist

In general, 'the realist' experiences low inner turmoil and an abundance of inner peace. However, due to a traumatic setback or loss during her young to middle adult years, she experiences inner turmoil that is foreign to her life-world. For 'the realist' alcohol dependence develops during adulthood as a result of being unable to deal with sudden trauma or loss. Due to the small discrepancy between her lived experiences in her life-worlds and her awareness of her disorder 'the realist' sees her alcohol dependence as a temporary feature in her life. However, she is realistic and acknowledges that alcohol is a life long problem and a battle that she has to fight on a daily basis. 'The realist' is a team player and acknowledges and appreciates the presence of significant others in her life-world. Like 'the condemned' and 'the utopian', she uses lies and manipulation to maintain her drinking behaviour. As with 'the utopian' her lies centre on her drinking behaviour and she often blames her drinking

behaviour on her inability to fulfil her role as a woman. In general ‘the realist’ has a single rehabilitation admission and repeat admissions are uncommon. Overall, ‘the realist’ has the best chance of remaining sober following rehabilitation.

7.5. Female versus male alcohol dependence

The differences between male and female alcohol dependence were not investigated in the present study. It seems that the only dimension of alcohol dependence that differentiates female and male alcohol dependents is the lived experiences associated with the life-world of ‘the covert chauvinist’. In order to compare these two populations further research could investigate the life-worlds and lived experiences of male alcohol dependence.

7.6. Limitations of the present study

This study is characterised by two limitations. The nature of the qualitative methodology limits the findings to the co-researchers in the present study. Verifying my interpretations after the third interviews was not possible as I was unable to remain in contact with the co-researchers.

7.7. Recommendations

The preceding discussion has provided the reader with a perspective that extends our existing knowledge of female alcohol dependence. The findings show that the lived experiences of female alcohol dependence play a significant role in the development and maintenance of their disorder. As a result, it is important to see what role this plays in future research and treatment of alcohol dependence among women. First and foremost, it is of utmost importance to discover a female alcohol dependent’s life-worlds. Even though some phenomenological studies in the past have focused on female alcohol dependence, their focus was either specific (Klaich, 1996) or descriptive (Nehls & Sallman, 2005) in nature. The researchers did not become part of the co-researchers’ life-worlds. The findings indicate that the female alcohol dependents’ life-worlds are highly complex and ambiguous. Each

individual's life-worlds are unique. The lived experiences within the female alcohol dependents' life-worlds are not obvious and are not available to their conscious awareness and therefore need to be discovered. The findings also indicate that neither the alcohol dependent nor the healthcare professional can gain access to this life-world on their own. It is a joint attempt and requires recurrent visits. Even though discovering the life-worlds is a lengthy process the intricacy involved in each life-world makes it worthwhile. Discovering the life-worlds reveals what underlies the individual's thoughts, behaviour, attitudes and drinking behaviour. Furthermore, the importance female alcohol dependents' place on their social, cultural and contexts, their 'situated freedom' (Lavery, 2003), also needs to be incorporated into their life-worlds. This should form the foundation from which treatment approaches are designed. The findings also highlight the importance of questioning an individual's life-worlds. It is only through questioning that the female alcohol dependent's existence will become meaningful (Lavery, 2003; Steiner, 1989). One way this could be achieved would be through stimulating a conscious effort to empathise with the female alcohol dependent's circumstances. The findings in this study further indicate that an individual's beliefs and logical systems seem to make their true nature, their *Dasein* or being-in-the-world, difficult to fathom. Language use such as constant repetition of certain phrases, as well as gestures, laughter and expressions also indicate what lies at the core of an individual's existence within their life-world and need to form another core area of focus during rehabilitation. A healthcare professional must bear in mind that the way in which a female alcohol dependent consciously experiences her disorder does not necessarily indicate the way she experiences it in her life-worlds. Spending time with female alcohol dependents revealed that there is vast discrepancy between their conscious awareness of the various facets of their disorder, and their lived experience of alcohol dependence. Only by going on a journey together, will the alcohol dependent and the healthcare professional find individual answers for each alcohol dependent. As a result, although the findings indicate that female alcohol dependents could be treated

according to a standardised treatment method, it is important to go one step further to establish how they experience their disorder. This hidden world will unlock many unanswered questions for both healthcare professionals and alcohol dependents.

7.8. Conclusion

The above discussion has shown that there is an added dimension to female alcohol dependence that has previously been hidden. The four life-worlds of female alcohol dependence clearly indicate that this disorder exists on a multitude of levels and dimensions, and is accompanied by various emotions, thoughts and behaviours that are outside of the female alcohol dependents' conscious awareness. The lived experiences associated with each life-world also revealed that this multi-faceted disorder is unique for each and every female alcohol dependent. However, the findings in the present study allowed me to propose a lived experience typology of female alcohol dependence.

In conclusion, the research question 'what is the lived experience of female alcohol dependence?' revealed a world of female alcohol dependence more extreme, powerful and eventful than I could have ever imagined. I now look at female alcohol dependents from a different perspective. It is not a compassionate stance but rather an understanding that their existence, their being-in-the-world, hides a wealth of information that remains hidden from the outside world and themselves. If one aims to assist them in their recovery, it is of utmost importance to enter this world and make the contents thereof known.

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LETTER OF INVITATION

The lived experience of female alcohol dependence:

A hermeneutic phenomenological approach

To : [Contact person]
Rehabilitation centre : [Various rehabilitation centres]
Contact details : [Contact details]
From : Riana McArthur (nee Rabie)
Contact details : 083 980 4590 / (011) 686 8400
Email address : riana.mcarthur@ipsos.com / rianame@gmail.com

As per our telephonic conversation, herewith an overview of the research project:

Background to the study:

An extensive literature review showed that:

- During the past few decades research on alcohol dependents have been conducted on male participants and the findings of these studies have been generalised to female alcohol dependents; hence forming the norm and standard for the diagnosis and treatment of all alcohol dependents;
- This research has mostly been of a quantitative nature determining the needs of alcohol dependents; and
- There appears to be a lack of qualitative research on female alcohol dependents.

Based on the above discussion, bear in mind the following:

- The extent of the physical deterioration due to excessive alcohol intake by women;
- The high prevalence of depression among female alcohol dependents;
- The high prevalence of sexual, physical and emotional abuse among female alcohol dependents;
- The barriers to treatment not experienced by their male counterparts; and
- The magnitude of the social stigma women alcohol dependents have to endure when compared to male alcohol dependents.

It is clear that there is a possibility that alcohol dependent women could very well be a misunderstood population.

The purpose of this project is to provide alcohol dependent women an opportunity to talk, to share their lived experience of alcohol dependence with me. The findings of this study could also indicate that these women are indeed different to alcohol dependent men and must be treated differently.

In order to achieve this, I will follow a qualitative phenomenological method where the research participants (co-researchers), through in-depth interviews, can share their experience of alcohol dependence with me but at the same time allow me as the researcher to share my own experience (based on my father's alcohol dependence) with them.

Participants / Co-researchers:

- 2 – 4 female alcohol dependents currently in rehabilitation for alcohol dependence.

Interviews:

- Three interviews per participant/co-researchers, average one hour each, to take part ideally one week apart.

Interview one – Focussed life history:

- In the first interview I will provide an overview of the process as well as take the participant/co-researcher through the informed consent form, explaining anonymity, etc. I will also tell the participant/co-researcher why I have an interest in alcohol dependence and what I would like to achieve with the study.
- This interview will focus on the context of the participant/co-researcher's life (as well as the significant others in this context, such as family, school, friends, neighbourhood) from childhood to adulthood, as it is through placing behaviour in context that it becomes meaningful and understandable.
- At the end of the first interview the participant/co-researcher will receive a diary if she feels there is anything else she would like to share but did not mention during the interview.

Interview two – The details of the experience:

- This interview will focus on a day in the participant/co-researcher's life. The participant/co-researcher will reconstruct a day in her life.
- She will also talk about her relationships with significant others.

Interview three – Reflection on the meaning

- The participant/co-researcher will reflect on the meaning of her experience with alcohol dependence, e.g.
 - what does it mean to her?
 - how does she interpret it?
 - what is her opinion of aspects mentioned in the first two interviews?
 - what are her emotional connections with all the aspects mentioned?
 - what does it mean to her to be alcohol dependent?
 - where does she see herself in the future?
- In essence, the goal is to look at how the factors in the participant/co-researcher's life interacted to bring her to her present situation.

I would appreciate it if you could advise if I could conduct my research at [rehabilitation centre] and if so, when it would be convenient to discuss the project in more detail.

Please do not hesitate to contact me should you have any queries.

Kind regards

Riana McArthur (nee Rabie)

INFORMED CONSENT LETTER

Researcher : Riana McArthur (nee Rabie)

Contact details : (011) 686 8443 (office hours)
083 980 4590

Thank you for agreeing to participate in this study that will take place on _____ at _____. This form outlines the purposes of the study and provides a description of your involvement and rights as a participant.

The purpose of this project is to:

- 1) fulfil a course requirement for the Masters of Arts in Research Psychology (DIS434-L), overseen by Prof K Grieve, my supervisor at the University of South Africa;
- 2) gain insights and experience into the lived experience of female alcohol dependence.

The methods to be used to collect information for this study are explained below. From this information, I will write a case report about you.

I will conduct three (3) interviews with you wherein I would like you to talk to me about your life of alcohol dependence. You are free to talk about anything you wish to talk about as that is the goal of the study. The interviews will be tape recorded and I will also make notes during the interviews to assist me in the data analysis.

As mentioned, I will use the information from this study to write a case report about you. This report will be read by you, the supervisor, and optionally by other academic individuals if you give permission, in order to check on the accuracy of the report. The case report will not be made available to any other person to read without your permission.

I guarantee the following conditions will be met:

- 1) your real name will not be used at any point of information collection, or in the written case report; instead, you will be given (or you can choose) a pseudonym that will be used in all verbal and written records and reports;
- 2) if you grant permission for audio taping, no audio tapes will be used for any purposes other than to do this study, and will not be played for any reason other than to do this study. At your discretion, these tapes will either be destroyed or returned to you;
- 3) your participation in this research is voluntary, you have the right to withdraw at any point of the study, for any reason, and without any prejudice, and the information collected and records and reports written will be turned over to you;
- 4) you will receive a copy of the final report before it is handed in, so that you have the opportunity to suggest changes if necessary; and
- 5) you will receive a copy of the report that is handed over to my supervisor.

You are encouraged to ask any questions at any time about the nature of the study and the methods that I am using. Your suggestions and concerns are important to me; please contact me at any time on the phone numbers listed above.

Do you grant permission to be quoted directly?

Yes _____ No _____

Do you grant permission to be audio-taped?

Yes _____ No _____

I agree to the terms:

Participant _____ Date _____

I agree to the terms:

Researcher _____ Date _____