Researching with Women in Recovery: How midlife women with alcohol use disorder maintain quality abstinent recovery and wellbeing

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2013

This thesis is submitted in fulfilment of the requirements for the degree of Doctor of Philosophy, University of Western Sydney
DEDICATION

To the women who shared the richness and darkness of their recovery.

For the women and practitioners who bring compassion and expertise to enable more midlife women to become abstinent and well.

To the living recoveries that contribute to the greater whole.

Flowers represented the women’s lived experiences of recovery throughout the 'Researching with Women in Recovery' study.
ACKNOWLEDGEMENTS

How can I express my gratitude to the people who have supported me throughout my candidature and those that have contributed over a sustained period to the Researching with Women in Recovery study. This I express here through the learning they have shared with me.

Firstly, I acknowledge the willingness of those persons who have enabled my research practice to expand through principled, creative and thorough methods; and secondly to persist with and to support my completion of a demanding transdisciplinary action research project, cognisant of the need for ethical care of the vulnerable and wise participants, to improve midlife women’s addiction healthcare.

The women in recovery and healthcare practitioners who volunteered for the study were dedicated to bringing the best of nurturing healthcare, developing partnerships in continuing care and ongoing community support. I learned how false stereotypes, and ongoing stigma and shame so often prevent an achievable whole-person recovery. The contributors to the study wanted to move beyond harm reduction treatment and name and resolve societal discrimination. The women and their supporters provided the means for more women to celebrate abstinence and live well in recovery.

My supervisors, Professor Stuart Hill, Associate Professor Sharon Bourgeois and my early supervisor Dr John Cameron, helped me to understand the importance of engaging with people’s lived experiences in a natural setting, along with academic protocols to develop an original study (exploring the personal, sociocultural, environmental and spiritual factors), implement and evaluate evidence-based research from multiple disciplines to contribute to knowledge and to support people’s mental health and wellbeing.

I wish also to acknowledge my medical team with whom I learned about how to continue to plan and to achieve my research objectives as a mature woman contributing to society whilst also in ongoing healthcare.

Members of my School and University have provided me with experiences and a learning-research environment with professional support and resources to explore,
innovate and share new research knowledge. An exceptional ‘proof in practice’ at the University of Western Sydney is their commitment to support innovative studies and individual student’ needs. The staff of Disability Support Services and their assistants made the physical demands of the study achievable. School staff encouraged and advocated for this significant study and for my candidature to progress whilst providing compassion and optimism; with special thanks to Steve Wilson, Mary Moody, Nikki Pearson, David Wright, Linda Lamond and to Markie Lugton who, with great goodwill, always helped with the seemingly daunting administration tasks.

The University Library staff and IT staff (Sarah Fearnley and Peter Wilcockson), who by their ongoing training and expertise, made continuing with a complex study that contained multiple software versions and equipment changes, possible. There are memories of extraordinary technology-based events that have been addressed, such support has always been provided with an affirmative attitude.

I acknowledge the many inspiring people who contributed their energy, passion, expertise and good humour to the mental health and alcohol and drug fields. Studying in a changing ‘live’ research environment challenged my thinking whilst experiencing anger, trust, fear, joy and peace of mind. I was surprised by the connections that were made possible through the research processes and how this has strengthened my beliefs and continued practice.

Finally to acknowledge the contribution of those I hold dear, my adult children and friends; friends who provided the advice below. My children and I have learned and matured together; the study has contributed to lowering their and my anxieties around physical health. The unexpected benefit was our greater understanding of the value of mental health and the power of people working together.

I believe I can now answer their concerned and jovial question asked many times – “are we there yet?” Today, my answer is yes, and let’s enjoy the moment.

**Inner peace**

Be on the lookout for symptoms of Inner Peace. The hearts of a great many have already been exposed to Inner Peace, and it is possible that people everywhere could
come down with it in epidemic proportions. This could pose a serious threat to what has, up to now, been a fairly stable condition of conflict in the world.

**Some signs and symptoms of Inner Peace**

A tendency to think and act spontaneously, rather than on fears based on past experiences:

- An unmistakable ability to enjoy each moment.
- A loss of interest in judging other people.
- A loss of interest in interpreting the actions of others.
- A loss of interest in conflict.
- A loss of the ability to worry. (This is a very serious symptom.)
- Frequent, overwhelming episodes of appreciation and gratitude.
- Contented feelings of connectedness with others and nature.
- An increasing tendency to let things happen – rather than make them happen.
- An increased susceptibility to the love extended by others, as well as the uncontrollable urge to extend it!

If you have some or all of the above symptoms – please be advised that your condition of Inner Peace may be so far advanced as to not be curable. If you are exposed to anyone exhibiting any of these symptoms, remain exposed only at your own risk (source unknown).
STATEMENT OF AUTHENTICATION

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. The thesis has been written by me and any help that I have received in the writing process, in preparing it, and all sources used, have been acknowledged in the thesis. I hereby declare that the material contained in this thesis has not already been submitted and is not being submitted, either in full or in part for a degree at this or any other institution.

Janice Withnall
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The items on the Researching with Women in Recovery DVD* (contact Janice Withnall for this information at jbwithnall@gmail.com) contains the thesis appendices, bibliography, data collection and analysis instruments, the RWR e-book draft (complete Researching with Women in Recovery Report) and Chapter detail to further illustrate the content, process and context of this important study.

To meet the action research objectives of RWR the documents on this DVD will become the outcomes of the study and be distributed to alcohol and drug organisations, healthcare practitioners, community groups, tertiary educators, policymakers, specialist clinicians, the Australian media and academic journals and conferences. The material also illustrates the research detail of the RWR study’s transdisciplinary, mixed methods, multimedia approach that I have used to discover more about midlife women’s mental health and wellbeing from the participants. The limited academic literature on midlife women also highlighted the need for more participatory and praxis-oriented research studies.

Content of RWR DVD by folders

1. RWR Complete Appendices
2. RWR Bibliography by Chapters
3. RWR Complete Research Report (e-book, 800 pages)
4. RWR Complete Glossary and references
5. RWR Abbreviations, Acronyms, Terms
6. RWR Ethics Approval
7. RWR Data Collection Master
8. RWR Analysis NVIVO data
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11. RWR Media Coverage examples
12. RWR Tertiary Education
13. RWR Chapters extra detail 1-7
   - Action Cycles – tracking participant involvement
   - Details of the Dynamic Lines of Inquiry
   - Examples of RWR models Multiple Analysis process
   - Examples of Participant transactions
   - Results Summary – RWR Recovery Continuum

*Please note: The information on the DVD can be used for study purposes with approval of the author and the University of Western Sydney up to 31st March 2014. After which the information can be used with the citation, Withnall, Hill & Bourgeois 2013.
GLOSSARY

**Abstinence** Refraining from using drugs.

**Addiction** Physical and psychological craving for a drug or drugs and related behaviours. The process of addiction is progressive and chronic. Addiction is more commonly referred to as psychological and physical dependence.

**Alcohol abuse** A maladaptive pattern of alcohol use manifested by recurrent and significant harmful consequences related to repeated use of alcohol (in the absence of the diagnosis of dependence syndrome; DSM-IV-R).

**Alcohol** The term ‘alcohol’ describes a series of organic chemical compounds, but only one type, ethyl alcohol or ethanol, is found in drinks intended for human consumption, and this is the type that is the subject of these guidelines. Other forms of alcohol, including methanol, are more toxic to humans than ethanol and are not suitable for human consumption.

**Alcohol dependence or alcohol dependence syndrome** A cluster of cognitive, behavioural and physiological characteristics indicating that the patient continues using alcohol despite significant alcohol-related problems (DSM-IV-R; ICD-10).

**Alcohol-related harm** adverse health and social outcomes resulting from consumption of alcohol. A number of terms are commonly used in the research literature to describe the levels of drinking that reflect the previous set of guidelines (NHMRC 2001). These guidelines recognised three levels of alcohol consumption (low risk, risky and high risk) in terms of short-term harm (such as risk of accidents and injuries occurring immediately after drinking) and long-term-harm (such as risk of developing alcohol-related disease).

**Assessment** Taking a good history, opportunistic communication, observations and investigations and the use of appropriate screening tools are generic assessment strategies. Assessment of AOD problems includes:

- history of drug use and treatment, medical and psychiatric problems, psychosocial factors
- physical examination and where needed laboratory tests to confirm drug use/investigate abnormalities and/or screen for illnesses predisposed by the drugs used
- create opportunities for harm reduction (injecting behaviour, sexual behaviour, immunisation).

**Binge drinking** Usually refers to the pattern of heavy episodic drinking that can result in significant harm to the drinker and others.

**Comorbidity or dual diagnosis** Refers to a person who has a substance use problem(s) and a mental health problem(s) (e.g. depression or anxiety) at the same time. Interaction between the two can have serious consequences for a person’s health and wellbeing; therefore appropriate diagnosis is essential in the
management of comorbidity. Comorbid problems generally require long-term management approaches and an integrated approach with other services.

**Cravings** A strong desire or urge to use drugs, most apparent during drug withdrawal and may persist long after cessation of drug use. Symptoms are both psychological and physiological. Cravings may be triggered by a number of cues; e.g. seeing a dealer, music/object association such as walking past a pub.

**Dependence** Alcohol dependence refers to situations where a person feels a strong need to drink so that drinking is given priority over other behaviours that the person had previously found much more important. Dependence ranges from mild to severe. People with severe dependence drink regularly at high-risk levels, often find it hard to limit how much they drink, and generally have marked tolerance to the effects of alcohol. If they stop drinking for a few hours, they experience tremulousness and anxiety.

**Drinking occasion** A drinking occasion refers to a sequence of drinks taken without the blood alcohol concentration reaching zero in between. This might include a drink at home at the end of the day or over dinner, or at a specific event, such as a party, night out, visit to the pub, a family or business event or other function. It may also include drinking spread across more than one context or venue, for instance on a ‘Friday night out’.

**Detox/detoxification** Is synonymous with and more commonly termed withdrawal. Usually it refers to supervised withdrawal for a person who is dependent. It may or may not involve medication.

**Fetal Alcohol Syndrome (FAS)** FAS is a disorder of permanent birth defects that can occur in the offspring of women who drink alcohol during pregnancy. These defects include growth deficiency, characteristic facial features, and central nervous system damage.

**Fetal Alcohol Spectrum disorder (FASD)** FASD describes a continuum of permanent birth defects related to a maternal consumption of alcohol during pregnancy, which includes FAS. Other subtypes with evolving nomenclature and definitions based on partial expressions of FAS, including Partial Fetal Alcohol Syndrome (PFAS), Alcohol-Related Neurodevelopmental Disorder (ARND), Alcohol-Related Birth Defects (ARBD), and Fetal Alcohol Effect (FAE).

**Harmful alcohol use** A pattern of alcohol use that is causing damage to health. The damage may be physical or mental (in the absence of the diagnosis of dependence syndrome) (ICD-10). It should be noted, that ‘alcohol-related harm’ and ‘problems related to alcohol consumption’ are regarded as equivalent terms and usually have wider meaning than harm to the drinker’s health. In practice they usually refer to a range of health and social problems to the drinker and to others, since they affect both the individual and society at various levels (WHO 2007).

**Harm minimisation** Underpinned the National Drug Strategy and aims to promote better health, social and economic outcomes for the community and individual. Harm minimisation includes preventing anticipated harm and reducing actual harm from licit and illicit drugs. It is a comprehensive approach to drug-related harm, involving demand reduction, supply reduction and harm reduction strategies. It takes into account three interacting factors: the individual, the environment/setting and the drug(s).
**Harm reduction** Aims to reduce the impact of drug-related harm within society, at an individual and community level. It includes reducing the physical and social harms associated with drug use, encompassing the prevention of disease, death, incarceration and isolation. It acknowledges that drug use exists and will continue to, and therefore it focuses on promoting harm reduction methods. Examples: clean needles and syringe programs, methadone as a treatment option for opioid dependency, experimental, supervised injecting facilities, brief advice and information pamphlets.

**High risk levels** Levels at which there is substantial risk of serious harm, and above which risk continues to increase rapidly. A number of terms have been traditionally used in clinical practice and professional literature to describe levels and patterns of alcohol consumption. The terms – binge drinking, hazardous drinking, heavy drinking, problematic drinking and risky drinking – are difficult to accurately define as they usually reflect the period of time in which the literature was published or indicate the levels and patterns of drinking specific to a particular publication.

**Hazardous drinking** Indicates a level of consumption or pattern of drinking that is likely to result in harm if current drinking pattern continues.

**Heavy drinking** Usually closest in meaning to harmful and high risk drinking levels defined above.

**Interventions** A set of sequenced and planned actions designed to reduce risky behaviours in society. Intervention often targets a specific group (risk group) in order to reduce the adoption of potentially harmful behaviours (such as drug use). In the GP setting interventions are synonymous with treatment plan activities, which are negotiated with the patient.

**Intoxication** The acute effects of a drug when taken on a single occasion that produce behavioural and/or physical changes. When intoxicated the amount of a drug(s) exceeds the individual’s tolerance. The capacity to think and act within a normal range of ability diminishes.

**Lapse/lapse–relapse cycle** The first use of drugs after a period of abstinence. A relapse refers to a return to uncontrolled use or use at levels similar to those prior to abstinence. It is important to recognise that lapse/relapse is not ‘failure’ but a step towards behaviour change. Research indicates that the absence of coping skills and certain belief systems (e.g. ‘I’m an addict and can’t stop’) are major predictors of relapse risk.

**Low risk levels** A level of drinking at which there is minimal risk of harm, and for some the likelihood of health benefits.

**Neuro-adaptation** The process whereby the brain adapts to the presence of a drug. The brain becomes relatively insensitive to normal levels of neurotransmitters by a number of postulated mechanisms. This is one explanation for craving. The drug user may experience under-stimulation (without drugs), a reduction in euphoria/pleasure and need to increase the dose to maintain the drug’s euphoric effects.

**Neurotransmitters** Chemical messengers that are released by neurones to communicate across synapses. They bind to particular receptor sites, exciting or
inhibiting an action. Psychoactive drug molecules can behave like neurotransmitters, binding to a particular receptor site and occupying the neurotransmitter’s position.

**Patient centred approach** This is recommended in order to encourage a good therapeutic relationship and trust with the patient. It includes regarding the person’s behaviour as their choice, expressing empathy, encouraging the person to decide how much of a problem they have, avoiding arguments/confrontation, encouraging discrepancy and revaluation of substance use. These strategies have been empirically demonstrated to enhance the quality of support to drug users and enhance the likelihood of behaviour change.

**Prevention** Interventions that are designed to stop or delay the uptake of drugs or reduce further problems among those using drugs. Interventions can be categorised as primary, secondary or tertiary.

**Problematic drinking** Usually refers to the level of drinking at which the person develops some alcohol-related problem or is at risk of developing such problems but has no diagnosis of dependence.

**Risky levels** Levels at which risk of harm is significantly increased beyond any possible benefits.

**Risky drinking** Is close in its meaning to drinking at risky levels defined above. Some of these terms are used in these guidelines where recommendations or statements are based on evidence that includes such terminology.

**Screening tools** Questionnaires that assist in screening for drug use and related harms. They provide useful information and facilitate further discussion between the patient and GP. Screening tools are not designed to replace a good history but are complementary to, and time saving. Examples AUDIT, FAST (based on the AUDIT) & CAGE for alcohol use SDS for psychological dependence ASSIST for alcohol and other drug use.

**Shared care** An integrated approach to provide effective, planned delivery of care for patients with chronic or complex conditions. The AOD shared care model focuses on joint provision of clinical services by GPs and specialist AOD agencies to those patients with AOD problems and ongoing education and training for GPs.

**Standard drink** The Australian standard drink contains 10 grams of alcohol (equivalent to 12.5 ml of pure alcohol).

**Therapeutic Community (TC)** A structured residential environment in which people live whilst undergoing drug treatment (National Drug Strategic Framework 1998). Therapeutic communities are long-term residential programs (often at least three months) that provide a holistic approach to therapy via counselling, group therapy, and other self-help strategies.

**Tolerance** The immediate effects of alcohol on the brain are often less apparent in people who drink regularly, as they acquire a degree of tolerance. Tolerance occurs in part because the liver becomes more efficient at breaking down alcohol. The person learns to cope with, and compensate for, the deficits induced by alcohol.
**Treatment options/modalities** The choice of treatment option(s) depends upon the nature and severity of the drug problem/habit, the social and environmental context in which the patient lives and the resources that exist within and outside the GP setting. There is a range of treatment options.

**Withdrawal syndrome** Describes a range of physical and psychological symptoms that occur when a person stops or substantially reduces substance use if they have been using for a long period or/and at high doses. Generally, signs and symptoms are opposite of the acute effects of the drug. The course of the withdrawal depends upon the level of tolerance developed, other illnesses and the psychosocial environment.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
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<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACOSH</td>
<td>Australian Council on Smoking and Health</td>
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<td>ADCA</td>
<td>Alcohol and other Drugs Council of Australia</td>
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<td>ADDR</td>
<td>Australian Drug Data Report</td>
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<td>ADFA</td>
<td>Alcohol and Drug Foundation Australia</td>
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<td>ADFQ</td>
<td>Alcohol and Drug Foundation Queensland</td>
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<td>ADIN</td>
<td>Australian Drug Information Network</td>
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<td>AERF</td>
<td>Alcohol Education Rehabilitation Foundation</td>
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<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<td>AHMC</td>
<td>Australian Health Ministers’ Conference</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMA</td>
<td>Australian Medical Association</td>
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<td>ANCD</td>
<td>Australian National Council on Drugs</td>
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<td>AOD</td>
<td>Alcohol and Other Drugs</td>
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<td>AODTS-NMDS</td>
<td>Alcohol and Other Drug Treatment Services National Minimum Data Set</td>
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<tr>
<td>ASMI</td>
<td>Australian Self-medication Industry</td>
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<td>ASSDA</td>
<td>Australian Social Science Data Archive</td>
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<tr>
<td>ATSIPCAP</td>
<td>Aboriginal and Torres Strait Islander Peoples Complementary Action Plan</td>
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<tr>
<td>CERG</td>
<td>Comorbidity Expert Reference Group</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CPI</td>
<td>Community Partnerships Initiative</td>
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<tr>
<td>DALYs</td>
<td>Disability-Adjusted Life Years</td>
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<tr>
<td>DAO WA</td>
<td>Drug and Alcohol Office, Government of Western Australia</td>
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<td>DAS SA</td>
<td>Drug and Alcohol Service, South Australia</td>
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<tr>
<td>DEEWR</td>
<td>Australian Government Department of Education, Employment and Workplace Relations</td>
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<tr>
<td>DEST</td>
<td>Australian Government Department of Education, Science and Training [now DEEWR]</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>DETYA</td>
<td>Australian Government Department of Employment, Training and Youth Affairs</td>
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<td>DHS</td>
<td>Department of Human Services</td>
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<td>DoHA</td>
<td>Australian Government Department of Health and Ageing</td>
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<tr>
<td>FaHCSIA</td>
<td>Australian Government Department of Families, Housing, Community Services and Indigenous Affairs</td>
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<tr>
<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorder</td>
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<td>FECCA</td>
<td>Federation of Ethnic Community Council</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HCV</td>
<td>Hepatitis C virus</td>
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<td>ICD</td>
<td>International Statistical Classification of Diseases and Related Health Problems</td>
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<td>ICP</td>
<td>Integrated Care Pathway</td>
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<td>KPIs</td>
<td>Key Performance Indicators</td>
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<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<td>MCDS</td>
<td>Ministerial Council on Drug Strategy</td>
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<td>MCEETYA</td>
<td>Ministerial Council on Education, Employment, Training and Youth Affairs</td>
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<td>NABIC</td>
<td>National Alcohol Beverage Industries Council</td>
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<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>NACSDE</td>
<td>National Advisory Committee on School Drug Education</td>
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<td>NADA</td>
<td>Network of Alcohol and Other Drugs Agencies</td>
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<td>NAS</td>
<td>National Alcohol Strategy</td>
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<td>NCETA</td>
<td>National Centre for Education and Training on Addiction</td>
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<td>NCI</td>
<td>National Comorbidity Initiative</td>
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<td>NDARC</td>
<td>National Drug Alcohol Research Centre</td>
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<td>NDRCE</td>
<td>National Drug Research Centres of Excellence</td>
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<td>NDRI</td>
<td>National Drug Research Institute</td>
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<td>NDS</td>
<td>National Drug Strategy</td>
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<td>National Drug Strategy Household Survey</td>
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<td>NEAC</td>
<td>National Expert Advisory Committee</td>
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<tr>
<td>NEACT</td>
<td>National Expert Advisory Committee on Tobacco</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NEAP</td>
<td>National Expert Advisory Panel</td>
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<td>NEG</td>
<td>National Expert Group</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NGOTGP</td>
<td>Non-Government Organisation Treatment Grants Program</td>
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<td>NHHRC</td>
<td>National Health and Hospitals Reform Commission</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<td>National Health Survey</td>
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<td>National Indigenous Drug and Alcohol Committee</td>
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<td>NIDE</td>
<td>National Initiatives in Drug Education</td>
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<td>NIDIP</td>
<td>National Illicit Drug Indicators Project</td>
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<td>NTS</td>
<td>National Tobacco Strategy</td>
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<tr>
<td>OATSIH</td>
<td>Office of Aboriginal and Torres Strait Islander Health</td>
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<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<td>PGA</td>
<td>Pharmacy Guild of Australia</td>
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<td>PGAQ</td>
<td>Pharmacy Guild of Australia, Queensland</td>
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<td>PHOFA</td>
<td>Public Health Outcome Funding Agreements</td>
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<td>PSA</td>
<td>Pharmaceutical Society of Australia</td>
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<td>QADREC</td>
<td>Queensland Alcohol and Drug Research and Education Centre</td>
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<td>RBT</td>
<td>Random Breath Testing</td>
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<td>RSA</td>
<td>Responsible Service of Alcohol</td>
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<td>SBDP</td>
<td>School-Based Drug Prevention</td>
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<td>SES</td>
<td>Social Economic Status</td>
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<td>SRG</td>
<td>State Reference Groups</td>
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<td>TGA</td>
<td>Therapeutic Goods Administration</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<td>VADA</td>
<td>Victorian Alcohol and Drug Agencies</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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ABSTRACT

How midlife women with alcohol use disorders maintain quality abstinent recovery: a transdisciplinary and participatory study to explore women’s health needs when establishing and sustaining recovery.

This Participatory Action Research (PAR) explored how alcohol dependent midlife women in Australia maintain abstinent recovery. The aim was to identify, based on the women’s lived experiences, critical recovery change processes, and to recommend women-oriented ways to improve healthcare services, including professional training, to meet women’s needs for long-term recovery and wellbeing.

The context of the study was the:

1. doubling in percentage (to 16 per cent) in high-risk drinking by midlife women (35 to 59 years) in Australia from 1995 to 2012;
2. common delays in correct medical diagnosis of women’s alcohol use disorders (AUDs), compounded by the stigma of female alcohol addiction (different and greater than for men);
3. lack of easy access to effective, midlife women-focussed AUDs treatment programs and related essential mental and physical healthcare;
4. lack of adequate targeted health policies and practices for women’s long-term abstinent recovery and wellbeing;
5. lack of accessible and comprehensive public health information on women’s AUDs and person-centred treatments;
6. inadequate recognition by healthcare services of the need for ongoing chronic healthcare for AUD women; and
7. insufficient professional education and contemporary knowledge of women’s AUDs care needs.

The study’s primary objectives were to:

1. identify, with women in recovery and practitioners (professionals providing addiction healthcare), the lived experiences and processes that enable women with AUDs to have an enriching experience of recovery;
2. explore the barriers for the ‘whole-person’ care required by midlife women to become and remain abstinent, well, and socially effective;
3. provide evidence-based actionable recommendations and necessary tools for health providers to improve midlife women’s ‘recovery care and development’;

4. prioritise the particular aspects of ‘recovery support’ needed by midlife women (e.g. to address trauma and chronic pain) to sustain abstinence and personal wellbeing; and

5. to increase access by practitioners, media professionals, tertiary educators, family and friends to the best currently available female-focused, evidence-based AUDs information.

The primary participants of Researching with Women in Recovery (RWR) comprised 246 midlife women in abstinent recovery (with 2 to 31 years of abstinence) and 106 practitioners (with recognised qualifications in addiction care) who were working with AUDs clients. By the completion of the six Action Cycles, there were 805 participants who had been recruited using the purposive and snowball recruitment strategy. I also observed (over seven years) 18 ‘communities of practice’ (groups involved with drug and alcohol services), and 12 alcohol and drug recovery ‘mutual-support groups’, such as AA (n = 110 observations). This research (through the RWR Transactive Methodology) drew upon the thoughts, feelings and actions relating to women’s alcohol use disorders and abstinence, to increase and add depth to our understanding of the change processes that enable midlife women to sustain recovery and wellbeing.

The RWR Transactive Methodology employed four lines of inquiry (Document and Expert Exchange and Action Science along with PAR and Direct and Indirect Observation) and a mixed-methods strategy to explore with the participants’ their real-life contextual understandings, multi-level perspectives, and the sociocultural influences informing their ways of recovery and recovery care. With completion of the RWR Meta-study (beginning from Action Cycle 4 and continuing after Action Cycle 6) 970 people had volunteered and contributed to RWR.

Data were generated using six methods of collection (surveys, face-to-face ‘open’ interviews and telephone ‘semi-structured’ interviews, email questionnaires, five transdisciplinary literature reviews and direct observation), over six cycles, in the everyday community environment. Data analysis was reiterative through the Action Cycles and Meta-study to identify and explore with participants the holistic meaning and understanding of the processes and constructs of abstinence, recovery and wellbeing for midlife women. The comprehensive analysis involved the following seven processes, and it intentionally integrated these methods to draw upon the strengths of each:

1. Familiarisation and interpretation of the study’s data through a text analysis procedure (using the NVivo versions 7, 8 and 9 software);
2. Examining and modelling purposeful data clusters, categories, connections and outliers within the data, and searching for similarities, comparison and contrasts across and beyond the disciplinary literature;

3. Action science, triple-loop critical thinking to identify recursive factors, patterns and associations across the six Action Cycles;

4. Integration of Action Cycle results to explore and refine concepts and develop explanations;

5. Synthesis of findings, both from the RWR study and the transdisciplinary literature;

6. Meta-analysis of secondary (government) data records and planning documents; and

7. Meta-study of RWR the databases to generate findings, conclusions and recommendations.

The following six phases of the women’s Recovery Continuum (abstinence to long-term recovery) were identified, described in detail and found to be instrumental in their abstinent, autonomous and authentic recovery: 1. Distressed recovery; 2. Enacting recovery; 3. Enabling recovery; 4. I’m in recovery; 5. Complex recovery and, 6. Valued recovery. The results of this research were shared with the participants during the study, and their feedback further improved the processes for achieving ‘recovery care’, ‘recovery development’ and ‘recovery support’. These improvements included particularly:

1. Forming people-focused, holistic-care partnerships for delivering integrated, transformative treatment through individual recovery management plans for AUD women;

2. Targeting subgroups of midlife women (e.g. those with comorbid disorders) for specific interventions and treatments;

3. Using trained ‘expert volunteers’ (women with experiences from their own recovery) to help the women to meet their recovery needs;

4. Providing safe women-specific spaces (which I called ’WmSpaces’) within the community where midlife women in recovery could learn to socialise without alcohol; and

5. Enabling sustained Wise Recovery by supporting capability-building and flourishing as the women progress through improved selfhood, adulthood and womanhood.
Ongoing respect and sensitivity for participant choices and contributions during the prolonged and persistent engagement of RWR helped the women to build trust and rapport. The comprehensive research design, particularly the participative mixed-methods strategies, contributed to the integrity of this critical research and its results. Careful management of the rich data and the cooperative scrutiny during data analysis, coupled with the thoroughness of six Action Cycles and the final Meta-study contributed to the trustworthiness of the research. The Transactive Methodology delivered confirmability to the findings and conclusions and met the ethical research goals of RWR.

The presentation of the comprehensive findings of RWR (e.g. the ‘Recovery triad of women’s AUDs healthcare practice’) also employed knowledge translation techniques that met the aim of sharing the RWR’s actionable knowledge – for example, through the production of draft protocols for clinical practice (particularly early identification of midlife women with AUDs) – to enable prompt progress to establish abstinence and recovery and identify women needing more support to maintain recovery.

A praxis-based synthesis (critical analysis to identify explanations and actions to meet midlife women’s needs) was completed at the close of the Meta-study on all the accumulated and scrutinised data and transdisciplinary literature. This synthesis led to two outcomes; the development of local working theories, and identifying practical actions for sustaining recovery. The practical actions focused upon women’s ways for maintaining wellness as they developed and aged in their long-term and ongoing recovery. The development of the local working theories (i.e. constructs of women’s recovery; for example, cooperative independence assisting long-term recovery) were based on the intimate detail in the data collected during the participants’ explanations, over the seven years of the study, of their lived experiences in recovery. The refined practical actions and the local working theories were considered in the ‘review and reflect’ participant evaluations of the participative research, which contributed to the study’s conclusions and recommendations.

The RWR conclusions and evidence-based recommendations emphasise how improvement for women with AUDs can be made through policy development, public and media psycho-education, updating tertiary education teaching curricula and professional leadership, to apply optimal ‘abstinent recovery care and development-based interventions for women’ in the Australian health and medical care systems. The RWR study has provided the best proactive practice for midlife women’s complex health needs to enable a growing (previously un-recognised) population to establish and maintain recovery and wellbeing over their lifespan.

**Keywords:** alcohol, midlife women, recovery, emotion, mental health, participatory action research, self-development, abstinence, wellbeing
Women’s ways of recovery work for women

Healing and recovery can be efficiently and respectfully provided for women with Alcohol Use Disorder (AUDs) using women’s ways of abstinent recovery as a starting point. This was a positioning and guiding statement for the Researching with Women in Recovery (RWR) action research discussed in this thesis. The research aimed to find explanations through participatory research for how recovery works for midlife women, and to identify the ways women can be enabled to improve their health and wellness when affected with AUDs. The objective was to develop, with women in recovery and practitioners, women-oriented research-informed processes that support women to become abstinent and well in the challenging change processes of women’s AUDs recovery.

Recovery in this study is a form of healing.

... those physical, mental, social, and spiritual processes of recovery, repair, renewal, and transformation that increase wholeness, and often (though not invariably), order and coherence. Healing is an emergent process of the whole system and may or may not involve curing.
(Dossey 2003 p Al 1)

How the research began

The idea of a study about the recovery of midlife women with AUDs began to evolve in the early 2000s in Sydney (the time of the Millennia celebrations and the Olympic Games in Australia). My interest was based on observations of women with mental illness, receiving care for post traumatic stress disorder and chronic and terminal physical illnesses, and of their women supporters who were coping with crises by engaging in shared drinking sessions. My decision to undertake research with

1 AUDs: I have placed an ‘s’ at the end of the abbreviation for Alcohol Use Disorder (AUD) to represent the likely comorbid disorder(s) and chronic illness(es) common to midlife and older women with alcohol dependence. Alcohol is causally related to more than 60 different medical conditions. Overall, 4 per cent of the global burden of disease is attributable to alcohol, which accounts for about as much death and disability as tobacco and hypertension. The major chronic illnesses related to AUDs include anxiety and mood disorder, Type 2 diabetes, ischaemic heart disease, haemorrhagic stroke, cirrhosis of the liver and oesophagus, breast and colon cancers (Room, Babor & Rehm 2005).
women in recovery grew after studying women’s increasing alcohol consumption (Roche & Deehan 2002; Young & Powers 2005), the associated physical harm (Read & Brown 2003; Crews et al 2005) particularly neurobiological and neuroanatomical effects, and the psychological distress (Armeli et al 2000) caused by alcohol consumption and alcohol dependence.

Midlife career women in business, government and tertiary education had been found to be drinking alcohol to reduce their level of stress, particularly their emotional distress (Karoll 2002). I had also observed that socialising in Australia was increasingly associated with the consumption of alcohol, e.g. a group bushwalk would commonly be followed by drinks at a pre-selected venue at the end of the planned walk. Self-medicating with alcohol to alleviate stress was increasing (Svikis & Reid-Quin 2003; Oei & Morawska 2004). Many adults (unfortunately including some GPs and practice nurses; Loxley 2005), lacked adequate alcohol education to name alcohol as a sedative-hypnotic drug that alters brain function and has toxic affects on physiological systems (Goldman & Barr 2002) although it is classed as a depressant psychoactive drug which alters mood, cognition and behaviour (Leshner et al 1998; WHO 2004). As well as this, reference was increasingly being made to adults ignoring ‘do not drink alcohol while taking this medication’ warnings, and that a culture of ‘determined drunkenness’ (Measham 2006) was developing.

Studying the available research highlighted the lack of early intervention screening, person-oriented treatment and continuing care processes based on studies identifying women’s needs, particularly age and individual circumstances (Covington 2000; Greenfield 2002). Women’s life-course issues were inadequately addressed in AUDs treatment (Niv & Hser 2006) as were the female genetic pre-disposition, familial history and environmental factors which contribute to women’s AUDs recurring along the lifespan (Prescott 2002; Pescosolido et al 2008). All these led me to conduct a trial study called Creative Recovery².

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² The trial, Creative Recovery, was conducted in 2005 and 2006 with eight participants in a psychiatric hospital. I developed a recovery care module for women that could be used as an adjunct to an existing alcohol and other drug detoxification and rehabilitation program in Sydney, Australia (Withnall & Hill 2006; Masters & Carlson 2006).
The need for relevant research evidence on women’s recovery

Preparing for the major RWR study required broader literature searches and more discussions with practitioners, women in recovery and researchers. My search for reliable sources of evidence (research documents, treatment guidelines, professional education, development and training materials and clinical papers) revealed the limited study of the specifics of women’s alcohol dependence in contemporary Australia and a paucity of information3 on what were the important processes necessary to reach and maintain stable abstinent recovery for the lifespan. A small amount of research had been published in the mid 1990s regarding women and alcohol in Australia but research has been sporadic since then (Hands et al 1995). From 2005 to 2012 there is no abstinent recovery care documented in the clinical treatment of midlife women in Australia.

Academic sources did not provide adequate explanations for my personal observations related to the extent and effects of alcohol use by women, e.g. through my attendance at AA meetings, at the international symposia, Research Society on Alcoholism and the International Biological Research on Alcohol in Sydney (2006) and the International Association for Women’s Mental Health in Melbourne (2006). Attending these events confirmed for me the need for research using a recovery focus with the goal of a detail-rich exploration of women’s ways of living well in midlife recovery.

Myths of women being less ‘alcoholic’ than men are less likely in the academic literature (Angove & Fothergill 2003), there are common misunderstandings about appropriate quantities of alcohol (larger than standard drinks are often consumed) and incorrect ideas about types of alcohol drinks that are not damaging to women, i.e. wine, spirits or beer, continue in Australia (NHMRC 2009). Evidence of a pre-disposition to AUDs has emerged through neurological and genetic studies (Sullivan, Rosenbloom & Pfefferbaum 2002) as has the connection to stress through psychoendoneuroimmunology studies (PENI; Ray 2004). Studies on women as ‘a

3 The references in the Preface reflect the majority of studies around the early 2000s. Search terms entered into bibliographic databases produced many results, however, when female or wom* terms were included, far fewer studies remained. Placing midlife, mid-aged, middle-aged terms in the search string produced minimal results including citations to our own work in the 2000s (Withnall, Hill & Bourgeois 2008).
special population’ (a recognised group targeted to receive grants for women’s addiction research; Lisansky Gomberg 2006) have presented such facts as, i.e. women with higher occupational grades are more likely than men to be alcohol dependent (Head, Stansfeld & Siegrist 2004).

Research focus refined

The lived recovery experiences of the women participants provided intimate information and enabled the identification of the unique challenges being faced by the women; for example, obtaining treatment for alcohol dependence\(^4\) while being the primary ‘carer’ within their family (and sometimes also within their community).

Practitioners also shared their understanding and concerns about women with AUDs. The practitioners were direct with their answers to questions about ‘problems with healthcare’. Treatment seeking was often hindered by a complex array of issues, including lack of transportation, social stigma, the women themselves not wanting to be an ‘alcoholic’, a genuine fear of losing their children, abuse from their intimate partner, and a reluctance on the part of primary care physicians to recommend that the women receive more support (Small, Curran & Booth 2010). A concern raised in planning discussions was how progress towards women’s abstinence and wellness was being left aside, confused or made more difficult by the health system and the women’s significant others. This focus on how progress to wellness could be achieved became a major part of my study.

For most of the women in the study, recovery was not about being a victim or survivor, but coming to a comfortable ‘sense of self’, of being midlife women and accepting themselves. The women were mature, healthy individuals, non-drinking and living an in recovery way of life, each day. The women with AUDs in midlife believed that an everyday process was a great achievement for them, their supporters, mutual self-help peers, and healthcare practitioners agreed. To reach stable recovery, the women worked in, and on, the most difficult experiences of coming to know themselves without alcohol and with the knowledge that abstinence

\(^4\) As a central figure in the family or group, the women perceived themselves as flawed and deviant. They believed themselves to be powerless to change and their self-blame for any negative event increased (Van Vliet 2009).
was their priority as their chronic illness was in remission only. The term learning about their existing abilities and new capabilities took them many years. The benefits, as described in RWR, were the positive value of self-awareness and hindsight to bring to personal and selected social activities, emotional stability, continuing maturation and peace of mind. Important, for the women and practitioners, was the insight of knowing when they ‘did not know’ and how to proceed to take action and seek the guidance of knowledgeable, trusted others so that actions are responsible and a true reflection of an authentic, joyful, and well woman, in the present moment.

I, the researcher and, we, the participants

I am a woman in midlife and a researcher who acknowledged salient self-questioning about my role and decisions involving the RWR participants. I questioned my tasks as a representative, a collaborator and as a co-researcher. My personal aim was to assist participants to become more empowered through the six Action Cycles of the research. I purposefully aimed to limit power differences between the participants and myself by creating a transparent research environment that valued cooperation, candid views, and confidential, safe sharing of personal experiences. From the beginning, researching with women and practitioners meant a transparent and cooperative research practice which continued as priority throughout the study. By the end of RWR there was an atmosphere of trust, achievement and goodwill.

My self-location in the research shifted a number of times in response to the evolving form of the study and to the participants involved. A large proportion of participants contributed to a minimum of three Action Cycles. In the trial study on Creative Recovery, I was in close proximity with participants, and my writing about the experience reflected that closeness. At the beginning of the major study until the end of Action Cycle 4, I was more reserved, in order to establish an environment of mutual contribution and to limit my influence on the participants (Gergen & Gergen 2003). By Action Cycle 5, I was well known to the participants, their communities of practice, and my presence as an observer within the community activities of women

5 The women participants did not use the word remission. They referred to being ‘in recovery’.
in recovery, mainly in the eastern states and one territory of Australia, was acknowledged not questioned.

The women were provided with knowledge and skill opportunities to expand their capabilities during the study by volunteering for trials (Chapter 3, Research Design). My commitment in RWR was to be reciprocal with the sharing of information. I used as a starting point for the trials: Damasio’s (2000) core self research; Boyd and McKay’s (2000) study on women drinking to stop the feeling of alienation from self and others; Downey, Rosengren and Donovan’s (2002) work on self-concept and identity development from self-protection to self-elaboration; and Kralik’s (2003) work on transition and healthcare. The process enabled me to work with participants who were committed to helping more women, like themselves, to be well and in recovery with AUDs.

The seven-year study provided a unique opportunity to conduct research with both women in recovery and practitioners and I immersed myself in the philosophies of researching with people, with an objective of actionable knowledge (Maller et al 2005). Maintaining confidentiality was especially necessary, as sensitive, and perhaps discreditable experiences were knowingly shared (no woman or practitioner received information on who was an RWR participant). Confidence in the participatory action research grew with participants providing feedback on the RWR newsletters containing updates on the study and their responses became more detailed in interviews and email discussions. As the participants continued in the study, more intimate information was offered (and accepted) through words, music, poetry and images.

I monitored the flexibility of the RWR mixed methods research strategy to provide inclusiveness and mutuality (Humphreys & Noke 1997), e.g. through reviewing preliminary results together (Chapter 4, Transactive Methodology and Results). I was able to observe social interaction and the healthy relationships the women in recovery developed (Covington & Surrey 2000). In recovery and as RWR participants, the women continued to mature as they learned new ways of expressing their knowing, connecting and exchanging meaning with self and others (Bauer & McAdam 2004). The length of recovery was not the only factor leading to adult integration of body, mind and spirit. Participants contributed to how lived experiences of an emerging, authentic non-drinking self and in recovery identity
required new skills, peer friendships and continuing in recovery ways of living with chronic illness healthcare management.

The women recalled important events and processes with as much detail as possible and I was privileged to analyse their data. The women’s difficulties with their personal and interpersonal growth were described and analysed: differing perceptions of reality and beliefs; adjusting to sensory feelings; working with emotional fragility and stability; difficulty with reasoning, alternate ways of thinking and perspective-taking; and resisting playful expressions (Sherman & McConnell 1995). Comparison in the Meta-study of health and wellness with active AUDs, early recovery, maintaining recovery and participant’s current ways of abstinence and wellbeing was completed with substantive findings (Chapter 5).

The RWR outcomes on wellness and recovery that were of most interest to me were: 1) Women establishing self-aware emotional and cognitive stability and the ways women can effectively use anger as a legitimate emotion in all relationships; 2) Midlife women changing their identities and roles and addressing discrimination through experience and recovery capabilities in partnerships with like-minded people, and 3) Cooperating with other women can be enriching as well as an essential network of support for both pleasure and comorbid disorders and distressing events, e.g. post traumatic stress disorders, asthma or emotional abuse (Redgrave, Swartz & Romanoski 2003).

At the close of the study, the Participant Reference Group members and I were confident in presenting the outcomes to decision-makers to discuss the next steps towards use. We, the participants and I, will continue to support use of participatory research to meet women’s recovery needs. The findings can inform change for women, practitioners and supporters and contribute to develop a desirable quality of life in recovery with new capabilities for the individuals and their significant others over their lifespan. There were many effective tools provided through the RWR participatory action research to assist more Australian women into abstinent recovery (Chapter 6). Baby Boomers, Generation X and now Generation Y women can receive individualised assistance enabled by informed practitioners using RWR actionable knowledge (Renwanz, Boyle & Davis 2006).
As a feminist in midlife, I tend to take the perspective of critical feminist work explicating the systematic ‘othering’ of women. The pervasive prejudice in Australia for female ‘alchies’ is ongoing and damaging (Schmitt, Branscombe & Postimes 2003). I was fortunate to observe women in long term recovery who had transcended into wise womanhood. Self-actualising was a stark contrast to traumatised women wavering in despair with being mentally ill, physically ill and drinking again (Pfaffenberger 2005). My contact and research with midlife women in recovery has re-affirmed that with improved mental healthcare, AOD and addiction care, primary care and community care as supportive partners, more women can be abstinent. This is a positive start to learn how to deal effectively with difficult personal change as a new recovery ‘response-ability’.

Preventing more midlife women from secreting away their drinking (and life) is probable with the use of the results in this study. The Chapters that follow also describe the women-oriented recovery evidence-based programs of care with social marketing and advocacy plans and materials. The outcomes of RWR contributed to my understanding of recovery and reinforced the message that ‘Midlife Women Matter’ and ‘Recovery Works’. The women’s intergenerational AUDs work can now be planned as a future participatory study with three generations of women contributing to preventing AUDs (Perosa et al 2002).

**RWR documents: Presentation information**

**Print meta-document and e-book**

A printed meta-document of the Researching with Women in recovery (RWR) study was produced to meet the requirements of the thesis examination. The research findings make a significant contribution to gaps in the literature relating to how to establish, maintain, develop and support ongoing abstinent midlife women’s recovery and wellbeing. The blue highlighted sections of the complete ‘RWR Table of Contents’ in Appendix 0.1 indicate the material that was selected for inclusion in the meta-document. Women in recovery and practitioners may find the detailed information of interest.

All content generated during RWR is included in the DVD component (e-book), including the bibliography and appendices. The e-book will be provided to all participants as academic matters are finalised, e.g. a report to the UWS Human
Research Ethics Committee. The aim of the RWR participants and myself, was to improve midlife recovery in Australia by providing evidence-based knowledge for healthcare practitioners (including Expert Volunteers, see Findings Chapter 5) in their day-to-day process of enabling women’s wellness and individual recovery with AUDs.

**Evidence-based content for a variety of readers**

This dissertation was written for women, healthcare practitioners, researchers, educators, policymakers and women’s supporters who have a strong interest in improving the recovery of midlife women with AUDs. The chapters are written to provide as much information to stand alone and be read by particular audiences, e.g. the Findings Chapter may be read separately by women in long-term recovery. There are few studies that report, with such detail (if any), about women’s ongoing recovery after two years abstinence, e.g. that include the transdisciplinary research detail and empirical data and analysis provided here. The primary readers of the Results and Conclusion and Recommendations Chapters are most likely to be practitioners; researchers would probably be most interested in the Research Design Chapter; and the media would most likely focus on the Results and Key Influences Chapters. Policy-makers are regarded as an important audience for the Conclusion and Recommendations Chapter, and health educators would find material that they could use in the Praxis and Findings Chapters. The majority of research detail (data collection and analysis) for each chapter are on the DVD.

**Extensive footnotes**

Details relevant to women’s recovery processes and related key issues are provided within the pages of each chapter as footnotes. Most provide research-sourced information as explanations of the presented ideas. They are also used to link my RWR study to other related studies, disciplines, and research fields in order to achieve a broader understanding that can improve care.

**Boxed information**

Discussions of particular features raised in the research are provided in boxes; so that readers have the choice to read this information as a particular interest arises or to continue with the reading of the main document.
Terminology

Terms from a variety of disciplines are used in the document to indicate similar ideas across research areas, clinical fields, education systems, economics of the public and private health systems, and the politics of local, state and federal governments in the Commonwealth of Australia. Colloquial language is also presented to give a realistic overview of the ways in which recovery with AUDs is expressed in everyday life by the women.

Also, the use of the range of terms illustrates how a multidisciplinary team can assist in recovery healthcare. The terms are representative of the diverse philosophies, perspectives and politics of healthcare. Through cooperation, a variety of people can bring their knowledge to engage for the common good to support and progress women’s recovery development.

Words and phrases have been created to indicate concepts that I have developed from the data. These terms are shown in single quotation marks. Each term has been reviewed in relation to the relevant literature with the intent of checking for similar terms and the manner of use by the various disciplines. This terminology enriches the transdisciplinary nature of the study, e.g. ‘recovery respite care’ is used to indicate ‘respite care’ that is specifically designed to support individuals in recovery.

Explanations are provided to clarify the particular use and value of terms used for concepts that are important in meeting the women’s healthcare needs, e.g. respite, rehabilitation, aftercare and relapse. Respite is suggested for non-recovery women; the women are abstinent, but not progressing (not in a recovery process of developing mature adult capabilities). Respite is a means for returning to recovery development and for helping the women to address the underlying issues linked to their AUDs. Rehabilitation comprises a short (and limited) education program to enable the women to function without alcohol in everyday life, usually following a detoxification process. Aftercare is a health program that the women can attend after rehabilitation, as a supportive reminder to not return to drinking, and to continue to apply their new skills and knowledge to improve the quality of their living. Relapse programs provide the women with careful monitoring and the skills to return to hospital care and not active alcoholism. They are particularly necessary for women with prior relapses and for women who need to make major life changes
to remain abstinent, e.g. a move to new accommodation. The stress of large events is best monitored as day patients. Attending seminars two days each week along with frequent attendance at mutual help groups and a daily recovery plan\(^6\) immerses women in a fruitful way of life.

As is customary in this style of writing, names of organisations, processes or techniques are abbreviated in brackets on the first use, e.g. Australian Institute of Health and Welfare (AIWH). The organisation is then referred to in-text as AIHW (Style manual, Commonwealth of Australia 2002). Organisations and people change their names and where possible the old name is noted with the new name.

Strings of initial letters (and sometimes other letters) – acronyms – pronounced as a word are an essential element in assisting people to remember. The technique was used in RWR where the terms and acronyms created were trialled by the participants and researcher: e.g. ASK, ELLA, ENACT, AIR and Be-Come-Well together.

At various meetings (e.g. open recovery and community of practice gatherings) I had observed the effective use of acronyms and abbreviations as prompts and reminders of beneficial recovery practices. Subsequently, the women participants within my study were adamant that the abbreviations and acronyms that we used could be remembered in times of stress, and that having access to them enabled them to more easily maintain their recovery practices.

Being able to refer to such terms reminded the women of what they had learned and how this worked to strengthen their recovery. They explained how their commitment and volition (post-intention action; Sneddon 2006; Schwarzer 2008) to remain in recovery with peers was reinforced by their being able to use acronyms (such as FEAR: Face Everything And Recover). Their ‘sense of belonging’ to the research actions was reinforced by this ‘in the know’, ‘she is one of us’ use of language, which could be shared with personal dignity and respect. The acronyms used in this study were adopted because they ‘spoke to the women’.

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\(^6\) An RWR program aims for no relapses by integrating recovery respite care. A woman’s Chronic Recovery Management Plan incorporates rehabilitation and long-term aftercare (see Results Chapter 4 and Findings Chapter 5).
Affirmations and reminder statements expressed in phrases such as ‘one day at a time’ used by women in recovery were collected and used where appropriate in the thesis. These phrases were relevant to the communities, networks and groups who were using language to differentiate their type of recovery. They were also important indicators of the methods that they were using to sustain wellness with other people.

VANDA, Action Cycle 5, Practitioner feedback on Action Cycle 4 summaries, using email: Women in recovery show/model wellness (clear eyes and skin). This motivates women in early recovery to think, ‘I want that too’. Shame reduction and self-acceptance is helped by being ‘ill not bad’. The identification process and freedom to talk about alcoholic behaviours without shame; with trust based on confidentiality, respect, and unconditional love (one alcoholic to another alcoholic).
RWR is a participatory, transdisciplinary action research study that uses a mixed methods inquiry strategy to understand how women progress from active alcohol dependence to abstinence, then establish recovery and maintain wellbeing. My action research design (detailed in Chapter 3) has guided a progressive study on women’s abstinent recovery during midlife with the focus on ways of developing effective cooperative early intervention. RWR was designed in part in recognition of Webster’s (above) statement to the Australian Parliamentary Committee seeking answers to the alcohol and drug problems in Australia.

**Structure of this chapter**

This chapter provides an overview of the priorities of the study and introduces how the results and the manner of research can improve women’s AUDs’ healthcare, in a cooperative, practical and comprehensive way. Most references cited in this chapter are prior to 2008 to indicate the research literature available for developing the research questions and research design including the early Action Cycles.

The chapter contents are presented under the following three headings:

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7 Alcohol Use Disorder in RWR was based on Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR; Substance Related Disorders, APA 2000) and International Classification of Diseases, Tenth Edition (ICD-10; Alcoholism [chronic]; WHO 2004). I have followed the AUD discussions about the next generation of mental disorders diagnostic tools, DSM-V and ICD-11; these are discussed in the Key Influences Chapter 2. I did not use the term substance use disorder as the participants connected illicit drug use with this term. I advocate for a complex system model of addiction for alcohol use disorder and have chosen to use the term alcohol dependence rather than alcoholism (Griffith & Larkin 2004; West 2006; Graham et al 2008; Kovac 2012).

8 The Key Influences Chapter 2 extends references to 2013. In the remaining chapters the literature covered spans approximately 40 years.
6. **Researching with Women in Recovery (RWR) study**: In this section the research question, associated critical concepts, and the rationale for the study are outlined.

7. **The phenomenon investigated through secondary research questions**: Women’s abstinent recovery was explored through six secondary research questions with the aim of improving AUDs healthcare in the Australian societal and health institution context. The people important to the study and participation priorities are outlined. The boundaries of the study are delineated with reference to how RWR contributes to the Alcohol and Other Drugs (AODs), addiction and mental health literature.

8. **Significance of the RWR study and its outcomes**: The importance of the research for developing strategies for midlife women’s AUDs abstinent recovery care in Australia is briefly presented. The participants’ valuable experiences and the results of RWR can contribute to evidence-based changes to policy and practice guidelines, as well as to promoting recovery through abstinence as a wise, integrative healthcare approach.

**RWR questions and working descriptions of the critical concepts**

The research question for the main study began as, ‘How do midlife women with AUDs most effectively establish abstinent recovery with alcohol dependence in Australia, and maintain wellness and sustain wellbeing’? The research goal, to improve AUDs healthcare and to assist more women to enter and remain ‘in recovery’, was made more realistic by studying with the people directly involved. To enable this goal, I invited and welcomed midlife women with alcohol dependence who had been in recovery for more than two years to participate and share their lived experiences of ‘being in recovery’. Recognising that Alcohol Use Disorder is a medical condition, and that in Australia healthcare professionals provide treatment, I also invited those practitioners who are qualified to provide alcohol and drug treatment to participate (Timko et al 2000, 2011). Additional detail of how the research was developed with the participants is provided in the Preface and in Chapter 3 (Research Design).
Midlife a life-stage

My aim was to research with midlife women (35 to 59 years of age) who were in recovery to identify and explain the critical recovery change processes that can resolve their dependence and lead to abstinence and wellness with AUDs when in remission. I drew upon a variety of studies to better understand the midlife characteristics and contexts of such women participants. The midlife women were members of the ‘sandwich-generation’, with the rewards (e.g. competence) and stresses (e.g. being overwhelmed) of caretaking (children and parents) and the conflict and confluence of workforce and personal roles (Petrovich 2008). Published life-course and lifespan research provided background material on midlife women’s cognitive functioning, personality and the self, emotions, social relationships, work, and physical health (e.g. Lachman 2004). Population research classified the midlife women as being from the Baby Boomer and Generation X cohorts and within these cohorts’ particular socio-demographic and psychodemographic features are present (Lancaster and Stillman 2002).

The meanings of recovery in RWR

Many ongoing debates exist relating to definitions of recovery, alcohol dependence diagnosis, appropriate treatment (including aftercare). A range of AUDs and addiction theories and models are discussed in Chapter 2. The priority research objective was to explore, with women in recovery and with qualified practitioners, their understandings of recovery and explanations of how it came about. I expected to be confronted with a variety of recovery meanings, and I prepared myself for this by studying the span of ideas and processes through a transdisciplinary research search strategy (Montouri 2005).

There were a range of health perspectives and academic fields offering propositions and methods to assist with alcohol dependence and recovery, for example: the public

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9 The generation cohort names and range of years of birth used in this research was: Silent Generation or traditionalists (born before 1946), Baby Boomers (born between 1946 and 1964), Generation X (born between 1965 and 1981; Freeman et al 2009) and Generation Y (born between 1980 and 1990; Dodd et al 2009).

10 According to the ICD–10, Chapter 5, Classification of Mental and Behavioural Disorders, a disorder implies the existence of a clinically recognisable set of symptoms or behaviours associated, in most cases, with distress and with interference with personal functions (WHO 1992). Most diagnoses require criteria relating to particular levels of severity and duration to be met.
health risk and burden perspective of alcohol use disorder (Delany et al 2008); addiction and recovery (White 2007); versions of recovery based on harm minimisation (drug and alcohol perspective; Kellogg 2003) and abstinence approaches (alcohol and drug perspective; Kelly et al 2007); the social work recovery process (Russell & Gockel 2005) and mental health and recovery (Oades et al 2005). I refer to these and other studies in Chapter 2 (Key Influences).

Initially I understood recovery in relation to the healing processes involved in an individual stopping drinking, becoming well and learning healthy self-care and supportive ways of living. Recovery involved more than treating an AUDs patient through a medical intervention, a cure-oriented or problem-solution approach (Withnall, Hill & Bourgeois 2008). I selected the following two definitions from the academic literature to provide an overview of my approach to the study, and to help recruit participants for the research.

For White, Kurtz & Sanders (2006), recovery included the continuing process through which alcohol dependence\(^{11}\) was resolved in tandem with the development of physical, psychological, emotional and ontological (spirituality, life meaning), relational and occupational health.

Glover’s (2005) definition from a mental health perspective introduced important personal, social and living environment recovery needs.

> I have constructed the points of a five-pointed star of recovery. These can be constructed differently but could be simply understood as:

1. The work of upholding **HOPE** (moving from despair to hope)
2. The work of engaging and **Active Sense of Self** (moving from passivity to activity)

\(^{11}\) Alcohol dependence is clinically significant impairment marked by at least three of the following in a 12-month period: tolerance, withdrawal, loss of control (erosion of volitional control over quantity and duration of use), failed efforts to cease or reduce use; significant time involved in alcohol procurement, alcohol use, and recovery from alcohol effects; social, occupational, or recreational activities forsaken or reduced due to drug use; and continued use in spite of adverse physical or psychological problems caused by substance use (White & Kurtz 2003; American Psychiatric Association 1994).
3. The work of supporting **Personal Responsibility** (moving from others taking responsibility for me to taking personal responsibility)

4. The work of unpacking **Discovery** (moving from a sense of alienation and not knowing to discovery and meaning) and;

5. The work of remaining **Connected** (moving from a place of disconnection to connection with myself, relationships and community).

There will be many tensions as we continue to shift mental health services towards a recovery based paradigm. (Glover 2005 p 4)

**Health, wellness and wellbeing**

The World Health Organisation has defined health not only as the absence of disease, but also as a state of physical, mental and social wellbeing (WHO 1984). The idea of quality of life (QoL) incorporates these WHO health dimensions; it has been defined as “an individual’s perception of their position in life, and in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns” (Lahmek et al 2009 p60).

Subjective wellbeing refers to the psychological wellbeing of a person and how satisfying a person believes his or her life is. “Good subjective wellbeing involves good mental adjustment and having a positive acceptance of one’s life in general” (Friedman, Kern & Reynolds 2010 p189). The initial use of the term ‘wellness’ to describe a state of being, emerged from studies in counselling, psychology and adult development. To experience it, people are encouraged to explore their personal strengths, and to develop new skills and learn new knowledge. In recovery, wellness routines can help the women to meet their midlife circumstances and change while maintaining satisfaction with life and feeling well (Myers & Sweeney 2004; Degges-White & Myers 2006).

**Why ‘abstinent recovery’ for women with AUDs**

My term ‘abstinent recovery’ was based on the planning stage of the main study and on advice from the midlife women in recovery and practitioners, also my observation experiences outlined in the Preface, the trial results (Appendix 1.1) and studying transdisciplinary literature (Chapter 2), particularly the contemporary work in the
neuroscience and mental health fields. Engaging with women’s ways of managing long-term and life threatening illnesses, including their choice of terminology, was a priority (Wilkinson 2000, 2003, 2005).

Alcohol dependence (a severe form of AUD) is a chronic mental illness with physical damage to all systems of the body, including the brain that is attributable to addictively drinking alcohol (ASAM 2011). By abstaining and not drinking alcohol (a toxic substance and addictive substance for people with gene-environment and life circumstance combinations for dependence) there is an opportunity for women to heal and develop the psychological and physiological capacities needed to live well in remission. Alcohol dependence changes the brain and central nervous system in ways that result in AUDs being a lifelong condition (the addicted brain; Leshner 1998; Goldman & Barr 2002; Lingford-Hughes & Nutt 2003).

If a person stops drinking and then returns to drinking they will re-activate the disorder; the physiological and psychological drive to drink alcohol will continue, and more negative consequences are likely to be experienced at each return (USA National Epidemiologic Survey on Alcohol and Related Conditions [NESARC] Cohen et al 2007; Rehm, Room & Taylor 2008). Consequences include a higher likelihood of injury, death, permanent brain damage (alcoholic dementia and Wernicke-Korsakoff syndrome), liver cirrhosis and liver cancer (Pfefferbaum, Adalsteinsson & Sullivan 2006; Harper 1998; Harper et al 2003; Lorenzo et al 2006; Stokkeland et al 2007). The women also commonly lose personal relationships, property (material possessions), work arrangements, financial stability and accommodation, with further family, social and community disruption (Plant 2003; Bloomfield, Gmel & Wilsnack 2006).

12 Findings from the 2000s on how gene-environment interactions can contribute to people becoming alcohol dependent may be useful for prevention programs (Dai, Thavundayil & Gianoulakis 2005). Cause-effect combinations are unlikely for this complex disorder, and processes to assist people in stopping consumption requires further study (Whitfield et al 2004). However, the development of an individual’s alcohol dependence may be known, including earlier interventions taken to address the woman’s particular life circumstances, e.g. abuse (Sartor et al 2008).

13 I monitored the ‘cure industry’ debate and the disputes about pharmacotherapy, psychopathology and anti-psychiatry (Thomas, Bracken & Power 2008). Most participants were unaware of antipsychiatry, wanted less emphasis on psychopathology labels and accepted pharmacotherapy for comorbid disorders.
The Center for Substance Abuse Treatment (CSAT 2006) defined recovery as “a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life” (p 9). Abstinence has benefits including opportunities for improved socioemotional development, engaging with support networks and a more stable cognitive-affective understanding (Brewer & Stree 2003; Vaillant 2005; Fein et al 2006).

A critical question in the literature of the late 1990s and 2000s was, ‘Should abstinence be the goal for alcohol treatment?’ (Owen & Marlatt 2001). Research on the disorder in the midlife cohort was scarce for both males and females. Studies reported that achieving a new self-concept and self-standards, with goals of long-term recovery involved becoming abstinent (Laudet, Savage & Mahmood 2002). Abstinence self-efficacy, with optimism and self-mastery was evaluated as being effective, as were the AA programs of recovery (Majer, Jason & Olson 2004; Vaillant 2005). In Australia this understanding was undermined by the narrow policy of harm minimisation of the National Drug Strategy, and in some treatment facilities the abstinence and recovery objective was (incorrectly) regarded as being outside the harm minimisation approach.

Effective abstinent recovery is more likely to occur with access to knowledgeable, enabling and compassionate healthcare (Covington 2000; Brown & Straussner 2002; Bourgeois 2005). However, such need for help, for a woman with an alcohol damaged body and mind, is commonly not recognised or is dismissed by those in primary care, including General Practitioners, and staff in accident, emergency, and acute care in hospitals (Roche, Freeman & Skinner 2006; Proudfoot 2006; Popay et al 2007). Treatment in midlife for alcohol dependence is a difficult process. However, supportive information is available concerning its chronicity characteristics (Larkin & Griffith 2002), and the women’s associated physical struggles, mental suffering and emotionless enduring (Ohman, Soderberg & Lundman 2003).

My understanding of the evidence-based papers, and participant lived-experience information available to me indicated that when patient-centred care can meet the women’s sometimes chaotic, unstable need to stop drinking, a safe bond between
patient\textsuperscript{14} and practitioner can develop to nurture a return to physical, spiritual and mental health through abstinence and recovery (Zemore 2007). Dennis and colleagues (2003, 2005, 2007, 2009) have argued for a shift in focus from acute episodes of treatment to the management of recovery over a longer period of time. RWR explored and explained how this could be possible for women with AUDs in Australia, based on how recovery was achieved by the participants; and recommendations for improvements are provided for consideration by Australian healthcare policy makers and senior practitioners (Chapter 7).

The need for the study and the need for action in Australia

The Australian health system was not, and is not\textsuperscript{15}, providing the growing number of women who are alcohol dependent with timely and specific healthcare for their AUDs. Outlined below are the particulars of the Australian scenario in 2006 (when I started my RWR study). The increase in the number of midlife alcohol dependent women, and what was not being provided by the healthcare systems. The number of alcohol-caused deaths for women in the 1990s showed an increase in women aged from 35 years and peaking at 60 to 64 years (Chikritzhs et al 2000).

In Australia, since the 1980s women have increased their alcohol consumption, and more women are drinking alcohol (first noted by the National Heart Foundation Annual Report 1986). The same trend has been recorded in countries with similar sociodemographics, and it has been highlighted that the women were more likely than ever before to consume alcohol in harmful ways (Wilsnack, Wilsnack, & Klassen 1984).

Since the 1990s in Australia, the increasing amount of alcohol being consumed by women in their 30s, 40s and 50s has been noted in the medical literature (Corti & Ibrahim 1990) and the alcohol and drug literature (1990-2001; Chikritzhs et al

\textsuperscript{14} The terms patient and client are used in Australian healthcare. The RWR participants often used the term ‘patient’ when the women were most fragile and the term ‘client’ further along the healthcare process. Also, the women in their 50s tended to use the word patient.

\textsuperscript{15} Women clients often have additional factors such as family responsibilities, financial difficulties, or abuse histories that provide extra challenges to remaining in care. Women-focused drug treatment agencies in the USA selected relational-based interventions to engage clients in treatment and improved four-week treatment retention from 66 percent to 76 percent. Conclusions emphasised that process improvement interventions in women-focused treatment may be useful to improve healthcare engagement (Wisdom et al 2009).
Australian studies have focused on women’s changing alcohol consumption, the need for more research, and the provision of special treatment for female teenagers, indigenous women and pregnant women (Copeland & Hall 1992; Long et al 1994; Hands et al 1995; Broom 1995; Swift & Copeland 1996 and Fleming 1996).

The inconsistent research findings regarding diagnosis and treatment (screening and brief interventions) when applied to women, compared to men, were noted as indicating a need for further study, as was the lack of effective strategies for recognising AUDs in women, and the growing awareness of the need to improve healthcare for women with AUDs (Higgins-Biddle et al 1997). RWR has extended the Australian empirical research knowledge of midlife women suffering with AUDs; and, importantly, it has focused upon how women become abstinent, well and able to live in recovery.

The important work of the Australian Longitudinal Study on Women’s Health began in 1996 and included reports on Australian women’s alcohol consumption. The trend from 1996 revealed the likelihood of individuals who show an escalation of consumption to be at risk of developing alcohol-related problems across the lifespan (Young & Powers 2005; Young & Powers 2007). The scale of the ‘alcohol problem’ is substantive with a growing Australian personal, familial and social tragedy. Alcohol-caused death (1990 to 1997 and not including alcohol-related death) was an estimated average of 2,309 male and 1,013 female deaths every year by high-risk alcohol consumption (Chikritzhs et al 2000). Excessive consumption is responsible from 3,000 to 6,000 alcohol-related deaths and costs the community a minimum of 6 billion dollars each year (University of Sydney 2006). The substantive gap of approximately 3000 is explained by the ‘reason for death’ parameters being adjusted and standardised across the country (AIHW 2002).

In the 2000s the gender gap for alcohol dependence had converged, particularly for persons between 30 and 64 years of age (Roche & Deehan 2002; Grant et al 2004). The more rapid psychological and physical damage at low levels of alcohol intake for women was confirmed, as was comorbid disorders (Johnson et al 2005; Hall, Lynskey & Teeson 2001). Disappointingly, in both the 2001 and 2006 National Alcohol Strategy no strategy to address and provide care for the growing midlife group of women with alcohol dependence and comorbid disorders was included (Commonwealth of Australia 2001, 2006). In the mid-2000s it was generally
accepted by addiction and alcoholism researchers that the risk of future alcoholism increases with the daily amount of alcohol consumed (Stevenson & Masters 2005).

My detailed analysis of statistical data cubes (ABS 1996-2006), research reports, longitudinal health studies and mental health clinical papers confirmed for me that in Australia between 12 and 18 percent of women in the midlife range of 35 to 59 years of age were alcohol dependent, and that this was a rising trend (Withnall, Hill & Bourgeois 2007). Recent lifetime criteria for alcohol dependence in women has been estimated at 16.1 per cent in the USA (physician assessed; Vinson et al 2013), and 16.1 per cent in Australia (median age of the sample was 30 years; Lynskey et al 2005). Also, increasing numbers of older women from the Silent Generation are returning (or starting) to drink alcohol at dependence levels, indicating the lifelong nature of this disorder (Fink et al 1996, 2002; Schutte et al 2003; Blow et al 2004; Moos et al 2005).

The Australian RWR participants in our planning discussions explained that multigenerational alcoholism was hidden as a toxic secret into the 1980s and 1990s (Pretorious 2010). In 2006, programs were (and still are) urgently needed, as the Baby Boomer and Generation X women were drinking more alcohol in secret at home16 (Apparent Consumption of Alcohol, ABS Australia 2004-2005; Stockwell et al 2004). Most current treatments in Australia lead to abstinence in only one out of three cases, and approximately 50 percent of these will relapse within three months of completing treatment (Haber 2005).

The young women drinking at high-risk who were 16 to 24 years old in 1997 (AIHW 1997) were now 32 to 43 years of age; many of these Generation Y women were now sharing the shame and guilt of their alcohol-dependent mothers and grandmothers (Dearing, Stuewig & Price Tangney 2005). Young women were, and are, continuing to consume alcohol at high-risk levels, with many female role models engaging in

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16 It should be noted that population surveys of self-reported alcohol consumption result in estimates of per capita consumption well below the level estimated from alcohol sales data (Dawson 2000). The usual range of coverage from surveys is in the region of 40–60 per cent of known alcohol sales data (Knibbe & Bloomfield 2001). The least accurate method of questioning is for quantity and frequency, which provided only 49.8 per cent of estimates in the 2001 national household drug use survey. Using a ‘yesterday’ question in the Stockwell study (2004) showed the proportion of the Australian population consuming alcohol at high-risk on that day was 61 per cent.
high-risk consumption (18 to 24 years, 18 to 23 per cent; Australian Household Drug Survey 2007).

The phenomenon investigated through secondary research questions

The six issues listed below were selected as my research topics to address the need to improve women’s AUD healthcare and the societal and healthcare context in Australia. The issues form a RWR research guide, as secondary research questions\(^{17}\) to study midlife women’s recovery with AUDs, the phenomenon of the major study. RWR did not focus on the individual’s pre-AUDs and active AUDs events, apart from the critical information this provided for recovery care.

The following topics (and associated questions) focus on the women’s needs and their ability to adjust: 1) meeting women’s AUDs healthcare needs; 2) developing good practice for women’s AUDs healthcare; 3) working with healthcare providers to engage in healthcare partnerships; 4) decreasing public misinformation to limit societal discrimination; 5) improving educational content and accessing training and professional development; and 6) advocating for the inclusion of a midlife women’s recovery strategy.

These six issues were refined into research questions relating the ‘personal’ to institutional aspects, using a social ecology and systems thinking approach (Hill 1995, 2004). My research questions were constructed based on my transdisciplinary literature analysis and discussions with the women with AUDs and practitioners associated with the trial study (Nicolescu 2005). Proceeding in this way was part of the participatory action research approach that I had planned for the RWR\(^{18}\) study.

\(^{17}\) The research topics relating to the healthcare system (and they involve healthcare providers, strategy and policy, education of professionals and public understanding) were selected based on my initial interviews with government health system representatives, educators and science communication and media personnel (Abraham et al 2007). This was further supported by discussions with senior clinicians and researchers about the outcomes of my proposals to gain research access to health providers, practitioners and patients in 2006 and 2007.

\(^{18}\) I am pleased at the end of the study to confirm that action research (an intense immersion into women’s recovery) can deliver useful findings. The processes of participation, exploration and cooperation enabled a synthesis of many people’s experiences, knowledge and skills, with the support of academic literature across many disciplines. This enabled me to recommend improvements to the current untenable situation for midlife women with AUDs.
Meeting women’s AUDs healthcare needs

How can the AUDs healthcare needs of alcohol dependent midlife women be met?

Brain research and substantive studies of male and female alcohol misuse reveal the particular environmental, psychosocial and genetic predisposition factors that affect alcohol use disorder in women; thus, whereas women have an environment: gene predisposition of 60:40, men’s is 30:70 (Nutt et al 2007). The Collaborative Study on the Genetics of Alcoholism (COGA) revealed that childhood trauma made a significant contribution to the development of depression, alcohol dependence and risk of a suicide attempt (Mayfield, Harris & Schuckit 2008).

There is a legitimate need to provide quality healthcare for midlife women and to enable and support their abstinence and wellness while dealing with the disorder being misunderstood as a personal flaw, the disparities of equity of care for people with a mental illness, lack of choice with care options, and women feeling shame and a burden on the family and community (Kahn, Wilson & Wise 2005; La Fave & Desportes Eschols 1999; Schreiber & Hartnik 2002; Begg et al 2003).

Australian adults and healthcare practitioners are generally unaware of the existence of a growing group of midlife women with AUDs. The needs of this midlife group are not described in Alcohol and Other Drugs practice guidelines in Australia (NSW Department of Health 2008). Women may present to healthcare providers, as described by the women participants and practitioners in my study, as seeking help for a stress problem, menstruation or fertility related problems, low mood, relationship difficulties and being fatigued, anxious and overwhelmed. Being aware that AUDs may be associated with the presentation of such symptoms can assist

\footnote{The Study of Women’s Health Across the Nation (SWAN; Avis et al 2004) emphasised that perceived midlife women’s quality of life (QOL) was likely to be driven by contextual, as well as personality factors. The associations between QOL and education, marital status, perceived stress and social support varied across ethnic groups. Perceived stress was highly related to overall QOL across all racial/ethnic groups.}
with early intervention and ongoing care to prevent complications and comorbid illness.

Women’s metabolic, hormonal and neuroendocrine functions are negatively affected by alcohol (Mello, Mendelson & Teoh 1993), and physical damage can include cancer of the lip, oral cavity, pharynx, oesophagus, colon, rectum, liver, larynx, and breast, essential hypertension, coronary heart disease, stroke, cirrhosis, non-cirrhotic chronic liver disease, chronic pancreatitis, and diverse injuries (White, Altmann & Nanchahal 2002).

Women commonly do not recognise the seriousness of their alcohol problem (similar to general public ignorance of the nature of the disorder), but they generally are aware of their growing distress of physical withdrawal from alcohol, anger and alienation. Practitioners also often do not recognise the indicative symptoms, including the women’s lack of self-awareness and/or loss of interest in life, and lack of engagement with people, which are characteristic of this mental illness (Heinz, Wilwer & Mann 2003). The women who are aware that their drinking is a problem, generally fear other people’s harsh uninformed reactions, including those of healthcare practitioners.

**Developing good practice for women’s AUDs healthcare**

*How can health practitioners provide the best possible care for midlife women with AUDs?*

Alcohol dependence is at the severe end of the alcohol use disorder (AUDs) continuum, and has been described as an ‘addiction brain disease’ (Erickson 2007) and a mental illness for which healthcare is available (though often with limited effectiveness). As with many other brain diseases, addiction has a pathophysiology, a disrupted-distressed sense of self, and behavioural characteristics and social impacts that are important parts of the disorder itself. Therefore, the most effective therapy approaches must include integrated personal care for the biological, behavioural, and social-context components (Leshner 1998; Andrews & Burruss 2004).

The therapeutic change processes involved in recovery are not well understood in many AUDs interventions (Morgenstern & Longabaugh 2002; McKay 2007). More
research, to follow RWR, is needed on women’s recovery change processes in particular treatments. More neurobiomedical evidence of women’s alcohol dependence is being published (Crews et al 2005). AUDs information on midlife women is limited. However, it is known that a female’s threshold for dependence is much lower than men’s; a lesser quantity of alcohol over a shorter time has a greater effect (Stokkeland et al 2007). Withdrawal effects (tremor, rising blood pressure, dehydration, anxiety) for females are not as pronounced as for men, and the social consequences are more alienating. Women and men can have early onset AUDs, a continuation of teenager-young adult drinking, or late onset alcoholism, which may be triggered by significant environmental and physical stressors, and by the onset of depression (Cloninger et al 1996; Zucker et al 2006).

Research with midlife women with AUDs who are well was needed to learn more about the processes involved in recovery. The detail of how the changes happen for midlife women (a research priority) and what are the important elements to assist not drinking and good health for both women and health practitioners was also investigated to improve AUDs recovery care outcomes. The important details collected in the action research cycles were early simplified AUDs assessment, including assessing for possible trauma and other factors that can contribute to women’s distress; diagnosis, including possible comorbid conditions; integrated continuing, whole-person healthcare, with treatment choices selected to meet the individual woman’s objectives and goals; monitoring and assisting with self-shame and social stigma around female alcohol addiction; enabling positive interaction for midlife women with the help of peers in recovery and supportive social groups, as important contributors to healthcare.

The most difficult characteristic for the RWR midlife women, in relation to their AUDs, during their active drinking period and in recovery, was the associated emotional pain (Charles et al 2003). This suffering was discussed in detail by

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20 Rae Davis’s study (1997) of New Zealand women who were alcohol dependent described a context of great emotional despair prior to their step into recovery. The results reported that recovery meant women living in ways congruent with their own values, taking better care of themselves emotionally and physically and confronting their tendency to escape into ‘workaholism’.

21 Our emotions are one element of affect (mood, motivation, memory and emotion; Davidson, Scherer & Goldsmith 2003). The body and the mind carry emotion as sensory memories, as well as abstracted ideas (Mauss et al 2005). The sensory emotional memory is one of the patterns of
participants in the trial project and the planning discussions, but it was rarely mentioned by General Practitioners and AODs practitioners. Many alcohol dependent women clients have histories of high rates of emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect; these are all potent factors that affect women’s choices to drink or not drink (Roy 2001, 2003).

**Working with healthcare providers to engage in healthcare partnerships**

*How can practitioners be assisted to establish whole-person healthcare in cooperative partnerships with midlife women?*

Women living with AUDs struggle to find adequate healthcare and support (NIAA 2004). The rise in the number of midlife women with alcohol dependence continues (discussed earlier in this Chapter). Practitioners in AUDs healthcare services receive limited support to build therapeutic relationships for recovery-style programs (Jones 2005). Approaches that enable women-oriented recovery pathways with peers into community mutual self-help whilst maintaining the healthcare relationship were/are necessary and currently unlikely (Bifulco & Moran 1998; Timko, DeBenedetti & Billow 2006).

Practitioners are unprepared to care for midlife women as there are no clinical supervision or AOD guidelines of care for this age group and sex (NCETA 2005). This is disheartening for practitioners and it plays a part in why women leave healthcare. Fewer women than men seek assistance, in contrast to the belief that more women than men enter treatment (Greenfield 2007). The women seeking treatment are often malnourished, presenting with liver damage, clinical anxiety and depression as well as AUDs (Weisner, Matzger & Kaskutas 2006; Flensborg-Marsden 2007).

Most midlife women with AUDs in Australia today have experienced no treatment (or only a detoxification stay), treatment without adequate personal safety, male-

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communication from which meaning is derived. While drinking alcohol, bodily emotions dominate cognitive understanding.

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22 Sources in this chapter are around 2006 and earlier to provide the information used in the preparation of the study and Action Cycle 1.

23 Rarely discussed is the high rate of women’s anxiety in Australia; 64 per cent of midlife women exhibit symptoms of general anxiety disorder (Women Australia 2007, 2008).
oriented treatment applied with negative results, and the women’s needs not being met, e.g. mixed group discussions that can be particularly distressing for women with sexual-abuse backgrounds. Providing safety and practitioners who are able to engage in a nurturing manner with the women is the recovery care priority (Kearney 1998). Acknowledging the suffering (the mental illness, the emotional pain and the negative, false personal beliefs) that continues to trigger women’s drinking is the way to begin the therapeutic relationship necessary for recovery living and stopping drinking (Rist et al 2005).

A complex disorder is unlikely to be treated by a simple Cognitive Behaviour Therapy program; learning healthy protective capabilities and having access to supportive resources were the needs of the women participants in the trial (Moos & Moos 2005). Although there have been years of addiction and alcoholism research, no treatment has yet been recognised as being the most effective (Edwards 1992; UKATT research team 2001; NDARC 2008; Health Canada 2006). An integrated individualised assessment, and an ongoing therapy program providing flexibility to use different techniques, is the sort of positive framework that is needed (Najavits et al 1998; Fallot & Harris 2005). In relation to this, there are packages of therapies that are being tested (Iliff et al 2007). Age, sex and gender are important factors to consider. Appropriate therapies, including personal encouragement, and enabling access to role models and recovery groups for social development, are discussed in the following chapters (Timko, DeBenedetti & Billow 2006; Litt et al 2007; Groh et al 2007).

It is difficult for overworked and stressed practitioners to meet the wellness needs of midlife women with alcohol dependent conditions and chronic illnesses (Copeland 2002). The proposition that AUDs recovery needs to move to a chronic illness management plan can also contribute to the development of more integrated structures for effective complex case management (such plans in Australia must involve more than one registered practitioner and a General Practitioner). It is expected that a healthcare team (with input from different specialties) will be needed to achieve effective AUDs chronic illness care (White, Boyle & Loveland 2002). Helper-therapy, clients and practitioners being assisted by in recovery women, can provide the ongoing support that is needed, and this can strengthen the
connections to community self-help groups\textsuperscript{24} (also called mutual-health, mutual-aid groups; Magura 2003).

**Decreasing public misinformation to limit societal discrimination**

*How can psycho-education\textsuperscript{25} on the positive outcomes of recovery and facts on the disorder be provided and pathways to women-oriented AUDs care be promoted?*

Research has shown that people who feel greater stigma (due to their disease or disorder) postpone acknowledgement of their illness, are less likely to begin treatment, and more likely to drop out of treatment prematurely (Corrigan et al 2000). Shame and self-blame are common reactions to the stigma around alcohol use disorder that leads to diminished motivation to participate in healthcare plans and to postpone change to personal actions and lifestyle (Pescosolido & Boyer 1999).

In Australia’s culture of supporting alcohol drinking, it is very difficult for people to acknowledge their inability to drink alcohol without creating disruption and harm (being regarded as an abnormal peer). Midlife women in these circumstances carry into their daily lives sexism, ageism, detrimental media representations and incidents of unfair and uninformed treatment, along with self-stigma (Lyons 2003).

Action is required on multiple factors in a complex environment with a complicated disorder in order to limit self-stigma, and empower women to seek legitimate assistance for AUDs (Rusch et al 2006).

In the public sphere and the media, alcohol advertising is highly persuasive (Weintraub Austin, Chen & Grube 2006). When misinformation about alcoholism and drinking alcohol, rather than no information, exists in the public sphere, providing correct information is unlikely to effectively decrease or remove the misinformation. Indeed, it can have the opposite, boomerang effect. Counter-advertising by the alcohol industry, a response to government advertisements warning about alcohol consumption, has been successful in maintaining sales (Agostinelli & Grube 2002).

\textsuperscript{24} Alcoholic Anonymous and SMART (Self-Management and Recovery Training) are examples.

\textsuperscript{25} Research on how to best educate tertiary health and medical students and faculty members can assist in public understanding campaigns for AUDs (Manwell, Pfeifer & Stauffacher 2006).
False ideas about the causes of alcohol dependence (e.g. deserved punishment for an immoral act or personality fault) often leads to individuals hiding that ‘fault’ rather than modifying their behaviour and seeking healthcare. Astute health campaigns (social marketing; McDonald 2000) and psycho-education are needed to support the women’s progression into abstinent recovery (Onken et al 2007). Oversimplified public health messages can have a negative effect, particularly when they expose women’s trauma events (van der Kolk 2003). The methods of bringing research-based information to the public, with RWR participant input, are discussed in Chapter 6 (Praxis).

The challenge is to enable the broader public to understand that many women have AUDs, and that confidential healthcare that can meet the women’s needs is available. Women’s recovery care processes can contribute to emotional stability, self-care, an enriched quality of life, relationship functioning, and being able to make active contributions to communities and to the wider society (White et al 2003).

Health advertising and social marketing for the public good

In health advertising campaigns, particularly special case advertising, negative and shocking public announcements are more likely to be used to first attract attention to false beliefs, e.g. HIV Aids, smoking, sun exposure (Cook et al 2010). They are then followed by information that counters the misinformation as directly as possible, e.g. that heterosexuals, men and women, can be HIV positive, not only homosexual men (a discriminatory belief). This leads to curiosity and most people move to an information-seeking mode (Cline & Young 2004).

Explanations of HIV Aids are then provided by concerned experts, highlighting action needed, with a group objective of how people (us) can work together to make a positive difference. Media-trained experts then continue to explain the effective health precautions we can take as good citizens. The facts are backed-up by everyday people telling ‘real-world’ and good news stories, e.g. how, although a wife became HIV positive through a blood transfusion, the husband and wife, through informed support, can take precautions and have a safe and strengthened relationship.

The special populations of the disorder (gay men, intravenous drug users, prostitutes, bisexuals) receive targeted information (McInnes & Murphy 2011), often through representative groups, outlining non-identifying screening and advice, and assurance of non-prejudicial treatment and support (at no cost or low cost).
Prejudice and fear still attach to people with a chaotic and disruptive alcohol problem, a mental disorder or a virus such as Hepatitis C (Smith et al 2002). Such conditions (and associated prejudices) all require specialist public communication, as well as health promotion and prevention techniques (Randolph & Viswanath 2004; Vandiver 2007). I outline in the Box ‘Health advertising’, the techniques used to address the HIV AIDS health initiative as an example for women’s AUDs recovery (Kaldor & McDonald 2003).

**Improving educational content and accessing training and professional development**

*How can consistent, effective and efficient women-oriented midlife services be provided across Australia?*

Input from practitioners, administrators, supporters and women in recovery can bring a broader understanding to ways to improve AUDs healthcare. Basic healthcare information can be distributed to the various service providers to highlight how updating practitioners with similar information can provide an opportunity for integrating healthcare teams and therapies (Baker et al 2010). The basic information should cover the following topics: meeting the needs of the female physiology, the women’s age and gendered recovery requirements, and the need for a combination of therapies and specialist care to achieve recovery. Combinations of interventions and treatments may include neurobiomedical treatment and a psychosocial therapy for anxiety (Shiloh et al 2007), along with abstinence care and enabling social networking for recovery (Nicholls 2007).

The recent research of the mid-2000s provides more information on physical differences in male and female alcohol use disorders, and on what is necessary and useful for women’s recovery, e.g. an evidence-based screening that is more suitable

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26 Current, research-based, targeted and translated information can be helpful in fostering a receptive climate for implementing effective policies and organisational change. The information must be part of a promotion strategy to meet community needs and modify community attitudes and behaviours (Howat et al 2007).

27 Implementation research has entered the mental health field to reduce the gap between what is known about effective care and what is provided to consumers who are making choices about care options (Drake et al 2001). In RWR the gap was also between research outcomes and professional development for contemporary practice. The findings of implementation science can assist in updating the content of education and training courses (Proctor et al 2009).
for women, ‘Dependence in Women Scale’ (O’Neil & Maranda 2007; Oades 2007). Research is needed on alcohol dependence and affect disorders (i.e. dominating negative emotions, and/or high affect intensity of both positive and negative emotions; Thorberg & Lyvers 2006) as there are few empirical studies with women participants (Brown et al 1995; Brotchie et al 2007). Studies on therapies for the comorbidity of alcohol dependence, depression and anxiety need to continue (with more emphasis on women’s mood disorders; Burns, Teesson & O’Neill 2005).

The paradox of being alcohol dependent and yet, in the public sphere, apparently functioning brings midlife women to extremes of despair, shame and more secret drinking. Having been ‘the self-reliant and capable person’ is also a major barrier for women’s recovery, as it leads to a false sense of self-sufficiency, guilt and the postponement of asking for help. This is best addressed by a greater awareness on the part of health practitioners and the community concerning how women present with this stigmatised mental disorder. They need to continue to reassure these women that questions are welcome, and that women-oriented healthcare is available, along with confidential support for quality recovery living.

It is likely that the women’s midlife history will have distorted their beliefs, perceptions, expectations and perspectives, and this is likely to lead to their denial of the seriousness of the situation. It is also common for midlife women with AUDs to believe (in colloquial terms) that ‘no one can help me because I am bad, useless, hopeless, a waste of effort, and the world is better off without me’ (Wall, Thrussell & Lalonde 2003). Practitioners must understand that suitable therapy for women in this midlife age group is likely to require addressing diverse issues relating to emotional trauma (Lisansky Gomberg, Hedenus & Zucker 1998; White, Altmann & Nanchahal 2002; Skultety & Krauss Whitbourne 2004). Fragile, vulnerable midlife women, who have survived many events in their life, and also succeeded in many tasks and roles, need development-focused care to support their learning of new skills (emotion and cognition; Kliegel, Jager & Phillips 2007).

Practitioners must accept that societal gender discrimination plays a major role in limiting and stopping women’s AUDs healthcare (Dawson et al 1992; Blume 1994; Wilsnack & Wilsnack 2000; Timko, Finney & Moos 2005; Haberle & White 2007). Sociocultural factors and the women’s living environment, as well as genetics and personal history, contribute to women’s AUDs. Women are often coerced to leave
care by employers, intimate partners, grandparents or daughters to care for grandchildren, and as a result of family crises and social group pressure (Wild, Cunningham & Ryan 2006). It is important to identify the reasons for the women leaving, at a deeper level than ‘I’m OK and I feel well’ (physical health returns before mental health), so that enriching individual care plans can be developed (Schmitt, Branscombe & Postmes 2003).

**Advocating for the inclusion of a midlife women’s recovery strategy**

*How to develop a national strategy for enabling more Australian midlife women with AUDs to receive abstinent recovery healthcare?*

The primary research question ‘How do midlife women with AUDs most effectively establish abstinent recovery with alcohol dependence in Australia, and maintain wellness and sustain wellbeing?’ and the secondary research questions provided, through the RWR results, means to advocate for women-oriented, ongoing recovery care.

RWR participants contributed their recovery experiences to bring a women-focused strategy closer to being implemented. Translating28 the RWR evidence in consultation with decision makers responsible for the National Alcohol Strategy and the Australian Guidelines (NHMRC29) was and is an action research goal for the study (Chapters 6 and 7). An effective healthcare strategy for midlife women with AUDs must be concerned with much more than just survival and treatment; rather it involves establishing guidelines to sustain women’s wellbeing in long-term recovery. Advocacy based on my RWR research findings can help to redress the lack of effective care for midlife women with AUDs.

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28 The goal of translational science in mental health is to progress the use of findings from best science into usual-care settings and to build partnerships between research and practice constituencies (Rhotten 2005; Brekke, Ell & Palinkas 2007). This also needs to involve the formation of partnerships with policy-makers and healthcare services administrators and managers.

29 The National Health and Medical Research Council (NHMRC) are responsible for updating ‘The Australian Guidelines to Reduce Health Risks from Drinking Alcohol’. The decision makers are representatives of recognised groups (e.g. Alcohol and Drug Council of Australia; ADCA) who contribute to the guidelines and strategy.
An auxiliary question of interest to me was, ‘Why has no specific strategy been initiated for midlife women with AUDs?’ Investigating this question revealed a range of associated issues and barriers. The argument that midlife women in good health (and who are not in active alcoholism) are of high worth to a society has been argued for other projects with limited success (Aldrich et al. 2003), despite them being a large cohort who contribute to the community, and have significant socioeconomic and political capital. In Australia, as in most industrialised countries, midlife women are generally ‘unseen’ and assumed to be ‘happy’ (Burns & Leonard 2005). There is a societal expectation that midlife women are, nevertheless, the responsible problem solvers, the calm and capable carers, who do not need any special societal and government support. It is often assumed that midlife women will know if they are ill, and will seek the appropriate healthcare to become well (a neoliberal perspective; Davies et al. 2005). The everyday facts of women with AUDs are far different, and are outlined under Key Influences (in Chapter 2).

Another challenge for the development of an effective national strategy is addressing the lack of integration across the AOD-related health and medical fields, which is made more difficult by competitive rather than complementary healthcare approaches. The range of issues and approaches that need to be considered and integrated for AUDs include: neurobiomedical-based care with pharmacotherapy treatment; AUDs being considered as a psychopathology requiring harm minimisation treatment; limited neuropsychosocial, mental health, social work and allied health input; and recovery care options not promoted due to multiple political agendas surrounding harm minimisation goals (Cox et al. 2004).

Some positive innovations have occurred recently in the AOD field in Australia, with low level take-up in the healthcare system, e.g. having a nurse practitioner and alcohol and drug liaison workers in emergency care and other hospital units (Shoobridge 2005; DHA 2004). A most perplexing question for me concerned the reasons behind the resistance to trialling the mental health research-based recovery programs in the AODs field. In response to my questions it was suggested by the

30 Interdisciplinary health, integrated allied health and multidisciplinary medical teams do exist, and transdisciplinary health teams are slowly emerging (Rhoten 2005; Wickson Carew & Russell 2006). Biomedical researchers (e.g. epidemiologists) are exploring health interventions in social settings with allied disciplines to ensure that interventions have the intended positive individual and public health outcomes (Hiatt 2010).
RWR participants that the historical separation of AUDs healthcare from other healthcare areas, or only included as sub-categories of other specialties, was responsible for the slow progress in this area of care (Ellis & King 2003; Dinniss 2006; Royal College of Psychiatrists 2007). Another factor limiting the development to integrated healthcare was and is the growing number of service providers being non-government organisations who have been contracted to provide alcohol and other drug services (Non-government Alcohol and Drugs Association [NADA]).

**Significance of the RWR study and its outcomes**

RWR is the only study that has been conducted in Australia of midlife women with AUDs explaining how they established and now live in abstinent recovery. Their lived experiences of ‘how to enter and sustain recovery’ have been, through robust participatory action research, translated into pragmatic healthcare processes. These ‘how to’ findings provide practitioners with effective methods to enable midlife women with AUDs to experience wellness and a high quality of living in abstinent recovery. Recovery in the manner described in the following chapters aims to provide a caring approach, while also a high capital return on funds spent (Laudet & White 2008; Osbourne, Baum & Ziersch 2012).

The outcomes as the study moved forwards through the Action Cycles included:

- The women participants with AUDs continued to progress along their recovery pathways throughout the RWR study. Depicting AUDs recovery as a process (not a mechanistic on/off cause and effect explanation) conveyed that initiating, maintaining and sustaining recovery involved quite different processes (Laudet 2008). Achieving abstinence and recovery involved the women developing from perceiving their lives as empty and hopeless, and recognising their damaged body, distressed mind and defeated spirit, to fostering and sustaining being vital, gracious women with purpose, passion, clarity of thought and times of inner calm (Swain et al 2009). Abstinent recovery required a transformative journey, a life changing experience (Hser, Longshore & Anglin 2007). This suggested a significant lengthening of the time scale for the recovery process, and for the ongoing healthcare monitoring required for midlife women to enjoy wellbeing as they aged, i.e. following a comfortable self-care routine, feeling competent, confident and able to
recognise the need to continue learning for cooperative recovery and good health.

AGC1, Action Cycle 4, New women interview: “... in my early thirties I wasn’t thinking about midlife or anything. When I was drinking I didn’t expect to make it past about thirty five.”

- RWR is the only study in Australia to investigate the increase in number of Baby Boomer and Generation X women drinking at alcohol dependent levels, and propose the range of women-oriented healthcare practices needed to enable effective earlier intervention and personal recovery care. A critical aspect of the growing number of alcohol dependent women is their higher level of death by suicide, alcohol toxicity, and alcohol-related diseases and injury than men. The suicide rate in midlife Caucasian women of age 45-49 years has surpassed all other age groups (Hu et al 2008). A recent German study (Ulrich et al 2013) found that annualised death rates over a 14-year period were 4.6-fold higher for women and 1.9-fold higher for men with alcohol dependence compared to the age- and sex-specific general population. With changes to the criteria for AUDs from the DSM-IV to the new DSM-V, significantly more people will be likely to be diagnosed with the disorder (Newton & Wallace 2012).

- RWR is the first study designed to describe and explain midlife women’s recovery change processes (mental, emotional, physical and spiritual) so that the findings can be used to help other women with AUDs, healthcare practitioners, peers in recovery, supporters, educators and policymakers. The study explained how AUDs as a chronic illness is not helped by emergency and acute care. People develop their sense of self through effective personal care practices and relationships with peers to share their thoughts and feelings with dignity (Neuroscience Addiction WHO 2004, 2007; NAO-UK 2008). An ongoing women-centred recovery plan can be developed and implemented (as the women in recovery proved). Abstinence was found to be necessary for the success of any plan, as any continuation of drinking did further damage to the midlife women’s brain; and the healing gained from abstinence was lost (Epstein, Fischer-Elber & Al-Otaiba 2007; Mancinelli, Vitali, & Ceccanti 2009).
RWR provides a strong base (the RWR Australian results and findings) for abstinence as the recommended first treatment objective, rather than a ‘minimum alcohol use’ approach (controlled drinking; Kosok 2006), waiting for natural recovery (as the disorder recurs across the lifespan; Tracy et al 2012) or staying with harm minimisation (underlying issues and comorbid and chronic illness are not fully addressed). In these situations, the person is likely to return to self-medicating (Dawson et al 2012). Having to wait for this abstinence focus in midlife is detrimental to the client and the effective implementation of abstinent recovery plans. A stop-gap measure may be providing women with AUDs with specialised alcohol dependence treatment related to the severity of their dependence, and that the women’s stay in care should enable them to work through their alcohol-related problems.

Throughout the RWR study transdisciplinary research information, and lived experiences, about how recovery was (and could be) maintained, was shared with the women and practitioner participants. Such sharing of information supported the emergence of the integrative recovery approaches needed by the women to accommodate their different backgrounds and to learn to live in recovery. Whole-person healthcare to meet the mental, emotional, physical, spiritual, practical and relational needs of midlife women with AUDs was features of the RWR study (Chapters 4 and 5). The research focused upon: early intervention techniques; the formation of healthcare partnerships; practical women-oriented recovery care tools; support for women’s development during respite; and the identification of preferred support processes (including the use of expert volunteers) in an integrated chronic illness recovery plan for enabling the women to experience wellness over the long term.

In RWR identifying, exploring and explaining midlife women’s recovery through a ‘social ecology’ systems framework, a feminist perspective and a people-focused healthcare approach, it was possible to achieve original and significant findings. Viewing recovery in this broader framework opened the way to improve care and provide what the women wanted: individualised women-centred, whole-person AUDs abstinent recovery healthcare. This is in keeping with the claim of the National Mental Health Strategy that recovery is most effective when the individual’s needs are placed at the centre of their care.
and treatment (Commonwealth of Australia 2010). This requires healthcare that takes into account cultural, social and environmental and personal needs that enable the implementation of integrated, flexible and responsible recovery care (Sheedy & Whittner 2009).

- RWR is the only study in Australia to seek progressive solutions to the inequality experienced by midlife women with AUDs who need to receive quality healthcare. Advocating for new ways of recovery care designed to meet the needs of midlife women with AUDs in Australia required documenting the experiences of the women who were receiving less than optimal care; and describing the RWR whole-person and whole-system options for midlife women’s AUDs healthcare (Roche, Freeman & Skinner 2006). Urgent changes in policy and strategy are needed to address the rising number of midlife women with alcohol dependence and the severity of the women’s chronic illnesses and accompanying physical and psychological damage (Chapter 7).

- RWR revealed how to enable women to realise their personal potential, experience social inclusion and make significant contributions to the community. By doing this they can also serve as role models of recovery and so enable significant intergenerational change (Chapter 2).

- The relatively recent change in United States addiction treatment from pathology, to intervention, to recovery, has now spread to the United Kingdom and the European Union (Anex 2012; Keane 2011; Kelly & White 2011; Laudet & White 2010; Best 2010). Although the Australian National Drug Strategy 2010-2015 (Commonwealth of Australia 2010) does not define recovery, recovery is well supported in the mental health field in Australia, and it has the support of knowledgeable practitioners in my RWR study.

- RWR is the only contemporary study in Australia of women’s AUDs recovery to include in the research methodology, praxis techniques (integrating theory and practice) designed to inform theory based on the progressive implementation of the RWR findings. Praxis involves action informed by practical theory and improved practical action informed by the transformed theory (Freshwater 2005). With access to the multiple layers of RWR data collected and analysed through the action cycles and four lines of inquiry it
was possible to engage in local theory-building (Kvale 1995) and practical knowledge translation (Armstrong et al 2006). I present in Chapter 6 five local working theories that provide explanations of why the different phases of women’s recovery occur.

Overview of chapter content

In the following section, I outline the content of the remaining chapters.

Chapter 2 consists of a broad-based document collection (academic literature and professional reports) and review. The literature search was expanded whenever a question arose during the study that could not be answered from the information that I had already gathered on addiction, alcohol use disorder, mental, physical and spiritual health, and self-care for women in midlife. This literature was drawn from fields such as the neurosciences and humanities (brain, mind, core self and self-concept; Damasio 2000, 2010); social work and social sciences (Rocher in Twohig & Kalitzkus 2008); and epidemiology and ecohealth31, sustaining good health in the living environment (Rolfe 2006).

I conducted a transdisciplinary literature search and analysis to find the best possible information that supported women-oriented AUDs care. This included reviews of related longitudinal studies and secondary data, e.g. investigating public health and medical databases, also international studies such as the National Survey of Midlife in the United States (MIDUS II; Ryff & Almeida 2009), and the Gender, Alcohol, and Culture: An International Study (GENACIS; Wilsnack et al 2009).

Participants were also encouraged from the beginning of the study to be involved and to take action to bridge gaps in their understanding by questioning what was missing from their healthcare and community health information. I felt it was important to gather research information on what interested the participants and what was necessary for the women to engage in healthy recovery living.

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31 An “ecohealth approach aims to improve human health and wellbeing while simultaneously maintaining a healthy ecosystem ... Transdisciplinarity, participation, and equity are its three essential methodological components” (Mertens et al 2005 p114).
The knowledge gained through the literature and from talking with participants was shared among them. The healthcare practitioners requested more detail on contemporary evidence-based practices for making appropriate care decisions and the suitable recovery treatments required for the women. I also shared the relevant new knowledge with researchers, clinicians and educators. This knowledge sharing enabled me to develop new personal, relational and collective initiatives for improving recovery.

A discussion is also provided in Chapter 2 of the positive and negative dimensions of the philosophies, politics and economics relevant to the therapeutic processes involved in AUDs, including: recovery as an ethical ideal (Kleinig 2008), combining abstinence and harm reduction (Kellogg 2003; Sword et al 2009), recovery capital and harm minimisation as a political necessity (ANEX 2012; AER 2010).

Chapter 3 details the research design. Researching with Women in Recovery (RWR) was based upon ‘transactive participation’; this included sharing lived experiences, and integrating purposeful action, enaction (sense of self, people’s intrapersonal recognition), and interaction with others for a common research purpose. RWR was a unique person-focused study, to improve women’s’ AUD healthcare. The topics of discussion in this chapter relate to the features of the RWR research design, why they were created and how they were applied.

RWR was planned as cooperative research using the Transactive Participative Research Process (TPRP). The process informed a purposeful RWR Knowledge Production Framework (KPF); it incorporated a social ecology-systems thinking perspective, acknowledging feminist viewpoints and the use of transdisciplinary sources of information (a consistent Tri-Thread). The Dynamic Lines of Inquiry strategy (DLI) provided four ways to study the complex issue using mixed methods. The DLI were:

1. Participatory Action Research (PAR) – Research discovery using iterative joint action;
2. Unobtrusive Observation (UO) – Research discovery using recursive action;
3. Document Examination and Expert Exchange (DE) – Research discovery using discursive action; and
The mixed methods were applied for data collection and analysis in all of the six Action Research Cycles. The gathering of data to understand women’s healthcare needs highlighted the importance of their having access to a range of therapies and support to enable them to follow different life paths into recovery (Newton & Stewart 2010).

Chapter 4 discusses the transactive methodology, the analysis and the results. The study’s results are presented here with the major result relating to the six-stage Recovery Continuum of midlife women’s change from active AUDs to wellbeing. The results were outcomes of the RWR Knowledge Production Framework (discussed in Chapter 3: Research Design), and particularly of the methods of data collection and analysis using the ‘Diamonds and Pearls’ approach (Diamonds represent data collection and Pearls represent data analysis).

The RWR results from Action Cycles 1, 2 and 3 illustrate why women struggled: 1) feeling unsafe and dependent in a childlike way, with low self-worth; 2) having low intrapersonal understanding, with negative emotion and interpersonal conflict; 3) less ability to self-care and connect in intimate relationships; and 4) a lack of AOD-related clinical knowledge and practice for midlife women, particularly in connection with their respite and peer support options (also, four major themes representing factors contributing to the women’s relapse were identified; Sun 2007). Planning therapy around the above four topics helped the women to lower their levels of distress and begin to discuss their fearful feelings, thoughts and behaviours. The aim for Action Cycles 3, 4, 5 and 6 was to explore with the participants how midlife women could be encouraged to recognise their abilities and progress through learning useful processes that could assist them to make major recovery changes.

Information from the RWR participants helped me to describe the particular features of the six phases of recovery. These involve the processes, contexts and issues as the women progress from Distressed recovery (1), at one end of the RWR Recovery Continuum, to reach Valued recovery (6) at the other end. All women in recovery do not necessarily reach Complex or Valued recovery. The Recovery Continuum identifies the successive phases where the specific choices involved in recovery must be made. The women and their practitioners must collaborate to evaluate what is most helpful.
In Chapter 4 I discuss what can help the practitioners to support the women in progressing through the following six phases of change; including tools appropriate for skill development and options for different therapies suitable for the client. The objectives for each of the phases, which need to be discussed with the client, are likely to be:

1. **Distressed recovery**: Improving ‘self’ awareness and emotional stability;

2. **Enacting recovery**: Establishing a non-drinking self with in recovery peers;

3. **Enabling recovery**: Sharing personal and social development to form an in recovery identity;

4. **I’m in recovery**: Supporting women forming partnerships for specific healthcare needs;

5. **Complex recovery**: Exploring the women’s self-in-relationships, and identifying their needs and skills for maintaining recovery; and

6. **Valued recovery**: Ongoing progress for achieving mutual objectives in a robust long-term recovery.

In Chapter 5, the significant and pragmatic findings of Researching with Women in Recovery (RWR) are presented. The women’s personal developmental and transformative journeys were analysed through the Meta-study process (Chapters 4 and 5), from the end of active AUDs to long-term sustainable recovery with wellbeing. The women’s ways for engaging in recovery change, and how this involved the Recovery Triad (RWR recovery care, development and support), provided the information that could be used to enable more women with AUDs, and their practitioners, to establish a desirable and functional way of life without drinking alcohol. The findings include recommendations (based on the experiences of the women and practitioners) for high quality abstinence and being ‘better than well’ in recovery (AA; Gomes & Hart 2009, http://ccar.us; Valentine 2011).

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32 The underlined words are the headings I used to help me integrate and implement the RWR results; this included learning new information, understanding the experiences, developing suitable treatment techniques, and the informed development of skills and nurturing methods of support.
In this chapter, Wise Recovery, as evolving selfhood, adulthood and womanhood, is described and explained. My detailed analysis of the RWR Meta-study database, using NVivo 9 software, showcases how to prevent non-recovery and relapse with the support of Respite Care. Critical to recovery is the formation of integrated recovery healthcare teams, including Expert Volunteers, and enhanced ways to live well using an individual Chronic Illness Recovery Management Plan.

In Chapter 6, refining the women’s recovery pathways and early identifiers of emerging alcohol dependence were clarified for use in community education and practitioner training and development. This information was discussed with tertiary education curriculum developers, as well as negotiated with media personnel and other organisations interested in improving Australian women’s chronic illness care throughout their life-course.

The following two outcomes are highlighted in this chapter: creating effective communication forms to distribute actionable knowledge from the RWR results and findings to clinicians, policy makers and the community; and secondly, the development of my Local Working Theories of RWR (LWT 1-5). Both outcomes were means of adding to the understanding of women’s recovery with AUDs, applying my research to practice, and contributing to the emerging field of implementation science (Eccles & Mittman 2006; MacLean et al 2010, 2012).

The ‘Be-Come-Well’ information developed in the study outlined how women can develop a robust emotional wellbeing that enables them to deal with the stresses and strains in their lives without drinking. I gathered feedback on the Be-Come-Well package from ‘communities of practice’, and modified the information to be a part of a package for practitioners entitled ‘Recovery Triad of Practice’.

Chapter 7 details the barriers that hinder midlife women’s abstinence recovery and that undermine their short-term and long-term care. Pragmatic approaches to limit and remove these barriers are recommended, along with details of ‘how to’ assist women to progress in recovery. Nine conclusions are offered which can be used to enable the improvement of healthcare and living in recovery for women with AUDs; these include the use of integrated teams helping the women to deal with their socioemotional issues, and having access to support from Expert Volunteer and Respite care for their ongoing recovery development. I focused upon mental
functioning and how, with abstinence and opportunities to nurture oneself, participating in selected therapies can be of great benefit to develop understanding of a changing self to continue to maintain robust wellness.

This chapter discusses the fact that midlife women with AUDs need to have access to a ‘whole-person-healing-in-context’ approach to be able to achieve sustainable abstinrent recovery. Promoting the concept that ‘abstinent recovery works for women’ is endorsed by contemporary evidence. A successful pathway can be negotiated; early intervention is possible and, overtime, greater self-managed personal recovery with healthcare monitoring for long-term quality of life is achievable. The RWR recommendations and conclusions illustrate how recovery care can be modified for women with severe dependence, early dependence and alcohol dependence with comorbid disorders. Women’s self-regard, potential and vitality for recovery living in their community are positive examples of mental health with AUDs.

Sun49, Action Cycle 5, Senior Practitioner interview (Alcohol dependence) creates a despair and hopelessness. ‘I am untreatable ... no-one’s going to be able to help me. I want this to stop, but I can’t’. And that’s quite clear. They can’t without knowledgeable help and time.

Cat1, Action Cycle 3, Women’s interviews (women selected which question set they would talk about): Yes I do feel content and at peace when I put my head on the pillow at night. I don’t have that horrible self-loathing and the depression and everything that went with it anymore. I know my daughter and my family and my close friends are just so proud and sometimes they don’t have to even say anything. I think the biggest thing is I feel good.
Midlife Women in Alcoholism

Janice Withnall, Professor Stuart Hill and Dr Sharon Bourgeois

In this feminist action research study participants are alcohol and drug professionals in Australia and women (in midlife) who have abstained from alcohol for more than two years. The goal is to recognise and learn from the lived experience of mid-aged women who have experienced recovery and stayed sober and to contribute to helping other women to share in a gender-sensitive, sustained recovery.

Stage 1 results indicate that the Recovery perspective (E.E. & R.W.R.) has been taken up by the national mental health strategy (Department for Recovery, 2006) and this is being disseminated. The Alcoholic Anonymous research, with these women, morphs the harm reduction/abstinence focus of the substance abuse policies in Australia (National Drug Strategy 2004 & National Alcohol Strategy 2006) and some associated treatment and research groups (Luskey et al, 2005). Recovery from alcoholism is considered as a positive outcome: that is, a woman can stop drinking and sustain not drinking with recovery-oriented support throughout a happy and useful life.

Alcohol Dependent Midlife Women (48-68 years in Australia)

- 1967: Prohibition
- 1999: New laws

More women are becoming alcohol dependent today at a greater rate than men only 1 in 5 people and only 1 in 3 of these are women who receive treatment (see table). Greenfield et al (2008). More indigenous women in their 20s and 30s are becoming sober and choosing abstinence: this is not, however, for indigenous women in their 40s and 50s (GAA, 2004). Identified in this study also is that younger women need appropriate care to maintain recovery, with a sustained recovery being influenced by supportive individual interactions within a social context (Sanner et al, 2006).

The women participants described that they needed a task supporting, community-based group who listened to them to develop skills and to enhance awareness so they could maintain their sobriety. The women found the core group of 5 to 6 women best suited to help them develop skills of self-control, instrumental and verbatim support from other women and to be linked with a more formal group. This core group comprised mostly women who have chosen to be sober, who meet weekly to develop their own skills to re-engage in the community.

The Australian crisis point for this age group, and the surrounding generations, is now rapidly apparent. Unexpectedly, at-risk women drinking alcohol tend to more rapidly, over a 1 to 3 year period, from heavy drinking to abusing (Carlisle et al, 1996) and they experience higher mortality than alcohol dependent men. Such women in Australia, with a complex predisposition of interacting genetic, developmental and environmental factors affecting them, can be as high as 135 per cent at risk for suicide (Carlisle et al, 2007). The fact that gene expression changes with environmental conditions, such as intergenerational stressors, which, in turn, need to be acknowledged Wilkinson (2003). Women at risk are experiencing further negative cultural influences (the term women is proposed by Deaux, 1999, to describe ingrown cultural traits) of Australian society as a post colonial reality of expression (Carlisle 2000). An example is the issue of MUST (being the "good woman") the expected role of children, partners, grandchildren and aging parents, the community volunteer, whilst completing most domestic tasks AND working outside the home. Depressed women exposed to such stress often drink more to "feel better", feel nothing" or "not worry". This in turn leads them to become different individuals. The individuals who drink in this way are regularly described as the bad, sad and mad woman (Crawford 2002). Isolated support not discrimination of marginalised groups is necessary to heal an intergenerational public health and social risk.

In Australia in 2007 - Why are More Women Alcohol Dependent?

This may be because:

- Women bring in non-healthier social and community environments and family environments are at a higher risk of dependence (Nutt, et al, 2007).
- Women as active agents, difficult, dysfunctional and dependent (Deaux 2007), they and women who drink being active agents, difficult, dysfunctional and dependent (Deaux 2007), they are less likely to be treated. Isolating women who drink, being active agents, difficult, dysfunctional and dependent (Deaux 2007).

The attached brochure has been designed based on the responses from the women in recovery from alcoholism and getting their understanding of the experience of being alcohol dependent and becoming sober. Communication techniques, simulation, role play, and interviews, have carefully considered (Oxid & Nava, 2008). Related health promotion programs must take into account the value of such "women's experiences" as a valid information source (Powell & Coulter, 2008). It is estimated that only 1 in 10 women seek treatment for alcoholism in Australia (Cullen et al, 2007). Therefore, women need encouragement and support, not stigmatization and discrimination, to seek effective help (Kavanagh, 1999). Women seek help from trusted women in their lives and the women who drink should consume less and be more active agents, difficult, dysfunctional and dependent (Deaux 2007), they are less likely to be treated. Isolating women who drink, being active agents, difficult, dysfunctional and dependent (Deaux 2007).

The women are being asked to participate in a workshop on the process of recovery and the NAA is debating changing its name to National Institute on Alcohol Disorders and Health.

The word woman is used here to refer to the women in this study who have abstained from alcohol for more than two years and who have abstained from alcohol for more than two years and who have abstained from alcohol for more than two years.

Note: Each of the Action Cycles was symbolised by flowers. The hibiscus represented Action Cycle 1 and 2.

Figure 1.1: An RWR research poster presented at The Public Health Association of Australia Conference, Alice Springs, Australia, 23-26 September 2007
Chapter 2: A Dynamic Participatory Five-Stage Literature Search

An ongoing literature search and analysis process was conducted to enable the women and their practitioners to better understand each others’ recovery priorities, and to provide answers to my research questions. This sharing of relevant literature continued throughout the study and was appreciated by the participants. The literature search highlighted the large gaps in understanding of midlife women’s AUDs and recovery, and clarified what needed to be investigated in the RWR study. My synthesis of the rich variety of data sources used with participants at each of the Action Cycles in RWR is presented here. It is presented in ways that were most useful to the women themselves.

The following six substantial areas of influence on women’s abstinent recovery with AUDs were identified (Pawson 2005). They each illustrate the complex nature of healthcare required for individual midlife women to abstain and become well. Each of the six areas is discussed further below.

1. Understanding some of the causes and consequences of alcohol use disorders;
2. The importance of peers;
3. Attention and role change;
4. Identity and individuation;
5. Theories and models suitable for midlife women’s healthcare; and
6. Recovery health systems and barriers to recovery.

I created an orderly system of record keeping and data management (the RWR transdisciplinary database) for the ongoing RWR literature explorations,

Montuori (2005) cites five cornerstones of the transdisciplinary project, and I collected related research studies across disciplines suitable for women’s AUDs healthcare. The database held this material in a searchable form and was incorporated in RWR NVivo projects to analyse with primary
document exchanges and secondary data examination (n=145 publications), using selected software programs. The methods used for data collection relating to the above six areas are provided in Appendix 2.1 (Joanna Briggs Institute 2013).

The types of literature incorporated into the study were dependent on data available (from disciplinary and interdisciplinary searches, secondary data [including ABS data cubes], transdisciplinary investigations, major reports and longitudinal studies from Centres of Research Excellence). The goal was to better understand the existing recovery literature and its limits, and the similarities, differences, connections and interpretations in relation to the responses of RWR participants (Szto, Furman & Langer 2005).

Based on the above aims, the following four analysis approaches were incorporated:

1. Critical appraisal (Booth & Brice 2006): this involved collecting peer-reviewed literature that was applicable to the practice of women’s recovery and healthcare (mental health, medical research-based sources of data as evidence). I also conducted critical interpretive critiques of the complex qualitative literature (Dixon-Woods et al 2005). My aim was to bring together participant experiences, transdisciplinary ideas and insights from the disciplinary literature for meaningful analysis that could be used to improve women’s AUDs healthcare.

2. Systemic thinking (Marshall 2004): to identify relevant phenomena that acknowledge the complexity and interconnectedness of the key factors, and of the relevance of the contexts within which they operate. Living is an experience of connectedness, with knowable and unknown systemic properties and dynamics, persistence of patterns, and resilience.

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data. The documents in the transdisciplinary database were translated into communicative exchange information for participants (Appendix 2.2). Transdisciplinarity is:

- inquiry-driven rather than exclusively discipline-driven
- meta-paradigmatic rather than exclusively intraparadigmatic
- informed by a kind of thinking that is creative, contextualizing, and connective
- inquiry as a creative process that combines rigor and
- imagination (Montuori, 2005 p154).
3. Critical reflection: Among the various approaches, I chose ‘critical creativity’, which is a more organic, developmental approach, using a ‘praxis spiral’ (McCormack & Titchen 2006). I emphasised spontaneity, engagement and meaningful, intentional action to maximise individuals’ potential for growth and wellbeing (Titchen 2000b; Titchen & Higgs 2001). The critical reflection processes used were based on the ideas of Reason (1993), Boud and Walker (1998), Mezirow (2000) and Lincoln and Denzin (2000), which emphasise being aware of the context of the research and of one’s assumptions.

4. Thresholds and turning points (Somerville 2008): Somerville, as a feminist researcher, pursues the emerging ideas between data and meaning-making concerning the self and relationships. This was particularly relevant to collecting transdisciplinary information on women’s recovery and exploring how situations improved for people involved in this difficult process. By being open to the ‘unknown’ ways of changing, new possibilities for women’s recovery emerged; these included supporting transitions for healing (Gionavelli 2008), transformation for wellness (Pals 2006), and transposition for wellbeing (Gallagher in Hermans & Gieser 2012).

**Literature exploration as communicative action**

The multiple literature searches were conducted particularly to communicate and share information with the participants. The participants as ‘experts through experience’ offered new perspectives on research materials. The planned running of the searches and review were:

1. during the trial project (Trial Report in Chapter 1);
2. at each of the six Action Cycles (Chapter 3);

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34. Humans are meaning-making beings that encounter and experience the world. Guidance and empathy assists women to stay in the ‘real moment’ to use their abilities to perceive and engage safely with life events. The practitioner and peers can support this process (Pickering 2006).

35. Communicative actions assist in designing and implementing how people, as part of a group, intrinsically organise using meaning negotiations. This process also provides possibilities of continuing the emergence of self with respect for selected cultural norms (Fairhurst 2000; Fairhurst & Putnam 2004). The women learn to reduce pain and create hope by being seen and confirmed in social relationships, and by being helped to verbalise issues and openly discuss possible solutions (Biong & Ravdal 2007).
3. while preparing for the Meta-study using the preliminary results (Chapter 4) and the secondary data (Chapter 5);

4. while using the praxis method of study (Chapter 6); and

5. during the final evaluation processes of RWR (Chapter 7).

The Key influences (in the first instance of six Action Cycles) were identified by the researcher by applying critical reflection techniques at the end of each Action Cycle and evaluating what had added to, diminished or altered the proposed questions for the next Action Cycle (Brooks 2009; Wilson & McCormack 2006). An example was that the women in recovery explained their priorities for maintaining abstinence, such as learning about emotional balance. I then searched for relevant information on emotion, such as the socioemotional selectivity theory and the regulation of emotion in the second half of life (Carstensen, Fung & Charles 2003). This information was provided to the participants through newsletters, emails, conference presentations and during the next Action Cycle of RWR.

The relevance of women’s feeling about events and processes is important to acknowledge and explore as emotions contribute to motivation, memory and mood, and these all influence cognitive and social processes (Frewen et al 2011). Socioemotional selectivity theory begins to explain the women’s past and present social unease in relation to learning and developing intrapersonal and interpersonal skills. The theory provides reasons why replacing drinking with learning how to converse with peers can help abstinence and recovery. As people become older, regulation of emotions is prioritised, and they tend to want to attend to the positive, forget the negative, and focus on present experiences. The theory posits that increased attention to emotional goals results in greater complexity of emotional experience and better regulation of the emotions experienced in everyday life. Older

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36 Socioemotional selectivity theory focuses on two main classes of psychological goals: one comprises expansive goals, such as acquiring knowledge and making new social contacts; the second comprises goals related to feelings, and it is explored in relation to balancing emotional states and sensing that one is needed by others. Health benefits understood through socioemotional selectivity theory are largely related to shifts in time and the changing perspective of an adult developing, maturing and ageing. This shift as a person becomes older affects (influences) cognitive processing. Even basic cognitive processes, such as categorisation, reflect dimensions of life that matter, and they affect a person’s perspective.
adults also disproportionately remember emotional, particularly positive, information relative to younger adults.

Four external data collection processes were completed in RWR to contribute to the participant data and find answers for RWR questions and issues: the first involved disciplinary and interdisciplinary searches and collection of relevant materials; the second focused on specific topic-oriented literature searches, e.g. the difficulties of shame and stigma and the vital benefits of peer conversation, and openness in practitioner-client discussions to support midlife women in recovery with AUDs. The third was concerned with transdisciplinary academic literature collection and analysis, as part of the dynamic nature of action research (Becker 2002; Jacobs & Frickel 2009). The fourth external data search focused on research methodology, particularly literature that would help me design, develop and modify the RWR study. Many of the search topics, particularly for the third search, were nominated by the participants, through their responses to research questions and personal needs (Appendix 2.3). The products of all of the literature searches were referred to in the writing of all of the chapters of the thesis, to find information that might improve midlife women’s recovery.

The four types of literature searches also generated information about Key influences and associated credible data that could help explain the women’s and practitioners’ healthcare issues. Throughout the study (from 2006 to 2013) the searches and analyses were conducted as a cooperative project, which led to the establishment of the RWR transdisciplinary database (multi-media RWR Knowledge base). This database, which was added to throughout the study, is available to concerned and interested people. At the end of the Action Cycles the Key influences were sorted into five categories, and these were used to inform the results and organise the Meta-study (Chapters 4 and 5).

The project has brought together over 8,000 publications relating to women with AUDs attaining abstinence and developing through recovery change to live in wellbeing. The database also contains research-based information to assist practitioners and supporters in their provision of suitable healthcare, development and support.
Figure 2.1: Recovery and alcohol dependence: What works for mid-aged women in Australia, International Congress on Women’s Mental Health, Melbourne, Australia, 17-20 March 2008

Key: The camellia is shown on a conference poster presented representing the Action Cycle 3 results and participants. The decision to extend the study from three Action Cycles to six Action Cycles was prompted by feedback at the conference and more people volunteering to participate. Importantly the participants of Action Cycles 1, 2 and 3 were willing to continue with the study.
Selecting sources of data to investigate topics that unexpectedly arose throughout the RWR research process followed a critical decision-making process. These sources were additional to the data collected from the RWR participants and my observations. The decision to conduct a search was based on the following four criteria: 1) most of the participants wanted to know more about the issue; 2) I had recognised the topic as being relevant to the study’s process and objectives; 3) a brief search identified that a credible person or organisation was associated with studying the topic; and 4) the research process or credible information used to establish the claim was explained. An example was the publication Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field, National Centre for Education and Training on Addiction (Skinner et al 2005, NCETA), Flinders University, Adelaide, Australia.

Another example was becoming aware of the Jean Baker Miller Training Institute (JBMFI, at the Wellesley Centers for Women, Harvard University) as the home of Relational-Cultural Theory (RCT), which posits that people grow through and toward relationships throughout their lifespan. The work of this Institute was valuable in understanding the results of the early RWR Action Cycles. The scholars and clinicians at JBMTI reframe the psychology of women by focusing on relationship issues (Baker Miller, Jordan, Stiver & Surrey 1976-2012). The Institute has offered an array of training experiences and it supports the development of ongoing RCT practice communities; they offer intensive clinical practice seminars and workshops that focus on relational leadership, mother-daughter relationships, mothers and sons, relational mindfulness, the neurobiology of connection, working with shame, mentoring, relational resilience and transformative relationships. The decision to rely on the mother-daughter relationship as a source of support was a sad and fragile one for many of the RWR women in recovery during early abstinence. Also, the women in recovery who were mothers were most concerned that their children would have positive relationship experiences, and develop the needed skills and knowledge to support this.

I also studied how research knowledge is judged as credible and can become competent health practice (e.g. involving translation science from the laboratory to the clinic; Miller & McEwan 2006), and contribute to the evidence-based treatment of addiction, general practice and community health, public health and health administration programs (substance abuse; Miller et al 2006, medicine; Miles &

**Six substantial areas of influence on women’s abstinent recovery**

I first explored the influential topics related to midlife women’s recovery based on the participants’ past and present experiences. Because literature was limited on the topics in the addiction and mental health fields, to meet the research goals, I examined studies from a variety of disciplines.

**The past:** earlier Australian studies focused on women’s changing alcohol consumption, the need for more research, and the provision of special treatment for female teenagers, indigenous women and pregnant women (National Women’s Health Policy 1989; Copeland & Hall 1992; Long & Mullen 1994; Broom 1995; Hands, Banwell & Hamilton 1995; Swift, Copeland & Hall 1996; Fleming 1996; Copeland 1997, 1998; Fleming et al 1998; ABS Mental Health and Wellbeing: Profile of Adults, Australia 1998). The inconsistent findings regarding diagnosis and treatment (screening and brief interventions) when applied to women, compared to men, were noted as indicating a need for further study, as was the lack of effective strategies for recognising AUDs in women, and the need to improve healthcare for women with AUDs (Higgins-Biddle et al 1997). RWR has extended the Australian empirical research knowledge of midlife women suffering with AUDs; and, importantly, it has focused upon how women become abstinent, well and able to live in recovery.

The number of midlife women in the high-risk category of alcohol consumption (12 to 16 percent) was based on my analysis of health, mental health and addiction studies conducted in Australia prior to 2006. Women’s alcohol dependence (lifetime incidence) has been estimated at 16.1 per cent in Australia (median age of 30 years; Lynskey et al 2005). During RWR the trend upward, more women

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37 The documents studied were the ABS National Drug Strategy Household Survey 2001; Roche & Deehan 2002; Latt et al 2002 and Midford 2005. The healthcare figures related to alcohol use were monitored over the RWR study, e.g. in 2007, 30.5 per cent of Australian women aged 14 years and over drank at risky and high risk levels (Women’s Health Policy 2010).
drinking at high-risk, continued. The problem of no-response bias in health surveys was reported in longitudinal studies with the outcome of underestimating high-risk drinking in Australian women (Clemens et al 2008). The Multinational Genesis Project ‘Gender and Alcohol Consumption’ emphasised the unexpected prevalence of drinking in women that did not decline with increasing age (Wilsnack 2009, 2012).

Health authorities in 2010 were refuting media announcements of a reduction in drinking alcohol in the Australian population. They confirmed an upward trend in per capita alcohol consumption (PCC). Recent research had established that with higher total consumption more people were alcohol dependent and the greater need for recovery-oriented services, rather than the previous argument that the same people were drinking more alcohol (Laudet & White 2010):

*Until recently, official national annual totals of PCC of alcohol were underestimated and led to the mistaken impression that levels of alcohol consumption had been stable since the early 1990s. In fact, Australia’s total PCC has been increasing significantly over time because of a gradual increase in the alcohol content and market share of wine and is now at one of its highest points since 1991–92. This new information is consistent with evidence of increasing alcohol-related harm and highlights the need for timely and accurate data on alcohol sales and harms across Australia.* (Chikritzhs et al 2010 p594)

Women’s increasing alcohol consumption patterns (Midford 2005; Withnall & Hill 2006; Withnall, Hill & Bourgeois 2007, 2008, 2009, 2010, 2011, 2012, 2013) began with the increase in wine consumption by Australian women in the 1970s. Drinking in integrated social settings, such as during family meals was more acceptable (changing norms; Room 1988; accessibility or stress; Hammer & Vaglum 1989; Peele 1997). Favourable changes to the taxation of wine in the early 1970s also played a part in Australians (more women) buying more wine (Stockwell 2004). Advertising, marketing and sponsorship strategies for brands of alcohol were developed with growing customer influence (Weintraub Austin, Chen & Grube 2006). Wine sales increased with Generation X women consuming more alcohol (Howard & Stonier 2001). The alcohol content of wine increased from the 1990s and prompted debates on the emerging alcohol problem to be limited by sales tax calculated by alcohol content in beverages.
The present: the actions of the alcohol industry in changing the taste of products and creating new type of drinks, such as alcopops, to appeal to younger women was identified and challenged (Australian Divisions of General Practice 2003). There currently discussion about the use of relationship marketing and emotional marketing by the alcohol industry as the techniques, used in advertising products, associates with consumers’ values processing. Viewers of the advertising feel they are in a positive relationship when drinking and believe they will be happy when they drink. Connecting with consumer emotions can persuade and more easily override ‘drink alcohol wisely’ public health messages, even people with educative information on the affects of alcohol on a person’s body and mind (Grönroos 2004; Rytel 2010).

Alcohol dependence features for women have been described from multiple scholarly perspectives. From around 2005 studies focusing on women increased, however, there was limited age specific detail: women’s biomedical description (Albrecht 2008); differences in men and women with alcoholism (Edens et al 2008); alcohol dependence impact on health (Carguilo 2006); gene environment interactions in addictive disorder (Gorwood et al 2007); spouses, extended family and children (Knis-Matthews 2007); pharmacological treatments and medications (Johnson et al 2006; Sinha et al 2009); severity of dependence (Bischof et al 2005); abstinence and gender (Wilsnack et al 2009); stress and alcohol dependence (Dai, Thavundayil & Gianoulakis 2005); alcohol dependence treatment in early recovery (Bird Gulliver et al 2005; Rivaux et al 2008); alcohol dependence tobacco use, depression and suicidality (Patten et al 2003; Lau-Barraco, Skewes & Stasiewicz 2009); involuntary treatment of alcohol dependent patients (Latt et al 2003); and alcohol dependence and continuing care (de Vries & Wierdsma 2009).

1. Understanding some of the causes and consequences of women’s AUDs

Emotional pain and memory

Most women with AUDs in recovery have unknowingly learned to inhibit pain signals (including distress), as they expect that any physical or psychological expression of such suffering (a weakness) will initiate negative responses, even
threats, from the people around them. At other times some women exaggerate their pain to elicit care giving responses (Kozlowska 2009)\textsuperscript{38}. The often conflicting and confusing signals given by women of their pain reflect learned adaptations to unsupportive past experiences.

\textit{Pain, together with a host of other self-protective responses – interoceptive, hormonal, physiological, motor-sensory, cognitive and affective – is part of the basic mechanism of life regulation. Pain is both a homeostatic and a relational emotion. It heralds that a physical or emotional injury has occurred, triggers the body’s allostatic systems, and motivates a protective motor response. Pain signals are rapidly detected by observers and [they can] promote rapid, nonverbal communication about potential dangers which threaten the survival of individuals or their social group. (Kozlowska 2009 p1020)}

RWR women participants had rarely felt safe enough to let their inevitable vulnerabilities show. On the contrary, the women felt that they must not show weakness, that they needed to present as always being highly competent (perfect) and stoic (rigid) in difficult times (Egan et al 2007). Alcohol abuse drove the women’s self-sufficiency into alienation and addiction\textsuperscript{39} gave rise to a great fear of failure and feeling that they were not worthy to even contemplate seeking help (Swendsen & Le Moal 2011).

In safe recovery treatment, clear explanations about emotional pain can be provided. These include behavioural and mental strategies that women can learn, if they have not had the opportunity in their previous life circumstances. People learn from a young age how they can maximise the chance of receiving comforting responses and minimise threatening responses from people deemed important, such as mothers. Relating to other women prior to and in early recovery was also found to be challenging (Osborne, Baum & Ziersch 2009). Important relationships and their affect on women in recovery are discussed in Chapters 4, 5 and 6.

\textsuperscript{38} The dynamic-maturational model (DMM) explores how individual responses to pain, and the signalling of pain, reflect self-protective patterns that were shaped in childhood, and that may be continued in relationships from adolescent to old-age.

\textsuperscript{39} Research on individual differences that encompass cultural and sociodemographic factors, psychiatric and psychological vulnerability, and biological and genetic propensity to addiction is helping to stimulate research across a range of disciplines to improve intervention and prevention processes.
As recovery continues, remembered events can interrupt daily activities. Important information for women in recovery is that many people misinterpret events in the present because of their links to moods and emotions that are associated with unconscious memories (Kelly & Masterman 2008). My describing what memory is (networks of information processing and storage based on sensory input) was helpful for women in recovery that feared their memories. The women commonly reported being ‘hijacked’ by memories and returning to drinking as they did not want to remember and feared possible outcomes (Durazzo et al 2008).

Alcohol-related memory associations have long been implicated in drinking behaviour. For example, depressed affect increases self-reported craving and motivation to drink (Willner et al 1998). Nervous moods predict increased drinking (Swendsen et al 2000), and negative affect is a frequently endorsed antecedent to relapse in drinkers undergoing treatment (Strowig 2000).

RWR participants emphasised that drinking to enhance positive mood was very unlikely with alcohol dependent midlife women. Positive mood enhancement motives were more likely in adolescents and women in their 20s. With older people, the central nervous system reacting in a negative way to a painful memory (a flashback) is more likely to trigger them to want to drink. Participants emphasised the importance of assuring women in treatment that any questions about memory that they initiate will be answered.

Healthcare practitioners can help midlife women in recovery by identifying their strengths and weaknesses, and so enable them to refine their living skills and improve their recovery plans (Gollwitzer & Sheeran 2006; Scholtz et al 2007). The RWR practitioner participants noted that the women’s practice of internalising shame was difficult to address, and that leaving aside the most painful details until the client was less vulnerable and personally ready was advisable (Dearing, Stuewig

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40 Distortions of understanding past events also occurs through repeated intrusive memories and abnormalities in neurotransmitter systems (Rise et al 2009).

41 Memory can be affected by psychological trauma (Brewing et al 2007), alcohol-related brain damage (Harper 2009), and normal forgetting due to disruption at the time of the initial registration of information.

42 Length of time abstinent and brain damage repair can increase working memory capacity for everyday self-regulation (Hofman et al 2008).
Eventually the shame slipped away, and a sense of coherence as an adult in recovery became an achievable priority for women with AUDs.

Abstinent recovery was necessary for the women to be able to learn about robust emotional acceptance (McHugh 2012). This helped the women to integrate their internal and external experiences, and to understand the interrelationships between, and significance of, intradependence (with self) and interdependence (with others). Enabling women to remain present with their emotions, and accept their emotions as their own, brings them closer to understanding this natural part of human perception and experience (Gratz et al 2005, 2007). With further recovery experience, the women can also no longer accept the common prejudices about alcoholism as a mental disorder, including self-stigmatisation; learning how to not carry destructive guilt is an important process for the midlife women's recovery (Rusch et al 2006).

It is difficult for women to speak about traumatic events even when they feel this is necessary. Understanding that this is what occurs in relation to such events can lower their feelings of anxiety. Dangerous situations limit verbal, visuo-spatial and temporal memories at the time of the event. Also, high anxiety can be misperceived, and ‘aggressive faces’ in the present can be unknowingly linked to past negative events. Research is being conducted on the individual differences (Hoffman et al 2008) in the ways that thought and memory (intrusion and suppression) affect intelligence. Studies of the psychoneuroendocrine system (Brewin & Beaton 2002; Irwin 2008) are also providing alcohol and drug practitioners and their clients with new understandings of trauma, and of brain and central nervous system functioning. Working memory capacity (WMC) is not directly about memory; it is about using attention to maintain (or suppress) information useful to problem solving (Engle 2002; Hoffman et al 2008). Recent studies have involved training working memory to assist with self-regulation. Transformative learning43 may be more useful in this process, and overall can help with recovery and trauma healing.

43 Transformation is typically chosen only when what we currently have available no longer serves us, or we reach a point where what we value is not valued in the same way, creating the need for a new purpose, coping pathway, and/or resource (King-Keenan 2010). Healthcare and recovery can bring a subsystem that encourages new self-organisation to emerge, a forming self, one of worth, dignity and capability.
Women in recovery found that information on trauma action and reaction from a whole-person perspective, along with affective neuroscience information, was helpful. Non-traumatised people feel a connectedness with the world about them, a fluidity and wholeness as a result of psychoformative processes. With traumatisation, the psychoformative processes are disrupted. This involves psychological numbing, fragmentation, and a loss of self-structure (Lifton & Olson 1976). Trauma, thus, has the potential to ‘collapse’ the self (Benyaker, Kutz, Dasberg & Stern 1989). Reorganisation is then required to restore self-continuity and a sense of wholeness. Lifton (1993) focuses on how some traumatised people have learned to consciously use the capacity to fragment and reorganize to build their resilience.

Learning about memory assists with transformation. Memories and flashbacks that are accompanied by high emotions (with little detail of events, people and places) are significant barriers to maintaining recovery and wellness. Through the Meta-study, explanations of trauma memories were studied and addressed (Chapter 5).

Trauma and transformation involve critical changes, and recovery can help with healing and provide ways to change using healthy techniques. Learning processes to help with trauma take time, and require the support of knowledgeable people in a safe and confidential environment (McWhinney & Markos 2003). New life opportunities can be started through recovery transformation with an understanding of what memories and traumatised memory means (Hall & Kondora 2005, vicarious memory; Sabin-Farrell & Turpin 2003).

Most practitioners felt that the best way to help women to remain in early recovery when memories intrude is through ongoing reassurance of their safety; and to assure women that recall of memories will not be required during initial AUDs treatment and early recovery. Supporters can also be reminded that alcohol dependence is traumatic in itself for the women and their significant others. The RWR women in recovery repeatedly emphasised that in withdrawal from alcohol and early recovery they have low working memory reserves; so they need to stay away from events and

44 There are different types of memory (verbal, episodic memory, visuospatial, body memory and working memory). All are useful and professional help can be provided about remembering or not remembering trauma when recovery is established. Ways of recognising, reminiscing, reminding, and commiserating are tools to assist with memory and emotion effectively (Martin 2009).
places where alcohol is present. The brain is damaged and is less able to restrain actions and suppress urges to drink.

**Effects on the immune system and the brain**

The mind (psyche) is negatively affected by alcohol, because it changes and damages the neuroendocrine and immune systems of the brain and central nervous system. This can be shown by having a psycho-neuro-endo-immunology (PENI) check-up, which needs to be followed by lessons on relaxation, breath work and yoga exercise (Kulkarni & Bera 2009). The long-term immune-endocrine effects accompanying women’s AUDs (Naito 2006) must be considered when designing a Chronic illness Recovery management plan (CiRmp) if a whole-person healthcare approach is the goal.

Stress induced alterations in immunity are not transient, but persist after acute experiences (Burleson et al 2002). Although a single issue may trigger a woman’s active alcoholism, contributing factors will have accumulated over many years to cause such a response (Kudielka, Hellhammer & Wüst 2009). For the RWR women participants, relationship conflicts, abuse, premature deaths or loss of a loved one, and personal physical and emotional distress led to their increased drinking. Distress induces vulnerable physiologic and pathologic conditions that are exacerbated by alcohol (Mix, Goertsches & Zettl 2007). Studies on women with high levels of stress and mood disturbance indicate that they have the most marked changes in their immune function compared with controls (Janusek 2002).

Alcohol dependence is associated with serotonergic abnormalities in brain regions that are known to be involved in planning, judgment, self-control, and emotional regulation (Fahlke et al 2011). The World Health Organisation (Neuroscience Addiction 2004, 2007; NAO-UK 2008) endorses the idea that the prolonged use of alcohol is associated with major impairment of the brain, which can be partially reversed after a period of complete abstinence. Further studies show a minimum of three years (extending up to six to eight years) of abstinence is required for these reversals to become apparent in abilities testing. Any level of continuation of drinking damages the brain more rapidly; and the healing gained from abstinence is lost quickly and new damage occurs more swiftly. As people age, more damage is experienced, and limited or no repair occurs. There is also agreement that women
have a greater physiologic vulnerability to the effects of alcohol than men. The physical consequences of alcohol use to various organ systems, for example, liver and brain, are more severe in women (Epstein, Fischer-Elber & Al-Otaiba 2007; Mancinelli, Vitali, & Ceccanti 2009). Assessment and review of the women’s complex psycho-socio-cultural midlife circumstances\textsuperscript{45}, with encouragement for women’s abstinence and recovery changes, is critical for healing and wellness. An integrated health-care team can monitor the psychosomatic screening, diagnosis, treatment and prognosis to contribute to modifying the women’s neuroendocrine system for wellbeing in recovery (Rilling, King-Casas & Sanfey 2008).

The women’s recovery development processes need to address the ways in which their AUDs contribute to their experiential avoidance, emotional instability and confusion concerning human emotions (Gratz et al 2007; Jain & Labouie-Vief 2010). The detrimental effects of extreme negative emotions and maladaptive health behaviours on whole-person mental and physical health and wellbeing need to become clear for women with AUDs in early recovery. Drinking alcohol limits and distorts emotional processing and produces decision-making deficits in substance abusers. Neuroimaging studies have shown that altered decision-making in addiction and PTSD is associated with abnormal functioning of a distributed neural network that is critical for the processing of emotional information (Jovanovic & Ressler 2010).

2. The importance of peers

Talking with knowledgeable and honest women in a group that has healthy psychosocial boundaries enables the women in recovery to safely express and receive emotion (Matto 2010). Such groups may provide learning and practice that was not possible or criticised in family situations. Alternative social meanings offered in

\textsuperscript{45} Studies of healthy and impaired neurogenesis in the adult brain are contributing to our understanding of mental health (Abrous, Koehl & Le Moal 2005). Well-developed theories of both adaptive phenotypic brain plasticity and adaptive genetic variations in stress-response systems now exist (Ellis, James Jackson & Boyce 2006; Ellis & Boyce 2008). Epigenetic misregulation in predisposed individuals accumulates until phenotype changes occur; e.g. affect, cognition and addiction disorders. The misregulation is shaped by multiple factors: natural selection; an adaptation to multi-niche environments; an integration of genetic influences; and context-derived sensitivities (Ptak & Petronius 2008).
recovery discussions and events can be used to by the women to change their positions when ready.46

Such recovery discussions, over time, helped the women to realise that the way they talk reveals their identity and self-knowledge (Edwards & Potter 2005). Socialising with peers helped them to identify the differences between their past self and present non-drinking self (Krause 2007). This cooperative communication and social connectedness, involving women helping other women with words and phrases, helped the women in the study to be able to explain how they recognised the barriers that had formed around their younger ‘innocent self’, before their AUDs. Through such exchanges of ideas and phrases, the women were enabled to define their new ‘self-in-recovery’. What did not suit could be put aside (Ready, Carvalho & Åkerstedt 2011).

Cooperation with peers in recovery helps women to form new identities and choose new roles, while maintaining their non-drinking and in recovery identity. This involves more than just restoring their mental health internally and relating stories to others (Korobov 2010). They learn to bring their non-drinking self into a safe relational sphere; learning techniques in a supportive, not judgmental ways.

The topics of the women’s honest discussions and conversations with other women in recovery were often about what they were experiencing in recovery: relating to their emerging personal self; their possible new identities; and selected roles in the process of becoming mature women (Damasio 2010). I observed the women as part of their recovery ‘practice in the community’. They were exploring and expressing their past destructive struggle as their drinking had increased, and talking in hindsight about what had occurred. What was surprising, and helpful, was their recognition that a personal naïve self was also present in those dangerous years of living with active AUDs, along with their distorted selves and identities that were part of their frightening inner world of alcoholism (Harré & Moghaddam 2003).

46 Interrelationships of body, mind, spirit and environment are assumed in psychosomatic medicine and biopsychosocial perspectives of health. Environmental and personal history factors may have positive, neutral or negative effects on women’s health, wellbeing and recovery (Petitt, Grover & Lewinson 2007; Lyon, Margot & Barbalet 1994). Awareness of such factors can improve the design of the individual’s recovery process and plan.
The women’s life experiences in recovery, including learning to no longer deny one’s personal self, become useful wellbeing resources to share with family and peers on similar life-courses (Moen & Chesley 2008). Individualised care in a supportive network can promote cooperative relationships of self-care and shared care as part of recovery change (Watson, Schein & McMullen 2010). The flow of recovery benefits is more likely to contribute to healthy pro-social and sustainable neighbourhood work (Biglan & Hinds 2009), and provide protective factors in an adults’ sense of community to address intergenerational trauma and the distress resulting from alcohol misuse (Greenfield & Marks 2010; Stockdale et al 2007).

Managing multiple relationships, and sustaining wellbeing through human and natural connections, can be baffling for women with AUDs. Being alive always means ‘being in relationship’ (Joerke 2005; Pfleiderer 2010). The RWR midlife women found that it was difficult (often embarrassing) for them to practice basic social skills in everyday environments. Women’s learning about low-key conversation (small-talk as a bonding process) opens opportunities to talk about common maladaptive actions, e.g. women with AUDs problem-seek to control by excessive organising, doing and fixing, which raises stress levels; followed by distress through perfectionism, compulsive self-reliance and isolation (Egan et al 2007; Andersson & Eisemann 2004).

3. **Attention and role change**

Attention47 is often referred to as the selective aspect of information processing, enabling people to focus on goal-relevant information (e.g. report writing) and ignore goal-irrelevant information (e.g. loud music next door; Ochnser & Olsen 2005). Most adults can describe the lapses of attention experienced when multitasking and daydreaming, and their inability to block out distracting thoughts and feelings generated by environmental stimuli and internal feelings of dissonance.

Being aware when lapses of attention are occurring and redirecting attention is a skilful response to life circumstances. Conscious processes – such as alertness,

47 Attentional control processes can be associated with executive functions and working memory (Heedon 2006). These terms, however, have been claimed to be misleading, and are being re-addressed in neuropsychology research (Pitel et al 2009) using brain imaging technologies (Chanraud et al 2010).
intention, control, effort – assist with attention (Bargh 1994; Bargh & Williams 2007). Attention to awareness can, in contexts of high emotion, alter hypersensitivity and distress, e.g. through mindfulness training (Weick & Putnam 2006). The practice of mindfulness involves self-regulation of an attentional state: a non-reactive, non-evaluative monitoring of moment-by-moment cognition, emotion, perception and sensation without fixation on thoughts relating to the past and future (Garland et al 2010). A decentering awareness is also described with mindfulness. Decentering (also termed reperceiving; Shapiro et al 2006) is defined as the process of disidentification from thoughts, emotions and sensations, and is claimed to lessen the impact of potentially distressing mental content.

Attention lowers in a negative manner with alcohol abuse, disordered mood and affect/cognition dysregulation (Bowen, Block & Baetz 2008). Negative emotions also narrow the scope of people’s attention (Garland et al 2010). Positive emotions can broaden attentional focus and thought-action repertoires. The aim with attentional control is to experience a sense of contentment, self-compassion and empathy.

Acknowledgement and recognition of their current personal mental states, wherever they are (e.g. at a railway station) and at whatever time (e.g. at 10am or in the middle of the night), enables the women to be less reactive in automatic ways to external stimuli (noise and crowds), and to act in a calm manner. Being more mindful48 of their personal senses, the objects and processes of the environment, and of human responses to these, brings less fear, and an ability to recognise fear as underlying distress, and this improves women’s abilities to continue with their life activities.

Another aim of women learning about awareness and attention in their present life circumstances is to assist with role transitions (Scalea et al 2012). More information is found on roles in Chapter 4; however, understanding how to maintain attention and prepare for roles emerged as important in the Action Cycles discussion to improve ways midlife women can recover.

48 A mindfulness technique (Witkiewitz, Marlatt & Walker 2005).
Improved attention can help the women to select appropriate midlife roles (Traynor, Brown & Dibellow 2007), which may be multiple and evolving. However, all selected roles need to be congruent with the woman’s contemporary in recovery identity. Whether or not a role serves as a risk or a protective factor is critical for women in recovery. Women in discussion with their healthcare team and peers in recovery will need to pay careful attention to what are acceptable roles, and to nominate the terms of the roles suitable for their ongoing recovery.

Explanations by practitioners about roles and identities being emergent and inherently incomplete are important for women’s understanding and decision making (Stenius et al 2005). Roles provide an anchor for identities that sustain a sense of continuity over time. They define the social position of an individual within a given social system (e.g. being a schoolteacher), are based on enduring relations with other people, and provide both a sense of identity and behavioural guidance (Staland-Nyman, Alexanderson & Hensing 2008; Josellson 1994). Holding a role can be seen as a vehicle that mediates and negotiates the meanings constructed in relational interactions. People perform (take action, prepared or improvised) according to role norms in social situations. In practice, roles are what people do, in order for them to achieve something, particularly when working together (Harvey & Haraway 1995).

The number of roles per se does not have a significant effect on mental health although issues relating to multiple roles and role strain are receiving increased attention (Nyman 2008). Roles can involve both psychological distress and subjective wellbeing (Brown 2002). Midlife is a time of changes in roles, e.g. when children grow and leave home, and elderly parents are less able to care for themselves. RWR women in recovery discussed their difficulties in meeting their own and others role expectations. Both social and gender roles were viewed by the women as involving difficult and uncomfortable tasks.

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49 Role reward buffers the negative impact of stress on functioning and depression, but not on anxiety. A rewarding experience within one role can buffer the negative mental health effects of another stressful role (inter-role buffering effect). Role stress can be eased by seeking and receiving social support (Scalea 2012).

50 Roles can translate meanings in identity construction processes (Simpson & Carroll 2008). A role can provide the ‘object’ and ‘meaning’ to one’s life (Kuntsche 2009).
Gender-related roles, in particular, need to be discussed with women in recovery (Hodgson & Johns 2004; Johns et al 2008). Levels of psychological masculinity and femininity appear to be important factors in mental health in general, and also appear to play a part in the change process. Psychologically masculine type and feminine types are not based on a person’s sex, e.g. women may prefer masculine type activities. Understanding gender-role orientation and sex differences can help with choice of treatment (Greyson, Becu & Morgan 2010) since the physiological and psychological effects of alcohol consumption on damage and recovery differ between sexes.

The multiple identities experienced by the women can result in conflict and create psychological tension (Stets & Carter 2011). Practitioners and peers in long-term recovery can provide examples of possible conflicts, and what might address their associated tensions. The women can find that on occasions their multiple identities can also interact, e.g. their mother, wife, and manager identities may be activated within a single scenario. Women who had been in long-term recovery explained that when they need to decide which value set or principles are needed to select the identity that can best inform their actions in particular circumstances, they return to their core self and in recovery identity to enable them to do this (Rangel, Camerer & Montague 2008). This core self is developed and strengthened by process of individuation.

4. Identity and individuation

Building their awareness of themselves enables women with AUDs to act in a thoughtful, rather than an emotionally reactive, manner, i.e. it enables their self-differentiation as an individual. Self-differentiation refers to the individual’s ability to separate, in a healthy manner, their thinking and feeling states from the thoughts and feelings of other people (Cattapan & Grimwade 2008). Differentiation of self is a developmental process that can be influenced by personal loss and other negative filial attachment events. Inadequate differentiation in women, especially relating to a heightened feeling of needing to care for others, increases the negative outcomes of identity diffusion and distress (Perosa, Perosa & Tam 2002).
### Table 2.1: Women’s individuation and personal growth in recovery

<table>
<thead>
<tr>
<th>Categories of issues to consider</th>
<th>Activities recommended by the women</th>
<th>Women’s negative personal experiences through alcohol: Concerns to be monitored in relapse</th>
<th>Related transdisciplinary literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women seeking recovery experiences</td>
<td>Volition (choosing value-based motives)</td>
<td>Isolation as distress (unrecognised fear) dominates</td>
<td>Individuation &amp; construal (Fujitsu &amp; Han 2009)</td>
</tr>
<tr>
<td>Attention &amp; intention</td>
<td>Self-care &amp; in recovery safety daily practices</td>
<td>Arousal then reaction</td>
<td>Alert &amp; attentive (Fadardi &amp; Cox 2009)</td>
</tr>
<tr>
<td>Sensory content</td>
<td>Experiencing all senses Noticing thoughts &amp; feeling with openness</td>
<td>Flooding (hyper or hypo reaction) &amp; returning to the past</td>
<td>Safe mindfulness (Brown, Ryan &amp; Cresswell 2007)</td>
</tr>
<tr>
<td>Communication &amp; response arbitration (Considering alternatives)</td>
<td>Self-expression Verbalising the hypersensitive need to be secure Learning to ask for advice &amp; mentoring</td>
<td>Merging with other people Confusing emotions &amp; rumination Acting on negative emotions</td>
<td>Expanding language &amp; sharing experiences with others (Lindquist et al 2006; Shanahan 2008)</td>
</tr>
<tr>
<td>Directed activity for a set purpose</td>
<td>Care of mind, body &amp; spirit Learning to agree and stay on an appropriate task</td>
<td>Just doing, fixing &amp; organising</td>
<td>Focus (brain care) &amp; short-term objectives (Attridge &amp; Ghali 2010)</td>
</tr>
<tr>
<td>Review &amp; relaxation time</td>
<td>Supportive reflection &amp; care of mind &amp; body connection Develop kind &amp; gentle ways with people</td>
<td>Recrimination &amp; self-censure</td>
<td>Experiencing self &amp; interpersonal sharing (Rime 2009)</td>
</tr>
</tbody>
</table>
The identity-forming process begins with women better understanding their personal unresolved self-differentiation (Heinonen et al 2006). Non-differentiation (triggered by past circumstances, stress and drinking) is evident as intense feelings that are associated with other people’s emotions; and being unable to differentiate between these and one’s own emotions. As mentioned above, some women reported being engulfed by the emotions of group discussion members during therapy sessions. This can be confusing, as it overwhelms the women’s still fragile self-schema (Sutherland et al 2009). Low levels of differentiation predict psychological reactance, and ‘acting out’ behaviours. High levels of self-differentiated personal knowledge (integrated feeling, sensing and thinking) can help the women to experience low levels of social anxiety and low physiological stress symptoms (Peleg 2005).

Separation refers to the development of women’s personal limits (boundaries), the differentiation between self and other. Personal boundaries, as known through individuation, are needed for healthy interaction with self and others (Marcia et al 1993; Simpson & Carroll 2008). Optimal separation in childhood occurs as a gentle process of individuation with the development of core self, a sense of identity and individual cognitive affective integrations (Wiley & Beerman 2012). Adult women with AUDs found that self-differentiation and boundaries can be learned in a ‘safe haven’ in recovery care using individualised rapprochement support (Mahler 1971; Dobbs 2006).

Rapprochement involves adult nurturing as part of treatment to assist clients to complete stalled child, adolescent and young adult development processes, particularly by stabilising their core self and sense of identity, with recognisable, acceptable and comfortable adult boundaries (Lyons-Ruth 1991). Such healthcare is needed by woman with AUDs who have not formed a secure sense of self and identity (Hankin, Kassel & Abela 2005). Women who have developed an in recovery identity are then able to use their interdependence and cooperative independence for healthy living in difficult circumstances (as discussed in the Recovery Continuum, Chapter 4).

Women’s recovery stability is learned through re-enforcing individuation, and through congruent actions of personal expression and social appropriateness (combining intradependence and interdependence). Effective recovery treatment
includes, women interacting in a planned way with the support of recovery networks, and they are enabled to gather personal growth experiences to form authentic in recovery identities. The processes that RWR participants experienced are summarised in Table 2.1. The RWR study provided ways to assist practitioners, the women and their supporters to strengthen both their recovery and cooperative understanding.

New tools to continue to explore recovery itself (e.g. verbal or written elaboration of images and sensations, different forms of reasoning, reflection on attitudes shifting and insights) make clearer the richness of a maturing in recovery identity that buffers relapse vulnerabilities (Bouchard et al 2008).

5. Theories and models suitable for midlife women's healthcare

The number of theories and models for AUDs and addiction is daunting and my approach was to question and remain open-minded throughout the study. A summary paper on comparing theories is provided in Appendix 2.4. My questioning of existing theories began with the contested validity of the Trans Theoretical Model (TTM; Prochaska & DiClemente 1986, 1992), sometimes called Stages of Change (Adams & White 2005), which is one of the most influential conceptual models that still "guides in a mythical, folk story, anecdotal way current alcoholism treatment development" (Sutton 2001). And while studies of the use of behavioural treatments for AUD are a high priority for researchers there is still limited understanding regarding how and why such treatments work and even fewer studies on how and why recovery happens and is sustained (Longabaugh 2007; Longabaugh & Morgenstern 1999; Morgenstern & Longabaugh 2000; Longabaugh 2001).

Based on my transdisciplinary and social ecology perspective I tended towards a more ecological and discursive approach that provided ways to advance our understanding of women's alcohol dependence and, importantly, ways for sustaining their recovery (Venner 2006). Ideas of shared change and developing volition, meaningful change and transformation were central concepts and ways of living for the RWR participants (Forcehimes 2005). For me, a disease and treatment focus distorted the phenomenon, whereas a 'living life' approach could provide a better framework to further theoretical understanding (Bouchard et al 2008).
As the RWR study drew to a close, my theories of AUDs recovery joined the small handful that were presently available, e.g. Kearney’s (1998) truthful self-nurturing as a grounded formal theory of women’s addiction recovery. Further discussion of theorising recovery is provided in Chapter 6 (Praxis).

In regard to addiction, I was more in agreement with Kovac’s (2010) theory of a synergy of elements in a complex framework for an individual’s addiction. RWR data was somewhat aligned to the work on a unified framework for addiction focusing on an individual’s vulnerabilities in the decision process (Redish, Jensen & Johnson 2008). I identified similarities in participant’s experiences with the theories of Henderson (2010) a substantive theory of recovery from the effects of severe persistent mental illness, West (2006) a synthetic theory of addiction.

I reviewed 27 models of addiction with the data of the trial study (Appendix 2.5), Action Cycle 0, and prepared a working model of early recovery relevant for midlife women with AUDs. RWR participants during the Action Cycles were asked for feedback on Stephanie Brown’s Developmental Model of Recovery that has evolved through her research focus on women (1982, 1985, 1994, 2002). Their responses are found in the results of RWR in Chapter 4.

*Participants overwhelmingly agreed that, for the active alcoholic, drinking must be labelled as the primary problem, and it must stop before therapy can proceed to other issues with any success. The common dynamic view that alcoholism is a symptom of a more primary problem (Bissell 1982) maintains this idea. (Brown 1985 p4)*

The two models that influenced my understanding of early recovery were the Relational Model of women’s psychological development and the Addicted-Self Model. The Relational Model indicated the growth towards human connection was an effective healing process for women with AUDs (Covington & Surrey in Wilsnack & Wilsnack 1997; Covington 2000, 2002). Changes in self-efficacy, negative drug use expectancies, and abstinence acceptance can assist alcohol abstinence in the Addicted-Self Model (Fiorentine & Hillhouse 2004).
Figure 2.2: Midlife women with alcohol use disorders in early recovery

The distress, stigma and disorder the women experienced after withdrawal was the starting point for their recovery care.

**Key:** The *three spheres* represent the midlife women’s personal background, living environment, and social situation as women enter recovery. The women were also being influenced by external factors (the communities they lived in, the health and welfare system they were being treated by, and their own recovery thoughts and feelings about abstinence; particularly their deep (not necessarily shared with themselves or others) internal assumptions and beliefs. The *overlapping of the spheres* acknowledges the negative experiences of disconnection in their lives. The disconnections that AUDs and past circumstances developed were the central focus for women’s early AUDs healthcare. The *rectangles* of Safety and purposeful peace, Mutual support and Wellbeing are possible outcomes in abstinent recovery. Practitioners and supporters can emphasise recovery works with healthcare that nurtures (the *triangles* are examples of care processes).
The women in long-term recovery and senior practitioners agreed that alcohol dependence behaviour is more likely to cease when the addict attributes the loss of control to personal reasons for alcohol use and is willing to discover a stable self and embrace the need for life-long abstinence. However, assisting midlife women with AUDs in Australia to do this was a major challenge\textsuperscript{51}. One starting point was studying the USA rehabilitation treatment offered to midlife women entering the Betty Ford Clinic (Waite-O’Brien in Straussner & Brown 2002). In Australia, research identifying the need for women’s AUDs healthcare conducted between 1990 and 2005 had not addressed midlife women, and evidence-based women’s AUDs recovery programs had not been implemented in the Australian health system (see pp 9 & 41).

The triangles represent the trial results. Practitioners can focus on three processes to encourage women to change and establish in recovery living. Engaging effectively with women with trauma backgrounds and co-occurring mental disorders requires easy access to a safe and suitable place for healthcare (a barrier for practitioners in current hospital settings). Having access to a safe place (shelter) brings their circumstances and disorders into a suitable environment for protected abstinence. Embodying change at a fundamental level of being, requires time (more than is offered in current treatment) to understand and to develop a sense of self. Enriching relief, happiness and usefulness is achievable in abstinence when the recovery care, development and support are carefully enabled (again, often not easily done within current care and treatment frameworks).

From the trial study, it was evident that midlife women’s recovery involved a process of women becoming more aware of the various parts of their ‘self’ (reconnecting with self; Kartalove-O’Doherty 2010), and considering what was beneficial and destructive to them, and therefore what needed to change for them to become well\textsuperscript{52}.

\textsuperscript{51} I found that creating models and using other media, visuals and audio (e.g. ‘participant’s talking’ data) was of help when considering how elements of recovery may integrate and what activity might enable gentle recovery.

\textsuperscript{52} The practitioner response ‘come back when you’re motivated’ is no longer an acceptable therapeutic response (Sellman 2009). Recovery is the goal and AUDs is currently more likely to result in death than wellness for midlife women.
6. **Health systems for recovery**

In the Progress Report 2006-07 of the Council Of Australian Governments (COAG) National Action Plan on Mental Health – 2006-2011 alcohol was a major cause of death, injury and illness in Australia. The prevalence of alcohol use in drug use figures for 2004 was 90.7 percent. Smoking was the next drug used at 47.1 percent. Tobacco addiction is treated separately to other addictions in the Australian health system.

The Australian Alcohol and Other Drugs sector (AODs), also known as the Drug and Alcohol field (D & A), operates within a harm minimisation/reduction policy framework. However, alcohol dependence care is more commonly practiced within an acute care model (biomedical) or a psychosocial model (Shiloh et al 2007). Practitioners (RWR participants) with 20 to 30 years of experience in the Australian AOD sector often experienced women coming in for short-term stays with (predictably) only short-term benefits, characterised by repeated hospital attendance, not recovery. Providing such acute care for this type of chronic illness does not help people to develop the sense of self, effective personal care practices and relationships with peers needed to establish new ways of healthy living.

In 2010 the National Human and Medical Research Council (of Australia) reduced the quantity of alcohol nominated to damage people’s health from four standard drinks to two standard drinks in one session. The reduction in the number of standard drinks causing harm also contributed to eliminating false ideas about the quantity-frequency of alcohol consumed needing to be high or severe before AUD care was implemented.

Midlife women with AUDs need advocacy for action to meet their growing needs as the Australian ‘alcohol problem’ is being identified in more government documents and the Australian media (ADCA 2005; ALSWH 2005; Begg et al 2006; Australian alcohol guidelines for low-risk drinking NHMRC 2007; Alcohol and work AIHW

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53 Harm reduction is an umbrella term for interventions aiming to reduce the problematic effects of behaviours (Marlatt, 1998; Logan & Marlatt 2010). Harm reduction also applies to any decisions that have negative consequences associated with them. For example, at one end of the spectrum, harm reduction may seek to reduce the risk of HIV transmission by supporting needle exchange programs.
Harm minimisation and harm reduction difficulties

In Australia the contemporary response to alcohol and other drug problems has been based on harm minimisation – incorporating supply reduction, demand reduction and harm reduction (Loxley 2005). Harm reduction refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop (IHRA 2009). The focus is on people who continue to use drugs not those who want to try to stop alcohol use. At the same time supply reduction (including legislation around policing to control manufacture and sale of substances) is attempted through increasing the price of alcohol and reducing the number of licensed outlets that sell alcohol. Supply reduction uses the principle of: the prevention of crime and disorder; the promotion of public safety; the prevention of public nuisance; the promotion of public health; and the protection of children from harm (O’Donnell 2006). Harm reduction in this context aims to reduce harm to individuals, particularly people with low consumption or non-drinkers.

More than 84 per cent of the Australian population over 14 years (the legal age for purchase and consumption of alcohol is 18 years) drink alcohol and almost 75 per cent of adults in Australia having been adversely affected by someone else’s drinking (AIHW 2007; Chikritzhs et al 2010). Demand reduction is a process that incorporates health promotion messages and education, e.g. preventive medicine, advice by GPs or school curriculum material (e.g. the moderation when drinking message) has limited success. Interventions to reduce the quantity of alcohol consumed per occasion by specific groups of Australians remains highly unlikely. The ‘best-fit’ solution is aiming for a significant drop in total population consumption and more early healthcare interventions (Stockwell 2006).

The burden of harm associated with the alcohol use of Australian workers is not restricted to those traditionally defined as ‘heavy’ or ‘problem’ drinkers. It has been estimated that in 2001, nearly 2,700,000 work days were lost due to workers’ alcohol use, at a cost of $437m (Pidd et al 2006a, 2006b). Workers who drank at ‘risky’ and ‘high risk’ levels\(^{54}\) occasionally accounted for more than half this alcohol-related absenteeism (Pidd et al 2006a, 2006b; Roche et al 2008). In 2013 the cost of alcohol-related loss of productivity in Australia is $14 billion dollars (Smith et al 2013).

\(^{54}\) Targeting people with background and behaviour likely to be at risk of AUDs would need societal acceptance of a disorder needing for healthcare with non-judgement, non-discriminatory consequences for people who meet the criteria through medical screening (see detail in Chapter 5). Straightforward, accessible guidelines and a compassionate approach will need to be prominent as ‘hiding’ alcohol consumption already occurs. Very few people want to be alcoholics.
The new DSM5 was released for discussion in 2010; it nominated a single-factor continuum approach for AUD diagnosis, which meant more people in Australia who would require treatment for a diagnosed disorder (Newton et al 2011). Work was completed on whether dimensionality, as well as the one factor continuum, increased understanding of factors for lifetime AUD (McBride et al 2011); the result was that a continuum was judged to be adequate. My RWR studies support their conclusions that AUD is a lifetime disorder, and that the application of ongoing healthcare management is required for this chronic condition. The RWR results also support a single factor continuum rather than severity categories for evaluating alcohol abuse, alcohol dependence and addiction.

Severity categories have been obstacles to acceptance by practitioner and clients of the disorder and of the need for early treatment to limit AUDs harm, comorbid disorders and associated chronic illness (detail in Chapters 4 and 5).

Throughout the Action Cycles I collected information that supported recovery care and also harm minimisation strategies. The practitioners and women in recovery participants who had experience of both types of healthcare provided many examples. My research study has helped to reveal the effective ways women prefer to establish and maintain midlife abstinent recovery. To lower high-risk drinking and associated AUDs for women from the ages of 35 to 59 years (Baby Boomers and Generation X) in Australia, action through a targeted recovery healthcare policy in the AODs field is justified and necessary. It is difficult to achieve harm minimisation as a goal in a culture of intoxication with evidence of determined drunkenness amongst young people, adults, midlife and older people (Measham 2006). In a society that is well aware of an alcohol problem, the idea of harm minimisation, which rests on the practice of supported self-regulation, may help some, but it is far less effective with women with AUDs. Participant practitioners and women in recovery emphasised that for midlife clients, abstinence and recovery was the desirable goal.

**New recovery**

At the same time as questioning the approach of alcohol harm minimisation, and the emphasis on public health risk and cost burden, a debate on ‘new recovery’ philosophies has emerged in Australia. Discussion topics include the value of the
The participants in RWR, women in recovery, practitioners and supporters, were ambivalent about whether the recent adoption of recovery rhetoric into clinical practice in Australia reflects a genuine shift in values and action (Best & Haber 2012; Anex 2011; Best et al 2010). In Australia, many clinicians are sceptical about the value of a recovery approach (Davidson et al 2006; Weatherburn 2010). The long-term development of effective recovery services will be more likely through a combination of good will for prevention and early AUDs screening (Solberg, Maciosek & Edwards 2008), advocacy for person-centred care (McIntosh 2005), implementation of relevant recovery research findings (McNaught et al 2007; White 2009; Laudet 2012), the cost of acute care and work days lost (Collins & Lapsley 2008) and, most importantly, a client’s expressed recovery needs in the face of practitioner resistance and scholarly and advocacy efforts to maintain the policy and current strategies as status quo (UK Government 2008; Masterson & Owen 2008; Greener et al 2007; Scottish Recovery Network 2006).

Health service providers

Within the Australian health, medical and allied healthcare system there are public hospitals, private hospitals and clinics, and four service provider groups for AUDs treatment; the Alcohol and other Drug field\(^ {55}\), Mental Health services, registered Non Government Organisations providing drug and alcohol services and Other groups. The issues in this arrangement include; problems with workforce capacity, independence, governance and funding. Factors contributing to these issues relate to the competitive tendering funding model, for example: accountability requirements and tied funding (Spooner & Dadich 2010).

Amongst the different providers there is limited collaboration, as an example, the Fourth Mental Health Plan 2009-2014 calls for the National Mental Health Services

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\(^{55}\) The Australian Alcohol and Other Drugs sector (AODs) and the Drug and Alcohol field (D & A) identify which part of the health system provides the service. This may be useful for health administration, but is a major barrier for clients in need of help.
Standards (2010) to be incorporated into the delivery of services such as indigenous health services, alcohol tobacco and other drug services (ATODS; the mental health term) and aged care services, where they are responsible for the delivery of mental healthcare within the service. For stand-alone Alcohol and Other Drugs Treatment Services (AODTS; a term used in the Drug and Alcohol field and by the Australian Institute of Health and Welfare) the Mental Health services should be able to demonstrate that they are developing or have collaborative /partnership arrangements in place to ensure integration and coordination of care for consumers with Substance Use Disorders including alcohol dependence.

The RWR women and practitioners provided detail of many people who had stopped seeking help because the providers’ maze was yet another great burden. Lack of easy access to comprehensive services, formal follow-up of individual needs and acknowledgement of midlife women was daunting and contributed to negative health outcomes and welfare problems (Durazzo et al 2008). Dropping out of primary and community healthcare often led to relapse, increased mental disorder, physical injury, illness and repeated hospitalisation (Graham 2008). Improved promotion and availability of midlife abstinence-based services for alcohol dependence (Dawson, Goldstein & Grant 2007) and adult mental health development needs was necessary to provide care to support and strengthen the women’s complex recovery processes (Sun 2007; Johns et al 2009). To maintain sobriety in Australia, integrated comorbid healthcare (e.g. sequential combined treatment; Neto et al 2008; Mills et al 2009) is necessary to limit and manage chronic illness and save lives (Saarni et al 2008).

Women did better while under treatment and achieved a better long-term drinking outcome. (Bravo et al 2012 p1)

Currently this is not being achieved, nor is it a goal for the Australian health system or community.

56 The range of qualified personnel, without explanation of the different healthcare they provided, added to the difficulty for women to find suitable alcohol addiction care. The women are currently faced with a choice of; specialist medical practitioners, psychiatrists qualified in addiction medicine, psychologists, drug and alcohol nurses, counsellors, social workers, and drug and alcohol workers.
**Abstinence and therapies**

In Australia there are various combinations of healing, cure and recovery philosophies, politicoeconomic debates and AUDs therapeutic processes. The positive and negative dimensions are discussed in Chapters 4 and 5; particularly in relation to recovery as an ethical ideal (Kleinig 2008), and to combining abstinence and harm reduction/minimisation (Kellogg 2003; Sword et al 2009) and harm minimisation as a political necessity (ANEX 2012; AER 2010). There is further evidence (the RWR results, Chapter 4) that supports having an Australian AODs strategy that names recovery care as a valid harm minimisation program, as it is in mental healthcare.

The Australian National Drug Strategy does not provide information on abstinence as an achievable goal and on recovery as a treatment approach. The consultancy Siggins Miller evaluated the outcomes of the 2004-2009 Australian National Drug Strategy and recommended 14 changes. They noted that the harm minimisation term raises doubt and lack of confidence in healthcare workers assisting people with addictions.

Based on the results of the trial study, I decided to focus on women who were abstinent (the women in recovery also used the terms ‘sober’, or ‘not drinking alcohol at all’) in the PhD research. I was also influenced by the emerging idea that abstinence may be needed for women as they get older to maintain recovery over the life-course (Greenfield 2007, 2008). Wilkinson (2000, 2003, 2005) supported engaging with a women’s ways of managing long-term or life threatening illnesses. Women in recovery participating in Action Cycles 0 and 1 emphasised from their understanding and experience that abstinence helped them to prevent relapse. Many of the participants described the ‘catastrophes’ that occurred when they tried to drink ‘like normal people’ (Witkiewitz & Marlatt 2007). This information supports Allen Dean’s (1997) work on chaos and intoxication.

> **Sobriety ... is considered to be primary and necessary for a recovery lifestyle.** (Belleau et al 2007 p222)

The options for harm minimisation and moderate drinking as a treatment goal was unlikely to bring satisfaction and is less stable over time than abstinence (Ilgen,
Wilbourne, Moos & Moos 2008). An accurate understanding of the long-term course of alcohol use and problems could help shape expectations about the realistic probability of positive outcomes for individuals who are abstinent. Decreased impulsivity appears to mediate reductions in alcohol-related problems in abstinent people attending Alcoholics Anonymous. Also, there are better psychosocial outcomes; greater social support, better coping and self-efficacy as outcomes (Blonigen 2010).

The gap in understanding that midlife women need recovery care slows adoption of ways to assist midlife women, e.g. using lifespan developmental conceptualisations and a life-course perspective to prepare for likely turning point events that can be impact women’s abstinence (Hser, Longshore & Anglin 2007). It is also not an easy task to support and act upon client needs if work practices and research do not include knowledge translated so that practitioners in addiction and AODs specialities are supported with contemporary practices (Schulenberg & Maggs 2008). Maintaining recovery may be a lifelong process (e.g. maintaining certain practices), to sustain wellbeing in recovery. More women in the USA and UK, aware of all healthcare options, choose total abstinence as their goal (Burman 1997; Maisto, Longabaugh & Beattie 2002; Laudet & Storey 2006; Laudet 2007).

During RWR there appeared to be an Australian healthcare practitioner change of awareness after 2009, illustrated by an increase in GP referrals for specialist care, requesting healthcare for ‘abstention from alcohol’. However, the range of treatments for abstinence and recovery is limited in Australia. In the early Action Cycles of the research I based my selection of useful healthcare interventions on their ability to firstly enable effective delivery of support by practitioners for the women’s processes of abstinence, including encouragement for action to be in recovery. Secondly the interventions enable the women to reclaim their mental health (Corey & Keyes 2002), rather than remain a patients being treated for psychopathologies. Thirdly, the following program and therapies, integrate healthcare, counselling and mutual self-help to assist women to progress over their lifespan in fulfilling recovery. Finally that the therapy has been and is currently studied using evidence-based research:

1. AA program (Laudet & Stannick 2010; Straussner & Byrne 2009; Sanders 2006; Vaillant 2005)
2. Acceptance and Commitment Therapy (Hayes 2006)

3. Schema Therapy (Young, Klosko & Weishaar 2003; Corte & Farchaus Stein 2007)

4. Dialectical Behaviour Therapy (Dimeff & Linehan 2008)

5. Methods of Levels (Carey 2008, 2009)

6. Psychoanalysis Metacognitive Therapy – Autonomy, Beneficence, Quality of Life (Koenig & Crisp 2008).

The women participants emphasised that recovery development also involved therapeutic risk-taking (Luthar & Brown 2007); so detailed discussion with the women about options is essential in the provision of respectful healthcare. Integrated services with a team of practitioners from needed specialties are an ideal at the close of the study57 (Baker Kavanagh Kay-Lambkin 2009). Research continues for recovery treatment that focuses upon: patterns [early diagnosis]; relationships with other women; trauma; intimate relationships; anger; body image; sanctuary; spirituality and strength; self-discovery and self-acceptance (Betty Ford Consensus Panel 2012).

**Explorations during the final evaluation processes of RWR**

By the close of the study, particular key influences were assessed as providing inspiring answers to the research questions. The assessment was based on the transparent and collaborative practice which continued throughout the study, of analysing the literature collected with the RWR data, and listening to the participant’s viewpoints (Wilson & McCormack 2006). By combining these factors this evaluation of RWR processes was appraised through improved understanding of: ‘how women stop drinking, become abstinent, establish and maintain recovery’, and live their changing lives in wellness with AUDs?

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57 The 109 treatments based upon research, the 12 therapies, and 38 services studied in RWR are included in the bibliography.
A major evaluation process throughout the study was working with multiple terms, definitions and perspectives; known as terminological ambiguity (Klein 2006). My way of assisting participants and my understanding was to make sure the disciplines the terms were selected from (and therefore those related paradigm, worldview or perspectives) were initially named, e.g. public health social ecology (Earls & Carlson 2001) substance use social ecology (Bell, Carlson & Richard 1998), social ecology of treatment (Stjorbork 2006) and progressive change, collaborative learning, redesign for sustainability through social ecology (Hill 2006, 2011).

The term ‘adequate evidence’ is difficult to define. I followed the approach that my inquiry strategy (which was based on a Transactive Participatory Research Process) was capable of producing meaningful and reliable answers to my research questions. The transparent and declared collection and analysis of data provided good reasons (‘adequate evidence’) for accepting the explanations presented as RWR results (Miller & Fredericks 2003; Boyatis 1998; Lipton 1993). The completion of the RWR Research Design, including the Meta-Study (Chapters 4 and 5) in 2012, supports the legitimacy of the findings and conclusions made in RWR (Lincoln & Guba 1985). Other researchers’ work was carefully studied to find the most suitable care for midlife women (Appendix 2.6).

Providing evidence-based and praxis-oriented outcomes through RWR was my personal research focus. My prolonged engagement with participants (seven years) and persistent observation of the phenomenon in the community (n = 110) contributed to the trustworthiness of the RWR conclusions (Polit & Beck 2012). I addressed the difficulties encountered during each Action Cycle, the Meta-study, and the knowledge translation and praxis procedures by continued reading about research designs and methodologies used to provide robust findings (Hesse-Biber 2010, 2012; Crilly, Jashapara & Ferlie 2010).

pen1, Action Cycle 2, Women ‘s interviews: I have learnt in the last four years of recovery is that my default system is to just misbehave and blame somebody. But slowly that default is becoming a more mature response. I need the time to think. I need that clear thinking time if I’m under pressure. I need that structure.

Jaf6, Action Cycle 3, Women responding to practitioners’ results summary: Learning and growing into a mature woman that I can love.

CBS6, Action Cycle 4, New women’s interview: I feel a bit more mature these days. I front up. I have responsibilities that I’m grateful to have.
CHAPTER 3: RESEARCH DESIGN

Introduction: Transactive participation

To improve understanding of substance use disorders, progressive researchers have emphasised the need for innovative thinking and creative research designs (Orford et al 2006; Venner et al 2006; Heubner & Tonigan 2007; Grant 2008; White 2008; Laudet 2008; Dawson 2009). The strategy (and philosophy) for my study ‘Researching with Women in Recovery’ (RWR) is based upon ‘transactive participation’ (this includes and integrates action, enaction and interaction). To best achieve my goals, I selected and integrated a combination of inquiry strategies; particularly Participatory Action Research, Action Science and unobtrusive observation.

The RWR study was developed through the participants’ expressions of recovery and exchanges of their (Appendix 3.1). The inquiry remained coherent through the researcher’s iterative analysis, reflective reporting and ongoing re-evaluation of the methodology; this was based on participant responses and the objective of gathering relevant and rich detail for achieving clarity of understanding.

The topics of discussion in this chapter (listed below) are the features of the RWR research design, why they were created and how they were applied.

1. Researching with Women in Recovery (RWR): designing a study to answer the research question (RWR Transdisciplinary Researching of AUDs, Recovery and Wellbeing figure)

   a) Developing ‘How to Begin and Continue in Recovery?’ as cooperative research for exploration and explication (RWR Recovery Phenomena Research Rainbow figure); and

   b) Designing a flexible and robust ‘transactive and participatory’ research process with the focus on Researching with Women in Recovery (RWR

58 Substance use disorders include alcohol use disorders (AUDs).
TPRP, RWR Women in Early Recovery, and Practitioners providing AUDs Recovery Healthcare figures).

2. RWR Transactive Participation Research Process and RWR Transactive Knowledge Production Framework (detail in Chapters 3 and 4; RWR TPRP, RWR Transactive Knowledge Production Framework, RWR Spiral Tri-Thread and RWR Dynamic Lines of Inquiry);

3. RWR Transactive Meaning through Methods: people-oriented data collection and analysis, with praxis-oriented objectives (detail in Chapters 3 and 4);

4. RWR Transactive Methodology (detail in Chapter 4; RWR Transactive Methodology Diamonds and Pearls figure);

5. RWR Transactive Knowledge Creation Paradigm: praxis, theory-building, knowledge translation (RWR Double Helix figure; details in Chapters 5 and 6);

6. RWR Transactive Meta-Levels: aiming for participatory meaning-making to contribute to positive change for women’s health and wellbeing (detail in Chapters 4 and 5), the community and the practice of transactive participatory inquiry:
   a) Improved AUDs recovery action in daily life and clinical practice;
   b) Education for help-seeking and intergenerational prevention; and
   c) Knowledge translation and theory-building.

7. The background of the RWR approach: the trial study (Cycle 0), ontology, epistemology and methodology combined as declaring values of the research, acknowledging different ways of knowing, and the ‘do no harm’ care in action of the RWR strategy.

**Researching with Women in Recovery**

The research question was developed after conducting an action research trial study with women in early recovery. The question for the major study began as, ‘How do women in midlife with AUDs most effectively establish abstinent recovery and sustain wellbeing’? The major study’s focus was researching with women (35 years to 59 years) living through the experiences of ‘women in recovery’, and exploring
and explicating with them to improve health and community care for sustaining recovery.

My transactive participation approach is an extension of the more familiar action and participatory action research (PAR; Heron & Reason 1997; Reason & Torbert 2001; Kemmis & McTaggart 2006; Reason & Bradbury 2008) and action science (Argyris & Schon 1974; Argyris, Putnam & Smith 1985; Torbert 1991; Putnam 1999; Toumlin & Gustaven 2001; Argyris 2003; Seo 2003 and Arcidiacono 2009). My emphasis was making transparent the meaning-making processes in my research, and acknowledging the value of exchange and of the sharing of information with interested people (including, particularly, the vulnerable women living the experience).

The transactive nature of the research participation was based on my idea of an important process that appeared to occur for women in early recovery; this had emerged during the trial study, and I further developed it in preparation for the major study. ‘Transactions’ refers to the actions of the women, practitioners and supporters; the women were making choices on how to act (with support) as women with AUDs who were becoming well and were preparing, developing and making commitments to abstinence and a life in recovery. Through the RWR research, design gaps in understanding of such important transactions could be identified and bridged with new knowledge to improve women’s AUDs recovery care, policy development and community awareness of recovery. The process could be applied to sustaining women’s wellbeing in recovery and sharing new understandings for improved complex care in clinical and community practice, academic and professional education, and to contribute to associated scholarly fields.

Throughout the formal history of action research59, the approach has acknowledged the complexity of human phenomena; it is a dynamic field that has had an evolving view of partnership and participation (Action Research Manifesto 2010).

59 The term action research has been attributed to Kurt Lewin (in 1944; Peters & Robinson 1984) and Lewin’s model for collaborative action research (1946, 1947 in Trickett & Espino 2004).
Figure 3.1: Researching women’s recovery: A phenomenon with a rainbow of research possibilities (developed from R Waur 1986)

Key: This participatory action research study (RWR) began with enthusiasm and openness. The initial plan illustrated in this figure was constructed by observing and listening to women with AUDs, academics and clinicians and exploring current studies. The goal started and remained to share knowledge with participants and contribute to current research to improve AUDs healthcare for midlife women seeking self, recovery and wellbeing.
Many viable transdisciplinary studies with praxis outcomes to meet life issues and to improve people’s daily-life needs had their beginnings in the Tavistock Institute of Human Relations in London in the late 1940s (Argyris 1997). Both transdisciplinarity (Abrams 2006; Christens & Perkins 2008) and praxis (Wickson, Carew & Russell 2006, also praxis of participation; Bradbury Huang 2010) were incorporated in my RWR study.

**Transdisciplinary studies with praxis outcomes**

As a design feature of RWR, transdisciplinarity was incorporated at the preparation stage of the major study as being essential to my search for improved ways to resolve women’s health and wellness disparities (Abrams 2006). I worked with a range of transdisciplinary concepts that emphasised: building a network of understanding for AUDs recovery and prevention (Valente, Gallaher & Moutappa 2004); collaborative content and methodology (Christens & Perkins 2008); and that were supportive of my commitment to find ways to enable recovery through transformative change (Miller 2010). The RWR design also included plans for synthesis in data analysis (Voils et al 2008), and for obtaining expert feedback on selected research outcomes (particularly those that spanned new fields and disciplines) to maintain rigour while using this transdisciplinary approach.

... conceptual and methodologically integrative collaboration across multiple disciplines. (Christens & Perkins 2006 p1)

In particular, transdisciplinarity in RWR design drew upon complex thought (Morin 2008) and the processes (Montuori 2005) of:

1. being inquiry-driven rather than exclusively discipline-driven;
2. being meta-paradigmatic rather than exclusively intraparadigmatic;
3. being informed by a kind of thinking that is creative, contextualised and connective; and
4. regarding inquiry as a creative process that combines rigour and imagination.
Figure 3.2: Transdisciplinary researching of AUDs recovery and wellbeing

Being guided by the processes involved in selecting transactive and participative ways of ‘answering the research question’, I was also able to build into the design of the research, features to improve the praxis of authentic participation (Rahman 2008 in Reason & Bradbury 2008). The design purposefully met the research participants’ need for credible information to be shared, as well as their need for an enriching participatory experience (Heron 1992; Cargo & Mercer 2008). These features included embedding in the research theoretical understanding of transformative (Mezirow 2003; Hill 2007) and intentional change (Boyatsis & McKee 2005) through dialogue (Lewis 2002) and negotiation (Ambery 2003).
Vixl, Action Cycle 2, Women’s interview: *I don’t think I am deluding myself but I believe I am leading a very meaningful life today. I am a functional committed member of the community. I guess my key purposes in my life would be, first, to maintain my sobriety. Because, otherwise I lose everything else. If I don’t maintain sobriety then I would forfeit most of the other stuff that’s good in my life. My second most important life purpose is living my life in a way that doesn’t harm or cause conflict for others. To be contributing would be my other purpose.*

The process of grounding these theoretical concepts of change in the research is evident in the language strategy that was used (Glenberg et al 2005): the women’s expression of being ‘in recovery’ and their descriptions of the features involved were exchanged amongst participants, including practitioners, and an agreed understanding was developed of the chosen living processes involved in being well ‘in recovery’.

**Developing ‘How to begin and continue in recovery’ as cooperative research**

The trial study applied action research (particularly cooperative inquiry; Heron 1992, 1996, 2001) using creative expression of early recovery to explore a range of women’s AUDs recovery experiences (Withnall, Hill & Bourgeois 2008). For example, women exchanging artwork enabled them to share their ‘problems’ (Runco 2004), as their ‘abstinent self’ emerged during their early treatment period of abstinence. The women developed an improved capacity for safe talk and trust, and this made possible conversations during which they were able to explore their emotions, and receive and seek nurturing care. The process of women’s early recovery involved an important transition; this included their increased awareness of being in the liminal spaces between sickness and health (Scott et al 2005), and in transliminality, between conscious and unconscious states (Fleck et al 2008). As a result of the women being able to engage in the multimodal communication (Plucker, Beghetto & Dow 2004) involved in expressing and listening to the viewpoints and experiences of peers and practitioners, a grounding experience of safety and abstinence began to develop. The trial study provided information on suitable research processes for women in recovery with AUDs, and it revealed what the women and practitioners most wanted to explore.
My approach in the trial, which continued throughout the major study, emphasised doing research ‘with’ the women rather than ‘on or to’ them. In particular, this involved investigating, with the women, the roles of the various contributing contexts (personal, social and environmental living spaces, resources and time availability) in their recovery process. Enabling women to express and exchange viewpoints amongst participants (women, practitioners and researcher) also encouraged sharing, critical thinking (Brookfield 1987; Boud & Walker 1998), and the questioning of the information available to them in their everyday lives. To enable me to analyse and consider new knowledge in a reciprocating manner I, as researcher, purposefully drew meaning from the experiential action of all involved in the context of our daily living experiences (enactment). New knowledge was synthesised through analysis, and this was used to improve the research process; this offered the potential of ongoing refinement (being critical and transformative; Mezirow & Dirx 2006), partly through the cooperative research process, and through the formulation of knowledge applications, including the development of recommendations to improve women’s healthcare.

The generative and inclusive data gathering process that followed the trial study, continued in each Action Cycle of the study and the type of data broadened as illustrated in the Recovery Phenomena Research Rainbow (Figure 3.1). The emphasis in my recovery research (both trial and major study) was organic and generative rather than mechanistic and formist (Parker 2001). Individuals’ experiences of living were accepted not as parts of a clockwork structure, but as a network of relations of interrelated subjective, biological, environmental processes, and social and cultural events (Birch 1990).

The literature gathering was also pragmatic (Morgan 2007 in Tashakkori & Creswell 2007), as the exploration considered women’s ways (Mendlinger & Cwikel 2008) within a planned preparation stage. This involved following a spiral of ‘abductive’ reasoning (re ‘what might be’; Dunne & Martin 2006) that moved between deduction and induction (Adler 2008); this was based upon an exchange of responses amongst trial participants, and the iterative and recursive design process of cooperative action research. This exploring and reasoning process continued throughout the research, particularly when difficult ideas and situations were encountered.
Combining transactive and participatory elements

The study as a process acknowledged and used living system dynamics (enactivism; Varella 1984; Varella, Thompson & Rosch 1991; Torrance 2006), and it supported the ethical making of meaning (Rothfork 1995; Geppert & Bogenschutz 2009). Transactive actions60 using transdisciplinary thinking (particularly transdisciplinary thinking in healthcare; Albrecht, Freeman & Higginbotham 1998) provided the researcher with an understanding of health and wellbeing that takes into account complexity, non-linear relationships, interactive causality and the emergent properties of complex systems. Emergence and complexity (Prigogine & Stengers 1984; Kauffman 1995) were critical concepts for engaging in RWR, as they are an important dimension of human participation, connection and belonging. Emergence of order as a change process is a valued concept in understanding the process of recovery; this is sometimes chaotic, and involves self-organising and complex processes.

I enthusiastically prepared for working with a diversity of people (who met the sample criteria) in the research; as I was aware that diversity can enable the emergence of richer (more productive) patterns of being and doing. Facilitating co-evolving research required my immersion in ideas of exchange and adaption through transfer (Macauley & Cree 1999), transitions (van Loon & Kralik 2005; Degges-White & Meyers 2006; Giovanni 2008; Dawson et al 2009) and transformation (Taylor 1998; Merriam 2004; Cranton et al 2006; Erickson 2007; Hill 2007; Brock 2009); all acting in concert through the dynamics of the designed methodology. The dynamic participatory processes of RWR enabled me to facilitate the research process’ progression in four complementary ways, by:

1. Supporting the emergence of the participants’ ideas and explanations of women changing self and the changing of others;

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60 My idea of transaction as an important process for women entering and remaining in recovery was formed through the preparatory stage, and from my discussions with women in long-term recovery and with experienced professionals (with more than 25 years of AUDs care experience). A transaction was the starting point: ‘a declared choice women make and act upon (with support) when they are becoming well in early treatment’. It involves commitment to the personal choice frames relevant to the women’s individual integrated care, preparation for community support, and a recovery development process to stabilise the women’s abstinence and support the processes associated with beginning their life in recovery with peer support.
2. Exploring our experiential understanding of recovery, which included experiencing and learning (Kolb, Boyatzis & Mainmelis 1999; Webb 2003; Ballon, Moon & Fowler 2007; Silver & Fidler 2008), and experiential avoidance (Chapman, Gratz & Brown 2006);

3. Enacting adult learning and understanding (Fenwick 2006; Yolles 2008) to improve and continue the research process; and

4. Generating new knowledge (Lubert & Sternberg 1998; Amabile et al 2004; Jung et al 2010) about a critical phenomenon in varied forms; including policy papers, findings for professional development conference presentations, media articles and materials for educational use.

**Designing a robust and flexible Transactive Participation Research Process**

The RWR Transactive Participation Research Process (RWR TPRP), which was based upon the trial study and follow-up preparation for the major study, became the foundation for my methodology. Also understood was that in the process of working in participation with people’s transaction choices, ongoing adjustment of methodology had to be expected. My focus was exploring the lived experiences of women’s recovery, particularly through recording and analysing shared actions (interaction), discursive actions (enaction), and actions for change. Research participants volunteered to contribute, collaborate (Townsend 2003, 2007) and consider experiences and information on women’s recovery, and on sustaining wellbeing in recovery. Sharing and explaining change processes that supported improved recovery care and wellness for more women with AUDs, was openly acknowledged as the research goal. All agreed that the research objectives were:

1. Contributing to the knowledgebase for women’s recovery;

2. Advocating for participatory research-informed improvements to women’s AUDs care and recovery development; and

3. Enabling AUDs recovery management in using meaningful practices of complex ongoing care and support (Bourgeois & Johnson 2004).
The epistemology of ‘developmental constructivism’ was compatible with my methodology for ‘Researching with Women in Recovery’ and with my worldview. Developmental constructivism (Burrell 1987; Guidano 1987; Mahoney 1991; Lyddon 1993; Burrell & Jaffe 1999) assumes that people actively and proactively construct meaning and patterns of self-organisation (based on self-organising systems; Maturana Romesin 2002); and that throughout our lives we attempt to adapt to our construed existential circumstances and social contexts. Self-organisational patterns and constructive processes are viewed as primarily tacit (Polanyi 1966), in that they guide our choices and constructions of meaning without our being fully aware of, or able to articulate, their precise nature. A person’s active efforts to construct meaning can occur on multiple levels and at various scales: mini, micro, mezzo, and macro. This is in part due to people being premise-based, active, purposive, goal directed meaning-making organisms (radical humanism; Rychlak 1988; Johnson, Pfenninger & Wenzel 2005).

To enable planning, change and implementation of the research strategies, it was necessary for the design of my RWR TPRP to be both robust and flexible. My approach to robustness was informed by a critical, feminist health perspective (Lupton 1997, 1999; Ussher, Hunter & Cariss 2002; Ussher 2006; Cheek 2003; Cheek et al 2005). Beyond second- and third-wave feminism (Sullivan 2001), I also took into account power in all aspects of my research; highlighting paradoxes that indicate the potential for broader and new perspectives (my optimistic view) for feminist-oriented research in mental health: power such as ‘strength in vulnerability’ (Jordan 2010); results from therapies focusing upon empowerment of women with chronic physical illness (Vail & Xenakis 2007); studies of power and status revealing ways to reconsider theories of emotions (Kemper 2006); Braidotti’s concept (2006) of transposition as a way for women to move into ways of living they appreciate; and combinations of empowerment, individualism, and comfort with one’s own femininity (Liss & Erchull 2010).

**Field work in natural settings assisting robust and flexible research**

The environment offered glimpses of the participant’s backgrounds, and of the relevance of their personal contexts (Moos 2003; Shinn & Toohey 2003), in their processes of recovery; particularly through their ‘sharing’ during the sessions. Field work observations, such as ‘public recovery meetings and events’ (e.g. NEWYPAA [a
two-day conference for newcomers and young people in Alcoholics Anonymous) social systems and cultural influences) enabled me to identify possible recovery factors (Brewer 2006) that I could then use to better understand participants’ responses and develop concepts and constructs.

Observing recovery in the community, and gathering literature to study and improve my knowledge base on the topics assisted in refining methodological possibilities, and provided me with means to identify and progress the changing transaction and participation processes. My contributions as the facilitator of the process were purposefully aimed at enabling both the participants and myself to remain open to ‘other ways of knowing’ about recovery, life and the contemporary world, of which we are part, and to which we are connected and belong. The ideas that emerged for the participants (and for me) were affected by the nature of everyday life events and by the changes that were occurring; so, these were regarded as providing useful ongoing contributions to the study. From working through the trial study, I became aware of the slow movement, resistance, retreat and occasional sudden progress that was evident in the women’s healing processes. Thus, flexibility was required to accommodate individual differences.

Seeking to identify the catalysts of recovery required identifying the levels, shifting layers and interconnections involved in recovery, and also the factors influencing regression, stability, and both subtle and dramatic improvement. This also involved paying attention to the roles of: comorbidity (Graham et al 2008), brain mediators and moderators (Buhringer et al 2008), therapy (Higgenson & Mansel 2008), organisations (Chun, Guydish & Delucci 2009), environment (Myers 2009), self (Teeson 2010), gender (Tuchman 2010), and reprocessing (Marich 2010). I found that these factors could be best explored, described and explained by taking into account both individual and similar life circumstances, using a social ecology perspective (Hill 2002, 2010, 2011), which integrates the sociocultural, personal and spiritual dimensions, and environmental factors of living (Weisner 1986; Bell, Carlson & Richard 1998; Storbjork 2006).

All of these factors interact with each other over time, and help to shape the participant’s adaptation processes (Becker et al 2007) throughout their lives (ontogenic development; Kauffman 1995). Lifespan development (taking a life-cycle approach) recognises these connections and the complexity for women’s physical
and mental health (Romans & Seeman 2006). Theorising about human development (Burman 2007) in psychology, while witnessing the influences (affect and effect) of the various biological and ecological factors (intra, inter, trans; Piaget 1950, 1990, and epigenetic landscape; Waddington 1957, 1975), in the context of complexity, raised, for me, further empirical and philosophical arguments about the notions of humans’ ‘progress from’ and ‘progress towards’ better ways of being and doing. Although some sociologists are exploring and explaining how various social ties influence health behaviours (Umbertson, Crosnoe & Reczek 2010) at different life stages (noting early life-course experiences), and how these processes accumulate and reverberate (with continuity and change) throughout the life-course, the developing field of psychosocial welfare (Stenner & Taylor 2008) is providing an emerging transdisciplinary, more integrated, approach for the effective care of AODs.

**Participants**

Several categories of research participants were involved in the study. On completion, there were ten categories of participants. Four core categories were prominent throughout the study and are described below. Through later Action Cycles, the number and categories of participants expanded; this assisted the gathering of information on emerging issues during the six Action Cycles of research.

For Cycles 1, 2 and 3, I planned for four groups of people, who met the selection criteria, to participate. The groups were:

1. **Women** in recovery: Midlife women (35 years to 59 years of age) who volunteered to participate, lived in recovery in Australia, and were self-defined as ‘in recovery from alcohol dependence’. The women agreed to share their lived experiences: how they came to change drinking to non-drinking, choose recovery and heal and manage their illness, enact ways to live well, and embody wellbeing.

2. **Practitioners** caring for women in recovery: The practitioners who volunteered held Australian-recognised qualifications for providing care for
people with alcohol dependence. As they included psychologists, drug and alcohol workers, they offered a spectrum of care priorities and approaches.

3. **Experts** in the fields associated with Alcohol Use Disorders: Because RWR was a transdisciplinary study, it was important to access a broad range of knowledge bases – including the neurosciences – that might contribute to the women’s recovery. Consequently, I identified appropriate experts from the research literature and contacted them to discuss various topics, and exchange information on issues raised by the other research participants.

The RWR **Expert Panel** was established as a specific group through the UWS Human Ethics Research Committee. They were available for my supervisors and myself to contact about any issue emerging during the study. The Expert Panel received summaries of each Cycle’s results and conference posters, presentation handout materials, and the RWR newsletter to enable them to keep up to date with the study’s progress.

4. **Communities of Practice** (practitioners in related fields of work (e.g. drug and alcohol nurses), and **Practice (of recovery) in the Community** by people wanting self-help, mutual help and peer support.

A further six categories of participants were introduced over Cycles 4, 5 and 6: (i) Participant reference group; (ii) Senior women; (iii) Practitioners; (iv) Contributors; (v) Special cases; and (vi) Contacts. These are described in the Transactive Methodology explained in Chapter 4.

With advice from my supervisors and some of the experts (a practitioner from a not-for-profit organisation, a general practitioner, a researcher, an educator/academic, and a government department staff member), I took the approach that whoever responded to the call to participate was authentic. It was highly unlikely that women without an addiction would come forward to participate in RWR. The credibility of the volunteers was also validated through their:

1. Responses in the Informed Consent Forms, which included details of healthcare providers for women in recovery, qualifications of practitioners, and organisations providing care for women in recovery;
2. Selection of ways in which they would be willing to contribute. Participants nominated on their Informed Consent Form, in consultation with the Information Sheet, which method(s) of gathering information they wanted to engage with during the research. Cycle 1 provided three ways to contribute information: questionnaire (with a mixture of question types, i.e. select one of three answers or nominate topics you want to explore in the study); semi-structured interview; and free choice expression in response to the nominated topic; and

3. Willingness to participate in the telephone conversations that were held for clarification of the choices made by the women and practitioners, and the way they requested material be provided to them, i.e. in person, by mail, or by email.

Participants were required to be English speaking (not necessarily first language) and literate. The priority ‘units of study’ were phrases, terms and words that could maximise the ability to identify and elucidate answers for the ‘how to’ questions. Two women in recovery who had limited literacy (one who identified as suffering alcohol-related brain damage) contacted me and I recorded their Informed Consent and responses to interview questions. I followed up the research process by talking with them about preliminary results.

The above participant selection criteria and processes were partly justified by studying the research literature; however there is a paucity of relevant studies of adults, fewer focusing on women or identifying male and female cohorts, beyond one year in recovery (Chapter 4 and 5). There were no studies of midlife women with AUDs and their recovery care needs and issues beyond six months. Checking what was occurring in the related fields was necessary; and this made observation an important starting point. My observations during the 2006 and 2007 studies included Communities of Practice (e.g. Drug and Alcohol Nurses Association) events in the various states and regions of Australia (e.g. Drug and Alcohol Summer School [Queensland, Brisbane] and International Council on Women’s Health issues (ICOWHI) [New South Wales, Sydney], and Practice in the Community events [e.g. AA meetings in Victoria, Melbourne and NSW, Coffs Harbour, Broken Hill and Richmond]). My observations also indicated that considering ‘ordinary adults’
cognitive and conative skills is important when evaluating recovery situations (Polkinghorne 2004, 2006).

**Recruiting participants**

Strategies of recruitment (Primavera 2004) and maintaining involvement (entrée, engagement, negotiation, ongoing participation and closure) were demanding because of the number of cycles, length of process time (preparation, action, review and results), the diversity of participant groups and the individuals’ choices of data gathering methods. Collecting meaningful and ‘messy data’ was complicated by false starts, compromise, and adjustments to meet particular circumstances.

Four recruitment processes were applied: submitting requests for access through the health departments in Australia; research contact; media editorials; and snowball sampling (Mendlinger & Cwikel 2008). Recruitment continued throughout the six Action Cycles, attracting participants through public information media reports and as a result of my research profile on research portals. I also accessed likely participants by talking with women in the trial study, practitioners (Lovi & Barr 2009), women in recovery in AA meetings, and researchers in the HIV-AIDS field. The experiences and techniques of AIDS researchers studying with people with a stigma-laden disease was useful.

I was expecting a modest sample; this was because of the nature of the illness, and the stigma that surrounded being a (female) alcoholic in Australian society. However, at the time of the research (2006 to 2010) the presence of older women with AUDs was being noticed in some rehabilitation units in Australia. The lack of awareness of their needs and practitioners’ lack of adequate training in treatment for women with alcohol problems were beginning to be perceived. I particularly became aware of this through my discussions with researchers, practitioners and women with more than 25 years in recovery. The conversations about the proposed, and then progressing, study provided anecdotes that supported the need for improved knowledge concerning intervention and provision of care, as a trend of Baby Boomer women’s harmful consumption of alcohol was emerging. One practitioner in Sydney admitted: ‘I don’t know what to do with the older women’ (Withnall 2007 field note).
RWR women in recovery were volunteers with alcohol dependence and more than two years abstinent recovery, aged between 35 to 59 years of age. This age group met the midlife criteria and the cohort criteria of Baby Boomer and Generation X (Bowes Traynor 2007; Dodd, Saggers & Wildy 2009). A minimum of two years of abstinence was advised by local experts, and this was supported by my observations in treatment facilities and self-help groups, i.e. AA and Smart Recovery.

Practitioners were more difficult to attract. My discussions with practitioners revealed a shortage of experienced practitioners, large workloads, time-constraints and their self-perceived low status in the medical hierarchy. The lack of recognition of the need for research-generated clinical knowledge and professional development was often mentioned. Based on these experiences, I developed an approach to attract practitioners to become participants by using professional associations and proposing development activities. I validated their importance in the healthcare process, their experiences being worthy of study and that mutual sharing of current knowledge was embedded in the research process. Certified health and welfare workers with experience of care of women with AUDs were the first to volunteer. Participation of degree-qualified practitioners took more time; their volunteering increased as the preliminary results were distributed through professional groups, with the benefits of their involvement being explained (see below). Also, to aid participation, new methods to collect information from practitioners (e.g. reply emails) were introduced. Practitioners provided their qualifications and recent care roles with women with AUDs on the Informed Consent Form. Volunteers with qualifications who were working in recognised (accredited) care organisations (government, non-government, community and corporate enterprises) were also included. Practitioners’ contributions were anonymous and confidential, with arrangements for code-names; archive procedures and agreement for use of raw data were standard for all participants.

Representatives of women (e.g. of women in goal) were recorded as interested contacts/supporters; and they were sent research Update letters and RWR newsletters. Family and intimate partners of women in recovery (or in active alcoholism) were not recorded and not sent newsletters. However, interested family members and intimate partners, with their permission, were mailed an RWR Information Sheet listing legitimate healthcare internet sites, e.g. www.alcohol.gov.au, Australian Institute of Health and Welfare details, and
telephone numbers for related support groups with a recognised care history, credibility, and no cost or only nominal fees.

No financial compensations were given to the participants in the study. No therapy was offered, and no therapist details were provided to participants.

I drew upon my communication and media background to prepare editorials for the popular press; for example, about how more women were becoming alcohol dependent in their 30s, and to raise awareness and attraction of a positive study to improve women’s AUDs healthcare. This involved 95 media contacts from 2006 to 2011, examples of the media stories on RWR are in Appendix 3.2. The initiating contact involved providing information on:

1. How recovery and wellness happens in Australia, and on the information required to bring about positive recovery care;

2. The fact that many non-drinking (abstinent) women (35 years to 59 years of age) with alcohol dependence and in recovery are living in our communities; and

3. My need for women with two years recovery to contribute to a study, whose aim is for more women to receive earlier and improved healthcare based on their needs, not inappropriate programs directed at teenage needs.

I approached media organisations and, in particular, feature writers and discussed providing information on alcohol use and misuse by Australian women in midlife with the proviso of publication of RWR contact details for women interested in the study. There were a range of print, radio, television and on-line journalists who reported on the issue of recovery and the study. Women in recovery, practitioners and concerned members of the public, who were willing to be part of the process of investigating the questions of abstinence, recovery and wellbeing to change AUD outcomes, made contact with me.
Figure 3.3: Purposive recruitment of RWR participants

**Key:** The horizontal axis represents 'change', the vertical axis represents 'research analysis'. The Action Cycles are represented by the numbered semi-circles. The number of participants in each Cycle were: Action Cycle 0 (n=12), Action Cycle 1 (n=88), Action Cycle 2 (n=112) Action Cycle 3 (n=162) Action Cycle 4 (n=276), Action Cycle 5 (n=36), and Action Cycle 6 (n=119). The total number of participants in the Participatory Action Research was 805, in ten categories*. The Meta-study began in Action Cycle 4 and was completed after Action Cycle 6, bringing the number of RWR participants to 970 at the end of the Meta-study. The Meta-study of RWR is introduced on p71 and the details begin on page p115.

The most difficult task with media personnel (e.g. journalists) was to persuade them that negative media stories about rising alcohol dependence by midlife women were not helping to remedy the problem, whereas improving health services that can meet the women’s needs could provide an important opportunity for more women to enter recovery. Particularly challenging to many of them was the study’s mixed methods of qualitative (not quantitative) research, the ways in which random control trials and clinical research could be actioned to improve health services, policy, and the quality of tertiary education. Changes to the National Medical and Health Research Council guidelines relating to alcohol consumption, and society events, e.g. government elections (and the release of political party’ policy), provided me with opportunities to continue to raise the issue and benefits of midlife women’s abstinent recovery healthcare strategy from alcohol misuse.

Sal6, Action Cycle 4, New Women interview: *I think it’s really important because women have to have a lot of positive reinforcement to stay sober. Especially in the early days ... without respect it can be very hard for people to continue on. It was hard to believe that anyone would ever give me respect, but it certainly helped.*

An ongoing editorial process was established and maintained, with ‘a story’ being developed at each Action Cycle of the study as a press release by the University media officers. These ‘stories’ were distributed to newswires, newspapers, radio and internet services around the country (Appendix 3.3). I spoke with all of the women who responded (by telephone, email and letter) to these ‘stories’, explaining the positive aims of the study, and how they might participate. An RWR Information package was sent by mail and email (Appendix 3.4), with careful attention to anonymity in all communications. Women were forthright in expressing their recovery understanding in an anonymous and confidential manner, and I reciprocated as a respectful facilitator of this important participatory research.

Each contact was a transaction, including participants inviting colleagues and peers to become involved in a positive research process. I regarded this ‘snowball sampling process’ as an illustration of one of the benefits of TPRP (Somekh & Lewin 2004).
Figure 3.4: Researching with Women in Recovery (RWR) is a living ‘alive’ action research study

Key: This research design flower image was discussed with participants at the start the RWR study. The ‘flower’ reflected the nature of the ‘lived experience’ process of RWR. The petals carry the women, the practitioners, the researcher and ‘the unknown’ in a multi-level design all based on a core Transactive Participation Research Process (TPRP, see p78). All participants were incorporated in TPRP as the research evolved. The concurrent Dynamic Lines of Inquiry (DLI, see p115) are symbolised by the four diamonds: Participatory Action Research (PAR); Unobtrusive Observation (UO); Documents and Experts (D&E); and Action Science (AS). The Tri-thread (see p91) envelopes the petals and connects with the Diamonds (methods of data collection) and the Action Cycles (as concentric circles in the centre, see p103), forming Pearls of understanding through data analysis (discussed in more detail in Chapter 4, see p114).
Mapping the study

The starting point I used to describe the design of the study is illustrated in Figure 3.4. This mapping of the study (the flower being an attractive non-threatening symbol) was used to describe the embedded Transactive Participation Research Processes of the research design. In this figure, the symbols of circles, triangles and diamonds in the flower shape represent the important processes of the Tri-thread and the Dynamic Lines of Inquiry. I used this mapping/modelling approach for each Cycle, and each Cycle had a different representation based on a ‘living’ symbol of flowers.

The Cycles (circles) move outwards as a ripple, then with more people the layers of meaning (forming a pearl) are created with more participants volunteering and being recruited for later Cycles (3, 4, 5 and 6). The participants become a dominant influence in the Action Cycles moving outward across the research design framework. The features of the Levels 1, 2 and 3 of the petals and the Dynamic Lines of Inquiry diamonds come into action with the need for multiple data source analysis. Interpretation (1st level), moves to integration (2nd Level) and then synthesis (3rd Level). By Action Cycle 6 research participants have co-generated knowledge, as a valuable outcome: a RWR pearl.

The PAR (Participatory Action Research) and UO (Unobtrusive Observation) sitting together at the base provide the grounding of the study, with UO and D&E (Documents and Experts) bringing a first level of analysis. The D&E and AS (Action Science) at the second level provides interpretation and integration guides. The third level, which sits between AS and PAR as this type of meaning making with participants, was essential to reach actionable knowledge: findings and conclusions. The centre of the flower as Cycle 0 emerges as Cycles 6 with the richness of participants’ sharing of praxis through knowledge translation.

The Tri-Thread was designed to accommodate changes during my study of women’s recovery topics as they were identified, prioritised and developed within the research process. The three threads that supported research on improved women-focused healthcare services for midlife abstinence, wellness and long-term recovery are as follows:
1. **Systems and Ecological Thinking (SET)** related to AUDs and recovery (Room 1992, Municipal public health; Victorian Government 2001; Gunderson & Holling 2002; Cook, Jardine & Weinstein 2004; Parkes 2006; van Loo & Martens 2007). Systems and ecological thinking broadens the phenomenon’s conceptual boundary, whereas the social ecology perspective ‘holds’ (Kegan 1994) the inquiry’s focus on midlife women’s recovery. The researcher facilitated providing information from SET with each Action Cycle to participants, in parallel to participant women and practitioners responses in the cycles. The research was a mutual exchange of ideas.

2. **Transdisciplinary Spectrum (TS)** of literature searches (Abrahms 2000, 2006; Nicolescu 2008) and reviews offering new perspectives, plausible alternates, integration and synthesis opportunities. Transdisciplinary literature searches were completed to meet the complicated needs of the women’s changing lives and the practitioners and supporters needs involved in enabling the seeking of recovery by the individual women. All participants were considered as expert peers (Newbould, Taylor & Bury 2006).

3. **Communicative Exchange (CE)** was the principle (Matsumoto 2009) and method used to ensure the sharing of information and ideas from the study as the study progressed; particularly in relation to methods of care, and to how AUDs recovery and women’s sense of self can improve and sustain wellbeing. Meaning accrued in the participants’ research activities through talk and texts (from the intimate interaction to the broadest modes of communication, e.g. personal conversations of distress and hope and email discussion of mass media portrayals of drinking).

As the study progressed we purposefully exchanged selected research-oriented information (Communicative Exchange). This enabled participants to express, share and enhance and change their understandings of recovery as they interacted in recovery research; I, as facilitator and observer, was immersed throughout the study in the phenomenon of women’s recovery.

RWR focused upon recovery and the change from active AUDs to abstinence, then to recovery and good health. From the results of the trial study (Action Cycle 0) improvements can be made in early healthcare to enable midlife women to engage
with becoming well. The major study’s objective of understanding the ‘how to’ centred upon a positive outcome, represented by the inner circle of the Researcher’s understanding figure and the research design and processes investigated the factors that impact (in a negative or positive manner) the women’s sustained wellbeing shown below by the three spheres and the overlaps that is recovery with AUDs.

**Figure 3.5: Researcher’s understanding of ways to study women’s wellness**

**Key:** Studying with well women in recovery with AUDs, began with my observations and discussions with women, practitioners and supporters. The **three spheres** represent what women draw upon for whole-person recovery; their personal self-understanding (including spirituality), their living environment and the sociocultural constructs that ‘organise’ their community and may assist in good health. Recovery can enable women to accept the opportunities to learn how to connect with all three spheres of their life; to be a woman who is abstinent and contributes to her family, workplace and neighbourhood. The features in the **overlaps of spheres** were important to identify through RWR; including how women feel comfortable in their daily recovery living. The identification of the what, how and why in the overlaps (the skills, practices and understanding) was needed to assist women through improved recovery healthcare.
My personal research starting point was an understanding of a healthy person as a ‘dynamic whole’ (Lewin 1997). The women participants described being, at the end of their active alcoholism, lost and ‘shattered’. Recovery involved healing and integration of ‘the parts’ that fragmented with active AUDs.

The ‘how’ of integration was studied in a constructive manner by exploring information in the three spheres: the women’s personal concepts, e.g. shame; the constructs of the society and the times, e.g. a culture of intoxication that stigmatises people who don’t drink or drink too much; and the context of midlife women’s AUDs environment, e.g. a closed, disconnected (alienated and isolated) and vulnerable way of living (in a poor physical, psychological and spiritual condition). The overlaps represent the possible processes or actions that can enable or disable women’s recovery. Drawn from the trial study results are three means or techniques to progress to abstinence and recovery, they are: to learn to engage with intradependence (engagement61); to receive support and embody interdependence (bioneuroecopsychosociocultural62), and to connect in a healthy, enriching way through co-independence (opportunities for profound learning63).

**Recognising participant objectives**

For most participants it was the opportunity to help others to stop drinking and come into recovery that motivated their involvement in the study. Through these exchanges there was recognition of similar health stories, lifesaving changes of not drinking and recovery, and life circumstances of regret and sadness. However, the main concern of the women and practitioners was that abstinence and recovery took so long to achieve, and that it was difficult to find informed help and stable support

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61 Alcohol dependence is a complex disorder that requires complex care. The care integrates treatments for the biological and broad (eco) psychological, social and cultural underlying causes of each individual’s illness. Treating one of these elements does not ‘cure’ the client. AUDs is a chronic condition that can only be managed by enabling the women to become self-aware, develop a sense of belonging, and enjoy life with others.

62 The term ‘bioneuroecopsychosociocultural’62 was used in the study as a reminder of all factors being experienced, observed and considered in women’s recovery. Participants added and subtracted categories, e.g. spiritual and politicoeconomic.

63 ‘Triple-loop action learning’ (Nielsen 1996) can further encourage women to reconsider their personal attitudes, values and beliefs. Triple-loop action learning seeks to uncover the traditions and norms where the individual’s governing beliefs are nested, and to actively link them to a deeper and broader awareness of their present situation, the reality of their AUDs, together with the initiating effective actions for sustaining recovery change and wellbeing.
to both begin and maintain recovery. In recognising their addiction they acknowledged their self-deception and ability to appear strong and functional while in great emotional pain and drinking more.

Many of the participants were unwilling to focus on their disorder when their drinking was making them feel destructive. They suggested more preferable earlier intervention points, and highlighted not only the disruption of their alarming actions, but also their feelings of despair, and their hidden and manipulative actions as they withdrew from everyday activity. The lack of knowledge about women’s AUDs and recovery, as well as the disgust and dismissal experienced by many of the women, had prevented their seeking help directly. The accounts of using stress, anxiety, and depression as leverage to receive help and limit the fear and anger from which they attempted to escape was common. Helping to prevent women reaching physiological and psychological breaking points was an important outcome for the participants.

Participants chose what contributions they would make to the study, and they were asked about how the research might meet their particular needs. The credibility of the study was strengthened by their accounts of living real lives of recovery and wellness, rather than disorder, destruction and despair. The experiences that they shared were of a surprising depth and breadth: these included the contributing events to midlife women’s AUDs, and the intergenerational outcomes of women’s alcoholism, relevant physiological (particularly the brain) and psychological details, world-views (harm minimisation and abstinence) and existential concepts, examples of their affect and cognitive responses (particularly education relating to their emotions), communicative preferences, and the sociocultural and spiritual beliefs that offered transformative possibilities.

**Ethics, research safety, confidentiality and equity**

All participants, at the commencement of their involvement with the study, were provided with University of Western Sydney, Human Ethics Committee (UWSHERC 06/091) approved information. Informed Consent forms (updated each year) with details for emergency medical care were required for participation. RWR research background statements (see below) were provided, with access information for addiction and mental health help-lines, and government approved information
booklets and websites. As recruitment continued through the study, material provided was updated. Early Cycle material was available and was provided after the participants first Informed Consent was returned to me.

The ethical implications of actions and the principle of ‘do no harm’ were considered and discussed with supervisors throughout the study. I implemented the tenets of action research to emphasise and maintain safety and care of participants, and the intimacy of experiences of self-healing, nurturing and containment was held in high and confidential regard. Details of the UWS Ethics Guidelines for the study are provided in Appendix 3.5.

The psychoanalytic perspective considers that primitive anxiety (Erlick Robinson in Romans & Seemans 2002) is never fully transcended, and that it can be reactivated, sometimes intensely, at moments of change and transition. I decided, with expert and literature consultation, that women participants needed to be in recovery for a minimum of two years for participation in cycles one to four; and preferably with more than five years abstinently recovered in cycles five and six. All participants received a RWR Information package. This included a comprehensive list of agencies that could provide support. All women provided their medical practitioner details, and this was checked for currency at each cycle. At no time was the research presented as therapy.

Maintaining confidentiality (research on vulnerability was helpful; DeLaine 2000) was especially necessary as sensitive, perhaps discreditable (possibly illegal and/or immoral) experiences were knowingly shared. Participants’ nominated personal code-names, and their preferences for receiving and sending information, were checked for each Cycle when renewing their Informed Consent. As the participants continued in the study, more intimate information was offered (through words, music, poetry, and images), and gratefully accepted. All research data were held in locked cabinets, password protected databases and security access buildings at the University of Western Sydney. The women’s contributions were anonymous (using their nominated code-names) and confidentiality was confirmed for a minimum of five years, when documents would be archived as confidential. Only with agreement of participants could the raw data be accessed and used for further research.
Figure 3.6: Explanation of RWR Transactive Participation Research Process development

Key: The process that I employed was a relatively 'open' research system. The three circles represent one cycle. The top line of the figure – questions, facilitation, answers and questions – depicts my responsibility as the researcher. The terms in the bottom line – concepts and constructs, content, context – relate to the inputs from the participants and the research constructs developed by the researcher. These cycles were repeated seven times in the major study (cycles 1 to 6, starting with cycle 0 as the trial study), each cycle enabling me to further clarify my understanding of the processes involved, and make pragmatic recommendations for improvement of recovery care for women with AUDs.
The participation equity rationale was that no participant was treated as privileged, nor were the researcher’s or the university’s authority imposed in the Cycles of study. The option was always present for participants to withdraw (without reason; brief notification was valued). A few participants did withdraw because of time restraints, reaching a need for closure, returning to tertiary study and moving house.

**RWR Transactive Participation Research Process (RWR TPRP)**

The Explanation of TPRP (Figure 3.6) is based on two sources of data: firstly, from my facilitation of the transactions between the participants of the study, particularly through the questions asked, and the answers provided; and secondly, from the definitions relating to the research processes (more theoretical and analytic information) that were particularly associated with concepts and constructs, content and context.

The formal research action cycle, shown as a **solid (spiral) line**, involved the researcher observing the external factors relating to the research (including media articles on alcohol consumption – shown as a **dashed line**), and the women and practitioners participants proceeding with their lives (represented as a **wavy line**). Transactive Participation begins (arrows left to right) as **acts** (by the researcher) to **prepare** each successive cycle of inquiry; this was based on participant answers (analysis of the responses from the trial study and from the previous cycle). Information from my ongoing survey of relevant research literature and discussion with researchers also contributed (Appendix 3.6). By reviewing this data I was able to **propose** action options and explain to participants their potential value. The participants were asked formal ‘**questions**’ through surveys and interviews; and throughout each cycle they could contribute information in a free-choice form (through letters, sharing of literature, etc).

**Participants action options** – an example of this was that in action Cycle 2 the participants could choose to contribute by posting on an RWR web discussion board (hosted by the university with participant password access), and/or responding in a telephone interview to set questions being asked by the researcher (Appendix 3.7). The web discussion board also included the specific questions relating to each cycle, and an area where the participants could anonymously post material in the form of other expressions relating to their recovery, e.g. poems, stories, images, etc. My work
involved co-ordinating the process, providing participants with the response actions they preferred, and regularly gathering and sorting the information, planning, and analysing and managing the data. The analysis techniques used in Action Cycles 1 and 2 were concerned with content, themes, terms and categories (Krippendorff 2004; Abraham et al 2007; Nelson 2008). As the Action Cycles continued, more specific analysis was completed, e.g. typology of social bonds, social learning and social roles (Boeri, Sterk & Elifson 2006). Analysis methods are explained in Chapter 4, RWR Transactive Methodology, and analysis details are provided in Appendix 3.8.

I took time to reflect on the responses that the participants provided, particularly by observing their selected action options (formal methods and free-form choices). Based on my analysis of the answers to the questions asked, together with information from related research, and my observations of recovery in the community, I regularly prepared summaries of draft results for discussion with participants. To be able to generate meaningful ‘answers’, the analysis process (which followed a propose, act, reflect cycle) also included external observations; and a second (critical) reflective process ([ ] is used to indicate that this involved returning to past cycles).

Participants received these ‘answers’, which were a summary of the draft results. This included an exchange, whereby the women received the draft results of practitioners’ responses, and the practitioners received the draft results of the responses of the women in recovery. Both groups were invited to provide their exchange responses to the researcher. Based on my review of these exchange responses, in the context of the processes involved in the past cycles (represented by the right to left arrows), I highlighted interesting ideas, and also possible problems for the study, and then planned for the next cycle.

I provided the participants with a précis of this early analysis work in the form of an RWR newsletter (electronic via email or print-mail). The précis of the events of the cycle also contained proposed actions for the next cycles, and requested feedback. Based on this communicative action (Habermas 1984; Luhman 1996), the next cycle was designed, taking into account influencing external factors, my observations, the participants’ contributions, and insights from relevant literature that had come to my attention.
The initial questions used in the main study were developed from the results of the trial project, particularly from results with no or few explanations in the literature on women’s AUDs and recovery. As an example, many of the participants reported that at the end of a bout of drinking, what commonly emerged were their chaotic explanations to both hide and justify the drinking. The women expressed in words the physical and psychological distress, through outbursts (erratic behaviours) and withdrawal from people with an ‘I don’t care’ statement. These reactions were a desperate, alcohol-influenced response to the mounting negative (usually relational) experiences felt by the women, for example:

- *I don’t care that you don’t care about me* (many of the women felt ignored, humiliated and shunned)
- *I can’t care about you (all of you) anymore; I can’t keep doing everything for everyone else... there is nothing of me left.*
- *I don’t care about me because I’m not worth caring about.*

**Example question:** How did ‘caring about yourself’ affect your recovery?

**Example answer:** I’ve learned that to care for others, I have to care for myself first.

**Follow-on question:** How did you care for yourself in early abstinence?

New questions came from participants, the researcher, literature reviewed, and, on occasion, from expert feedback. Over the successive cycles, the topics that the women emphasised were highlighted, e.g. various aspects of emotional (Dayton 2007) and spiritual understanding (a common feature of long-term recovery; Chen 2006; Galanter 2007; Carrico, Gifford & Moos 2007; Piderman et al 2008; Bliss 2009).

**Facilitation**

My main roles were as the researcher, as a woman, and as the facilitator of the transactions. I drew on my social ecology and health and science communication backgrounds, and particularly on my experiences during the trial with the women in
early recovery. I believed that my transactive participatory approach would open the way to forthright expression by the women, including their experiences of active alcoholism, the positives of recovery, and to sharing their difficulties in times of major change.

To enable social inclusion and justice for women with AUDs, who must overcome ‘mighty’ barriers to experience wellbeing, the inquiry process was designed specifically to enable authentic representation, and counteract these midlife women’s invisibility (Wilkinson 2000, 2003); this included a consideration of the following possible influencing variables:

- Expectations of midlife lifestyle cohorts (the women were Baby Boomers or Generation Xs)
- Addiction and the physiological, psychological and spiritual damage associated with alcohol use disorders
- Comorbid mental and physical chronic illnesses
- Extra challenges of identifying as a female alcoholic (much greater than for a male).

To gain a deeper understanding of the processes involved in effective facilitation, asking questions and considering answers and expressions, I spent time listening to women in recovery in several communities (in the eastern States of Australia and South Australia). This enabled me to better understand the roles of contextual factors in the lives of midlife women with AUDs. One of the main findings, based on my numerous conversations with women who had been abstinent for many years was their need to keep remembering their early years of recovery.

Drinking as an alcoholic midlife woman appeared to involve a process of frustrated aspirations, distress with life events, disconnection and grieving for the unknown, a hopelessness of ever living a happy life, and a sense of desperation to avoid ‘pain’, as well as a physiological and psychological addiction. The women emphasised that their recovery, in contrast to the above experiences, was expansive, worthwhile, demanding and exciting: a vast change in their process of living.
As the data-collection process was ‘continual’, I (as researcher) was able to carry out analysis, integration and synthesis of preliminary results (quantitative meta-analyses; Roesch & Weiner 2001; Martins, Ramalho & Morin 2010, qualitative meta-synthesis; Zimmer 2006; Finfgeld-Connett 2010). This involved considering contexts, facilitating the gathering of related information (particularly secondary data), and managing the **content** (as data) to enable the best possible future synthesis. Time was also needed to integrate ideas and develop possible **concepts and constructs**, which were used to inform the next ‘**action**’ cycle, and ultimately inform the findings. However, answering the research question – how to best assist in improved AUDs care and wellbeing in recovery for midlife women – was the dominant guiding factor for the design and implementation of all of the mixed methods research processes (Bazely 2002; Hanson 2005; Teddlie & Tashakori 2006); and the role of the researcher was to facilitate reaching this goal in a scholarly manner.

**RWR Knowledge Production Framework**

My approach to ‘Knowledge Production’ (Gaenellos & Wilson 2006) in this Transactive Participation study provided a pragmatic tool for co-coordinating complex and robust research with adult participants to provide informed recommendations and actionable outcomes for women’s healthcare. In Table 3.1, the Knowledge Production Framework (KPF) is used to explain how my focus on the ‘lived experiences’ of the RWR participants generated new knowledge (Gredig 2011) and enabled improvement in women’s AUDs healthcare.

The KPF suggested critical research processes for conducting a thorough and contextually relevant study. Thus, at each cycle of the study I considered if the contributed experiences and information being generated could be used to design and implement more positive recovery outcomes, e.g. by providing better answers to how and why the women (who had been abstinent for more than 15 years) were healthy and happy, and contributing to society.
Table 3.1: Relationships between Research with Women in Recovery (RWR) ‘Transactive Participation Recovery Processes’ (TPRP) and the ‘Knowledge Production Framework’ (KPF)

<table>
<thead>
<tr>
<th>RWR TPRP</th>
<th>Processes</th>
<th>Knowledge Production</th>
<th>Framework (KPF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transactive</td>
<td>Participation</td>
<td>Tri-Thread symbol</td>
<td>Lines of Inquiry symbol</td>
</tr>
<tr>
<td>symbol</td>
<td>(1st)</td>
<td>(2nd)</td>
<td>(3rd)</td>
</tr>
<tr>
<td>Interact – enrich</td>
<td>joint action</td>
<td>Systems and</td>
<td>Recursive Unobtrusive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ecological thinking</td>
<td>Observation</td>
</tr>
<tr>
<td>Enact – embody</td>
<td>discourse</td>
<td>Experiences and</td>
<td>Generative Participatory Action</td>
</tr>
<tr>
<td></td>
<td>action</td>
<td>transdisciplinarity</td>
<td>and Action Science</td>
</tr>
<tr>
<td>Act – engage</td>
<td>action for change</td>
<td>Everyday communicative</td>
<td>Iterative Critical Reflection and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>exchange</td>
<td>Expert Feedback</td>
</tr>
</tbody>
</table>

The first feature of Table 3.1, the two columns on the left making up RWR TPRP Processes, lists the key features of the primary research process and philosophy (as discussed earlier in this chapter). The connected second RWR design feature is shown in the two columns on the right side; together they comprise the RWR Knowledge Production Framework (KPF). This Framework combines the RWR Tri-Thread and the RWR Dynamic Lines of Inquiry (TPRP), as a combination of perspectives and techniques. The RWR Tri-Thread and the Dynamic Lines of Inquiry strategy describe key aspects of my dynamic approach to answering the research questions with the various groups of people involved in AUDs care and recovery (Chapter 4 and Appendix 3.9). The knowledge derived from the research using RWR TPRP and RWR KPF integrated:

- the women’s understanding (to assist peers with the complex chronic illness and their extended families)
- with the practitioners understanding (to assist practitioners, community services and families).

The integration of these findings increased the probability of making care and services improvements that could meet (through safe, knowledgeable care and compassion) the needs of more women with active alcoholism.
RWR Transactive Meaning Making of Action Cycle data

The techniques of RWR Transactive Meaning Making were Basic analysis, Pearl interpretation with mixed methods triangulation (Cresswell 2009). I outline the Basic Analysis in this Chapter and the complete collection and analysis process, ‘Diamonds and Pearls’, in Chapter 4. The Basic analysis techniques were applied to the data collected from the Action Cycles focused on joint action, discursive action and action for change. Together the collection and analysis provided a legitimate and ethical base to present the results as representative of the participants’ experiences of recovery (Onwuegbuzie & Teddlie 2003; Greene 2007).

1. Data collection methods providing categories and topics

The RWR dataset included all Action Cycle 1 to 6 responses; these were recorded in the two RWR databases (RWR Excel database64 and RWR NVivo database65). All participant responses, including verbal responses in transcription form, digital documents (e.g. questionnaires filled out via an email system) and handwritten documents were entered and saved in the RWR Excel database.

2. Participants

Participants offered important ideas and asked questions that were used as coding terms, e.g. those relating to spirituality. The RWR NVivo database was used for examining participant ideas and nominated subjects. Data from the Action Cycles 1 to 6 were entered into the NVivo program progressively as structured data (i.e. documents identified by Action Cycle, method and participant codename), open data (free nodes for data exploration of possibilities and probing for confirmation), source attributes (e.g. a woman participant using CBT and AA), and as researcher memos on particular analysis processes and circumstances.

64 The initial RWR Excel spreadsheet categories (Miles & Hubermann 1994) was developed from participant demographic information and questions answered in the Informed Consent, the topics of the first data collection questionnaires for women in recovery and practitioners, and from reference to critical terms, such as abstinence/abstinent/abstain.

65 For participant contributions of more than 200 words the information was entered into the RWR NVivo database (software versions 7, 8 and 9); this was designed for studying large amounts of text data content and structure (Bazeley 2003; Richards 1999).
I took the opportunity with my field notes to apply Paradox and Gestalt (a data analysis interpretation technique focused on identifying transformative ideas), and recorded emerging concepts for further investigation, e.g. ‘seeking without for what is within’ and yearning for ‘peace of mind’.

mmd1, Action Cycle 2, Women interview: *I felt that a lot of my decisions were based on fear, obligations or guilt. I didn’t realise that I had some choices that I could make to fulfil. I feel that has made a big difference in my recovery.*

### A coding scheme for RWR multiple data sources and data analysis

The interpretive processes involved in recognising substantive statements and their meaning (Frost et al. 2010) from the RWR data collected (RWR dataset) was guided by the inquiry’s purpose; to co-generate actionable knowledge to improve midlife women’s recovery. Thorough multiple analysis and interpretation methods to study the data, were based upon inductive, deductive and abductive reasoning (Bradley, Curry & Devers 2007). Analysis occurred with single Action Cycles, pairs, triplets and all Action.

Participants’ responses were not forced to fit the coding scheme. New ideas created new possible codes and sub codes (a taxonomy, a hierarchy). Depending on their relevance, such new ideas were evaluated in the next Action Cycle for inclusion, or to be put aside. Coding possibilities (terms, phrases and words) were selected in the six following ways.

My observation notes of professional communities of practice and recovery practice in the community recorded instances of new ideas from which codes were developed, e.g. well educated midlife women starting new relationships when in recovery, because their pre-recovery partners did not adjust to the women’s new way of life.

### Methods of analysis

The Basic analysis (within the Action Cycles) offered an opportunity to trial my analysis techniques. To consider possible new ideas, I experimented with a variety of forms of content analysis (Mayring 2002, 2003; Krippendorff 2004), ways of establishing meaning of colloquial phrases (Doran et al 2008; Nelson 2008), theme analysis (Black & Rubinstein 2004; Abraham et al 2007), and studying data using abduction (Miller 2003; Dunne & Martin 2006; Upshur 2007). These trials contributed to finding suitable ways of thorough meaning-making (van den Heuvel
& Demerouti 2009), integrating data (van Kouwen, Schot & Wasslen 2008) and synthesising data (Suri & Clarke 2009).

**Coding and cooperative analysis**

The Basic analysis process contributed to identification and clarification of meaning, as well as for naming issues that impacted on women’s positive recovery, and for identifying what was regarded as being important to the participants. This valuable input, and my unobserved observation experiences (Hess-Biber & Yasser 2004), assisted in building a relevant coding scheme as part of the RWR Knowledge Production Framework (see p 102). Serendipity experiences during the study were also noted for possible inclusion (Plunkett 2001).

... _the meaning of acting, meaning of reflecting and meaning of relating._ (Biong & Raundal 2007 p 246)

3. **Outcomes of data analysis processes and interpretation techniques**

In each Action Cycle I studied a selection of participant responses and trialled the analysis methods and interpretation techniques listed in the Pearls Cooperative Analysis and Interpretation table (Table 4.2). When promising outcomes emerged (e.g. a characteristic such as self-stigma, a specific process [AA women’s weekends] or theme [emotional sobriety]), the Excel and NVivo databases were run to investigate this type of information and surrounding ideas in the larger datasets. The investigation continued using the features of the software, such as comparison in NVivo of:

- responses from women and practitioners about AA women’s weekends

- descriptive numeric information on the frequency of the use of the word ‘shame’ by a group of participants, and in what circumstances (quantitising qualitative data; Small 2011)

- the detail surrounding the emotional sobriety term to better understand the meaning of the term, its features and the formative factors involved.
In the three meaning making reviews of the Action Cycles I applied three processes: 1) find in the data systemic change processes (Macchi 2006); 2) check the condensing of the data to identify topics of information that crystallised women’s recovery concepts or constructs (Robertson 2011; Richardson 2000); and 3) cross check categories and themes through trials of integrating the Action Cycle preliminary results.

Detail of the review methods

Through the Action Cycles I was learning about the content of the participant experiences, the participants’ engagement in the study as well as refining techniques for studying the data and communicating with participants about the results (Cresswell & Piano-Clark 2007).

1. Finding change

I drew upon the eating disorders research of Macchi (2006) to identify systemic change processes in the RWR data. The defining terms Macchi used for change cluster categories were:

- Attributive: defining of self
- Conjunctive: people and contextual connections
- Activative: effecting fluctuations, boundaries and thresholds
- Situated: cycles and patterns of time and place.

The process also contributed to preparing working statements for recovery theory-building (Chapter 6).

Example interpretation

Being abstinent (situated) AND an authentic woman (attributive), aware of paths to self-actualise (activative), required major adjustment of whom the woman associated with, their roles and goals in society (conjunctive).

Action Cycle 4 email, SHA1: Stressors left out of the list for me ... It’s one thing to go through your own hell of addiction, but another thing to witness your child self-destructing ... even though he was only a baby
when I started getting sober … The nightmare of assisting him to get into a rehab was something shocking, with waiting lists (some up to 6 months) at EVERY rehab in NSW.

2. Converge the ‘likeness’ and reduce the large amounts of data

Crystallisation (Richardson 2000) occurred through identifying repeated phrases, terms and patterns of ideas in the data, of so-called ‘simple’ systems (Lewin 1999) which were indicative of more complex ones. An example of a simple system was women’s outbursts of rage (Gonzalez – Prendes 2006) and the damaging consequences, all of which were unexpected, frightening and bewildering to the women. The rage was linked to more than consumption of alcohol or withdrawal from alcohol. The rage was also based on complex interconnections of self-focused attention, worrying and ruminating (Hughes, Alloy & Cogswell 2008); these behaviours were further exacerbated by the added burden of stress from the women’s drive to be perfect and to please others.

The women’s background and life history repeated neglect (and/or deprivation and/or trauma) with the rage based on underlying feelings of insecurity and fear. To assist recovery, factors within the women’s life context and belief structure needed to be recognised and addressed as a part of their healthcare needs. The condensing of the women’s need for safety (Robertson 2011) highlighted the support work needed around victimhood, suppression and/or repression, to support the women to experience feelings of being whole and worthy (Grauerholz 2000; Mills et al 2006; Rahm, Renck & Ringsberg 2006; Makhija & Sher 2007; Kendall-Tackett 2009; Suzuki, Geffner & Bucky 2012). Women in recovery spoke of the difficulty and necessity of paying attention to what the rage indicated and related to, for individual women and their continued wellness in recovery.

3. Checking categories and themes

Selected NVivo inquiry processes provided a mechanism for and studying different visual representations of the outcomes (e.g. Cluster analyses). This involved revisiting categories and themes. Participants’ words represented an active meaning-making endeavour in RWR at each Action Cycle (Richardson & St. Pierre 2005). Possible convergence points were noted through quantitising text with a check for repetition of content and similar, complementary and contradictory ideas. An
example was the ‘wanting’ of recovery (Figure 3.7) and what that meant in practice for the women and practitioners, i.e. for women, being open and willing to be guided to stop drinking by expert peers and selected practitioners, and for practitioners, women completing new tasks of self-care.

**Example of theme checking**

A strong recovery theme in the data was valuing sobriety. The participants contributed information on distinguishing abstinence and sobriety and the ‘dry drunk’ phenomenon (Nixon 2005). Participants wanted a greater emphasis on abstinent recovery over harm-minimisation policies and services, and more social marketing (Rytel 2010) to transform Australia’s cultural acceptance of intoxication (determined drunkenness; Measham 2006). Participants agreed that most medical and health professionals were significantly unaware of the rapid increase of alcohol dependence among women, with the consequent complex and chronic mental and physical illnesses (Wilhem 2008).

**jan4, Action Cycle 2, Women interview:** *I think I tackled that one by saying abstinence means not drinking, being sober, but not having sobriety. I think sobriety is the peace of mind that I now have – that I can deal with life without alcohol. That’s more than just not drinking; that’s learning to handle life. So that’s what I consider to be the difference. Being sober or having sobriety is peace of mind. Being able to cope with life as life dishes it out to me, and not needing you giving me alcohol or anything like that to getting me over the various day-to-day life.*

**3Q9, Action Cycle 5, Practitioner questionnaire:** *Abstinence is essential to recover. Recovery is a long slow process. . . . I think midlife women need extensive competent therapy. We heal through relationships once we are abstinent. The process of recovery requires we rebuild trust. Thus, the competence of the counsellor is crucial. . . . Education of the damage alcohol causes, and education as to how and where to get help. The local GP is generally not aware of the disease of addiction, and suggesting moderation to an alcoholic is frankly useless.*
Figure 3.7: Want and Need tree maps with neuroscience literature (NVivo 9 RWR data queries)

Key: Neuroscience is assisting with understanding the complex process of dependence and recovery. Studying women’s experiences with active participants and research literature was likely to reveal 'what, how and why an action was taken'. This process also encourages looking beyond the surface explanations, 'because I had to'. Women’s alcohol dependence becoming a personal, valued recovery is a rich and important study (Rangel, Camerer & Montague 2008). Observations, questioning and interpretations can reveal underlying attitudes that lead to a new understanding of contributors to wellness and recovery. The attitude (Hagger, Chatzisarantis & Harris 2006) is likely to have three components to explore: the affective (happy to sad appeal), the instrumental (effective need-satisfaction) and the moral (bad to good worthiness).
Last element of the review

I met the RWR information sharing agreement as part of the RWR mutual cooperative analysis, and completed evaluating the RWR Transactive Participation Research Process. The objective to be inclusive and transparent established a firm base for a transactive Meta-study. Below are three examples of RWR as reciprocal and cooperative research:

1. The Participant Reference Group members confirmed that the Basic analysis learning and exchange of summaries of preliminary results (crossovers of documents for practitioners and women in recovery) was occurring and that the process led to new insights.

2. Participants’ ideas that I investigated were reported back via RWR newsletters, e.g. with information about action science literature that revealed useful leadership, management and marketing concepts for recovery treatment promotion and AUDs prevention; and recent neuroscience publications on socioemotional communication and psychosocial welfare that I and participants could identify as being helpful for recovery (Goldsmith, Pollack & Davidson 2008; Frewen et al 2011).

3. In Action Cycle 5, as part of the transparent reciprocal exchange of data, participants received transcripts of their long-form open interview66, with a copy of my first level of analysis notes attached for their consideration and comment.

The RWR cooperative analysis is well illustrated in the NVivo presentation of the data collected and discussed with the Expert Panel. The women’s wanting and needing to drink alcohol is a complex process. The nature of the disorder also adds to the complexity of recovery. Recovery will involve variations of resistance (not

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66 The long-form open interviews were conducted with volunteer participants in three groups: senior practitioners with more than 20 years experience; women with more than 15 years of recovery; and women with more than 25 years of recovery. I provided criteria for checking my analysis notes (e.g. Relevancy, Accuracy, ‘Do no harm’ criteria) and welcomed the participants’ comments. In this process many ‘terms’ used by the participants and myself were explained; this involved discussing misunderstandings, inaccuracies and learning new phrases. The dialogue on new research, preferences of older women for recovery care and support and new intriguing womanhood ideas for recovery illustrated the meaningful and useful outcomes of the RWR Meta-study.
wanting to drink and then lapse), protest and attraction (wanting to drink and remaining abstinent). This is a characteristic of a push-pull dynamic system (a panarchy; Walker 2006).

Combining the women’s ‘wanting and needing’ data with neuroscience literature assisted my understanding of alcohol dependence and why recovery is an active process to maintain abstinence and to live life to the full. The women with AUDs have complex vulnerabilities (interacting life issues and health conditions) with the added burden of their illness perceived from multiple perspectives of the community, significant others and service providers (multiple burdens; Holt et al 2007).
CHAPTER 4: TRANSACTIVE METHODOLOGY, ANALYSIS AND RESULTS

This Chapter reports on the results, the data analysis and interpretation methods relating to the Recovery continuum of midlife women’s change from active AUDs to wellbeing. The results were outcomes of data collection and analysis using the RWR Transactive Methodology, ‘Diamonds and Pearls’, with Diamonds representing data collection and Pearls representing data analysis, detailed below. The participants and I (the researcher) were enabled, through the ‘Diamonds and Pearls’ transparent processes and principles, to focus on producing actionable knowledge (Corfield, Paton & Little 2013), such as:

CBS 6, Action Cycle 4, New women interview: *Just being able to take action that makes my life better. You know, not being so fearful and unable to do simple things like pay my bills on time.*

In the first section of this Chapter, I describe the detail and purpose of the ‘Diamonds and Pearls’ methodology. In the second section, I present and discuss the key RWR results that form a Recovery Continuum – phases of care, development and support – that meets women’s needs for abstinence and wellbeing in long-term recovery. The details of each phase of the Continuum concern women’s ways of engaging in recovery change processes. They were derived from a cooperative analysis of participant responses of lived experiences, and from my review of secondary data (e.g. related longitudinal studies) and transdisciplinary literature analysis. At the close of the chapter a third section, the RWR Meta-study, is introduced and the RWR findings in Chapter 5 were created from this process (Collins, Onwuegbuzie & Johnson 2012; Teddlie & Tashakkori 2009; Voils et al

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67 Participants reported talking with and sharing RWR Newsletters with other people interested in recovery. Also, the media was reporting on the presentations of RWR Action Cycle preliminary results to professionals, self-help groups and recovery supporters via the internet. People enthused by the information contacted the researcher and were provided with a package to read and make a decision if they would become a participant. New participants also completed Action Cycle data collection from past Cycles as well as continuing in new Action Cycle data collections. People who did not meet the age, sex and two years in recovery criteria were provided with information to firstly speak with their GP, then government and accredited Community Drug and Alcohol information centres.
Meta-study is a recent term for a range of analysis, interpretation, integration and synthesis techniques developed, in the main, through meta-ethnography, grounded theory, mixed methods research and action research. The research input up to RWR Action Cycle 4 provided evidence and reason, based on the rich data provided, for conducting a Meta-study.

The RWR results describe and explain how midlife women began and continue in recovery, and how each woman’s recovery from AUDs evolves as a sequence of active efforts for achieving wellness, to construct meaning about herself, to better understand her social contexts, and to live an informed recovery way of life in relationship with others. Each woman’s healing and actions in recovery can improve her wellbeing and chosen life path, initially through safe healthcare that is specifically designed for midlife women’s nurturing as a maturing adult, then through learning to adapt to the everyday in a robust manner by having access to the interactive recovery support of professionals, peers and informed friends and family.

I discuss and illustrate, using participant responses, how the Recovery Continuum integrates suitable interventions and processes that can contribute to resolving women’ midlife active AUDs and related issues. Outlined also are ways to enrich the provision of the Recovery Continuum phases of care and development. The results can be used to meet the needs of individual women and to enable practitioners, peers, supporters, and institutions and communities, to lower the impact of AUDs on midlife women, and to help to prevent more damaging events leading to further chronicity and comorbidity.

**The Dynamic Lines of Inquiry: Diamonds and Pearls**

Diamonds and Pearls (the RWR Transactive Methodology) begins by combining the four Dynamic Lines of Inquiry (Participatory Action Research [PAR], Unobserved Observation [UO], Document and Expert Exchange [D&E], and Action Science [AS]) in each of the six Action Cycles.

The four Dynamic Lines, which formed the Diamonds of data collection (Figure 4.2), allowed me to accommodate the women’s dialogue and their diverse perspectives on ‘meaningful action’ (ecology of mind: Ibanez & Cosmelli 2008; Haye 2008). By focusing on people expressing their concerns, values, expectations and practical
information, I was guided to pursue, through questioning, women’s ‘realities of recovery’. At a critical midpoint in the RWR study the idea of being inclusive and committed, despite conflict (Varcoe 2006), enabled the women to identify as important the seeking of self and of being aware of affect on their early recovery and wellness (Christens & Perkins 2008; Prilleltensky 2008). This helped to focus the Transactive Participatory Research Practice (TPRP) component of the study. Techniques for exploring paradoxical answers, heartfelt conversations, and detailed discussion about sense of self were developed (discussed in this chapter). In the later phases of the study, the potential long-term recovery for women through the development of personal integrity, negotiated healthcare partnerships and social mutuality emerged as prominent recovery needs. The Transactive Methodology used in this study is illustrated in Table 4.1.

The Initial Basic cooperative analysis objectives and selected mixed method techniques helped the participants and myself to immerse ourselves in the study, converge on similarities and note differences. The analysis process provided research opportunities to identify gaps in knowledge, possible alternatives and new factors that indicated that there may be a better way to meet women’s healthcare needs.

Mixed Methods Triangulation: Looking for constructs and modalities, ‘ways of understanding’, was a useful interpretation process when studying participants’ thoughts, feelings and/or actions. Ways of understanding introduced me to women’s awareness and interest in language usage (alliteration, acronyms and metaphors; this helped me to identify themes in the women’s needs, pragmatic concepts and exemplars; Conroy 2003). Also, by enabling the formation of mental maps through alliteration and acronyms, people may consider ‘changing’ their minds, and, with repetition of the idea through practice, their behaviours change.

CBS6, Action Cycle 4, New women, Women’s Questionnaire, My Recovery: Alcoholism: Oh, ugly would be the word that comes to my mind.
Table 4.1: Goals of Dynamic Lines of Inquiry of the Researching with Women in Recovery Transactive Methodology

<table>
<thead>
<tr>
<th>Dynamic Lines of Inquiry</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common characteristics</strong> comprise sharing experiences, understanding the capabilities to self-enact, embody &amp; continue enriching recovery change for wellness</td>
<td>Detail the women’s &amp; practitioners’ needed commitment, creativity &amp; skills for achieving abstinence through progressive care (‘know-what &amp; know-how’) to support &amp; develop strategies for wellness in midlife recovery</td>
</tr>
<tr>
<td><strong>Initial Basic cooperative analysis</strong> (Onwuegbuzie, Johnson &amp; Collins 2009) objectives with each Cycle</td>
<td>Describing actions &amp; putting forward draft explanations</td>
</tr>
</tbody>
</table>
Importantly the RWR Diamonds and Pearls Methodology applied data collection and analysis methods for transacting, interacting and enacting. This helped me to engage with the people and data and assisted reaching intersections of ideas through a crystallisation approach in relation to the Action Cycles (Richardson 2000). The crystallisation occurred through recognition of continuums and patterns of ideas, of so-called ‘simple’ systems indicating more complex ones (Lewin 1999).

A simple system was the women’s outbursts of rage, which was linked to complex interconnections of self-focused attention, worrying and ruminating (Hughes, Alloy & Cogswell 2008); this was exacerbated by the stress of the women’s need to perfect and please, which was based on their fear and underlying insecurity.

Exploring edges of knowledge (Hughes in Reason & Bradbury 2008) and people’s accepted knowing (e.g. women’s low levels of trust) showed what was not known (e.g. about AUDs complications, abstinence being valued, aftercare and theories of change; ActKnowledge 2003). Identifying the unknown in women’s midlife encouraged my exploration of useful approaches for learning to satisfy adult development needs in order to provide choices to stop the maladaptive patterns of action.

As the researcher (JW68) I facilitated the practicalities of RWR, conducted the mixed methods strategy, and recorded and investigated the results of my:

- observing in an open-minded way the variations, the multiple fragments and the flow of action.
- deciding what were the next research actions, questions and propositions for consideration.
- exercising vigilance in monitoring change and seeking connections.
- being innovative in communicating about the plausible and the possible connections.

68 My way of researching included immersion and a number of times I needed to move away from direct contact with participants to regain my perspective and focus (Gioia & Petre 1990). RWR provided a trust experience that benefitted participants and myself, along with in-depth understanding and new knowledge to share.
My role through Action Cycles 1 to 6 was to record data, facilitate information sharing, document knowledge creation, and to frankly discuss the uncertainty of midlife women's recovery support with participants to find ways to improve recovery care (Jasonoff 2003, 2007). Briefly, I found that women's recovery is irregular and was positively and negatively influenced by practitioners and supporters. A coherence of recovery was maintained through the participants’ abstinent actions to seek principled wellbeing.

Qualia as an important feature of Researching with Women in Recovery

Qualia became an important feature of the research. I decided that it was necessary to explore a deeper understanding of women’s recovery change through the quality-bearing sensations of perceptual experiences, known as qualia (Smith 2002). The sensations of ‘feeling healthy’ and ‘being in recovery’ were important to record as they provided information on subtle and essential indicators of progress into recovery or, on the other hand, into regression to active dependence. The identification and explanation of such indicators can illustrate what recovery care is required to meet the women’s changing recovery needs over the long-term. Ways to become satisfied and comfortable (reported by the women in recovery and by the practitioners) were not only attractive, but of critical value for women’s wellbeing in midlife.

My decision to pursue analysis and interpretation of qualia was confirmed through data and further literature analysis as a necessity to reveal and acknowledge the content, resources and priorities of the women’s in recovery progress. The everyday attitudes and processes of action, people’s deeply held beliefs and opinions of existing treatments, and detailed descriptions of the context and circumstances of recovery also assisted in understanding the issues that hindered women’s experience of wellbeing.

"Meaning is not only experience in the world, but experience with others.”
(Cornejo 2007 p a-8)

Selection of research methods

Decisions relating to the selection of methods, the application of data collection and ways of analysis in RWR began as the research question was posed, formalised further in the research design, and evaluated in the RWR trial Action Cycle o. With the goals of Dynamic Lines of Inquiry (above), the importance of prolonged engagement with RWR participants was more apparent. The methods needed to also suit the participants’ preferred ways of interacting to share detailed and intimate information.
The participants were acknowledged as co-contributors and generators of RWR knowledge, and this was reflected in the research design. I valued their experiences, capabilities and. Studying with participants provided me with opportunities to observe them enacting and enabling their recovery during RWR, as well as during their ongoing day-to-day lives, i.e. as in the timeline of the study. The selected mixed methods were applied concurrently in the four Dynamic Lines of Inquiry in each Action Cycle, and data were collected to describe and explain midlife women's wellness, barriers to wellness in recovery, and ways to improve care. The research process helped me to highlight the details of the women being well; as an authentic (Landau et al 2010), abstinent adult, a healthy and integrated midlife woman with AUDs.

The application and management of the chosen methods (see Methods selected below) was guided by the following five principles: 1. the research aims; 2. knowledge being co-constructed; 3. heeding participant preferences and requests; 4. the researcher practicing the established Transactive Participation Research Process in the Knowledge Production Framework; and 5. the use of methods over the six Action Cycles of the study. The description of the method categories below includes references to illustrate the conceptual understanding bought to the practical application of the methods.

**Mixed methods**

The Diamonds and Pearls Transactive Methodology of RWR were the actionable outcomes of the mixed methods approach (Creswell & Pianoclark 2006), whereby data were mixed purposefully through a plan of applying methods. The data collection methods selected for application through the Research Design are described below; this is followed by the Mixed Methods Triangulation process, and then the data analysis processes of the Pearls. The methods were pragmatically applied and conducted, with further suitable methods being introduced as new understanding emerged in RWR. Traditional health and medical research methods (e.g. clinical trials) were studied to provide further understanding on what was
needed from an action research-mixed methods\textsuperscript{69} inquiry of AUDs, addiction comorbidity and mental health.

**Collecting credible data**

In a complicated world there are no innocent ‘methods’ of research; all involve forms of personal and social practice that in some way or other impact on the patterns of the physical, metaphysical, cultural and the social (Law 2004). The methodological practice embedded within the study’s Transactive Methodology included respect for participants’ mutual ‘know-that’ and ‘know-how’ for actionable purposes (Sexton & Lu 2009).

All of the materials developed for Researching with Women in Recovery Action Cycles 0 to 6 included questions (e.g. demographic questions in the Informed Consent documents) and encouragement to respond, e.g. in the RWR Newsletter. Some of the data collection and analysis strategies were continued over the seven Action Cycles to assist in understanding the creative processes, choice and commitment decisions, and for working through the detrimental occurrences for midlife women living in recovery. The analyses (detailed in Appendix 4.1 and the e-book) also explored ways that best enabled multi-layered comparison, combination, integration, appraisal and synthesis of data.

**Questionnaires**

The form of the questionnaires was different in each Action Cycle. During Action Cycles 1 and 2, the *My Recovery Questionnaire* (58 questions) for women in recovery, and the *Practitioners Questionnaire* (34 questions) were designed to explore, in detail, a range of participant experiences (all Questionnaires, and all data collection instruments are provided in Appendix 4.2). The questions were crafted to encourage description and explanation, as well as elicit free-form responses. I drew on Peavey’s (2005) Strategic Questioning approach, and ongoing discussions with

\textsuperscript{69} Action research approaches have a history of being open to mixed methods and mixed models. Greenwood and Levin (2001) state “....effective action research cannot accept an a priori limitation to one or another research modality” (in Reason & Bradbury 2001 p98). In the early 1990s the qualitative-quantitative and paradigm debate (Denzin & Lincoln 2000) was moving to accepting and integrating mixed methods (Tashakkori & Teddlie 1998, 2003; Tashakkori & Cresswell 2007) as a legitimate process of research.
my supervisors, to carefully consider wording, structure and flow for each questionnaire. Strategic questions ask ‘How can ...?’ and create movement (Peavey 2005). Asking such dynamic questions can help people explore how they can move forward on an issue. Rather than putting ideas into a person’s head, including new language, you are actually allowing the person to take what’s already in their head and to more effectively work with it.

Preparatory attendance and listening during community activities (e.g. AA meetings and practitioner seminars) provided useful terms and ideas. Women’s attitudes and actions were illustrated in their discussions (Nikander 2009), which informed my preparation of questions and statements to reflect and explore the women’s recovery. My observation and study of the literature, including practice guidelines, revealed multiple AUDs discourses (e.g. concerning mental health, alcohol and other drugs and primary health) and midlife women’s own discursive style. The trialling of research questions that contained terms and asked for descriptions was an important process, as was acknowledging the participants provision of their own terms and queries for the next Action Cycle. The use of strategic questioning helped me to avoid manipulation.

From Action Cycle 2, more short questionnaires were used to convergence processes for understanding (Pluye et al 2009). The number of questions in the questionnaire was reduced, as topics were saturated with responses. The question content was also based on the participants’ requests for particular questions to be included, my observation field notes, new literature and results from the previous Action Cycles. Studying and reflecting on the ideas that arose during the dynamic Action Cycle process was informative in directing and focusing new queries.70

At Action Cycle 4 the type of questions and the collection of responses shifted considerably. The cogent reasons for the change illustrated the coherence of data gathering in Action Cycles 0, 1, 2, and 3 for achieving progress in Action Cycle 4. Details of the modifications involving reconciliation of ideas that seemed contrary in

70 The number of questions were reduced, enabling the documents to be changed from two pages (Action Cycle 2 Women’s Matters, 14 questions) to one page (Action Cycle 3, Practitioners five questions), then to just four questions (Action Cycle 3, Women’s Q3 + 1). These research documents are in the Appendix.
Action Cycle 2, and then supportive in Action Cycle 4, is provided in the following sections of the Chapter and in Appendix 4.3. Recruiting new participants for Action Cycles 4, 5 and 6 provided opportunities to address ways to explore exceptions and contrary results. The new participants contributed to checking prior results, providing more detail on significant themes (e.g. a woman seeking an authentic self in recovery and living purposefully in midlife), as well as sharing integrated results of Action Cycle 4 and investigating any participant’s new ideas brought to RWR.

The questionnaires also provided opportunities to share complicated details of physiological and psychological recovery, the world-view concepts (harm minimisation and abstinence), the participants’ attitudes, beliefs and affect responses. The My Recovery Questionnaire (58 questions) for women in recovery and the Practitioners Questionnaire (34 questions) were introduced to new participants in later Action Cycles to confirm results. Over Action Cycles 4, 5 and 6 a total of 37 questions from the Q 58 questionnaire were put forward by women in recovery for discussion in RWR, and they were included in the RWR Information Updates (a summary of research progress for core-participants). The practitioners provided seven questions that they wanted asked in the study; these were also later included in the RWR Information Updates. All communication documents sent to the participants are on the DVD.

All materials developed in Action Cycles 3 and 4 included demographic questions, e.g. in the Informed Consent renewals. The two-way nature, or transactive aspect, of the Action Cycles were enabled through the provision of study materials, e.g. the RWR Newsletters continued to provide a broad (from Portal contributors) and rich information base (from Special Cases) for analysis and learning. In Action Cycle 2, an interactive web discussion board for women in recovery received a poor response, whereas RWR emails to experts in Action Cycle 4 and contributors in Action Cycles 5 and 6 provided a fruitful source of feedback for one or two questions. The preferred modes for collecting content from the participants were having the women write narratives or, for practitioners, presenting highlights in dot point form.

In Action Cycles 5 and 6, the participants’ mental, emotional and spiritual understanding, and their insights on context, provided valuable data. Self-understanding and purposeful actions with participants’ sociocultural description and recovery explanations helped to focus my ongoing exploration of the
transdisciplinary literature. As RWR involved action research, the processes of self-healing, nurturing and development in attitudes and actions that occurred in the study itself were critical to understanding and relating to what was needed in lifespan recovery care to support women’s midlife priorities.

**Researcher immersed in participant interactions**

Participatory research requires intersubjectivity (Dahlberg et al 2001) between participants and the researcher in an ethical manner. The valuing of participants’ experiences enabled a detailed understanding of different lengths of recovery, circumstances and health outcomes (from 2 to 32 years), while experiences from recently qualified to senior practitioners (up to 25 years of experience) were also rich sources of similarities and differences to explore and understand recovery progress and difficulties. The process and presentation of ‘thick description’ (Geertz 1973, also used in thick-concept analysis; Levering 2003, and knowledge translation studies; McWilliam et al 2009) allowed participants and readers to determine the useability of the study’s results and recommendations as the study progressed through Action Cycles 1 to 6. The generosity and spirited involvement by participants substantially contributed to the quality of the project.

The study involved prolonged participant engagement (Creswell 2009). Participants made choices on how they wanted to be involved in the Action Cycles. They provided valued contributions, including cooperation with trial methods and requests for feedback (Sexton & Lu 2009). Peer review (researchers, educators and practitioners) and debriefing with supervisors and experts was sought to consider alternative interpretations of results. Self-memoing, concepts and constructive onset mapping, and recording of ideas for ongoing review enabled monitoring of research decisions throughout the study. Following discussion with my supervisors, variations in the research strategy to meet participant suggestions and requests were made.

The Diamonds and Pearls (the RWR Transactive Methodology) provided a manageable and compact representation of the larger research reality of RWR. I was aware during the trial Action Cycle 0 of the dynamics of change research, in that some changes in the research process were expected because of the nature of participatory action research. In the research design, and the methodology, flexible techniques were included (e.g. open-ended questions) and removal of unsuitable
processes were possible, as well as adding relevant methods (Graziano & Raulin 1989). The Diamonds and Pearls was constructed to accommodate the key features of human actions; these included:

- the notion of open, non-linear systems
- the emergent nature of change
- change as self-organised adaptation
- the role of agent interaction in change
- inherent unpredictability and sensitivity to initial conditions
- feed-forward (iteration and abduction\(^ {71} \)) and feedback (recursion, for checking connections with previous outcomes, and retroduction\(^ {72} \))
- self-organisation and system stability.

In this methodology, the Pearls represent the mixed methods analysis strategies that were selected (Oleson 2003) to focus on the How, What and Why aspects of women living well in recovery. The data analysis concepts and techniques of the Pearls as the Action Cycles proceed are outlined below with examples.

Creating knowledge through purposeful cooperation required analysis techniques that were appropriate for analysing the data concerning the participants’ lived experiences, as collected through Action Cycles 1 to 6 of the research.

As a cooperative research process, analysis was shared with the participants to attain consensus of meanings and new knowledge of ‘how to do recovery well’. The objective was accomplished through agreed research transactions between researcher and participants, and participants with participants. This enabled

\(^{71} \) In the research process I incorporated a spiral of abductive and retroductive reasoning (‘what might be’; Dunne & Martin 2006) that completed a deduction and induction (Adler 2008) critical circle of analysis when exchanging responses amongst participants.

\(^{72} \) A point in action cycle analysis, that the exploration of data is exhausted (no new outcomes) which indicates successful analysis. It also signals a choice to begin a new cycle or complete the study.
purposeful research actions that were motivated by having access to stated values, with an outcome of a representative understanding and a documentation of women’s midlife recovery. Research management techniques (e.g. creating the RWR response databases), discussing what types of information were to be collected and analysed, and a how to best conduct mixed-methods triangulation (Cresswell 2009) were the starting points.

The six Action Cycles (Stringer 2007; Reason & Bradbury 2008) also encouraged learning amongst the participants and researcher. The Transactive Participation Research Process was enacted through participant-researcher contact (McTaggart 2006), which developed in a positive manner over the first three years (Action Cycles 0, 1, 2, 3), and continued to develop throughout the further four years (Action Cycles 3, 4, 5, 6) to completion of the study.

### Units of meaning in the Researching with Women in Recovery study

The appropriate use of words became an essential part of studying the participants’ lived experiences in all the strategies of the inquiry. Identifying substantive statements and analysing their meaning and purpose was the basic systematic study technique used to begin analysis and complete the research with substantial RWR outcomes. An initial master list of recovery terms (‘units of meaning’ in Appendix 4.4) was created based on my reading of practice guidelines, book glossaries and responses from participants in Action Cycles 0 and 1. The terms were used for test coding data from Action Cycle 1 (Appendix 4.5). During each Action Cycle, critical ideas, issues and phrases used by participants were collected and recorded. These were regarded as important information for identifying meaning, as they reflected the priorities for the women’s recovery.

The exchange of words with a wide range of people in a RWRs communicative space was an enlightening experience. I also selected participant’ expressions, sentiments and ideas and ran specific transdisciplinary literature searches to identify a range of definitions, associated concepts and detailed explanations to share with participants and assist RWR analysis and interpretation. Key literature, including transdisciplinary literature, was saved in a growing RWR Knowledge Database of women-related documents (>5000 in total). This database also served as a tool for considering themes, concepts and constructs (Chapter 5: Findings). Agreement on the terms that were prominent was also an important element of the knowledge translation and praxis process being applied to achieve pragmatic research outcomes, e.g. current women’s recovery research-based information for practitioners, the production of public information brochures (website friendly) and tertiary education curriculum materials.
In Action Cycle 2, for example, improvements were made in ‘Diamonds and Pearls’ to accommodate the following two features that were requested by the participants:

1. Communication with participants to support RWR knowledge transfer, and to continue to inform participants of potential outcomes from RWR results; and

2. For myself, focusing data and literature collection, and analysis approaches through extended feedback (and reflection) for making progress towards praxis-oriented findings.

The Action Cycles and Diamonds and Pearls drew upon my readings of feminist health research (Morrow & Hankivsky 2007; Fonow & Cook 2005) and a research principle of mutual exchange of rich detail of midlife women’s recovery. The increase in participants and detailed responses over the Action Cycles (Figure 4.1) occurred in response to the following enabling factors: the participants had grown to trust the research process; their viewpoints were appreciated and used to improve recovery practices; their interests were being met by the Action Cycle content and methods; many of the participants asked their associates to become involved with the project as they felt a part of it; communication was valued (e.g. the RWR Update newsletter and summary of Action Cycle outcomes provided them with a feeling of achievement); and continuing to participate was regarded as a worthwhile effort.

KMP1, Action Cycle 4, Participant Reference Group questionnaire:
*I share feminist psychology approach with all my recovery clients, males and females. Discovering how to self-empower by seeing choices and practicing self-validation has been essential. Also, DBT (Dialectical Behaviour Therapy) for recognising emotions (fear, anger) rather than repressing them; and learning how to express emotions in healthy rather than in an unhealthy hurt child way.*

The RWR Action Cycles and Methodology (Diamonds and Pearls) provided a formalised conceptual foundation for combining gathered information to explore, confirm or disconfirm, scrutinise, explain and re-question current midlife women’s processes of recovery (Castro et al 2010). This occurred through awareness of the evolving nature of the inquiry, transparency of the choices available, and the decisions made at each stage or turning points of the inquiry (Reason 2006). The designing, planning and appraising at each cycle of RWR was documented throughout by my procedural note-taking (Douglas & Douglas 2005) and recorded supervision meetings.
Figure 4.1: Diamonds and Pearls – Action Cycles
Key: Action Cycle numbers are shown on the left side of the figure. The process illustrated above was applied to Action Cycles 4, 5 and 6).

‘N’ in the figure is the number of Action Cycle participants. Participants were people involved directly with the research process. Research participants volunteered to contribute, collaborate (Townsend 2003, 2007) and scrutinise experiences and information which sustained and hindered women’s wellbeing in recovery.

The four sides of the Diamond shape indicate the four Dynamic Lines of Inquiry: Participatory Action Research, Observation, Document and Expert Exchange, and Action Science.

Pearl analysis is represented by the circles between the Diamonds. Layers of analysis are indicated by the increasing numbers of circles in the Pearls.

The infinity symbol represents the Transactive Participation Research Process (with the Tri-thread) that occurred in each Diamond to purposefully incorporate the core-participants and the researcher in the mixed methods strategy of the Action Cycles. The mixed method strategy (Cresswell 2009) of data collection, management, analysis and presentation that occurred in each Diamond is detailed later in this Chapter and in the e-book.

The X inside each Diamond represents the action research process of RWR (detail in Chapter 3: Research Design). The basics of the process involved the following actions: prepare, propose the questions, act with participants, critically reflect on answers (act on their outcomes when necessary) and begin to plan for the next Action Cycle, including discussions with participants.

The rectangles at the base of the Diamond provides a brief outline of the research purpose, and also represents my engaging with the participants. Maintaining action, enaction, interaction and transaction with participants in the Action Cycles was a critical factor. The design, application and transactions were based on trustworthiness, and were implemented to sustain research relationships.

The first three Action Cycles of the research were named to describe their method focal point:

1. Enaction (En): establishing credibility to investigate whilst limiting risk (do no harm)
2. Action (Act): conducting initial processes such as collecting data, experimenting with heuristics for experiential clarity, and encouraging mutual participation
3. Interaction (Inter): exploring and describing the influences, particularly the transformative and phronetic

The squares indicate the basic analysis focus for the Action Cycle (analysis detail is later in the Chapter).

In Action Cycle 3 a decision was made to complete another three Action Cycles as the participants were willing to continue to contribute. The next focus for the following Action Cycles was: Transaction (Trans), which involved focusing on the connections through complementary ideas and credible improvement pathways for long-term recovery.

Links projects conducted by the researcher were based on the needs expressed by participants through their responses. Links are explained later in the Chapter.

Levels indicating a combination of selected analysis techniques for Pearl interpretations (detail follows). The Levels provided a common focus on the Dynamic Lines of Inquiry and Action Cycles.
Data categories and coding

I established the following four preliminary categories of data:

1. The quality-bearing life sensations of human perceptual experience known as qualia (Smith 2002) that contributed to the flow of the women’s in recovery processes, e.g. belonging;

2. The content and structure of the women’s recovery, and the issues and contexts that contributed to and diminished their recovery;

3. The detail of processes, choices, expressions, circumstances and consequences of women’s ways of knowing themselves and living in recovery; and

4. The participants’ descriptions and evaluations of their experiences that drew upon their beliefs and basic concepts of living.

The initial open questioning in Action Cycle 1 was designed to:

1. Encourage breadth and depth of the participants’ shared information about their positive, negative73 and ambivalent lived experiences (elicited through varied question and answer formats);

2. Understand the women’s healing and wellbeing as ways of recovery care and change, to develop pragmatic midlife interventions, education materials and policy recommendations; and

3. Combining the various forms of data, such as numeric74, literal and visual (e.g. through meta-triangulation; Lewis & Grimes 1999), to explore different types of knowledge creation through transactive research, e.g. theorising.

73 My critical reflection (CR), as ‘researcher’, did sometimes limit empathy and, on occasion, it was necessary to place some mental space, at least during gathering of data on ‘events of excess’ and with experiences of suffering and hardship. I did not conduct CR directly after demanding data collection. To record my critical reflections, I used the following forms of diarising: critical reflection journaling (Kitchener & King 1994), fieldwork memos-to-self; and sketches and models for meaning-making.

74 The Australian Bureau of Statistics completed the National Health Survey (2007-2008), with the summary of results being distributed in 2009. The group of women with the greatest level of high-
The processes involved in recognising substantive statements and their meaning (Frost et al. 2010) from all of the RWR data collected (RWR dataset) was guided by the inquiry’s purpose (to co-generate actionable knowledge to improve midlife women’s recovery), my use of multiple analysis and interpretation methods\textsuperscript{75} to view the data, and applying inductive, deductive and abductive reasoning (Bradley, Curry & Devers 2007). Response data were not forced to fit the coding scheme. New ideas created new possible codes, and these were evaluated in the next Action Cycle for inclusion. Coding possibilities (terms, phrases and words) were selected in six ways (detail is provided below).

**TMAR Pearls analysis and interpretation**

The multiple analysis strategy (Pearls) provided appropriate data analysis methods for the mixed data collection techniques in RWR (Cresswell & Piano-Clark 2007). Pearls analysis was completed in planned steps. To meet the RWR goals, analysis and interpretation\textsuperscript{76} of the data was cooperative, complementary and integrative (Polkinghorne 2006; Greene, Krieder & Mayer 2011). The broad and specific ways of analysing the data were selected to be relevant to the topics, data collection methods\textsuperscript{77} and the needs of the participants.

\textsuperscript{75} A range of data collection and data analysis tools provided a means to foreground a multidimensional view of recovery reality (Meetoo & Temple 2003). The aim was to represent the participants’ experiences of the phenomena being studied and select through analysis methods the data that contributed answers to the research question (Hesse-Biber 2010). The research respondents became ‘the expert’; it is his or her view of reality that the researcher seeks to interpret. With multiple voices, interpretation also explores the process of human meaning making. As the researcher I facilitated reaching a consensus of understanding (from empathic to critical) of the data contributed.

\textsuperscript{76} I distinguish between interpretation and analysis. Analysis techniques (based on close scrutiny, investigating and examining collected data) comprised ways of studying descriptions, propositions, explanations and constructs of understanding (Frost et al 2010). I understood interpretation, following the etymological explanation of Klein (1971 p 383 in Van Manen 1990 p 26), to mean explaining in ways that mediate: between the participants, researcher and the reader/listener/viewer. I was open to both my analysis and interpretation being confirmed or disputed by participants, as part of their contributions to the robustness of the research.

\textsuperscript{77} Effective data management was a priority; it involved the ongoing recording, cleaning and entering of text into the RWR databases. New data included material received from outside of the formal Action Cycles, e.g. an email from a practitioner, a new ABS data cube. At weekly intervals, a variety of materials (now data) were categorised, batched by date, and set aside to be included in the data analysis process.
### Table 4.2: Pearl analysis and interpretation techniques

<table>
<thead>
<tr>
<th>Total participant responses over the six Action Cycles</th>
<th>Participatory Action Research</th>
<th>Unobserved Observation</th>
<th>Document &amp; Expert Exchange</th>
<th>Action Science</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 110 visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 119</td>
<td></td>
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</tbody>
</table>

**Overview**

Cognitive semantics (Kuhn, Raubal & Gärdenfors 2006) studies how human minds construct meanings in the form of natural languages, as well as symbol systems.

A priority for RWR understanding was the women’s changing recovery needs and suitable ways to improve women’s health, self-knowledge and adult development over the long-term.
My role was to maintain the transactive nature of the study and an ongoing critical, yet progressive, focus\textsuperscript{78}; this was to find and develop successful ways to improve women’s recovery care (Rhodes & Coomber 2010). The designing, planning and appraising of analysis at each Action Cycle of RWR was documented by my procedural note-taking (Douglas & Douglas 2005) and recorded supervision meetings.

\begin{center}
\textit{The process of progressive focusing emphasises discovery and development, the use of induction and flexible research design.} (Rhodes & Coomber in Miller Strang & Miller 2010 p64)
\end{center}

**Extended content and concept analysis** – The following three content and concept analysis approaches (Hsieh & Shannon 2005) were applied to interpret the RWR data that was collected\textsuperscript{79}. 1) conventional content analysis, with coding categories derived directly from the text data; 2) the directed approach, in which analysis starts with a theory or relevant research findings as guidance for assigning the initial codes, e.g. allostatic load theory and stress (McEwan 2005); and 3) a summative content analysis,\textsuperscript{80} which involved counting and comparisons, usually of keywords from selected literature or glossary terms. Common words evident in the interview texts of the women in recovery and practitioners were checked with AOD guidelines.

\textsuperscript{78} The focus was regarded as being ‘progressive’ as it was open to new ideas; this involved identifying similar ideas in the accumulated data in order to progress the focus towards the most important factors for women’s sustained recovery (Bryant & Sharmaz 2007; Rhodes & Coomber in Miller, Strang & Miller 2010). The value of a progressive focusing process became more apparent with the increase in participants and data; and I responded to this through the use of systemic thinking (Marshall 2004) and critical reflection (Brock 2009).

\textsuperscript{79} The success of content analysis depended on the coding process (the RWR process is explained earlier in this Chapter). The RWR coding scheme involved the development of processes and rules of data analysis that were sufficiently systematic and trustworthy to be able to reveal a richer understanding of the phenomena being studied. The basic coding process organised the large quantities of text into much fewer content categories. These categories were subject patterns and topics that had been directly expressed in the text or derived from the text through analysis, e.g. beliefs. As analysis proceeded, additional codes were developed, and the initial coding scheme was revised and refined. The outcomes offered potential for preparing working statements to consider as RWR findings.

\textsuperscript{80} The summative approach to content analysis is fundamentally different from the other two approaches. The text is approached as single words, or in relation to particular content, e.g. AUDs interventions. An analysis of the patterns enables the researcher to interpret the contextual meaning of specific terms and content. These meanings were then presented to the participants, and to attendees at research and professional conferences for consideration and feedback.
My analysis of the patterns led to an interpretation of the contextual meaning of specific terms and content; followed by working interpretations of the underlying context; and an exploration of the beliefs and assumptions associated with the words being used. The interpretations were distributed to the participants in the RWR newsletters for feedback and comment. Exploring the data revealed how the process of meeting recovery development needs also served as catalysts for women remaining in recovery, such as learning better decision-making skills.

wyn7, Action Cycle 2, Q58 Questionnaire: Childhood memories are helping me understand myself now. I had a safe and secure home (no violence or abuse), but I always had fear and self-consciousness. Facing up to my fear and taking risks and accepting change are all aspects of [the] recovery I keep 'chipping away' at. I am sometimes still quite fearful of change, and can find it hard to make decisions [I become immobilised].

**Thick-concept analysis and critical reflection** – Levering (2002) used thick concepts[^81] to understand the descriptive part of people’s expression, which often included the language of feeling, e.g. disappointment. It was particularly useful for my Unobserved Observation. This technique differentiates between general concepts, such as learning (often highly defined and abstracted), large concepts, such as deceiving, promising and shyness, and 'thick concepts', such as bullying and teasing (disturbing and damaging). Thick concepts are also action-guiding; they are not decisive in the taking of action, but they play an important part (van Manen & Levering 1996). Thick concept analysis challenges investigators to proceed at a deeper level – moving beyond examination of ‘what happens and how?’ to ‘how we think and feel about what happens’, and to ‘what does this mean and why does this occur’?

[^81]: Williams (1985) describes the characteristics of thick concepts as forms of unity of fact and norm. The qualitative character (I suggest the qualia) was found in the descriptive component of this research. The descriptive part of women’s recovery enables personal beliefs and truths, as well as social and physical explanations, to be used to elaborate on the circumstances of the practice in context, e.g. stigma.
Relational analysis, themes – Two broad processes were used to manage the condensation of data\(^{82}\) (Robinson 2011). The first parallel process (parallel to analysis in Participatory Action Research, Unobserved Observation and Action Science) was used to condense textual data from core participants, selected transdisciplinary literature and expert contributions (Document and Expert Exchange). The initial process involved combining of themes and topics by inferring relations between them (relational analysis). The second process involved the locating and labelling of discrete, meaningful parts of the participant responses, e.g. subjects from the content analysis that were related to, or contrary to, the themes and topics. The search for connections, and finding no connections, enriched my understanding of the participants’ responses. When data were combined within and across Lines of Inquiry, new understandings of relationships were revealed. Initial topics and themes became more meaningful and coherent, and some were able to represent or convey broader holistic concepts and constructs of women’s identified recovery issues, structures and processes.

Themes were selected that characterised specific experiences of individual participants according to the more general insights that were apparent from the whole of the data, particularly my Unobserved Observations field notes. ‘Living a principled life in the everyday’ was one theme that emerged with women who had more than eight years in recovery. For understanding midlife women’s ongoing recovery, thematic analysis (Boyatzis 1998) contributed to local working theory-building\(^{83}\), using higher order thematic categories, known in RWR as clusters and groups.

Classifying terms and themes (words as meaningful subjects in the data) was used throughout the study to organise research content for each subsequent Action Cycle. This provided opportunities to work with participants to prioritise, clarify or change, if necessary, the meaning of terms and categories and the relative importance of recovery themes. Participants (the women and the practitioners) were

\(^{82}\) Relational analysis is an integrative technique that can be applied, with the support of suitable software programs that can handle large amounts of text for analysis (in RWR, NVivo 8 and 9). NVivo was used to explore possible relationships in the RWR data (Robinson 2011). Data combinations in RWR included analytic themes, clusters, subject grouping and preliminary results.

\(^{83}\) Modifiable propositions that help explain, predict, and interpret events and phenomena of interest (Patton 2002).
asked to check topics based upon their priority of needs. I considered the input needs for investigating new subjects and suggested configurations and relationships between topics. The information relating to terms and themes was refined to make sure that what was most needed by women in recovery, was prominent in the results. This contributed to a corresponding hierarchy of ‘priorities for care’ to assist practitioners and expert peers. For example, in early recovery, women feeling safe was a more important care priority than women feeling happy.

kmp2, Action Cycle 2, Practitioner questionnaire: My job ... developing inner calm and self-caring nurturing.

**Concept mapping** – Concept maps\(^{84}\) (mind maps) in RWR served as graphic organisers (Nesbit & Adescope 2006) that showed labelled processes and entities, e.g. personal, social and environmental factors, with notations denoting relationships among key elements. By placing ideas in different forms (e.g. triangles, representing important details using icons, or showing dimensions of movement, place and time with colours), critical and creative thinking was stimulated, and connections and sequences were revealed. An example is my recognising respite as an important process to prevent relapse.

In RWR, concept mapping was used to develop adequate understandings of commonly nominated situations that the women and practitioners reported as being important features of recovery. This mapping provided another Action Science record (along with output from Participatory Action Research, Unobserved Observation and Document and Expert Exchange) of recurrent elements and factors that were used to identify unifying concepts (e.g. long-term abstinence requires recovery development); these were based on statements about subjects in the original data. Concept mapping also provided a way to initiate dialogue (Risisky et al 2008) with women, practitioners and interested community members to stimulate intuitive thinking among stakeholders, including families and government, around the topics of AUDs recovery, abstinence, health and wellbeing.

sue8, Action Cycle 1, Women’s questionnaire, My Recovery: Shame, fear, anger, misery, I wound them all up. Worried about how fearful I was.

\(^{84}\) An example, developing a resilience sketch.
Depressed about my misery, ashamed of my anger, angry about my shame. Stuck!

Identifying cognitive information (mentalisation; people’s thoughts, feelings and beliefs) and the social contexts of the information (situatedness) provides a useful technique for understanding a phenomenon (Kuhn, Raubal & Gärdenfors 2006). Cognitive semantics is concerned with understanding how human minds construct meanings in the form of natural languages, as well as symbol systems. As a research benefit, the socially situated nature of language (norms and conventions) also highlights social process and context, including constraints. For women in recovery to be able to experience a particular situation (e.g. attending functions without drinking and engaging with people at the function), it became clear that they needed to learn a new language, and be supported to experience new social interactions with experienced recovery peers.

An example of the outcomes that the cooperative RWR Pearl analysis and interpretation provided: emotions and purposeful recovery

Participants’ shared their ways of recovery in Action Cycles 0, 1 and 2, by answering questions about ‘what happened, and what helped and hindered recovery?’ Their responses enabled me to investigate at a deeper level how women’s thoughts, feelings and actions (Damasio 1999) affect their recovery. Women’s recovery involved the meaningful discovery of an aware non-drinking ‘me’, finding mature ways to work towards joy (emotion science; Moses & Barlow 2007), peace and wellness (Myers, Sweeney & Witmer 2000) through highly valued long-term abstinence (Vaillant 2005; Fein et al 2006; Dawson, Goldstein, & Grant 2007; Grant 2009; Laudet 2010).

Critical to the process was women and significant others learning about emotions and how structural, anticipatory, and consequent emotions (power and status process of emotions; Kemper 2008) have effects on oneself, and on one’s ability to relate to others (social emotions; Frewen & Dozois 2011) and live a personal and comfortable work, leisure and social life.

In Action Cycles 3 and 4, analysing the participant responses about emotions revealed an important lack of knowledge and skill; being aware of and able to

85 The ontology of cognitive semantics is that meaning is a perception, a psychological phenomenon, based on phenomena in the world. An individual has a situated embodiment of meaning, where meaning has been and is developed through experiencing the personal and social settings of language use. Semantics need to relate to meanings in human minds: ‘Words don’t mean; people do’. These meanings have observable affect and effect, primarily in the form of actions in the world resulting from pre-existing forms of understanding meanings, and the dynamics of contributing through action for achieving new meaning and understanding.
initiate the human process of signalling emotional and physical availability for social communication (De Leo 2008). Women in recovery coming to understand their guilty feelings, the releasing of shame (Corrigan et al 2006; Price Tangney, Stuewig & Mashek 2007) and reclaiming worthiness were critical recovery development processes. However, women’s capabilities of interaction and transactions (e.g. social expression of an autonomous self) in recovery were critical for wellbeing.

Aware interdependence strengthened the women’s volition (post-intention action; Sneddon 2006; Schwarzer 2008) to remain in recovery and develop dignity and ways to sustain wellness with other people in their life.

My role was to follow-up on participant requests for information, ways to learn about gendered emotion (Shields et al 2006), and practice the language of emotions with helpful peers. Providing relevant and current evidence-based studies on interventions provided the women with choices for taking knowledgeable action.

Actions informed by understanding and experiences of emotion (and memory, mood and motivation) enabled the women to build agency through the release of helplessness and reclaiming of personal power (Kemper 2008). The midlife women learned to build autonomy and authenticity through facilitated release in early recovery (the first six years of abstinence) from personal disturbance and trauma (overcoming fear; Lowenstein & O’Donoghue 2006; McLean & Anderson 2009). Also, with the provision of informed therapeutic care and peer support, the women’s identification of anger (expressing the feeling; Rime 2009) helped them to reclaim their self-reflective mature identity (Hartman & Zimberoff 2004) and develop skills of critical reflection, and so experience mental, emotional, physical and spiritual comfort.

In Action Cycle 4, women making abstinence and recovery decisions regarding multiple identities and roles required discussion with informed and trusted peers and practitioners (James 2002; White et al 2003; Padilla-Walker 2008; Stephens 2009). The process provided an experience of adult dialogue, learned in the context of safely experiencing emotional and physical healing (Bargh & Williams 2007), mental health and eventually wellbeing (Cummins 2008) of the mind, body and spirit. Women’s beliefs and attitudes (Marich 2010; Jorgenson 2010) were gently explored with knowledgeable people (with occasions of painful exploration), along with discussion of agreed recovery direction, intentions and actions for adult effectiveness (Thase 2006). In Action Cycles 5 and 6, it was agreed that developing a robust sense of self that was able to determine optimal actions in recovery (self-concept maturation; Corte & Zucker 2008) was a challenge for 35 to 59 year old women. Prioritising self-care (physical health, reflecting on possible transitions, considering existential life purpose with mental and emotional coherence; Mauss et al 2005), and a sense of belonging in the community with connection to peers in recovery took self-management and relationship skills. Sustaining recovery required the women to enact over time their perceived worth and hope, self-awareness and presence in everyday activities, social adjustment (Attridge & Ghali 2011), sharing collective efficacy and with earned resilience (including emotional sobriety; Dayton 2007), effective personal response to uncertainty, and new experiences.
Cognitive semantics was recognised as a necessary meaning-making tool as RWR Action Cycles progressed. The communication and language in use was being shaped by research processes much more than by a static structure of interaction via surveys. These meaning-making processes helped me to remember that ‘whole people’ have information needs. The transactions were more than abstract research methods, the situational and personal context influenced my seeking both useful and usable solutions to the women’s circumstances. It was therefore essential to seek feedback on interpretations from participants.

The six phases of the Recovery Continuum

Action Cycles 1 to 6 revealed, through the women’s and practitioners’ experiences of abstinence and AUDs healthcare, a continuum of recovery. The six phases of the Recovery Continuum – Distressed, Enact, Enable, “I’m in recovery”, Complex and Valued Recovery – represent the changes in wellness processes that are involved in the women’s midlife recovery. These changes involved: an identity-challenging experience; the important processing of an adult self and the meaning of related negative and positive events; the emotional, mental, physical and spiritual impact of the AUDs experience; necessary enabling guidance to work through detrimental issues; and the women committing to long-term recovery as a catalyst for positive self-transformation.

Each of the six Recovery Continuum phases discussed below include a theme, an RWR Essential Recovery tool and recovery information in the form of a message to support more women in being able to address their AUDs.

Distressed Recovery

This first phase involves women and practitioners, and their families and friends, in understanding how women’s disorganised schemas of active AUDs can change from destructive actions to abstinent awareness and recovery action. Recovery is possible and can work for the long term.

Destructive actions, CBS6 woman, New women interview: I felt that if the children were away, then no-one would know or care if I was alive or dead.
Recovery action, jah1 woman, Face-to-face interview: *I think that it’s becoming really important for me to have people around who are trusting and respectful and care.*

Providing midlife women during detoxification and in early recovery healing with an environment with knowledgeable people who provide respectful nurturing, is the major **theme** of this phase (Kearney 1998). Engaging midlife women with safe and non-judgmental care to enable expression of their experiences is essential, but not enough to begin AUDs recovery. Enabling midlife women to feel ‘cared for by an adult’ and ‘listened to’ with nothing expected in return provides a place and time to stop the daily struggle and begin to heal. Women asking questions are supported by providing simple explanations of the physical and psychological damage in conversations to meet the women’s needs. This is far from the women’s common experience of growing anger at ‘being told what to do’ and becoming more vulnerable, withdrawn and fearful.

The **ASK tool** might appear simplistic, however, women with AUDs find making contact with people very difficult to maintain and they need close guidance and practice to create this important process as a routine in their daily lives in early recovery. **ASK:** **A** is taking personal small **Action** steps **Away** from alcoholism and into recovery; **S** is **Seeking** a Safe non-drinking place, **Speaking** with/texting **people** who understand non-drinking **Self-care** and recovery; and **K** is **Keep-on asking** Knowledgeable people for assistance to stay safe and not drink.

The **messages** that women in recovery wanted to emphasise to help other women at any ‘drinking problem’ discussion or consultation were:

1. ‘Women are Worthy’ of supported self-discovery in recovery care;

2. ‘Recovery Works’, and abstinence in midlife is a survival priority for women because of the severity of damage of chronic alcohol dependence on a female body; and

3. ‘Midlife Women Matter’, especially in a state of suffering; feeling shame, guilt and fear.
The ideas were used to create Knowledge Translation resources for public education and professional education (Chapter 3: Praxis). Such resources were and are an urgent health need. Over 17 per cent of clients using alcohol and drug treatment services in 2006–2007 were aged 45 years or over. This client group is more likely to have used alcohol and other drugs for longer periods creating greater likelihood of having a range of other physical and mental health problems including chronic illnesses such as diabetes, liver, kidney and heart disease, cognitive impairment and dual diagnosis (VicHealth 2009).

**ENACT Recovery**

Enacting is an early recovery process for understanding and accepting AUDs diagnosis, and for transforming the negatives (e.g. shame), and experiencing the positives. Enacting early recovery living is achieved with the care and help of nominated supporters, as the women begin to take the difficult ‘I’m no longer drinking’ actions. Nominated supporters are selected by practitioners and peers in recovery. Family and friends are included as agreed by the women.

Whole person healing\(^{86}\) in early recovery is a difficult process, primarily because of the complexity of the disorder. The women begin to face their present situation as alcoholics who are no longer drinking. They remember fragments of active alcoholism and are respectfully reminded by supportive family and friends of what occurred. A critical learning drawn from participant responses for this period was that facing such adversity and uncertainty alone most often resulted in a return to drinking.

Alcohol consumption and brain damage is well documented, with neuropsychological rehabilitation (with no consumption of alcohol) being recommended (Bates et al 2005). Understanding the physiological damage and psychological disorder of AUDs begins to limit the misunderstanding that alcoholism is a subjective choice. Genetics and life events both contribute.

\(^{86}\) Psychosomatic research, with the inclusion of brain neuroscience, is healthcare for whole-of-self wellbeing (the biopsychosocial including emotional wellbeing) rather than a dualistic mind-body approach to health and medicine (Lane et al 2009).
Being with people who are abstinent, even when the women are resistant, provides realistic examples of self-caring and healthy recovery living. Empathy and encouragement by practitioners and peers to also self-care is a beginning of an effective process to maintain recovery. The ENACT process developed in RWR, encourages self-discovery and learning for personal recovery; this means that, without alcohol, the women must deal with their emotions, question their beliefs, heal their bodies and explore their values explored (Fadardi & Shamloo 2009; Sheppard 2011; Kelly, Stout & Magill 2009).

Cat1, Action Cycle 2, woman, Face-to-face interview: ... with everyday stresses you can be prepared if you’re taking care of yourself.

At this time in women’s recovery, the ‘I’m so tired’ phrase was a common theme. Meeting the particular exhaustion needs described by all women participants can improve recovery care. A knowledge gap was identified in the alcohol and other drug and addiction literature; this was resolved with the integration of Action Cycle preliminary results and synoptic thinking.

Mxf4, Action Cycle 4, Women’s interviews: I was exhausted. I went and had a heart check, I thought I had heart problems, and I told the doctor I was going through menopause, and then I went to an anxiety management clinic.

I went to drug and alcohol counselling and I listened to them while they told me about the different alcohol content (in different drinks). I put up my hand and nodded my head and said yep I had tried control drinking. And I’d leave there and I would go to the bottle shop.

I told my husband that I was going to leave and go and seek help because I could no longer go on destroying the family. My little boy, my son was eight then (he is 21 soon), told me that I didn’t have to go.

Fatigue is a result of the damaged brain-pain mechanisms (Gatchel et al 2007), physiological damage to all body systems (Diehl 2007), and the women’s complicated psychosocial position. Midlife women being correctly informed about

87 Applying a synoptic thinking process means bringing together (from transdisciplinary literature searches) a range of complementary understandings on one issue (Bohm On Dialogue 1996), leading not to consensus, but to a deeper understanding of the whole (Brown et al 2006). Synoptic thinking will be discussed further in the Knowledge Translation section of Chapter 3 (Praxis).
high levels of fatigue during early abstinence, and following healthcare advice to heal, can help to reduce this fatigue. Explanation of the difference between tiredness, as usually being transient and temporary, and fatigue as being felt as an ongoing characteristic, creates a first understanding. In alcohol dependent women (even when abstinent), fatigue is generated by cognitive distress, physical and emotional pain, spiritual or moral guilt and shame. Complex fatigue is a legitimate care need in early recovery, and not a ‘self-pity’ complaint, as perceived by some practitioners, family members and the women themselves. The ignorant retort ‘you have brought this upon yourself’ (experienced by all of the women in recovery participants) does not reduce fatigue or assist AUDs recovery.

gle4, Action Cycle 4, Participant Reference Group, questionnaire feedback: [Women's] ongoing fatigue adds to relationship distress. They [women] are unable to cope with such things as disrupted sleep, eating too little, increased headaches, dealing with symptoms of anxiety or depression (such as panic attacks).

The women talked about an overwhelming sense of exhaustion88 and an absolute decreased capacity for physical and mental work; and that relief was difficult, even with food, rest, sleeping and simple pleasures (a gentle nature walk, a massage). There is too little known about the pathophysiology and the neuropsychological impact in regard to fatigue of recovery from AUDs. In developing an understanding of this sense of fatigue, it is known that appropriate activity can help to reduce fatigue during depression (Weaver 2000). Piper (1997) has identified the following six general dimensions of fatigue. These are listed with examples from the RWR participant Action Cycle responses (in italics):

- Temporal: Timekeeping was difficult for women in early abstinence, all activities took far longer than expected, and to remain present (accurately perceiving the environment and context) took conscious effort.

- Sensory: The women reported startling vividness and acute recognition of sight and sound. Taste, touch and smell often seemed unusual, and took

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88 The effects of alcohol (Fox et al. 2008) on a woman’s body, mind and spirit needs to be outlined and provided as a brochure. With chronic alcohol dependence, at midlife, it is usual for extensive and lifelong co-morbidity to appear (White 2002; Dingle & King 2009). The need for an extended hospital or clinic stay to receive complex care and monitoring is more likely in midlife. Respite stays to avoid relapse is an effective strategy, but difficult to arrange in the current healthcare system.
months to return to expectation. Sometimes touch was impaired by neural damage through alcohol consumption.

- Cognitive: Mental abilities were ‘slow, lacking focus and concentration, and the women were often forgetful’ (due to brain atrophy; Mann et al 2005), ‘the fog takes time to lift’.

- Affective: This was the most difficult area for the women’s progress, and it added to the fatigue; limited abilities of emotional awareness, false belief recognition, mood regulation, the presence of imposing memories, and extremes of motivation and action.

- Behavioural: It took time for the women to be aware and experience being part of daily life routines and events; when they felt pressured they often reacted abruptly, followed by self-reprimand behaviours that were difficult to stop.

- Physiological: Learning about craving and being slowly introduced to the damage to their bodies (e.g. acknowledging the level of liver damage alcoholic cirrhosis), and understanding and accepting realistic assessments of the time and actions needed to heal were difficult.

Achieving physical health after detoxification needed focused attention and careful prioritising in the use of their energy. Medication routines, making appointments (e.g. dental) and attending counselling to begin to talk about difficult topics, such as partner relations, protective denying and lying, social activities and ‘feelings of wanting or needing a drink’ are essential. Preparation of food for addressing malnutrition and weight loss or gain is necessary, along with controlled mobility until skeletal frame and bone density is checked. The need to be mobile is important for avoiding constipation, maintenance of muscle and bone strength and circulation.

The women and practitioners also noted the opposite to procrastination occurring,

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89 RWR participants emphasised that anxiety and fatigue when interacting with other people would occur. They described noticeable draining of energy required to be alert, communicate or participate in group activities, and that thinking about a drink was often a following consequence. Being with non-drinking people at events took time to learn how to interact, and most women had needed to practice or roleplay with supporters to gain such experience.

90 Patients with alcoholic cirrhosis seem to be predisposed to the hepatotoxic effects of alcohol, and the affected women seem to be even more sensitised. Binge drinking, rather than continuous drinking, does not seem to be especially associated with the development of cirrhosis. That women had drunk less alcohol during binge drinking further emphasizes this (Stokkeland et al 2007).
in that many of the women became overactive (‘doing’) and over-physical (‘gym junkies’). Guidance by AUDs-aware physiotherapists in exercise routines suitable for recovery is suggested.

red1, Action Cycle 1, Women’s questionnaire, My Recovery: I have a choice today to either return to my ‘old’ life of fear, shame, loss of dignity, or to continue with my new life, which is exactly that – new. I don’t want one single part of my old life back ever! I am so very grateful that I have been given this ‘gift’ of recovery as early as I have.

Enacting is not a ‘quick fix’. Recovery from AUDs involves a complete change of ways of living. A common objective of midlife women in early recovery is to change self and the world by the weekend. The new energy, after the women’s body is detoxified, excites women to pursue unrealistic expectations (e.g. perfection) based on false assumptions, particularly, that they can readily control their AUDs and life circumstances (Lachman & Agrigoroacei 2011). The women then swing to an ‘everything and everyone is wrong’ stance, combined with a ‘just do it’ problem-solving approach, which is vastly unsuccessful and the women drink again. This is why guidance in enacting midlife recovery is necessary. The critical care objective of ENACT is to present gently to women in early recovery useful and helpful processes, with an understanding that their perception and perspectives of the world and themselves are distorted by AUDs. The greatest distortion is they can be a non-alcoholic unique woman who has AUDs and lives well with drinking because ‘I can control’.

Action Cycle 1, Women’s questionnaire, My Recovery: jah1 It’s a daily process for me. I am a dual addict so sober for me is specific to my alcohol. It means to me that I haven’t had a drink today, and that I am in control of my life and my mind – that I have chosen not to have a drink today.

trag: Relief – at last I knew what was wrong with me [alcohol dependence]. I was fearful – would I be able to change? I had no choice, change or die.

Not knowing how change happens, from addiction to abstinence, is the topic of articles through the close of the study in 2013. An example in 2005; ‘models of change should be broadened so that treatment is seen as a complex system of parts, facilitating a nexus of cognitive, social and behavioural changes, embedded within a broader system of events and processes catalysing change’ (Orford 2005 p60).

Comment made by many women who shared in open AA meetings which the researcher attended.
The essential **tool** in enacting is to meet developmental needs while recovery occurs. Difficult change is a ‘response-ability’ for an adult; and women with AUDs will need safety and socio-emotional support to transition from reactions to achieve positive responses and outcomes (Jame 2002; Kralik 2003; Hunter Institute of Mental Health 2007; Damsio 2000, 2010). According to RWR participants, profound midlife change of women’s mind, body and spirit (Vaillant 2005; Sanders 2006; Oakes 2008; Straussner & Byrne 2009) can sustain recovery. However, such profound changes require knowledgeable care[93] and support. The five features of ENACT provide a resource guide for people who care for women in recovery with AUDs.

The **message** for women from other women in the enacting phase of recovery is to recognise the deceptive paradox that consuming alcohol to produce a ‘relaxed’ self, yet remain in control of all current circumstances had the opposite effect. Primal drives dominated the women’s lives in active alcoholism, and there was little if any control of the situation and context while consuming alcohol (neurobiology of addiction; Erickson & White 2009). The women’s hypersensitivity to underlying threats, fears and anger, became more apparent to them when abstinent (Chandet & Stanick 2010), and because of this, hypersensitivity could more readily be lowered through professional care and self-help group support. Also, when recovery was more comfortable, underlying emotional events could be reconsidered with developmental guidance.

The women participants also emphasised that ‘concerned others’ needed support and education not only on AUDs, but also on the recovery continuum. Discussion is also needed with healthcare professionals, and with the women and people close to them to reach agreements on practical ways to be most helpful (part of an ethical approach; Kleinig 2008). The women needed to be able to express their support and cooperation by explaining, for example, the need during recovery to limit interaction for a set time.

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93  RWR was a means to understand how women stopped drinking, established abstinence and lived well in recovery. I was influenced to study women’s recovery when reading the proceedings summary of the International Society for Biomedical Research on Alcoholism (ISBRA, Mannheim, Germany 2004). ‘Alcoholic neurobiology – changes in dependence and recovery’ (Crews et al 2005). There was an understanding of changes that occur during active alcoholism, and what may occur during ‘recovery-abstinence’ from alcohol dependence.
CBS64, Action Cycle 4, New women interview: *I mean, for me, recovery has allowed me to grow up. It’s allowed me to behave a little bit more like an adult. I am a very responsible adult, I manage a team of people and make school lunches and feel like I am a successful human being.*

wyn7, practitioner, Action Cycle 4, Participant Reference Group questionnaire: *We need more useful ways a health practitioner can identify a woman who may have a drinking problem, AND help the woman to identify her alcohol dependence disorder. I think the indicator and contextual questions are a good idea.*

The process of healing the psyche and physiology, to establish a core self and then an autonomous individual (including an abstinent-in recovery primary identity), is essential (Withnall, Hill & Bourgeois 2007). Likely marginalising and threatening experiences, including family, work and community expectations dominating the women’s recovery, can limit or reverse the transitions (Leonard & Eiden 2007). Life turning points are more likely to be dramatic moments, rather than things experienced in continuity (Elders & Johnson 2003). Time, energy and focus are essential resources, as the recovery process involves personal transcendent experiences and building resilience (Smith-Osborne 2007). There is also a need for awareness of seeking a personal equilibrium of fixedness and flux that is harmonious for the woman’s core self, primary identity\(^94\) and everyday life-course maturation in recovery.

ycs1, Action Cycle 1, Women’s questionnaire, My Recovery: *Being a good role model to my grown children. Being a responsible parent who listens.*

The participants emphasised that practitioners need to be prepared for women ‘not knowing’ or not comprehending that their general distress and sickness are outcomes of alcohol dependence\(^95\). Resistance (including women preferring a diagnosis of anxiety or depression, and not alcohol dependence) that is associated with the stigma attached to alcoholism (Sane 2006) can be worked through with

\(^{94}\) Personal identity formation in adulthood, constituted by particular values, i.e. non-drinker, is an understudied area of middle adulthood.

\(^{95}\) Participants referred me to situations of unethical behaviour by doctors when their patients were under the influence of alcohol (Medical Board of Victoria 2007).
weekly primary care appointments\textsuperscript{96}, e.g. self-care, medication and nutrition advice, guidance to attend self-help groups or ancillary health appointments, and physiotherapy (necessary for long-term recovery; White 2009). Frankness developed in a therapeutic relationship can lead to referrals for specialist counselling and admission for in-patient care for abstinent recovery programs, depression monitoring and the development of improved relationship skills.

The other important group of participants comprised the health and medical practitioners\textsuperscript{97} of the alcohol and drug, and addiction sphere of the health and medical system. What I learned in the trial was that it was particularly important to communicate with the practitioners with respect and care, and to open a space in which their unexplicated and deep structure beliefs and feelings could emerge and be addressed (Bishop et al 2002). The practitioners’ story is incorporated into this study of women in recovery; particularly their recognition of the need for services that can better provide quality abstinent recovery care; their difficulty with the integration and delivery of complex care; and their limited and rare experiences with ongoing complex care and client management for monitoring and supporting women’s recovery over their lifespan. A transactive participation research study with the practitioners is needed to help improve the provision of quality care; this would be an important future study.

Mental health and drug and alcohol nurses who provide care for clients with AUDs often experience misunderstanding and prejudice in relation to their clients and to their professional role (Cleary, Horsfall & Happell 2009; de Crespigney & Cusack 2003). For example, when I was trying to involve practitioners in my study, I experienced difficulties accessing hospital emergency unit staff and drug and alcohol liaison consultants; general practitioners (National Heart Foundation of

\textsuperscript{96} Primary GP care has been criticised, modified and new ventures are required. The study highlights the role GPs play in helping people deal with social problems, but also identifies limitations in their response to these problems. It points to the need for more integrated pathways to accessing help and advice for social problems. Primary care can make existing pathways more visible and accessible, and create new pathways through, for example, the new commissioning role and extending the scope of social prescribing (Popay et al 2007).

\textsuperscript{97} The participating practitioners came from varying training and education backgrounds, and many – particularly those who were alcohol and other drug workers (AOD; Kelly 2009), community counsellors and social workers – spoke of being ‘fringe dwellers’ in the Australian healthcare system. As fringe dwellers, their isolation also made therapy difficult and sometimes ‘extra’ difficult because of prejudice and the associated exclusion experiences of both client and practitioner within the health field.
Australia & the Royal Australian College of General Practitioners 2008) and psychologists, psychiatrists and addiction specialists.

Over the seven years of the study I maintained contact with professional associations, observed their communities of practice, and continued to submit research proposals and result summaries (e.g. RADAR [Register of Drug and Alcohol Research] and ROAR [Divisions of General Practice, Primary Health Care Research Information Services] portals and the Drug and Alcohol Nursing Association, Royal Australian and New Zealand College of Physicians, Addiction Medicine) to attract more participants from these groups. There was, nevertheless, a small number of this ‘difficult to access’ group of professionals who did participate.

According to Huberman (1999 p311), “Mindshifts are invariably self-initiated”. Polkinghorne (2002) found that practitioners depend largely on internalised and culturally provided background knowledge to guide their work.

Addiction: the reliance on a short term solution that causes a worse problem than the one it was meant to solve. This short term solution becomes necessary and fundamentally weakens the system at the same time. (O’Connor & McDermott 1997 p249)

The practitioners indicated their frustration with the frequency of limited and late treatment for midlife women; when more could be achieved with an abstinent recovery approach than with a harm minimisation framework. Caring through enacting and enabling was their preferred treatment approach. To achieve this with midlife women, the practitioners’ own experiences needed to be broadened through the development of improved adult learning techniques, provided through professional development channels.

Triple-loop learning is used to address not only instrumental actions (skills, single-loop) and driving values (double-loop), but also possible errors embedded in personal beliefs and familial tradition systems. It is these particular norms (that can be naïve, incorrect, misconstrued and/or maladapted) that shape and constrain people’s values, perceptions, expectations and actions (Seo 2003).

The overlaps in the practitioner model (Figure 4.2) represent their everyday interactions, difficult as they were with traumatised adults that held false beliefs.
Figure 4.2: Needs of practitioners caring for midlife women with alcohol use disorders

**Key:** The **three spheres** represent the practitioners' personal abilities, their work environment and their place in the health and social system. The **overlaps in the figure** were identified as the difficulties the practitioners experienced when providing care for women with AUDs. The RWR study explored how to assist practitioners to improve abstinence recovery healthcare, identify their personal professional development needs, and ways to encourage change in their organisations to enable more women-oriented, abstinent recovery treatments. The large **boxes and arrows** acknowledge RWR activities to provide practical outcomes, i.e. actionable knowledge of recovery care, development and support. **The centre** of the overlapped spheres is the difficulties practitioners face to assist women, importantly, *How to begin the process?*. RWR offered proposals to assist practitioners to enable recovery change with Engage, Embody and Enrich in Action Cycle 2. The process was refined by participants and the complete intervention is explained in the results; ‘Complex Recovery’ of the ‘Recovery Continuum’ later in this Chapter.
The practitioners in the study wanted access to more education and resources, and agreed pathways to integrate safe care and support as the women’s abstinence stabilised and their recovery changed.

**Engaging** effectively with women with trauma backgrounds and co-occurring mental disorders requires access to suitable therapies that can address their circumstances and disorders to sustain abstinence. **Embodying** change at a fundamental level of being, requires time (more than is usually available) to understand and to develop a sense of self. **Enriching** relief, happiness and usefulness is achievable in abstinence when the recovery care, development and support are carefully enabled (again, often not easily done within current frameworks).

**Praxis** – Initially, my definition of praxis was informed by my observations of committed practice and critical care (a modification of Carr & Kemmis 1986) by the practitioners. New understanding through the research process and awareness that the study was providing more detail than expected meant that my emphasis on praxis could expand. I extended the data analysis to incorporate theory-building for AOD, and the related fields of addiction and mental health.

> Praxis ... to refer to a cycle of activity that includes (1) philosophical, (2) contextual, (3) human needs, and (4) pragmatic considerations. These four considerations form the basis of a framework designed to help us bridge across disciplines and integrate values, research, and action. (Prilleltensky 2001 p748)

**KT** – Knowledge Translation of health, women’s needs and ecological understanding of recovery (Quinn, Thompson & Ott 2005) was provided in the study through by considering living system scales, from micro to mezzo. Developing knowledge that can be translated (Van de Ven & Johnson 2003) into pragmatic materials was demanding. It began with defining my objectives to: improve practitioner intervention skills; develop broader meaning-making for early intervention and prevention of women’s AUDs; and facilitate recovery ways of knowing that acknowledge the needs of midlife women and of long-term abstinence.

KT is a particular feature of the communicative exchange and the praxis components of the study. The combined techniques helped me to apply the research findings (e.g.
in the development of tertiary curriculum materials and health education and promotion messages) to improving the practices of the professions and public understanding of women’s recovery.

The methods of the study provided data well beyond individual AUDs interventions, community and personal care and revealed barriers to women’s care and ways that could improve the efficiency of access to services and continuing complex care. The underlying causes for the deficiencies in long-term support for women included a lack of: integration and collaboration between the various health organisations involved (e.g. Australian College of Mental Health Nurses, Network of Alcohol and Drug Associations, The Australian College of Applied Psychology, Australian Counselling Association and Psychotherapy and Counselling Federation of Australia). Collaboration is needed for adequate and appropriate professional education, and public and community health system operations. Although the structural aspects of the institutions involved (their infrastructure and operating systems) were not the focus of my research, by observing the professionals and the organisations where they worked I was able to identify opportunities for transactional, and first-order change (Chapman 2002), and for second-order change98 (this would be an ideal topic for future research).

Enable Recovery

The Enable Recovery theme derives from the women’s interests in forming self-knowledge, a sense of individuality (Jenkins 2001) and an interpersonal self, with known values and a principled autonomy.

ycs1, Action Cycle 1, Women’s questionnaire, My Recovery: Knowing I can reach out and I have the power to change. I believe one needs to look within and deal with what is within before the external can change. Once the inner is dealt with the external can heal.

98 Transformative dynamics refers to deep-structural, episodic and second-order change (Chapman 2002); this could enable significant improvements in organisational culture and behaviour. Other ways for supporting such organisational change include taking a ‘syntegration’ approach (Beers 2004), and establishing and strengthening collaborative small networks (a nexus approach; Buchanan 2002).
Enable Recovery is focused on helping the women, their peers and the practitioners to collaborate in enabling the optimal development of the women’s individual recovery. It guides the choice of ways to meet the women’s personal needs through shared conversation, daily recovery actions, reflection and selected therapy. At this time, as indicated in the participants’ lived experience responses, critical information and discussion on self-concept\(^99\), values, identity and wellness support the women’s early living recovery. The objective is to facilitate an emerging new identity\(^{100}\) based on the women’s core self\(^{101}\), capacities and potential for achieving mental and physical health.

The Enable Recovery process begins with ways to identify and establish appropriate links between self, identity, and the autonomous individual, and the social structures to which women desire connection and belonging. The women needed to start with a core self and one prime identity (particularly including being a non-drinking midlife woman in recovery) which they can comfortably inhabit (no longer living behind a mask, or as an empty container). This requires knowledgeable nurturing, a quiet available environment as a ‘safe haven’, focus and time for the priority of integrating women’s primary identity, health and wellness.

Baz4, Action Cycle 4, New women interview: *I think the business of believing in myself has been pretty much most of what I have talked about so far. And that was getting to know myself and getting to realise*

\(^99\) Identity theory proposes that individuals are a compilation of discrete identities (an outgrowth of one’s core self and primary identity), often tied to an individual’s social roles (Kuntsche, Knibbe & Gmel 2009), which become salient as situations call for them. Authentic identities (autonomy and authenticity; Oshana 2007) serve as anchors for actions (behaviour) and understanding of the self in the ongoing flow of human interaction. While women are healing, assistance towards formation of self-identity (self-concept; Alicke & Sedikides 2011) in the new circumstances of recovery is critical for the women to stabilise and feel hope and health. The women come to know a core self, and primary identity leads to exploration of personal competencies and ways to support the emergence of the multiple identities of a midlife autonomous individual (identity theory; Stryker 1980; Stryker & Burke 2000; Thoits 2003).

\(^{100}\) An inconsistent identity becomes self-alienation, whereby a person’s self is incongruent with actual experiences and deeply held beliefs (Joseph & Woods 2010).

\(^{101}\) The finding of self is a problematic one for women with AUDs. Importantly, for a woman seeking self in recovery, awareness and expression of her shifts in thinking and meaning-making are important in consciously acknowledging (Rychlak 1994) the change of focus from ‘me’ and ‘I’ to ‘us’ and ‘we’, in contrast to ‘them’. Healthcare and support is needed to also lessen the intrapersonal and interpersonal pain that self-identification may create (Ryan & Brown 2003; Brown, Ryan & Cresswell 2007). The research on whether the self is a fluid or stable entity continues, with tentative conclusions that self-perception is a context-dependent process (self-categorisation; Onorato & Turner 2004, self-schema; Corte 2007). Self-concept has a dynamic quality; for example, the shift from personal to social identity represents an important type of fluidity in the formation of self-concept and identity.
that I don’t have to please everybody. Realising that when I have said no I can’t do that today or no I can’t help you. Those people still care about me and still like me.

Cooperation and gentle interaction to contain marginalising and threatening experiences are critical elements of each woman’s AUDs healthcare plan. Supporters’ understanding of the process is essential: qualified practitioners must inform friends and ‘intimate others’ that family, work and community expectations are not to dominate the individual’s evolving process. There is also a need for the women to spend time with knowledgeable people who can recognise recovery disequilibrium at an early stage. Knowledgeable people (for example, those who have experience of women in recovery, and alcohol and drug counsellors) can help the women to maintain a way of being in the present that is harmonious for the difficult exploration of the women’s core self, a non-drinking identity and learning about ongoing life-course maturation in recovery.

In recovery, the women’s sharing with peers opened the way to being comfortable, firstly at non-drinking events, then when considering interaction with ‘drinkers’. The AIR\textsuperscript{102} tool assists with ongoing recovery when novelty needs to be replaced by the consistency of abstinent recovery. A is affect and affirming action, I is a specific individual practicing personal interaction preparing for effective group interaction, and R is reinforcing Recovery with respite and action research on vital processes for women to enable wellness in recovery. This tool was developed by the researcher in response to the feedback from participants, and from a review of transdisciplinary literature. The women described how family and friend tension can limit their recovery actions. Others’ discontent with the women’s new identity, actions and role changes can initially bring more uncertainty to their relationships\textsuperscript{103}. Finding effective ways to express feelings and ideas (especially negative reactions), altering and stabilising living arrangements, and the women’s affiliations (social interactions) are essential in maintaining recovery.

\textsuperscript{102} ‘Clearing the air’ was a phrase used by participants as a reminder to complete positive actions in facing difficult situations which they would previously avoid, dismiss, or react to, and then drink.

\textsuperscript{103} The complication is that women react to stress (a threat to security) by seeking out social support (‘tend and befriend’), a tendency that is influenced in part by oxytocin and endogenous opioid peptides, and epigenetics (Taylor et al 2000, 2002; Davidson et al 2000; Gillath et al 2008). The women overreact and provide care giving or drinking, rather than soothing the anxiety through self-care and speaking with knowledgeable supporters.
The Enable Recovery **message** for women with AUDs is drawn from participant responses to appropriate healthcare for midlife recovery: that diagnosis brings a nexus of care (a means of connection to self, helpful people and healthy abilities to participate in midlife experiences); that change and development can prevail through supported self-care to manifest the prognosis of wellbeing; and that healthcare team (including the client) choices can be catalysts for treatment of, and care for, wellness in long-term recovery. The specifics of such care are outlined in Chapter 5 (Findings). Below are the parameters of diagnosis, prognosis and treatment that can meet women’s needs in care.

PER1, Action Cycle 1, Women’s questionnaire, My Recovery: *It’s a constant process of change. I am becoming more and more me as time goes on. I guess recovery is what happens on the inside. It’s the spiritual evolution of self.*

‘I’m in recovery’

The ‘I’m in recovery’ phase of the continuum focuses on the developmental needs of the women, and on aligning enthusiasm towards energetic completion of important recovery tasks. Clients work with healthcare practitioners, peers and supporters to broaden their understanding and experiencing of the vitality of living, and the demands and delights of life without alcohol. RWR participants reported positive recovery experiences and outcomes that helped them to identify opportunities and new potentials. Also, negative events were described, as were how the women realigned with what they experienced in life as vital new understandings (loss, grief and crises) and deeper self-knowledge.

The Recovery **theme** of growth, thriving and progress draws together the women’s process of becoming a fully functioning person able to adapt and change in positive ways (Mruk et al 2008). The growth is similar to Mazlow’s hierarchy\(^\text{104}\). However, meeting women’s recovery needs in midlife also requires building of trust, guidance to work through threat, loss and distress, to establish emotional stability and thrive (Bower et al 2008; Park, Chmielewski & Blank 2010). Progress is felt and

\(^\text{104} \)Psychological growth is linked to authenticity and self-actualisation (Maslow 1964). Some environments are more toxic to personal growth than others, so a connection to a trustworthy person, practitioners and recovery peers is also necessary for progress, along with the women’s individual strengths and AUDs circumstances.
understood by women in recovery when their act of making a choice involves not only the act of choosing, but thoughts and feelings discussion about the potential options, abstinence as priority and what aligns with their principles (Rangel, Camerer & Montague 2008; Nielsen Mather 2011).

The important recovery objectives nominated by women in recovery implied a lengthy list of goals. I summarised the objectives in five categories: self-determination; personal relationships and social inclusion; personal direction (with restraint and reflection); meaningful work (including time put aside to consider life’s meaning); and a novel category for new learning and exploring the unknown. The long list often involved disagreement and a tension amongst the health team of practitioners, supporters and women in recovery. The women needed to engage in meaningful activities (including questioning how the priorities are set), while not being overburdened (which can raise the risk of returning to drinking). The women reported being uncomfortable, vulnerable, defensive (withdrawing or displaying bravado), and feeling bullied or a failure when establishing the order of what activities were to be completed. A common sense approach, recognising which activities can generate simple positive effort and outcome, is the initial way to direct priorities, as the process of resolving difference is the development task.

Limiting long lists of tasks is best approached by conducting a pragmatic physical health and cognitive and affect skill review and deciding on a few interwoven tasks

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105 Mansell and Carey (2009) explained the notion of Perception Control Theory and their Methods of Levels Therapy. This can help in establishing a robust recovery, when women acknowledge that it is time to address confrontation and fear. When people’s lives transpire as intended, self-disciplined choice is seamless and continuous, when people find themselves struggling, anxious and in conflict with self and others, restraint and wise action or no action needs practiced application.

106 Developmental differences (people have different life paths, e.g. a maltreatment life path; Ayoub & Fischer 2006) are likely to be observed in the women’s ability to identify origins of feelings, thinking and actions or non-action (such as a ‘freezing’ reaction). A higher order task being
(one task supporting a number of objectives). The process involves producing a short doable list (which can be useful for modifying women’s impulsiveness), followed by re-prioritising of tasks in response to changing circumstances. The process may provide new insights into the causes and possible remediation of women’s current unhealthy ‘doing’, higher than normal expectations, and procrastination. Social workers use intervention development as a way of guiding clients through options that can highlight tasks that are compatible, focus commitment\textsuperscript{107} and reinforce collaboration; all leading to re-establishing client autonomy in leading their own lives (Gredig 2011).

Evaluation, reflection on motivation\textsuperscript{108} and pros and cons for judgments are teachable skills; and, with practice, they can be evoked automatically in relevant situations. Developing such skills opens the way for creativity and intuitions that can support ongoing recovery.

The Be-Come-Well together tool derives from the ‘I’m in recovery’ message, drawn from participant responses, that remaining an unconnected single individual (‘I’) is detrimental to recovery, and limits the women’s potential. Being an authentic individual is an all-embracing connection (Master & Coulson 2006) of we, us, you, me and I, providing a liberated state of adult being in the world. The women’s old ways of apartness did not serve to enrich their lives. A false belief of ‘being special’\textsuperscript{109}, was upheld prior to, in active alcoholism and during early recovery.

\textsuperscript{107} Research emerging from the new field of affective neuroscience supports the conceptualisation of emotion and cognition as separate but interacting mental functions mediated by separate but interacting brain systems (Le Deoux 1996). Affect, by being so densely interconnected with other brain areas, has a significant influence on decision making. Ultimately, cognition and emotion are inextricably linked, so that cognition often works in the service of affective goals, whereas emotion often is a response to cognition (Greenberg 2008).

\textsuperscript{108} Motivation and volition have a reciprocal relationship. Volitional processes are particularly important when internal and external distractions might compete with the intended actions (Garcia, McCann, Turner, & Roska, 1998). One view that has gained favour is that volitional processes start where motivational processes end; motivation is the commitment, but volition is the ‘follow through’.

\textsuperscript{109} The women participants all carried a deep feeling of worthlessness and a strong belief that ‘the real me’ would always be rejected’. Being ‘special’ (a dazzling star or a troubled rebel) provided women with a defence or justification to manage feeling different and not belonging. Establishing an identity with chosen core values and beliefs that provide a truth and a personal energy to develop competence as an adult was intense and required difficult growth work. The process included internalisation of experiencing ‘being’ a woman in recovery: being alone, with people, part of a group, work and recreation in individual ways to develop a healthy sense of autonomy, relatedness and integration for roles and life purpose (self-determination theory; Groshkova 2010).
Autonomy and wellbeing in recovery included being with people, together but not dependent, for improved health and wellbeing.

The Be-Come-Well together tool for women with AUDs to develop in recovery must ‘Be’ on not drinking and personal recovery that confirmed their values and ‘gut’ feelings\textsuperscript{110}, and on ‘Come’, discovering, allocating and persisting with personal time to address new learning\textsuperscript{111}, particularly stopping the punishing self-criticism and expectations of perfection. The ‘Well’ through healing\textsuperscript{112} required interpersonal development using multiple techniques to express needs and establish effective friendships. This is the ‘together’ for wellness with others. Creating an authentic core self, self-identity and autonomy as an individual required, in its very nature, self-care priorities and facing the necessity of effective negotiation, with newly developed skills, around roles and task commitments to establish a satisfying psychosocial quality of life (Vallence et al 2010).

It was a difficult and surprising acknowledgement for women with AUDs that their way of living (as well as their alcoholism) was contributing to their difficulties and despair. The women recognised that their past may influence their wellness, and they swung between being a victim and a rebel. A ‘no blame or judgement’ approach to AUDs care at this point was essential. An opportunity for women to develop a passionate self-acceptance (Payne 2010) was provided in recovery through them making adult choices to support their own (and interconnected) satisfying and purposeful life path.

\textsuperscript{110} Conflicting values within individuals can lead to widespread uncertainty and caution. Two types of value sets exist: ‘explicit values’ (based on occupational training) and ‘implicit values’ (based on personal beliefs and subjective perceptions). There was evidence of women with AUDs being confused by conflicting values (Scott et al 2011). In recovery the conflict can sometime be resolved by making a judgment via intuition, which involves a dynamic interplay of cognition and affect (Sadler-Smith, Hodgkinson & Sinclair 2008).

\textsuperscript{111} Practitioners are also facilitators who can guide and enable clients in new ways of learning, e.g. through transformative learning (Erickson 2007). Recovery peers can be role models and influence, based on their successful recovery experiences, other women to gain new understandings (Kegan 1994).

\textsuperscript{112} A women’s way to “Be-Come-Well together” approach was drafted by me (the researcher) for participant feedback. ‘Be-Come-Well together’ also broached the concerns of senior practitioners; addressing women’s misperception, rigid thinking, unreal expectations and limited perspectives. The women sought effective techniques to work through the consequences of their drinking, while maintaining care for self. The women participants believed that more continuing care for mental health (Rohrer, Rush Pierce & Blackburn 2005) was necessary for midlife women to stay in recovery.
CBS610, Action Cycle 4, New women interview: “And one of the things about recovery and (the) structure of recovery program that I’m in, gives me is a sense of community, a sense of purpose, a sense of belonging, a sense of value. You know, that makes being in reality and consciously living worth the effort. Because I don’t want to miss out on that.”

**Goals and preparing to take risks**

Women can be encouraged and guided in taking risks in the everyday environment. The women’s experience in a supported care situation contributed to taking on and developing fresh viewpoints. Goals can be formed and initiated through non-conscious and conscious experiencing. Coherent reasoning (e.g. relational, holistic, pragmatic, creative, analytical and vigilant) can also contribute in the longer term to ongoing recovery. Participants explained about their being fearful of leaving in-patient programs and their own homes due to increasing triggers (cues and craving) to drink. Ongoing appointments for guidance and reassurance can be extended through self-sent text reminders, recovery peers phone calls and attending recovery program meetings.

Routines and peers in recovery provide opportunities to achieve new recovery objectives with preparation and learning new skills, including ways of handling changing circumstances and dealing with disappointment, which then enhance self-efficacy in not drinking. The risk scenarios and, more importantly, the distorted expectations held by the women about difficult events or activities that can distress and threaten abstinence included:

- returning to the family and old routines (memories and consequences to be faced with support)
- feeling guilty for not meeting all home care and work responsibilities (a reality check for family members and household members that sharing the load must occur to improve all members’ mental health)
- entering public areas with unease, agitation or sense of threat (calming techniques practised as sedation from alcohol is no longer occurring)
- being anxious and fearful (perhaps in a panic) with people who are drinking (adult choice not to drink and the freedom to leave, no matter what is happening)
- wanting to be well quickly (a realistic outcome for midlife healing in one to five years, the brain has altered and by not drinking the brain and body heal)
- focusing on ‘doing’ health not harm (practice of gentle, self-care to stop the cycle of addiction).

All participants insisted that whatever was ‘wrong’, ‘bad’ and ‘unbearable’ would be worse with a drink. Importantly, the women participants emphasised the necessity to never drink, as they recounted experiences of many peers who had returned to drinking and became rapidly unwell, and returned to recovery in far worse circumstances or died, or were no longer contactable.
A critical learning for the women (and a necessary acceptance) through Be-Come-Well together was that the old skills used when feeling threatened, even when there was no actual threat, was self-destructive in midlife (Marich 2010). It took time and ongoing guidance for the women to recognise that these techniques learned at an earlier time had also led to high distress, alienation and self-damaging drinking. The women were not at fault by applying the survival techniques, but had a restricted repertoire of skills and perspectives due to their life history. With limited ways of handling life, alcohol assisted in relieving the anxiety and distress.

Rather than run from being themselves (which women initially denied in recovery), a more satisfying process was learning to be open and add new skills for effective living, including resisting old ways, with the priority of not drinking. The benefits would include the re-emergence of self and development of emotional and environmental intelligence (Golman 1995, 2009) and for the adventurous, the ecological self (Naess 1989).

The Australian Health Ministers (Harrison 2004) define recovery as:

... a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability.

Anonymous 2007, Action Cycle 1, Issues discussion: I now talk a lot of stuff through to try and get a better idea that what I am thinking is realistic? And sometimes, particularly in my relationship with my partner I have to remember it doesn’t have to all go my way. Partnership is about a link and a personal relationship for me took a lot of learning how to negotiate. I didn’t have a very good handle on being with people prior to getting into AA. Those are the things I had to learn how to do.

In early recovery, feeling states (including arousal) and discrete emotional states infuse the decisions to drink or not drink. Also, prior reactions and patterns of behaviour can interfere with not drinking, because they are stored cues in memory and can lead to drives of obsession and compulsion to drink if not consciously monitored. The women participants who were placing priority on recovery needed reinforcement and reassurance on a regular (daily) basis. Ongoing reassurance by
practitioners and peers of the necessity of being abstinent was a critical belief and attitude for women to live a useful, happy life.

CBS6, Action Cycle 4, New women interview: So what I’m able to do today is to focus my energies on the things that I can change and that makes me a bit calmer and more pleasant to be around. Hopefully, it also means that my energies are more effective and useful. I don’t waste so much energy on stuff.

Complex Recovery

RWR participants provided ways to proceed to wellness with AUDs and continue with their difficult change processes by learning a variety of abilities for ‘response-ability’ as an adult. The Complex recovery theme of preparing for new roles describes how women decided upon and prepared for key roles and associated stable multiple identities for purposeful action in recovery, e.g. trainee, mother. The coherent combination of self, primary identity, roles and related multiple identities is critical to remaining in recovery and requires guidance to align critical characteristics of identities and roles with values based upon the women’s authentic wellbeing. A component of this guidance is to ensure that as roles and identities change, then emotional stability for abstinence remains the important goal necessary for recovery and creativity.

Anonymous 2007, Action Cycle 1, Issues discussion: I dress in a feminine way, wear make-up with confidence, and feel good about myself and my role as a woman, a mother, a sister, a lover and a member of society.

Social roles (Sternius et al 2005) play a significant part in helping women heal. Finding individual purpose in selected roles contributes to women’s greater self-worth, confidence and understanding of idiosyncratic attributes that differentiate themselves from others (Tajfel & Turner 1986; Thoits & Virshup 1997). The process of selecting roles (e.g. marriage partner) incorporates learning about personal key attributes and change. In addition, the women need to let go of devalued roles to increase their self-worth and of unsuitable roles to ease dissonance, anxiety and low mood.
Multiple identities (Burke 2006) reflect multiple social connection, and changes occurring in self-perception and direction, e.g. a midlife woman in recovery as a member of a group learning Qigong. The women’s selection and number of identities (Padilla-Walker et al 2008) needs counsel on congruence for recovery so that the women’s new self-concept is not overwhelmed. For these women, who develop identities based on intrinsic belief and life purpose, this enables the in recovery parameters for health and wellness to continue. Moving away from the newly accepted, authentic primary identity by engaging in old actions to appease others through identity accommodation or identity assimilation can raise conflict within the women themselves and with others (Sneed & Whitbourne 2003).

Practitioners and supporters can help women by using the Recovery Essential tool (EEE) – Engaging, Embodying and Enriching their (and their significant others’) lives – to enable the women to establish midlife selfhood and womanhood. One strategy to use would be discussing joint contributions, linking personal care needs and care goals to begin an ongoing process of an individual and integrated recovery plan. These processes are useful for practitioners, supporters and the women to enable them to Engage in needed self-care, with people, their surroundings and nature; Embody recovery effectiveness and prosociality through transitions113, and Enrich recovery living to guide the women’s purposeful self-actualising114 and contemplation.

The Complex recovery phase included identifying the women’s non-recovery actions and finding ways to modify them. This includes involving acknowledged expert peers and mutual self-help. The preparation and processes for establishing integrated care teams also raises the issue of role adequacy for practitioners (Skinner et al 2005) and evaluating recovery outcomes.

Jann1, Action Cycle 2, Women’s interview: I learned to eventually accept and forgive me and then to care greatly about my life and where that life might take me in recovery.

113 Transitions expand with ongoing recovery to include transformation, transposition and transcendence (Bunder & Neilsen 2005).
114 Self-actualising can involve generativity, career consolidation, experiencing meaningful living, integrity, dignity, active imagination and spontaneity (Mann 1985; Hastings 2012).
The **message** for women from the women at the Complex recovery phase for positive abstinence was to interact by linking emotion, language and action in a self-assertive manner. The participants were definite that midlife women have to place a priority on abstinent recovery to experience mature womanhood. However, individuals can devise their own creative change and commitment approaches (commitment is an example of ‘Cs’ in this phase; Burke & Stets 1999). They can express personal beliefs in their new roles and identities, and through developing life objectives based on personal recovery values for emancipated maturity (practitioner values can influence clients; Phillips & Bourne 2008, maturity; Bauer & McAdams 2004).

Cooperative healthcare decision-making with team capacity-building (including clients and expert volunteers) can become over time an ‘ecology of recovery’, a network of people whose members mutually maintain and sustain (Olsson 2006) each other in recovery. The question of responsibility in this process raises important viewpoints from a moral, rational, relational and volitional perspective (Smith 2005). These viewpoints are in addition to the legal, professional and ethical guidelines (National Standards for Mental Health Services [NSMHS 2008], National Health and Medical Research Council [NHMRC 2009], Australian Professional Registration Boards). There are personal (client, practitioner, supporter), group and organisation levels of responsibility in healthcare. Studies of attributing responsibility for recovery have found that the clients confirm their responsibility for outcomes (Feign & Sapir 2005).

SEJ9, Action Cycle 1, Women’s questionnaire, My Recovery: *At age 50 I did my qualification in Nursing, and loved it, making me feel 10 ft. tall, happy and responsible.*

Along with healthcare meeting standards and team objectives, the participants also recommended new input, group members on occasions purposefully finding and

115 Practitioners as professionals are involved in monitoring a client’s awareness and actions, by acknowledging their personal attitudes and beliefs, their understanding of societal norms, and showing capabilities to discuss circumstances. In midlife, discussions can include evaluations, appraisals and judgments of personal conduct and attitudes (framed by compassion and collaboration).
discussing new ways for sustaining a quality recovery over the lifespan. This included support for the following ideas:

1. Improving recovery care\(^{116}\), with a ‘do no harm’ credo, can incorporate creative processes (everyday and eminent creative process; Beghetto & Plucker 2007) to enable stability, commitment and reliability.

2. The development of responsible healthy women with AUDs involves the paradox of flowing with change, not trying to control all change.

3. Using the outcomes of the RWR Action Cycle o trial of the women’s interest in creative expression for recovery, extension activities and new challenges can be a part of recovery interventions for awareness of perception, adaptation and problem-solving.

In the trial, the women found different ways of thinking by focusing on their actions in one moment (in flow\(^{117}\)) to limit ruminating. I investigated long-term recovery experiences of women participants with more than 20 years abstinence. The women offered examples of maturing imagination (Biggs 1999), intuition and insight\(^{118}\) using divergent thinking (fluid intelligence; Batey, Furnham & Salullina 2010).

mmd155, Action Cycle 3, Women’s telephone interview: Peace of mind, less stress, more freedom, no drama; I think and act more clearly”.

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\(^{116}\) The increasing complexity in healthcare delivery might impede the achievement of continuity of care, being defined as ‘one patient experiencing care over time as coherent and linked’ (Waibel et al 2011). Improvement for practitioners and women meant establishing an understanding about perceptions of relational care with therapy, informational care across supporters and healthcare team members, and management continuity (negotiations including the client) across care levels.

\(^{117}\) With more years in recovery, the early skills of paying attention to basic functions, being able to quieten the mind and detach from a worrying event contributing to the home, workplace and leisure time continued to develop (Heddon et al 2006; Demerouti et al 2012). Feeling engaged, comfortable and satisfied with set tasks or unexpected opportunities were rich benefits of women developing through recovery living (Baumann & Schefferinth 2011).

\(^{118}\) Insight, a flash of recognition of how a problem is solved (Jung-Beeman et al 2004) is supported by ‘flow’, paraphrased as ‘when the person is fully immersed in what he or she is doing by a feeling of energised focus, full involvement, and success in the process of the activity’ (Csikszentmihalyi 1996).
Divergent thinking (the generation of variety and quantity of information; Cohen 1989; Jung et al 2010) reflects attention and reasoning abilities of the first form operating across domains of information, e.g. social, environmental, cognitive, and novel ones such as emotions. An example of first form thinking was demonstrated by the women’s constancy of commitment to recovery in changing circumstances.

I invited the RWR Participant Reference Group to consider the Four C Model (Creativity, Crystallised intelligence, Mini c, Pro c) forms of thinking, which explores forms of creativity (Kaufman & Beghetto 2009). Participants through their experiences provided responses illustrating crystallised intelligence (second form), which reflected declarative knowledge acquired from acculturated learning experiences, e.g. ‘if you don’t pickup the first drink, you don’t get drunk’.

KAT3, Action Cycle 3, Women’s telephone interview: I was an Al-Anon member and the truth was revealed. I felt a sense of impending doom. I decided to stop drinking and discovered I could not. I realised I no longer controlled alcohol; it controlled me. I still hoped I could drink and it would change, but a few AA meetings dispelled this.

The newly proposed Mini-c creativity (third form of Four C thinking) includes the ‘personal’ (Runco 1996, 2004) and ‘developmental’ (Cohen 1989) aspects of creativity. Mini-c creativity concentrates on subjective self-discoveries – the novel and personally meaningful insights and interpretations inherent in learning process such as self-discovery in recovery. Mini-c may involve experiencing one’s potential when one solves an equation, shares a joke, tells a story, or finishes a floral arrangement. Pro-c creativity (fourth form) refers to professional-level creators who have not yet attained truly eminent status. Entrepreneurs, not-for-profit experts by experience and academics (geologists, radiologist, English literature critics) are considered examples of pro-c creators. They are likely to create and converge on the best solutions for a selected problem, i.e. by emphasising utility.

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119 Fluid cognitive ability (flexibility) enables adults to deal with smaller stressor-related increases in negative mood, primarily created by interpersonal tensions and social network stressors. Flexibility also contributes to people’s ability to go with smaller stressor-related decreases in positive mood again when dealing with interpersonal tensions (Stawski et al 2010).
**Valued Recovery**

At the Valued recovery phase of the recovery continuum, the women in long-term recovery reported having a stable sense of self and comprehension of their world (a sense of coherence and presence; Antonovsky 1987; Corte & Zucker 2008). They prioritised a thriving way of abstinent living and addressed their new circumstances, with requests for autonomy support as needed. Valued recovery enabled resilience to become a new process in the women’s recovery; and it helped them to experience midlife fulfilment and flourishing.

CAT1, Action Cycle 1, Women’s Questionnaire, My Recovery: *It means I live with freedom from the need to drink and with a large degree of comfortability and acceptance.*

In the final Action Cycles (5 and 6), women’s ‘**wellness through well-doing**’ emerged as a valued part of midlife recovery actions for the RWR participants. Making abstinence and recovery decisions and completing practices regarding a non-drinking identity and enriching roles (Stephens 2009) was best learned through daily routines with peers and practitioners in the context of safely experiencing self-health\(^{120}\), recovery care, development and support. Eventually the women were encouraged and enabled to progress to an authentic, autonomous and joyful experience of wellbeing of the mind, body and spirit (Cummins 2008). At the Valued recovery phase, they focused on:

1. Robustly capable living in everyday life, with personal resilience\(^{121}\) broadening recovery to thriving using their strengths and capabilities;

2. Sharing processes for wellness;

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\(^{120}\) Self-health monitoring is a process of innovative, integrated self-care management plans monitored by a collaborative health team. The individual’s perception of their mental and physical state in daily functioning and feeling of wellbeing is a respected contribution to planning an annual program of recovery (Happell & Taylor 1999, 2012; Swartz 2012; Kimball et al 2007).

\(^{121}\) Resilience in recovery (as applied by RWR participants) involves three distinguishable though overlapping components (Zautra, Arewasikporn & Davis 2010). First, recovery involves a return to baseline functioning following a major stressor, consistent with a homeostatic approach. Second, building sustainability into recovery skills to continue forward during stressful situations and maintain functioning without major disruption. Third, the development and growth towards enhanced adaptation (preferably conscious change) to progress beyond original levels of functioning.
3. Learning and experiencing ‘normal and ordinary’ living in relationship\textsuperscript{122}, i.e. women feeling contented, satisfied and fulfilled; and

4. Addressing tendencies of languishing and regression by guided personality\textsuperscript{123} exploration to develop commitment and persistence, and social action to experience flourishing.

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**Temperament and disposition**

Personality research relevant to RWR participants included information about personality development, stability and how personalities change (Newton & Stewart 2005, 2010; Caspi, Roberts & Shiner 2005). The Temperament and Character Model of personality (Stinson et al 2008) is a useful tool for helping to define and discuss suitable roles for adults with AUDs. Traits and psychosomatic combinations are now also studied for use with chronic illness management, and it is applicable to AUDs (Erlen et al 2011).

Recent studies are revealing flexibility of personality over the lifespan, the complexity of adult health and wellbeing, and the potential for change and improvement in relation to personality disorders (Kubzansky, Martin & Buka 2009; Van der Linden 2010). Personality and dispositional resources, such as the self-healing personality initiatives (Friedman 1991, 2007), self-health and self-management, bring options for women in long-term recovery with comorbid ageing disorders (Schetter & Dolbier 2011).

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CBS6, Action Cycle 4, New women interview: *The reality is that I feel happy and more content when there’s balance in my life. I do consciously work at trying to keep my life balance. You know, to not do ridiculous hours at work, to make sure I get enough sleep, to have days off exercising, to eat chocolate. To make sure that I’m getting to meetings, (I’m) being of service, but also asking for help.*

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\textsuperscript{122} Healthy growth-fostering relationships (Miller 1986, 1990) provide: 1) increased zest and vitality; 2) empowerment to act; 3) knowledge of self and other; 4) self-worth; and 5) a desire for more connection. Desirable relationships for women provide openness to growth, respect for personal authenticity, mutual empathy and empowerment, commitment to connection, intimacy, and supportive enjoyment (Covington & Surrey 2000; Jordan, Walker & Hartling 2004; Jordan 2008).

\textsuperscript{123} “Personality traits are enduring patterns of perceiving, relating to, and thinking about oneself and the environment that are exhibited in a wide range of social and personal contexts” (American Psychiatric Association 1994 p630). Stability and plasticity are being considered to subsume the ‘Big Five’ factors describing personality (extraversion, agreeableness, conscientiousness, neuroticism, openness to experiences; Costa & McCrae 1992; van der Linden 2010; Nijenhuis & Bakker 2010). The theoretical discussion about the number of underlying basic personality dimensions (dispositions) remains open (McAdams & Olsen 2010).
The outcome of women’s recovery self-awareness involved developing a deep understanding of being a well, authentic individual. This state of being opened the way for women to live the important process of belonging:

... the need to be and perception of being involved with others at differing interpersonal levels ... which contributes to one’s sense of connectedness (being part of, feeling accepted, and fitting in), and esteem (being cared about, valued and respected by others), while providing reciprocal acceptance, caring and valuing to others. (Somers 1999 p16, based on the work of Baumeister & Leary 1995, in Levett-Jones et al 2007)

Women sustaining their recovery

The Valued recovery Theme, Tool and Message highlight what factors can best sustain midlife women in recovery. The benefits for women were often created in adversity, through lengthy painful experiences. Their continued suffering of non-recovery was described by women who had witnessed peers experiencing the torment and despair. The in recovery and non-recovery states provided a potent comparison.

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Values-based healthcare

Values are “desirable trans-situational goals, varying in importance, that serve as guiding principles in the life of a person or other social entity” (Schwartz 1994 p21). The primary content of a value is the type of goal or motivational concern that it expresses. Values fulfil five criteria, they: 1) are ideas or beliefs, 2) pertain to desirable end states or actions, 3) transcend specific situations, 4) guide selection or evaluation of actions and events, and 5) are ordered by relative

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124 Suffering is thought to be caused by a perceived need for things to be other than what they are, including both the desire to acquire or maintain for oneself what is not present (craving), and to pursue ways to remove what is, e.g. blaming others, feeling anger or hatred of self (Ricard 2011).

125 Non-recovery also includes women with AUDs not drinking alcohol. The factors and processes were described by participants that they named as being ‘dry drunks’. The characteristics included a disordered self, secretive, self-punishing and destructive, highly vulnerable through unaware acting-out of a non-integrated identity. The women were experiencing the suffering without drinking alcohol.

126 The brain damage caused by alcohol dependence also means the women can be taken advantage of in early recovery, and suggestions of at least three people as peers to seek advice from was discussed by the practitioners and women in recovery. Time is required for healing and a safe routine when engaging with people is also required, along with ways to express interpersonal trust, talking about trust when betrayed, and learning appropriate ways to engage in mutual trust activities (Koschik & Tranel 2010).
importance (Withnall modified from Schwartz 1992).

Values-based medicine (VBM; Scott et al 2011) involves a partnership between clinicians, clients, their carers, and practitioners from a wide range of related disciplines. VBM emerged from within the medical profession (Fulford et al 2002) as recognition that values affect every stage of the clinical encounters from diagnosis to discharge, and every form of healthcare.

The need for VBM with chronic illness management is particularly evident in mental health and general practice, where recognition that diversity rather than uniformity of values is the norm. Values-based practice seeks to rebuild trust through shared decision making in which evidence and values, science and individual human needs, are regarded as equal partners (Woodbridge & Fulford 2004).

Participants’ descriptions and explanations were analysed by me to contribute to more effective processes of providing complex chronic care before lapse or relapse, as well as suggested intergenerational prevention techniques. RWR participants recommended ways for the Australian healthcare system, and the multiple fields dealing with outcomes of AUDs, to offer and enable a less damaging access to long-term recovery pathways (Chapter 7, Recommendations).

The Valued recovery theme was focused on the women’s search for personal womanhood and maturation. Their values (Marich 2010; Jorgenson 2010) and attitudes needed to be gently explored during the recovery progression from wellness to wellbeing. It was usual that painful times also occurred during such explorations. Attitudes incorporate the feelings and opinions that a person holds about various aspects of their life and personal experiences, all of which can affect behaviours, reactions and responses (Mikulincer & Shaver 2004, 2007). For adult effectiveness, this exploration process was needed to ensure that a deep sense of

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127 The term ‘posttraumatic growth’ is being explored alongside emotional pain, with early empirical evidence supporting the ancient wisdom, ‘that great good can come from great suffering (Tedeschi & Calhoun 2004). The researchers in this field are also wary and seek further study before public announcements are made about growth and trauma (Wortman 2004).
personal understanding and commitment accompanied the agreed recovery direction, intention and action\textsuperscript{128} (Thase 2006).

Baz7, Action Cycle 4, New women interview: To start ... abstinence. 
Don’t pick up that first drink. Number two would be self-knowledge, to know yourself ... to the best of your ability be a good person. Know that you are a good person and to start to love yourself. I now know that as I grew up I never loved myself.

Examples in the RWR data of women’s attitudes\textsuperscript{129} (with associated ideas and values) included statements about ‘high-functioning drunks’ (women who appeared to be able to keep a job and live certain aspects of a regular life with active alcohol dependence). Through discussion (during interviews) the women admitted that their addiction had changed (in negative ways) their perception of being a woman. In active addiction, the women described themselves as being, for example, a liar, crazy, special, miserable, or secretive (terms that no longer apply to their current abstinent definition or description of themselves, or of someone acting in a high-functioning manner).

CBS6, Action Cycle 4, New women interview: That I don’t get to experience change in my life just because I want it. I’ve learnt maturity things and being an adult ... there’s some hard work in life and good things that are also on offer.

By analysing similarities in the Action Cycle preliminary results, it became clear that the emergence of womanhood is a gendered identity-formation process, with emergence of a mature woman being an individual having a unique combination of strengths and limits. The identities of the women were characterised by a complex blend of ‘anchors and webs’ that were continually being modified, although their

\textsuperscript{128} Currently attitude is recognised as a three component structure that comprises cognition (the beliefs-based evaluative component), affect (the feeling – based component) and conation (the behaviour or intention to perform a behaviour); it has no preset hierarchy or relationship structure (Ajzen 2001). In attitude theory, strong attitudes affect information processing, are resistant to change*, persist over time, and can predict behaviour.

\textsuperscript{129} The attitude change process is determined by the salience of the affect or cognition that an individual holds for an attitude (Millar & Millar 1990). Attitudes that are rooted in emotions are more susceptible to cognitive and affect persuasion attempts, whereas cognition-rooted attitudes are more susceptible to emotions. The dominance of the attitude component depends on how the attitudes are formed (Edwards 1990). A person’s pre-persuasion conative responses are primarily affect driven, whereas the post-persuasion responses tend to be mainly thought related (Breckler & Wiggins 1991).
central core remained unchanged (Josselson 1987 p178). General models of womanhood formation stress independence and autonomy as hallmarks of adulthood\(^{130}\), however, Josselson (1987 p 191) found that women’s cornerstones were “communion, connection, relational embeddedness, spirituality, [and] affiliation”. The maturity principle in personality dispositions (Caspi et al 2005) indicates that people become more dominant, agreeable, conscientious and emotionally stable over the course of their adult life, or, at least, up to and through late middle age.

In recovery, a mature woman can draw on capabilities and apply helpful self-control\(^{131}\) to create authenticity in life, overcome intense fear of the unknown, and lower defences and resistance to change (Muraven et al 2002, 2008). Practitioners and supporters emphasised that for women with AUDs, formal health reviews and peer and supporter reminders were necessary to guide recognition of their present circumstances, alter unrealistic goals, enable helpful (not depleting) self-control, and limit or remove punishing personal expectations. In Valued recovery, the aim for the women was to live with changing contexts through acceptance, gratitude, perception shifts and planned wellness actions. The key indicators of maturity\(^{132}\) were integrating the day-to-day processes needed to benefit the women’s chosen roles and identities, meet the pragmatics of their life objectives, while investing in well-doing to provide the needed groundwork and practice for positive future experiences.

The **EMBER tool** focuses upon ways to help the women to integrate competent self-functioning in ongoing recovery, with changes in personality occurring through assimilation and accommodation processes, along with ways to develop their

\(^{130}\) Adulthood is the time to create meaning in life through appropriate decision-making and life-building around in relation to one’s core self. The leading anxieties around life building for women with AUDs were feelings of unworthiness, the struggle between alienation and connection in relationships, emotional maturity, and spiritual struggles over the ‘loss of soul’ (Hartman & Zimberoff 2004).

\(^{131}\) Feeling forced (including forcing yourself) or pressured to exert self-control may lead to greater depletion of self-control resources than exerting self-control for more volitional or autonomous reasons (Muraven, Gagne & Rosman 2008). Discussion and support for volitional action can reduce the magnitude of depleted resources and limit women’s vulnerability for a return to drinking.

\(^{132}\) Midlife is the time when the developing adult’s increasing investment in normative social roles related to family, work, and civic involvement is usually greatest (Roberts et al 2006); and, equally important, the biological imperatives for generative actions (Costa & McCrae 2006) to help to assure that adults care for the next generation and take on the social responsibilities that encourage wellness for young and old. I would add, from the participant’s responses in RWR, other sustaining activities for achieving an ecology of recovery wellbeing, in a vital and responsible community and society.
strengths and self-manage their resources to sustain long-term recovery. The transdisciplinary literature on women’s turning points is relevant; it included, for example, accounts of women being “historically squelched, marginalised and ignored” (McAdams, Josselson & Lieblich 2001 pxii). Obstacles to maintaining recovery (such as problems concerning relatedness\(^\text{133}\); Kasser & Ryan 1999) were nominated by participants and addressed through EMBER in ways that could help practitioners and in recovery peers to meet the women’s needs. Although EMBER is challenging, it can reduce burdens and contribute to the women’s self-actualising, transpositions and self-transcendence. The research process also revealed why non-recovery comes about because the essential needs of the women are not being addressed.

The following addresses the meaning for the women of each of the letters of EMBER.

**E – Energy** use, vitality for developing recovery attitudes and interrelations

Subjective vitality is defined as “a subjective feeling of aliveness and energy” (Ryan & Frederick 1997 p 529) that arises from feelings of freedom, intrinsic motivation and autonomy support. Although positive affect has some similarities, it is different from vitality (Nix et al 1999). The women participants displayed vitality during interviews. Their exuberance was ‘contagious’. Vitality increases when people engage in actions that feel autonomous and self-directed, and it decreases when people feel pressure to act. In this vitality cycle, feelings of autonomy support lead to enhanced feelings of subjective vitality and contribute to self-discipline (Hoyt et al 2009). This increased vitality can help to replenish: self-understanding; identity focus; stability for relating with others; and better monitoring of effective recovery outcomes.

Vitality is a suggested mediator of positive self-control (Nix et al 1999; Ryan & Frederick 1997). Individuals who exert self-control in a more autonomous (and supported) condition can have greater feelings of vitality, and this leads to more authentic activities and better outcomes (Tice et al 2007). These outcomes include self-determined energising, decline in struggle and fatigue, and the positive experience of regulating one’s actions for acknowledged reasons, e.g. self-care and

\(^{133}\) The need for relatedness reflects innate desires to be supported by others and be supportive of others when engaging in life activities (Talmi et al 2007).
interpersonal choices. As the women spent more time experiencing vitality with less struggle they were able to engage in more focussed actions, determined persistence, and were able to achieve more effective results and express their curiosity. Their greater clarity helped them to strengthen their volition for recovery and for achieving wellness (Jordan 2010).

The women participants shared their understanding of key recovery attitudes, e.g. integrity in all actions, making purposeful progress, gratitude for experiencing the moment and enriched living, and achieving ‘wellness through well-doing’ with other people. They recounted developing new attitudes that were influenced by role models, working in groups and being guided by mentors. The awareness of attitudes and expressing personal viewpoints helped them to integrate subjective norms with their self-worth. The women made more effective situation-based decisions, including social decisions, and completed authentic, relevant actions (Mruk 2008). Questioning other people’s attitudes also led to self-change at a deep and satisfying level.

The midlife women’s recovery practices included evaluative judgment, which helped them to improve their attitude formation and modification. What makes an attitude ‘ours’ is our own evaluative judgments and appraisals of actions. Reviewing perplexing personal actions using analysis and reflection can reveal the attitudes underlying those actions. Finding personal attitudes that match personal values and beliefs provides opportunities to address the mismatch and reinforce or change the attitude, e.g. from ‘people from the West are vulgar and dangerous’, to ‘all people are equal and have strengths and rights’. Being aware and comfortable with personal attitudes and resultant actions can bring happiness, limit despair and encourage willingness to explore life’s meanings and processes (Maddi 1998).

134 Neuroscience is helping us to better understand this complex process. The reason ‘why an action was taken’ can be explained, and this process limits the ‘because I wanted to’ naïve explanation. An adult can review an event by analysing it: reflecting on what it represents and what is valued in this representation; considering the actions of those involved in relation to their values; and to the outcomes (Rangel, Camerer & Montague 2008). Interpretations of the underlying attitude/s can be decided and discussed with others. The attitude (Hagger, Chatzisarantis & Harris 2006) will have three components: the affective (happy to sad appeal), the instrumental (effective need-satisfaction) and the moral (bad to good worthiness).
In recovery, women’s stability and effective interrelations (with people, places, events, objects and the sacred) requires further decisions involving attitudes that fit with their recovery self-knowledge (e.g. perspectives, intuition, intentions and expectations) mediated by the current context (Hagger, Chatzisarantis & Harris 2006). Comprehending one’s own attitudes and actions can help with fruitful living and limit struggle. Choices can be made about useful and preferred interrelations for reaching an objective by noting its appeal, efficacy and worthiness. Cognitive hardiness\textsuperscript{135} (being able to welcome challenge, control and commitment\textsuperscript{136}) can also help the process (Beasley, Thompson & Davidson 2003; McAdams 2010).

Hardiness is a personality disposition that supports extraversion (social competence, not narcissism), conscientiousness and openness to experience (McAdam 2010). Women need and want to feel comfortably connected to others and to society in meaningful ways, and to know that burdens can be lightened and obstacles in life resolved. Sharing evaluations and responsibilities as partners in new activities is a respectful and successful process for forming and modifying attitudes. This reciprocating and mutuality also progresses growth with others and gaining increased understanding of the dynamic nature of interrelations. The development of authentic and pragmatic hardiness in making judgments (not false-choice due to susceptibility to voluntary control) involves a complex and ongoing maturation process (Rilling, King-Casis & Sanfey 2008). Women in long-term recovery accept these beneficial change processes as a normal part of life.

\textit{jog1, Action Cycle 1, Women’s questionnaire, My Recovery: [I] don’t shirk them [responsibilities]. [I] embrace them, they become my strength. I love being responsible!}

Women’s growing recovery competence in line with their stated values involves improving their understanding that attitudes and autonomous motives influence their actions, and that this provides more opportunities to respectfully explore their

\textsuperscript{135} It is a challenge for midlife and older women to have to deal with change in a self-confident manner; for them control involves believing in one’s own capabilities; and commitment involves gaining a strong sense of personal meaning from social activities and enjoying interactions with others.

\textsuperscript{136} Practitioners are also challenged to question ‘apriori assumptions’. Referring to new research findings can help counsellors and psychotherapists to be less set in their beliefs; and more open to the unique experiences, characteristics and wants of each individual client (Cooper 2010).
womanhood and lived experiences. Womanhood, Wise Recovery and the active mind are significant RWR areas of findings (discussed in Chapter 5).

M – Comprehending mentalisation to meet women’s needs for flourishing and personality exploration

Mentalisation is a therapy term for enabling a person’s awareness and ability to understand how their mind organises experiences and information (Sugarman 2006; Zemansky 2007). It helps people to express their individual process and content of mind to themselves and selected others. Improvements in this area can be transformative, as the women consciously improve their self-functioning and self-management (Kernberg 2012). Comprehending our intentional and purposeful mental states (states of mind), which include the particulars of personal wishes, needs, convictions and feelings, is also a way of questioning unconscious and deeper mind and brain processes, and these may also be the basis of actions of self and of significant others.

Vixl, Action Cycle 2, Women’s Interview: Sobriety to me is actually a state of mind. It’s about all of me, about what I think, how I’m feeling, how I am behaving. And sobriety to me is actually a condition of living rather than the absence of alcohol.

Mentalisation and reflective functions can initiate competent change via small iterations that are practiced and sustained, e.g. exploring and discussing interpretation of events, making comparisons, and recognising discrepancies and

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137 Mentalisation is related to the theory of mind (Leslie A 1987). Broadly the focus is on ‘what is the mind’, and how we use the mind for personal organisation and effective (functional) wellbeing. The mind*, its processes and its functions become progressively more organised as development proceeds (Sugarman 2006). Humans develop using body action and so progress to formation of a psychic structure (Freedman 1977). The ‘talking’ therapy process (e.g. psychoanalysis) helps people to regain their capacity to experience, reflect and communicate the workings of their mind in an abstract fashion. The use of symbolic representations (e.g. language) of their current experience of self through mental states (e.g. I am feeling frustrated) are indicators of growth. Recourse to physical acting-out, such as drinking, is no longer ‘needed’.

138 Knowledge of the brain system and associated networks throughout the body can improve the content of mental health education and intervention, as clients can begin to understand (or at least not fear) the things going on in their mind. The RWR participants found that information about the following areas of the nervous system was helpful: the limbic system and related central nervous system; the thalamus as a centre of sensation (centre meaning part of a distributed whole-body complex network); the hippocampus as a centre of memory; and the hypothalamus as a centre of affect activation (Panksepp 1998).
alternatives (Jordan, Walker & Hartling 2004). Sustaining is more than just maintaining attention and effort, it involves a nourishing process that is integral to recovery living. Nourishing activities need to include a focus on enduring goals, values and relationships, a striving, but not overworking of mutual care, and pleasant interactions (Zantra 2009; Schetter & Dolbier 2010). The repertoire of skills and actions for maintaining a sustained representing of self, focusing upon personal recovery intentions and the broadening of life goals include insight, empathy with significant others, and mindfulness, e.g. acceptance and commitment therapy (Hayes 2004; Hayes et al 2006).

Personality and social functioning

Theories of human personality predate modern scientific methods (Wundt 1896). Early in the 20th century, experimental psychologists turned their attention to describing individual differences, and measuring them. Whereas some focused on traits related to intelligence (Binet 1905; Pavlov 1935; Lewin 1936), others focused on traits related to emotional and social functioning.

The socioemotional traits explanation of personality focused upon the dynamic organisation within the individual of those psychophysical systems that determine characteristics of behaviour and thought (Allport & Odbert 1936). The current personality theory used to explore the RWR preliminary results focused upon investigating the functional and dysfunctional underlying structures and on the dimensionality of the women's personality descriptions of themselves and others (McAdams & Olsen 2010).

Traditionally, 'temperament' referred to 'immature' traits of biological origin, whereas 'character' referred to 'mature' traits that have been sculpted by socialisation139. Both types of traits were originally considered under the rubric of 'personality' (Allport 1961). Recent studies suggest that both 'temperamental' and 'characterological' traits share comparable degrees of heritability (Plomin et al 1990; Bottlender & Soyka 2003), and measures of each separately are often intercorrelated (Cloninger et al 1993; Herbst et al 2000).

Tendencies to react to, interpret, select, manipulate, and reject environments in accord with one’s initial temperament/trait tendencies suggest that genes and environments conspire, with genes taking the lead role, in the gradual elaboration of childhood temperament into dispositional traits in adulthood (Roberts et al 2008).

139 Self-directedness within the temperament and character model (Cloninger, Srivakic & Przybeck 1993) helps conscientiousness to increase and neuroticism to decrease within the five-factor model (Costa & McCrae 1992).
The factors of Stability and Plasticity are being considered to subsume the ‘Big Five’ personality traits (in bold below; van der Linden, Nijenhuis & Bakker 2010). Stability subsumes Conscientiousness, Agreeableness, and Emotional Stability and refers to the extent to which an individual is consistent in motivation, mood, and social interactions; Plasticity encompasses Openness to Experience, and Extraversion and refers to the extent to which a person actively searches for new and rewarding experiences, both intellectual and social.

Empathy involves directly perceiving someone as being in a certain mental state (Stueber 2006). Mindfulness enables careful attention and achieving a detached perspective (Waters et al 2009; Brown, Ryan & Cresswell 2007). Insight is a broad term (Abrams 1996; Bowden & Jung-Beeman 2007; Subramaniam et al 2009) referring to the combination of the context, personal cognitive awareness, emotional awareness and, for some, spiritual motivation (Emmons 2005).

KAT3, Action Cycle 4, New Women interview: *I am not the centre of the universe; there is a Higher Power and it’s not me. I am not helpless. I have peace of mind and good health.*

Insight is a personal interpretation, a self-inquiry process, and it involves self-reflective awareness of the mental operations\footnote{Intellectual and emotional awareness of the intricate processes of the mind (Damasio 2000, 2010) includes understanding that a non-conscious level of mind exists. The unconscious (including all automatic processes) can also modulate and influence both experiencing and expressing. Educating the cognitive unconscious, and perhaps the rest of the non-conscious, is a possibility (Damasio 2010). By studying personal action, and what urges or feelings initiated the action (e.g. a perceived threat), a reasonable equilibrium of states of mind, body and spirit can be maintained.} that shape a person’s present experience, e.g. personal prohibitions and ideals (Kounios et al 2008). Women’s experience, character dispositions and contributions can be more easily accepted based on their new understanding of the influence of attitudes and emotions that derive from the past (and the non-conscious) and that are part of the whole person (Sugarman 2006). Integration of the multiple connections and capacities of the mind, with peer and practitioner support, can help the women in recovery to achieve maturity, stability and personal empowerment (Bernstein 2005).

Below I briefly discuss four results from personality research that helped the women in their mentalisation processes.
Personality Systems Interaction theory\textsuperscript{141, 142} (PSI theory) uses the neuropsychological understanding of flow\textsuperscript{143}, personality and action control. Based on my Preliminary results, the women’s recovery need was to enable self-determination and efficacy to re-enforce self-worth and increase positive recovery outcomes. The flow experience involves an immersed engagement in tasks being performed using effortless attention for optimal outcomes (Nakamura & Csikszentmihalyi 2002). It can increase self-determination and work and pleasure efficacy (Baumann & Scheffer 2010). The combination of personality, action control and change processes can bring midlife women to self-actualising, transcendence and transposition turning points (discussed in detail in Chapter 5: Findings).

Characteristics of flow, such as absorption and enjoyment, were significantly associated with increased energy after work was completed (Demerouti et al 2012). This energy can contribute to the women’s ongoing action control, setting realistic achievement expectations, seeking autonomy support and persisting with activities for planned outcomes. Flow, in these circumstances, can provide means for the women to experience more effortless attention in the moment. Understandings in neuroscience suggest that an optimal coupling between intention memory\textsuperscript{144} and its output system (intuitive behaviour control) assists effortless attention and enjoyable activities (flow; Ullen et al 2012).

Positive affect and flow states help people to progress along the continuum of less negative to more positive states of being. A person who has experienced negative

\textsuperscript{141} Personality Systems Interaction theory (Baumann Kuhl & Kazen 2005) incorporates flow and autotelic personality in action control processes (Baumann & Scheffer 2010). People can flourish with focused attention and engagement in tasks and may benefit from a flow experience (Demerouti et al 2012).

\textsuperscript{142} Flow is described as a short-term peak experience characterised by absorption, enjoyment, and intrinsic motivation (Csikszentmihalyi 1988). Such positive states have been shown to broaden our behavioural repertoires and enable us to develop skills and resources that help us be more resilient when confronted with adversity.

\textsuperscript{143} Action control processes (Kuhl 1994) limit failure related to action orientation (AOF; the ability to down-regulate negative affect) and increase decision-related action orientation (the ability to self-generate positive affect). With accumulating life experience, people are able to spontaneously perceive, comprehend and master difficult tasks by total involvement involving: planning, analytical problem solving, spreading optimism, high commitment, and staying power.

\textsuperscript{144} Intention memory (a mental state) can decouple intentions from action to make clearer decisions about goals and to prepare effective plans. According to PSI theory, it takes positive affect to recouple intention memory with its output system of action (Kaze’n & Kuhl 2005; Baumann & Scheffer 2010). Overt actions such as ‘spreading optimism’ may indicate a greater ability of an individual to achieve flow and its benefits.
distractions, ongoing mental effort and suffering, can be enabled to focus their attention on the present moment and, through absorption and conscientiousness, be able to experience fulfilment and achievement as part of their recovery (Demerouti et al 2012). People with autotelic personalities exhibit traits that enable them to combine work, play and meditative states, and this permits them to develop their potential and new talents for achieving worthwhile outcomes (Csikszentmihalyi 1993, 2000). Women in recovery, if the characteristics of the autotelic personality resonate, can be helped to reduce their task-specific anxiety and to seek and position themselves in situations that enable frequent experiences of flow states (Fullagar, Knight & Sovern 2012).

mlm6, Action Cycle 1, Women’s questionnaire, My Recovery: I don’t ‘cope’ any more. Such a sad little word! I embrace my life.

**Life course models of personality and health** can be supportive of enabling self-motivation (particularly volition) that can help the women to complete challenging recovery tasks in a positive mindset (Baumann & Scheffer 2010; Baumann, Kuhl & Kažen 2005). Discussing and understanding the life-course links between child and adult personality development is a useful growth process for midlife women (Caspi et al 2005). They can contemplate the following evidence-based information and their life experiences and make suitable adjustments to protect their recovery with the support of knowledgeable practitioners and expert peers:

1. Temperament dimensions of anxious/fearful distress and irritable distress in children (Rothbart et al 2000) may foreshadow the development of neuroticism and negative emotionality in adulthood (with irritable distress perhaps also being a precursor to low agreeableness).

2. Childhood capacities for focused attention and effortful control (Kochanska et al 2000), as well as aspects of behavioural inhibition in children (Fox et al 2005), may underlie the development of the adult traits of conscientiousness, constraint, and aspects of agreeableness.
3. An engagement preference in child temperament\textsuperscript{145} (encompassing positive affectivity and positive approach) may herald the development of adult traits that have been traditionally subsumed within the extraversion and positive emotionality domain.

Women participants in long-term recovery were aware of learning to focus on the present, and to ‘pay attention’. The benefits included being able to: be flexible yet principled; release anxiety (including low mood; Bowen, Gerald & Baetz 2008); self-generate positive affect (e.g. after achievement); and review completed actions. The adult characteristics that the women noted as being particularly helpful with attention were commitment, gratitude, persistence and insight, all of which the women developed in recovery. Paying attention also opened ways to new opportunities: mutual work objectives; reciprocal processes of care to maintain good health; and close association with peers to continue learning about relationships. Paying attention contributed to experiencing simple pleasures. Experiencing happiness, tolerance and honesty with others, while not drinking, continued to develop the women’s trust-building with others and their belief in themselves. Celebration and commiseration were also shared.

OM6, Action Cycle 1, Women’s questionnaire, My Recovery: ... dignity, freedom, happiness and to have a life.

The recognition of being able to focus attention by a decision to do so and repeat this process was an important understanding for the women participants. Attention control is not task dependent, but is a factor in any task that requires this ability. Attention always relies on working memory capacity, while executive attention of memory also plays an important role. Continued abstinence is essential for increasing working memory capacity. Memory is discussed further in E – the Emotion section of \textit{EMBER}.

\textsuperscript{145} Temperament refers to biases in automatic responses to emotional stimuli and is moderately heritable. There is debate on temperament being stable or modifiable through events, culture and social learning (Carless et al 2006; Ostlund et al 2007). Four independent dimensions of temperament have been identified: harm avoidance; novelty seeking; reward dependence; and persistence. Temperament can be confused with character. Character is about individual differences in our voluntary goals and values, which are based on insight, and concepts about ourselves, particularly: self-directedness; cooperativeness; and self-transcendence.
The women in recovery slowly came to recognise that alcohol (as an external locus of control) was not effective in managing their internal locus of control, e.g. needed to be a competent adult contributing to their family, friends and community. The women recognised that their quality of life and growing feelings of self-worth lowered their need to pay attention to or focus attention on alcohol (Fardardi & Cox 2009). However, being vigilant and attentive\textsuperscript{146} in recovery to not drink was a necessity that all participants emphasised.

\begin{quote}
\textit{tcl5, Action Cycle 2, Women’s interview: Yes it was a struggle not to relapse. It was running to what I always went to before which was the alcohol. I didn’t think through to the end of problems. I just busted the once … There was so much pressure on me I am still trying to fit in with my work. Trying to help everyone else and still leaving myself not allowing myself any freedom. Any love and attention, just giving it all away.}
\end{quote}

Lack of attention and intention contribute to undercontrol\textsuperscript{147}. Undercontrol is a paradox to women in early recovery. The women participants described and explained how undercontrol changed during their recovery. The paradox and process of change became a source of humour, sadness, a painful lesson and a rich resource. The women’s early dogmatic need to control was mainly due to learned dysfunction, fear, and their AUDs symptoms. Guidance in recovery included learning self-regulation and that reference to sociocultural norms was helpful. The women found that their agitation and struggle with self-discipline became, with time, calm through self-discipline.

\textsuperscript{146} Brain neuroimaging shows that lapses of attention may involve the failure to switch from a focus on internal feelings and thoughts to the external task at hand. People can become aware of such a lapse, e.g. the feeling of multiple tasks confusing the desired focus and external action. Adults consciously redirect attention. Humans learn to redirect more quickly on the next occasion (Hedden & Gabrieli 2006). Lapse and relapse to active alcoholism can occur if women’s feelings and thoughts interfere with attention control.

\textsuperscript{147} The women’s extreme behavioural undercontrol can be linked to childhood adversity, deprivation as a young adult, and trauma events during the lifespan. Environmental influences impacted on the midlife women’s personality and their AUDs. Experiences in life affect the RNA of DNA (Holmes et al 2005) and contribute to an epigenetic influence for AUDs (Mehler et al 2008). The effect of the environment on the human genotype is also applicable to addiction predisposition and continued use of drugs over the lifespan (Wolf, Lindell & Backstrom 2010). A recent literature review discussed the influence of traits related to impulsivity and sensation seeking as risks for pre-alcoholic traits in genetic and environment interactions for teenagers (Schuckit 2009). Genetic predisposition to a specific drug and repetition of its use continues to be studied, along with genetic phenotype influences of impulsivity and undercontrol on addiction (Mayfield, Harris & Schukit 2008; AUDs midlife twin studies; Slutske et al 2002; Uhl et al 2008).
The importance of developing a robust sequence of attention, intention and action control for wellness (executive control; Sniehotta et al 2005) is discussed in personality factors, item 3 and item 4 below. Forms of control for recovery are detailed in Chapter 5 (Findings).

3. **Personality, social development, values and wellbeing:** Personality development and how personalities change continues to be studied (Newton & Stewart 2005, 2010). Psychological individuality is described as forming a second layer to basic dispositional traits in mid-childhood that speak directly to what people want and do not want in life, e.g. influenced by fear (McAdam 2009). Our personal characteristics and social experiences organise how we go about getting what we want and avoid what we do not want in particular situations, during particular times in our lives, and with respect to particular social roles. The second layer consists of a wide assortment of motivational (e.g. Deci & Ryan 1991, 2001; Murray 1938/2008), social-cognitive (e.g. Mischel & Shoda 1995), and developmental constructs, e.g. theories of personality (Erikson 1963; Loevinger 1976). Characteristic adaptations in the second layer are more specific than the dispositional traits and are contextualised with respect to time, place and social role (McAdams 2009; McAdams & Pals 2006). These constructs include values, goals, strivings, personal projects, interests, defence mechanisms, coping strategies, relational schemata, and possible selves.

Wyn3, Action Cycle 2, Women’s interview: *Today I see myself as more accepting of the inner conflicts I feel and can live more comfortably as a person who can be both strong and needing other people. I value my unique qualities more and let them shine through as my confidence grows.*

The midlife women participants described the amount of work (through trial and error) that they had to do to find out about personality, adult development and wellbeing processes (e.g. social neuroscience; Nielsen & Mather 2011) to build capabilities for ongoing recovery. The women were distressed with having to find solutions, and then arrange access to assistance, and with the complexity of the interventions, family care and self-help. Importantly, they explained, and their life story emphasised, how they were nearly defeated by all the unknowns, e.g. emotional processing of social stimuli (Sakaki, Niki & Mather 2012).
Wyn7, Action Cycle 4, Participant Reference Group interview:
Approaches I consider as being most effective for sustaining long-term recovery include:

- Not believing you’ve got it ‘nailed’. It is a journey and there is always a risk of relapse.
- Remaining willing to ask for help, not matter what!
- Staying connected to other people in recovery and also having friends/supports outside your recovery network.
- Having a sense of purpose in helping other people to get well but without it dominating your life.
- Continuing to grow by facing up to long-held fears. I believe as we progress in recovery, ever deeper fears emerge and are opportunities for growth.

In personality development, life stories are layered over goals and motives, which are layered over dispositional traits. Emotional temperament can also affect the vulnerability and strength of an individual (Erlen et al 2011) in recovery.

The midlife women’s social development and experiencing of affect (experiential and rationalistic; Maas & van den Bos 2009) can be helped by improving their understanding of how people perceive and gather data for information processing and for deciding how to act. Working memory training\(^{148}\) may provide beneficial effects for the self-regulation of action; by improving Working Memory Capacity (WMC; Hoffmann et al 2008). Automatic actions, attitudes and traits (such as tending to retaliate when hurt) can be modified. Such modifications contribute to stability. WMC can play a critical role in shielding short-term and long-term goals from current circumstances that trigger detrimental personality traits (such as aggression or timidity). The interference of automatic and longstanding dispositions can include wanting a drink. With awareness and guidance, the general distinction between processes that are automatic, in the sense of fast, unintentional and...

\(^{148}\) People’s Working Memory Capacity (WMC) can be improved. Individuals low in WMC may be more prone to draw on their gut feelings as a basis for a personal ‘I like’ judgment (self-oriented, limited reflection or reasoning), whereas those high in WMC may be more likely to automatically reject activated affect (sensation seeking) as a valid basis for their judgments (Lieberman & Eisenberger 2004). They can instead draw on additional sources of information: past learning (self-knowledge), possible conditions, contexts and consequences. Emotional memory, which includes arousal-biased competition, can also be identified and worked with effectively, rather than being overwhelmed by such emotions (Mather & Sutherland 2011).
effortless (impulsive), and those that are controlled, that is, slow, intentional (reflective) and effortful, can be distinguished, and negative impulses blocked (dual processing theories of the mind and self-regulatory behaviour; Bargh 1994; Matto, Strolin & Mogro-Wilson 2008; Evans 2008; Aase, Jason & LaVome Robinson 2008).

Vixl, Action Cycle 2, Women’s interview: One of the things I do is I either do some writing about it or I talk about it with somebody else in AA. I try to get a bit of reality as well as my emotional state.

Personality changes (e.g. by adjusting through progressive assimilation and accommodation) in a normative or idiosyncratic shift, brings social development as well. Women living well in recovery can maintain controlled dispositions; they purposefully counter behavioural undercontrol by motivated cognition and positive affect (Mather & Cartensen 2005). The women participants in long-term recovery described being in an aware, active (attentive) state that was used as a standard of reference for monitoring intention and carrying out effective action (Carver & Scheier 1998; Weiber & Sassenberg 2006). Examples of maintained dispositions include orderliness and maintaining a prosocial orientation. Orderliness is significantly protective; alcoholism can be more manageable when one has a clearer, more organised vision of life. A high level of prosocial orientation can help an individual to use treatment support systems (DeShon & Gillespie 2005). The women can then more effectively access self-help and their support systems, which can, in turn, protect them against relapse. A more prosocial orientation allows an individual to engage in sharing the burden of their daily struggle for sobriety with a group.

The women are more able to attain their goals if they maintain their intentions over-time, improve their capabilities to put aside abuse and adversity, access support and resources, and actively monitor their actions with wellness as a guide (Sachs-Ericsson et al 2011). The sequence of paying attention, refining their intentions with judgment, and then engaging in planned action control using awareness of their own personality and life circumstances brought fulfilment. Even difficult subjects, such as intimacy, could be slowly understood and experienced. Time and nurturing environments with people willing to enable and support self-efficacy processes helped the women to maintain progress over the long-term (Webber & Sheran 2008).
Psychodynamic discussion that focuses upon current life events to limit high risk drinking and enable clients to remain abstinent can be assisted by Mentalisation Based Treatment (MBT; Bateman & Fonagy 2004). The therapist and client create a transitional area of relatedness in which thoughts and emotions can be ‘played with or worked through’ (process-experiential change; Elliott et al 2005). The emphasis is not deep unconscious concerns, but the current circumstances and the person’s mental state (the client’s thoughts, feelings, wishes and desires), with the aim of building up sturdy internal states for recovery.

4. Personality disorders refers to a loss of ability to recognise functional and dysfunctional patterns of behaviour. As part of a collection of personality information in RWR during Action Cycle 4, a Myers Briggs inventory was distributed. The participants were very interested in discovering their personality preferences. Personality disorders have a complex and contested history of diagnosis, treatment and prognosis (Kernberg 2012; Fonagy & Target 2007; Fonagy & Bateman 2006; Fonagy, Roth & Higgitt 2005).

Understanding personality disorders (perceptions and mental states that distort or block the ability to look at one’s own actions and recognise functional and dysfunctional patterns; Yates et al 2003) can provide explanations for the reluctance of people to face the realities of their lives. People with active personality and mood disorders have great difficulty with self-reflection; and their feeling of threat and fragility undermine their ability to look back at their own behaviours and recognise

149 The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR and DSM-V-TR) describe mental, emotional and behavioural disorders, including personality. These disorders incur high personal, psychosocial and economic costs (O’Connell et al 2009). The common background for personality disorders is early relationship neglect, gene, neurobiology and environment combinations, and trauma events (Johnson & Lindley 2011). Mental disorders can occur and recur throughout life, including in older people for the first time (Rosowsky 2009). Early intervention, identification of precursors and prevention are the ideals sort by governments and communities (NHMRC 2009; AIHW 2008). Suitable healthcare intervention, promotion of services, for limiting relapse and co-morbid disabilities, are lower priorities within the current prevention and risk-management focus of the Australian Government (2010, 2011).
patterns. Women with AUDs, prior to abstinence, recalled not being able to review their past without great distress, or to effectively draw upon their midlife insights (Subramanian et al 2009). Instead they concealed (Bosun, Weaver & Prewitt-Freilino 2010), presented sophisticated distractions, and avoided close connection, e.g. the loftiest defences of humour and altruism can shield and prevent interaction. Such actions added to their intrapsychic stress and distress.

Years of shame and self-punishment also distorts self-knowledge and intuition, and falsely highlights being undeserving of care and comfort. This is especially difficult in mid to old age, when women are attempting to block their universal tendency to reminisce in the service of self-continuity (and perhaps for the development of wisdom). For women with comorbidity of AUDs and personality disorders, this blocking produces fragmentation and raises vulnerability (Lenzenwegger et al 2012).

Further evidence-based practice and clinical experience are essential for designing and delivering effective comorbid care for midlife women with AUDs.

**B – Belonging:** Developing effective connections with others, and being able to take relational stances (such as clearly distinguishing ‘us and me’, ‘you and me’, ‘we and I’) requires the clear communication of emotions (Fairhurst 2008). In active alcoholism the links between emotion, language and action are ‘numbed’ (impaired

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150 The mental world of beliefs, desires, and emotions are central to psychoanalysis (Fonagy 2007). Midlife and aging persons’ mental healthcare can draw upon lengthy studies of personality, PTSD and mood disorders interventions for comorbid AUDs integrated care. Asking women if they were comfortable completing the processes below is useful for introducing a need for individualised comorbid care in recovery. Are you able to?
- Lower negative affect and lower anger or aggression
- Focus on a self that is able to immerse in positive daily functioning and easy social adjustment
- Lower the levels of perceived external control and demands for urgent action
- Increase your tolerance of conflict.

151 There are many practice guidelines, working with people with AUDs, one for each profession, and for the different roles in these professions. As yet the guidelines are not integrated or linked, e.g. Clinical Supervision of Postgraduate Psychologist Trainees Undertaking Placements in Alcohol and Other Drug Services (Indner 2008).
or disconnected) as a result of stress and trauma events prior to and during active AUDs. When AUD women consume alcohol there is extensive physiological and psychological damage\textsuperscript{152}, and destructive change to the circumstances and context of their lives (Taylor et al 2004; McEwan 2007; Sinha & Li 2007; Sinha 2009). For women in long-term recovery, as authentic\textsuperscript{153} individuals, emotion is an important essence of their womanhood and an affect that benefits cognition. Based on RWR participant responses to RWR trials that investigated the importance that women placed on emotional stability (Lam 2006), the **ELLA** matrix (**Emotion Language Linked Action**) was effective in showing the women how emotion relates to creativity (Rowe, Hirsh & Anderson 2007), productivity and recovery change. Emotion, as part of affect, is essential to being fully human, and it influences personal perception (percept genesis; Andersson 2007), information processing, expressing ideas, and reflecting and relating (Biong & Raundal 2007); all of which are necessary processes and skills for developing the women’s chosen roles. During healthy long-term recovery, the clear communication of purposeful action can contribute to the development of closer connections with family, workplace colleagues and the community. The ELLA process helped to focus my research observations and expanded my view in identifying what the women participants stated were their preferred women-oriented communications about recovery.

For ELLA we explored participant experiences of **Emotional development** (**E**), and the importance placed on **Language** (**L**) to express self and to share outcomes with others. Understanding emotions, and their expression through language, was highlighted as an essential recovery skill. This was **Linked** (**L**) to recovery learning and women taking **Action** (**A**) to remain abstinent and to value wellness. Mature adults experience self, other people and life events emotionally (Pals 2006; Frewin et al 2011); and emotional competence is needed to experience health and wellbeing.

\textsuperscript{152} Chronic alcohol consumption influences communication in gross and subtle ways; with abstinence, these effects ease as the brain and central nervous system repair over time. However, with a return to drinking (at any level of consumption, when the person is alcohol dependent), there are advanced negative impacts to the central nervous system. Gains made while abstinent are lost, and drinking any amount of alcohol accumulates harm with dangerous consequences; this has been referred to as the ‘wet brain’ or Wernicke-Korsakoff Syndrome (WKS: vitamin B1 deficiency and Wernicke’s encephalopathy*, with Korsakoff’s psychosis; Bates et al 2005).

\textsuperscript{153} Authenticity connotes a sense of being true to oneself (Lester 2009). Nuances of language and discussion can help in understanding what one person means by their words and actions as an expression or reflection of themselves, e.g. pride may mean being ‘accomplished’ and ‘confident’ or being ‘arrogant’ and ‘conceited’ (Carve, Sinclair & Johnson 2010). Authenticity can also involve people developing capacities to act in accordance with their values and ideals.
The ELLA matrix figure illustrates how women recover using their learning about emotion and its expression through language. Developing connections between their thoughts, feelings, sensations and actions enabled the women to understand their individual emotions and to share with significant others their positive and negative affects and outcomes.

The combined process outlined in the ELLA matrix is based upon my preliminary results, the transdisciplinary literature, and my interpretation and evaluation of the information. This integrated process enables the women to lower their anxiety and progress towards authentic wellness by experiencing wellbeing in recovery (not just during abstinence or inactive addiction).

AGC1, Action Cycle 4, New women interview: *For many years there was a cold stone in my chest, the fear that I was going to get found out. The fear that I was going to screw everything up; the fear that I was going to lose everything. So in the end, I realised I needed to quit or I decided I wanted to quit.*

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**ELLA matrix, a Pearl 1st Level data interpretation**

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Women with AUDs</th>
<th>Practitioners &amp; Supporters</th>
</tr>
</thead>
<tbody>
<tr>
<td>E motion</td>
<td>HALT</td>
<td>Enable engagement</td>
</tr>
<tr>
<td>Language</td>
<td>HEAL</td>
<td>Encourage embodiment</td>
</tr>
<tr>
<td>Linked</td>
<td>for recovery</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>HEALTH</td>
<td>Enhance &amp; enrich</td>
</tr>
<tr>
<td></td>
<td>for abstinence</td>
<td>Appreciate wellness</td>
</tr>
</tbody>
</table>

*Figure 4.3: The ELLA matrix*
Key: In the left column is the ELLA acronym, described above.

The middle column represents women’s processes to be healthy and effective in recovery, using techniques that were contributed to by the participants, including the researcher, e.g. HALT: Hungry, Angry, Lonely, and Tired. The women perceive a sensation (affect) and then activate the HALT (decision to not drink). The women are encouraged to label sensations using an emotion, and to practice HEAL (Healthy Emotions for Abstinence Learning; see Character Strengths in Box below). The women link their HALT and HEAL learning to recovery actions to abstain for enhanced health (body, mind, spirit, natural world and relationships; Adams 2012; Blissland 2012).

The right column represents the tools for practitioners and supporters as they assist the midlife women in the RWR Ways of Recovery: Engage, Embody and Enrich (outlined earlier in this section). Research information with women as the focus of the study provided current material about AUDs (Aldwin 2012; Krafcik 2012) for communicating with interested people to broaden their understanding of AUDs and abstinence, recovery and wellness; such information included findings that:

- A broad family history of alcoholism (Gomberg 1993) predisposes individuals; more women with AUDs have fathers with drinking problems (Corte & Becherer 2007)
- A family history of women being more impulsive (Perry, Kirby & Kranzler 2002), with more maladaptive consequences (Campanella et al 2009) if action is prematurely executed without planning
- That the chronicity of alcohol dependence also includes vulnerability to ‘ageing’ diseases (Watkins 2003; AIHW 2006; AGPN 2009)
- Comorbidity of alcohol disorders include:
  - women with binge eating patterns (Bulik et al 2004). Some of the women in the RWR study used alcohol to reduce weight: by drinking more, they could not or did not eat.
  - a high rate of depression in women with AUDs (Sinha & Rounsaville 2002).
  - a risk of mild cognitive impairment (Bates et al 2005) and dementia in old age (Attilat et al 2004).

Emotion in communication is continuous when meeting people, when engaging with the media and when watching, listening, hearing and reading about contemporary life (Nikander 2007). Practitioners, expert peers and supporters can help in the ELLA process by providing simple guidance when the women’s emotions surface; by asking questions about how they feel and what the feeling might be about. The objective is to enable the women to experience in safety their emotions, and handle
any discomfort without recrimination. The preferred ways, the useful processes applied by participants to work with emotions and stabilise responses to them, were developed in the study as recovery tools (the RWR tools, developed as sayings and acronyms, are described in the Recovery Continuum and summarised in the Box below). The HEAL acronym (below) helped the women to remember the action to take when emotions are high. It enabled the women to not drink when drinking was their first reaction to emerging emotions. These basics are the critical recovery capabilities required, because emotions cannot be avoided.

Alcohol and drug addiction has been described as a ‘disease of frozen feelings’ (Zignon 2010). This description resonated with RWR participants. Women in active alcoholism and early recovery are emotively incapable of relating to themselves as well as the people around them. The social nature of emotions has been well described by anthropologists (e.g. Lindquist 2006). Expressing emotions can be regarded as an interpersonal process that involved the naming of affect to reinforce a mutual emotion perception (emotional paradox; Barrett 2006). Forming such interconnections is central to the construction of personal and social identities (Haslam & Ellamers 2006; Crisp & Hewstone 2007).

Women in recovery require time to come to understand their feelings of guilt, to release the shame (Corrigan et al 2006; Price Tangney, Stuewig & Mashek 2007), and to reclaim a sense of worthiness. A midlife woman in early recovery can learn to build authenticity through facilitated release of shame, guilt and blame; RWR participants estimated that it took the first six years of abstinence to achieve this. The same process can be applied to addressing personal disturbance (anger) and trauma (and associated fear; Lowenstein & O’Donoghue 2006; McLean & Anderson 2009).

The consequences of negative emotions include limiting goal-reaching activities (Garland 2010). Negative emotions occur when circumstances interfere with necessary and planned purposeful activities. If the pursuit of a goal is substantially slowed down, or if it is blocked, this results in a negative emotional state, e.g. sadness, anger, fear, shame (Carver & Scheier 1990, 2001).

trf5, Action Cycle 3, Question 58, New women: I steadily improve as I take more responsibility for myself and don’t enter into old family
roles. I want my life to be about other things – not just self-contemplation. I want to get out of the locker room and play the game.

Such states (emotional reactions and moods; Johnson et al 2008) generally limit looking beyond the visible part of an iceberg, where current attention is focused (Bowen et al 2008). Negative emotional conditions leave a large wake of personal, confused cognition and affect, with a wave of detrimental social consequences behind them. Healthcare, including recovery development skills and guided experiences, can help the women to acknowledge, as a start, that ‘something’ of their own perception or expectation is generating the feeling, confusion and the tendency to want to isolate themselves.

arj3, Action Cycle 1, Women’s Questionnaire, My Recovery: My perception of reality is not always accurate. I have a tendency to view the world as a bad place, i.e. the glass is half empty. In reality, I am very fortunate; I use sponsorship and meditation to check my new perceptions. My beliefs about myself also have changed. There was a time when I felt there was nothing good about me. Now I am able to appreciate my good qualities.

Emotions activate people’s attachment system and the seeking of ‘soothing’ through bonding (Panksepp 2004). This type of human seeking involves action to remedy separation distress (which can elevate to panic). Healthy adults nurture themselves by interacting, through contemplation, and by asking for assistance (Ryff, Friedman & Morozink 2012). Women with AUDs, with undeveloped skills, attempted many times to interact and, predictably, they found it difficult to lower their frustrations, agitation and thwart their fears. The women participants (and their practitioners) described the damaging ways in which they attempted to soothe themselves, e.g. through false ambivalence, resistance (Norris, Nurius & Dimeff 1997), mimicry and counterfeit intimacy (Moffitt 2010).

Without positive outcomes (bonding or relaxing) the stimulants for social exchange can drop away. The intrusive thoughts, and such ruminating, increase negative emotions and form links with negative beliefs (Shields 2005, 2006); and a negative

154 Whereas fear, vulnerability and emotional suffering are inevitable aspects of life, the experience of fear is distorted when connections with people are not safe, when vulnerability is not supported, and fear is denied or viewed as a sign of weakness and unworthiness (Jordan 2010).
spiral is internalised. Ineffective intrapersonal experiences limit information searching, dissonance escalates\textsuperscript{155} and this makes action more insistent, or the person becomes withdrawn.

Women facing confusing experiences with limited interaction and understanding of social comparison\textsuperscript{156} and consensus\textsuperscript{157} are vulnerable and at risk of physical and mental ill-health. The need to find reasons, meanings and solutions to ease the distress becomes further distorted. The dysphoric, fearful, and anhedonic states are characteristic of persons with emotion-related mood disorders; and they are tend to be associated with high comorbidity in women with AUDs (Thorberg & Lyvers 2006, including depression and anxiety; Wilhelm et al 2008).

Negative emotions can accrue into defensive behaviour\textsuperscript{158}. Women participants described everyday life as being alert and watching for threat, growing feelings of inefficiency, and increasing withdrawal and isolation. The women feared being exposed to further impoverished life experiences, and they drank to limit their

\textsuperscript{155} Negative emotions can initiate a state of cognitive dissonance (Festinger 1957). Dissonance reduction can be promptly eased by interpersonal connection with like-minded people, supporters, mentors and an understanding family. Adults search for perspective-taking, emotional support and intimacy through contact with perceived attachment figures (Busch 2012). When this fails, substitutes are likely to be used, e.g. alcohol consumption.

\textsuperscript{156} Social comparison (Festinger 1954) describes how individuals are continuously motivated to assess their own perceptions and opinions by combining two sources of information: their sense organs and people around them. It is this double reliance that allows them to label, categorise, understand, and endow with meanings the objects and events that they come across. Comparison of the everyday social consensus (self, objects and wellbeing; Laundrey & Mercurio 2008) can aid discussion and agreement about values, opinions, concepts and so forth.

\textsuperscript{157} The less frequent and intense positive emotional experiences of people with social difficulties also stops the usual experimentation, exploration, and play that lead to life enhancements such as learning, problem-solving skills, and the creation of positive social interactions and relationships. With everyday social interactions their negative ruminating about perceived social failures increases as does the fear and anger around their potential devaluation by others (Kashdan & Collins 2008).

\textsuperscript{158} Women who have experienced harsh circumstances throughout their lives develop defences that, as mentioned by the women participants, were also crucial in alleviating suicidality at points of lowest self-regard (Titelman et al 2011). Healthcare techniques are being developed to identify early ‘nearness to suicide’ markers based upon the process of percept genesis (gathering and understanding sensations and behaviour in a non-conscious manner, e.g. luminal experiences). What was discovered by using the PORT technique\textsuperscript{*} was that the women had low levels of relatedness, identity insecurity and devaluation (displayed in psychosomatic problems from depression to eating disorders to substance abuse), which they initially could not verbalise; and that with knowledgeable care they could describe, and that this enabled the healing and therapy processes to begin.
mounting distress (distress and alcohol use in late adulthood; Blow, Serras & Lawton Barry 2007).

Positive emotions are not mere epiphenomena (Garland 2010). They broaden thought and action repertoires, increase mental flexibility, augment meaning-based coping, and motivate engagement in novel activities and social relationships. Importantly, positive emotions, although transient, have lasting consequences; they build durable personal resources whose accrual triggers further positive emotions, leading to self-sustaining positive functioning (Joseph & Wood 2010).

Women speaking with others about the sensations they feel makes the present real and reinforces the positive activity of sharing words and interacting (connecting; Adams 2008). This everyday process regulates the sensations and supports not drinking. A focus on the interaction process expands the experience and expression of emotion (Goldsmith & Richards 2004), and it helps the women to understand that such expression is a significant change in itself, and that this can alter context-dependent emotional responses (affect and interpersonal skills; Lau-Barraco, Skewes & Stasiewicz 2009). Individual differences affect emotion regulation (Barret, Niedenthal & Winkielman 2005), and these need to be taken into account.

Practitioners, and women in recovery who are supporting women with AUDs, emphasised the importance of the pragmatic and caring capabilities of compassion, curiosity, and courage. They also described in detail the difficult, or rarely possible, objective of ‘always’ being positive, and the personal exasperation with the use of certain words, e.g. balance. To enable healthy recovery, the necessity of continuing to relate with others who are not in stable recovery, and who are unwell, brings the

159 Percept genetic Object Relations Test (PORT; Karolinska Institute 2011, A project of the National Prevention of Suicide and Mental ill-health program, Sweden).

160 Emotion regulation is a partially heritable characteristic, as well as a learned socialising process (Goldsmith et al 2011). Genetics investigations of emotion awareness, ‘awareness of’ and ‘awareness why’ (Prinz 2005) implicates endophenotypes, especially in relation to fear and anxiety. The complex internalising and externalising domain of emotion requires that multiple endophenotypes be viewed at an intermediate level between the levels of genes and actions. These endophenotypes are the ‘formula’ for the start of ‘regulated’ and ‘regulatory’ aspect of emotion; and still other endophenotypic measures might reflect the product of reactive and regulatory processes.
practice of tolerating the actions of others to the fore. The challenge is to be able to choose wisely what might be required at times of: “complexity, conflict, and confusion in a spirit of shared humanity, humour, and humility” (Jordan 2008 p250).

The ‘other-praising emotions’ can be classed as positive emotions. They are different from members of the happiness family (joy and amusement; Algoe & Haidt 2009). Emotions such as elevation (a response to moral excellence) motivate prosocial and affiliative behaviour; gratitude motivates improved relationships with benefactors; and admiration motivates self-improvement. People are often profoundly moved by the virtues and skills of others, and women in long-term recovery freely use the ‘other-praising’ family of emotions. Participants described chills or warm feelings in the chest when another person displayed talent, perseverance, generosity, kindness, and other skills and virtues.

We are born to form attachments, that our brains are physically wired to develop in tandem with another’s through emotional communication, beginning before words are spoken. (Jordon 2010 p243).

A critical process for women in abstinence is to learn how to express associated emotions through language, and therefore reconnect to their sense of self, in recovery identity, selected roles and other people. Self-talk is normal in moderation, however ‘talking about’ internal feelings and thoughts and intended activities with other people can focus the daily living in recovery processes and limit the women’s feeling to drink. Sharing with trusted peers and supporters can quiet the circular and damaging self-talk that the women participants described. The women’s communication about ‘I and me’; Cooper 2004) can bridge their acceptance and perspectives of their personal recovery; and of their evolving womanhood with rich, transitions, transformations, transpositions and transcendence possibilities.

Women’s conversation (chats) has been described as reflexive thinking aloud (Wilkinson 2008). Such talk involves a capability for personal power and assurance. Women who do not engage in conversation (through fear based on past
circumstances and a lack of role modelling and practice) are disadvantaged in such talks\textsuperscript{161} (‘we need to talk’) and chats. It is of importance to take women’s chat seriously as it offers a way of considering their perspective on events (conversation analysis; Cooper & Burnett 2006).

Meaning accrues in practical activities of talk in social contexts, and adults can achieve finely tuned communicative actions in particular work and social settings.

HI and C, Action Cycle 2, Women’s Interviews: Where there are high emotions or perceived threat I am practicing restraint and trying to stay focussed on the issue. Again, sometimes it doesn’t work and my highly reactive emotional state can make it hard for me to express myself. I give myself permission to move out of the situation and come back to the issue when I am not so fearful.

Discursive practices enable interaction and informing self and others of important experiences and personal understanding. A discursive perspective explores the particular actions performed by talk, including how people actively construct their identities\textsuperscript{162} in conversation with others. Any communicative action (a discussion) is regarded as being context-shaped (as understandable – by participants – only by reference to the ongoing sequence of actions of which it forms a part) and as context-renewing (contributing to the immediate context within which the next action will be understood). Discussions in groups engage the group members and enable ongoing associations and affiliations (communal relationships; Crocker & Canevello 2008).

kmp1, Action Cycle 6, Participant Reference Group questionnaire: Being a woman means recognising and accepting the qualities I have and that I can develop, to live as I wish. It means understanding why I struggle at times and how I can help myself to not struggle as much by talking with other women.

\textsuperscript{161} Reclaiming normality (Bytheway 2009) for midlife women with AUDs begins with ‘what one says’.

\textsuperscript{162} A discursive identity enables women to state their intentions to be able to function adequately. The women need to be heard and supported (Matsumoto 2009). What we might otherwise dismiss as ‘just small talk’ justifies an audience, relationally (amongst peers) and support networks of affiliates and multigenerational groups.
Dialogue and identity might be best thought of as a relational process; and involve a dialogue between ‘who we are’, ‘who in the social frames we are exposed to’, and ‘who we might be expected to be by others’. Dialogue provides opportunities to establish parameters of ideas, processes, social identities and standards for roles (Lewis 2002). Dialogue can be viewed as people working to achieve understanding, enlightenment and consciousness raising (Freire 1970). Dialogue can also include discussions with others about time spent with oneself, e.g. Rowan (transpersonal psychology; 2010) proposed observing our lives with our mental ego (‘needs praise’), with our authentic self (‘likes praise’) and our soul or subtle self that connects with the divine. Such experiences can connect our subtle self, authentic self and mental ego enabling heartfelt praise for others.

People also take on communicative roles and form relationships for the purpose of exploring their interests, social norms and assumptions (Burman 1993). Questions that the women participants found challenging to have clear answers to included: ‘how do women of different ages speak with each other?’ and ‘are there patterns and processes that we can discern to improve intergenerational communication with males and females?’ (Kjeldgaard & Askegaard 2006). Sex and age-related identities are always matters of contextualisation (sociocultural, political, economic, urban-rural), and their values have to be constructed and selected through discussion (conversation and dialogue) relative to particular work, family and community contexts.

When people engage in dialogue they also narrate their identities (Norrick 2009). The narration is a primary resource for recovery development and negotiating personal change\(^{163}\) in the context of groups and ongoing sociocultural change. People construct different versions of themselves (Linde 1993, 2009); it is essential for the women and their supporters to review such versions to be able to slowly remove the fusions of past, present and future expectations to enable fresh

\(^{163}\) Alcohol dependence and post-traumatic stress disorder are hopeless states (Bessel Van der Kolk, 1987) that generate psychological defences (Titelman et al 2011). The women’s plea ‘please don’t judge me (by my present frail state)’ is a telling invocation for the opportunity that recovery care provides for supporting their potential (that may have never been supported).
understandings that represent the women’s current recovery self\textsuperscript{164}, identity and role (Ready, Carvalho & Åkerstedt 2011).

ELLA is an example of creating communication spaces (time, resources and routines) for women in recovery to identify their present reality and to relay this to another person (a peer in recovery) for feedback and simplification. Women in recovery are assisted by checking-in (at a set time) by telephone with a respected recovery peer to talk about what is happening in the present moment (by sharing their thoughts, feelings, sensations and actions). The checking-in phone call enables practiced awareness as they describe the setting (sounds, smells, sights), and it helps them to focus on their next simple activity for that day.

Both the women and their practitioners explained how regular contact with other people can help the women to repeat their recovery routines (HALT, AIR, ENACT, AA meetings, therapy sessions, medical appointments) so that when they are feeling stressed they can ask (ASK) about what are possible and appropriate responses to their circumstances, rather than reverting to a negative or hyper-reaction\textsuperscript{165}, they have other options. They need to be able to promptly identify, through daily routines, when assistance is required for dealing with the stressors of avoidance, conflict and negotiation (Bahl & Milne 2010) before distress develops. Enabling the

\textsuperscript{164} A conceptual framework for recovery in mental health can be evaluated for women with AUDs “The emergent conceptual framework consists of: a) 13 characteristics of the recovery journey; b) five recovery processes comprising: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (giving the acronym CHIME); and c) recovery stage descriptions which mapped onto the transtheoretical model of change” (Leamy et al 2011 p445). Studies that focused on recovery for individuals showed a greater emphasis on spirituality and stigma and also identified two additional themes: culturally specific facilitating factors and collectivist notions of recovery. I question the mapping of descriptions on TTC and recommend Henderson’s work, a substantive theory of recovery (2011).

\textsuperscript{165} A person with hypersensitivity is being vulnerable in all mental states and reacting using negative cognitive and negative affect actions (Scher, Ingram & Segal 2005).
women to work with the currently accessible resources and opportunities (Webb & Sheeran 2008) is the priority.

**R** – reviewing recovery progress and considering **resilience** as a sustaining process for women

In Action Cycle 3, when I asked about resilience the women in recovery responded, in the main, with negative or ‘uninterested’ phrases. They (and their concerned others) appeared to confuse resilience with stubbornness, self-preservation, resistance, denial, survival, extreme self-sufficiency and vulnerability. The women had a tendency to connect resilience with their life histories of adversity, deprivation and trauma. Engaging with resilience in early recovery seemed unlikely to provide positive outcomes, and perhaps it increased distress and memories of hardship.

The development of resilience is a natural process that is involved in growing-up, developing and maturing into an adult (Luthar, Cicchetti & Becker 2000). Building resilience in adulthood with at risk, vulnerable individuals (women in recovery) is a multidimensional and dynamic process that involves positive protective methods being used for capacity building and developing individual potentials. In my RWR study of midlife women with AUDs the development of resilience involved: socioemotional learning attuned with social intelligence, making informed decisions, developing a broader understanding of roles, contributing to mutual projects for the community and individuals, and experiencing the present mindfully and joyfully.

“Resilience does not mean invulnerability”; it involves “struggling well”, experiencing both suffering and courage, and effectively working through internal and interpersonal difficulties (Walsh 1998 p270).

Researchers debate the multiple attributes of resilience (as a resource, outcome or process). The notion of resilience has been explored to further our understanding of its role in helping people adapt to the everyday environment, and to comprehend the interconnections between people, culture and nature (Folke et al. 2004). Resilience also refers to the capacity of a system (a human community, animal, plant, landscape, infrastructure, and social institution combinations) to absorb disturbance and reorganise while undergoing change, so as to still retain essentially the same function, structure, identity and feedbacks (Walker 2006). The heritability of
resilience (based on a positive outlook on life) has also been studied, and self-acceptance appears to account for this attribute (MIDUS; Boardman, Blalock & Button 2003). Resilience in mid-term to long-term recovery can extend opportunities for ongoing lifespan recovery.

For women in recovery, maintaining openness to engage with others, in the context of living a dynamic, healthy and complex life, required focused effort, optimism and positive emotions. The variety and difficulty of experiences can also provide turning points and transitions for individuals to: find new purpose and meaning; form and strengthen bonds with others; and to increase competence in overcoming, working with or letting pass, stressful experiences (Ryff & Singer 1998; Ryff et al 2012). Such experiences may provide new opportunities for growth, to thrive and transform (Carver 1998; Tedeschi & Calloun, Ryff & Singer 2004; Bonnano 2004; Rutter 2006; Dunkel Schetter & Dolbier 2010). There is also a potential for enhancing the person’s capacity for adaptation (Zautra & Reich 2010).

The vulnerability factor is a composite of psychological conditions thought to place the person at risk; it is affected by: anxiety, depression, emotionality, interpersonal sensitivity and pessimism (Smith & Zautra 2008). Detrimental outcomes include rising distress towards involvement in yet another struggle. A reminder can be a turning point; that the women’s circumstances have changed, and that she has

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166 The research and study of resilience has provided a broad array of features and definitions (Ryff & Singer 2008). I focused on the most recent work that combined the perspectives of health and wellbeing for the whole person in their local environment: the psychological, positive functioning for mental health; the biological, managing allostatic load, improving immune function and neural circuitry; the sociological, cooperative living, engaging with mutual help groups and health networks; and ecological connections, human experiences of nature, the spiritual and the cosmos (Zautra et al 2010; King Keenan 2010; Dunkel Schetter & Dolbier 2011; Ryff et al 2012; Aldwin & Igarashi 2012).

167 Early recovery: less than six years sober; mid-term recovery: less than 16 years; and long-term recovery: over 17 years.

168 Women can also be in precarious states, at a new limit or ‘threshold’ that, if breached without care, development and support, leads them to focus on negative feelings, and also alcohol (the old
changed and improved. Accepting that in recovery struggles are unlike struggle and survival in active addiction, opens ways for growth opportunities and learning resilience skills (Tedeschi & Calhoun 2004; maturity and wellbeing; Bauer & McAdam 2004). Even though the tension can raise uncomfortable memories of life difficulties, failures, loss and grief, the actions of resilient recovery can reduce such high distress feelings. In abstinence, the choice to self-care is a more attractive one.

Women’s attributes can be firstly nurtured, with time in recovery easing distress and providing new skills. Interventions that assist flourishing in recovery were then possible through guiding the women in individual, self-aware schemas, particularly for working through conflict and self-confusion (Cornwall 2007). Schema-based therapeutic approaches for women with alcohol dependence helped the women with maladaptive schemas to limit their detrimental actions: where dominance (extreme control) was being used to stop their feelings of rejection, mistrust was likely to be present because of their history of abuse; and emotional limits were maintained to avoid alienation, and defectiveness and helplessness were commonly dramatised to hide shame.

Anonymous female practitioner, Action Cycle 5, Practitioner questionnaire: I think midlife women need extensive competent therapy. We heal through relationships once we are abstinent. The process of recovery requires we rebuild trust. Thus the competence of the counsellor is crucial.

Accommodating change when renewing roles and engaging with recovery living in societal structures (e.g. changing work roles and healthcare plans) seemed to be a time that highlighted the women’s under-developed resilience (Luther & Brown 2007). Also, learning about and renewing intimate relationships were major challenges in recovery; because they involved the brain (and all biological systems) in dealing with the associated distress, changing ideas, attitudes and actions, and feelings, including excitement (Curtis & Cicchetti 2003). The women did not nominate or claim, “I’m resilient.”

Maintaining recovery in RWR meant that change could be accommodated if routines were in place: having a positive outlook with activity plans prepared; understanding

patterns emerge); this makes abstaining and recovery difficult, and relapse a possibility (Zywiak et al 2006; Sun 2007; Neto et al 2008).
that going with the flow of daily living was often the best option, as was regulating emotion, and integrating socially while completing purposeful tasks and roles. Practitioners may need further education to be able to contribute to midlife women maintaining recovery and ongoing wellbeing by working with common disruptions, e.g. menopausal symptoms (Northrup 2006), adult children’s successes and being a grandparent. Light-handed guidance can limit detrimental outcomes, with learning new ways of extending personal competence through collective, cultural, and spiritual ways to handle change (King Keenan 2010).

Practitioners and women in recovery agreed that, at regular times in recovery, it is necessary to conduct a planned review of achievements, future plans, mistakes (or less effective actions) and consequences; and that this be done preferably within a small group of supportive knowledgeable people: healthcare practitioner, peer in recovery, a supporter and the client. Such reviews involve more than just an annual physical and mental check-up; they need to include a discussion of objectives for suitable ongoing care, new actions, assistance with new skills and services, and leisure goals (Waibel et al 2012).

Participating in only a recovery maintenance process, and an occasional review, may not be enough to maintain some women’s commitment to lifespan recovery. The women participants spoke of needing ‘more’ to help them address the risk of relapse. Sustaining recovery can include respite\textsuperscript{169} to enable the women to develop the protective skills and build the capacity for living well in mid- to older-age. The women with more than 16 years abstinence emphasised that it was the development of their self-differentiation skills that they relied on in the face of high-risk (Reynolds et al 2010; NHMRC 2009; Taylor 2008), and also extended stressful

\textsuperscript{169} At times carers and families need respite from a stressful situation. Such respite can also be offered to women to focus on self-care (community health; Letcher & Perlow 2009).
events (adult child or ageing parent with addiction, intimate partner relationships change), and that these could be developed in workshops involving a sequence of day or evening sessions, or a weekend workshop, for individuals or small groups, where they could explore and practice the techniques of resilience.

For women to progress towards self-managed long-term recovery in an ongoing healthcare partnership requires them to engage in capacity building that includes the development of assertive communication, and negotiation skills for interdependence and co-independence (including expression of anger; Thomas, Bannister & Hall 2012). Such partnerships provide a safe place to deal with complex thoughts and feelings\textsuperscript{170}: by lessening the impact of negative stressors and thus improving recovery, and by encouraging and sustaining positive emotional intelligence experiences (Smith & Zautra 2006; Zautra et al 2008).

Women in long-term recovery discussed their change options, attitude shifts, and their altered desired goals in a non-threatening manner, as an energising part of everyday life (Stead et al 2009). Capacity-building can also strengthen resilience (Kent & Davis 2009). The following qualities are needed to meet their midlife recovery needs:

- Positive emotions
- Control (self-understanding to limit impulsive actions\textsuperscript{171})
- Active coping (discussion of who is responsible in the particular situation prior to engagement with specific fear and anger)
- Cognitive flexibility
- Meaning and value in adversity
- Altruism

\textsuperscript{170} Self-understanding (complex feelings and beliefs) about a purposeful life (Frankl, 1959/1992) can strengthen self-definition, and personal in recovery identities and roles.

\textsuperscript{171} Peoples' Locus of Control (LOC) affect health risks associated with self-control, fatalism, achievement-oriented behaviour, deferment of gratification rather impulsive actions, personal values and feelings of alienation. Gwandere and Mayekismo (2012) reported that there were significant differences in health risks between those with an internal LOC and those with an external LOC. Strengthening and reinforcing internal locus of control can assist midlife women entering recovery.
• Spirituality

• Training in stoicism.\textsuperscript{172}

The end product of capacity building is a deep sense of innate wellbeing. From the responses of practitioners, their understanding of women’s enacting skills can be limited, based on false perceptions and focusing on out-of-date processes that have been based on male only research studies. Training and development for meeting older client needs is also required, including appropriate therapy and support with positive actions (Van Orden 2010).

,\textsuperscript{jog1} Action Cycle 1, Women’s questionnaire, My Recovery: Be honest with yourself, you can only make it through if you want to know yourself. Strip down to your bare emotions, expose your fears, hold that child, [and] comfort yourself. Others can pat you on the back and tell you you’re ok, but you can heal yourself. It’s hard, but you must believe you are worthy.

I associated resilience with sustainability and holistic good health. Wellbeing characteristics (Ryff & Singer 2008 p201) are linked to resilience. Discussing and workshopping such skills and experience can help the women to sustain their recovery and achieve:

• Autonomy – the capacity for self-determination

• Environmental mastery\textsuperscript{173} – the ability to effectively manage one’s life and surrounding world

• Personal growth – the realisation of personal potential and continued development

• Positive relations with others – the possession of close, rewarding ties with others

\textsuperscript{172} Women participants identified needed alterations to the model for recovery. Clarifying what is their part in an event is an important step, as women can feel responsible for all aspects rather than just their own contribution. Women participants questioned needing training in stoicism.

\textsuperscript{173} Mastery was a word that the Baby Boomer and Generation X women wanted changed, e.g. they preferred ‘effectiveness’ rather than mastery.
• Purpose in life – the capacity to find life meaningful and have goals in living

• Self-acceptance – holding a generally positive view of one’s self and past life.

Five primary factors that contribute to high-level resiliency\textsuperscript{174} and to being able to claim equality as an adult were: a stable self-concept, self-awareness, robust identity, emotional self-management, vision or direction, and access to social capital resources (Hartman 2009; Osbourne 2009). The basics within recovery (e.g. understanding internal and external locus of control, living well with realistic aspirations and growing competence) offer a good base for refining healthcare partnership skills, particularly tapping into social capital resources and reciprocating through community input.

 CBS64, Action Cycle 4, New women interview: That I don’t get to experience change in my life just because I want it. I’ve learnt in terms of some of those maturity things. Being an adult then, there’s some hard work in life that’s on offer, in terms of the good things that are also on offer.

A powerful force in resilience comes from our belief systems (Boyden & Mann 2005). Our beliefs enable us to make meaning of our experiences, which we construct, organise, and synthesise. Adversity and the accompanying distress become tensions and organising principles for a potential disruption of personal integration, or they may provide opportunities for transformation. Sobriety increases the likelihood of transformation. A new vision and purpose for life often comes with new circumstances that enable clarification concerning the use of personal resources\textsuperscript{175} (Hobfoll 2001), development of protective factors (Fraser et al 2004), and finding new meanings.

During Action Cycles 5 and 6, I discussed with senior practitioners and the women in long-term recovery if a group learning process, for resilience, might assist with midlife fulfilment and flourishing. My analysis of Action Cycles 1 to 5 showed that

\textsuperscript{174} Managing change includes working with how biological systems self organise to meet the current environment; through accommodating fluctuations of continuity, new directions and unexpected (non-linear) forms of change (Lewis 2000; Thelen & Smith 2006).

\textsuperscript{175} Appraisal (perception, associations, expectancies, plans) and interpretation of the situation, resources, and coping methods (Lewis 2002) stabilises through connection to emotions, values and beliefs.
elements of resilience (as general characteristics applied by RWR participants) involved three distinguishable, though overlapping, processes (Zautra, Arewasikporn & Davis 2010). First, recovery involves a return to baseline functioning following a major stressor, consistent with a homeostatic approach. Second, building sustainability of recovery skills to be able to continue progressing forward during stressors and maintain functioning without major disruption. Third, the women’s development and growth enhances adaptation beyond the original levels of functioning.

mmd1, Action Cycle 1, Women’s questionnaire, My Recovery: ... never assume anything, learn to do reality checks, learn to say maybe I’m wrong, I can make mistakes.

Resilience can also involve having a flexible and hopeful approach to living. Women in recovery with continuity of care and a network of peers, can mature to their potential, face life difficulties, and enact self-efficacy (Kranz 2003, gender specific aspects; Davis & Jason 2005). Developing perspective and understanding that life events and lifespans are multilayered can help the women to make more sense of disruptive events and their place and contribution in their lives (life-course events; Levy et al 2005). Women in recovery establish a fidelity to their selfhood (Erikson 1963), then maturity of adulthood (with addiction; Adams 2008) and, from my study of the data and observation of women in recovery in the community, womanhood and generativity (creating wellness and sharing that process) in midlife recovery.

An important outcome of resilience training is that it can also help to ‘depathologise’ AUDs recovery and benefit individuals through normalising the need to ask for help and receive respectful assistance with developmental tasks (Cloud & Granfield 2008; White & Cloud 2008). Women in recovery shift towards facilitated education, negotiating with dignity further recovery development, and recognise and provide their contributions to social capital (Cloud & Granfield 2002). The accomplishment of a stable self concept also contribute to secure, harmonious and caring relationships (Rutter 2006), which in turn support a resilience and recovery combination.
Women’s resilience in recovery

I selected the statements below to help the women and their practitioners to better understand the roles of resilience in recovery.

Resilience research has a broad base, including ecology (Holling 1973), child development and developmental psychopathology (Rutter 1987; Cicchetti & Cohen 2006), leadership and management (Kaminsky 2006), stress recognition, emotional coping and cognitive hardiness176 to buffer distress (Beasley, Thompson & Davidson 2003), and gene-environment contributions (Krueger & Johnson in John et al 2008). Loss of focus on maintaining abstinence when learning new resilience skills requires monitoring and changing plans if the distraction is raising risk of a return to drinking alcohol. Resilience understanding and practice can benefit women in recovery by strengthening their ability to help family members and community wellbeing (Serbin & Karp 2004; Selman 2009).

Resilient recovery from an acute event can be characterised as a rapid return to a baseline condition (Bonanno et al 2006). Luthar (2006) simply defined resilience as positive adaptation under adversity, challenge and threat in sustainable recovery; resilience encompasses the personal values and goals, while meeting the challenges of acute and chronic difficulties (Zautra 2009). As with recovery care, the effects of the immediate social context and the larger sociocultural environment on resilience are also being studied (Aldwin & Igarashi 2012; Masten & Wright 2009).

“A developmental phenomenon … a multifaceted phenomenon influenced by both natural and nurturant factor” resilience propels human capacity of vision and stamina to reach objectives as they evolve over time (Higgins 1994).

Resilience involves people coming to terms with the past, and then integrating that meaningful understanding into their current lives of comfort as they learn and progress. A positive outlook of future hopes and dreams are best coupled with affirming recovery strengths and transcendent beliefs for values and purpose (Walsh 1998).

Two experiences most influential to resilience were successful accomplishment of important tasks and secure harmonious love relationships. Well people bounce back emotionally from stressful events (Masten 2001; Rutter 1987). Good intimate relationships in adult life can do much to bolster people’s positive concepts about themselves and their worth in other people’s eyes. Accepting that self and self-understanding continues to be modified by life experiences can release energy (used to fight or flee in the past) to sustain women’s confidence and competence under stress. The women in mid- and long-term recovery have done well in this process and have the skills to deal with life, on life’s terms.

176 Hardiness is an attribute comprising sense of meaning, purpose and perseverance (Kent & Davis 2009; Reich, Zautra & Hall 2009).
Women’s resilient recovery can include living in harmony with the local environment and community, being able to adapt in a reasonable fashion (with humour) and, at least, de-catastrophise when not feeling happily positive about life events.

Developing resilience to support forming and maintaining stable affiliations and being able to enjoy accomplishments is an attractive learning and maturing recovery training package. Valued recovery can enable resilience to become a new and essential process in women’s recovery.

We are just beginning to understand how social networks can facilitate (or impede) resilience within communities. Further research will help identify the features that promote mental health and community resilience (Luthar & Brown 2007).

Wyn7, Action Cycle 4, Participant Reference Group interview: *Continuing to grow by facing up to people and long-held fears ... I believe as we progress in recovery, ever deeper fears emerge and are opportunities for growth.*

Enabling the women to establish self, and build resilience for a deeper sense of interdependence and co-independence, requires a capability for making progress towards effective health-care partnerships (Christensen 1990; Cheek 2003; Knight 2009). Partnerships can take different forms, from weekly appointments to biannual meetings on self-managed long-term recovery\(^ {177} \) in a continuing healthcare plan of abstinence and wellbeing. Having expert volunteers as members of the team can provide ongoing womanly support and up-to-date community connections, which may strengthen links to healthcare services. In an ongoing healthcare partnership for recovery progress, action research can include women-oriented evaluations on ways to continue collaborative development of health with chronic illness and sustainable recovery (Appendix 4.6, How participants contributed to these outcomes).

\(^ {177} \) In RWR, self-managed long-term recovery involves the client, a woman in recovery, as a healthcare team member. There is a personal responsibility for the woman to be engaged, open and respectful. A partnership is best formalised through a chronic illness management plan phase (Chapters 5 and 6: Findings and Praxis).
In conjunction with efficient recovery, resilience encompasses the sustainability of values and goals, while meeting the challenges\(^\text{178}\) of acute and chronic difficulties (Zautra 2009). Realistic health and wellbeing decisions can be promptly made in a principled manner with support for recovery action as a priority, e.g. occupational therapy. Being able to deal with change with informed people in a health network or recovery ecology can also provide relative stability for entering new thresholds, turning points and surprising trajectories. Diversity and breadth of knowledge can be on offer from members’ experiences, connections and wisdom.

The Valued Recovery message relates to the following.

sue8, Action Cycle 1, Women’s questionnaire, My Recovery:  
*Contentment – it’s beautiful. I have fruit trees and leisure.*

The reminder **message** for other women with AUDs was to enjoy recovery: The acronym that helped keep the pleasant things in life as an essential part of recovery was **HEAL**. A Healthy adult takes time to Enjoy pleasurable Activities with other people, and to learn about personal Leisure and what is of interest and on offer.

Recent research has improved our understanding of how the human mind, body and spirit respond well to and benefit from fun activities, especially when being together with other supportive people\(^\text{179}\). There are cortical networks in the brain that act in concert to support interactions with people (highly responsive hypothalamic–midbrain–limbic–paralimbic–cortical circuits; Swain 2010). The well adapted human (with coordinated motivation, thoughts, feelings and actions) experiences pleasure and goodwill. For the women in recovery, the experience of relaxing without alcohol is a critical process that needs many repetitions to alter their dysfunctional actions and their associated affect and cognition states.

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\(^{178}\) Long-term abstinence supports the repairing of executive skills, and the improvement of memory, visuo-spatial skills, and postural stability (Wegner et al. 2001; Bates et al. 2002; Rosenbloom et al. 2004). Factors that may affect the magnitude of neurocognitive dysfunction and recovery with AUDs include: age, sex, treatment history, level of alcohol consumption, relapse history, nutritional status, a family history of alcoholism, genetically-based resilience, comorbid psychiatric conditions, physical disease and illness, and concurrent abuse of other substances (Sullivan & Pfefferbaum 2005).

\(^{179}\) The neurobiology of being ‘left out’ of social activities is useful for understanding the physiology of emotional pain (Eisenberger & Lieberman 2005).
Leisure and pleasure may need to be introduced to women in recovery as beneficial self-work, and as providing opportunities for practicing connection with others (Hood 2003). Women participants explained that the feeling of not deserving happiness can persist as a strong belief for many years in recovery. Leisure provides them with experiences of choice and fun, and it limits over reaction, impetuosity and negative risk-taking.

aKc1, Action Cycle 1, Women’s questionnaire, My Recovery: I enjoy good clean fun now ... enjoy creative activities. I'm better at communicating now, so I enjoy healthy leisure activities.

Women in recovery can be reassured that in wellness, with peer education and adult development180 in social environments (Bondi 2008), they can legitimately be comfortable and enthusiastic. In the main, adults value social activity and willingly accept responsibility for regulating their behaviour (Ryan et al 2011). Women in recovery need to feel free to ask ‘dumb’ questions to learn about what is happening in leisure activities; just seeing the action is not necessarily understanding and experiencing the much needed midlife activities. Enabling women to state the fact of being a beginner or novice at a sport or hobby is a major step forward in recovery, and it can lead to further deepening of their understanding of their likes and dislikes, strengths and weaknesses.

Perseverance and practice with group leisure, sport and pleasure activities teaches mutual responsiveness, reciprocity and tolerance. Such experience creates growth in an essential part of the brain181, and interruption of mutuality interferes with its development.

Relating to one’s family when in recovery can take time, planning and preparation. Also, contact may not be suitable or acceptable to some members, including the women (Gabb 2009). Women in recovery emphasised that they needed healthcare practitioners or knowledgeable supporters to be present with them during their first

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180 Social engagement has common dimensions (such as a warm greeting when meeting; Coupland 2009). Social identities and roles have dimensions that are constructed or attributed, i.e. to gender, sexuality, class, culture, religion, nationality and profession.

181 Perception of emotional states occurs in the right prefrontal cortex of the brain (Allan & Schore 2003); it is this area that mediates empathic cognition and modulates amygdala functions.
meetings with their families after alcohol withdrawal; to help them to discuss simple matters and, when ready, major issues. The participants described many family, partner and friend engagements that were frightening, sad, angry and over exciting (Orford et al 2006; Steele & Pearson Scott 2007).

Discussion of what the four elements of **HEAL** mean to women can help practitioners and expert volunteers who are working with clients to enable them to experience joy, delight and have fun (Zemore & Kaskutas 2008). Information on the functioning of the brain in relation to HEAL can enable an understanding of the neuroscience of sensory, intellectual and aesthetic pleasures, personal and cultural beliefs, differences and similarities in personality (e.g. self-doubt and confidence), making conversation and social norms (Berridge 2003; Cole & Sabik 2010; Erlen et al 2011).

Most of the women, including those in recovery, experienced uncomfortable self-perceptions, embarrassment for using incorrect words and actions, contradictory and confused beliefs around women’s roles, reaction to inequality, and challenging relational dynamics (Bem 1993), competition and conflict (Norem-Hebeisen & Johnson 2006). Being able to engage in social interaction in a relaxed manner may require explanations of the give-and-take of imperfect relationships (affective and social neuroscience; Frewen et al 2011). Focusing on communicating in all forms (verbal, visual, tactile, intuitive tacit and unconscious) can help the women to better understand the importance of reciprocity and mutuality, both being necessary processes for positive leisure experiences. The provision of support to build skills of relational autonomy for women can counter-balance their feelings of inadequacy (Mackenzie & Stoljar 2000).

The women in recovery participants talked about limiting time with people, as they found that growing anxiety could lead to being over emotional or frozen (affective dysfunction; Cheetham et al 2010). A remedy for disaffect (Baker 2006) within recovery, and particularly useful for HEAL, can include discussion about mutual empathy, the process of expressing concern, and caring for others. Being comfortable with known people (peers in recovery) can be a start in exploring together and expressing more nuanced and elaborated affects and cognitions; which can lessen panic, isolation and the fear that accompanies them. A process of simply
cultivating positive emotions in leisure activities extends to a process of learning how to negotiate the ebb and flow of 'normal' associations with others in life.

mmd1, Action Cycle 1, Women questionnaire, My Recovery: *I took up scrapbooking, very healing. I made new friends, non-drinkers, because old friends were toxic. I became child-like instead of childish ... became humble and non-judgemental.*

Experiencing positive co-regulation of affect while involved in a group sport or hobby can also begin within recovery groups. The women, as authentic people known within their recovery group182, can express emotion and be subtly monitored for fragility and wellness. The group can acknowledge distress, sadness and over-excitement, and support the women by calming them in a gentle or humorous manner (Butner, Diamond & Hicks 2007). Emotions are no longer an impediment, but rather a tool that can be used for strengthening awareness and as a support for developing the women’s sociality and principled living in recovery.

Leisure, pleasurable group activities and sport are also resources for developing the women’s identification of their own state of integrated self-functioning. They can continue to develop heightened abilities to effectively adjust to people and the environment (concordance; Thrash & Elliot 2002). The women participants (with the help of the practitioners) in the Valued recovery phase develop and express their creativity, competence and their satisfying contribution to those connected with them, and to themselves and their community.

**The Meta-study**

From Action Cycle 3 more people joined the study as the media was reporting on the growing Australian alcohol problem (public health, primary care and community health, hospitals, and specialised health services recorded increases in alcohol caused and alcohol related damage, illness and injury; AIHW 2008; VicHealth2008).

182 I observed recovery groups within the community and the actions to support and stabilise upset individuals within the groups (affect intensity; Maas & van den Bos 2009).
The principal diagnosis of Mental and behavioural disorders due to use of alcohol accounted for the largest number of separations (admissions/discharges; 16,361 or 19.1%). It was the most commonly reported diagnosis for public acute and private hospitals. (AIHW 2008 p371)

The planning and structuring of the Meta-study became a part of the RWR study. The dataset was substantial at the end of the Action Cycles and included: six Action Cycles of data collection; six Basic analyses and preliminary results; six Pearl interpretation cycles with accumulating secondary data; documented analysis trials; and three Pearl analysis review summaries (Sandelowski 2002; Hanson et al 2005; Castro & Coe 2007). On this basis, the integrated results were presented as the Recovery Continuum, detailed earlier in this Chapter.

**Integrating and exploring RWR data as a comprehensive dataset**

The challenge of integrating data was considered in the research design, and RWR processes for integration were reviewed formally at Action Cycles 3 and 6 and changed as a result of these reviews (Charles 1998; Tashakkori & Creswell 2007; Castro & Coe 2007; van Kouwen, Schot & Wasslen 2008; Castro et al 2010; Teddlie & Tashakkori 2010; Bazeley 2010, 2011). The overall aim was to deliver a thorough representation of participant responses through suitable research parameters (Onwuegbuzie, Johnson & Collins 2011, 2012). Studies using multiple methods of analysis, which are both iterative and recursive, require detailed documentation of the processes required to investigate the depth and breadth of complex issues (Johnston & Baumann 2007; Onwuegbuzie et al 2009). My decision to use multiple analytical perspectives yielded a more comprehensive picture of women’s recovery than was possible from one perspective alone.

Integration using different but complementary sources best occurs at the stage where results are being composed, well before the final conclusions are made. (Bazeley 2012)

The integration also included the Action Cycle pair outcomes, Action Cycle triplet outcomes and Reviews (examples are provided below) developed throughout the research (Figure 4.4). The RWR Pearl Analysis (below) examines the particulars of how the RWR multiple source research data were studied and integrated through a ‘Level of analysis focus’, over the six Action Cycles and four Dynamic Lines of
Inquiry. The integration work with the RWR data resulted in my total immersion with the material and participants. The Pearl Analysis also provided a fully integrative research analysis and interpretation plan for meta-analysis (Dreher 1994; Schulze 2004; Hanson et al 2005; Creswell 2005; Bryman 2007).

**Figure 4.4:** Researching with Women in Recovery Pearl analysis and interpretation for integration

**Key:** (Verticals) The Dynamic Lines of Inquiry as used in all Action Cycles. They are a consistent, core data collection strategy through to Action Cycle 6.

**Lens x** represents the mixed methods triangulation which occurred throughout the study.

**On the right** side is the six Action Cycles. The **analysis** was a comprehensive and multiple integrations of Action Cycle results183.

**On the left** is the Pearls analysis in **Levels** (see pages 348 and 349) to manage and explore the large amount of data collected as the Action Cycles continued. The combined data and

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183 Research analysis, interpretation and integration processes were completed on the complete RWR dataset. The content of the dataset (loaded into NVivo 7, 8 and 9) included the Action Cycle data, participant summary responses, my unobserved observation notes and analysis memos as the primary sources of data. Selected transdisciplinary literature, related longitudinal studies, Australian Government reports and population statistics were secondary sources, e.g. Australian Bureau of Statistics data cubes.
results were used for meta-analysis (Cooper 2009). Further detail on the multiple analysis applied in RWR is in Appendix 4.8.

(Horizontal) The Level terms represent what was influencing interpretation in the study: Transition\(^{184}\), the decision to increase from three Action Cycles to six Action Cycles; Transformation as more practitioners became involved; and explanations along with special cases, e.g. searching for examples of change happening at ‘edges’ of events and their circumstances (Hughes in Reason & Bradbury 2008). Events included women with children attending special recovery programs to improve their parenting skills. There is also an important role for qualitative and mixed methods action research in efforts to understand the recovery with AUDs phenomenon, refine theories of women’s recovery wellbeing and develop strategies to promote recovery sustainment practices (Stilman et al 2012).

Over the six Action Cycles, the cooperative analysis of preliminary results was augmented by updates to participants on the progress of the study. RWR newsletters (Appendix 4.7) were sent by postal services or email to contributors; the contents included concepts to discuss, new research, and sharing the realities and qualities of women’s recovery and healthcare grounded in fundamental properties of Australian society and ‘do no harm’ research principles. My concerns expanded with the revealing of advanced liberal discourses of preventive healthcare as an exercise of individual responsibility to return to a functioning and productive norm and prevent recurrence (O’Brien 2012). This political, economic and moral enterprise of health articulates a ‘recovery imperative’ which overlooks the gendered context that impedes women’s recovery.

**Preparing for meta-analysis**

The Pearl analysis and interpretation techniques also provided opportunities to place an emphasis on complicated data and to ‘tag it’ for subsequent meta-analysis (Dreher 1994; Schulz 2004; Hanson 2005; Bryman 2007). Meta-analysis required a comprehensive data management plan, and ongoing updating as the study progressed. I found that systemic thinking and the creation of mind maps (Marshall 2004) for maintaining details of the research process was useful, and applying a

\(^{184}\) The terms also reflected external changes impacting on the study. Transition, from three to six Action Cycles, also required me to be more familiar with the dataset and able to investigate more related longitudinal studies (Mills study; Paris & Bradley 2001; ALSWH; Young & Powers 2005; Powers & Young 2008, Wisconsin, Molander, Yonker & Krahn 2010). Transformation included the changing context of public healthcare in Australia through the release of new Alcohol Use Guidelines (NHMRC 2009-2010) and the Fourth National Mental Health Plan (2009-2014, Commonwealth of Australia).
‘reflecting in action’ mindset (Reason 2006), with critical reflection journaling was essential (Brooks 2009).\textsuperscript{185}

\textit{The Meta-study and RWR findings}

The Meta-study was an effective use of critical analysis, interpretation and evaluation tools to more thoroughly explore the substantial RWR dataset\textsuperscript{186} of the Action Cycles (Greene 2007), particularly Action Cycles 4, 5 and 6. The three techniques involved in the meta-analysis (listed above) were particularly suited to the dataset and participants, as well as being an extension of existing methods: refining the language focus (exploring paradoxes that might reframe the research; Kohlbacher 2006); extending the research reasoning (broader inference; Tashakkori & Teddlie 2003), and gathering more of the participants’ recovery learning experiences (gestalt experiences; Kerr & Key 2011) through their ongoing feedback.

The RWR results raised for myself and participants more questions about women’s recovery. By Action Cycle 4, with the increasing number of participants and amount of collected transdisciplinary literature and secondary data, a large dataset was available for further exploration. Also, the data was in forms that could be studied using different techniques in NVivo 9. The raw data had been cleaned and sorted into the following four RWR databases: 1) ongoing communication with 10 categories of participants (Microsoft Office [including Excel] 2003, 2007), 2) the RWR Transdisciplinary Knowledgebase (Adobe Master Class CS3), 3) Nvivo projects (software versions 7, 8 and 9) and 4) EndNote (versions 7, 11 and 14) memos and annotations. The processes of meta-analysis could be now be applied through cooperative analysis (Schultz 2004; Lipsey & Wilson 2001), collaborative sense-making (Wideen, Mayer Smith & Moon 1998), the continuing use of multiple lenses (Peshkin 2001), and concept maps (Suri & Clarke 2009; Pettigrew & Roberts 2006).

\textsuperscript{185} Tagging data involved including analysis memos where ideas such as THINK were placed. THINK was an acronym developed from an idea shared by the women at an AA meeting, and this information was entered into the NVivo program: T for think before responding with H for honesty, N for nurturing and K for kindness.

\textsuperscript{186} Data development occurred as the results from one analysis type were used to inform data collected and analysed using another analysis type (mixed methods triangulation; Creswell 2009).
The meta-analysis of the new dataset (Chapter 5) produced analytic themes (e.g. women’s gratitude and sharing motivations and outcomes), constructs (Recovery Care, Development and Support), clusters of concepts (e.g. identity and role formation) and subject groupings (e.g. women’s ways of building personal in recovery relationships). The preparatory Meta-study work with participants (970 people contributed to the Meta-study) contributed to generating the RWR Findings, which are detailed in Chapter 5.
CHAPTER 5: FINDINGS

Women’s recovery change enabled in a Recovery Triad

The pragmatic findings of Researching with Women in Recovery (RWR), detailing how recovery can work for women, are presented here. They comprise the ‘Meta-study’ (Chapter 3: Research Design; Sandelowski, Barroso & Voils 2007). Four questions (listed below) developed from the results (Chapter 4) provided the starting point for interrogation of the meta-dataset using selected techniques of ‘meta-analysis’ (Martins, Ramalho & Morin 2010), critical ‘interpretive synthesis’ (Dixon-Woods et al 2005; Dixon-Woods, Cavers & Agarwal 2006) and ‘meta-synthesis’ (Thorne et al 2004). Using NVivo 8 and 9, key ideas were generated from the meta-analysis of the answers to each of these questions. An analysis of the outcomes led to the identification of the meta-processes that the women completed, which I named (these RWR meta-process terms are explained in the box below). These terms were then used to recommend effective treatment programs that can meet the women’s specific needs, e.g. Recovery Respite Care; and The Recovery Triad processes, which can help the women to progress to Valued Recovery, and on to a sustainable recovery for their lifespan. The women’s personal development and their transformative journey from the end of active AUDs to such a long-term sustainable recovery with wellbeing is organised into four sections relating to the four questions.

Question 1: How can Recovery happen in a simpler way?

Summarised answer: Health and community care practitioners need to provide earlier interventions for midlife women to significantly reduce the chronicity and comorbidity that are associated with AUDs. The recommended interventions must

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187 The Meta-study used the RWR meta-dataset containing ‘cleaned’ RWR Action Cycle results, Small Diamond outcomes, Pearls analysis results, and Results of the feedback of participants located within selected transdisciplinary datasets (see the Meta-study box below, the Summarising Meta-synthesis Table).

188 Meta-synthesis (see Appendix 5.4) entails a comparison, translation, and analysis of original findings from which new interpretations are generated, encompassing and distilling the meanings in the constituent studies (Zimmer 2006).
be suitable for midlife women, and enable them to begin their individualised and shared recovery.

**Section 1: Related Discussion Topics** – An effective nexus of women’s AUDs care, Recovery Change processes and a Recovery Triad

**Question 2:** Why do women stay in recovery?

**Summarised answer:** What is needed is a recovery process that is rich and (at times) complex, providing the women with a fulfilling living process that is supported by an individualised healthcare plan. A recovery plan integrates whole-person healing, women-oriented development, life-purpose exploration, and sharing with in recovery peers and significant others.

**Section 2: Related Discussion Topics** – Recovery Care constructs, Recovery Development concepts and clusters, and Recovery Support subjects (RCDs) to improve healthcare intervention outcomes.

**Question 3:** Why does non-recovery occur, and what can change this outcome?

**Summarised answer:** Female-oriented care needs are currently not being met, and effective specific treatment options are not being provided for midlife women. Non-recovery lacks recovery engagement and action for wellness. In a continuing care process women are enabled to progress. Robust recovery pathways based on relevant treatment approaches must be established to help individuals develop their capabilities.

**Section 3: Related Discussion Topics** – Non-recovery and assistance for relapse through constructive recovery respite care. Unexpected themes from the Meta-study provided ways to improve healthcare for sustainable recovery.

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189 The Recovery Triad combines women’s: 1) Recovery Continuum (Chapter 4: Results); with 2) Recovery Care, Development and Support (RCDs); and 3) individualised recovery management plans suitable for maintaining midlife women's health and wellness; and its use can lead to robust long-term recovery with a nurturing and progressive quality of life.
**Question 4:** How does self-discovery, collaboration and collectivism work in women’s recovery partnerships?

**Summarised answer:** The women reach a major learning plateau of cooperative independence. With access to further individual care options, e.g. robust wellness, the women are able to develop sustaining recovery to contribute, as socially-effective individuals with AUDs, within their families and communities.

**Section 4: Related Discussion Topics** – Wise Recovery: living well with others.

Midlife women can stabilise abstinence, then through their in recovery routines, guided by a healthcare team (including Expert Volunteers and peers in recovery), find new ways to live a satisfying life. The Meta-study revealed the learned capabilities that enabled women to experience self-actualisation and optimal human development (Pffaffenberger 2007). With use of the Recovery Triad (discussed in this Chapter) a more robust recovery is likely for women. Living well with others, using skills developed and practiced in recovery increases women’s potential for a personal, sustaining Wise Recovery.

**A Meta-study process**

By the completion of Action Cycle 6, the integration of mixed methods Action Cycle results with the combined data from the four Dynamic Lines of Inquiry190 in the NVivo program provided an RWR meta-dataset ready to be studied (Castro et al 2010; Bazeley 2011). To illustrate, the Meta-study revealed the main processes that were used in the women’s complex recovery, and that women’s ways of recovery strengthened their core self and changed their mindset away from victimhood, whilst heightening their awareness that they were worthy and capable of effectively exploring, understanding and developing their potential.

190 The four lines of inquiry also provided data that were entered into the software programs, e.g. field notes from my Observation of women’s recovery ‘practice in the community’, conclusions from selected longitudinal studies of women’s midlife health from the Document and Expert Exchange line of inquiry, and the psychiatric specialist feedback on result presentations at their annual research and clinical practice conferences as part of the Action Science inquiry process.
The RWR Transactive Knowledge Creation Paradigm (Dietrich 2004; Schwarz et al 2007; Jung et al 2010), which is the final feature of the RWR Transactive Methodology (Chapter 3: Research Design), incorporated a comprehensive meta-analysis. By the end of Action Cycle 4, the data collection and ongoing Cycle analysis that I had completed indicated that a meta-analysis was possible, and that it would be of value to the study results (Pluye et al 2009). The aim of this analysis was to explore how integration and synthesis of the collected data in digital form could add depth through the selected RWR Meta-study techniques (Martins, Ramalho & Morin 2010). Each of the interpretation techniques that were used are explained in this Chapter.

The Meta-study methods for the RWR dataset included the use of higher-order abstraction and theorising to better understand how and why Recovery Works for Women (Martins, Ramalho & Morin 2010). These methods are briefly explained in this Chapter, with more detailed information being provided in Appendix 5.1. The meta-analysis was also aligned with the philosophy of Transactive Participatory Research, to create the critical perspective of RWR as a mixed methods study (Suri & Clarke 2009).

The interpretive synthesis of meta-data (Dixon-Woods et al 2005; Dixon-Woods, Cavers & Agarwal 2006) revealed new ideas that can help to empower abstinent women with AUDs to pursue recovery change, with support persons, an individualised recovery plan (Turton et al 2011). Many of the participants shared conversations and recordings of personal insights and experiences that contributed to the researcher’s method of abduction (as one component of meta-synthesis191) for examining and considering explanations of why particular techniques produced positive outcomes for women with AUDs (McLaughlin et al 2011; Pearce 2012). Of particular concern for the women was their need to receive optimum supportive services in one place, where the providers were aware of the oppressive stigmatisation faced by midlife women with AUDs (Dickens & Picchioni 2012).

191 The essential task of meta-synthesis* (involving induction, broad inference, abduction and cooperative interpretation) was subsuming the concepts identified in the Action Cycles and meta-analysis, into a higher-order theoretical structure(Noblit & Hare 1988; Thorne et al 2004).
Because of this, much courage and suffering was commonly required to ask for support and begin to stop drinking.

The critical understanding, drawn from the meta-synthesis, was that the current forms of health, community and specialist care can limit women’s progress towards recovery and in recovery. This can occur by ‘carers’ trying to ‘solve a problem’ or ‘manage harm’, rather than enabling abstinence for womanhood and wellbeing, and the essential acknowledgment of the wisdom of women who have persisted in long-term recovery. Explanations of new understandings and effective processes emerged. For example, the realisation that Expert Volunteers should be included as members of integrated healthcare teams, and that cooperative independence, a step between a person’s interdependence and independence, is a capacity that needs to be learned to accommodate the respectful interactions between the members of the ongoing healthcare teams and the women in recovery.

Rich understandings of women’s recovery change, from the socio-cultural to the intrapersonal (Mertens 2007), are substantive findings that are suitable for application in personal lives, professional healthcare and social welfare, education sectors and government policy.

**Resechning with Women in Recovery Meta-process Terms**

The RWR meta-process terms are described briefly below and explained in the relevant Sections of the Chapter.

**Recovery Change** is an essential part of the women’s life-course that is needed to develop healthy self-care through adult learning and clinical and community care. The women thrive when their needs are being met, and when they feel respected for their personal efforts; this relates to their social–cognitive maturity and social–emotional wellbeing (Bauer & McAdams 2004). The women are then more likely to seek further guidance from their integrated healthcare team to sustain abstinent recovery. The change processes (e.g. identity development and decisions on personal values) are difficult yet achievable using the Recovery Triad with the help of knowledgeable and supportive people.

**Recovery Care, Development and Support (RCDs)** is an outcome of my Meta-study that revealed women’s ways of ongoing experiential learning and capability-building for sustaining recovery, which can be enabled by particular healthcare approaches.
Women’s AUDs healthcare includes concepts of: an Ecology of Recovery, community care through access to a WmSpace; and the identification of relevant personal womanhood goals.

Ecology of Recovery (EoR): Treatment in an Ecology of Recovery network encourages, and somewhat normalises, the therapy and recovery activities. Taking an Ecology of Recovery approach includes specialist and self-help peer support, and mutual-help group involvement, e.g. AA.

WmSpace: A community space (e.g. a room booked through a local government organisation) for sharing recovery ideas with midlife women and enabling a fun way of growth. It adds another connection to community for women who have experienced alienation and exclusion (including self-exclusion). In this space, conversation skills and expression of empathy can support women’s ongoing development through social interaction. Time in WmSpace expands women’s skill base by offering a safe means for practicing socio-emotional learning while in recovery with other women.

The Recovery Continuum (Chapter 4: Results) can guide and facilitate the women, and their practitioners and supporters to work towards achieving an integrated long-term and sustainable recovery.

Chronic illness Recovery management plans (CiRmp) are plans that are suitable for maintaining the health and wellness of midlife women with AUDs and comorbidity issues. These negotiated and individualised plans can help the women to develop robust midlife womanhood with a nurturing and progressive quality of life that is linked to continuity of care and growth towards Wise Recovery.

The Recovery Triad combines women’s: 1) Recovery Continuum with; 2) Recovery Care, Development and Support (RCDs); and 3) individualised Chronic illness Recovery management plans (CiRmp) that are suitable for maintaining the midlife women’s health and wellness, and that can lead to robust long-term recovery with a nurturing and adaptive quality of life.

The Recovery Triad is multidimensional and it provides options for women’s individualised recovery, because ‘Women in Midlife Matter’. It is designed to provide women with much more than just services relating to detoxification and rehabilitation. It makes available pathways for abstinent and sustained recovery and the achievement of wellbeing, and not relapse. The options include:

1. Women’s care and treatment: Recovery Works for Women through Intradependence (3Is) for well-doing as part of a Triad of care and treatment (RCDs are discussed in the following Sections).

2. Women’s development: based on people, processes and practices, by using Transpositions (3Ts) as part of a Triad for women’s wellness (RCDs are outlined below).
3. Women’s support: needs being met and Potentials (3Ps) explored with the support of an integrated healthcare team (including community services) that is contributing to the women’s wellbeing, growth and sustainable recovery as part of a Triad for practice (RCDs are explained in this Chapter).

The Recovery Triad processes were guided by objectives and interventions suitable for midlife women; they involved the provision of support for: Intradependence for well-doing (3Is: Intradependence, Interdependence and Independence); Transpositions to wellbeing (3Ts: Transition, Transformation and Transposition); and personal Potentials (3Ps: Protect, Prepare and Prevent), where women are assisted by an integrated healthcare team with a negotiated objective of sustainable recovery.

Section Content Summary

The following two pages provide a Section Content Overview of the RWR findings. The four Sections that follow provide the detail of the answers to the RWR Meta-study questions drawn from RWR data, and from selected transdisciplinary literature. The findings provide new details of women’s ways of recovery that can improve the health and quality of life of women with AUDs over their changing life-course.

The findings in each Section are evidence-based broad inferences that comprehensively articulate the experiences of in recovery midlife women with AUDs, and of the practitioners that care for them. I discuss the findings as interrelated components, together with the selected theories that can begin to explain at an abstract level how women’s recovery processes and practice work. As an example, aspects of the women’s recovery illustrate the value and importance of: sensory and emotional memory therapy (Charles 2005), effective psychosomatic care (Pettit, Grover & Lewinsohn 2007), and experts contributing to a healthcare team (McMurran 2012).

192 In each of the four sections of the Chapter a brief explanation of each research method is provided as footnotes, with more detail being provided in the Table at the end of the Chapter.

193 A research inference is expected to capture the meaning of the phenomenon under consideration from the perspective of the participants in the study (Druckman 2005).
Importantly, these findings are the first research-based accounts of midlife women’s recovery processes in Australia, and they provide an explanation for achieving improved professional recovery practice and community support for these women.

**Section 1 Discussion overview**

*Recovery Change and a Recovery Triad as an effective nexus of women’s AUDs care*

The Recovery Triad is the nexus for describing how RWR women become well in recovery, and the particulars of their ongoing Recovery Change for achieving long-term recovery. The Recovery Triad is the combination of RWR Recovery Change, the Recovery Continuum (see the Results Chapter), and a synergy of individualised actions through the framework of Recovery Care, Development and Support (RCDs). The outcome is an evidence-based flexible Recovery Triad that can be used as a healthcare plan for midlife women with AUDs.

Recovery Change provides a process for providing earlier intervention for midlife women to lessen AUDs chronicity and comorbidity (DSM IV APA 2004). The processes explained in this Chapter can enable midlife women to heal, become abstinent while forming a core self, evolve an in recovery identity, and progress towards wellbeing.

The Recovery Triad is multidimensional; this enables options to be provided for women’s individualised recovery. The options emphasise the message that ‘Women in Midlife Matter’. The Recovery Triad includes:

1. Women’s care and treatment: Recovery Works for Women through well-doing;
2. Women’s development: people, processes and practices for recovery wellness; and
3. Women’s support: meeting women’s needs, through an integrated healthcare team, to develop wellbeing and release the potential of women in recovery in their community.
Section 2 Discussion overview

Recovery Care constructs, Recovery Development concepts and clusters, and Recovery Support subjects (RCDs) designed to improve intervention outcomes are explained in this section. The importance of whole-person healing and ways for women to flourish and share with in recovery peers are important factors that must be addressed for developing a robust recovery. Effective individualised ongoing recovery plans must enable individuals to select the aspects (explained in this Section) that best suit them.

**Recovery Care constructs**

As a healthcare priority, the RWR Recovery Care constructs provide an important explanation of effective ways to work with midlife women with AUDs in relation to their anger. How to assist women with conflict responses in a way that contributes to whole-person healing, improved interaction skills and interpersonal knowledge is outlined.

In recovery, risk of suicide is still a concern. Learning protective behaviours to lower suicide risk also helps to ensure that meeting the women’s particular needs will be a priority in recovery therapy. With knowledgeable support, women who have thought of suicide, and who have attempted suicide, can be enabled through recovery interventions to strengthen their commitment to a recovery way of living, and to continue both experiencing enjoyment and their efforts for achieving wellbeing.

**Recovery Development concepts**

The following two Recovery development concepts detail ways to improve women’s wellness in their individual recovery. They are particularly significant for maintaining recovery during difficult times (discussed further in Chapter 6).

**Recovery Development clusters**

The elements of the Recovery Development clusters, trust in recovery, and gifts of generativity are the researcher’s compilations from the work of a diverse group of specialists’ that can contribute to recovery healthcare. The distinctive qualities of
trust in recovery relationships are highlighted, as this is a common factor for enabling women to flourish in long-term recovery.

**Recovery Support subjects**

Recovery Support subjects comprise a group of important explanations for working with midlife women with AUDs who are seeking friendships and sustaining social connections as a healthcare priority.

**Section 3 Discussion overview**

The RWR Meta-dataset was studied using particular techniques (described in Table 5.2 to reveal meta-themes and analytical themes. These themes indicated particular negative and positive elements of women’s recovery, and how to provide care to women to enable them to progress through the difficulties and issues faced when abstinent. Without such care and support, delays in recovery occur, and when not addressed these may lead women to relapse (Neto et al 2008).

**Meta-themes: Non-recovery**

The RWR results and Meta-study findings provided an in-depth understanding of women’s non-recovery and their capabilities for robust wellness in recovery and Wise Recovery. Non-recovery is a state of being when women with AUDs are not drinking alcohol, however in non-recovery there is a growing risk of relapse because of their lack of engagement in non-drinking activities and also associated underlying negative issues (e.g. emotional abuse; Haynes et al 2008). Midlife women in non-recovery have undeveloped adult abilities for recovery change and therefore they limit their life satisfaction in recovery. Non-recovery is at the Distressed recovery end of the Recovery Continuum and it prolongs suffering for women (Hart & Singh 2009). Through this study of non-recovery, I developed a ‘Recovery Respite Care program’, based on the midlife women’s means, as a way of engaging them in active recovery.
Analytical themes: Enabling support for further self-discovery

Some of the participant women entered recovery in a mid-range phase\(^{194}\), e.g. ‘I’m in recovery’. These women, who are suffering less physical damage with lower impact social ramifications, are likely to have less comorbid disorders and trauma history. The focus became ‘How can women with AUDs maintain their recovery by addressing their personal wellbeing and self-discovery needs? Findings of longitudinal and empirical transdisciplinary studies, robust wellness and resilience, contributed to exploring the question (Thomas & Harden 2008).

Section 4 Discussion overview

Wise Recovery: Living well with others

The meta-synthesis of data (Table 5.2) revealed characteristics and processes of women’s recovery to present an informed explanation answering ‘What is Wise Recovery?’. The essence of Wise Recovery is the women’s momentum of openness to life’s experiences drawing on their insights and skills of Complex and Valued Recovery (Graham et al 2008). In RWR, Wise Recovery is a meaningful collaboration with people, purpose and process, as complex and beneficial of recovery (Resnicow & Vaughn 2006). Wise Recovery was indicated by the women’s individualised understanding about selfhood, adulthood and womanhood. The women were able to pass on their comprehensive understanding and experiences to other women and practitioners through RWR.

The RWR findings make a significant contribution to research knowledge on women’s recovery; they provide evidence-based information for policy-making and healthcare strategies, updates for tertiary education curricula and public information to assist community understanding about recovery benefits, and recovery contributions.

\(^{194}\) The women’s AUDs are not compounded by comorbidity and or loss of relationships.
Section 1 Discussion

Midlife women’s recovery: Self-discovery and mental health

Women’s ongoing Recovery Change for long-term recovery\textsuperscript{195} is presented here in a form that can help the women and their practitioners to improve recovery care. The key features of Recovery Change were drawn from the Meta-study database using analysis with NVivo 8 and 9. Four key areas were selected for reporting: a) midlife women’s recovery – self-discovery and mental health; b) perception and control influencing recovery change; c) women experiencing abstinence and learning in recovery; and d) women in recovery clinical practice and whole-person healing in midlife.

Recovery Change focuses upon women’s meaningful growth during which they begin to replace their maladaptive seeking of alcohol to feel at ease with life events with health and wellbeing-enabling alternative strategies. Seeking\textsuperscript{196} is a basic human drive, e.g. to forage for food, eat, and then feel satisfied (satiated) (Panksepp 1998). The human seeking system promotes energetic exploratory searching and learning, which develops into planning and completing specific goal-directed activities (Panksepp 2004).

With the help of ongoing psychosomatic healthcare and support networks, Recovery Change becomes an organic (not a mechanistic) way to enable women to explore abstinence, discover their adult self-concept, and develop their emotional stability (Fiori, Antonucci & Cortina 2006). Women progress through learning about accepting knowledgeable care, abstaining, and self-caring recovery, and understanding personal beliefs to develop a mature non-drinking identity that evolves over their life-course; similar to learning about diabetes self-care (Meetoo & Temple 2003).

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\textsuperscript{195} Recovery is considered here through a feminist praxis lens as a political action in which knowledge is not simply defined as ‘knowledge about what’, but also ‘knowledge for’ (Harding & Norberg 2005; Stanley 1990).

\textsuperscript{196} With nurturing care and support, the women can become aware that their ‘false seeking’, which was initially met through the substitution of alcohol, was an unconscious attempt to meet their basic need for safety and security with other people. The primal seeking response is not a simple pleasure, reward or reinforcement system (Panksepp & Moskal 2003; Berridge & Robinson 2003). Women increasing their alcohol consumption became misdirected in their self-care, and with appropriate support, they were able to gain motivation to survive their mental and physical distress. Seeking is discussed in detail in the Chapter 6 (Praxis).
Women with AUDs are enabled through guidance for Recovery Change to establish mental health baseline characteristics without the use of alcohol. Practitioners and supporters help midlife women to engage in women-oriented experiential learning about identity, gender-roles and self in responsible relationships to enable a substantive, desirable, evolving quality of life in abstinent long-term recovery. The basic features needed for healthy adult Recovery Change is self-coherence, a sense of purpose, positive alliances and support for engaging in flexible goal-directed action (Higginson, Mansell & Wood 2011).

**Self-stigma and stigma replaced by self-discovery, understanding and acceptance**

The women’s sense of self during active addiction is often unrecognisable and frightening. Women participants provided details about difficulties experienced while trying to comprehend their AUDs; and how over many years they had turned to many professionals (often GPs) to express their emotional pain and distress with unsatisfactory outcomes (Corrigan, Watson & Miller 2006). Practitioners who are caring for women who are in AUDs recovery and who are experiencing abstinence can provide a knowable starting point for addressing their associated distresses. Emphasising safety in care and listening with warm sentiments, rather than judgment, can open ways to discuss with the women their common feelings, thoughts and actions about any confusion associated with AUDs.

Practitioners indicating to their female clients the reality of their actions when inebriated (drunk) and when not drunk can help to shift the women’s thinking toward the reality of their AUDs, e.g. the resulting physiological damage, particularly that involving the brain and central nervous system (Campanella et al 2009). Early positive recovery care experiences that involved the practitioners in a healthcare team talking with (not at) the women about what they felt about AUDs was recognised as a memorable, hope-filled intervention.

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197 Mental health [and wellbeing]: “A state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential. It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities.” (Australian Health Ministers 2003)
Practitioners in the study reported that it took years of experience to explain to colleagues, clients and supporters why the women’s particular reported AUDs actions and feelings occurred, such as: women trying not to drink, and drinking ‘against her will’ due to the physical and mental addiction processes; the women’s silent shame about drinking based on her own and society’s misunderstandings about the disorder; describing common behaviours associated with addiction, e.g. of lying about, and hiding, alcohol (DiBacco 2010); and that alcohol dependence can be treated by healthcare practitioners and through mutual self-help networks.

Females also have a later age of onset, a more compressed, course of symptom development, and a higher rate of physical complications. (Gogineni et al 2004)

The opportunity to heal while being in safe care with the likelihood of becoming well when abstinent can be seen as attractive and empowering for midlife women. Meeting the specific recovery needs (perceived needs) of women with AUDs enables them to embark on a positive journey of life achievement (Edlund, Unützer & Curran 2006). Women-oriented care can enable discovery and acceptance of self. Learning beneficial recovery change processes can help the women to handle the difficult therapy processes. Addressing the midlife women’s guilt for being an alcoholic requires careful counsel, because, particularly in Australia, the ‘alcoholic’ label highlights female deviance, and it creates misery and anguish for these women and their significant others (Adler & Adler 2006; VanVliet 2009).

Recovery Change: Women no longer acting on AUDs misperceptions

Supporting midlife women to not drink alcohol while they are influenced by the misperceptions generated by their AUDs is difficult. The main answer to my research question ‘How do midlife women with AUDs recover?’ was that they need to be enabled to have access to a nurturing safe environment that supports healing and the building of self-awareness, so that they can better understand the nature of their AUDs and choose to not drink alcohol.

198 Wellbeing focuses on psychological functioning, good relationships with others, self-realisation and the development of human potential (Parkinson 2007).
Initially, successful Recovery Change for achieving abstinence needs to focus on physical healing for women, with the support of appropriate healthcare resources (Australian Government 2010).

What change is possible?

As adults, we compare what we perceive ‘outside’ in the external environment with our internalised standards; and if they are equivalent, then living feels ‘comfortable’. There is congruence of the internal with the external. The human need is to feel and understand a ‘right’ sense of self in the everyday environment. The internal standard is predetermined through life events, and if there is a difference adults pursue change to make the internal and external feel at ease, rather than being in conflict (locus of control; Gwandure & Mayekiso 2012). The difference (as dissonance or conflict) is addressed by one’s control systems (Carey 2008).

Making significant changes to the external environment is more difficult to control and achieve than changing the internal environment of perception, expectation and intention. Most midlife women with AUDs have certain internal standards that are extreme, e.g. their perfectionism and/or high threat sensitivity, and control had often developed to enable them to deal with their complicated daily experiences (Egan et al 2007). The ongoing stress and distress they feel results in the drinking of alcohol as a way to avoid their feelings of dissonance, so that they may feel, at least temporally, at ease.

Perception Control Theory (PCT; Powers 1973; Young 2005; Carey 2006; Mansell & Carey 2009; Higginson, Mansell & Wood 2011) can help to explain the efforts that women will go to for them to take more control, such as excessive worrying, as a result of their loss of personal control. When people’s lives transpire as intended, self-control is intuitive, seamless and continuous. When people find themselves struggling or distressed in unexpected situations, they feel an internal unease and proceed to act to nullify such feelings. They may have to exert a great deal of effort (control) to stop the unease. Their feeling of control is further disrupted when they unsuccessfully try to change external factors. Dissonance heightens (the women’s intentions and expectations are not being met) as they continue and persist. Whether the task is completed or not, the feeling of being in control is lost. The need to control at such levels of effort also limits their ability to perceive that reorganisation or different types of actions are needed to meet the circumstances. The more that this type of control is expressed, the greater the barriers the women must overcome when making changes to meet their internal standards.

“The main psychological way that loss of control is prevented is through internal conflict\textsuperscript{199} being minimised.” (Carey 2006)

\textsuperscript{199} Experiencing conflict at multiple levels, internal and external, is a challenge for midlife women and for their ongoing recovery; further discussion of this is provided later in the chapter.
The healthcare and initial recovery plan needs to be designed and integrated to enable the women to recognise and change their perceptions\(^{200}\) and associated maladaptive patterns of behaviour and, in many cases, their life goals. Perception Control Theory offers an explanation as to why the seeking drive of women with AUDs resulted in such high consumption of alcohol that they became alcohol dependent (Mansell & Carey 2009). Also, how modifying seeking and control actions are important for Recovery Change, and how they can support abstinent recovery (see Box for details).

**A process of abstaining to be ‘in recovery’**

The RWR participants agreed that abstinence has many benefits (an enhanced quality of life; De Maeyer, Vanderplasschen & Broekaert 2009); and that it is required for making wise midlife choices, and for the development of the capabilities needed to endure and accrue over the women’s lifespan. Commitment to abstinence (a motivational construct) is a strong predictor of significant reductions in drug and alcohol use (Laudet & Stanick 2010). Abstinent wellbeing was an important motivational construct for RWR women when maintaining recovery.

Women with AUDs described the processes that enabled them to change their perception to achieve their abstinent and recovery goal. Changing the language they used to describe relevant events (rehearsed internally and articulated to others) was one technique, as was acting ‘as if’ what was sought (recovery) already existed. However, accepting what are generally agreed facts of the matter (the events and issues) provided the most appropriate circumstances to work with to achieve abstinence. A most difficult concept for midlife women to conceive, retain and act upon is the fact that it may not be possible to change their circumstances, e.g. her diagnosis of having an AUD. The primary action needed for a woman to be well is for her to change herself by not drinking alcohol.

\(^{200}\) Perceptions created through sensing the current state of the environment (use of sensory organs) leads to our awareness of experiencing a physical object in the world. Perceptions are also the sensations of the internal experiences of the body (including the mind), e.g. the women noted that they sometimes felt overemotional, and they described the experience as physical flushing of the face, racing, not clear thinking, feeling butterflies in the stomach or tightening in the throat.
A priority for women who are endeavouring to start and maintain abstinent recovery is having access to empathic support throughout what women described as a painful experience, as they came to understand and accept the prognosis of their AUDs (and the associated fears of insanity and death). Comprehending the diagnosis, treatment and prognosis may require repeated explanations. Most RWR practitioners understood the effects of women’s likely cognitive impairment, however, not all of them applied this to a need to repeat to women explanations of what actions are required to stop drinking\(^{201}\) (Loeber et al 2009).

Critical to the women remaining in ongoing Recovery care was seeing the positive outcomes of other women in recovery and listening to them talking enthusiastically about their new lives. Women maintaining recovery were able to explain the highs and lows, their misunderstandings and new experiences of safe activities, ways to address their misperceptions and feelings of distress (Kahler, McCrady & Epstein 2003).

### Control and intense activity

The women in recovery emphasised that the old pattern of tight control and high activity to achieve a task emerged at times in recovery (Morling & Evered 2006). They spoke of needing to be reminded that even with more effort they could not control all of the aspects of their lives. Commitment to abstinence helped them to limit the desire to control, particularly when situated within a network of support for abstinence. The practitioners understood and acknowledged the women’s need to be engaged in activities as they re-organise their lives when physically able. It was important to explain to the women in early recovery that their need to be very active was a maladaptive defensive strategy to release their feelings of stress. Such actions are engaged in to provide a shield, and should not be regarded as a deception (Grèzes, Berthoz & Passingham 2006).

\[\text{Control is the natural phenomenon that occurs when constancy is maintained in the midst of change. (Powers 1973 p33)}\]

\(^{201}\) Alcohol-related morbidity and Wernicke-Korsakoff Syndrome needs to be discussed with the women (Popoola, Keating & Cassidy 2008).
Women who had been in recovery for several years were well equipped to engage in appropriate control activities (Mansell & Carey 2009). Recovery became an essential part of their learning about how to accept the realities of everyday life. When they were less rigid, they developed a new sense of responsibility, whether in non-stressful or difficult circumstances (Feigin & Sapir 2005). As the women become clearer about their feelings of positive effect, negative affect and satisfaction they are able to make clearer choices between actions that involve change and control (Diener, Oishi & Lucas 2003). Choice becomes more evident as women continue their recovery.

Recovery is “a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life” (Center for Substance Abuse Treatment [CSAT] 2007). This requirement for abstinence (not harm minimisation) in midlife was emphasised by the RWR women, and in the AUDs research emerging in the mid-2000s (Krentzman et al 2010):

*Sobriety ... is considered to be primary and necessary for a recovery lifestyle.* (Belleau et al 2007)

Women in the RWR study understood from their lived experiences that abstinence (sobriety was also a term used by some participants) was their first priority in their recovery. They were willing to seek and continue to learn and take action for care of self and purposeful recovery living that supported their abstinent wellbeing (this is supported by previous research with both men and women; Brewer & Streel 2003; Cox et al 2004; Vaillant 2005; Fein et al 2006; Kleinig 2008; Saarni et al 2008; Laudet & Stanick 2010).

To stop drinking, women must accept that they will need to learn new competencies and to access resources based on contemporary AUDs information, as well as continuing their own physical healing and attending regular healthcare appointments. Supporters can attend to protective processes with women by helping small recovery changes to occur, e.g. by eating well. There will be a need to negotiate living environments, family education and work arrangements, particularly if some of their supporters are still promoting drinking. Healthy adults with dysfunctional family, abuse and trauma backgrounds are able to develop insights, cooperative independence, positive relationships, initiatives, creativity and humour.
Capabilities for Recovery Change

Older females (from approximately 40 years of age) were more likely to achieve abstinence when this was a primary goal in treatment (Dawson et al 2010). RWR participants recommended preparing women for deciding on the abstinence goal. GPs and Drug and Alcohol counsellors can explain the benefits of abstinent recovery and introduce an Expert Volunteer to the women to assist by recalling her early experiences and the contemporary multi-resourced approach (Chapter 4 [Results] and this Chapter for details of women-oriented interventions). Research conclusions on contemporary abstinence programs report that after five years of leaving treatment following a multi-resourced approach the women were still enjoying wellbeing (in one study, a 69 per cent level of abstinence; Ray, Weisner & Mertens 2005).

Practitioners can help by explaining the best-evidence option is a goal of abstinence for midlife women and a recovery management plan that recognises this (Laudet & Stanick 2010; Best & Lubman 2012). The women may attend an in-patient treatment program, learn about community support services, be advised on the range of mental health therapy available, and visit an AA meeting with an Expert Volunteer (or another suitable mutual self-help and peer group network).

The key beliefs for midlife women who were able to maintain recovery included: accepting the AUDs experience and the benefits of abstinence; recognising that positive outcomes can come from most life-changing adversity; holding a more flexible perspective to tolerate diversity of opinion; accepting solace and comfort; affirming one’s strengths (e.g. honesty) and possibilities (e.g. openness); and exploring transcendent beliefs for clarifying one’s values and life purpose (Wiggs 2010). Importantly, midlife women in recovery can dispute unhelpful suggestions and beliefs by discussing their ideas with associates, and willingly explore their new recovery experiences and emerging interdependence with supportive others.

Practitioners emphasised that supporters can further enable the women’s recovery by sharing good will and the attitude that abstinent recovery is an important objective, and that long-term abstinent recovery is possible and can assist midlife women (Tracy et al 2012). Women in recovery recommended being with other women in recovery, because this encourages mutuality, trust, closeness, collaboration, and comfort in relating (Charrel et al 2010). Over time such recovery can contribute to people healing many of their wounds from the past, enabling them to stabilise emotionally and spiritually, take respectful responsibility for their lives (rather than attempting to do this by controlling others), and to go on to live fully and love well. The adult learning process is designed to continue recovery with fewer struggles.

Sustaining recovery led to an enriching way of living (with improved self-knowledge; Teesson 2010). The sharing of women’s insights, tacit knowledge, socio-cultural capital and local politicoeconomic influence was an important benefit provided by the sharing and mutual support between women in long-term recovery.

Sustaining recovery required gathering experience and capabilities at three interrelated levels: within the person (insights, tacit knowledge), the group (socio-
cultural capital) and the network (local politicoeconomic influence; Schensul 2009). Sustaining recovery encouraged self-renewal for the women, e.g. by volunteering in organisations and making purposeful contributions to their community. This rich capacity-building and cooperation can develop pro-social actions and enable the women to share their wellbeing experiences with intimate others.

**Experiencing and learning in recovery**

Enjoying recovery includes overcoming the difficulties associated with taking recovery actions and maintaining recovery. Women in long-term recovery clearly articulated conscious appreciation that the actions, thoughts and feelings learned while being abstinent became easier as they became part of a daily routine. However, they warned that not consciously conforming to the ways of recovery resulted in their drifting to old behaviours, becoming discouraged and feeling somewhat lost, even though they may not be drinking. They had to deal with memories and emotions that were reminders of their past distressed child-like actions, their old fears and vulnerabilities, and feeling the need to drink. Success in dealing with this provides an important reminder, as women return to everyday life, that recovery action experiences can provide positive outcomes. Acknowledging their alcohol dependence and not acting on their addiction affirms the importance of abstinent recovery; and the gift of being able to live in the present and the opportunity of learning across their lifespan (Gibeau 2009).

Recovery involves a learning process that through early and whole-person interventions can reduce the chronicity and comorbidity of the women’s AUDs, and improve their mental health and wellness (in relation to overcoming alcohol dependence; Slade & Watson 2006, achieving personal recovery; Slade, Amering & Oades 2008 and experiencing wellness; Choate 2009).

The process involved in women’s recovery learning, and what women are able to engage with to grow and mature, are illustrated in Table 5.1. It reads from left to right as women heal, develop routines for good health and learn to live with confidence and vitality. The women’s learning was helped by information gathered
using the four levels of RWR techniques. In each box, the second group of words (in italics) are concepts related to the practices in the first group of words in each box.

jah1, Action Cycle 3, Contribute by a letter or email: *I neglected me my whole life, and now I have to deal with the consequences and learn to look after myself.*

*I had to learn to care about myself and others – let people care about me rather than push them away. I have to learn new coping strategies to deal with what’s there rather than avoid things. I have to learn to make positive decisions in all aspects of my life. I have to learn to accept my dual addiction (drugs and alcohol) and dual mental health problems. I have to learn to recognise these and deal with them positively – through counselling. It’s important for my recovery.*

**Recovery Triad and Recovery Care, Development with Support (RCDs)**

The RWR Recovery Triad is based on the lived experiences of women in recovery and is derived from the Meta-study analysis. The Triad provided details and explanations of care and treatment that lead to the development of the women’s healthy non-drinking identity\(^{202}\) (Burke 2004). Effective AUDs mental and physical health treatment supports the women who are now non-drinking and in a stable state, and it enables them to negotiate an effective integrated healthcare plan. The Recovery Triad\(^{203}\) combination, as developed by the researcher, provides a guide for individuals to sustain recovery in complex and enriching ways that brings women’s capabilities to the fore in their life-course events and over their lifespan.

wyn7, Action Cycle 4, participant Reference Group questionnaire: *I could not think straight when I was in active addiction or in very early recovery, so I think trying to fix relationship issues when a person is emotionally and cognitively impaired is almost impossible.*

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\(^{202}\) An identity (adults can have multiple identities) is a stable set of self-meanings that defines who one is (Burke & Reitzes 1981), Burke & Reitzes 1991; Eichler & Burke 2006).

\(^{203}\) The RWR Recovery Triad is a combination of the Recovery Continuum (see Results Chapter), Recovery Care, Recovery Development and Recovery Support (Reds; see figure below) and individualised care plans. Content that can be used to help practitioners using the Recovery Triad is further developed and discussed in the Praxis Chapter.
Table 5.1: Key findings about women’s Recovery Change: for use by healthcare teams and Expert Volunteers

<table>
<thead>
<tr>
<th>Analysis Levels</th>
<th>Well-doing in early recovery through skills</th>
<th>Wellness as women’s knowledge &amp; understanding grows</th>
<th>Wellbeing as women experience robust development and progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Action Cycles</td>
<td>Learning by experiential action</td>
<td>Learning occurs with new information</td>
<td>Women’s intuitive lived experience is valued</td>
</tr>
<tr>
<td></td>
<td><em>Recovery learning can be explored using transactive &amp; participative practice</em></td>
<td><em>Women benefit from praxis, guiding practice using new knowledge</em></td>
<td><em>Learning about recovery transformation &amp; broader collaboration</em></td>
</tr>
<tr>
<td>2 Basic small diamonds</td>
<td>Conversation activity for meaning-making with practitioners, supporters and expert peers</td>
<td>Women discovering a transitional self &amp; working with others in chosen roles</td>
<td>Conscious attention to living well through sharing &amp; seeking useful experiential knowledge</td>
</tr>
<tr>
<td></td>
<td><em>Focus on experiencing the present without alcohol &amp; with recovery care &amp; support</em></td>
<td><em>Responsible expression of identities in multiple ways including sharing care</em></td>
<td><em>Feeling connected to self, self with others and self with greater beliefs</em></td>
</tr>
<tr>
<td>3 Pearl Analysis</td>
<td>Women’s assimilation with recovery networks</td>
<td>Reciprocating with women in recovery, communal sharing of understanding &amp; awakening curiosity</td>
<td>Women’s mutuality &amp; change for wellbeing based on values, insight &amp; context</td>
</tr>
<tr>
<td></td>
<td><em>Self-determining moments</em></td>
<td><em>Self-actualising to maintain recovery</em></td>
<td><em>Understanding that not all is known, or a knowable experience</em></td>
</tr>
<tr>
<td>4 Meta-study</td>
<td>Women coming to active self-agreements, articulating beliefs &amp; attitudes to act upon</td>
<td>Preparation and participation to learn about personal unknowns and recovery with others</td>
<td>Discuss catalysts of care &amp; change to care negotiated in an adult partnership</td>
</tr>
<tr>
<td></td>
<td><em>Integration, post-traumatic growth &amp; self-knowledge</em></td>
<td><em>Synergy of people, places &amp; principles for transcendence</em></td>
<td><em>Sharing recovery understanding with generations – generativity</em></td>
</tr>
</tbody>
</table>

**Key:** Women’s Recovery Change involves processes of learning that are designed to change mindsets by providing knowable care and enabling learning about mental, physical, emotional and spiritual healing. The Recovery Change processes reflect a layered understanding (see Levels 1 to 4). Recovery Change begins with women becoming aware that the ‘real me’ is different from the ‘addicted me’. Women addressing dependence characteristics and a related harmful AUDs identity, with careful support, can learn and move (left to right) from well-doing with others, toward a sustainable non-drinking self and an in recovery identity. Maintaining recovery requires and enables ongoing learning about wellness with AUDs. The women’s recovery learning, from experiential action (see top left corner) to recovery transformation (see top right corner), can sustain their wellbeing. Recovery Change is achievable with guidance, engagement and persistence. The healthcare team provides midlife women with current psycho-education information through selected activities and individualised support. Detailed explanation is in Appendix 5.2. The numbers 1, 2, 3 and 4 in the left column represent the research process that revealed different levels of understanding about the women’s recovery: 1) Action Cycles; 2) Small Diamonds; 3) Pearl Analysis; and 4) Meta-study (see Appendix 5.3).
Recovery Triad and Wise Recovery opportunities

Exploring midlife women’s potential as unique individuals who are contributing to the community is an important recovery care process. Women with a non-drinking identity can be strengthened through the Recovery Triad, with progress being made through the Recovery Continuum and onto the possibility of reaching Wise Recovery (see end of this Chapter). Four processes bring the women’s non-drinking identity into being: women describing their actions in culturally acceptable language with an articulated set of meanings that have a personal standard, i.e. I do not drink alcohol (no amount, on no occasion); women apply their resources to maintaining the known standard (no alcohol); the identity applies to the roles women place as first priority as well as the non-drinker role; and where the identity can be verified by others (Oyserman, Fryberg & Yoder 2007).

A woman with a non-drinking identity can commit to healthy actions for achieving recovery; her recovery actions are confirmed by recognition of her by others as a dynamic non-drinking identity. Learning new skills and the practicing experience (discussed below) helps the women to change their identity from one that is a currently non-drinking identity to an in recovery identity. Women with an in recovery identity function in everyday life, perform coherent actions, and persevere in roles and groups as active members of their community and society (organisation and structure; Burke & Reitzes 1991).

Identities are the sets of meanings people hold for themselves that define ‘what it means’ to be who they are as persons, as role occupants, and as group members. These meanings constitute what is called an identity standard. The identity standard serves as a reference with which persons compare their perceptions of self-relevant meanings in the interactive situation. (Burke 2004)

In recovery identity exploration

A women’s personal understanding of non-drinking and an individualised recovery requires a conscious process of taking steps towards developing an in recovery identity. The process of exploration toward these sets of self-meanings is similar to maturation experiences in early adulthood (Johnson, Berg & Sirotzki 2007). Women in recovery may have missed, or unconsciously subverted, these development processes earlier on in their lives. Women with AUDs will need to be initially guided
through the identity-forming process of being in recovery, including perception checks, talking about the experiences of the present, and being honest about the thoughts and feelings occurring as they develop a personal recovery way of living. Importantly, the healthcare team and supporters assisting the women in completing the important process must not be judgemental. The women are well aware of their own histories and that they carry with them cultural and socio-demographic factors, psychiatric or psychological vulnerability, and a biological or genetic propensity to addiction (Swendsen & Le Moal 2011).

The ways women develop a dynamic in recovery identity (one that can adapt to life events) can be expanded through making safe healthcare choices. As the women commit to abstinence, a non-drinking identity remains their core focus, which in turn provides freedom and responsibility to contribute and care for self and selected ‘others’ (meeting the women’s emotional and altruistic tendencies; Padilla-Walker et al 2008). Recovery care (see RCDs below) requires practitioners to provide ways for their clients’ in recovery identity to adjust and evolve in relation to improvements in their mental health and wellbeing.

An example of the need for pragmatic in recovery identity flexibility is, if and when the need arises, for the woman to conceal a stigmatised identity (Bosson, Weaver & Prewitt-Freilino 2011). Discussions for keeping the disorder confidential, and recorded in a non-damaging manner, are currently occurring in Australia. Women publicly identifying as alcoholic is not advised because of the ignorance that abounds about the disorder, as well as prejudicial reactions and discrimination. Women participants do adapt to the need to conceal, or reveal to selected individuals, being women in recovery. They must choose carefully. Self-verification of being in recovery, maintaining recovery and belonging with others in recovery is a mature and necessary responsibility.

The women’s stance on particular factors will form (and reflect) their non-drinking identity and their in recovery identity. The healthcare team, in discussion with their

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204 Burke (1991, 2004) provides extensive detail of the history of identity control theory, models and systems. I note that these ideas link with Perception control theory (Powers 1973), Identity control theory (Burke & Reitzes 1981), Affect control theory Heise 1979; Smith-Lovin 1988) and Self-verification theory (Swann Jr 1983; Swann & Read 1981), as they relate to the RWR Meta-study and women’s recovery development processes.
clients about recovery, can enrich the women’s understanding of their background and past development (Rutter 2012). The women’s preference for individualism or collectivism philosophies will make a difference to their ideas on identity status and social identity (individualism and collectivism; Greenfield et al 2010), human individual agency; Jenkins 2001, and social identity; Cornelissen, Haslam & Balmer 2007; Chrobot-Mason et al 2009). Women’s gender, age and birth cohort beliefs affect identity formation (gender; Padilla-Walker et al 2008), age and Baby Boomer cohort; Nikander 2009). Expressing their self-concept, personal disposition and values to align in a non-drinking, and then an in recovery, identity is a pragmatic and exciting activity (Schafer & Shippee 2010). These identities will increasingly become part of the women’s roles and healthy life actions (Oyserman, Fryberg & Yoder 2007).

**Identities and roles**

The information (spanning from the 1950s into 2000s) below provides examples of the RWR metadata, aligned with a variety of theories and processes that are useful in understanding what occurs in women’s recovery, together with opportunities for offering relevant care to midlife women. I also provide an example of how my theories apply in practice to extend and improve healthcare for women in recovery.

Of importance to the RWR study and identity control theory are the endeavours of Foote and Stryker (1951, 1968, 1980, in Burke 1991) to explain the connections and mutual influences towards action between self, identity, motivation, social categories, roles and social structures. I apply their process to women’s experience of being a mother. The role, mother, has an individual’s characteristics represented as an identity in those circumstances. The women’s non-drinking identity is a primary set of self-meanings (a symbol), an important commitment made in the role of mother for women in recovery with AUDs. Women can reflect upon, and appraise their actions as a mother, along with their non-drinking, in recovery identity. The reflection provides reinforcement and an example of self in relationship, the women as in recovery, robust individuals, as effective mothers.

Adults as they age hold many roles and aspects of themselves (self-meanings) that can be more or less dominant as needed. Maturation enables more conscious selecting and sharing of themselves in roles. How to select is a skill needed by in recovery women. Individuals hold in-depth cognitive, affective and behavioural frameworks of development and identity; this enables them to consciously value complex and integrated differences and similarities in themselves and in others (Chávez, Guido-DiBrito & Mallory 2003).

In summary, the content of identity for the aging individual is a complex, multidimensional construct that integrates physical characteristics, cognitive styles, and personality traits (Whitbourne 1996). Identity formation involves the
processing of information relating to these multifaceted areas. It is interactive and adaptive, and requires effort and control. Previous research has explored the identity processes, particularly in the domain of physical functioning (Whitbourne & Collins 1998) and in relation to dispositional differences in positive self-regard (Sneed & Whitbourne 2001). A paucity of evidence is available on reflection (intrapsychic negotiations) and self-concept changes through identity experiences.

Performing a role at either a surface or deep level involves choosing how separate, in contact or connected the woman wants to be (John et al 2008). The level of connection raises questions about relational identity, and the part it plays in meeting the needs of certain roles (relational identity; Hilton 2003; Binder & Nielsen 2005). Multiple theories about identity and how roles and identities interrelate exist (Burke 2004; Chrobot-Mason et al 2009). Useful for recovery identity is the idea that identities influence the way in which a role is played out. There is personal investment in chosen identities, and people are able to change their identity, particularly with identity distress, i.e. to an in recovery identity (Sneed & Whitbourne 2003). Discrepancies between the meanings of the identity standard (and identity status) and the meanings of the role performance will result in people engaged in changing. The change process is best done through discussion and with the support of knowledgeable, trusted people.

Intersections of more than one type of identity are not well understood. It is the intersection of identities that make it possible for us to recognise both similarity and difference in those around us (multiple dimensions of identity; Jones & McEwen 2000). The midlife individual embodies a collection of identities that they bring to relationships. There is interaction and possible blending of identities, with multiple dimensions of shared meaning (Stryker & Burke 2000; Thoits 2003; Burke 2006). Studies on marriage, intimate relationships and couple satisfaction, in particular, are examining relational identity (WEL; Myers, Luecht & Sweeney 2004, PREPARE; Fowers, Montel & Olson 1996; ENRICH; Fowers & Olson 1993).

The practitioners will also need to discuss with the women how identities change (and about multiple identities); and that such change involves an adaptive process that is sometimes challenging, and at other times comforting, but always worthwhile. A non-drinking identity needs to become a core identity that remains

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205 According to Shapiro (2008), “‘interdependent development ... [and that] recovery is evaluated multi-dimensionally while linked to individual, relational, and cultural expectations for restoring stability of everyday activities while moving forward toward redefined life goals.’” (p 56)

206 Changing identity involves such processes as identity assimilation (maintaining self-consistency), identity accommodation (making changes to the self), and identity balance (maintaining a sense of self, but changing when necessary). The aim is for an individual to construct harmonious identities that can support the roles involved in living a purposeful adulthood (Whitbourne, Sneed & Skultety 2002; Sneed & Whitbourne 2003).
stable for basic survival reasons. The in recovery identity will change over time as a result of interactive experiences, and it will progress through Complex, Valued and Wise Recovery opportunities.

**Section 2 Discussion**

**Recovery Care, Development with Support (RCDs)**

RCDs is a part of the Recovery Triad that provides treatment options for women’s individualised Recovery Care and Recovery Development in continuing healthcare with Recovery Support, i.e. RCDs. Ongoing healthcare is designed to help the women to maintain abstinent recovery over the long-term through individualised Chronic illness Recovery management plans (CiRmp) and through the supportive expertise of their integrated healthcare teams. The process complements and individualises the women’s care, along with the Recovery Continuum, and it extends the women’s recovery development in ways whereby they can enjoy recovery growth and take-up life opportunities (Wiley & Berman 2012). Examples from the Meta-study findings of women’s individual needs being met follow.

As the women seek to learn more about the calming and peaceful moments associated with recovery (Baldacchino et al 2012) they are able to develop their emotional and spiritual wellbeing, and their mental and physical health becomes more robust. Peace of mind and happiness were important qualities of life outcomes for women in recovery (Tracy et al 2012). Encouragement from practitioners and peers for women to explore peaceful experiences and calming actions helped the women to sustain long-term recovery, as outlined in the Valued Recovery phase (Chapter 4: Results).

At the earlier Distressed Recovery phase the women understood their AUDs as a struggle with life, holding a fear of self, exhibiting ‘control/threat’ patterns of behaviour, and memories of active alcoholism and painful early recovery.

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207 The process of change occurs both gradually and suddenly. The gradual component, described as impasse in the insight literature, can be explained as the manifestation of internal conflict and the coming to terms with the circumstances, what is not possible and what is suddenly possible; an ‘aha!’ experience. People’s perception, perspectives, beliefs, thoughts and feelings have reorganised, which brings peace and calm (Higginson & Mansell 2008; perception control theory; Carey 2007).
experiences. The women’s negative mood\textsuperscript{208} (usually perceived by the women as distress and not as a negative mood) was an indicator for RWR practitioners of how confused the women were. Acknowledgement of the women’s confusion and distress can be made, while emphasising that managed recovery is a safe option, and that it can provide a calm and respectful space of care. Clients can be reassured, based on contemporary studies, of being able to experience an improved quality of life through recovery, including positive experiences and productive functioning in the everyday world (Hibbert & Best 2010).

Practitioners can assist with healing alcohol induced traumas and underlying issues. They are likely to be working with a patient with a life history of: adversity, difficult life circumstances and traumatising events over her lifetime; a complex AUDs gene-environment combination; and the lack of positive attachment experiences, resulting in limited or negative personal and interpersonal skills, and interpersonal dependency (Bornstein et al 2010).

The interventions selected by practitioners for individualised Recovery Care, Development and Support will need compassion, discussion and time. Midlife women who have learned to survive by self-medicating (with alcohol) invariably have complex psychological, neurophysiological and physiological conditions. Not drinking and engaging in recovery change processes, at a minimum, will help to activate the woman’s healing body, help her to change and heal her damaging beliefs, mood\textsuperscript{209} disorders, traumas and maladapted strategies, and enable her to start to like herself and associate with supportive people (Kelly & White 2011).

The women participants shared with me the types of healthcare that were most helpful to them in exploring their moods, beliefs and affiliations, and in helping

\textsuperscript{208}Women need to know that moods are influenced by alcohol and drugs, as is memory and reasoning (Bowen, Block & Baetz 2008). Many of the RWR women participants explained that they were unaware that mood was more than feeling positive (being in a good mood) or negative (being in a bad mood). Practitioners informing women with AUDs about the range of moods people feel can help the women to improve their self-awareness and daily living experiences, i.e. by paying attention to their alertness and drowsiness, restlessness and relaxation (Kelly & Masterman 2008). Practitioners can be further informed by reading the current studies of mood change and alcohol dependence, including investigations of hormonal influences and the affect of long-term oral contraception (Toffel et al 2011).

\textsuperscript{209}The negative mood– alcohol memory association – appeared related to risky drinking, and these subtle implicit cognitive processes may warrant a special focus in intervention programs for high-risk drinkers (Kelly & Masterman 2008).
them to develop emotional stability, and eventually in achieving wellness. They were interested in emotional intelligence, in the mental functioning research on affect and cognition, and in the explanations that enabled them to experience wellbeing in recovery (Greenberg 2008). In the treatment processes of the RCDs, effective practitioners enabled the women to form a coherent sense of self, including being able to engage in socio-emotional learning with knowledgeable people (including Expert Volunteers, and women in self and mutual help groups). Practitioners reported that they noticed these women’s increased their understanding of emotional intelligence (Van Dusseldorp, Van Meijel & Derksen 2011).

Recovery approaches improving rehabilitation for AUDs

Rehabilitation is also known as ‘psychiatric rehabilitation’ and is a set of targeted interventions that are intended to prevent further, or reduce the disability that is associated with mental health problems. It is a process of assisting people to acquire and to use the strengths and skills, supports, and resources necessary for successful and satisfying living, learning, and working in the environments of their choice. (NSWHealth 2000)

Rehabilitation, gendered relapse and habilitation210 (learning new ways of functioning in daily life) are contentious areas of understanding in the alcohol and other drugs field (Sun 2007). The RWR Meta-study findings highlighted the need for improved rehabilitation, which involves more than just restoring health. Recovery needs to offer growth and new opportunities to overcome deprivation; both habilitation and rehabilitation are necessary for sustaining long-term, satisfying recovery in midlife. A women-oriented respite process involving a whole-person-in-context healthcare program was created to meet the women’s further needs around non-recovery (discussed later in this Chapter).

The RCDs model (Figure 5.1) shows the primary elements and processes that are essential for enabling the women to maintain abstinent recovery in midlife. My RCDs approach builds on the work previously reported on rehabilitation for AUDs

210 "... focusing not only on restoring what may have been impaired in a woman’s life due to AOD use but also on engendering the growth of certain new life areas that the woman may have missed the opportunities to develop while growing up; for example, development of life skills (self-worth and self-identity, independence, self-discipline, money management, sound decision-making) and vocational training or education enrichment.” (Sun 2007)
and emphasises rehabilitation development. A key element is that practitioners and midlife women in recovery operate as co-participants in such processes in the health system (referred to as System in the figure).

**Objective:** Women in abstinence recovery — achieving, flourishing, seeking & sharing generative wisdom

**Objective:** Practitioners informed & supported to provide professional recovery care & development

**Objective:** System care structured to meet person-centred needs connected to community ecohealth

**Figure 5.1:** Recovery Care, Development with Support (RCDs): Recovery methods improving rehabilitation

**Key:** W = women, P = practitioners, V = values, A = action’ Ps = principles, C = compassion

The **three ovals** in Figure 5.1 represent the women’s recovery environment and the therapeutic alliance required for the care of women with AUDs (Meier, Barrowclough & Donmall 2005). The **bottom left oval** represents the midlife women with AUDs; the **bottom right oval** represents the Practitioners, and the **upper oval** represents the System (the government and non-government organisations that provide programs for
women with AUDs; Spooner & Dadich 2009) and the health and community care structure in Australia. RCDs can support the women’s positive recovery, and this needs to be detailed in their integrated recovery healthcare plans.

Positive recovery outcomes can be achieved by improving the processes that occur where the circles overlap. This involves changes in the **women's values V**, community compassion C, **practitioners’ principles P**, and through the **provision of support A by the System** for RCDs as ‘Recovery Care’, ‘Recovery Development’ with ‘Recovery Support’. As co-participants, the women, practitioners and service providers must have interrelationships (V + A, P + C) that can improve the quality of the interventions, and provide support for the women’s long-term wellbeing.

**RCDs Objective (left bottom oval):** Women in abstinent recovery – achieving, flourishing, seeking and sharing generative wisdom (see Triad of care and treatment in this Chapter).

Care and treatment for Midlife women sustains recovery through support for engagement, i.e. the ‘3Is’ for well-doing (discussed in this Chapter). Women’s individuation will encompass learning about and experiencing the ‘3Is’ that were found to contribute to women’s in recovery identity, based on adult independence (an integration of authentic Intradependence, Interdependence and cooperative Independence). This process helps women in midlife recovery to bring harmony and resonance to their lives (Goldsmith, Pollak & Davidson 2008). Perspective-taking (Sze et al 2012) and focusing on meaningful activity in midlife contributes to women’s recovery, and it provides the powerful intergenerational message, through the women’s actions and positive outcomes, that ‘Recovery Works for Women’.

Women’s development (see Triad of women’s development later in the Chapter) proceeds through the following ‘3Ts’: Transition, Transformation and Transposition to wellness. Women’s self-concept in recovery is subject to ongoing modification as a result of their life experiences. These include their transition to not drinking, and towards a positive recovery, and their experiences within their communities (Rowan 2011). Encouragement in recovery, along with their development of new skills, brings improved self-efficacy in completing important tasks. A most helpful outcome is developing self-awareness in relating to the supportive people who are assisting the women’s recovery transformation. Transformation can shift women’s attitudes as they begin to question and then change their maladaptive thoughts and actions. Women appropriately negotiating change and challenges can result in positive self-regard, and what researchers have termed “successful aging” (Rowe & Kahn 1997; Rowe & Kahn 1998). As adaptive practices that can contribute to transposition into new recovery environments and Wise Recovery are adopted, a stable, maturing identity in recovery and related sense of wellbeing is increasingly valued and nurtured.

**RCDs Objective (right bottom oval):** Practitioners are informed and supported by the System to be cooperative and to extend their professional education and training.

The practitioners can then enable the associated service providers to develop the expertise needed to offer RCDs. The practitioners, service providers and women’s peers must encourage the women’s self-actualising and generativity behaviours. The caring principles and compassion shown by the practitioners can guide their work and bring workforce satisfaction, including appropriate rewards (providing more time to attend training and development, including seminars on the latest neuroscience research and socio-emotional techniques for clinical practice; Phillips & Bourne 2008; Page & Willey 2007).

The women’s needs are met through exploring their potentials. RCDs ‘3Ps’ begin with a basic Protect, Prepare and Prevent sequence of care by practitioners. An integrated healthcare and community team contribute (including Expert Volunteers) to the women’s growth and sustainable recovery as part of a Triad for supportive practice (explained below). Women with AUDs are enabled to mature as other people do. To do this they need protection, and to
be able to engage in the experiences of regulation and routines that involve the mental functions, emotional responses and physical activities, and learning that are required for wise decision-making (Redish, Jensen & Johnson 2008). Preparing and nurturing women through social interaction expands their discursive skills, thereby enabling them to improve their recovery communication and seek support from service providers before relapse might occur.

**RCDs Objective (Top, centre oval):** The System can be structured to meet person-centred needs, particularly by showing pathways for integrated healthcare teams to connect with community and regional ecohealth planning, public and preventative health resourcing (Mertens et al 2005), and by designing and maintaining healthy cities (Baum et al 2006).

The healthcare system can provide supportive awareness and action for midlife females with AUDs to receive appropriate care (Barlow & McHugh 2012). When women commit to be in recovery, they share personal Valued Action and contribute to recovery capital within their communities, benefitting their communities socio-culturally and economically (Best & Laudet 2010). Most RWR participants recognised the need for advocacy as part of effective care for women with AUDs. The ‘Midlife Women Matter’ outcome of RWR Action Cycle 4 is one example of raising awareness.

**Healthcare team management for women’s continuing recovery care**

Self-renewal, progressive care and trust influences the development of commitment and social capital in society, thereby making social order possible (Kincade, Seem & Evans 2010). Women’s stable recovery helps friends and family by lowering the level of worry and offering experiences of mental health. Affirming women’s ways in recovery nurtures peers and community members with knowledgeable positive actions and can lead to the development of enjoyable and productive group memberships and committed relationships. At the same time, the healthcare team, women’s peers and supporters share the delight of what can be accomplished in recovery. The group’s wellness also helps to build health-nurturing social capital (recovery capital; Best & Laudet 2010; Burke & Stets 1999).

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211 In Australia, the prevention of disease has been combined with the harm minimisation drug approach (Loxley 2005). RWR research indicates that this form of prevention is unsuitable for AUDs. The other sphere of prevention is the public health approach taken by the Australian Government (AustralianGovernment 2008; Australian Government 2009; Australian Government 2010). Finally, prevention can involve a mental health focus, and this is suitable for AUDs and for addressing the negative drinking culture in Australia (Australian Government 2009; McGorry 2010). Preventative medicine also provides a suitable philosophy for people at risk of AUDs (Rose 2008).

Change in the health and welfare system

Embedding flexibility to meet growth and the needs of a new population is a challenge for a health system (A Healthier Future for All Australians, Commonwealth of Australia 2009; MacLean, Berends & Mugavin 2012). However, through the appropriate support of individuals and agencies, effective change can be brought about, i.e. through redirection of resources to meet an emerging population in need of healthcare to limit chronic illness, for example, by supporting collaborative recovery (Lindsay Oades 2005). RWR participants identified as being important the need and the manner for improving recovery treatment, midlife AUDs prevention and screening programs, and sustained follow-up care that can support the achievement of wellbeing.

Access to person-centred and ‘whole-person’ healthcare in a nurturing environment is what women seek in recovery. It was established through the Meta-study synthesis that the women wanted nurturing and practical improvement of AUDs rehabilitation to focus upon the benefits of recovery change; more adult development training to assist abstinence and the formation of a non-drinking self; ways to identify and practice socioemotional knowledge and skills; and creating women’s ways to maintain recovery wellbeing over the lifespan. This could be achieved through the creation of WmSpaces in the local community. Such spaces, a non-threatening place within which to practice socialising with peers without alcohol, can help improve abstinent recovery and mental health while preventing chronic illness (Jalaludin & Garden 2011). Overall, the system being advocated here can enable improved midlife women’s mental, spiritual and physical health through the provision of a sustaining and satisfying in recovery environment (a purposeful network; Christakis & Fowler 2010) where in recovery identity and personal womanhood can be explored. Such exploration, through social interaction, can strengthen the woman’s identity, expand her abilities and enable her to engage in adult roles.

Training women who have experienced long-term recovery as Expert Volunteers and mentors (Mental Health Australia 2007, 2010) is part of a transition to a sustaining ecohealth system, an Ecology of Recovery approach that can self-perpetuate wellness and build recovery capital (Cloud & Granfield 2008). Such change, which is required to improve AUDs outcomes, can be achieved through the development of an Ecology of Recovery approach to experiencing wellbeing. The living system integrates
practitioners and Expert Volunteers with the health and community care system, and women with AUDs with peers and mutual help groups that provide prompt and safe means of maintaining recovery and commitment to others in the community (Jordan 2010).

**Politics of recovery and abstinent AUDs care**

Many women in recovery, and their practitioners and supporters, are ambivalent about whether the adoption of recovery rhetoric into clinical practice reflects a genuine shift in values and action (Anex 2010; Best & Day 2010; UKGovernment 2008; Scottish 2006). In Australia, many clinicians are sceptical about the value of a recovery approach (Davidson et al 2005; Weatherburn 2010). The long-term development of effective recovery services will be through a combination of good will for prevention and early AUDs screening (Solberg, Maciosek & Edwards 2008), advocacy for person-centred care (McIntosh 2005), implementation of relevant research findings (McNaught et al 2007; White 2009; Laudet 2012), costing of acute care and work days lost (Collins & Lapsley 2008) and, most importantly, addressing the client’s expressed recovery needs in the face of resistance and efforts to maintain the status quo (Masterson & Owen 2006; Greener et al 2007).

**Women’s recovery treatment details**

The Recovery Care, Development with Support approach (Figure 5.1 RCDs213) illustrates the primary elements and processes that are integrated when meeting midlife women’s AUDs healthcare needs through individualised recovery treatment. The features of Recovery Care, Development with Support (RCDs) were drawn from the Meta-study and my synthesis of related transdisciplinary and longitudinal studies. The details are outlined below and emphasise that women’s AUDs healthcare must address the discrimination barriers that the RWR participants had experienced, e.g. sexism, ageism, and AUDs deservedness of healthcare (Zucker & Landry 2007). It also emphasises the recovery message that, ‘Women in Midlife Matter’.

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213 The RCDs entity enables women to maintain abstinent recovery in midlife.
The RCDs contribute to answer the question, ‘how to best enable midlife women to sustain abstinent recovery through person-centred recovery healthcare?’ The three triads of the RCDs incorporate action for women, practitioners, supporters and the healthcare system. Each triad has a distinct focus: Care and Treatment, Development, and Supportive practice that can contribute robust and adaptive features to enable midlife women’s wellbeing in recovery. Enabling the women’s wellbeing, using the following three triads, is the priority along with productive and enriching recovery living:

1. Women’s recovery care and treatment and an Ecology of Recovery (3Is triad for well-doing);

2. Women’s recovery development and WmSpace (3Ts triad for wellness); and

3. Supportive recovery practices for women and Expert Volunteers (3Ps triads for wellbeing).

The healthcare and healing recovery experiences offered through the triads can lead women to be abstinent and well during Recovery Change processes, such as: personal reflection on life purpose (3Is); the development of social interaction techniques that promote authenticity (3Ts); and a partnership with practitioners and the healthcare system for progressive midlife women-oriented care (3Ps).

Through the Meta-study, I explored different means of enabling women’s long-term recovery to be not only supported by continuing healthcare, but also by being more sustainable. I also present with the triads the related and plausible sustaining recovery features of: an Ecology of Recovery; WmSpace; and Expert Volunteers.

Cooperative change: Healthcare relationships

From RWR participant contributions it became clear that through our interdependence and cooperative independence meaningful lives are best sustained. The women in recovery emphasised the importance of accountability, loyalty, and mutual commitment in creating a foundation for experiencing interrelationships and change with a flow onto robust personal relations in recovery (Urch Druskat &

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214 Support of continuing recovery care plans is needed. The detail of the Chronic illness Recovery management plans are outlined in this Chapter.
Pescosolido 2002). From the Meta-study outcomes, both the women and practitioners can move between idealisation, disillusionment, becoming and remaining cynical or strongly negative about healthcare interactions and healthcare team affiliations. Having unrealistic intimate relationship expectations for healthcare partnerships can distort and make healthcare ineffective (Niehuis et al 2009). The healthcare parameters need careful discussion and agreement (Coulter 2006).

Partnerships with healthcare practitioners can provide time to practice reaching agreements and maintaining agreed roles, and for completing agreed plans and actions (Proctor et al 2007). Sustaining a health and medical concord, a CiRmp, is an important goal. Negotiating a partnership and recovery plan incorporates a responsibility to commit to and continue. The Meta-study identified the following five processes that helped the women with their partnership and team actions:

1. Owning ideas attribution (my opinion);
2. Engaging in disclosure at a slow pace (comfortable revealing myself);
3. Empathy for practitioners;
4. Monitoring team performance with respect; and
5. Cooperation towards an agreed objective.

A health partnership, through which many changes will occur, must be based upon collaboratively understood parameters and enactment of what is compatible and capable (Cheek 2003). Women’s beliefs may be questioned, and ways to handle disagreement or unease must be discussed. Finding out about options, prioritising choices, and the adult requirement of providing choice justifications215 need open consideration of the circumstances surrounding the women’s situation. The RWR women emphasised that they prioritised firstly by considering the personal risk of a return to drinking, maintaining emotional wellbeing, the negative impact of time

215 The neurobiology of decision making is a burgeoning field (Rangel, Camerer & Montague 2008). Making judgments based on evidence also involves weighing up the likely consequences and the value of the outcomes.
pressure, their cognitive load, key tasks requiring attention and the complex social context of midlife living (Weber & Morris 2010).

... power and powerlessness are in one sense transitory – the result of being positioned in one way or another, of being positioned or positioning oneself in terms of one category or another, in terms of one discourse or another, as one who can and should act/speak/write powerfully, or as one who cannot or should not. (Davies & Hunt 1994, in Cheek 2003)

With a transposition, such as entering a healthcare partnership, women can practice and process their experiences using rational thinking (affected cognition) as the basis for personal decision-making. Paying respect to requested routine tasks, developing positive affiliation skills and personal efficacy within a group are some of the benefits that a functioning healthcare team can provide to a client (Knight 2009). Women with AUDs in recovery can continue to find a greater sense of individuation and personal authority in their midlife recovery using a well-premised recovery plan.

**Painful experiences and transposition**

The RWR women in recovery all discussed how the pain in their lives sometimes heightened their difficulties in maintaining a stable sense of self, affecting their various identities, and their chance of relapsing. Concerns about relapsing during distressing events can also indicate the need for therapy around emerging issues (Neto et al 2008). The RWR women explained that when abstinent they sometimes felt confused about life events, and their responses could become more disparate as they discovered themselves, i.e. they began to exhibit sensitivity, irritation, impatience, and unavailability by returning to the past or trying to predict the future (a common preoccupation). An increase in physical and emotional pain can occur (and it can also cease) for women at all stages of recovery, including women who have been in long-term recovery, e.g. for more than 18 years.

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216 Personal authority, the choice of one’s own wellbeing over the subtle and direct mandates of significant others, can be practiced by the women. With long-term recovery, midlife women retain a sense of identity and regard the ‘self’ as being able to make appropriate decisions and state opinions (Hensley Choate 2009; Kearney 1998).
Chronic pain was an emerging issue for many of the midlife women in recovery, and if such early recovery pain continued health discussions and investigations needed to be carried out to provide treatment. Treatment of pain requires a complete review of medical conditions, treatment history, medications and lifestyle factors. New information from pain research can offer more options for midlife women with AUDs (Gatchel et al 2007).

Most RWR women found that actually being present, in context, in new and exciting circumstances was very fatiguing, and many experienced feelings of unease, agitation and anxiety (Morris, Stewart & Ham 2005). The practitioners and women in long-term recovery emphasised the need to share their seeming disquiet; at times, it was a positive awakening as the body, mind and spirit became less fragmented and healthy. The most useful response, for the women in recovery, was the seeking of help at these times, as well as maintaining their routines for nutritious food, exercise, recovery activities and sleep. Activities in natural places, the healing that contact and time in wild environments and botanic gardens provided, was a positive way to assist mental and physical health (Malley et al 2005).

**Psychological disquiet with others**

The women’s psychological disquiet and physical discomfort can be the product of repressed emotional pain that is able to be expressed in a safe recovery environment. Most of the women with AUDs in recovery had unknowingly learned to inhibit emotional pain signals, as they had come to expect that any expression of pain would be met with punitive or negative responses from the people around them. This behaviour had developed to address their past need to avoid both emotional and physical harm (Kliegel, Jaeger & Phillips 2007; Sze et al 2012).

In safe recovery development, treatment explanations can be given to the women about disquiet and upset. Most women with AUDs have formed behavioural and mental strategies to maximise comforting responses and minimise threatening responses, e.g. their tendencies to placate to stall hostile reaction\(^\text{217}\) and avoid

\(^{217}\) Ingratiation, sentimentality, declaration of inferiority, shyness, fatigability, fear of uncertainty and negative evaluation, pervasive passivity and anticipatory worry and are some of the processes that the RWR women had learned to remain safe.
abandonment by people deemed as important. Many of the RWR women had
developed patterned behaviours of both over-achievement and helplessness as forms
of interpersonal dependency (a dependent personality orientation; Bornstein et al
2008). These characteristics contributed to their lack of understanding and poor
development of the skills that are needed for effective everyday social interaction
with others.

In the first eight years in recovery (approximately), the RWR women still had only a
limited understanding of how their relationship expectations can be false or involve
misperceptions (Adams 2007). Many of the women noted that their relationships
with the important people in their lives involved both idealisation and
disillusionment, which often involved the following progression of feelings: (1) initial
optimism (high idealisation with little or no disillusionment), (2) increasing
confusion (as a result of their high levels of both idealisation and disillusionment),
(3) realism (low levels of both idealisation and disillusionment), and (4) devastation
(high disillusionment in the presence of little or no idealisation; Niehuis et al 2011)).
With the support of their healthcare partnerships, role models in work and
educational settings, and peer affiliations within their recovery environment, most of
the women in recovery were able to learn the actualities of effective bonding with
others Caudillo 2011).

Midlife women in collective relationship: For the greater good

The contemporary cohorts of women aged 50 and older have commonly had
significant experiences of taking positions to contribute to social justice and to
question privileging men and women’s multigenerational roles as caregivers
(McHugh 2012). The RWR women noted that ideologies of advocacy and activism
have changed from first to second wave feminism (Baumgardner & Richards 2005).
The meaning of constructs such as the collective, agency and empowerment had
shifted (Wray 2004).

A more relational view to meet the women’s equity needs was being explored by a
small number of RWR participants (Payne 2006). The combining of the women in
recovery within a group – to experiment with their autonomy and connection, their
independence and community-orientation, and the roles of social media and
mentoring – was considered (Caiazza 2006). These ideas and the Meta-study
findings contributed to the WmSpace construct for providing group support (discussed later in this Chapter).

Change processes, such as transposition, also invite contributions of ideas from respected others, and draw on the women’s intuition. During the RWR research, the older midlife women (in their 50s and older) contributed most to and benefitted from social capital, connections among individuals in social networks, and the norms of reciprocity (Caiazza & Putnam 2002). Women’s wellness and healthy ageing groups do exist within some local communities in Australia, but only a small number of the women participants were involved.

The social, political and economic difficulties facing ageing women with chronic illnesses and minimal financial support have been discussed throughout the RWR Action Cycles. These issues impact on recovery living and on the community and healthcare choices needed to provide assistance to sustain the women’s recovery into old-age. An important and growing cost of our 21st century way of life is ‘cultural fraud’: the promotion of images and ideals of “the good life that serve the economy but do not meet psychological needs or reflect social realities” (Eckersley 2008 p257).

The need to experience wellbeing with chronic illness is a matter of fact for many of the RWR women; they viewed an uprising of social wellness, culture, gender and equality in a co-creative society less likely than in younger years (McHugh 2012). The RWR women steered away from being advocates and preferred to be engaged in generative work with younger and older women as their contribution to community health and wellbeing. The women spoke of burnout and an unwillingness to tackle (again) the ‘facts’ of low numbers of women in leadership positions in Australia (Maslach & Leiter 2008). Questions about supporting younger women raised new topics of conversation and stories of suffering, joy and hope. There was a willingness to support younger women to maintain recovery, stand aside as their recovery life unfolded and engage in learning from each other (Traynor, Brown & Dibello 2007).

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218 The factors that influence choice making include individual differences in cognitive ability, life experiences and personality (Appelt et al 2010).
The RWR women spoke of passing on their new learning to peers and family in various ways. Their recovery learning involved attaining new and relevant knowledge of relevance to organising, questioning, making decisions, and exploring their own assumptions and constructions of reality. Most participants’ emphasised that learning took place spontaneously in action at events, rather than being explicitly prescribed along a path. Learning was a process, not a program. As an example, one topic that many of the women in the study wanted to know more about was how to have an equitable relationship with an intimate partner (Rodman Aronson & Schaler Buchholz 2001).

Transposition, transformation and transition were experienced through contradictions and possible resolution of contraries. Learning to live well with change and uncertainty was possible, as was a Wise Recovery process (McWhinney & Markos 2012). In such a fluid-learning mode, the women are able to engage concurrently with the details of the moment while retaining a view of the whole, and importantly attaining humility in the presence of the infinite.

The RWR women in long-term recovery discussed how they consciously spent time meditating, praying and discussing processes of relationship with the vast ecology or aesthetics of the cosmos, a spiritual force. Experiencing both a flow feeling and their ability to focus on the minutiae of life was an important recovery skill. Every detail of the universe was sometimes seen as proposing a view of the whole.

... mental health policy positions women as responsible for their own recovery and as failed citizens should they experience relapse ... This suggests that mental health policy’s focus on ‘optimal individual outcomes’ (Commonwealth of Australia, 2009) requires rethinking in light of the pressure women feel to conform to what they perceive as normalized outcomes. It also highlights the need to understand the complexity of mid-life women’s recovery as a gendered and embodied experience and not simply as the correction to neurochemical deficiencies or the changing of erroneous thoughts and behaviours. (O’Brien 2012 p579)

An integrated healthcare team

The team, as described by RWR participants and from data in the Meta-study, is a people-oriented partnership for enabling effective agreed, abstinent recovery care processes and objectives. The reality of midlife AUDs means that complex treatment,
development and support is best organised as an alliance across medical, health and welfare services of specialists, and ancillary health professionals with addiction knowledge. The focus is agreement on AUDs abstinence and wellbeing through patient-focused continuing recovery change, development and supportive care principles. The members include practitioners, women in recovery, Expert Volunteers219 and, if appropriate, significant others as supporters.

**The practitioners**

Practitioners using the 3Ps of the Recovery Triad provide supportive buffers and barriers, with the care issues progressively being handed over to the women to manage as they attain the knowledge and skills to do so (Krause 2007). Practitioners, through the RCDs (particularly the supportive practices), work with the women in recovery to help them to identify and address the following types of personal barriers to recovery:

- **Personal illusions and distortions of current situations** (protect the client to return to awareness of their substantive non-drinking self and an in recovery identity);

- **Misinterpretations and unreal expectations** (prepare, with the client, new actions as alternatives for their maladaptive reactions); and

- **Misunderstandings** (prevent, with supporters and the client, any return to old unhealthy beliefs and behaviours, by focusing on the current recovery reality).

RWR women participants reported the need for assistance to change their deflecting and distracting attitudes and actions that moved them away from recovery. These women noted that they found it difficult to stop self-defeating ‘sorry’ remarks, self-derogatory thoughts, and taking responsibility for ‘all’ failures. Practitioners can help to shift the women’s thinking to meet their new realities of mental, physical and spiritual health. Learning how to self-affirm requires assistance through the provision of examples such as: (1) appreciating positive affect; (2) accepting self-

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219 Some participants were concerned that the women’s expertise would not be valued if the term volunteer or carer was used. Other names that were considered were ‘experts in practice’ and ‘expert mentors’. Ideally it should be a term that is agreed to by the members of the healthcare team.
regard; (3) acknowledging a sense of purpose and meaning; (4) fostering self-continuity in recovery; and (5) strengthening relational bonds and perceptions of social support (Sedikides et al 2009).

The women as members of the healthcare team

Women in recovery can learn to meet their personal recovery needs and explore their potentials for wellbeing with a healthcare team cooperating and prioritising abstinence, the non-drinking self, and the women’s in recovery identities and roles. The outcomes of the women being healthcare team members included their being able to maintain realistic self-regard, self-consistency and self-restraint, with increasing opportunities to achieve their potentials (Teeser 2000). The initial learning for women interacting with the team leader and team members included their being aware of the present (the place, time, and people), practicing open describing and explaining personal actions, feelings and thoughts, and heeding the safe ambience of calm and balance that can provide the clarity for beginning and completing tasks.

The integrated healthcare team is well placed to work towards supporting women’s enhancement-oriented thinking, feeling and acting, i.e. favourable construals, self-affirming reflections and positive feedback. A difficult task, which may only be partially achieved, is women’s in recovery protection-oriented characteristic of defensiveness. Lowering such defensiveness can improve the women’s wellness and wellbeing (Hepper, Gramzow & Sedikides 2010). Such lowering will require capability-building around openness, self-respect and self-discipline.

Expert Volunteers

Expert Volunteers can contribute as mentors to women with AUDs, as recommended by a healthcare team. Training women with long-term recovery as Expert Volunteers and mentors (Mental Health Australia 2007, 2010) assists the RCDs approach. Expert Volunteers can integrate with the team (health and community care system), support the women with AUDs as peers in recovery, and liaise with the mutual-help groups within the community. Expert Volunteers can help to provide prompt support as a safe means of maintaining recovery with other midlife women. Mentoring about connecting with other women increases commitment to personal recovery and to others in recovery (Jordan 2010).
Awareness of each woman’s individual recovery needs can guide how the Expert Volunteers can best provide support, along with healthcare team briefings. The Peer Support Worker program and the Expert Patient Program are two successful examples of non-clinician support (Nestor & Galletly 2009; David Taylor & Michael Bury 2007). This type of social support, with special emphasis on nurturance during recovery change, can provide opportunities for increasing the women’s sense of coherence as women in recovery who are no longer alone (Langeland & Wahl 2009). Expert Volunteers can also bring a sustaining factor to the health system that can include an Ecology of Recovery approach, which self-perpetuates wellness and the building of recovery capital (Cloud & Granfield 2009).

Expert Volunteers are needed to listen well and offer experiential knowledge to provide opportunities for the women to consider changing their beliefs, attitudes and actions for pursuing a better recovery path. Expert Volunteers, being themselves, sober, with productive and happy lives, can comment on how AUDs distorted their understandings of their everyday world. Their anecdotes and ways they learned to support their recovery can enrich the 3 PPPs process; particularly their descriptions and explanations of how they came to notice, adjust and change unhelpful mental states, such as:

- Naive and oversimplified dichotomised thinking;
- Unattainable expectations;
- Assumptions about assumptions;
- Actions that are overzealous or withdrawn;
- Accommodative (people pleasing) behaviour; and
- Limiting enmeshment and conflict.

**Participation and roles for significant others as supporters**

RWR participants questioned whether family members could be part of the healthcare team. The particulars of the patient’s situation and the women’s views may be the only reasonable guide on this matter. Whatever is decided, the training of supporters for best outcomes is required. The first step involves addressing the
supporter’s recovery process for himself or herself, which may involve attending a twelve-step program, such as Al-Anon, and engaging in talk therapy with a counsellor or psychotherapist. Both of these methods can provide tools, encouragement for personal growth, and guidance for the individual in making choices that promote appropriate detachment from the women with AUDs. Detachment, in this sense, is the ability to let go of the judgments that are commonly placed on oneself and others. Any blame, shame, guilt, fear, anger and sadness experienced with a significant other’s AUDs must be processed. Detachment is a type of mental awareness that allows an individual to maintain personal healthy boundaries without fear of others’ responses, and to continue to live their own life while supporting a loved one; and it is crucial for having a healthy relationship that includes mutual respect, balance, trust and commitment to the partnership with women in recovery.

Detachment requires hard work and a daily commitment, but the payoff is rewarding. Feeling good about yourself and feeling free to live your life in whatever way is pleasing to you, are two gifts that detachment promises (Casey 2008 p 55).

Examples of the Protect, Prepare and Prevent approach for the team as a whole and from each team member’s perspective are outlined below. The subtle application of the 3Ps enables women with AUDs to learn new methods and capabilities, in order for them to provide themselves with a desired quality of life as they continue their personal recovery.

**Practitioners and Expert Volunteers benefitting from the Recovery Triad for wellbeing**

For enabling the midlife women’s Complex and Valued Recovery, the best proactive practice approaches must enable the development of the most appropriate interventions for sustained recovery and wellbeing over the lifespan. The RWR Meta-study indicated that an action research approach to clinical practice can provide a record of care that has not previously been available for improving interventions for midlife and older women. This type of modification to a practitioner’s practice can address the requests for help by the women in recovery, as identified in RWR. These modifications include:
• Identifying ways in which the health and education system might better integrate emotional, socio-emotional and pro-social wellbeing knowledge and skills into medical care and health professional training;

• Development and nurturance of women’s ageing self, including spiritual and existential exploration, and physical connection with nature and people; and

• Recognising early identifiers of women’s alcohol misuse (which can begin at any time across the lifespan).

Women–oriented Chronic illness Recovery management plans (CiRmp)

The following two essential health management features of successful midlife women’s recovery were revealed in the RWR Meta-study data: 1) the need for ongoing, active healthcare to reduce risk\textsuperscript{220} of further chronic illness; and 2) introducing treatment practices outlined in the Recovery Continuum and RCDs that strengthen women’s learning of ‘responsible recovery wellness. Management of the evidence-based health issues (the women in recovery were at a higher level of risk for most ‘ageing diseases’) includes the current RWR recommendations for clinical use, education, expertise development and public information that abstinent recovery works for women (Chapters 6 and 7).

There are options of intervention and treatment for women’s recovery change, and there are diverse ways of structuring women’s recovery healthcare. Studying the variety of interpretations of beneficial recovery healthcare, elements of effective women’ ways to become well with AUDs can be co-created, illustrating to women and Expert Volunteers the need for long-term commitment using adult initiative and perseverance. When women participate in dialogic (not didactic) co-creating to meet their individual needs, and engage with a personal CiRmp as part of a team, this provides a relevant structure with role models to guide initiatives and to assist with the development of new capabilities.

\textsuperscript{220} "Continued heavy alcohol use also hastens the onset of heart disease, stroke, cancers, and liver cirrhosis, by affecting the cardiovascular, gastrointestinal and immune systems. Heavy drinking can also cause mild anterograde amnesias, temporary cognitive deficits, sleep problems, and peripheral neuropathy; cause gastrointestinal problems; decrease bone density and the production of blood cells; and cause foetal alcohol syndrome." (Schukit 2009 p 262-263)
Women’s growing experience of worthy outcomes and their endurance to experience fulfilling recovery can help them to continue to change. Those who use initiative as a form of assertiveness (Wolin & Wolin 1993) are most able to contribute to solutions for wellness in their recovery. These women, by experimenting within a nurturing healthcare team, are dignified through such adult action, and also through negotiation, compromise and perseverance (Bondi 2006). Slowly, development of the social emotional skills of adult negotiation will negate the women’s old triggers to automatically crave alcohol and drink to reduce their distress (Evans 2007, 2008; Stanovich 2004, 2009).

The women’s ability to focus on realistic goals of wellness, and on making reasonable choices when initial strategies do not work, can be recognised as being important life-changing experiences. Choice options, and the adult requirement of choice justifications, are based on a consideration of the specific circumstances of each situation. For women in recovery, taking into account one’s particular circumstances can be prioritised by limiting the personal risk of a return to drinking. Based on the findings of my RWR Meta-study, the main factors contributing to this risk were: the women taking on additional tasks that add time-related pressures, their emotional wellbeing slipping as a result of negative feelings not being promptly addressed, and when their cognitive load increases as a result of them taking on heavier roles to deal with changing social conditions (Weber & Morris 2010). In the early years of recovery, to be able to address these factors effectively, the women will require guidance from the healthcare team (Marin et al 2011). By being able to discuss such events with team members and peers in recovery, the women can be enabled to practice ways to acknowledge difficult times and reduce any distress by lessening and modifying their commitments.

Practitioners may be surprised by midlife women’s tentative, as well as their tenacious, approach to contributing to their healthcare planning. Adjusting to group work, which requires establishing and maintaining an open-minded form of mutual engagement, can be explained. Personal style will take practice, interaction, time and trial and error. The intent to find an approach that is best suited to the individual midlife woman, with awareness by the practitioner of compassion and subject to their expertise, was deemed important to achieve.
Women and practitioners who are following their agreed Recovery Triad for abstinent recovery are enabled to provide extensive, focused and continuing healthcare for midlife women with AUDs. A stable affiliation with community and local recovery networks (e.g. Magura 2008) provides extension and continuation of care that can have reciprocal benefits for partnerships, such as giving and receiving of support. Contributing to inclusive knowledge generation are discussions and evaluations of collective insights, plus recording of care and treatment for midlife women. With permission, the lead practitioner and patient can share comprehensive chronic illness recovery management plans (de-identified and in a generic form) that inform future practice as a baseline for other individual plans.

**Coalitions of holistic care**

The women’s reciprocity, generativity and spirituality provide energy for activities that affirm their abstinence and recovery as an inspiring way of life. Commitment to positive relationships (Jordan 2010) becomes personally empowering as the women contribute to effective recovery outcomes from complicated processes (Cockerham 2005). Mature adults, well into their sustaining recovery, bring awareness of building trust and close relationships to those in their network (Walker & Rosen 2004).

The women’s realistic expectations of personal wellbeing and flourishing are developed through engaging in social connection and relations with others. Positive social relations re-enforce one’s sense of self (Umberson, Crosnoe & Reczek 2010a). Inter-relationships improve women’s meaning-making, and highlight the importance of spending special times with others for leisure and renewal (Gallagher & Hutto 2008). Being with others brings to the women the possibility of realistic evaluation of themselves, and their current goals and mental health. The women’s commitment to mutuality, in an ‘ecology of Wise Recovery’ context, can continue to provide for others midlife recovery role models of individuals who are thriving (Bower et al 2008).

Among the RWR women in recovery, discussions relating to womanhood raised emotive responses; these ranged from heart-warming to heart-breaking expressions. This topic initiated with participants a rich email and letter exchange, and it requires further study, along with intergenerational recovery education for males and females.
(Rudman & Phelan 2007). The RWR midlife women in recovery were living a complex patchwork compilation of what was doable, but not necessarily desired. There was hope that a more balanced combination of roles was possible, and the women understood that in recovery they were responsible for making the choices that could maintain their abstinence and recovery (Fraser Moore 2007).

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**Expert Volunteers aware of supporter input**

Expert Volunteers need to understand the following five requirements (nominated by the integrated healthcare team) as healthcare team supporters; this needs to be made particularly clear during the initial team setup phase:

1. **Supporters must aim to attend advice and education sessions**, as nominated by practitioners, and should attend mutual self-help group meetings, e.g. Al Anon.

2. **Maltreatment** and safe care – Midlife women with AUDs are likely to have endured trauma and adversity, and may unknowingly suffer its affect (Thomas, Bannister & Hall 2012). Treatment literature reveals that compared to men, women tend to enter AUDs treatment with greater psychological distress, mental health problems and exposure to past and current violence and trauma (Hankin 2005; Grella 2008). It is particularly important to help the women to deal with trauma symptoms (in confidence) and to develop effective supports for their recovery (Tracy et al 2012).

3. **Wellness with illness** – Making progress with new adaptation techniques for change is an important step, e.g. as in women’s cancer groups (Cameron et al 2005, 2007). Women want to focus on their ability to work with wellness within a ‘wellness framework’ for ongoing recovery that can lead to wellbeing.

4. **Women and conflict** – A social conflict model can inform and benefit people with anger and fear. Conflict models clearly highlight ways of coping with social unease; and they can help to explain why social defeat can negatively affect being in families (Huhman 2006). The aggressive nature of women in ‘women-only’ groups, and the passive behaviour when women are in group therapy with men in early recovery, requires further study.

5. **Hope and despair** – The ‘false hope’ syndrome (Polivy & Herman1999) helps to explain the women’s tendency to just want a drink, and then having more than one drink. They hold false hope that, this time, this drink will not

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221 The women found information on deprivation (and neglect) a great help, in it began to explain their feeling of always wanting more or behaviour when younger of taking more of any treat or basic necessity offered (Cornwall 2007). Maltreatment outcomes such as women feeling self-loathing (rejected and defective) that they didn’t belong gave hope that being an outsider could change (Poortinga, Dunstan & Fone 2008).
have the negative consequences that it had in the past, and therefore they will not become alcohol dependent. Findings from the RWR study emphasise that in AUDs, drinking one drink begins the compulsion and obsession for continued drinking.

Unaware of past maltreatment

Significant others may not be aware of a woman’s past trauma and will be asked to not question the woman about this matter, or about any past related issue (Hitlin 2011). At the start of treatment, practitioners must protect their client from being personally overwhelmed (including going to the extremes of obsessively ‘doing’ to be well (I can), or being very fearfully ‘unable’ to function (I can’t). Recovery requires careful monitoring to achieve a safe, balanced approach. The ‘I don’t care’ (care about self and others) attitude is perhaps the most damaging and dangerous statement for women in recovery, and it requires prompt action to limit destructive reactions, including suicide. The women are developing a robust self-concept, and forging new relationships as an adult self in current circumstances (Diamond & Fagundes 2010). Such activities are essential features of the recovery process and provision of trauma assistance (Witte & Sherman 2002).

Hope

The language labels commonly used by clients, such as stupid, in-denial, resistant and non-compliant, could be better replaced by ‘false hope’. Real hope is possible with abstinence. The participants, particularly the women in long-term recovery, talked about the moment that they began to hope, describing it as an uplifting positive experience as they realised that they could move towards establishing abstinence and recovery. This feeling of initial hope to live without alcohol is deeply remembered in recovery.

The woman (not just her supporters) needs to say and know that alcohol will never deliver a safe place to hide from her frightening life, or be able to prevent her from ever deeply feeling anything again. The ‘early good’ times drinking does not return with alcohol dependence, or even with quantities reduced. Brain damage will continue to occur with exposures to the smallest amounts of alcohol.

A health alliance

All participants supported the intervention of prompt compassion and counselling to enable the women to address the issues and beliefs that might lead to a return to drinking. The therapeutic relationship (with healthcare professionals and Expert Volunteer) must provide a safe environment (Josselson 1996, 2003) for the women to establish and maintain abstinent recovery. To meet the needs of the midlife women, practitioners and Expert Volunteers must hold open the opportunity to stop drinking; gently contain the mental and physical distress of the woman, and explain
withdrawal processes and the supportive care they will receive. A practitioner maintaining a ‘safe place’ to which the woman can return no matter what happens is essential.

In midlife recovery, the women’s significant others may also need to be informed and be supported, with the understanding that the woman is the priority concern, and that she needs quality care and treatment, which they may not be equipped to provide. Having supporters help the integrated healthcare team, when asked, is the most useful way in which they can contribute. Practitioners must select what advice to give to significant others to enable them to help the woman’s individual recovery.

**Ecology of Recovery and WmSpace can assist practitioners and the women**

Embedding an Ecology of Recovery approach is concerned with designing and sustaining a satisfying in recovery environment (including a purposeful supportive network; Christakis & Fowler 2010). Women with AUDs in long-term recovery and senior practitioners both acknowledged the greater support that the Recovery Continuum, Complex and Valued Recovery approaches (see Results Chapter) provided for midlife women, as well as for the people associated with their recovery network, and with their work, family and community life.

With the development of a non-stigmatised health and wellbeing network, the women can, when needed, address their in recovery identity needs in an established supportive environment. Such self-care practices can strengthen the women’s broader social interactions. Technology such as the internet can be used to expand the scope of influence and contributions of EOR and WmSpace (discussed in 3Is and 3Ts above) to help maintain abstinence, prevent relapse and provide alternatives for women at home. Sustaining a supportive environment can contribute to the expansion of personal womanhood. With improved self-regard, self-restraint and the ongoing development of new abilities becoming routine, the women can take-up more responsible roles, including leadership positions that can draw upon their wealth of experience.
Expert Volunteers assisting Recovery Change in WmSpace

The information presented below is for Expert Volunteers; recognising that it will need be modified to suit the particular requirements of each integrated healthcare team and its women clients. The provision of such information is one of the first actions in the establishment of an effective partnership, and it enables Expert Volunteers to ask to discuss this information. It is important to clarify amongst the healthcare team the differences between ‘carers’, AA sponsors and Expert Volunteers, and the roles and actions they each will undertake.

Within the integrated healthcare team, Expert Volunteers may function and be recognised as nurturers and mentors (Lee 2006). The women in recovery can learn self-nurturance from both the Expert Volunteer and peers in recovery. Self-nurturance is based on attachment theory, neurophysiology and mindfulness, and is a recent intervention for people with high levels of shame and self-criticism, e.g. by using Compassionate Mind Training (Gilbert & Proctor 2006).

Providing personal examples from the lives of Expert Volunteers can contribute to the women’s hope. The Meta-study findings indicated that the women with AUDs wanted information on particular topics, based on their time in abstinent and recovery experiences. Expert Volunteers can comment on these topics by:

1. Helping the women to be themselves in their everyday lives and social engagements, partly by letting go of their limiting defensive self-preservation and image management behaviours

2. Advocating tolerance (not judgment) in situations where they may consider that the other people may be wrong, irresponsible, worthless or even enemies

3. Acknowledging that being happy can be practiced. Positive emotion\(^\text{222}\) can increase by changing facial expression, e.g. smiling and presenting a cheerful disposition.

\(^{222}\) Positive emotions can recover positive mood, and decrease ruminative thoughts and intrusive memory recall (Reis 2009). Learning about emotions in social situations can markedly improve mood and memory recall.
Section 3 Discussion

Meta-themes: Non-recovery

The RWR results and Meta-study findings (Table 5.2) provided an in-depth understanding of women’s non-recovery and their capabilities for Wise Recovery. Non-recovery is a state of being when women with AUDs are not drinking alcohol, however in non-recovery there is a growing risk of relapse because of their lack of engagement in non-drinking activities and also associated underlying negative issues (e.g. emotional abuse; Haynes et al 2008). Midlife women in non-recovery have undeveloped adult abilities for recovery change and therefore they limit their life satisfaction in recovery. Non-recovery is at the Distressed Recovery end of the Recovery Continuum and it prolongs suffering for women (Hart & Singh 2009). Through RWR I studied non-recovery, and developed a ‘Recovery Respite Care’ program, based mainly on the midlife women’s experiences and transdisciplinary literature, as a way of engaging more women in active recovery.

In this section of the Chapter I will outline how a positive start to recovery for midlife women can slip into disorder, and the ways to enable them to return to a more stable recovery by using selected techniques promptly from those provided by the experiences of the RWR participants. Most of the RWR women recalled their progress in early recovery (agreed by participants as less than two years abstinence) and described their progress as being able to ‘take two steps forward and one step back’. However, all participants had experienced ‘taking one step forward and two steps back’ and required knowledgeable assistance and recovery care not to return to drinking.

Warning signs: Women returning to disorder and isolation

Slipping away from a focus on non-drinking and not paying attention to recovery practices can begin the downward spiral back towards drinking. Women are more likely to return to drinking alone at home. For women in recovery, feelings of vulnerability can return many times, e.g. RWR women spoke on various occasions of feeling unlovable and not worthy. The women’s unworthy feelings became self-attacks, both when drinking and also not-drinking in non-recovery (Gilbert & Irons in Gilbert 2005).
Table 5:3: RWR Meta-study matrix leading to meta-summary and meta-synthesis

<table>
<thead>
<tr>
<th>Focus of the analysis techniques and the data explored</th>
<th>Mini: Recursive Trial study and Actions Cycles 1-4 data</th>
<th>Mezzo: Iterative Action Cycles 1-6 and trials data</th>
<th>Macro: Integration of participant feedback (data) on preliminary results and results</th>
<th>Meta: The goal of critical recovery knowledges using the RWR dataset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breadth and variety of data collection</td>
<td>Beginning of gathering research evidence (Gonzalez &amp; Casho 2010)</td>
<td>Transdisciplinary and longitudinal Inquiries (Weiss Efal 2005)</td>
<td>Contradiction, paradox and discord, recheck ontology, epistemology and methodology (Small 2010)</td>
<td>Double helix spiral (Mendlinger &amp; Cwikel 2008)</td>
</tr>
<tr>
<td>Identification of dimensions</td>
<td>Descriptive attribute to articulate elements and factors, e.g. wanting to be part of and wary of belonging</td>
<td>Dimensions to differentiate data categories e.g. social ecology</td>
<td>Interrelationships (system features) to describe detailed patterns and procedures, e.g. emotions and actions</td>
<td>Elaboration and synthesis to consolidate concepts and constructs, e.g. women’s preparation and protection</td>
</tr>
<tr>
<td>Revealing combinations</td>
<td>Learning about core self and affect. Practising cognition and affect</td>
<td>Engaging with development and transformation, considering personal background</td>
<td>Explaining beliefs and emotions and processes of disorder and wellness</td>
<td>Identifying women’s recovery change through concepts and perspectives</td>
</tr>
<tr>
<td>Specifics of differentiation</td>
<td>Physiology and exercise, attending appointments and sleep</td>
<td>Connect with nature, mentors, passions and spirituality</td>
<td>Healing, values and mental relaxation activities for whole person development</td>
<td>Catalysts of care participant negotiation roles and issues</td>
</tr>
<tr>
<td>Recovery and life contexts</td>
<td>Creating personal, safe living spaces. Support activities for recovery</td>
<td>Associating with people at social cultural events, e.g. wedding</td>
<td>Environment, attitudes matching actions, e.g. belonging comfortably together</td>
<td>Ecology of Recovery living settings and relationships</td>
</tr>
</tbody>
</table>
**Key:**

**Meta-study processes:** The RWR Meta-study processes revealed meaningful findings assisted by a design that was expansive, inclusive, flexible and progressive (specific techniques are listed below). The general processes of the four main categories were:

1. **Top line of table**
   
   **Mini** – examining and modelling purposeful data categories, clusters and outliers within the data, and searching for similarities, comparison and contrasts across and beyond the disciplinary literature; cognitive semantics (Kuhn, Raubal, Gardenfors 2006).

   **Mezo** – action science triple-loop critical thinking to identify recursive factors, patterns and associations across the six cycles; critical reflection and ‘thick-concept’ analysis (Levering 2002).

   **Macro** – integration of cycle results to explore and refine concepts and develop explanations; grouping primary results, clusters and typology, and analytic themes (Kuhn 2003; Risisky 2008).

   **Meta** – represents broader elaboration or synthesis; concept mapping (Osigweh 1989, Nesbit & Adescope 2006).

2. **Vertical columns**
   
   **Mini recursive**, descriptive attributes (identifying features), e.g. Be Come Well (Hermeneutics; addiction, Kerns-Zucco & Greenfield 1998)
   - Types of physical variables (telescoping, chronic illness and wellness)
   - Types of affective variables (feelings or mood states such as anger, confusion, helplessness)
   - Types of cognitive variables (thoughts, ideas, attitudes, belief)

3. **Mezzo iterative**, themes and factors of content (Thomas & Harden 2008)
   
   Five major themes emerged: (a) feeling valued by self and others is important; (b) responding to the needs of others facilitates transcending from tremendous losses; (c) love and the memory of love has meaning; (d) maintaining an active mind, body, and spirit gives meaning to life; and (e) a belief in God or a higher power gives meaning to suffering and loss.

   Recovery Continuum3Rs – Recovery (social-responsible roles), Risk (personal – self becoming authentic and resilient) and Reality (environment – relate with respect)
**Macro integration** – Interrelationships (psychological and physiological) including a personal context and broader sociocultural issues and systems thinking, e.g. WmSpace; transformative paradigm (Mertons 2003, 2005, 2007)

**Meta critical** – The outcomes are detailed in the sections of the Findings Chapter

- Outcome Section 1: Recovery support and self-care; paradox & gestalt (psychodynamics; Doyle 2003)
- Outcome Section 2: Integrated and individualised health care; progressive focusing (Rhodes & Coomber in Miller, Strang & Miller 2010)
- Outcome Section 3: Complex and chronic illness management; conversational activity (Scharmer 2009; Crilly 2010)
- Outcome Section 4: Recovery development and decisions; extended content & concept analysis (Hsieh & Shannon 2005).

4. **Horizontal levels**

**Identification of dimensions** – An effort to identify key issues and contributing factors, e.g. discuss harmful self-beliefs to assist women to learn to care for self including negotiating with others about roles and expectations.

**Revealing combinations** – Connections, e.g. what factors help to maintain healthy balance, and bridge across important factors, e.g. self-transcendence and wellbeing, particularly in vulnerable individuals faced with difficult life challenges (Wayman & Gaydos 2005).

**Specifics for differentiation** – Making distinctions and/or discriminating along a dimension e.g. more, less. Women are supported to share the emotion draining, physically demanding and time-consuming care for others (Langer, Rudd & Syrjala 2007).

**Recovery context** – An elaboration on growth as it occurred in a nurturing environment that supports and challenges the recovery learning process, facilitates transformation of meaning systems and develops competence (Lange in Michel Alhadeff- Jones 2007).

*Mini (mixed analysis), Mezzo (triangulation), Macro fine detail (integration and synthesis), Meta big picture integration (contextual, systems information) and fine detail synthesis*
With such self-schemas fragmenting, the women’s emotional health, which is already fragile, declines further (Stein 2012); and learning about self-in-recovery is avoided. The potential to access the emotions that can reveal their extra rational abilities, such as intuition, spirituality and the body itself processing deep and significant change, becomes blocked (Frankl 2004; Hart & Singh 2009).

Many of the women and GPs in the study noted that the re-emerging risk of active AUDs for women is often not recognised (Proude et al 2006). The women’s unease with discussing their values, goals and beliefs is a critical indicator of them becoming confused and troubled. Many of the RWR women felt that it was their ‘fault’ that they were unable to be ‘wonderful’ in recovery all of the time. Their expectations included feeling that to succeed they should be able to relax, have fun, enjoy life and achieve all priority tasks for work, to perform in a better than perfect manner for career promotion, whilst also supporting a rich home-life as a significant member of their family, e.g. helping their teenagers to be responsible and succeed in life. Such extreme expectations are likely to combine with the women’s emerging anger, physical exhaustion, body pain and illness complications in early recovery. Their thinking about drinking accelerates into a frightening experience.

Not practicing the ‘new’ routines meant that the women could drift back to their old behaviours and feelings of discouragement, even though they may not be drinking (non-recovery). It is at these times of abstinent recovery that the women’s lack of recovery preparation, and their instability as non-drinking, in recovery women, was most evident to their peers (and often to the distressed women themselves). Purposeful soothing and simple changes that could enliven and strengthen the women’s wellness practices needed to be identified, discussed, explained and reinforced with positive affirmation (Shapiro 2002, 2006; Soloman & Shapiro 2008).

**Resisting what will assist: Being a part of**

Many of the women participants experienced strain when they were with other people in recovery and are establishing a base for a non-drinking self. Such a conceptualisation of the self occurs slowly. Practitioners’ fore-warning of a possible slow, uncomfortable and beneficial process is required along with discussion on patience, persistence and peer support. Such information and assurance are
important steps towards an in recovery identity which overtime and practice limit women’s distress (Marcussen & Large in Burke et al 2003). It is this type of monitoring and intervention that women participants needed and in most cases had not received from practitioners.

Interpersonal interactions, experiencing group and individual identity formation, and intra-group and personal emotions can be overwhelming for women in early recovery (Smith & Mackie 2008). Midlife women who are in the process of forming a non-drinking self have improved results when they associate with other women in recovery (Laudet, Morgan & White 2006). Being ‘part of’ a support network, such as AA, SMART recovery or post-treatment groups, is an essential action for achieving recovery and wellbeing (Atkins & Hawdon 2007). To be able to benefit from such a support group, and learn to receive and give peer nurturing, most of the women will need assistance from their integrated healthcare team, including from the Expert Volunteers, to enable them to develop the following four abilities:

1. **Attribution:** acknowledgement of who is in the group and the reasons why the others have joined into the group.

2. **Disclosure:** providing a brief introduction to the group, then extending information about oneself to questions and personal discovery statements (why do women need to be a group member).

3. **Empathy:** a growing awareness of compassion and socio-emotional exploration, e.g. nurturing.

4. **Cooperation:** help is offered and strengthened through ‘receiving and giving’ in collaboration with other group members and the healthcare team (Baber & Allen 1992).

Peers in recovery, by sharing the belief that recovery is possible, can provide significant support for women new to recovery. While providing gentle encouragement and guiding the women to participate in adult support experiences, the peers can offer explanations about the benefits and comfort of belonging. Group commitment brings stability; and by the women staying in nurturing groups they are able to learn about dialogue as a means to compromise, and as a way to negotiate high-quality recovery living (Gomes & Hart 2009). Being part of a well functioning
group is an evolutionary way of becoming an independent person who is in a process of progressive change and growth; together with people of different ages and different lifespan experiences (Leech & Kees 2005). Discussion within such groups can limit the formation of walls of self-enhancement and self-protecting behaviours, which often operate automatically during the rehabilitation and early recovery phase (Hepper, Gramzow & Sedikides 2010).

**Recovery energy falls and motivation drops**

When the novelty of detoxification, rehabilitation and short-term recovery (abstinent less than 12 months) had worn-off, there was appreciation by the women participants that it was difficult to maintain and complete recovery routines. They described their anxiety during the early months and years of recovery, along with the increased impulsivity and emotional reactivity, which was evident as procrastination, rushing, stopping and drifting behaviours (Kendler et al 2003). Limiting interaction with peers in recovery, not responding to efforts of support, and changing their place of residence were high-risk scenarios that could result in their returning to drinking.

The women who were wavering and struggling in this way often did not recognise that their present unease and negative experiences were reinforcing their vulnerability, and that their drinking could once again be triggered by simple life circumstances (Zywiak et al 2007). Indicators of the women’s non-recovery and relapse include the following negative behaviours: increasing agitation with peers in recovery; less sleep and exercise, reduced nutritious meals consumed; isolation; and, most importantly, not attending appointments with their healthcare team or support group meetings. Defensiveness and pessimism also tend to increase (Noreen in Leary & Hoyle 2009).

According to Shapiro (2008):

*Recovery is defined as the restoration of adaptive stability permitting flexible responsiveness to evolving challenges of interdependent development...[and that] recovery is evaluated multi-dimensionally while linked to individual, relational, and cultural expectations for restoring stability of everyday activities while moving forward toward redefined life goals.* (p 56)
The Meta-study findings provided the basis for designing the ‘Recovery Respite Care’ program that I developed for midlife women who are unwell and close to relapsing (returning to being women with active AUDs). It was evident from the medical and health literature that respite has been effectively used with other forms of illness, e.g. for cancer care. The focus on self-care, the physical, mental, emotional and spiritual healing during respite can help the women to try using suggested actions of recovery change. Practitioners can closely observe and enable the women to engage with peers in recovery and prepare and discuss a recovery routine that meets their needs, is pragmatic and offers hope and wellness. The program is well suited to be part of an individual’s Chronic illness Recovery Care plan.

**Introducing and preparing women for respite**

Women with high-risk drinking histories or who have been diagnosed with AUDs may be resistant to the idea of respite to meet their particular needs, and will require explanation and support to take the actions required to engage with necessary safe nurturing and self-care. The women in non-recovery (not progressing to active and enjoyable recovery), and women who are not able to remain abstinent, will be unlikely to agree with, begin, and continue the 10 ideas and routines presented below. This ‘checklist’ is best used as a discussion tool to illustrate the women’s symptoms of AUDs, e.g. an increase in obsessive thinking and limiting their recovery perceptions and abilities.

The 10 items form a section of the RWR Recovery Respite Care program that is designed to inform the healthcare team about what treatments might be most helpful to the women in early recovery/non-recovery circumstances; and it can be part of the Chronic illness Recovery management plan (CiRmp) prepared at a later stage. Participants recommended an open, not condescending, consultation and discussion in consecutive practitioner appointments to cover the 10 items:

1. Make time for everyday conversations and new ways of relaxing, and note that self-care is what significant others want for the women, not her doing more for them;

2. Explore and find the most effective ways to help the women to feel less panic (less tasks, only essential ones); confirming there are alternatives to drinking;
3. Acknowledge that being secure and cared for is essential for all people, and that good, bad and crisis events can happen to anyone; noting that professional help with post traumatic stress is available when needed;

4. Recognise the false perceptions of ‘unreal’ order and control, along with the ongoing struggle to deal with life’s ordinary day-to-day activities; and encourage them to ask how other people handle similar situations;

5. Talk about self-worth and how understanding mood, memory, motivation and emotions (affect) can help with effective planning and goal setting;

6. Limit the ‘distressed’ doing, struggling and being overwhelmed by unreal expectations; and encourage them instead to talk about their unexplainable emotional reactions and about their life changes and difficulties;

7. Explain that their alcohol use disorders (AUDs) is a treatable chronic health problem, and that help and support is available; and that in recovery there is hope of quality midlife living and a happy long-life;

8. Validate the healing that can be achieved by the women taking small self-integrating steps, e.g. greeting work colleagues, and purposefully finishing the evening by completing a sleep routine;

9. Explain the use of emotional intelligence, with cognitive affective development, as a valued and useful lifespan ability; and

10. Enable the women to improve their social wellbeing through sharing with significant others.

Expert Volunteers can assist practitioners to provide examples of what non-recovery is like in everyday life, starting with its colloquial name, ‘dry-drunk’. Non-recovery is abstinence without living a satisfying life. Ongoing fulfilling recovery is more than a ‘dry drunk’ state of being and enables the development of individual capabilities that can provide growth, progress and a high quality of life (women’s physical, emotional and relational health; Rittenour & Warner Colaner 2012).
Respite for recovery: The ‘RWR Recovery Respite Care’ program

The ‘RWR Recovery Respite Care’ program is introduced below by describing four likely scenarios women with AUDs can experience and from which they can recuperate and benefit via practitioners offering recovery respite. Firstly, the challenging aspects of respite for practitioners; secondly how to support women moving from relapse into active recovery; thirdly, to prevent relapse, and to address a short-duration slip that does not require detoxification (e.g. a one day drinking episode; see the Box below for explanations); and fourthly; in response to a woman’s particular challenging issue, e.g. rage episodes and extended isolation after the death of a parent.

The women participants believed that timely intervention involving respite can limit suffering and improve their recovery care. The recovery care suitable for the three scenarios of relapse, bust, and a challenging issue are explained as objectives, for practitioners and women working together to achieve. The goal is to enable the women to progress to a stable, enactive and sustaining recovery, rather than a likely return to dangerous active alcoholism in midlife.

1. Challenges for practitioners

The women entering respite may have previously attended detoxification programs, other forms of therapy, therapeutic communities, alcohol and other drugs rehabilitation and aftercare, and relapse prevention programs. Unfortunately, their ongoing feelings of despair, and further loss of self and disconnection from significant others, can result in them returning to active AUDs. The women emphasised that a prompt return to routines of living in recovery needed reassurance from practitioners that it was attainable. Particularly that they had a right to be abstinent and well in recovery.

Accepting help

RWR participants discussed in detail how women with AUDs were most damaged as a result of not accepting their AUDs diagnosis; and the recovery options (help) available to them. They had often falsely appraised their situation, made unhelpful individual choices, and had been overwhelmed by persisting in their over-demanding roles. Women with AUDs feel very threatened in non-recovery (Fillmore
et al 2007; Stokkeland et al 2008). The benefits of respite to lower their fear can be outlined, e.g. gentle care to lessen the women’s withdrawn, distracted, or angry behaviour, and assistance for women to understand their own attacking (verbally) of other people for what is ‘wrong’ in the women’s lives.

Practitioners can introduce experiential learning skills\textsuperscript{223} that can enable the women to ‘hold’ a sense of self, share their unease about particular situations with knowledgeable people, and modify their thinking and action around the issues confronting them (Kolb & Kolb 2005). Such learning can help the women to differentiate self, self-interest, self-centredness and self-restraint as a means to, over time; simultaneously ensure high personal welfare and midlife cooperation for sustaining good health (Murtaza 2011).

The RWR women participants detailed how it was important for them to verbalise their vulnerability (crying is verbalising) with the support of the healthcare team, and to be reassured that they can heal. The pragmatic phases of recovery (e.g. ENACT recovery; see Chapter 4, Results) are not doable while the women are experiencing high levels of distress (Marin et al 2011). However, in respite women can purposefully contribute to their own wellness and can inspire others to do the same, e.g. by engaging meaningfully with their peers in recovery, i.e. practising meditation, enjoying nature walks, playing board games and discussing interests and values and beliefs (spiritual/existential concepts).

\textit{Practitioner and supporter challenges}

Practitioners may need to co-opt supporters in helping the women to agree to enter respite. The next brief section provides background information for practitioners and supporters on the three most common recovery difficulties that extend non-recovery: the women’s personal beliefs; learning to feel and change emotions; and limiting negative influences of ‘significant others’ and of other aspects of home life.

\textsuperscript{223} The Experiential Learning Theory model portrays two dialectically related modes of grasping experience (Kolb 1999) – Concrete Experience (CE: sensory and post sensory) and Abstract Conceptualisation (AC: frontal integrative) – and two dialectically related modes of transforming experience – Reflective Observation (RO: temporal integrative) and Active Experimentation (AE: premotor and motor). The women’s active experiences can be assimilated and distilled into abstract concepts from which new implications for action can be drawn. These implications, or intentions, can be actively tested and serve as guides in creating new experiences and ways of living.
Practitioners must help significant others to understand that the midlife women may not be able (because of their AUDs) to ‘do the right thing’ (for them) at this time. When in early recovery, the brain damage is repairing and adult abilities may need to be re-learned (or even learned for the first time due to harsh life events and circumstances). The priority is for the women to be able to be in a safe place of care with knowledgeable supportive people to not drink, heal and ENACT recovery.

**Personal beliefs**

Beliefs\(^{224}\) reflect what people think is, was, and could be true about their world (Folkman & Stein 1997). After years of active AUDs, awareness of personal beliefs can be very limited. The woman’s self-understanding will be frail, and the beliefs she has constructed or been attracted to in order to survive (as schemas and worldviews) can be fiercely held through fear (Hoffart, Versland & Sexton 2002). Her memory and motivation may also distort her view of herself and of reality.

**Feeling emotions, changing emotions and being safe**

People’s maladaptive emotions have all been learned (Greenberg 2008). The anger that women with AUDs express is based on deeply felt fears. Awareness and expression of, and reflection on, emotion, and the ability to change their emotions, will be part of the women’s respite and recovery process. Information relating to this provided by the women to their supporters can give an indication of the work that they will need to do to become well. In treatment, maladaptive fear and loss begins to be altered by the conscious recognition and forming of healthy personal boundaries. When suitable, practitioners and peers will need to provide guidance and support to the women as they learn to evoke the softer feelings of compassion and joy (Greenberg 2002).

Discovering and building their self and self-worth can diminish the women’s feelings of depressive hopelessness and shame, as well as anxiety and fear. Being able to express their feelings of sadness, love, and forgiveness has also been observed to

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\(^{224}\) Beliefs (detail is provided in the Chapter 4: Results) are organised forms of knowledge that carry expectations about the state of some aspect of the world (Stein Hernandez & Trabasso). They often carry a value judgement (e.g. good or bad) or a preference (e.g. like or dislike) for the aspect of the object being evaluated. A person’s prior knowledge in the form of organised belief systems (schemas) is activated to evaluate and understand the personal impact of an event on wellbeing.
reduce their anger (Malcolm, Warwar & Greenberg 2004). One can argue that once learning to access emotions has been explored, guided and practiced, new mental states (neural pathways) can be forged (Greenberg 2007, 2008). Over time, the women develop greater understanding and confidence about accessing their emotions. Responding earlier to sensations, and naming the felt emotion is an example of productive recovery learning.

The conscious declaration of one-self in that moment is self-validating. The women then find (with practice) that they can be aware and attentive. The positive outcomes from this attention refine how they can purposefully focus and remain with a situation or issue. This progress builds self-confidence and is refined to the point that the women are able to be aware and alert to the flow of their day. Events previously considered as demanding are resolved in a simple manner by being able to draw on their tacit understanding of like experiences. Their conscious understanding of sense of self in the moment can be used to generate meaningful actions.

‘Significant others’ preventing recovery

The women may be in relationships that are unhelpful, damaging and even destructive. They may feel deep shame for being ‘an alcoholic’, believing they are failures, immoral, and ‘bad’ people (DiBacco 2011). Family members’ actions and poor understanding of the diagnosed illness can heighten these feelings and beliefs. The woman’s health and recovery must be the priority for her practitioner, whose advice needs to be followed by the woman’s family and supporters. Family members can benefit from an explanation of Relapse, Bust and Slip (see Box below).

**Relapse: Respite objective 1**

A person with AUDs relapses by returning to active drinking after they have purposefully stopped drinking (abstinence; Harris et al 2005; Sun 2007; Neto et al 2008). Relapse indicates a fragmented formation of a ‘non-drinking self’, inadequate skills to cope with emotional trauma, and limited and incomplete healthcare, recovery development and support. Without participating in Recovery Triad assistance, or similar techniques, midlife women struggle to learn to be abstinent and cannot complete and continue recovery change tasks.
Remembering a ‘bust’: Respite objective 2

RWR women participants provided many stories of ‘busting’, which can also be a form of acting-out for help. The RWR women described in detail (as if in slow motion), the recognition that in an instant they had decided to take the drink. Many repeated the following loud self-talk statement that had occurred in their head at that time: ‘I don’t care’. When the women are ready (stable), recalling the critical drinking events provided them with a safe expression of such memories, particularly the details of the associated fear, rage or despair and hopelessness that they felt. The RWR women participants also emphasised that being in recovery with their peers, in touch with their non-drinking self, and following a pleasant recovery routine, the same drinking event would be much less likely to occur. Supporters need to emphasise that ‘Recovery Works for Women’, and that they need to understand that AUDs, as a clinical syndrome, affects their neurocognition and brain neurobiology in toxic ways, and that recovery changes can help them to maintain their abstinence (Durazzo et al 2008). The longer that the women are abstinent and in recovery, the greater will be the chances that wellness experiences will build commitment to practical recovery actions.

A short-duration ‘slip’: Respite objective 2 continuing

Women who ‘slip’ are those who drink alcohol and then stop and promptly try to return to their abstinent recovery routine. For ‘at risk’ midlife women with AUDs (described above), prompt intervention that focuses on the women, rather than the drinking, is the primary ‘duty of care’ need. Support to return to recovery by providing calming reassurance is necessary. The women will be distressed, feeling anger, guilt and shame, and will need Expert Volunteers or peers in recovery to actively encourage them to be safe, and not continue drinking (Mertens et al 2012). For initiating a more active recovery process for the women, more contact with an Expert Volunteer needs to be emphasised, and followed up with phone calls or text messages of concern and encouragement to take action into recovery, e.g. with the support of more AA meetings, and healthcare team appointments.

2. Respite to move from relapse into active recovery

Objective: The RWR participants nominated the following five processes that can help women and their supporters to take healthy actions for establishing

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225 The term ‘bust’ was used by the women and their practitioners to denote when a person had started to drink alcohol again and was not therefore, abstinent. The term is more often used when a person has lived in abstinent recovery for more than two years and there was an event identified (e.g. unexpectedly losing a job) that the person had reacted against.

226 People living with the women can support them by not drinking at home for approximately three months.
abstinence. These processes aim at enabling women to accept and act upon being her non-drinking self, with an in recovery identity and a way of life for recovery wellness.

**i) Early in recovery relationship**

For women in relationships, recovery change can be disorientating; because the women are changing and are forming new beliefs about their relationships (Ogolsky 2009). Professional guidance is particularly needed for people who are in relationship. Priority care for children and teenagers within the family group may need to be arranged. Separate appointments need to be made for adult discussions with the women and their nominated ‘adult others’, i.e. husband, mother (Gabb 2009).

At this stressful time, people are prone to pay close attention to the behaviour of their partners and family members, and this may involve attributing meaning to them regardless of whether the meaning is correct. It is common to care deeply about how a partner will interpret and respond to intense situations of recovery.

The felt need to make ‘stay or leave decisions’ about the relationships creates an increased desire for finding quick answers (Rudman & Phelan 2007). High emotions are common, and this may motivate individuals to exaggerate the degree to which they believe their partners’ behaviours are meaningful indicators of their feelings (positive or negative) about the relationship. Taking good counsel at this time and not making far-reaching decisions is recommended.

**ii) Listening through self-talk**

If self-talk is occurring (talking to oneself; Bahl & Milne 2010), the seemingly simple act of listening when people express themselves is a difficult task. The women’s personal thoughts ‘running through’ their head will tend to interrupt or interfere with listening to others. Self-talk can continue for a number of years in recovery. Listening to self-talk is not schizophrenic behaviour. Women may have to learn to interact effectively, based on listening to others and using more skills; noticing people’s tone of voice (intonation as well as words), watching their body movements, and asking gentle questions to gain a better understanding of their views. The people
living with women with AUDs may also experience self-talk; this can occur in most people as a result of past and present feelings of distress.

**iii) Practising ‘no initial reaction’ agreements**

Women can express their thoughts and feelings (a challenging and uncomfortable process) with selected people, using a ‘no initial reaction’ agreement. These agreements involve women and significant others listening and not interrupting nor reacting immediately, e.g. not saying a sharp retort to defend or attack. It provides an opportunity for the women (and their practitioners, family and supporters) to listen and remember, perhaps discuss the conversation with peers and practitioners and then consider how to respond (Stanton 2005). This is a reciprocal process with nominated significant others to listen to the women in the same manner.

This process can identify for women and their families patterned communication (with associated emotions). With awareness, damaging patterns can be limited and changed to support the women to not drink and ease stress in family members (Chaplin et al 2008; Sinha et al 2008). Patterned behaviour with significant others can trigger craving. The goal is to practice new adult behaviour; e.g. take relaxed turns to think/talk and listen/reflect and respond with the likelihood of the need to set another time to discuss ideas as they may require careful consideration. Time taken for this orderly process alleviates conflict (which assists women to not drink) and brings adult thought and compassion to family communication rather than a ‘tit-for-tat’ destructive outcome.

**iv) Explaining the approach and avoid actions and choices**

Emotional turmoil is a likely trigger for women wanting to drink, and helping to lower sensitivity and establish a calm home environment assists and will take time.

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227 In the neurobiological literature there are at least five types of theories about craving: (i) “biochemical–receptorial (focus on the neurochemical processes in the “reward center” in the brain); (ii) psychobiological (distinguishes between different types of craving, such as desire for reward, desire to decrease tension, and obsessive craving, all of which stem from brain processes, but have different psychological consequences); (iii) phenomenological (suggests that addiction and obsessive–compulsive disorder might have common origins that make craving a common overlapping feature); (iv) conditioning (focus on cue-reactivity and learning to pair emotional–motivational states with physiological reactions); and (v) cognitive theories (expectancies and labeling of craving experiences in psychological terms).” (Addolorato et al 2005 in Eliason & Amodia 2007 p345)
and effort. The women have maladapted AUDs reactions, e.g. their ‘approach228
behaviour’ is for them to drink to participate in an event as a ‘let’s forget and all is
well’ state of mind. Their ‘avoid behaviour’ involves them drinking to not experience
intense feelings. Within respite they can learn the adaptive potential of recognising,
processing, and expressing their emotions (Austenfeld & Stanton 2004).

The effort to work with rising emotions will need supportive encouragement from
healthcare practitioners and peers along with explanations of the benefit of tolerance
and patience (Nestor & Galletly 2009). The women participants who had supported
other women in early recovery emphasised discussing and maintaining
confidentiality as abstinence continues. Establishing how women’s vulnerability and
privacy can be supported with the use of social media, also encourages women to
communicate (text, email or voice message) with less unease. Being guided through
using such technology introduces practices that bring familiarity and comfort in
maintaining contact with peer support.

It is a pragmatic strategy to discuss with the women other ways to deal with
overwhelming issues that had previously meant they drank alcohol to forget or not
feel (Langeland & Wahl 2009). Discussion of alternatives to drinking can help
women to explore what recovery can offer to meet their needs, i.e. helpful life skills
and more strategies to not drink alcohol.

v) Learning personal routines and relaxing

Reinforcing with women and others that pleasurable positive feelings can support a
healthy recovery also opens up discussion about making changes and practising new
recovery routines. Learning to ‘take on’ and integrate new or modified routines,
standards, values and objectives as one’s own process is difficult and important for
embracing healthy action and psychological functioning (Baumann, Kuhl & Kazen
2005).

Most women are, however, well able to engage in challenging activities. Learning to
get involved in fun activities, and continue with them over years, was difficult for the

228 These personality traits have been described as ‘Approach’ and ‘Avoid’ behaviours (Mortenson et al
2006; Oslund et al 2006; Staiger et al 2007).
RWR women as they felt that they did not deserve happiness (McCrady 2004). Enjoyable activities that assist with mental health can generate guilt reactions, and the women may feel the need to complete more important work before having ‘fun’. Those in recovery with mid-to-long-term abstinence can share their recovery stories to help other women to accept that they are worthy of living a good and joyful life.

3. Respite to prevent relapse and respite for a short duration slip

Objective: Use of the RCDs techniques (3Is, 3Ts and 3Ps, see earlier in the Chapter) that complement and further support the useful methods of the Distressed recovery phase and the ENACT recovery phase of the Recovery Continuum. The topics in this section are more complicated, and they require practitioners with experience to successfully deliver safe and rewarding outcomes. Working in a healthcare team means that the members can assist and mentor each other to expand their recovery treatment processes and experience.

Survivors of traumatic events: women in non-recovery

In midlife, the women in non-recovery can hold a false perception of their health, AUDs and their quality of life (Robinson 2006). The following four characteristics of non-recovery may be associated with prior trauma. If practitioners identify the possibility of trauma in the women’s history, they may need to develop a more specific recovery plan that can address the women’s fear responses to unrelated events (Harper et al 2009). RWR practitioners recommended that, in most cases, the women need to be protected ‘as if’ they are trauma survivors, particularly when they display any of these four factors:

1. Exhibit extreme emotions and actions when information is introduced to them about a trauma event;

2. Have difficulty processing the information provided;

3. Have significant memory loss, e.g. months or years; and

4. Narration of events is disorganised.
Trauma victims have flawed event-related memory systems. It has been suggested that this is because there is an underlying alteration in their adrenergic system and in the key psychobiological mechanisms that make trauma recovery difficult (Kendall-Tackett 2009).

**Alienation: Women’s social exclusion**

For women with AUDs, social exclusion experiences highlight their low awareness and limited practice in knowing what one should or should not do with other people in leisure activities, e.g. even during everyday conversations over coffee. The RWR women participants described a strange feeling of fearing being found out as an impostor or alien, a person that did not belong within the group (they experienced associated feelings of anxiety, shame and guilt; Sheikh & Janoff-Bulman 2010). This unease decreases their motivation to understand and partake in pro-social behaviour.

During recovery the women are likely to continue to experience a discrepancy between their sense of self and their identity (discussed in ‘I’m in Recovery’, Chapter 4. This discrepancy can be about a felt obligation to act in a particular manner, while not knowing what to do. The problem escalates as the fear reaction brings forth responses of self-justification, offense-taking and defensive rationalisation. The women then find themselves in a state of anger with others and feel a form of self-betrayal (Ellerton 2010).

Women with AUDs also experience high stigma reactions (Twenge 2007). Discussing social inclusion and normal interpersonal stressors can help them to engage with the women in long-term recovery and to practice everyday interactions. Women in recovery spoke of concealing who they were so that they could belong with others (pull-back), and countering with revealing themselves so that they could be known (push-forward; Bosson & Weaver 2009). Such behaviours raise questions and concerns within other people, and the exclusion loop continues.

**4. Taking respite care to work through a particular complex issue**

Objective: At this level of care for respite, comorbid disorders and chronic illness, such as rheumatoid arthritis, can create another layer of complexity, difficulty and
confusion for recovery and wellbeing. From the most recent research, remaining abstinent is the critical step that is required to enable the women to deal with these other physical, mental, emotional and spiritual issues (Best & Lubman 2012; Schlek 2011). The four important topics raised by RWR participants about handling complex midlife matters were: i) commitment to self; ii) limiting criticism through realistic evaluations; iii) stopping fabrications; and iv) false ideas. The four topics also reflect the women wanting help to improve and explore in recovery relationships with other people.

**i) Commitment to self**

Commitment to self through respite is about enabling the women to feel a positive reaction, even a slight one, about ‘the good’ that exists within themselves. Being in a satisfying intrapersonal relationship with herself is a primary recovery objective. The following initial features of the women’s commitment to self in respite (as selected from the Meta-study) are also critical to long-term recovery and thriving: dedication; and acknowledging and living within social constraints with suitable self-restraint. The paradox for women with AUDs was that such constraint bought relief by helping to lower stress, provide some freedom from obsessive thinking, and dampening or stopping the compulsion to drink (Schmidt, Helten & Soyka 2011).

Commitment can have negative associations for women with AUDs. A history of others failing the women, and the women not meeting their own expectations and society’s standards may contribute to their feelings of negativity. Women in midlife can adopt a pattern of commitment aversion, whereby they avoid engaging in behaviours that would require making a commitment, and instead they engage in behaviours that undermine and short-circuit the development of commitment (Birnie et al 2009).

The integrated healthcare team may need to carefully explore the women’s resistance. The women need to be assured that committing to their own safe, 

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229 The RWR women gave a number of reasons for why they refused beneficial healthcare: many expected to be locked away with no rights to leave; accepting healthcare meant being judged as a failure; that the people providing care may blame them for what had happened; and the cost was not affordable. Practitioners can help their clients by providing answers and explanations to their respite care concerns. Access to an ‘Answers to Frequently Asked Questions’ sheet can be particularly helpful.
personal recovery will enable them to heal from their painful wounds; and that they are worthy of this care and of continuing a healthy life with AUDs, and that this is possible. Expert Volunteers can provide many examples of positive outcomes; particularly examples of older women who have taken charge of their lives, and gone on to live productive and contented lives.

**ii) Limiting criticism through realistic evaluations**

For women in early recovery who have intense feelings and ruminative thoughts of being incompetent, strange or bad, personal fault-finding is common (critic-selector behaviour; Minsky 2006, 2008). Such criticism can be lowered by being in recovery and observing, in a tolerant manner, how most people make errors of judgment. Moderation is needed when talking about issues and circumstances to provide leeway to discuss validity, exceptions and falsehoods.

Most people tend to make more logical errors in response to emotional statements than factual incorrect statements (Blanchette & Richards 2004). Uninformed comments about emotions that negatively affect rational decision-making ignore the reality that emotions do influence peoples’ judgment. People also tend to make automatic evaluations based on the valence of a stimulus (how good or bad something feels). Such evaluations are more likely to contain logical errors, compared with those based on more traditional analytical decision-making approaches (Slovic et al 2002).

Research on judgment is useful for improving practitioner and client understanding. Emotional factors described as ‘motivated reasoning’ often occurs when people draw emotionally biased conclusions (Jost et al 2000, 2003). The phenomenon is now well documented and is essentially an extension of the psychodynamic concept of defence. Women with AUDs use defensive behaviours and biases, perhaps unknowingly, as their standard coping method. They twist their beliefs to fit what they would like to believe, and in many of the RWR women’s responses this was based on a highly critical evaluation of themselves.

Respite time can be used to explore how to use ‘motivated reasoning’ in a positive manner. Importantly for practitioners, women’s respite is a safe resting place for engaging in self-regard, nurturing routines, and for learning new means of self-
restraint. Rest helps the brain to heal, and fresh insights can emerge (Kounios 2008). It also offers an opportunity to trial treatment types that might benefit the individual women (Hildebrandt et al 2010).

iii) Fabrications to recognise and modify

The drive to feel safe and belong, before recovery is established, can create such high anxiety that the women may fabricate scenarios and manipulate people and current situations to seem to be in control, and still able to drink alcohol. The RWR women were very disturbed that this negative coping was continuing in recovery. Practitioners can explain that this is a somewhat normal reaction to feelings of threat and fear, and that their past maladaptations, which once served a purpose, must now be let go of as they will undermine their recovery.

Practitioners need to discuss with their clients that stopping fabricating stories will take time, and there are techniques to help them to do this. The first is the women’s recognition that it is now an unnecessary habit, and that it is linked to their AUDs. Another technique is to ask for the details of an event, as details can only be recalled when an event has actually been experienced. Thus vagueness and generalisation can indicate that the story is a fabrication.

General, and sweeping statements about extremes is also a form of fabrication that can cease, e.g. personal statements of ‘I’m a failure’ can become ‘I’m a failure when I don’t prepare for a presentation’. The detail provides the particular context and perspective that, when expressed, can receive feedback and enable discussion of why this occurs, and ways to make changes to routines to limit such non-preparation.

Compassionately challenging discrepant information is necessary as part of adult dialogue. Learning to discuss ideas and plans by expressing the underlying motivation (including emotions) for particular actions can be liberating, e.g. a plan of action can then be worked out to meet a declared need. This can be compared to the women’s previous experience of fatiguing coercive behaviours, i.e. because of their wanting to control situations to achieve their need to feel safe (Epstein et al 2005). Importantly, such control is unlikely to enable them to meet this need; and, the need on which the action of control is taken may not be recognised initially by the women.
**iv) False ideas**

Women’s AUDs cause diverse forms of delusion and they will require time and specific recovery activities for their resolution. The following two difficult topics that were raised in the RWR results were analysed further, and tools were developed to help the women in recovery to be able to deal with them. The RWR meta-data confirmed that the women were aware that they needed support to be able to work through their long-held false ideas and beliefs.

Women can self-deceive about the level of harm done as a result of past adverse events. The level of harm done by others to the women is often dismissed as ‘no harm done’. Or the women can apply blame to themselves for an act that was not their responsibility, e.g. violence against women. Negative outcomes do not have to continue in recovery. Old beliefs can be set aside; bad things no longer need to happen to a ‘bad girl’.

New ways of dealing with potential harm scenarios can be developed with trained practitioners. Women in recovery will need to work through what harm they are actually responsible for, and make plans to rectify the errors in a practical and hopefully low-conflict manner. It is essential that these actions are well discussed and planned so that recovery is not stopped, safety is not compromised and significant others are also aware and supported (Corrigan 2006). The women in long-term recovery recommended making amends through appropriate actions: to resolve financial matters with expert assistance; apologise with no expectation of the apology being accepted; and listen to people that they have hurt without critical comments or rationalising.

The women’s personal understanding of past (and present) events can be misleading. Talking with others can help them to find other ways to construe and conceptualise events in more constructive ways. Practitioners can explain how their ‘rejection sensitivity’ may be interfering with attempts at recovery (Mischel & Mendoza-Denton 2003). Women with rejection sensitivity process other people’s actions based on their expectation of rejection, perception of dislike and reaction to hostility, as if they were, in fact, being rejected.
"I want an apology!"

Women participants spoke about ‘wanting an apology from others who were at fault’, whom they believed were responsible for harm done (assigning guilt, blame and shame; Dearing, Stuewig & Tangney 2005). The women in long-term recovery strongly suggested that it was best to deal with the particular woman’s part in the event, and not insist on ‘who was right’, or pursue justice, punishment or revenge. The harm done to the women by taking action to receive an apology can be highly detrimental. Women prioritising where to place their energy, into personal objectives, can produce more important outcomes.

From the women in recovery experiences and observations, there was ample evidence that other people will blame and attack the alcoholic no matter what was fact, and would not concede to have played a part in the event, as it was the drunk’s fault. Women’s reactions of remorse and self-punishment in response to such attacks need to be monitored (Nelisson 2011). Counsel for the women on their ‘I’m sorry’ reaction is advisable. Women can automatically apologise when they feel anxious. When there is no purposeful fault, especially when simple mistakes and unavoidable accidents happen, the ‘I’m sorry’ habit needs to also cease.

Women moving away from the people who do not support her wellbeing can be complicated. Planning will be required with the healthcare team being fully aware and involved in loss and grief therapy; ‘moving on’ may be essential as abstinence is the women’s priority. The women in recovery recalled that over time many hurtful events, even betrayal, became insignificant, as they had ‘moved on’. Also, as the women remain in recovery, other people began to own and address their part in the problem.

The rejection prediction process is based on the women’s fears of betrayal and abandonment. The suggested way to work through the vulnerability involves protective and transformative processes (Jones, Zhang & Meleis 2003). The women’s selected situation is described, and then two alternative scenarios, other than rejection, are offered and agreed to be feasible. The practice continues, and the women provide their own alternative scenarios based on the details of the experience (what really happened), and then they invariably find that there may have been errors in their understanding, and respectful questions can be asked, or another time can be selected to discuss the matter agreed upon.

The women emphasised criminal activities required follow-up with legal assistance, and importantly practitioner and peer support.
5. Respite follow-up

Plans can be made for important post-respite appointments and for practitioners to outline the women’s health and medical needs to their supporters. Minimising ways for the women to return to drinking is of great benefit to the individual, the team, the health system, family, workplace and the community. The type of development work that the women can become engaged in through respite, and during regular retreats, can benefit their maturing needs, and also their recovery decision-making and judgment processes. The RWR participants emphasised that emotional experiencing took time, and the small instances of happiness, relief and hopefulness experienced were well worth any initial pain and confusion (Nein, Hernandez & Trabasso 2008). Three matters for the follow-up period were highlighted in the Meta-study: physical constraints; long appointments and mental health.

**Physical constraints not purposeful delay**

Practitioners and supporters may need to limit their assumptions relating to deceit and purposeful procrastination in the women with AUDs. The central nervous system is healing, and what is needed for the women’s continued recovery after respite is realistic guidance and support, not criticism.

Healthcare professionals must advise the women, and their significant others, to delay important decisions\(^{231}\) during the first 12 months of recovery. It will take time to integrate cognitive planning with clear motivation and emotions (Damasio 2010).

**Long appointments**

A sequence of ‘long appointments’ after respite will be needed to enable the women to adjust and stabilise their non-drinking core self in their everyday living. Respite can help the women to deal with the news of any comorbid diagnoses, and with making the best decisions about individual treatment to establish a robust in recovery identity. Learning during appointments about resources and knowledge that can help them in their recovery is attractive to many women. An example, from

\(^{231}\) Decision-making can be understood as a form of explicit emotion regulation. Every decision is simultaneously an act of emotion regulation, as the goal of any decision is to minimise current or future negative affect states and maximise positive one.
questions asked by RWR women participants that can be talked about in long appointments, is ‘how does emotion work?’ A typical response might explain that the emotion system of the brain (particularly the amygdala) and body allocate a ‘feeling tag’ to all sensory events. The ‘tag’ is a complex marker containing information relating to that moment: emotion is the dominant information, then mood, motivation and memory. The assignment is individualistic, and is influenced by the women’s history and gene-environment interactions. Importantly, discussing feelings can contribute to changing such assigned emotions (Le Doux 1992; Le Doux & Phelps in Lewis 2008).

Offering alternative ways to take positive small steps of self-care before the next appointment enables the women to engage in achievable post-respite routines. The approach is similar to PRIMEr, which is used in addressing nicotine addiction (West 2009). Long-term care and ongoing recovery is the realistic ‘best’ outcome, and abstinence is the key for maintaining the women’s wellbeing (Landf & Stannich 2010).

**Mental health through retreats**

Many of the RWR women who had experienced various lengths of recovery (e.g. 3 to 18 years) had benefited from short retreats during which they were able to learn new skills and knowledge for dealing with specific issues. Participants agreed that time-away from everyday pressures helped them to re-commit to recovery and improve their mental health. The mental health model of Jahoda (1958) is a helpful tool for professionals and clients to use during such respite and retreat sessions. It recognises the following six criteria as being of importance for mental health, which I have paraphrased here, using the RWR meta-data on women’s recovery, as: 1) the understanding and acceptance of the self; 2) the process of personal growth and development in relation to personal and social values; 3) the integration of self and an in recovery identity that can provide opportunities for exercising the flexibility needed to adjust between respectful quiet detachment and self-extension and commitment to the world; 4) movement towards practice and support of the interpersonal and cooperative independence in the immediate environment; 5) perceiving the realities and personal sensitivities of others; and 6) exploring relationships with the curiosity and empathy that can nurture adjustment and replenishment.
The RWR women spoke of looking for a place, ‘an environment of tranquillity and security’, where they could heal further and lift their energy to enable them to achieve abstinence and deal with the basics of their physical, social and mental health (Schneider et al 2004). Women can begin to rely on their recovery teams to provide such advice, useful development tools and support as part of the respite or retreat process. This involves the direct experience of building trust, developing the skills to feel healthy and know what to do to stay well, and opportunities to meet new people and strengthen existing bonds. The women referred to such times as being very special for discovering their capabilities and peace of mind, for redefining important plans and finding deeper understanding through simplicity and complexity.

**Section 3 Discussion continuing**

**Analytical themes: Enabling support for further self-discovery**

The Meta-study revealed women may become ready for learning more advanced capabilities that enabled them to more fully experience self, i.e. mature insight, flexibility to accommodate changing circumstances and context, tolerating contradictions and ambiguities well, discerning what is right for oneself and being open to fulfilling one’s potential (optimal human development; Pffaffenberger 2005).

Women in long-term recovery understood the experience of being their ‘true self’, as a genuine person with dignity. The women can be mentored to experience their conscious and critical understanding of their ‘old’ thoughts, feelings and actions, and to develop new ways of being competent and comfortable in midlife recovery. Their experience of external reality is invariably shaped through their important subjectivities and inter-subjectivities (Holloway 1999).

Past interpretations and current interpretations of events can be challenged along with exploring her own contemporary perception of self and her everyday reality. The women's unique change of perspective while in recovery, and of themselves in relation to others, is to be cherished, and such changes can lead to feelings of fulfilment and peace of mind.
Figure 5.2: Midlife women can enjoy robust wellness which can lead to Wise Recovery

Key: The central process of robust wellness in recovery is represented by the centre column listing topics 1 to 6. Practitioner can enable women’s self-actualisation by drawing upon the Recovery Continuum (Chapter 4) robust wellness and self-realisation work. Practitioners, Expert Volunteers and women in recovery can consider states of mind and actions tending towards Non-Recovery (right side of the figure, Chapter 5, p268) or shifting towards Wise Recovery (left side of the figure, Chapter 5, p301). Valued Recovery is a critical step to Wise Recovery as core beliefs are explored to build upon, alter or reject. Practitioners can also apply Wise Practice which is discussed in Chapter 6. The stages of development from robust wellness (Complex Recovery) to Valued and Wise Recovery are outlined below and are another tool to assist women in personal recovery change and development.

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232 Using conceptual analysis (Yehezkel 2005): a conceptual tie is defined as a connection between meaningful components of a language that forms a proposition to explore, such as playfulness and management.
Reflective practitioners\textsuperscript{233} can help the women to explore their insights about sustaining long-term recovery, the best ways to achieve wellbeing and what further self-discovery might entail (self-realisation; Dewey 1938; and self-actualisation Pfafffenberger 2007). The women realise that to continue quality abstinent recovery they will need to extend their abilities for lifespan change. Self-realisation healthcare is accompanied by the integration of an autonomous, gendered-self, with acknowledged authentic identities for selected roles. Women being in abstinent recovery, and living such self-realisation (as a psychic, physiological and spiritual experience), requires difficult self-work, even though it has positive outcomes (Fonagy & Target 2007). The RWR participants provided many examples of mature women flourishing through their self-discovery initiative, tenacity and endurance in recovery.

Importantly, if self-realisation is confounded, practitioners can use the techniques of Complex and Valued recovery. If a particularly challenging issue emerges, respite care and therapy to consolidate recovery should be promptly made available. The capabilities learned through self-realisation and growth can also be supported with peers in recovery, and through mutuality and reciprocity, which are available through self-help groups such as AA (Kelly, Sout & Slaymaker 2012). Such combinations of care resources can meet individual needs, and this can enable the midlife women to sustain their recovery during times of difficult life events and possible relapse.

**New tools for robust wellness**

The ongoing development of new skills and acquisition of new knowledge in relation to the following six areas were found to be essential for maintaining a robust recovery.

**i) Self-directed attention**

The capacity for sustained and controlled attention when faced with distracting and interfering tasks can be learned (Brewin & Beaton 2002). As outlined in the

\textsuperscript{233} Reflective practitioners work towards; “an epistemology of practice implicit in the artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness, and value conflict” (Schon 1983 p49).
Recovery Continuum phases, the working memory can be overloaded by growing anxiety with hypervigilence; this can lower the resources available for paying attention, and this, in turn, can interfere with efforts to suppress or inhibit unwanted thoughts, memories and urges to drink.

Women learn in recovery that their perceptions and assumptions of a recent experience or remembered events can be distorted through alcohol misuse. Affect is a mode that can attract and maintain conscious attention, as can cognition; however, the combination of cognition and affect can be a powerful development process used for sustaining wellbeing in abstinent recovery (Salovey et al in Lewis, Haviland-Jones & Barrett 2008). People are often inaccurate at determining whether an ongoing experience will eventually lead to enhanced liking, enhanced disliking or no change. Despite anticipation, expectation and prediction of the future, most people are quite poor at predicting their own near future.

Women with AUDs tend to magnify ‘normal’ behaviours, rehearse past experiences, and play out future experiences in their minds. Such processing can distort their perceptions of current situations. Describing and explaining these mental abilities as practiced combinations of emotion, mood, memory, motivation and appraisals of current, remembered and anticipated situations, can help the women to be more aware and attentive to the realities of their current experiences in recovery (Sandler, Grandjean & Scherer 2005). It is important women practice actions using their full attention, and seek others’ feedback in relation to remembered items and for predicting the near future (learn to express their emotions and thoughts about events; Stein, Hernandez & Trabasso in Lewis, Haviland-Jones & Barrett 2008).

**ii) Self-authority: Self-directing for neutral positions**

Women in recovery can be assured that they are similar to other adults when judging positive and negative possibilities. Practitioners can provide explanations of

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234 Appraisal is a conscious, discerning investigation to make meaning (for our internal world) of a context (external factors) we find ourselves within. Appraisal is influenced by acquired values, beliefs and thinking processes (Sandler, Grandjean & Scherer 2005). As a midlife adult, the process of clearly making decisions in relation to how actions will affect you requires much more than just acting on one’s primary drives.
the possible negative and positive\textsuperscript{235} outcomes of any activity, and remind women that negative concerns tend to dominate most people’s thinking. Consequently, it takes more effort and more consideration not to be negative than to be positive (Ellerman & Reed 2001). However, we may experience positive and negative concerns at the same time.

Importantly, for women in Complex and Valued recovery (see the Recovery Continuum in Chapter 4), the development of self-authority can be helped by first practicing moving to a neutral (rather than a positive or negative) position in relation to an event. A small shift towards a neutral position can be assuring that change is possible (Frijda 2005). In the presence of both positive and negative concerns, it is difficult for the brain to discern quickly and accurately. Therefore, by holding a neutral position, in the moment, the time needed to appraise the situation, consider choices and make the best decisions is made available.

\textbf{iii) Change-oriented mental states}

Steady states of calm are not remembered as well as change to an attentive, alert state of awareness. Thus, in relation to pain and pleasure, it is the peak and the termination (and the associated rise and fall of intense feelings) that is remembered, not necessarily the flow. Remembered feelings are usually associated with significant (not necessarily large) change. Aware experiencing, remembering and anticipating are powerful skills to have (Rozin 2003). The memory of an emotion-laden experience can determine future behaviour, with the feeling related to that experience, rather than the experience itself having the greatest influence.

\textsuperscript{235} Positive and negative emotions, the valence of an emotion, are not equal and opposite. On a multipoint scale of emotion from extreme dislike to extreme like, there are more scale points for dislike than for like (Fredrickson & Cohn in Lewis, Haviland-Jones & Barrett 2008).
iv) **Complex emotions**

Practitioners providing care for women needing to stabilise their emotional health\(^{236}\) may consider using aesthetic emotions as neutral examples. They involve high level appraisals that can be helpful for dealing with unexplainable emotional pain. The experience of music is an aesthetic emotion, involving a set of learned (style based) expectations. Complex emotion, such as aesthetic emotion, may have derived from comprehension of types of human-created complexity (Lindquist & Feldman Barrett in Lewis, Haviland-Jones & Barrett 2008). The feelings associated with creating art involve both aesthetic and mastery experiences that incorporate technical actions, as well as present and anticipated experiences. An example of a mastery emotion is the comprehension of a previously baffling complexity, also the humour experienced by understanding satire.

Maintaining robust wellness requires learning about our complex emotions (a combination of affect and cognition), and reflecting on experiences of need, want and desire to help to better understand the diversity of human actions. Our emotions provide important signals of change, which can be used by the women to enable them to act in the best possible ways within the contexts within which they live (Fischer & Manstead in Lewis, Haviland-Jones & Barrett 2008). The domains of moral concern, the importance of social hierarchy and socio-emotional interactions, and the degree of expression of personal emotions become more understandable with openness, education, practice and discussion.

v) **Optimal development with AUDs: Midlife women’s strengths**

Human strengths and life satisfaction\(^{237}\) are usually age specific (Carver & Scheier in Aspinwall & Staudinger 2003). Most older adults have higher levels of interpersonal

\(^{236}\) Complex emotions (affect and cognition) have direct links to our senses and our ability to appraise the living environment. Some complex emotions such as pride are non-sensory affect, i.e. related to our achievements. For midlife women, such explanations can help them to progress towards Valued and Wise Recovery. The direct sensory links are external and internal, and they can be beneficial, harmful or informative, e.g. through our hearing and seeing. The informative sense of smell can indicate what is potentially beneficial or harmful. The internal sensory links indicate that something harmful is occurring inside the body; a pain in the stomach area or pleasure sensation of touch and taste.

\(^{237}\) Women with higher generativity identity report having higher self-satisfaction and life satisfaction; Women with strong generativity identities also tend to identify themselves as feminists (Rittenour & Warner Colaner 2012).
and self-regulatory strengths, citizenship support, loving relationships and appreciation of beauty (Isaacowitz, Vaillant & Seligman 2003). RWR women nominated important strengths as they aged in recovery, e.g. self-regard based on taking actions (including not taking action) that are true to their personal principles (values). Many of the women in recovery participants nominated peace of mind as a strength, and they described how they gauged where their energy was to be placed based on what would or would not contribute to their peace of mind.

Anonymous 2007, Action Cycle 1, Practitioner questionnaire: Serenity and peace of mind are tools for life. Great wisdom is an ability to cope with life as it comes, and give back for what is received in an attitude of gratitude.

Complex abstinence: New experiences and capacities

The women participants explained how they routinely tried ‘doing the opposite’ to their first reaction. This had led to sharing insights, hindsights and intuitions with others before acting. They were pleasantly surprised as they learned to live by taking the ‘in-between’ choice when making decisions. Being more moderate was possible, as was being part of group making cooperative changes. Most of the women found that they were capable of adjusting their self-acceptance and acceptance of others through honesty, open-mindedness and willingness (HOW). Many participants nominated the HOW approach as a means to sustain wellbeing.

Most participants emphasised that the most important strength was to know when to disengage, to ‘let go’ (a common AA phrase), even after sustained exertion. The women explained that they had learned from their peers to ‘let go’ with dignity, and that such action was a realistic decision to best invest energy and resources in another way. The practitioners’ emphasised the need to explain to patients that disappointment with ‘letting go’ was normal. The processing of events needed to be completed; women in recovery expressed disappointment and sadness to self-

\[238\] Having a somewhat balanced development of knowledge and skills in a number of areas of interest is a reasonable aim for sustaining recovery. Stages of development, as states of mind, can be expanded and stabilised through consistent training. One practice, of a number of psycho-philosophies available for exploring states of mind, is the Integral Approach (Wilber 2006).

\[239\] Women participants spoke of learning negative adjectives to describe what they felt; hurt, annoyed, miserable, sad, disappointed, frustrated.
care. Maintaining some emotional equilibrium through other life activities while the
disappointment subsided was important for mental health (Saffrey & Ehrenberg
2007).

Section 4 Discussion

Wise Recovery as evolving selfhood, adulthood and womanhood

The Meta-study synthesis\textsuperscript{240} summaries and my review of specific aspects of wisdom
research enabled me to form an explanation of ‘What is women’s Wise Recovery?’; a
complex an enriching experience. Many of the women participants contributed their
insights from living a Complex and Valued Recovery with robust wellbeing. The
essence of Wise Recovery was the RWR women’s momentum of openness to life’s
experiences with discretion and meaningful collaboration.

Wise Recovery has outcomes such as individualised understanding about selfhood,
adulthood and womanhood. The features of Wise Recovery are presented below,
that integrate the Recovery Triad and RCDs with self-discovery (an analytical theme
discussed above). Practitioners and supporters can draw on this information to
enable more women to progress in long-term recovery, sustaining growth and
wellbeing.

Living well with others

Women participants who were in long-term recovery (suggested by participants as
more than 16 years in recovery) spoke of their insights from the past when further
support was needed to alter unhelpful personal expectations in recovery. Practicing
re-perceiving goals, changing perspective or realigning self-schemas took time, effort
and encouragement from a trained practitioner and peers (Liehr et al 2010). To
sustain their healthy and mature wellbeing into their later years, women with AUDs
require access to careful individual guidance on self-change and in-turn they can
provide advanced support within the community.

\textsuperscript{240} Interpretive synthesis using meta-analysis techniques (Dixon-Woods et al 2005), cumulative meta-
analysis (Martins 2010), and meta-synthesis (Suri & Clarke 2009) with mixed methods (Johnson,
Onwueguzie & Turner 2007).
Social inclusion and self-determination in abstinent recovery had prepared women for most crises and delights (De Maeyer, Vanderplasschen & Broekaert 2008). All participants supported the Meta-study summary: that quality of life was a realisable goal in women’s midlife circumstances of abstinent recovery. Particularly important to the women was feeling and knowing they belonged to enriching networks of like-minded people.

Women with AUDs seek an integrated authentic self in midlife recovery; the integration of personal understanding and abilities of intradependence, interdependence and independence (perhaps preferring cooperative independence). Cooperative independence\(^{241}\) (my term, influenced by the concept of co-creative partnerships; Northrup 2006) appeared to be an important subtle difference that helped the women to sustain wellness in recovery when events were particularly disturbing, e.g. when a woman’s teenage or young adult offspring was showing signs of alcohol abuse. If and when such issues arised, a network of recovery peers (established over many years), nurtured the woman. Expert Volunteers and practitioners can contribute to this needed network and were likely to receive assistance to support more women in early recovery.

Sharing of knowledge, goodwill and gratitude was a noticeable enriching feature of the women’s midlife quality recovery (Cohen 2006). Living well in recovery provided impetus for women to progress from robust Complex Recovery to Valued Recovery and then onto exploring personal Wise Recovery. Notably participants described experiences that enabled the building of transformative resilience (reframing resilience in terms of a relational model; Jordan 2004). Transformative resilience processes focus upon the forces involved in creating relationship de-connection, and becoming able to differentiate a weakening process, to using a strengthening process. An example from the women participants is the development of a sense of feeling a greater integrity while interacting with people; such that energy is created and not lost during such interactions. A feeling of personal dignity can grow and be shared in such relationships with others.

\(^{241}\) In the development of women’s wisdom (Northrup 2006), a process based on co-creative partnerships can mentor women in the establishment of authentic interdependence and independence.
For women to maintain well-being, handle crises and remain abstinent over the lifespan, connecting with people who understand comorbidity and chronic illness was essential. Recovery Support (as a help alliance; Ruglass et al 2012) is required from practitioners, Expert Volunteers and mutual self-help group members. This support alliance can also encourage adult learning with new experiences and exploration of ways to re-imagine wellness with comorbidity in changing situations. Difficult Recovery Change and further chronic illness over the lifespan may mean that the women need access to respite care for mental health. This was emphasised women participants over 50 years of age.

Importantly, the dataset findings framed Valued and Wise Recovery as a self-actualising process (e.g. a form of self-care using approaches such as Mindfulness Based Feminist Therapy; Crowder 2012), leading to a healthy, sustainable and Wise Recovery (Baltes & Smith 2008). In such circumstances when suitable and agreed to, a self-managed recovery plan, with healthcare monitoring, can be co-created for women in Valued and Wise Recovery. Such self-management further strengthens women’s cooperative independence and illustrates the women’s greater sense of connectedness to processes that transcend one’s current situation or limitations (Runquist & Reed 2007).

**Developing a structure to enable women’s Wise Recovery**

Wise Recovery can be a heuristic for women’s personal creative and enriching recovery. The combinations of suitable healthcare processes for women continuing in recovery can be integrated into an individual Recovery Care Management Plan or Chronic illness Recovery management plan that practitioners negotiate with patients and, when possible, also with Expert Volunteers and supporters. In updating management plans Valued and Wise Recovery are useful goals and discussions about self-actualising, generativity and transcendence to sustain wellbeing in recovery. Wise Practice, discussed in Chapter 6 (Praxis), can prepare practitioners for lifespan healthcare.

**Selfhood in recovery**

An explanation of how women form a core self and an in recovery identity is provided in the Recovery Continuum description in Chapter 4.
Selfhood, as a finding, illustrates synthesis\textsuperscript{242} in action; it is more than an abstract or academic idea. Self-discovery (as outlined earlier in the Chapter) that women gained selfhood through experience with others, sharing knowledge and, by applying it, gaining clarity (Hermans, Gieser & Thorsten 2012).

In a way, women in Valued and Wise recovery explore self-transcendence, which refers to the person’s capacity to expand self-boundaries intrapersonally, interpersonally, and transpersonally (Ellermann & Reed 2001). The theory of self-transcendence postulates that engaging in spiritual as well as terrestrial or everyday activities that expand personal boundaries can enhance wellbeing within the context of vulnerability (Reed, 1991a, 1997). In vulnerability there is strength (JBMI 2010).

From the Meta-study findings it was likely that women’s self-differentiation skills can be explored using the protective factors of scholastic competence and spiritual (meaning of life) beliefs (Sutherland 2009; Hartman et al 2009). Enabling the midlife women to realise their educational aspirations (especially if they have experienced familial dysfunction) can increase their sense of self-worth and pro-social coping abilities (Biglan & Hinds 2009). In Wise Recovery, psycho-spiritual development provides an important opportunity for exploring life-meaning and gaining peace of mind. Pursuing dialogues within oneself (aware of the possibility of self-deception) and with others invigorates the process and leads to many more exciting possibilities (Rowan 2010), e.g. not needing the esteem of others for self-validation (Maslow 1987).

The internal negotiation process that takes place when women are developing their self-concept (which is ongoing) enables inner conflicts to be resolved, or ‘let go of’, on an ongoing basis. An effective strategy for women in recovery is to aim to make decisions on the basis of their values and principles. This enables putting an end to the often distressful experience of inner conflict regarding their stressful feelings about other people and situations.

\textsuperscript{242} Synthesis can incorporate opposites and paradoxes through the exploration of relational experiences (Valsiner & Cabell in Hermans, Gieser & Thorsten 2012).
Adulthood in recovery

The feature of emerging adulthood that occurs in women’s midlife recovery can be described as aligning or a re-entering daily life with a sense of self and perspective. This is similar to the stages of older teenagers entering early adulthood. The following five characteristics of emerging adulthood apply to midlife women in recovery: a stage of identity exploration; a stage of instability; a self-focused stage; a stage of feeling in-between; and, a stage of possibilities (Arnett 2001, 2004, 2006). The most significant of these characteristics for midlife women is the stage of possibilities, which is carefully explored in Complex Recovery of the Recovery Continuum (Chapter 4).

Improving health, happiness and wellness in midlife adulthood (Ryff et al 2012) can comprise pragmatic aims for individualised recovery healthcare plans. This includes, for example, improving one’s self-acceptance, which is not about narcissistic self-love or superficial self-esteem, but involves a deep form of self-regard built on awareness of one’s positive and negative attributes, as well as coming to accept both the triumphs and disappointments of one’s life.

A stage of possibilities provides options for cooperative independence and highlighting purpose in recovery. This importantly involves the building of capacity and volition to commit to a direction in one’s life, especially when challenged or during confrontations with others. Meaning for midlife women with AUDs, as articulated by Frankl (1992), must extend beyond struggling with their trials and tribulations. Personal growth in recovery is about the continual realisation of one’s talents and potentials, particularly their ability to contribute to the greater good. Paradoxically, the development of new resources and strengths often occurs when individuals are confronted with adversity, and even with limited trauma (Joseph & Linley 2008).

Wise Recovery and adulthood requires focusing on the present; through environmental awareness and proactive engagement with one’s surroundings, including midlife work, family life, group and community involvement, and also through education about aging and wellbeing in the later years (Kaufman et al 2009). For women in recovery, positive relations with others may continue to be difficult, with experiences of intimacy and abiding love often needing to be
developed through respite and counselling. Maintaining such relational ties typically involves discussion, negotiation and time to resolve difficulties about principles; or women may need to move away from a decision until further support is available for reflection and new learning.

**Womanhood and Wise Recovery**

I was particularly open to receiving diverse participant responses concerning contentment, their day-to-day challenges, and ‘the best of’ recovery experiences of living, e.g. feeling a sense of fulfilment (Engenser 2012). Vitality, gratitude, willingness and self-acceptance emerged as key descriptors of Wise Recovery experience, knowledge, skill and potential. Particularly important was the women’s generativity, which they expressed as a strong commitment to promoting the wellbeing of future generations and improving the world in which they live (Erikson 1980; Bauer & McAdam 2008; McAdam 2010).

**Generativity and peace-building**

Individually express generativity through various roles, including parenting, teaching, mentoring, and volunteering. And, in these roles, individuals express generativity when generating new things [and activities] with people, caring for others, and by maintaining what is considered ‘good’ within their society. Generativity is situated as the seventh of eight successive human life cycle stages, and is considered to occur during midlife (Erikson 1950, 1963). Currently, research on the topic maintains that although individuals can have generative proclivities during any life stage, it is the most salient psychosocial developmental issue during midlife years (McAdams & Logan 2004). It can be learned through mentoring by women in recovery who have experienced the process and able to pass it on to other women.

Participants made many references to wanting peace and calm as a response to the conflict that they had experienced with alcoholism; and also, in many of the women’s lives, long before alcohol misuse. Peace-building can be a useful strategy (Bock 2001). A simple outline is presented here. Peace-building focuses on strengths and positive commitments to overcome, transcend or transform negative events and feelings. Peace-building is not appeasing or placating, it involves any activity that fosters understanding amongst people; and it can even be used with relationships.
damaged by past conflict (Risq 2008). The following choices of approach, depending on the situation (Bock 2001), can assist women’s recovery:

- Promotive peace-building is quiet, unobtrusive, and may use indirect strategies, to find common ground for discussion.
- Pre-emptive peace-building occurs when a conflict is growing, and when cautious attention can stop escalation.
- Preventive peace-building is somewhat more deliberated, and it occurs specifically in situations where enmity has begun, but constructive dialogue is still possible.

**Womanhood and fulfilment**

Variation in the ways that women sustain recovery (differences and similarities) can be related to, particular beliefs about womanhood. Womanhood is multi-dimensional, and finding ‘the right personal fit’ is part of women’s recovery. Intersecting roles and identities, inspiring and meaningful conceptions of one’s self and life (self-satisfaction and life satisfaction) can provide joy and exuberance; fulfilment (Rittenour & Warner Colaner 2012).

Fulfilment for women in long-term recovery often comes from working with unknowns, and experiencing many catalysts of change, including having to deal with gender inequity (Benschop et al 2012). The learning and experience with the unknowns can be offered to more women through mentoring, and by becoming Expert Volunteers (Brock 2009). Midlife women sharing with other midlife women provides valuable opportunities for learning together about their: human capacity; value as individuals and as members of groups; taking action that reflect their own deliberate subjectivity; intentions and responsibilities; as well as contributing to community, environmental and spiritual values.

Women participants did not expect to experience fulfilment or ‘Wise Recovery’ all the time. Their life events, emotional stability and circumstances of nurturing ongoing relationships with significant others meant that ‘wisdom’ was not always available. Further education, creating with others (Murtaza 2011), extending leisure and respite were increasingly necessary as the women aged (Payne 2010). Mature
womanhood and recovery wellbeing continued to involve a matching of actions, values and goals for the benefit of the combined self, the midlife individual living in day to day reality and the potential older woman.

**Agency and womanhood in Wise Recovery**

My searching the transdisciplinary sources on midlife development and women’s needs when ageing, the literature on human agency linked with Wise Recovery in three interrelated ways: iteration, projectivity and practical evaluation (Bandura 2006; Holt 2007). Agency characteristics can assist women to remain grounded, focussed on specific actions and sharing goals with others: iteration (accepting an evolving selfhood: the selective reactivation of past patterns of thought and action when useful), projectivity (adulthood: the imaginative generation of possible long-term objectives and action), and practical evaluation (womanhood: the capacity to make practical and normative judgments amongst alternative possibilities).

Women in recovery can include agency in their repertoire by engaging in realistic appraisal of what actions they can contribute within their family, workplace and community. A sense of agency\(^\text{243}\) is shaped by development within bounded social structures. Agency represents an individual capacity, one that is both the result of individual differences (e.g. planfulness), as well as achieved merits (self-efficacy), and a sense of temporal, self-reflective understanding about one’s life possibilities (e.g. optimism, playfulness). Women living well in recovery highlighted agency opportunities (including self-reflection) and advocacy potential (Hitlin & Elder 2007). Exercising one’s agency is an important micro-level aspect of making wise life-course decisions.

Practitioners participating in RWR raised concerns in regard to agency, wellness and recovery. Women in recovery will need to consider constraint, as a healthy necessity,

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\(^{243}\) A variety of concepts have been developed to enhance our understanding of human agency. Ideas like “structuration” (Giddens 1984) and “habitus” (Bourdieu 1977) attempt to capture notions of free will, choice, and the effective use of the “rules and resources” that underlie volitional action. Such ideas point to the struggle to adequately grasp the interrelated dimensions of persons and their social environments. Debates over the nature of agency remain quite abstract, and involve core principles that represent individual influences within structured societal pathways (Elder 1994; Cockerham 2005).
and modify agency for personal use (Marshall 2005). Women can be guided to
monitor personal agency activities and withdraw if:

1. The dominance of doing rather than ‘being’ hinders their ongoing
development of a coherent self;

2. Increased external proactivity and adaptation brings overload to internal self-
work a consistent self; and

3. Agency may be perceived as a masculine trait that involves taking charge and
making things happen. This may limit the use of women’s creative and
effective processes.

Women can exercise agency and experience dependency at the same time through
acknowledging previously unacknowledged anxieties, and by seeking soothing
support and nurturance (Gomart 2002, 2003). Being attentive to the combined
collective experience of self-regulation and generous constraint amongst women in
recovery can be productive in illustrating agency as ‘cooperative independence’,
which does extend and involve exploring capacities and planning for specific actions.

*This conscious, intuitive adjusting of role demand and self-identity is
the ultimate experience of agency. It expresses the self’s acceptance of
its separateness and of its connectedness.* (Hartmann & Zimberoff 2004
p 336)

Referring to the meta-dataset findings, women can draw upon further capacities
with the use of agency. The experience of women’s personal wholeness came about
through recovery with women’s wise choice of role and identity. Acting with
personal authenticity in new roles can expand the healthy aspects of the self, and
continue to extinguish the maladaptive conditioning that contributed to the
women’s AUDs.

**Growth and moving onto new partnerships**

The women who had done self-discovery, complex abstinence and robust wellbeing
recovery work were able to gain an internal locus of control; this enabled them to
more clearly reflect on their attitudes, outcomes, and their actions, which in turn,
empowered the self for further principled action. Creativity was available as the
women’s intuition more readily entered their awareness following worthy effort, and it continued to help them to extend their maturing abilities.

Not all events produce post traumatic growth, and practitioners and supporters need to carefully guide and not insist on the women having to process all past events in her robust wellness (Aldwin, Levenson & Kelly 2009). Practitioners and women in long-term recovery supported conservative remembering and following the lead of women, and suggest options.

Reflecting upon self-determining moments of their recovery, perhaps re-considering some difficulties, the women provided meaningful examples of wellbeing in recovery, e.g. when the women felt a relational confidence in being with others in growth-enhancing relationships (JBMTI 2010). Further studies on ways to assist older women to sustain recovery in intimate relationships as growth-enhancing partnerships are needed.

As a benefit of robust wellness and Wise Recovery and recovery care, women can experience satisfying closure of adult relationships. In respectful partnerships people can endure and accommodate team members moving on by the use of empathy and the team, particularly the patient, being supported to prepare the way for a meaningful farewell and a welcome of the new practitioner. The experience is also preparation for such similar closures in everyday life (Dicken & Picchiou 2011). Plans for briefing new practitioners ‘as a team’ and operating in pairs for a few appointments were examples provided by participants of experiences that had helped in similar scenarios.

In closures and new partnerships, tasks enabling further self-determination, midlife women are best mentored to outline what are their needs and expectations for

lyn1, Action Cycle 1, Women’s Questionnaire, My Recovery: A fairly big problem that is not being addressed properly is [the challenges associated with] ongoing relationships.
healthy relationships. The process builds on the foundation of trust needed for contemporary support of recovery, mental health and wellbeing: 

- Gender-sensitive and up-to-date with sex and age appropriate evidence-based interventions (DeMarinis, Scheffel-Birath & Hansagi 2008; Tuchman 2010; Benschop et al 2012);

- Aware of Baby Boomer and Generation X cohort issues, particularly in regard self-health menopause and personality change (not misconstrued as stereotypes; Twenge 2009; Turiano et al 2012);

- Attentive to issues involved in relational development (Jordan 2008, 2009; Umbertson, Crosnoe & Reczak 2010);

- Holistic in their selection of options for the provision of social, clinical and mental health respite services (for midlife women; Russell & Gockel 2005, involving sensory and emotional memory therapy; Charles 2005, and psychosomatics Pettit, Grover & Lewinsohn 2007; Turton et al 2011); and

- Mutual agreement on continuing self-care, generative care with others, and agreed parallel health and medical care to assist the women to begin new therapy relationship.

From findings to preparing for praxis

Researching with women in recovery elicited multiple findings across various dimensions indicating the women’s progress towards abstinence and wellbeing. For the women and practitioner participants, learning to share through RWR provided benefits that came about from an understanding of cyclical and emergent life changes (Chong et al 2006). The multiple findings were not only related to women and their approach to their recovery, but provided information for healthcare practitioners and future healthcare practice.

244 The practical outcomes from the research process were based on theoretical and experiential understanding, e.g. neural consciousness (Thompson & Varella 2001).
The RWR Meta-study revealed the women’s individual approaches for achieving robust wellness and how their recovery leads to a rich self-actualisation and transcendence (Teruya & Hser 2010):

1. reclaiming worthiness;

2. presenting their potential for action; and


Chapter 6

The findings, particularly in relation to the meta-processes of self-actualisation, continued to be refined in RWR by studying women’s recovery in Australia and the priorities for actionable RWR knowledge in the form of potential interventions. Acknowledgement of the environment that the women found themselves in revealed a complex system of influences. Perceiving and understanding the system enabled praxis (a meta-method, see the Double Helix Figure 5.3) to be applied and appropriate action activities initiated, e.g. playfulness and planfulness based on practitioner facilitation notes. The recovery action messages developed from the Meta-study information using knowledge translation and theory-building techniques are presented in Chapter 6.

The Meta-study outcomes were developed by applying the RWR Transactive Knowledge Creation Paradigm to enabling midlife women with AUDs to become abstinent and well.
Figure 5.3: The Double Helix representing the Diamonds (data collection) and Pearls (data analysis) with the Meta-study outcomes

Key:

**Double helix (3D)**

The Meta-study allowed me to explore new modes of analysis, enriching both the theoretical and empirical results. The double-helix provided a useful base to represent the complexities of the study and provide a visual heuristic of the Meta-study process.
Double line represents transactive research design; and transactive methodology.

The research design reflects the objectives of the study and its participative and transdisciplinary nature. The methodology accommodates the Action Cycle data and mixed methods strategy.

Connecting bars represent: Meta-analysis techniques
- Dialoguing with text – Zimmer 2006
- Prolonged engagement, variety of data collection, analysis and meta-analysis tools – Padgett 2008
- Reflexivity – Western 2008
- Intersectionality – Harding & Norberg 2005
- Critical thinking and feedback, assisted theory building – Westhams et al 2008

Spirals represent – The spiralling technique I employed was distinctly systems-oriented, organic and pragmatic in style. The spirals also show the dynamics involved in exploring with participants a difficult phenomenon. The technique is based on the assumption that one method does not fit all research needs and all types of data. My spiralling logic and methods are comparable to the abductive and retroductive (back-checking) reasoning that moves between deduction and induction (Morgan 2007).

Double helix (1D)

The RWR Transactive Knowledge Creation Paradigm (Dietrich 2004, 2007; Jung et al. 2010), which is the final feature of the RWR Transactive Methodology, incorporated a comprehensive meta-analysis (Bradley, Curry & Devers 2006). By the end of Action Cycle 4, the data collection and ongoing Action Cycle analysis (Appendix 5.4) that I had completed indicated that a meta-analysis was possible, and that it would be of value to the study results (Pluye et al 2009). The aim of this Meta-study (Onwuegbuzie & Combs 2011) was to explore how integration and synthesis of the collected data could add depth through the selected RWR meta-analysis techniques (Martins 2010).

Transaction research – A dynamic, evolving, growing study

The particulars of the double lines at the top left represent the research process and ongoing literature search, the top right relates to my observations of everyday recovery and clinical practice. The arrows inside the top lines indicate the researcher providing analysis and meta-analysis information.

The double lines indicate, from the bottom left, the practitioners (professional and personal contributions), and from the bottom right, the women (alcohol dependence and recovery contributions); and both participant groups providing lived experience contributions.

The centre of the spiral is shown as a twist to indicate combinations, interpretations, integration and synthesis techniques contributing to theory-building and knowledge translation as outcomes (Chapters 5 and 6). The outcomes provide evidence-based information for use by the women, practitioners, academics, educators, media personnel and policy makers.
CHAPTER 6: PRAXIS

Introduction: Practice informing theory

In this chapter I discuss my use of praxis and the outcomes resulting from its application in this study. My understanding of praxis at the beginning of the study was that it involves action informed by practical theory and, in turn, that practical action may inform and transform the theory (Freshwater 2005). My trial research design incorporated praxis as an action method linked to exploring local theory-building (Kvale 1995) and knowledge translation (Armstrong, Waters & Roberts 2006). I employed praxis as a meta-method (Dixon-Woods et al 2005) in the formal research design; and I was also influenced by the following understanding of care-related praxis:

... praxis and the praxiological knowledge that accrues from it is about seeking to overcome the external and internal barriers to achieving, in our case, human flourishing for all, through the delivery and receipt of person-centred, evidence-based care. (McCormack & Titchen 2006)

My particular use of praxis elements and processes are detailed in this chapter (e.g. the selected approach and purpose, the modalities of execution, in-study deliverables and end-study outcomes) as a contribution to enhance competencies in addiction and mental health research (Arcidiacono, Velleman & Protocentese 2007).

In RWR praxis also incorporated knowledge exchange, knowledge translation and creating working theories to contribute to building a case for action on women’s

245 “The Oxford English Dictionary defines a theory as ‘a scheme or system of ideas or statements held as an explanation or account of a group of facts or phenomena’. Much of what is proposed as theory may be considered by some to be too specific or descriptive to warrant the epithet. Often the terms ‘theory’ and ‘model’ are used interchangeably. Strictly speaking, a ‘model’ is better construed as a coherent representation of key elements of a structure or system and is thus more descriptive than explanatory, but in practice the dividing line between ‘model’ and ‘theory’ is new and open to differing interpretations” (addiction theorist; West 2001 p96).

246 Knowledge translation (Armstrong et al 2006) occurred in a reciprocal manner as participant volunteers were informed through their participation (questions, answers, clarification, explanation, feedback) in RWR on current statistics, women’s recovery needs, theories of addiction and recovery planning options.
AUDs healthcare (Swinburn et al. 2005) and the adaptation of research for different users (Lavis 2006).

I discuss praxis, knowledge translation, and theory-building using the RWR results and findings under the following five headings.

1. **The use of praxis in RWR participatory action research; its purpose and methods**

2. **Small r Recovery; for women’s robust engagement with abstinence and recovery**

3. **Wise practice; enhancing competencies using actionable RWR professional resources**

4. **Praxis contributing to theorising on women’s AUDs recovery; an in-study deliverable**

5. **Removing barriers to sustaining abstinent recovery; an end-study outcome**

**1. The use of praxis in participatory action research**

My research design and research practice established an environment conducive to actualising praxis based on a foundation of Participatory Action Research (PAR; Bradbury Huang 2010). Practical theory comes about, in the main, through lived experiences (Butler 2005). At its most productive, it becomes part of clinical work in that it can help participants (clients and practitioners) understand and act in more ‘careful’ and transformative ways within their particular situations (McCormack & Titchen 2006).

When using praxis as a meta-method I took into account the relationships between its tactical (immediate) and strategic (long-term) use; also between the micro-level (the one-on-one care of a midlife woman) and the macro-level (the institutional systems and communities of practice in health and medicine). Such considerations helped to add context data for detail (Lather 1995, 2007) when developing practical theory and effective practice (Spring et al. 2005; Van de Ven & Johnson 2006).
Figure 6.1: A flexible and purposeful research environment for praxis outcomes

**Key:** The three spheres represent important elements of the RWR praxis process; the participatory research framework that encourages participants’ involvement, the individual women and practitioners’ engagement, along with their everyday experiences in their communities of practice (COP) and the practice of recovery in community groups (POC). The individuals and the groups can combine to provide strength and support in recovery healthcare (as an effective synergy of the powerful and the vulnerable).

The intersections of the spheres shown above identify and acknowledge the process and work required to relate, create and translate through participatory action, which enables women’s change from addiction to recovery. The women’s AUDs recovery and wellbeing phenomenon explored using praxis as a research meta-method highlights the everyday practice and issues of recovery. People’s actions (experiences) and feedback were valued as important knowing to study, share as deliverables (e.g. Local Working Theories) and useful outcomes, ‘Recovery Works for Women’.

**Recovery change** (the central focus) involves the practitioners’ and women’s practical thinking (which includes reasoning with their emotions, imagination and values) with the researcher’s understanding of relevant theory and methods, fact and possibilities. This type of cooperation in recovery healthcare is an important intervention in itself, to bring positive change with women and practitioners learning to sustain long-term recovery (described in this Chapter).

Integrated recovery healthcare establishes agreed goals, the means of attaining them, particularly including ways for people to relate with each other. The healthcare relationships amongst COP, POC, the health system and researchers can enable wellbeing. The RWR research identified and explained the benefits of healthcare partnership and praxis extends and details how people, principles, processes and purpose can attain a particular desired recovery outcome in everyday contexts (Polkinghorne 2006).
Sharing research findings with many people

Meaning-making involves taking into account people’s assumptions, attitudes and values, which co-evolve with knowledge, technology, environment, and organisation (Norgaard 1995), to produce improved understanding. The process depends on people’s access to adequate resources (including education, and understanding words and phrases, particularly medical terms and processes); also, on avoiding infringements on the resources rights of other members, societies, generations and species that generate conflict and stress (Huhman 2006).

Language is the critical tool for sharing meaning and resources (Glenberg 2004); it is involved in all action, and is a critical variable in all human processes (Powers 2005; Evans 2008). When we converse we use our conceptual system (e.g. semantic memory; Barslou 2008) and can call upon a rich store of representations. Words are a cultural artefact because they are culturally gendered (Ahearn 2001) and change over time to reflect the contexts of our living situations. The use of language can also serve as a degrading and oppressive force, including through the misuse of socio-political power (Smith, Foley & Chaney 2008).

Human communication involves more than a simple act of transmission; it is about the construction and negotiation of meaning (Deetz 1992; De Leo 2008). We are communicative social beings, and quite capable of tying ourselves up in communication knots when discussing elusive experiences and abstract information and ideas, e.g. women’s mental health, work stress, life stress, sex, depression and anxiety (Sandanger et al 2004). Recognition in the field of neuropsychology (Shanahan 2008) that emotion and cognition are both tied to human language also explains why effective communication is a complicated and demanding process.

When an issue is not highly valued (such as choosing a restaurant versus being concerned with one’s survival), adults usually adapt to the circumstances, make meaning and take action. As adults mature they also use techniques such as engaging in discussion of contentious matters, and reaching consensus or negotiated compromise (Schroth, Bain-Chek & Caldwell 2005). Such capabilities require experiential learning, social modelling, training and education to achieve success.

For communication and understanding in times of stress, dealing with complex tasks also requires social cognition (Smeets, Dziobek & Wolf 2009). In midlife situations where people do not have experience, mentoring and communication ability (maladaption/adaptation; Krueger & Funder 2004; Seligman, Parks & Steen 2004) negative consequences are likely. Over time, false hope and fear of failure can develop (Herman & Polivy 2003) leading to ambivalence, overcompensation and avoidance (Cornwall 2007), followed by alienation (Baker 2006), and illness.
Knowledge translation

The difference between knowledge exchange and knowledge translation is explained. Knowledge exchange (used in RWR as document exchange and literature exchange with participants and experts) focuses on interactions between the producers and users of research and it highlights the functional transactions in participatory research (Goering et al 2010). Knowledge translation processes in a health context involve a series of discrete steps that evolve over time and require simultaneous consideration of many elements of meaning-making and understanding (Ward et al 2009b, 2010). Explanations of the research and knowledge translation process used in RWR are provided in the Box titled ‘Sharing research findings with many people’.

Knowledge translation was a particular and important aspect of the research design, aiming to develop pragmatic outcomes. My knowledge translation process (McWilliam et al 2009, 2008; Gibbons et al 1994) became a form of practical action within the RWR Transactive Participatory Research Methodology (Kemmis 2006; Cargo & Mercer 2008), particularly the Transactive Knowledge Creation Paradigm (Chapters 3 & 5) and it involved the following:

1. Participants were provided with a choice of methods for sharing their information. Research processes were transparent (Kralik, Koch & Telford 2001; Koch, Mann & Kralik 2005) and designed to be helpful;

2. Engaged sense making (Loon & Kralik 2005b), experiencing (Hartman & Zimberoff 2004), women’s recovery (Greenfield et al 2007) and constructing theory (de Treville et al 2008);

3. Information sharing and considering the views of others (Dillon & Wals 2006) through ethical and respectful engagement (UWS Human Ethics Research Committee 2006; Code of Ethics for the Australian Drug and Alcohol Field; Fry 2007 for ADCA, Declaration of Helsinki review; WMA 2008);

4. Patience and determination in defining terms and clarifying meaning across the diversity of private language (Panjvani 2008); sets of instructions, guidelines (Haber et al 2009), and explanations from particular disciplines and fields, group norms (e.g. private clinic patients and AA members; Groh, Jason & Keys 2008), and knowledge-translation processes; McWilliams, Kothari & Ward-Griffin 2009); and
Confidentiality and anonymity, reviewed at each research cycle (or annually), through ‘Informed Consent’ agreements; the agreements reflected my consideration of autonomy and beneficence (Koenig & Crisp 2008), and gender and age sensitivity (Geppert & Bogenschutz 2009).

The RWR findings (developed from a Meta-study and synthesis of RWR data to provide more informative explanations and good practice recovery evidence) were important in preparing policy submissions, professional development magazine articles and tertiary education curriculum materials known as the Recovery Triad of Practice, including an Ecology of Recovery (EOR) and the WmSpace programs to encourage, train and support ‘Expert Volunteers’. Examples are provided in Appendix 6.1 of a professional magazine article and long-term recovery information for tertiary education students (Appendix 6.2).

Below are RWR results translated into engaging social marketing messages. Effective community engagement programs (including advertising and publicity) can lower discrimination for women with AUDs and inform friends, families and midlife women of healthcare for wellness and AUDs recovery, such as:

- ‘It’s a ‘Tick’ When You Choose: I’m not drinking alcohol today’; by role-modelling this positive choice, midlife women can make a dramatic difference to their own health and the health of people they love.

- ‘Have a Break from Drinking’ and ‘Give your Mind and Body a Break – from Alcohol’: this is designed to encourage women to discuss the damage (greater, and more rapid, than for men) caused by alcohol on female bodies and minds.

- Care for women who misuse alcohol involves them in developing a robust emotional wellbeing that is able to deal with the stress and strains of their lives: ‘Be – Come – Well’ and ‘Small ‘r’ Recovery’.

- Women who are alcohol dependent can LIVE WELL longer: ‘Recovery Works for Women’ and ‘Big ‘R’ Recovery’.

- Australia could be the first country to develop an effective non-drinking campaign: ‘It’s a positive choice not to drink alcohol’.
Actionable professional resources

The Recovery Care constructs, Recovery Development concepts and clusters and Recovery Support subjects developed through the Meta-study (Chapter 5) were prepared by me as strategies, programs and tools for practitioners, Expert Volunteers, supporters and women in recovery to apply in their lives. Further detail is in the RWR e-book on the enclosed DVD (contact Janice Withnall).

Two examples of actionable resources are below. To complete the Knowledge Translation processes I return to the Action Cycles data analysis to ensure participants’ needs were met. I then searched for current academic literature to prepare research-oriented, people-centred RWR resources.

2. Small r Recovery Development: A strategy

As the women’s data were analysed (particularly the Recovery Development clusters247 of information) a noticeable difference on levels of severity for physical damage, psychological pathology, and fewer comorbid disorders and chronic illness was revealed. An individual recovery program is necessary; however, a program for women with less damage from AUDs is also needed in clinical practice. With the support of the participants I developed a ‘small r recovery strategy’ (Small r Recovery) that focuses on developing mature cooperative independence, at an ‘I’m in Recovery’ stage of the Recovery Continuum. This provides practitioners and clients with greater choice in meeting the different women’s needs. A self-efficacy tool, ‘playfulness and planfulness tool’, and a ‘working with anger program’ illustrate the content of the Small r Recovery Development strategy. The tool and program are described in the following pages.

- Playfulness and planfulness: both these concepts help women develop astute self-efficacy to prepare for robust engagement with life events.

- Anger as a recovery care and development focus assists women to sustain wellbeing in recovery.

247 My clustering of data topics and issues (cluster analysis; Mun, Windle & Schainker 2008) was based firstly on what was common, then similar, and finally on what I observed as distinctive amongst the participants.
Playfulness and planfulness for helping women preparing for everyday recovery activities

Play is a complex social process that is energised, creative and improvised, while also being orderly (Dougherty & Takacs 2004). Playful moments and activities provide skill development opportunities that can enable adaptive variability, heedful interrelating\(^{248}\), and social cooperation and constraint. Women’s negative feelings associated with self-perceptions of being undeserving of fun, happiness and pleasure can be decreased through playfulness with planful competence\(^{249}\) to improve self-efficacy.

Playful preparation

As a kind of open, improvised and energised flow of activities, play, in the main\(^{250}\)\(^{251}\), is voluntary, pleasant, and liberating (Terr 1999). It is through play that humans develop the capacity for the logical operations, and the cognitive processes needed to interact effectively with the world. Play allows us to recognise benign social rules, and to act in accordance with them, as well as develop the capacity to understand meaning in culturally specific contexts (Fine 1999).

Playfulness produces an ‘alternative instrument of intelligence’ that allows experimentation, and it leads to creative decision making, precisely because play allows for the ‘potentiation of adaptive variability’ (adaptive play; Glynn & Barr 2001). Playful activities – utilising games for training purposes, encouraging the use of intuition and irrationality, and staging silly contests – can reduce anxiety and

\(^{248}\) Heedful interrelating is the way a person interacts when they are aware of contributing in joint situations to a ‘bigger picture’ in which they play a part (Weick & Roberts 1993). Awareness of personal actions integrating with activities of others requires the women to be attentive, purposeful, conscientious and considerate (Druskat & Pescosolido 2002; Thorpe 2003; Dougherty & Takacs 2004).

\(^{249}\) The term ‘planful competence’ (Clausen 1991) was originally used to highlight adolescents’ active engagement in thinking about, gathering information for, and planning their futures. This process is also applicable to women in recovery who demonstrate impulsive tendencies.

\(^{250}\) Manifestations of play-deprivation take the form of low mood, insomnia, anxiety, headaches, lethargy and low self-esteem (Abrams 1997). Responsible play actions* in recovery can contribute to improving the everyday reality of the women, and of the lives of others around those in relationship with them.

\(^{251}\) Current child and adult development research provides detail on the importance of play in achieving wellbeing (Gronlund 2010; Frost, Wortham & Reifel 2012).
stress in adults, and help them to forge bonds and enhance collaborative innovative processes (Sutton-Smith 1997).

CBS64, Action Cycle 4, New women interview: *I mean, for me, recovery has allowed me to grow up. It [has] allowed me to behave a little bit more like an adult.*

For the women in recovery, learning to allow and become open to participate in fun and leisure time in a group, or just as an individual, took a number of years for them to be comfortable and spontaneous. Dropping barriers between ‘the real me’ and selected people was first a challenging task before it was experienced as pleasure for a new recovery way of living.

Word play was an amusing novelty for RWR participants. There were many acronyms, alliteration, mnemonics, rhetorical statements, parodies, metaphors, analogies and paradoxes to consider as representations of the participants’ lived experiences. Examples of the word play (Kjolsrod 2003), and my awareness of language and figures of speech (Putnam 2004; Vaara & Riad 2010), opened opportunities for oblique analysis and studying the language of women’s recovery to enhance communication in clinical practice, and within communities and public health education.

The women’s limiting of playfulness was associated with their fear of loss of control, insecurity, and a tendency to react in a tentative or threatened way in a changing unfamiliar context, e.g. when meeting new people. A woman may have jettisoned and subsequently lost her abilities to play, in an effort to cope with and survive early traumas (Hartman & Zimberoff 2004).

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252 Fun and friendship in social group participation (e.g. Red Hat Society, local Laughter groups) can contribute to women’s health and wellbeing (Hutchinson et al 2010).

253 Word play (play on meanings) invigorates the mind, e.g. alliteration (Fairclough 2005; Shannon 2007; Shoshana 2011) and humour (Myers, Sweeney & Witmer 2000), fun and leisure (Hood 2003; Fullagar 2008), and power of words and affect (Panksepp 2008) can help people to be more receptive and open to new ideas (Reicherts 2007).

254 Formal control requires the following three underlying conditions: codification; monitoring, and the construction and use of safeguards (Bijlsma-Frankema & Costa 2005).
Loss of innocence, courage, trust and playfulness, is a common early life occurrence for women with AUDs. Play can be healing for women who have lost or abandoned their playful qualities, with playfulness having the capacity to renew spontaneity and creativity into their daily life (Winnicott 1988). Also, play can contribute to developing a robustness of self and skills to deal with a variety of circumstances and uncertainties.

VIX1, Action Cycle 1, Women’s Questionnaire My Recovery: In early sobriety I sought out adrenaline-raising activities; now I'm seeking fulfilling hobbies that sustain me.

Importance of PLAY for women’s recovery

PLAY (acronym illustrated and explained below) contributes to successful transitions in maintaining enriching recovery.

P Perspective shift, openness to novelty and viewing other possibilities

L Leisure shared and personal ‘liking’ noted and explored

A Attitudes for responsible, positive recovery developed with maturing trustful action

Y Yearning directed through imagination, intuition and insight.

With the routine of self-care (including play and leisure), the perspective shift (a transformation) that the women participants reported included the routine of self-care (including play and leisure) that allowed them to improve their ability to plan and complete tasks. Liberating, refreshing and emotional were words used by RWR participants that enabled and enhanced their ‘freedom’ to transform their perceptions, judgments and motivations (Metzner 1998).

Leisure for people in midlife and older is usually most focused on personal interaction, mental stimulation and physical exercise (McCormack et al 2008).

255 “… trust is a psychological state comprising the intention to accept vulnerability based on positive expectations of the intentions or the behaviour of another.” (Rousseau et al 1998 p395)
Engaging women in new experiences, and in enjoying leisure activities, can broaden their transposition possibilities; in relation to this the women exhibited:

- Loose coupling, or reasonable flexibility, with awareness that people do not follow standardised, institutionalised life-courses;
- Awareness that there is variance in overcoming and resisting social structural barriers, and that this occurs through important life transition points;
- The questioning of individual and/or communal action; based on the premise that one has the responsibility to act appropriately; and
- A sense of capacity as a developing human, through their engagement with what is here and now, and their capacity to act planfully in relation to a future time through what is here and now (Conner & Abraham 2001; Rhodes, Courney & Jones 2002; Hagger, Chatzisarantis & Harris 2006).

Maturing action is supported by the development of planful competence (see below). The women in recovery learnt to build alliances and accrue resources to enable them to develop effective plans of action, e.g. involving their education, economic opportunities, social capital networks and informal peer ties (Sthyre et al 2008). Through cooperation, reciprocity and mutuality trust accumulates, leading to positive expectations and the willingness to become vulnerable resulting in the formation of intimate relationships (Bijlsma-Frankema & Costa 2005).

Yearning (a seeking characteristic) supports ‘re-centring and bouncing back’ after negative events (Rosowsky 2010). Yearning for a more authentic expression of self, equality and relationality is common in midlife women. The women participants wanted more time to devote to themselves, preferably to find ways of expressing and celebrating aspects of themselves that were not bound-up with life roles, such as being peers, colleagues, friends, daughters, partners, wives, aunts and mothers (Abrams 1997).

*aKc1, Action Cycle 1, Women’s Questionnaire, My Recovery: In my age group there was more stigma [that was] associated with being a drunken woman – especially a mother. It was important for me to belong to a woman’s group in the early days – it was a safe place to open up and allow vulnerability. I needed the honesty of other women; and I learned not to seek the affirmation I thought I needed from men.*
Women in long-term recovery are bemused about their old ways of taking life ‘so seriously’. A touch of adventure, light-heartedness and excitement are also part of their recovery. The women need to be enabled, encouraged and supported in pleasurable and meaningful activities (initially through planned tasks) to explore their potential to be content and challenged, thus enhancing their self-efficacy (outlined in the Box below). Discussion with the women is required about what they will need to include in their plans, if and whenever they ‘fail’. Practitioners can help their clients to experience mistakes, reappraise their beliefs and expectations, learn from the process and move forward.

Self-efficacy enabled through playfulness and planfulness

I created Table 6.1 to compare the processes involved when the individual gathers personal, social and environmental information (through play to planning) that can help them to maintain sobriety and enrich recovery. Table 6.1 contents draw on participant information and transdisciplinary literature to create a useful intermediary tool between play and the women achieving their significant objectives. The benefits of a midlife woman being relaxed and alert, present and effective in working towards achieving a desired goal, reinforces recovery actions. Such actions bring light moments, healing and contributions to reimburse society, as well as innovative thinking (Druskat & Pescoslido 2004).

The women and practitioners will need to discuss obstacles to recovery, and ways to be efficient in working through them by combining pleasant and utilitarian processes (playful and planful competence). Progress can open the way to potential ‘bigger pictures’ of transposition and transcendence experiences in midlife (Katalova-O’Doherty 2010).

In Table 6.1, Women’s PLAYfulness (left) for the development of PLANful competence (right) highlights a devolution of external authority, with women increasingly basing their actions on an authentic self. Growing self-efficacy in recovery (centre) requires adult discussion to be able to chart one’s activities.

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256 Table 6.1 indicates progression in women’s recovery tools from the previous Risk and Recovery framework (see I’m in recovery phase of the Recovery Continuum).
Table 6.1: Self-efficacy enabled through PLAYfulness and PLANfulness

<table>
<thead>
<tr>
<th>PLAY</th>
<th>Women’s recovery self-efficacy*</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opens potential</td>
<td>Positive states of being and willingness*</td>
<td>Productive minimalism*, with the review of likely consequences</td>
</tr>
<tr>
<td>Encourages curiosity and comfort*</td>
<td>Experiences of relating and creating for improved mental health</td>
<td>Applying acknowledged capacities and limits</td>
</tr>
<tr>
<td>Reveals possibilities to change</td>
<td>Insight into social circumstances and the availability of support for autonomous action</td>
<td>Choosing constraint* – being aware of the beginning and end of transitions</td>
</tr>
</tbody>
</table>

**Key:** The factors marked with * on Table 6.1 are described above and below, with the remainder having been discussed in Chapter 4, Results.

**Minimalism** is the word I selected for the approach described by the women participants that involved acknowledging their need to simplify their efforts in recovery; and to stop acting on an ‘all or nothing’ basis. It also describes how the women need to moderate their compulsion to excessively ‘do’ (things) to please others, and maintain their patterns of perfectionism. The women sought, and wanted to receive, straight forward feedback on their first efforts for completing a set objective. Such feedback can help clarify the boundaries of effort required by the women. They can then focus on completing the task in relation to the requirements of the situation, keeping in mind the option to try again, and their need for self-care.

**Comfort** is a soothing, calming and reassuring experience leading to contentment257, whereas comforts are background improvements in life, such as air-conditioning. For humans, there is an important distinction between pleasures (enjoyable experiences) and comforts. **Constraint** involves being aware of personal and social limits and boundary responsibilities to heed situation norms, and continued necessary reciprocity for effective living in midlife (Sonnentag, Mojza & Demerouti 2012).

**Recovery self-efficacy** for midlife women incorporates self-regard, self-competence and self-worth as the ability to be oneself and to face life’s challenges (Miller & Daniel 2007; Mruk 2008). The women and practitioners discussed how defensive or pseudo self-esteem (Mruk 2006; Katalova-O’Doherty 2009) may block progress; and I proposed that, for recovery, more assistance with human connectedness (Clarke & Kissane 2002) and exploration of personal beliefs can help to broach any defences that are present in positive therapeutic relationships.

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257 Contentment is an emotion that may not be well known to women in recovery. Discussion is helpful for women and supporters about basic human sensations such as pleasure and pain, as well as the ‘drive states’ such as hunger and thirst (Gordon 2007). Candace Pert (1999) described how neuropeptides and their receptors located in the limbic system (including the brain) are part of an important network that is involved in emotional experience.
**Willingness**, a readiness to listen to suggestions and experiment with them, can improve the women’s mood. Experiencing acceptance of current circumstances can bring emotional stability (Diehl & Prout 2002). With integrated mindfulness techniques (Cayoun 2011), the women can be helped to lower their urges to avoid feelings and to limit any struggle with demanding thoughts. By supporting their willingness to remain in recovery, and through the development of new skills, the women can be enabled to stop, or significantly reduce, their misuse of energy.

For women in recovery, each day can be more or less pleasant or fulfilling. Pleasures are unique events, illustrated by good meals, evenings with special friends, and enjoyable vacations and holidays. There is variety and distinctiveness in pleasures (which involve neurochemical processes; Berridge 2003, 2007). Among the participant responses about recovery it was common to hear that something was ‘a pleasant surprise’. Other important aspects of pleasure include its association with the past (remembering it, e.g. activities in a beautiful environment, and participating with family and friends during festive times) and the future (through anticipation).

**Working with Anger program as a recovery development focus**

The RWR Recovery Care construct\(^{258}\) (Chapter 5) provided findings that were used to outline how to assist women with their anger and conflict reactions as a specific goal that can contribute to improvement of their life skills and recovery knowledge. The anger program outlined below is a tool in the Small r Recovery strategy, as explained earlier in the Chapter. This anger program provides practitioners with suitable research-informed techniques to work with midlife women with alcohol dependence and who are progressing in abstinent recovery. The approach supports the women in achieving their life purposes (e.g. self-care for long-term recovery, contributing to community and experiencing life satisfaction as they age). The learning and practice also assists women with enriching experiences with intimate others, e.g. in recovery peers, family and/or supporters. A common barrier for the women (based on the Meta-study data analysis) was their fearing anger and conflict, and needing to address both of these areas of life with healthy actions, rather than

\(^{258}\) Summative constructs combine several properties of a thing (features, attributes), emphasising important properties that are useful for becoming acquainted with a situation (de-Treville et al 2011).
their previous damaging solution of drinking to ‘remove’ the emotion and forget the conflict.

**Confusing agitation, anger and conflict**

Forms of being agitated and tense (anxious-anxiety²⁵⁹) are a common concern for women with AUDs. Tension is associated with diminished positive affect; and it is often an expression of unrecognised elevated anger (Kashdana & Collins 2010). Many of the women participants described the agitation and personal frustration in situations that upset them. Most were related to a belief that they felt affronted by life circumstances, or a person/s, and they had a strong desire to set the upset right. The perceived slight or act of disrespect was regarded as an insulting attack or a wrongdoing. The women who were still drinking, or who were in early recovery, were often unable to look at such issues with openness and impartiality.

Women described their tension and unease as restlessness, irritability and discontent. Most participants were unaware that their feelings of agitation were also a physical response. AUDs damage the brain (alcohol related brain impairment; www.arbias.com.au); this will heal, however, with continuing abstinence and constructive living in recovery (Harper 2009). The women’s agitation levels lowered with ongoing recovery care, development of skills and support.

In an agitated frame of mind, women contemplated blame, punishment and repentance, guilt and apology and retaliation or revenge to redirect or avoid the growing level of stress (Appendix 6.3). In the past, drinking was used for this purpose. RWR results indicate that the women’s feelings and thoughts were commonly reactions to one or more of the following three conflict situations:

²⁵⁹ The words anxious or anxiety are discussed here as conversation terms that are commonly used by participants. Only a small number of participants could define clinical anxiety, distress and depression (Schade et al 2007). Most of the women recognised the feeling of tension in their body as a reaction that was difficult to describe. They tended to recognise such feelings in threatening situations, e.g. conflict (De Botton 2004). Alcohol use disorder has comorbidities of obsessive compulsive disorder and generalised anxiety disorder (Spader & Wells 2006). The recovery process described here was not designed to directly address anxiety disorder. Further study on AUDs and anxiety is planned based on RWR outcomes.
1. A form of indignation over a moral principle, e.g. not keeping to a promise or violating being an ally (betrayal), or other essential ingredients of a good friendship;

2. A long-standing relationship resentment, e.g. lack of parenting partnership when addressing school issues involving the children; and

3. Humiliation, such as a partner ‘put-down’ in a group activity resulting in the woman being an object of ridicule disguised as humour.

Building recovery strengths for women includes addressing the agitation, anger and conflict, so that they can begin to know themselves and engage in purposeful ‘well-doing’. An important objective for recovery is to enable the women to learn how to avoid escalation into attack and conflict through the appropriate expression of frustration and annoyance. The development of improved interpersonal interaction skills, and applying them as an initiative for contributing in a positive manner to the situation (well-doing), also assists women expressing an authentic self; and this can lower and extinguish misdirected coping with anger and conflict through manipulation (Morrison, Noel & Ogle 2012). Women with AUDs can raise their resistance to extremes of emotion (particularly anger) by understanding what the feelings are based upon, and avoiding the sort of misperception and maladaptation that can result in negative habitual behaviours.

arj3 Action Cycle 1, Women’s questionnaire, My recovery: Wilful, selfish behaviour however served to increase my fear and self-loathing and caused me conflict with others. To counteract that, I needed faith and desire to live according to spiritual principles.

Better ways to balance drives through emotion constraint and cognitive restraint can be learned to address women’s frustration and anxiety culminating in ‘anger’ (Westen & Blaklov 2007). Encouraging women to act in a positive way to assist their personal growth around anger is a ‘big step’ of seeking perspective, by halting decision-making, and discuss their anger with knowledgeable people. This positive action provides a limit, and an opportunity to initiate calm ‘I’m angry’ statements, and to accept that the matter can be completed in an adult manner.

Women’s cooperation and engagement with recovery processes, and their progress in tandem with people offering recovery care, development and support, is limited
by misguided anger causing an unacknowledged distraction. Most of the women participants described the damaging outcomes that followed ongoing anger; less interaction with others, and withdrawing from experiences of supportive, trust-based relationships (de-Silva 2009). Not communicating and registering silence was a common action associated with anger in RWR participants. Building recovery strengths260, performance goals and positive affirmation to deal with difficult issues was a necessary development skill to learn and assist them with de-escalating anger (Waibel et al 2012).

Complications of women’s unaddressed anger

The examples below can be used as indicators of the need for RWR Recovery Care, Development and Support action in relation to women’s anger:

4. Women’s anger is commonly linked to failure and achievement frustration, shame and helplessness, as well as increasing anxiety related to their circumstances (Pekrun 2006), e.g. the women commonly used anger-linked words without knowing that their feeling was anger; ill-will, annoyance, malice, fret and resentment.

5. Escape and avoidance via obsessive television or internet viewing and shopping were common reactions to anger; sometimes with conscious actions, and more often without awareness (Schmidt, Heltan & Soyka 2011).

6. At the social level, anger generated conflicts; and when this occurs there is likely to be confrontation and violence (Hegerty et al 2010, ‘love’ aggression; Kernberg 2012).

Anger may take a superiority stance, with feelings like disgust and contempt being displayed towards the ‘hated’ person. Anger also may become blended with other emotions, like fear and suspicion. Envy and jealousy are blend emotions, but they depend on anger for their existence in the person.

260 Participating in everyday activities, becoming comfortable in diverse situations, with development of interpersonal interaction to express an authentic self, will be a reliable strength for recovery (Labouvie-Vief 2009).
Participants’ early recovery experiences of anger and their misconceptions

The emotion of anger worried, if not frightened, many of the women participants. Anger was perceived as being dangerous, like fear, and it blocked the women’s ability to engage with whole-person healthcare. By better understanding their anger, the women (and practitioners) could nurture their personal abilities (including all of their emotions) and thereby improve their cooperation with others and continue to benefit from being well and in recovery.

Few women in early recovery can explain the basics of human anger; consequently, knowledge about anger for women with AUDs can be very helpful. Anger as a negative emotion is a reaction to dislike (aversion) of some aspects of experience (de Silva 2009). Anger is an emotion that can occur when there is a threat to self-worth, our bodies, property, ways of seeing the world and our desires.

Practitioners emphasised the need to take precautions, such as restraint, when working with women during an anger phase in their early recovery. It is helpful to encourage the women to release and ‘let go’ of the energy of ‘why I’m angry’ once they have expressed their concern, followed by using this energy to focus on acceptance, and on what was the most important and current matter at hand (remaining abstinent). Willingness by the women to readdress the anger if similar instances emerge in the future was also a more productive commitment that could be made between practitioner and client in early recovery. Developing positive emotions is important in that it stabilises such emotions as loving, kindness and forgiveness, which are needed to deal with anger. Also, transforming anger to assist with the endurance and long-term understanding of an individual’s true nature through insight was worthy of practice (de Silva 2005).

The women participants’ responses to anger differed greatly. The more years abstinent often indicated a better understanding of how to acknowledge anger. Some were able to experience angry feelings and use them as a way to solve problems rationally and effectively. Others turned their anger inward, and most who did this recognised that they were engaging in self-destructive behaviour. Some of the women also stated that they refused to acknowledge their anger for many years; or they confused it with other emotions, such as vulnerability or fear (Lehmann 2006). This repression fostered their use of anger escape routes, such as reacting without knowing what was occurring (impulsivity), and the use of diverse types of defence mechanisms, such as grandiosity (or, conversely, hiding). Other defences include expressing moral anger or righteous indignation, justifying the negativities of anger (a rationalisation), or projection of the anger as the responsibility of others, and that others are to blame.

The anger of women with child-abuse backgrounds ranged from non-productive, self-castigating behaviour to rage events. There are few examples of empowering,
righteous anger that has enabled women to protect and advocate for abused children and themselves (Sachs-Ericsson et al 2011; Thomas, Bannister & Hall 2011).

Dislike of self (self-anger) had become a dominant aversion for most of the women with AUDs. With the mind full of dislike, full of wanting to separate or withdraw from experiencing their life, drinking provided a way they could not feel such intense dislike. Their inability to express anger began with vacillations and ambivalence, then frustrated desires, misery, guilt, and on to suppressed resentments. Such escalation led to the ultimate ‘representative’ type of statement by all participant women in recovery about their active alcoholism: ‘I just didn’t care about anything, anymore’.

Practice responding effectively to address anger

Without the women’s anger being effectively addressed in early recovery, it remained as a direct block to maintaining their abstinence, recovery and healing. In a recovery care environment, practitioners can encourage women to explore, be informed and practice responding effectively to feelings of anger in selected ways:

- Studying the components and facets of an emotion like anger and sadness, and talking about these aspects one by one, in relation to: the body, feelings, thoughts, desires and social contexts. Acknowledging and recognising one’s own anger, as other women in mutual-help community groups describe their situations.

- Being enabled to see one’s personal anger with clarity through art, music and movement, and accepting that for improved recovery, anger exists and needs to be understood. Facing personal anger, sitting to calm oneself and becoming present through mindfulness-based actions (Garland et al 2010) was supported by women in recovery and practitioners. The next stage of this process is expressing anger with a supportive and non-judgmental listener in a space and at a time suitable for such expression.

- Raising women’s awareness that the past patterns of behaviour used by them to handle or bury (repress) their anger to survive was a legitimate means of survival in the past. Such discussions often relieved the women from believing
that they were ‘bad’, and helped them to recognise their state of intense self-alienation as a sad fact. By participating in formal therapy, women can become more aware of the avoiding techniques associated with anger, i.e. through self-deceptions, disguises, rationalisations, manipulations and the emphatic ‘No’ of denial.

Women’s Recovery Care, Development and Support, the Recovery Triad includes recognition and understanding of the positive uses of anger, thereby applying the natural energy for positive actions, and also ways to unlearn the many maladaptations of not clearly expressing anger. Examples of new strategies of positive anger are outlined below with detail in the e-book.

**Addressing anger and maintaining progress in recovery**

Anger, as with all emotions, is a type of assessment and appraisal of the environment (the circumstances of the situation) by the person, based on their memory, experiences and perception. Emotions arise when the person detects something that might have an impact on their wellbeing (Shanahan 2008). The skill of strengthening responses via emotional abilities, including accurately perceiving emotions in self and others, comprehending emotional information, allowance of emotions to facilitate thought processes and modulation of emotions, according to contextual demands, is a large task that must be developed and regulated to be beneficial (Mennin & Farach 2007).

Flow-based actions to meet anger challenges can also assist with anxiety and stress, and this makes it possible to work more effectively with anger (Fullagher et al 2012). Awareness in a flow activity of anger is noticed by unease and shifts of the women’s attention from the focused activity to the self and one’s task-related shortcomings. This creates a state of mind that is extremely self-conscious (Nakamura & Csikszentmihalyi 2002). A number of interventions can be used to encourage flexible processing of feelings of unease, such as those based on social cognitive and affective neuroscience (Frewen et al 2010).
Learning about human mentalisation\(^{261}\), and providing opportunities for developing acceptance-based coping and meaning-focused coping provided options for effectively addressing anger (Naito 2006; Vieten et al 2010). As recovery continues, helping women to focus on valuing and building on their capacities, strengths, experiences, knowledge and inherent worth is a necessity and limits anger.

Combining pro-social actions in recovery, which were named ‘doing-well’ by RWR participants, strengthened the women’s ability to maximise positive affect and minimise negative effect (Sze et al 2012). Guidance and more practice of re-directing emotional pulls and pushes, including anger, can assist. Women learning about appreciation, satisfaction and contentment are the types of re-interpretation of a set of circumstances that lessens the women’s negativity and anger.

**Anger and negative complications**

The women’s healing was often also affected by anger based on insecurity, violence in important relationships (attachment anxiety; Mikulincer 2009), and diagnoses of anxiety and depression (Troxel 2007; Hesse 2009). Specialist care will be needed for such combinations of disorders\(^{262}\), including personality disorders (Sherry 2008), PTSD and self-harm behaviours (Hien et al 2010; Norman et al 2010).

Of serious concern is suicidal behaviour (Pompili 2010) and the need in recovery healthcare for practitioners to be prepared for women’s: 1) Increasing psychological distress, including feelings of hopelessness, loneliness and depression; 2) Enhancing or facilitating aggressive behaviour, including self-aggression; 3) Changing an individual’s expectations, and helping to propel suicidal ideation into action; and 4) Constricting attention and inhibiting effective coping strategies that would facilitate avoiding suicidal behaviour. For continuity of effective AUDs healthcare, the priority of meeting the women’s needs for dealing with anger, conflict, suicidal ideation, and

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\(^{261}\) Women in recovery, researchers and practitioners can all benefit from regularly updating their understanding of mentalisation; individuals use many ways of thinking; including a rational style, characterised by a conscious, analytical approach, and an experiential style, characterised by a preconscious, affective, holistic approach (Appelt et al 2010). Significant progress is being made to understand the human conceptual system, particularly how the brain interprets experiences (Barsalou 2008).

\(^{262}\) To experience mental health, abstinence from alcohol is necessary for women with AUDs (Mills et al 2009; Fein & Nipp 2012).
low mood with disengagement from daily life must be clearly negotiated and acted upon (Waibel et al 2012).

**Suicide protection**

Most women in recovery with AUDs have considered suicide. They acknowledged this as fatal, intentional, involving a self-inflicted injury with the intent to end life. The need for professional help is necessary, as suicidal behaviour is influenced by a complex mix of genetic predisposition, environmental factors, age, AUDs pain and pessimism (Blow, Brockmann & Lawton 2004; Schafer & Shippee 2010). Processes and perceptions leading to suicide include thwarted belongingness, perceived burdensomeness, repeated episodes of physical pain and/or fear-inducing experiences, and feelings of hopelessness about such states (Van Orden et al 2010). Indicators for ‘nearness to suicidal acts’ are being studied as part of the percept-genesis project (Titelman et al 2011), with depression, devaluation, lack of attachment relationships, splitting and identity insecurity having been nominated as early warning signs.

Suicide is an important problem for midlife women with AUDs. Midlife women are completing suicide through poisoning at a higher rate than other groups (Hu et al 2009). Compared with others who have attempted suicide, alcohol dependent people who had attempted suicide were more likely to be female; have a family history of suicidal behaviour; experience more childhood trauma and greater levels of aggressive behaviour; began heavy drinking earlier, and were more likely to have received antidepressant medication (Roy & Janel 2007).

*Providing repeating help can prevent a return to ‘I am alone’*

Anger and conflict can bring social exclusion and feelings of alienation which can lead to negative (in-pain) behaviours such as drinking and self-harm (Twenge et al 2007). Shifting from feeling isolated to feeling moments of nurture and belonging which can heal is often purposefully blocked as women feel they are at risk of being hurt further (feeling greater anger and fear). This perceived risk, and ‘failure’ to express and release their pain, may happen many times before women are able to remain abstinent. Continuing the many acts of help, (particularly for women with abuse and neglect backgrounds) and the provision of hope given from one human to another are, e.g. NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW 2008; National Health and Medical Research Council, Australian Government 2009; Mental Health, Drug and Alcohol Disorder, Australian Government 2009.

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263 The RWR Recovery Care constructs have drawn upon the goals, priorities and guidelines of patient safety and care for health, medical and welfare professionals. The list of the guidelines referred to are, e.g. NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW 2008; National Health and Medical Research Council, Australian Government 2009; Mental Health, Drug and Alcohol Disorder, Australian Government 2009.
another is critical. One of these acts may become the special moment when recovery is taken up. The acts of help are acknowledgements that the women are human and worthy of receiving quality care. In this way, the women can be enabled to hear, receive and accept AUDs care and recovery.

3. Wise Practice

Wise Practice is the collection of RWR results and findings (practices and principles) that can assist practitioners to enable women to sustain their recovery across the lifespan. The RWR women participants reported on what had helped their long-term recovery and practitioners identified a small number of practices to support continuing wellbeing through progressive healthcare, i.e. using bi-annual reviews, working towards guided patient self-management. In response I designed the Recovery Respite Care program to further assist women and practitioners.

The Wise Practice collection illustrates the evolving nature of RWR. The findings of the Recovery Triad 3Ps (Protect, Prepare/Produce and Prevent) and Wise Recovery (selfhood, adulthood and womanhood) were flagged as incomplete using the Double Helix meta-synthesis method (Chapter 5). The needs of the women participants recorded in the feedback on the Action Cycle trails and preliminary findings were not adequately met.

Women’s potentials and supportive practices

Women’s long-term recovery needs can best be met by supportive practices to explore the women’s capabilities, vulnerabilities and potentials. Recovery care and development is more than assisting to resolve women’s problems and difficulties (Appendix 6.4). The Meta-study showed that although positive relationships are particularly beneficial in recovery, this (together with trauma work) was a most resisted topic in therapy. The following techniques can assist practitioners to prepare the women to consider working through such life issues (e.g. mistrust of her

264 Using NVivo 9 to analyse combinations of participant responses to meet Wise Recovery needs, the lack of development and support connections and links to care interventions for practitioners indicated a gap in treatment resources. Therefore practitioners and Expert Volunteers would be ill-equipped to enable women to progress into long-term recovery. I questioned the dataset further on long-term and sustaining recovery practices to meet the women participants’ needs, and the analysis indicated a possible practical combination which I developed as a Wise Practice strategy.
mother, other trauma events) and life enriching activities (e.g. building close relationships) and not return to drinking. The techniques are based on RWR women and practitioner participants input into the Recovery Triad and Wise Recovery (see RCDs in Chapter 5), and my surveys of new research and clinical practice.

Most people live, whether physically, intellectually or morally, in a very restricted circle of their potential being. They make use of a very small portion of their possible consciousness. We all have reservoirs of life to draw upon, of which we do not dream. (William James 1962 p51)

Healthcare professionals can assist women in recovery to acknowledge and attend to their strengths and improve and apply their capabilities. Four useful practices are listed as examples and what can be learned is presented in the brackets:

1. Making wise judgments (discerning levels of engagement and appropriateness of response; Fry & Kriger 2010);

2. Mental functioning and mood preparedness (positive ways to facilitate insight and creativity; Kounios et al 2008; Kounios et al 2006; Subramaniam et al 2009);

3. Affect stabilising techniques with selected supporters (learning about incidental and integral affect; Västfjäll, Peters & Slovic 2008); and

4. Personal risk analysis (what is dangerous for individual women with AUDs, more than in an actuarial sense; and clarifying individual life choices Templeton et al 2006; WHO 2007; Wood & Lasiuk 2008; Rivers, Reyna & Mills 2008; Slovic et al 2007; Appelt et al 2010).

Praxis can be applied by practitioners to translate such research-informed techniques to assist clients’ living in recovery. The manner of practitioners introducing such techniques was important for the women participants. Most

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265 After major events, the emotions raised during the event, can continue to influence ongoing judgment and decision-making without conscious awareness of this occurring. Communicating with knowledgeable people can assist women to appropriately disconnect the feeling around specific events for the next challenge the women may face or unexpectedly experience.
preferred collaborative discussion and setting out an agreed individual recovery plan. The plans’ goals attracted the women and encouraged them to develop advanced skills to assist with difficult life matters and benefit in long-term recovery. The goals and practices can be presented using an extension of the 3Is, 3Ts and 3Ps (Chapter 5). I selected an extension of 3Ps (adding Potential and Preparedness), based on senior practitioner interviews, to illustrate a Wise Practice example.

1. **Potentials explored through purposeful recovery development**

**An example of practitioner supporting potentials:** Providing feedback on women’s developing multiple identities and goals with suggestions to consider personal restraint.

Women in recovery experiencing a realistic self-regard, self-consistency and self-restraint increase opportunities available to achieve their potentials (Teeser 2000). As a partner in an integrated healthcare team women are well placed to work towards capability-building around openness and persistence to connect their interactions with people to their values and beliefs (Hepper, Gramzow & Sedikides 2010).

Encouraging women clients to discuss ways to take dignified responsibility for themselves (rational activity, volitional control and choice: Smith 2005) brings positive experiences that can increase the women’s sense of self-worth in recovery, acceptance of self-affirming reflections and feelings of wellbeing (Ryff & Singer 2008).

Personal growth in recovery is about the continual realisation of one’s present circumstances, contexts and talents, particularly when such abilities contribute to the greater good. It is of importance that practitioners discuss the likelihood that paradoxically, personal growth, the development of new abilities and strengths, often occurs when individuals are confronted with adversity, and even with limited trauma (Joseph & Linley 2008).
2. Preparedness for new life goals and empowered wellness

An example of practitioners supporting preparedness: Maintaining guidance for women to commit to a coherent and self-consistent relationship with themselves and nominated significant others such as Expert Volunteers.

Knowledgeable health professionals can facilitate women’s mutual sharing of high-level recovery development (Slade, Amering & Oades 2008). The tools developed through RWR for preparedness involved sharing feedback, integration of ideas and insight. As an integration example women found the ‘3Rs’ an effective reinforcement for sustaining recovery 1) Recovery and socially responsible roles; 2) Risk evaluations for a personal self becoming authentic and resilient; and 3) Recognising reality from different perspectives to establish a living environment that supported personal interactions and respect.

Women’s noting of detail, which was developed through their life history is beneficial in both insight and evaluation processes. Contributing to thoughtful reasoning, reflective thinking and practical rationalism assist evaluation (Stanovich, West & Toplak 2011). With lived insights women in recovery can provide clear and deep perceptions of unfolding situations. Midlife women in recovery are often able to understand the multiple factors contributing to complex events and grasp their inner nature intuitively.

*The Aha! Insight: You may not be sure how you came up with the answer, but are relatively confident that it is correct without having to mentally check it. It is as though the answer came into your mind all at once – when you first thought of the word, you simply knew it was the answer. This feeling does not have to be overwhelming, but should resemble what was just described.* (Bowden & Jung-Beerman 2007 p 96)

Considering only problematic paths is limiting for women in recovery, and unlikely to provide more complete (and often unexpected and enlivening) solutions to emergent challenges. For women in recovery, halting old patterns of behaviour (leading to problematic paths) is necessary, as it saps reserves and preserves the idea that their world can be controlled in a perfect manner.
3. **Practical protection for progress through self-care for wellbeing**

An example of ‘a protect’ technique’ practitioners can use in support:
Advising women on negotiation and cooperation with their team of practitioners can assist to lessen anxiety around association with their work colleagues and negotiations with other people.

Women expressing intentions linked to named objectives and describing briefly personal volition with team members, when forming plans to change an aspect of their life, assist themselves and their partners in taking informed cooperative action. Such negotiation (including goals and values) means deciding on what will be said about objectives, volition, personal values, emotions and motivation. Cooperative action also includes reviews, i.e. the discussion of the outcomes as a wise completion process.

A), B) and C) are able to be used separately and in different combinations to prepare midlife women wanting to improve their interactions at work and in the community as a way to prepare their negotiation capability.

**A) Lowering interpersonal stress**

The learned routines of a mature adult dealing with changing circumstances can provide protection and preparedness for women’s shifts of in recovery identity that will occur as she interacts with people. Change processes are an important part of mental health and wellbeing. The most common challenges for women in recovery to meet and process, identified by practitioners were:

- Interpersonal tensions associated with arguments and with avoiding them (heedful interrelating; Styre et al 2008);

- Feelings of overload: too much to do and not enough time and resources to accommodate their responsibilities (ways to address the work-home interface; Schaufeli, Bakker & van Rhenan 2009, fairness-engagement or incongruity, unfairness-burnout; Maslach & Leiter 2008); and

- Responding to the distresses of the others in their social networks (health initiatives; Smith & Christakis 2008, development of empathy and
B) **Soothing through self-compassion**

Practitioners can use self-compassion to model and enable women to experience relief from tension, overload and distress. Self-compassion is an important expression and indicator of self-care, and of moving towards self-love and self-forgiveness in recovery (Crowder 2012). A reasonable way to help women to make progress in relation to the feelings that they find difficult and uncomfortable (i.e. love) is to have discussions in the following three subject areas: 1) Extending kindness and understanding to oneself, rather than harsh self-judgment (Gilbert 2005); 2) Seeing one’s experiences as part of the larger human experience, rather than as separating and isolating; and 3) Holding one’s painful thoughts and feelings in balanced awareness, rather than over-identifying with them (Neff 2004). Each of these aspects of self-compassion is experienced differently, and they each influence the expression of the other aspects. Such personal experiences provide women with simple introductions to relationship ideas, and begin the development of the courage to love.

C) **Relief through social conversation skills**

Practitioners can use ‘recovery communication skills’ for women to establish and importantly continue interactions and meeting objectives.

Preparing and nurturing the women through social interaction experiences (including the feeling of being uncomfortable, even distressed) can begin with understanding discursive skills to improve their ‘recovery communication’ (the phrase is used to limit the belief that all people can communicate for wellness).

Many of the women participants spoke of not knowing how to engage in general conversation, although most agreed that communicating with people was a necessary skill for healthy living. Women can benefit in recovery by participating in interpersonal ‘talks’, which can lead them to seeing the world differently and to meeting people who may or may not become part of their life. Explaining the use of the following four different types of conversation can be helpful, and healthcare
practitioners can assist with introducing techniques (during appointments is preferred) for engaging in them (Scharmer 2009):

1. **Downloading:** Talking nice is when women speak about what practitioners or people in groups want to hear. ‘I don’t want to be seen in a negative light’, so they use polite and cautious phrases.

2. **Debate:** Talking tough is when women speak from ‘what I believe’; in an exchange of divergent views, women can perceive the authenticity of their views and may modify them. Also, they may find like-minded people for further interaction.

3. **Dialogue:** Reflective questioning is when women inquire about others’ viewpoints as they consider changing their ideas and tasks; ‘I can change my view’, and ‘I can see myself as part of the whole’, are important recovery statements. Women in recovery spoke of sometimes experiencing peace of mind beyond conflict, agitation, clash and controversy, after such discussions.

4. **Co-creative discussion:** When women want to contribute to the positives of adulthood and womanhood, e.g. expressing intuitions, checking an idea by saying it aloud, begin to reveal important positive outcomes and difficult struggles. Co-creating something new through talk, and working on an emerging future is an exciting prospect for women. Follow-up is important. Women need to return and to speak of their actions briefly (negative, neutral or positive). This re-engagement with a group signals that the women are rejoining the discussion and are willingly to contribute to and draw upon a collective energy. Many of the women participants described ‘recovery communication’ when they are present and experiencing the event as an enlivening process.

Practitioners using Wise practice can draw upon the five Local Working Theories below to expand their clinical methods. Expert Volunteers, women in recovery and educators will also benefit from this level of understanding women’s recovery.
4. **Praxis contributing to theorising on women’s AUDs recovery**

Practical theory is best developed through lived experiences and observation in natural settings (Lester 2009). My theory-building perspective was also based upon theoretical explanation contributing to critical problem-solving (Holmstrohm & Ketokivi 2009), and being more than ‘retrofitting and post hoc speculation’ (Van de Ven & Johnson 2006). I requested feedback from participants on my theory propositions (from Action Cycle 2 onwards) and identified from their responses what was understood and useful in daily living.

Quote from a practitioner participant response to RWR newsletter (2008): *I had to re-ask – ‘How do I identify a woman with an alcohol problem earlier?’ In a way that is non-judgmental and provides a beginning for co-operatively limiting and stopping misuse.*

Quote from a woman participant to RWR Newsletter (2009): *I really appreciated the hormone information. Men in recovery seem to have absolutely no concept of the emotional and physical strain that menopausal symptoms can put on women; and most men in AA seem to think it’s ‘just an excuse’ for us to cut down on meetings.*

The importance of abstraction and conceptualisation (thought processes assisting theory-building: Simpson & Carroll 2008) in RWR was more than just an external research process to produce a significant academic contribution. Interactions with participants were based upon theories, i.e. communication as action to bring about change (Habermas 2000; Luhman 1996). The cyclical use of theory (internal research process) is illustrated by the ‘Participant Reference Group’ reviewing the draft conclusions, and my incorporation of their feedback when refining important research report sections: ‘Barriers to Sustaining Abstinent Recovery’; ‘Suggested Short and Long-term Resolutions’; and ‘Recommendations for Improving Recovery Care strategies and implementation vehicles’. Most transactions involved theory and practice (praxis) leading to further theorising (Morse & Cheung 2003).

The added value was that the participants and contributors came to understand how everyday theory-making can be useful. Two examples were:
1. The articles on the theory of continued ‘central nervous system dysregulation’ in early recovery and how it normalised with abstinence (Weiss et al 2001; Koob 2003) was of importance to women and practitioners (Coyne et al 2006).

2. Channelling the energy of affect intensity or stress into mental functioning to prepare for productive and novel work is a learned capability for midlife women (based on cognitive-experiential self-theory; Maas & van den Bos 2009).

Working statements for theory-building, (Westhaus et al 2008) modelling and heuristics (Slovic et al 2007) provide a stepping stone to effective knowledge exchange (Van de Ven & Johnson 2006) and translation (Ward et al 2010). Transactions with potential users of knowledge for clinical application, such as practitioners, policy-makers, leading decision-makers, and researchers can also improve acknowledgement and distribution of theory with related applications. The collaboration is further improved if there is timely response by researchers to the knowledge needs identified by users, i.e. women in recovery care. This type of responsive interaction identifies needs of, ‘push’, ‘pull’ and ‘exchange’ as essential for the genesis of a collaborative model for knowledge translation (Canadian Health Services Research Foundation [CHSRF] 2000; Lavis et al 2003; Lavis 2006; Baumbusch et al 2008).

4. **Constructing local working theory**

My understanding of theories (Denzin & Lincoln 2006) and the RWR data and research goals were the basis for my approach to constructing the actual local working theories. The three important features that guided the process in RWR were:

1. Comprehensive identifying and ordering of processes, constructs and concepts to represent the ‘how’ women in recovery remain well and abstinent;

2. Contributing meaning to facts or phenomena that improve recovery understanding; and

3. Approximating ever nearer to what was perceived by RWR participants.
Table 6.2 Developing theories using Action Cycles questions, participant contributions, researcher observation, rich data and analysis

<table>
<thead>
<tr>
<th>Action Cycles</th>
<th>Participants (10 categories)</th>
<th>Major outcome</th>
<th>Negative (risks) &amp; Positive (resolves)</th>
<th>Integrated change processes</th>
<th>Guiding ‘care’ principles</th>
<th>Data analysis (Tashakkori &amp; Cresswell 2007)</th>
<th>Theory-building based on RWR data</th>
<th>Questioning continues</th>
</tr>
</thead>
<tbody>
<tr>
<td>ActionCycle 1 &amp; 2 review, progress &amp; reflect</td>
<td>Communities of practice observation, participants invitation &amp; involvement in trials e.g. web use</td>
<td>Acknowledging women as worthy &amp; identifying factors contributing to women’s pain &amp; suffering</td>
<td>Risk in seeking core self  Resolve to heal &amp; accept care &amp; support</td>
<td>Tending to female biology, sex &amp; gender norms  Midlife tipping points, sociocultural &amp; philosophical concepts</td>
<td>Protect through enabling safety &amp; providing non-judgemental care to heal  Produce posters – KT</td>
<td>Categorising, analysis &amp; pattern recognition (Nelson 2008)</td>
<td>LWTR1 Seeking volition to act as an intradependent self</td>
<td>How does recovery happen for women?  What is useful &amp; what can help?</td>
</tr>
<tr>
<td>Action Cycle 1, 2, 3 review &amp; seek feedback, reflect &amp; progress</td>
<td>Women’s practice in the community observed Volunteer Expert Panel feedback</td>
<td>Cohort characteristics &amp; context features required for individual care</td>
<td>Risk of interacting in new planful ways to not relapse  Resolve emotional wellbeing development</td>
<td>Transitions of unexpected and expected life-course events</td>
<td>Engage in productive women’s learning &amp; persistent recovery development  Submit manuscripts – KT</td>
<td>Interpreting &amp; considering ‘whole’ ideas (Szto, Furman &amp; Langer 2005)</td>
<td>LWTR2 Finding Integration of self &amp; current life</td>
<td>What won’t help?  Why do these experiences help?</td>
</tr>
<tr>
<td>Action Cycles</td>
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<tr>
<td>Action Cycle 2, 3 &amp; 4 review, seek feed-forward information based on needs, reflect &amp; progress Longitudinal studies &amp; practice guidelines</td>
<td>More participants recruited Participants Reference Group formed</td>
<td>Multiple identities &amp; roles &amp; Chosen age &amp; gendered action as an interdependent midlife woman</td>
<td>Risk, being creative &amp; purposeful Resolve self-disciplined, responsible interactions for wellness</td>
<td>Transformation, trauma, crisis and growth</td>
<td>Reinforce &amp; practice asking for recovery support not alcohol support Make policy submissions &amp; media information Present at conferences, KT</td>
<td>Integration with reflecting &amp; triple loop constructive thinking (van Kouwen, Schot &amp; Wasslen 2008)</td>
<td>LWTR3 Freedom from seeking dependence</td>
<td>What is missing? Who, when, where &amp; how?</td>
</tr>
<tr>
<td>Action Cycle 3, 4 &amp; 5 review, feed-forward, reflect, feedback &amp; progress Study quantitative data</td>
<td>More participants recruited Case studies investigated</td>
<td>Commitment to abstinent action &amp; persistence to achieve valued goals</td>
<td>Aware of risks in the environment Historical circumstances, &amp; personal grief Resolve sharing socioemotional wellbeing</td>
<td>Transposition, decisions to change Prepare, review &amp; protect</td>
<td>Encourage exploration of potentials Prepare, review &amp; protect Lifestyle magazine stories, professional journal articles &amp; considering feedback, KT</td>
<td>Synthesis &amp; syntegrity (Thomas &amp; Harder 2008; Enrico 2004)</td>
<td>LWTR4 Midlife adult development supporting maintenance of abstinent recovery</td>
<td>Consider what else can assist in positive futures, how &amp; why?</td>
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<tr>
<td>Action Cycle 4, 5 &amp; 6 review, feed-forward, reflect, feedback &amp; progress</td>
<td>More participants recruited n</td>
<td>Perspective taking &amp; focusing on the important meanings in their lives</td>
<td>Risk in seeking to know their true selves</td>
<td>Commitment practice &amp; patience for personal valued action, &amp; sociocultural advocacy regarding alcohol’s place in communities</td>
<td>Prevention practice curriculum, clinical guidelines &amp; social (public) marketing ideas, KT</td>
<td>Holographic or nested whole-person health in a network with many connection (Edwards 2005)</td>
<td>LWTR5 Robust independence through long-term abstinence recovery</td>
<td>How to test theory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk in seeking to know their true selves</td>
<td>Resolve passion for the day &amp; intergenerational mentoring</td>
<td>Prevention practice curriculum, clinical guidelines &amp; social (public) marketing ideas, KT</td>
<td>Holographic or nested whole-person health in a network with many connection (Edwards 2005)</td>
<td>LWTR5 Robust independence through long-term abstinence recovery</td>
<td>How to test theory</td>
<td></td>
</tr>
</tbody>
</table>

**Key:** The Table represents an example of the application of the dynamic RWR design, methodology, mixed methods and tools that enabled reasoned, praxis-oriented research decisions to be made and recorded. Options and alternatives were considered amongst the multiple themes, processes and connections by participants and myself. Participants were in 10 categories: Women in Recovery, Practitioners, Experts, Communities of Practice, Practice in the Community, Expert Panel, Participant Reference Group, Contributors, Special Cases and Contacts.

With the RWR theory-building I focused on the women’s difficulty in ‘staying stopped drinking, maintaining abstinent recovery and wellbeing. The treatment and local working theories were also developed to deal with non-recovery, and provide a broader understanding of women’s alcohol dependence in the context of recovery in Australia; in particular the distorted attitudes and discriminatory processes that limited women’s AUDs healthcare (Pickett & Wilcockson 2010).

**Analysis techniques to assist in theory-building**

The RWR Pearl Matrix (analysis and interpretation techniques; Figure 4.4) introduced the Levels of analysis that assisted in theory-making. As a matrix there was a vertical process of Levels of analysis and a horizontal process of Action Cycle analysis to identify and explore the intersecting data. The intersections indicated important information for the theory proposals.
Intersection examples

Identification of dimensions – Key issues and contributing factors, e.g. discuss harmful self-beliefs to assist women to learn to care for self including negotiating with others about roles and expectations.

Revealing combinations – Connections, e.g. what factors help to maintain healthy balance, and bridge across important factors, e.g. self-transcendence and wellbeing, particularly in vulnerable individuals faced with difficult life challenges (Wayman & Gaydos 2005).

Specifics for differentiation – Compare, contrast and agreement amongst distinctions, e.g. more, less, male, female. Women are supported to share the emotion draining, physically demanding and time-consuming care for others (Langer, Rudd & Syrjala 2007).

Recovery context – An environment for growth or damage, e.g. as it occurred in a nurturing environment that supports and challenges the recovery learning process, facilitates transformation of meaning systems and develops competence (Lange in Michel Alhadeff- Jones 2007).

Meta-study – Level 4 analysis

The Meta-study (Table 5.2) provided further processes to question the dataset and the answers included information for local working theories (LWT). Of particular importance for LWT was the fourth level of analysis summarised below:

Meta-critical review – The outcomes are followed by the intervention and the research techniques applied to the meta-data (Table 5.2).

a) Outcome – feeling valued by self and others is important: Recovery support and self-care, (paradox, gestalt & psychodynamics; Doyle 2003)

b) Outcome – responding to the needs of others facilitates transcending from tremendous losses: integrated and individualised recovery health care and respite, (progressive focusing; Rhodes & Coomber in Miller, Strang & Miller 2010)

c) Outcome – love and the memory of love has meaning: Complex and chronic illness management with Recovery support, (conversational activity; Scharmer 2009; Crilly 2010)

d) Outcome – maintaining an active mind, body, and spirit gives meaning to life: Recovery development and decisions, (extended content & concept analysis; Hsieh & Shannon 2005).
Local working theories are statements based on the analysed data of RWR and associated literature that can improve the design of change processes for recovery and wellbeing. Literature that was meaningful (e.g. the seeking of self, self-care and self-in-relation perspectives of women’s development) emerged as being essential for care management of the women’s complex chronic illness (Satre et al 2005).

The RWR results, findings, and knowledge translation and Local Working Theories I affectionately called ‘Big R Recovery’ which became a central document for the tertiary education curriculum materials (Appendix 6.5).

Local working theories (LWTs) that can be applied to practice:
LWTs enabling the process of recovery change

The research involved discussing and reading about intimate life moments experienced by the research participants that illustrated their process of recovery change. Studying their experiences revealed the critical characteristics of midlife women’s ways of maintaining abstinent recovery. I conducted further transdisciplinary literature searches to gather related material and examined the work of selected scholars to explore their approaches to building theory from the ‘know how’ that emerged from their data. I then put forward research-informed practical propositions (local working theories) to the Participant Reference Group for feedback. With feedback I then refined the proposals by studying the difficulties the women named and explained, i.e. the local working theories became ways of overcoming the difficulties of recovery. Seeking wellness and wellbeing in abstinent recovery

The neuroscientific understanding of seeking (in relation to survival), as distinct from ‘liking and wanting’ (Damasio 2000; Panksepp 2004), is critical to explaining the women’s compulsive actions and their repetition (maladapted seeking and consumption of alcohol); and this provided a foundational idea for the Local Working Theories of Recovery. The absence of mental health, the languishing and indifference (which can also exhibit as angry and fearful reaction or listless loss of interest) is illustrated in descriptions by both the women and the practitioners. Many participants described ‘liminal states of being’ at the end of their active drinking as equivalent to Keyes’ (2003) explanations of mental illness: a disorder of quiet despair, states of apathy, hollow empty distress, and debilitating impairment. There is an absence of positive emotions, personal feeling and psychosocial
functioning. Using redirected seeking as a recovery change process, the women’s mental, physical and spiritual health can return with guidance and healing of mental functioning, productive activities, fulfilling relationships, and developed capacities for adaptation and resilience.

The dominant feature in my study of midlife women’s recovery change was their commitment to taking valued actions to seek to know their true selves and the important meanings in their lives. This feature was evident in the experiences described by all of the women participants. The five local working theories (below in italics) are written to enable healthcare practitioners and recovery supporters to help women with AUDs to establish and sustain abstinent recovery and wellbeing. Each theory is accompanied by an explanation with supporting references.

**Seeking wellness and wellbeing in abstinent recovery**

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women with AUDs to establish and sustain abstinent recovery and wellbeing. Each theory is accompanied by an explanation with supporting references.

**Local Working Theory of Recovery 1**

**Seeking volition to act as an intradependent self (LWTR1)**

Women being able to seek intradependence (without alcohol) by forming a strong core self; being abstinent through volitional self-discipline and respect; nurtured by developing internal awareness, positive purpose including self-care, and acceptance of supportive recovery care and development. (Withnall & Hill 2006)

The use of psychopathological and stigmatising language (e.g. denial, which participants described as aggressive) is an example of insulting, stereotypical labelling that limits healthcare engagement for midlife women. Working with suitable language (Glenberg et al 2005; Shanahan 2008; Coupland 2009) is an important practice in therapy, e.g. self-discipline rather than regulation and control is a more appealing term and an affirmative process to enable women's recovery. The choice of words contributes to enabling the women to seek assistance, maintain change in recovery, and change their attitudes and actions. Understood and accepted words create openings to people’s unconscious, especially in resting and calm feeling states.

Marquee (2002) recommends that screening and assessing techniques should focus on questions relating to the client’s life story. Asking only specific medical questions is likely to trigger high anxiety and false responses. The provision of useful integral and multi-modal information, which clients were able to present in response to ‘my life’, adds to the interaction. This can reveal important aspects of the client’s physical and cultural environment, and what is most meaningful to them. The exchange can then be used to design a more comprehensive, efficient and helpful client-focused, therapeutic approach.

In relation to the above local working theory, it is important that the women recognise, through practitioner guidance, that personal insecurity can escalate to distress when living conditions are complex and adult attachment is poor (Hankin, Kassel & Abela 2005). Most women with AUDs have a diminished sense of self (many of the women participants described an annihilated self and terror reactions)
while they continue to make intense efforts to function well. They often feel confused, disturbed and distressed, and try to maintain their sense of self through a childlike dependence (not support) of others. When dependence on specific people failed to meet the women’s perceived needs (which would often occur) alcohol was used to dampen disappointment and fear. The interpersonal contact usually became increasingly conflicted and more alcohol was drunk.

A person’s ability to differentiate self (Sutherland et al 2009), and to separate thinking and feeling states, is an essential learning for women establishing abstinent recovery. As John Shea notes, the self “is rooted and disclosed in a feeling. It is a felt sense of depth. It has its own clear boundaries and exists in intimacy and it is its own responsible process of experiencing” (Shea 2003 p23). The journey to begin recovery change, requires women coming into the body as self, experiencing mental functions and affect (Fonagy, Greely & Jurist 2003). A safe environment assists working through the process of conscious (in the present) vital living. Initially this involves greater self-care, and developing better skills for coping with feelings (senses and emotions; Sideridis 2006). Eventually women in recovery develop into mature women competent at handling complex life matters and possessing a well-developed understanding of self and soul.

Meeting the needs of midlife women requires an emphasis on quality recovery care supported by practitioners with contemporary professional development. The matters to be explored, as identified by (Wiklund 2008b) are demanding:

1. The safety and time to create a new frame of reference for interpreting life, through which there is restored dignity and a sense of coherence:

2. The concept of community and attachment to community:

3. Confirmation of the reality of life and death:

4. Acceptance of the need to change, as part of a process of adjusting, with free choice and in a positive manner;

5. The notion of forgiveness and reconciliation: and

6. Building on comprehensibility, manageability and continuity.
Through this type of comprehensive recovery care, practitioners focus on supporting women’s individual values and processes for establishing volition, which can enable them to maintain a personal agenda for abstinent recovery.

**Local Working Theory of Recovery 2**

**Finding integration of self and current Life (LWTR2)**

Women seek the experience of being whole integrated core selves, as healthy abstinent individuals (exhibiting clarity and consistency about their own mind, body, spirit and congruent core self); interacting with current life situations, and engaging in interdependent actions with selected others in ways that support their abstinent recovery development (their stable mental states of thought and feeling resulting in positive actions). This leads to chosen identities and roles being pursued with recovery support. (Withnall, Hill & Bourgeois 2007)

General Practitioners facilitating reality checks for midlife women (e.g. recognising impending or unlikely threats to the self) is uncommon. The women more often have to faced growing distress alone (involving fear and anger) and seek relief through alcohol. Women’s avoidance and deflection of individual scrutiny (Cornwall 2007), and their hypersensitivity around perceiving themselves as ‘shameful alcoholics’, can begin to be identified with guided discussion about sensing, thoughts, feelings and actions, and the positives of recovery. Most importantly, for women to establish and maintain abstinent recovery they must better understand and appreciate the affect processes (involving emotion, memory, mood and motivation) that provide the instinctive energy of seeking.

With gentle care (acknowledging midlife women’s vulnerability) and encouraging respectful discussion the women can become open to the knowledgeable support and guided practice of practitioners and peers and learn from their ability to heal and be healthy. This can enable women to develop their own understanding of their individual reality (Jenkins 2001; Chávez, Guido-DiBrito & Mallory 2003) and volition to make wise choices (Bastian 2004; Scholz et al 2008). The women become able (and feel worthy enough) to discuss with peers in recovery possible actions, capabilities and attitudes. This is critical to experiencing self-nurturing affect, learning from it, and seeking and developing an identity that is true to their core self. Stephens (2009) suggests that we need to be aware that we have a subjective identity (part of our self-image) that can then develop into an improved new identity with
changed patterns of activity (identity in action). This is what is involved in recovery
integration; the women are transforming their identities through the activities of the
recovery change process.

Therapy can enable the women to explore their mental capacity for emotions,
attention, motivation and reasoning to plan and implement actions that can foster
their sustained health and wellbeing (Cacioppo et al 2000; Cacioppo, Hawkeley &
Rickett 2005). Through caring conversations, the women can begin to explore new
meanings, which can, in turn, enable them to perceive and alter their attitudes and
engage in life-affirming new experiences. This invariably includes effectively
questioning their gendered roles and the nature of their current adult relationships
(Rochlen & Mahalik 2004). People take up roles defined within their society and join
groups within which there is a culture that provides shared interactions and
meaning (Burke 2004). One’s unique identity is sustained through such biosocial
interactions. However, social and group identities carry expectations of reciprocity
and responsibility. Women in recovery can be supported in their choice of roles, and
in their group and personal interactions to continue to verify the positives of their
non-drinking core self as freedom to be oneself (a core-identity) and to act with
responsibility.

Local Working Theory of Recovery 3

*Freedom from seeking dependence (LWTR3)*

Women seeking conscious critical reflection and guidance to enable personal cognitive and affective integration and an ability to take a broader, yet self-disciplined, perspective to consider midlife personal and social objectives; being alert and attentive to the particulars of the current supportive non-drinking situation, their right to make personal choices not to drink, while becoming aware of past contributing factors to ‘needing’ a drink. (Withnall, Hill & Bourgeois 2008)

Women in recovery learn to interact (initially in an interpersonal way; Hargraves 2006) using their integrated core self and their developing emotional wellbeing. The five principles of change in the emotion domain for wellbeing that can be used in treatment are: “emotion awareness; expression; regulation; reflection on emotion; and the more novel principle of emotion transformation, by which emotion is changed by emotion” (Greenberg 2008 p49). With time, effective facilitation and
encouragement, the women can practice reflexive appraisal of 'sense of self', personal identity and their own boundaries when being with 'others' (Kartalova-O'Doherty 2010). Clarity on personal states of being, ‘being with’ and ‘connecting with’ other people emerges. The women realise that they can choose with whom they interact, and be able to prepare for possible negative interactions (McCrady et al 2009). Such abilities are further extended with recovery support through the development of self-discipline and self-management in social settings, and use of their social intelligence (Bar-On & Parker 2000; Goleman 2006).

The women’s cognition and affect integration supports affiliation and association processes in their socio-emotional relationships (Greco & Stenner 2002). I would add the emphasis that people seek positive interactions (and affection exchanges; Floyd & Riforgiate 2008) by being with and communicating with others. Also, women can be enabled to learn better thinking styles, to replace their previous limiting dichotomous thinking, ruminating (Egan et al 2007) and ‘care-as-worrying’ (Van Manen 2002). With guidance, the women can be introduced to constructive thinking to support positive actions (Epstein 1993), and divergent thinking to bolster creativity (Runco 2004). They can be supported in developing techniques for improved planning, through confidence-building and ‘reviewing of past errors’ (counterfactual thinking; Epstude & Roese 2008). Midlife women exploring such mature, adult capabilities are rewarded with critical reflection (Boud & Walker 1998), and can reconsider their attitudes and standards (Hofmann, Fries & Wiers 2008), along with their choices and decisions.

Practitioners will be better prepared to help women who are exhibiting conflict, fear and anger towards themselves and others by drawing upon the following theories: Perception Control Theory (Powers 1973, Mansell 2005); Affect Control Theory (Heise 1979); and Identity Control Theory (Burke & Reitzes 1991). My detailed discussion about the terms ‘control’, ‘agency’ and ‘regulation’ which arouse negativity in midlife women in early abstinence (Chapter 5), Choice (Carey 2002; Carey 2005) and self-discipline are preferred recovery words for midlife women. Detailed discussion of therapy techniques for choice-making that are suitable for midlife women, is found in Mansell and Carey (2009), for personal change and recovery in Higgenson and Mansell (2008), and action control in Sniehotta and Sharwzer (2006). Participants in my study, both women in recovery and practitioners, reported that the recovery processes enabled a change of perspective.
The compulsive need to ‘do’ and ‘have more’ also became less necessary, which further reinforced the worth of abstinent recovery and not drinking alcohol.

In midlife, the complexity (Walby 2007; Casti 1994) of the chronic illness and alcohol-related contexts (Krank et al 2005) in the women’s environment brings complications, and I suggest that to address this further work is needed by practitioners and their clients on emotion, status and power (Kemper 2006). The Power-Status Theory of Emotion is a deceptively simple formulation about what people do to, with, for, and against each other in social interactions. It is possible to generate quite complex examinations of emotions across a very broad spectrum of social situations.

Effective social relational actions (interactions) are usually about finding social balance and belonging (safety and security towards freedom and less fear and anxiety towards justice). New situations for women in recovery can raise anticipatory emotions, and during and after actions, consequent emotions in categories labelled excessive, balanced and inadequate. As an example, perceiving excess can generate the emotion of guilt; balance can generate feeling satisfied, contented and happy, whereas perceiving inadequacy generates feelings of shame and embarrassment. Explaining such a process when women are in treatment can help them begin to resolve their histories of threat and violence.

People use heuristics (expected patterns of action) in new social situations and gauge the power and status of others based on the roles and actions they observe. Women and men sense the emotions that accompany the environment they enter (which Kemper [2006] calls structural emotions) that can cause confusion and are experienced as anxiety. People exposed to deprivation and abuse can carry their particular heuristics, which may be different from or clash with other people’s readings of a situation. This is often a difficult area in therapy, yet working at the woman’s pace can answer questions around her distress and the dysfunction she exhibits in the normal course of ongoing interaction. Why such women see destructive outcomes of future interactions and develop low expectations begins to make sense as the reactions are based on past power and status outcomes and their manner of preparing for future events using negative power and status contingencies. Together, structural, anticipatory, and consequent emotions provide
a comprehensive account of emotions, and relatedness in social life. Clarity about personal power and status is critical to women’s emotional and relational wellbeing.

Practitioners can consider moving their case management of women maintaining recovery towards a client-practitioner shared management approach (Recovery Management Checkups; Rush et al 2008). Practitioners focusing on client-centred strategies with links to community resources (e.g. Expert Volunteers) and other treatment services coordinated by practitioners remains essential (Cochrane Review; Hesse et al 2009). Styles of engagement that may be used over time in the therapeutic relationship include: brokerage case management, which sets out to help clients identify their needs and broker services in one or two contacts; intensive case management with closer interaction between case manager and client; assertive community treatment providing assertive outreach and direct counselling services; and strengths-based case management focusing on self-direction and the use of informal networks rather than agency resources by applying active outreach. Negotiating entry for women to psycho-education, development programs and brief interventions at life ‘turning points’ may also be initiated by client or practitioner over the women’s lifespan.

With effective therapy the women’s ‘self’ (which includes being a non-drinker) then offers valuable information (via bodily feelings, phrase or image flashes, and first thoughts on waking) of the congruence of plans and actions the women have chosen. Women feeling incongruence, regardless of whether it’s positive or negative, are likely to experience emotional stress (Chaplan Hong & Bergquist 2008) which, when left unexpressed, leads to damaging negative physical and psychological effects (McEwen 2007; Irwin 2008).

Engaging in negative self-evaluation and rumination (Sneed & Whitbourne 2003) needs to be taken as a strong signal for the women to talk with nominated recovery supporters. The women participants consistently reported being aware when their ‘thinking changed’ and when their level of ‘self-talking’ (trying to work out the excitement, unease or conflict by internal discussion) rose. Peers can empathise, and explore why the women were prompted to take necessary self-care action. The importance of dialogue (Bahl & Milne 2010), or the less formal word conversation, often needs reinforcement with midlife women who have entrenched behaviours of
isolation. Talking about the word conversation (with the root terms being *conversari* – to live with – and *conversare* – the act to turn around) can create a starting point.

Repetition is essential to counsel women to engage in discussion when feeling unease. Their acceptance (Hayes et al 2006) of their present (very) anxious moments, through support and realistic expectations (Grunwald 2008), are critical processes that need to be a daily routine. Helping the women to maintain established abstinent recovery (being aware and attentive; Weick & Putnam 2006) in times of being uncertain, while considering change, experiencing crises (Lachman 2004b) and trauma (Brown 1994; Harris, Fallot & Berley 2005; Mills, Teesson & Ross 2006). Time heals assisted by rest and personal determination, supported by volition. Leisure, the joy of natural beauty and non-competitive fun encourages women to keep regular appointments. Maintaining contact with mutual self-help groups to relax and learn more effective positive routines (constructive social relationships; Gifford et al 2004, 2006, posttraumatic growth; Tedeschi & Calhoun 2004; Kendall-Tackett 2009, and productive and pleasurable outcomes; Hood 2003; Bartels et al 2007).

**Local Working Theory of Recovery 4**

*Midlife adult development supporting maintenance of abstinent recovery (LWTR4)*

*Women seeking knowledge and experience to develop an independent life direction, new mid-to-older lifespan capabilities, and stability through interdependent support for learning transitioning skills and transformation processes: women continue to draw strength from abstinent recovery affiliations, and to develop mature adult relational abilities including ecological relatedness. (Withnall, Hill & Bourgeois 2009)*

Practitioners can support women in developing independence by helping them to improve their awareness of their abilities and potential in midlife. Through conversation, associated practice and educational endeavours (using suitable approaches of situated learning; Lave & Wenger 1991), and enactive adult learning environments (Davis & Sumara 1997), the women’s capability in abstinent recovery evolves to leave behind the entrapment of drinking, maladaptive relationships, and onto considering purposeful life directions. The women commented on the relief.
they felt when they decided to put aside their simplistic and obsessive struggles around ‘needing and wanting’ to pursue meaningful rather than ‘driven’ goals.

Exploration of combining reasoning and affect, particularly mood, attention and memory (Bowen, Block & Baetz 2008; Kelly & Masterman 2008) can be challenging and exciting. Learning about intelligences (including fluid intelligence – working with novel information, and crystallised intelligence – considering the cultural meaning of information; Thorne & Kirkham 1997; Allen et al 2004) also brings appropriate satisfaction and realisation of personal achievement in the difficult processes that can support sustained recovery.

Participants in long-term recovery referred to their spiritual development through recovery as a vital ‘ever-present’ resource that helped them to gain perspective on current events. Spiritual intelligence refers to what human beings do with their deepest-held spiritual beliefs and values, whatever the doctrine, wisdom or tradition (McCormack & Titchen 2006). Zohar and Marshall (2000) and Titchen and Higgs (2001) suggest that spiritual intelligence enables people to address and solve problems of meaning and value, and to place their actions, lives and pathways in wider, richer, meaning-giving contexts. People can use their deep, intuitive sense of meaning and values to guide them when they are at the boundary of order and chaos. It allows them to discriminate, to aspire, to dream and to uplift and energise themselves. Spiritual intelligence lets people consider their priorities, work within their boundaries, explore the unknown with support and thoughtfully shape and transform situations.

My study revealed the key features of women’s transitioning abilities (Loon & Kralik 2005a) and transformative learning (Merriam 2004; Cranton, Dirkx & Gozawa 2006; Erickson 2007; Brock 2009) processes. The importance of holistic and integrated care emerged as being essential for women and their supporters to continue transformation processes to become well and maintain and sustain recovery. Integrated therapy that crossed specialisations (Stanfield 2003; Matto 2005; Amodia, Cano & Eliason 2007; Lubman, Hides & Elkins 2008), combined with integrated service provision in the health system (Boyle et al 2004; Fallot & Harris 2005; Smith & Clarke 2006; Pettit, Grover & Lewinsohn 2007; Andrew & Halcomb 2009; Greenfield et al 2010) is presented in the literature and needs to be implemented and accessible for midlife women to sustain abstinent recovery in
Australia. Sharing action, such as women involved in recreation and pleasurable pursuits (Kluge 2007), requires prompting, and perhaps practitioners providing explanations of ‘fun, adventure and play’ as being basic human transformational techniques (see playfulness earlier in the chapter).

A realistic, interrelating and consistent authentic self (Madden 2005) takes time to develop. Practitioners can continue to encourage and guide the women’s new ‘flexibility and constraint’ choice-making ability (considering what attracts personal attention, then following on with an ‘I wonder’ discussion with recovery supporters before acting with self-care; Withnall, Hill & Bourgeois 2010). Women using this basic planning process can work towards self-initiated positive change in their lives. Practitioners can update their knowledge on decision-making to assist midlife women in their recovery psycho-education. Humans have a multiple, interacting neurobiological system of decision-making that combines: the planning system, a habit system, and a situation-recognition system (Redish, Jensen & Johnson 2008).

Women with AUDs feel uncomfortable and vulnerable when using decision-making systems as they have developed alternative neural pathways associated with their addiction behaviour choices. Therefore it is essential for them to learn about the following 10 potential starting points that can drive maladaptive choices, so that they can be managed in abstinence (dependence vulnerabilities; Redish et al 2008). Each person will have different vulnerabilities at different levels of severity at different times in their lives: “(1) moving away from homeostasis, (2) changing allostatic set points, (3) euphorigenic ‘reward-like’ signals, (4) overvaluation in the planning system, (5) incorrect search of situation-action-outcome relationships, (6) misclassification of situations, (7) overvaluation in the habit system, (8) a mismatch in the balance of the decision systems, (9) over-fast discounting processes, and (10) changed learning rates” (p 415).

It is encouraging to know that even though the brain may suffer transient change, as well as permanent change as a result of alcohol consumption, abstinence can bring some ‘restoring’ of higher brain function and ‘re-priming’ (i.e. creating new neural pathways [Goldman in Miller 2000]) through recovery action in many non-drinking environments). However, as people age, or return to drinking any amount of alcohol, this ability for neurogenesis (Harper 2009) deteriorates as more cells (particularly brain cells) are killed, become damaged or mutate. Overall, there are positive
outcomes for sustaining abstinent recovery: midlife women, as independent adult women, become confident in seeking advice, planning their life and voicing their opinion in order to set their own recovery and wellness goals and proceed to take action in a committed manner.

The amount of detailed understanding required by addiction practitioners can be daunting, and fortunately computer systems to assist with client-practitioner therapy are being developed. An example is a software program to support shared decision-making, which has been trialled in a United States outpatient clinic (Deegan et al 2008). With peer-supporters assisting, clients (with severe mental disorders) in the waiting area create a one-page computer generated report (ticking boxes for those aspects of their psychopharmacological treatment they want to discuss) during their consultation. The preliminary results show the clients’ willingness to use this facility, and to discuss and comply with agreed treatments. The concept of ‘E’ health records being updated through such agreements would also be useful for parallel team care of a client, and be beneficial for the client when in distress, fatigued or embarrassed by verbalising or forgetting details when retelling their medical history and life events with new practitioners.

As women progress from maintaining recovery to sustaining recovery, relatedness comes to be understood as more deeply knowing the connections of their lives and interacting through them (with others, places, objects, events and history, even their own genes). This is a critical competence refined by action. Developing abilities for empowering ‘relatedness’ is a stepped process beginning with autonomy (the experience of acting with a sense of choice, volition and self-determination) then with competence (the belief that one has the ability to influence important personal outcomes; Sheldon, Arndt & Houser-Marko 2003). Empowering relatedness is the experience of having satisfying and supportive relationships in a sustaining way for all (everything involved), and it importantly enriches personal internalisation and integration that is conducive to health and wellbeing. For midlife women in recovery and their supporters it is a difficult and a productive endeavour using women-oriented research and practice (Covington 2000; Josselson 2003; Salmon & Hall 2004; Bowker, Rubin & Burgess 2006; Larkin, Woods & Griffiths 2006; Burk, Steglich & Snijders 2007; Mikulincer 2007; Vail & Xenakis 2007).
Satisfying relationships for midlife women often involves a complex ‘unlearning’ of misinformation and myths of ‘women and relationships’. Practitioners and clients can draw upon recent relevant research that addresses sex and gender difference in identity (Padilla-Walker et al 2008). The contemporary understanding of female, male, and age differences in the following emerging interdisciplinary fields has also identified misconceptions: the affective sciences (Davidson, Scherer & Goldsmith 2003), social neuroscience (Kessel, Rosenfield & Anderson 2008), developmental neuroscience (Goldsmith, Pollak & Davidson 2008), social cognitive and affective neuroscience (Steptoe 2010) and the re-emergence of neuroscience in psychosomatic medicine (Lane et al 2009). This vital knowledge can help us to improve the care of midlife women with AUDs who have Early Maladaptive Schemas (EMS) formed in childhood (Alwin et al 2006). EMS are activated throughout life by schema-relevant events and they generate disruptive emotions that interfere with core needs for self-expression, autonomy, interpersonal relatedness, social validation and social integration; all of which are central to one’s ‘sense of self’ and wellbeing as a mature adult.

Many women in recovery participants spoke of their difficulties with intimate relationships and their changing marriage and partnering roles. Marital unhappiness generally takes a greater toll on the health of wives than husbands, with unhappy wives having higher levels of cholesterol, depression, and alcohol abuse (Crawford & Novak 2005). Women’s experiences in the 20th century with concepts such as sacrifice, forgiveness, sacred vows and commitment (traditional marriage views based on religion, patriarchy, economic dependence, and procreation) often results in suffering and pain for the women and those closest to them (Hill 2007). As women in recovery, their ideas and expectations of partnered love had changed and their understanding had grown through their personal and social learning involving the development of mature interaction skills such as: acting respectfully, good communication, honouring equality, providing reliable interdependence, making agreements on priorities (e.g. work or family life), developing emotional intimacy, thoughtfully negotiating and decision-making on lifestyle choices, discussing sexual satisfaction, enjoying companionship, and being open about self-fulfilment. These capabilities were important goals in the women’s recovery work. However, as the women aged, priority was given to not being in an intimate relationship if there was limited or no understanding by the ‘partner’ that:
1. the women’s abstinence was essential;

2. self-care and honest personal effort towards the same or similar outcomes was necessary; and

3. an open-minded acceptance of personal spiritual growth and/or meaningful life purpose (i.e. peace of mind and harmony) for long-term relationships.

Understanding ecological relatedness (Capra 1996; Davis & Sumara 1997; Van Leeuwen et al 1999) can help to clarify long-term recovery perspectives on independence, interdependence and intradependence, and healthy dependence for both practitioners and midlife women working with recovery care, development and support objectives. The creation of ecological models of human development (micro to macro-relationships; Bateson 1979) to represent reality, allow people to better consider complex circumstances, devise multiple approaches and take prioritised action in manageable ways. In this way the influence of families, neighbourhoods, and communities can be considered without losing sight of the needs of individuals, including oneself (Reifsnider, Gallagher & Forgione 2005).

Awareness of the macro-relationships between the individual and ‘living on earth’ (the diversity, structure, function, connections and processes in nature that influence human systems and the individual; Mulligan & Hill 2001) provides knowledge for questioning life directions. This includes how lack of forethought about the ways in which actions in human systems are interrelated with nature and individuals often result in unintended consequences and extensive side-effects, and it highlights the need to comprehend and appreciate the reciprocity of our actions. The multiple scales of interrelated systems, from the cosmos down to the nano ‘worlds’, from a hospital to a person in an out-patient program, requires collaborative efforts to work, learn and achieve together. This is in the service of our common need to share knowledge, explain, illustrate the complexity of our lives, and contribute to the connected, dynamic and non-linear nature of living systems. The ecological relatedness approach also supports values of social and environmental justice, which gives primacy to the needs and interests of those situated at the bottom of the vulnerability chain. With addiction clients, this can extend to the value of self-determination; broadly defined as the capacity of individuals and groups to play an important role in charting their own courses. This is similar to efforts in
community psychology to ‘re-claim’ a social justice agenda, as opposed to the ‘at risk’ and risk behaviour models so popular today among the prevention scientists (Rappaport 2005).

My study was informed by collective knowledges of the participants and such fields as: social ecology (Hill 2006, 2011), clinical ecology (Randolph 1966), ecology of mind (Bateson 2000), ecological psychology (Gardner 1979), eco-epidemiology (March & Susser 2006) and whole-system health (Levins 2009). The evolving work on an ‘ecology of mental disorders’ and interest in age-period and cultural cohorts hold promise for improving the care of midlife women. Based on my findings I have proposed an ‘ecology of recovery’ (Chapters 4 & 5) as a reciprocal contribution to the evolving collective knowledge.

It may provoke controversy. It may make people we approach uneasy and even angry. It requires patience, imagination, courage, integrity, and a sense of humor. (Levins 2009)

Addiction is a contextual and socially constructed term. It is dependent on the policy implications of the behaviour and on the social disapproval of the said behaviour (Griffiths, Horsfall & Moore 2007). However, there are other behaviours that are maladaptive and socially disapproved of, but that are not addictive. One thing that is clear from the commentaries is that few people seem to agree on the core features of addiction, alcohol dependence and recovery. This is part of what makes addiction such a difficult and controversial research, policy and evolving healthcare issue. I believe that my view on seeking recovery, enabling individual capabilities and strengthening vulnerabilities may contribute to common features of living well in recovery. Theories in 2012 ranged across natural recovery (Boschloo 2012); partial
recovery (Colrain, Padilla & Baker 2012); harm reduction and new recovery (ANEX 2012); correlates of recovery (Dawson et al 2012); the importance of empathy, support and spirituality in recovery (Kelly et al 2012); and multi-dimensions of recovery care (Timko et al 2012).

My final Local Working Theory of Recovery is a synthesis of the previous four working theories. The theories are based on my research (studying experiences of the participants) and associated transdisciplinary results and findings to assist wise practice. Creating and finding the processes of care needed for midlife women with AUDs to move into abstinent recovery and sustain that ‘in recovery’ status was the goal. The explanatory notes (for each theory), provided below, can help practitioners and the women in recovery by providing them with access to evidence-based approaches to improve healing, wellness and wellbeing. The theory briefly proposes a way into AUDs and, more importantly, a way-out of active addiction to alcohol by enabling improved abstinent recovery care and development, with recovery support for midlife women.

Local Working Theory of Recovery 5

Robust independence through long-term abstinent recovery (LWTR5)

Midlife women in abstinent recovery are seeking independence, mature living abilities, vital relationships and personal truth. By women receiving recovery care to assist them to recognise their misguided seeking of self through alcohol consumption (a maladaptive, fearful and punishing action), the women become well through healing and abstinence, which provide a self-valuing and a nurturing recovery foundation. Recovery change processes, facilitated by people with knowledge of AUDs recovery development and support, guide women to increase their autonomy, authenticity and self-actualisation: a healthy facilitation of intradependence and interdependence to achieve independence. The paradox of women experiencing active alcohol dependence in a naive attempt to be independent is also a sociocultural failing which can be addressed through easily accessible women-oriented AUDs recovery care, development with recovery support. The seeking capability for sustainable self-care (and accompanying epigenetic change) that the women develop through abstinence and recovery can also enable them to develop relationships through which they share their experiences of responsible wellness and resilient wellbeing. (Withnall, Hill & Bourgeois 2011)
A practitioner’s mode of care has moved from the protective approach to supporting women’s productive and purposeful action (Oakes 2008) to reach their self-managing potential (with reflective self-exploring, and healthcare monitoring). Practitioners, supporters and ‘concerned others’ can help the women to perceive important objectives of stamina (bodily), persistence (mentally) and reflection (insightfully/spiritually) that continue to develop transformation and transposition capabilities (transposition is a combination of creativity; Plucker, Beghetto & Dow 2004). The women’s new perspectives to progress recovery change and pragmatic explorations of possibilities in recovery (with strong support networks) are healthy ways to wellbeing.

Updating practitioners on epigenetic change to share contemporary evidence-informed hope with women in early recovery is a critical step in professional development to improve healthcare outcomes. With recovery care for healing, ongoing abstinence through recovery development and support, long-term recovery can bring a physiological and mental change that reduces high stress hormonal release, which previously contributed to the women’s increasing consumption of alcohol. DNA sequence change and gene/environment modifications to inherited and acquired genes (Mehler 2008) can occur with abstinence and in recovery living (environmental enrichment for adult central nervous system change; Sweatt 2008).

Early adversity (Douglas et al 2010) and life-course traumatic events can result in an abnormal HPA axis function and alter gene expression in the brain (Caspi et al 2003). Recent sex difference studies suggest that an intersection of genetic and gonadal hormone influences provide complex contributions to vulnerabilities to stress-related diseases, including affective disorders (Holmes et al 2005) and drug addiction (Becker et al 2007). This foundation and women drinking alcohol to self-medicate, coupled with their increasing inability to function with stress stimuli as a result of increasing abnormal hormone release, primes the women’s need to increase alcohol consumption and can result in addiction (AUDs). Being biologically female brings a predisposition to risk as does being female at different ages when physiological and neurobiological transitions occur (McEwan 2007, Mann et al 2005). Being female, in peer and familial alcohol consumption environments as gendered social contexts, often lead over time to women’s high-risk drinking (Kaminsky, Wang & Petronis 2006).
... that females basally show an exaggerated sensitivity to stress and that if additional dysregulation occurs (such as may result from prenatal stress, maternal PTSD, or a combined impact of stress and gonadal hormones on brain development), this would push females over a ‘disease threshold’ making them more susceptible. (Becker et al 2007 p 11853)

Studies of people with depression (a likely combination with AUDs) and suicidality (Pompili et al 2010) are revealing useful and hopeful information for women with mental disorders (Sjöholm 2010). Over time, practitioners using evidence-informed practice can enable women to reduce their allostatic load set-point, often with peer support as the women gain experience in dealing with difficult circumstances. For people with AUDs, the set-point may reduce, but neural pathways for dependence remain. New neural pathways are laid down in abstinent recovery and the women establish new habits and continue to use new personal standards for healthy living. Being ‘in recovery’ is then an active process throughout the lifespan, because of our body memory and conscious and non-conscious memory. We are the embodied sum of all of our life experiences.

At the beginning of the sustaining recovery phase, it is recommended that practitioners start the process of offering care options, and negotiating and preparing for preventive care. Through this dialogue, respite opportunities, personality development issues (Finn 2009), changing treatment approaches (Hildebrandt et al 2010) and co-occurring disorders (Östlund, Hensing & Jakobsson 2007; Mills et al 2009) can be re-assessed. Through the options discussed in an assuring therapeutic space, the women’s individual pathways to sustainable wellbeing emerge. Currently a treatment aftercare plan can be offered, and the notion of avoiding a return to unhealthy ‘old feelings and thinking’ and ‘old behaviours’ and ‘relapse’ can be discussed (Marlatt & Witkiewitz 2005; Zywiak et al 2006; Kamberouropoulos & Staiger 2004; Sun 2007; Neto et al 2008). Based on my research results, a more affirmative, preventive and potential development approach is now available and desirable. A chronic illness management plan (Watkins, Pincus & Tanielian 2003; Krampe et al 2006) offers positive progression to meet midlife women’s ongoing lifespan needs. Importantly, the women are monitored regularly and there is discussion on: health assets and resources (Rotegard et al 2010) for midlife; ageing and women-oriented wellness; and their commitment to, and experience of, a strong recovery support network.
For effective long-term recovery change, midlife women need to develop their interdependent and independent identities (Hill 2003; Sneed & Whitbourne 2003; Nikander 2009) and roles (Magovcevic & Addis 2005; John et al 2008) that are coherent with their understanding of an intradependent core self. The making of suitable choices and decisions, followed by conscious and consistent actions to which the women can be committed, builds patterns of mature, adult self-respect and responsibility (Smith 2005). Such achievements can provide transformative power for the women in their difficult life circumstances and when seeking wellbeing. Ultimately, their seeking in recovery becomes wellbeing in recovery: a flourishing (Hart & Singh 2009) of becoming ‘true to self’ as a mature abstinent adult, living a new way of life with selected values, options and capabilities. The ‘others’ in the women’s lives also reap great benefits from their association with authentic, independent women (living in abstinent recovery) who are attentive and connected in vital ways (Masters & Carlson 2006).

The women participants, having from two to 31 years of abstinence, emphasised that abstinent, long-term recovery was their first priority in being a whole person living in a purposeful and joyful way. The participants explained that the critical factors for robust midlife recovery change and progress are: acceptance of abstinence for the long-term, trust (Glass 1977), openness to the dynamics of ‘the present’ through participation in active recovery (Resnicow & Vaughn 2006), and gratitude for ‘where they are at’ and for the inspiration provided by other women in recovery. Practitioners emphasised that it was the women acknowledging their non-drinking choice of abstinence (Dawson, Goldstein & Grant 2007) and their supportive relationships that most enriched the lives of their clients. From my findings, I would add that the women’s long-term recovery involved the processes of ‘being’ in harmony with people and their life circumstances. Attention and care was occurring in a network of supportive peers (Willenbring 2007) of their chronic health condition of alcohol dependence (Edens et al 2009), likely co-occurring physiological illness (Sacks et al 2008), and comorbid psychological disorders (Hesse 2009; Mills et al 2009). The peers helped each woman with critical and nurturing self-appraisal, through conversations that supported the woman’s volition (West 2005) to take the needed small meaningful steps of change (Kearney & O’Sullivan 2003).
Networks of stable affiliations are critical for midlife and older women. Smith-Doerr and Powers (2003) indicated the importance of webs and networks of people (as domains of exchange; Christarkis 2004 & 2008); these can provide valued social networks for taking a health and wellbeing approach, and Wilton and DeVerteuil (2006) have described and emphasised the importance of having access to groups of people in ‘healthy’ spaces that can provide opportunities for wellness (Conradson 2003; DHA 2008; Jayne, Valentine & Holloway 2008). I am confident that my approach of using a ‘WmSpace’ and an ‘ecology of recovery’ approach can provide for women’s needs through role modelling and the provision of a safe environment for experiential learning on recovery competence, relatedness and autonomy. The research participants described incidences of striving for truth, integrity, understanding of others, as well as demonstrations of love in their self-help and therapy groups. What was described was similar to the support of a ‘collective mind’ through heedful interrelating (Weicks & Roberts 1993, 2003), accumulating information and monitoring each other for achieving a common purpose. The female only groups also provided the basis for developing a female non-drinking cultural memory (memes; Dawkins 1993; Sartika 2004).

5. **Barriers to sustaining abstinent recovery**

Barriers to Sustaining Abstinent Recovery, ways to Resolve Surface factors, and ways to Resolve Underlying factors are summarised in Table 6.3. Boundary spanning is an approach (Koskinen 2008) that helps to breakdown the complexity of a barrier, to identify different perspectives on the matter, and assist with a more informed understanding of the level at which issues can be resolved; and to identify the people involved and the correct role and organisation to place responsibilities for positive action. Spanning is also required, as integration of actions make achieving removal of barriers more likely. Removal of barriers in addiction and mental healthcare is a likely and a complex scenario. Priority actions are ‘caring, preparing and the likelihood of learning new competencies, meeting new people who are intermediaries and working with concrete and ambiguous content and processes.
Table 6.3: Actions to enable women to sustain recovery

<table>
<thead>
<tr>
<th>Barriers to Sustaining Abstinent Recovery</th>
<th>Resolutions – Surface or short-term factors</th>
<th>Resolutions – Underlying or long-term factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate recognition of the severity of midlife women’s AUDs; the growing number of midlife women who are in need of safe access to women-focused, professional understanding and AUDs complex care; attending unaware health practitioners (themselves in need of education and support to meet midlife women’s AUD recovery needs)</td>
<td>People with responsibility and authority to provide plans for system-wide midlife women-specific treatment with the goal of abstinent recovery for wellbeing. Leaders promoting abstinence goals in midlife as part of the AUDs treatment continuum and a relevant option in an inclusive harm minimisation policy</td>
<td>Women culturally supported to seek help with misuse earlier in life and practitioners empowered through further professional development to respond to those seeking help for AUDs chronic illness. Public discussion extended by sharing lived experiences of ways to redress midlife women’s vulnerable self-concept and worth, stories of compassion and humour when learning about midlife development for women</td>
</tr>
<tr>
<td>No planned engagement with midlife women’s need for AUDs healthcare in current policy or strategy documents including access, women-focused treatment, retention, therapy completion, ongoing support and outcome monitoring. Professional magazines and websites unlikely to address (as case studies) demeaning and excluding practices (rejection) reported by AUDs clients</td>
<td>Screening midlife women with ‘stress’, emotional instability, low mood and fatigue for alcohol misuse using a ‘two question’ non-intrusive approach. Advice on toxicity of alcohol, damage to women’s bodies and life consequences with reminders of drinking a maximum of two drinks. Provide a set appointment for women misusing alcohol, with self-care and no-alcohol days/weeks priorities, techniques for dealing with stress, ‘blooms’ results discussions and adult self discovery goals</td>
<td>Promote that time in treatment is a positive contributor to removing resistance to abstinent recovery. Instigate recovery development and recovery support training for practitioners and expert volunteers to support establishing abstinence and maintaining recovery. Focused campaign to reveal advertising messages targeted at women and at the same time promote that not drinking is a legitimate choice at any time, including sociocultural events.</td>
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<tr>
<td>Barriers to Sustaining Abstinent Recovery</td>
<td>Resolutions – Surface or short-term factors</td>
<td>Resolutions – Underlying or long-term factors</td>
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<td>Critical lack of contemporary knowledge about specifics of midlife women AUDs and abstinent recovery in context: female epidemiology, psychosomatics of affect, sociocultural and environmental factors, and biopsychosocial consequences; and little awareness in primary, community and hospital services of AUDs recovery approaches.</td>
<td>Collate contemporary research and clinical practice; establish women and age subpopulation evaluations of interventions; initiate midlife trials and integrated follow-up monitoring and evaluation of women’s lifespan development approaches for maintaining abstinent recovery and continuing healthcare provided Update practitioner understanding of neuroscience of affect. Highlight need for practitioners to validate and respect emotions and emotional intelligence-related capabilities of clients.</td>
<td>Partnered research in practice to consider integrated care of AUDs pathophysiology and pathopsychology in context (Australian society, especially middle income families); also women’s long-term complex care and support for sustaining abstinent recovery Translate the research results as AUDs increasing in midlife and the factors involved to alert concerned people; provide clear messages that recovery works for women and contact information for confidential assistance.</td>
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<td>Inability to identify early indicators of women’s misuse; followed by limited complex medical and healthcare to meet midlife women’s rapid disease progression and establish safe abstinence; no AUDs chronic illness management over the women’s life cycle prioritised to maintain abstinent recovery</td>
<td>A client’s concern about alcohol is reason enough for a no-alcohol trial for a selected time. Stress and conflict are also reason for a no-alcohol trial, physical check-ups and follow-up appointments. Women with AUDs are unlikely to discuss alcohol (due to the nature of the illness); women ‘not caring’ and ‘worrying’, not attending pathology or physical check-up appointments are indicators</td>
<td>Provide practitioner support for introducing goals to trial no-drinking and take up a recovery way of living for midlife women, which involves encouragement and guidance to discover and develop herself to meet personal needs, increase socioemotional wellbeing, and pursue a purposeful long life. A new cultural learning and social acceptance of non-drinking self identity as part of legitimate attitude change to alcohol, that is, alcohol is not necessary for experiencing life events</td>
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<td>Inaccurate societal and professional assumptions and judgments based on stereotyping of women alcoholics; they can come back when they do as they are told, well-to-do women shouldn’t need help, too-far-gones are a waste of time and money, emotional women are too difficult to help. These are all major deterrents to accessing help.</td>
<td>Encourage understanding of the disorder not the perceived deviance in midlife women; education and training in midlife women’s continuing development of self, identities and roles to sustain wellbeing in professional curricula Discuss in public forums midlife distress, identity and role strain and vulnerable self-concept, especially for women with familial alcohol misuse and trauma backgrounds.</td>
<td>Realistic discussions about maintaining abstinent recovery which requires ongoing midlife adult development (and senior adult development) to help deal with new events; effort to sustain abstinence (including in-patient hospital respite) is more effective than effort and time to return to good health after relapse; women connected to non-drinking social networks and intergenerational mentoring recover Adequate long-term public health investment in social marketing campaigns to oppose advertising of high alcohol use as accepted social norms</td>
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<td>Delays in women’s early treatment through misdiagnosis of alcohol use disorders resulting in naïve drug-based treatments for anxiety and depression; practitioner expectations limiting women help-seeking and practitioner behaviour deterring women trying to communicate distress in perceived non-compassionate or mistrusting interaction</td>
<td>Acceptance of midlife women’s right to quality, supportive, initial AUDs-focused complex healthcare with assessment occurring over time to modify treatment to meet individual needs; comorbid illness is likely in midlife Publication of case studies of misinterpretations of AUDs in midlife women highlighting women’s patterns of fear, withdrawal and defensive compromise, perceived conflict and violation, dissociated and diversionary activities and non-productive if not damaging medical consultations.</td>
<td>Lobbying, guiding and informing more leaders about achievable abstinent recovery development with recovery support and respite to reduce acute care and emergency care costs Promote for public knowledge that there is hope and discrete care available for distress and drinking; alcohol use disorders are treatable illnesses; ways to improve health and medical practice for midlife women’s wellbeing; promoting community environments and activities that do not involve drinking</td>
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### Barriers to Sustaining Abstinent Recovery

| Discriminatory attitudes of women, practitioners and the general public towards women with AUDs as being ‘unworthy’ and potentially ‘deviant’. The attitudes and resultant alienating actions impose on women’s existing fear and self-stigma which prevents recovery change, asking for confidential healthcare and genuine self-care and positive action. |

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<th>Resolutions – Surface or short-term factors</th>
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<tr>
<td>Professionally and publically recognise women in recovery as well, productive ‘expert volunteers’ and ‘client representatives’. Sociocultural discussion of exclusion and emotional good health for community wellbeing and politicoeconomic impacts for women with strains of heavy social responsibility (including establishing careers for long-term employment and continuing education) and familial or community responsibility with teenagers, adult children at home, and ageing parents.</td>
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<tr>
<td>Informing community leaders that recovery processes work (using realistic language to attract women) and continuing safe self-care in cooperative community settings will produce more positive results. Initiate professional and public discussion of resilient abstinent recovery for women; and of the potential of intergenerational mentoring to reduce female alcohol misuse and consumption.</td>
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| No primary-care-related trials with long-term abstinent recovery midlife AUDs women. Very limited practitioner and patient studies for enabling improved identification of early indicators of misuse and recovery development through effective clinical practice; limited opportunities to monitor cooperation between GP and external recovery support (including pro-active respite in specialist units) necessary for relapse prevention and sustaining recovery |

| Linkage with existing primary care trials to explore inclusion of midlife women-focused (whole-of-health-in-context) recovery trials; developing effective partnerships across specialties for prompt intervention and referral pathways accessible to ensure complex chronic care for women with NGOs, AA and mutual self-help groups, community and hospital specialist services |

| Improve current understanding of chronic AUDs and related conditions and initiate discussion of developing in recovery peer support in community settings leading to midlife self-managing social health networks and. Encourage public discussion of sustainable living and health over the lifespan objectives with distribution of shared-care (intergenerational) resources in local areas to retain viability of communities |

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<tr>
<td>Lack of access to integrated complex care and long-term chronic AUDs services (e.g. diabetes care) suited to midlife women’s needs. Few practitioners working with ‘expert volunteers’ for recovery support of women returning home from special unit care; and no discussion of stepped-care that progresses women from complex abstinent recovery care to supported recovery development into self-managed care with long-term participatory healthcare guidance and medical monitoring.</td>
<td>Proposals supported for women-specific national AUDs policies, consistent alcohol and other drug nursing and counselling and addiction medical guidelines for women of different age groups and linked to mental health and public health initiatives Practitioner training and planning for cooperative, targeted midlife trials, of continuing chronic AUD care with a patient-practitioner negotiated chronic illness management plan. Support similar resourcing for community agencies and non-government organisations to meet midlife women’s needs.</td>
<td>Integrated practice monitoring by consumer health and welfare groups with ‘experts through experience’ assisting with special populations and providing feedback to practitioners and administrators. Ensure inclusion of essential age and gender specific questions included in programs such as the National Health Risk Survey Program; and client representation for AUDs midlife women with transdisciplinary health and wellbeing reference groups.</td>
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<td>No ‘E health’ progress to connect sectors involved in integrated AUDs and co-occurring mental illness and alcohol-related physiological diseases care, nor local community groups provided with access to data and evidence for treatment decision-making.</td>
<td>Participatory studies with women with substantial abstinent recovery (from Baby Boomer and Generation X with more than 12 years abstinence) joining with practitioners and Generation Y and Silent Generation women in abstinent recovery to explore characteristics of responsible recovery wellness across the lifespan.</td>
<td>Planning of transdisciplinary women with AUDs research and its translation into clinical and public health practice concentrating on affect and cognitive integration, socioemotional communication and relationships for wellbeing in lifespan development to meet gender and age needs. Support discussions of ‘ecology of recovery’ approaches in ecohealth strategies for ongoing human and community development.</td>
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Handling human-sized problems plays an important part in ways to resolve the barriers. Breaking down the matter by categories, timeframe and limiting the size of the obstacles by reducing the number of problems being tackled by the same people at the same time is essential for working together (aware of relational interactions; Simpson & Carroll 2008) planning and achieving positive outcomes. The following four categories (and defined boundaries) must be considered to be able to achieve a better understanding of the problems of enabling quality, women-focused alcohol dependence treatment for abstinent recovery, and for identifying better ways of accomplishing productive outcomes. The negative factors that limit this understanding are also listed.

**Personal and interpersonal**

- Limited or no attention given to women’s thoughts, feelings, opinions and decisions in medical discussions with women trying to optimise judgments and consequences of others

- No acknowledgement of women’s ways of multiple awareness, motivated reasoning and decision-making that takes into account emotional meaning (including affect evaluation Damasio 1994; Finucane 2000; Slovic 2002) and anticipated outcomes (Mellers & McGraw 2001)

- Limited attention given to working with women’s intelligence and purpose already attempted and their antecedent-oriented and response-oriented attempts to: change distressing realities directly (worldly behaviour); alter goals; reframe their way of seeing the situation; or controlling the emotion directly

**Environmental and historical**

- Genetic and environmental influences on behaviour, and peoples’ actions in the environment, change the psychoneuroendoimmunology of a person, their RNA, phenotypes and epigenesis process

- Having received inappropriate nurturing, deprived living circumstances, inadequate role models, limited learning opportunities, expectations, family history, and norms and traditions remain unexplained
Sociocultural

- Limited acknowledgment of the social right for a citizen to receive treatment for a recognised disease and ongoing commitment of care with chronic diseases

- Limited and conservative focus (patients pay) on midlife cohort’s medical issues that reduce and limit quality of life

- The idea that ‘intoxication is part of living life’, ‘relaxing and rewarding yourself through the purposeful use of alcohol’ and ‘determined drunkenness’ are all acceptable

Institutional: System of norms, politicoeconomic constraints, ideologies

- No action for abstinence and recovery approaches in the alcohol harm minimisation policy

- No treatment priority for high-risk midlife women

- No guidelines for translation of current wise practice through the sector, and no ongoing implementation and evaluation trials to maintain better practice suitable for long-term group work (patient, practitioners and supporters)

- Lack of cooperative, integrated recovery programs for addiction (severe dependence), and no long-term monitoring of in recovery clients, their physical and psychological illness and wellness

- No capacity for working with abstinent adults and supporters to prepare a healthy environment for recovery living in the community. Ongoing supportive partnerships for wellbeing mentoring and medical monitoring across associated fields are limited, e.g. between counsellors, GPs, physiotherapists and alcohol and other drug units.
Opposition to change

In any change process there will also be opposition, resistance and risk. Discussion and scanning for more positive ways to resolve the problems (not initially identified or considered), and then negotiated agreement to support the change, can assist with achieving positive outcomes (Schroth, Bain-Chekal, Caldwell 2005). Hidden obstacles are likely, including conflicting ‘agendas’ and ‘political and media spin’. Because of this, collaboration, leadership and communication, with the provision of required resources, are essential.

False barrier

The one false barrier that does not support healing is an overemphasis on personal responsibility, and blaming the women for not recognising the illness and seeking help. In these circumstances, compassion is required. In some circumstances, some of the people involved may prefer that the women remain dependent. It is often the nature of mental illness that the individual involved will fail to perceive symptoms and behaviours, even if basic self-survival is threatened. A sense of fear, shame and worthlessness that prevents lifesaving awareness and action is likely with midlife women. The phenomena of illusion, denial and repression (Andersson & Sandstrom 2010) can involve patients forgetting their illnesses and reporting being: least anxious, with low distress (‘OK’); and not remembering childhood interactions, and insisting current important relationships and activities are ‘fine’. This may occur through repression (conflict and defensive and avoidant coping, compromise through ‘formed’ accuracy and self-enhancement, deactivating feelings and numbness; Westen & Blagov 2007), and in the case of women with AUDs intoxication, blackout and being unconscious.

Resolutions

Short-term resolutions, such as adjustments to ease maladaptation, rarely provide a system solution for healthy lifespan living. However, because of the current high numbers of midlife women with AUDs, it is essential to have knowledgeable professionals and community leaders canvassing for the immediate needs of these women to be met through substantive care aimed at abstinence, recovery development and chronic illness support for maintaining recovery. Women in midlife do matter and can make a positive difference in their community. Excuses
for inaction and postponement (including higher priorities or needing more information) are as damaging in 2010 as resistance and rejection by people in authority of other ‘moral’, life threatening situation, e.g. HIV/AIDS.

The long-term resolutions proposed here are based on the participant’s contributions and my transdisciplinary literature reviews, analysis and critique. Both mid- and long-term multilevel resolutions will lower intergenerational alcohol consumption and support preventative health objectives, thereby reducing and eliminating alcohol misuse. A perspective shift is not only needed by women entering abstinent recovery, it is also needed to bridge complex boundaries of socio-cultural practices, familial environments, research disciplines, professions and institutions. With difficult, complex cases, this outcome can be more quickly achieved and bolstered through the provision of paradoxically long-term, quality of life healthcare that involves active engagement; in this way, more can be understood and learned. Also, the purposeful and resilient personal outcome of abstinent recovery for midlife women can be a robust multiplier event. Recipients support others more effectively, and they contribute to society in a generative way.

The researcher’s opinion

At the close of the Praxis chapter, I recommend the complete Local Working Theory of Recovery 5 (LWTR5) as a guide for practitioners to work with midlife women seeking AUDs independence (autonomy, authenticity and self-actualising), and as an advocacy tool for improving midlife women’s abstinent recovery healthcare. In-recovery women in my study have pursued and achieved valued goals and are capable of viewing life with a broader perspective and a deeper meaning. Their ways of recovery illustrate that a sustainable abstinent recovery can be achieved. A social ecology perspective of reducing the need for consummatory acts (Greenhalgh & Wessely 2004) can also contribute to a shift to more holistic healing practices that draw upon transdisciplinary knowledges and share the positives that are part of a human-valuing health system.

Throughout the Action Cycles the participants’ curiosity and desire for further information was constant to the point of becoming overwhelming at times. Their empathy for me as a facilitator was much appreciated. I was most impressed by the willingness and adeptness of the women who had experienced long-term abstinent
recovery to deal with journalists who wanted to hear their ‘personal stories’. Senior practitioners (with more than 20 years experience) illustrated a determined commitment to provide their clients with more time in quality care (in the face of ongoing institutional and governmental lack of support and resistance to seven day or 21 day programs), and to continue to seek the best therapy for their clients.

The relational experiences of the sub-groups within the study (e.g. Participant Reference Group, Senior Practitioners, and ADCA contributors) were observed by me. The participants did not have direct contact with each other. I was the intermediary; one of my roles being to ensure anonymity and confidentiality. The sub-groups did exhibit group identity based on the role of the group; and they were individually forthright (often passionately) in their expression.

**Participants’ responses to RWR**

The participants’ critical engagement in the study was illustrated by the questions they asked, the ways in which they responded to me (including sending me relevant articles), and my responding to what the participants wanted to explore by providing them with relevant literature. This research process helped to empower the participants to take better care of their lives (Newberry, Belkin & Ansari 2007; Bullough 2008; Lyons & Willott 2008). With reflection, it became possible over the cycles to articulate seemingly inexpressible and elusive experiences (Evans 2008); including some of the women describing their body memories in Action Cycles 4 and 5 (Grunewald 2008).

The participants in Action Cycles four, five and six discussed experiencing the liberating feeling of ‘freedom of choice’ (and appraisal of their situation; Tucker et al 2003). They explained that with their emerging abilities to evaluate and endorse (through exercising their judgment; Ardett et al 2010), the decisions of themselves and their peers were improving their lives. The recovery process, which was also reflected through the participants’ progress in each cycle, involved the learning and development of perceiving, acknowledging and responding with a multi-tiered (e.g. personal, social and environmental) understanding of the main influences affecting them. Becoming more stable individuals enabled them to better consider their interactions with others, the situations in which they found themselves, and to use their individual characteristics and strengths to meet their circumstances and,
eventually, their planned objectives. Their ability to engage with difficulties with less conflict and stress enabled them to develop more connected, useful and joyful ways of living within their families and communities.

Schwandt (2001 p 33) emphasises the importance of such developments, and of wise judgement, in the following statement:

... to resist the ‘colonisation’ of social and political life by expert knowledge based on method and to restore a sense of ‘praxis’ (in both public and civil society), many believe that we must recover the understanding that praxis involves judgement (phronesis), it requires moral wisdom, engagement and practical application to oneself.

The practitioner participants were surprised by the AUD women’s range and depth of knowledge. I found it interesting that the practitioners were not willing to engage in media interviews, even with RWR anonymity negotiated by myself (through the university) and by journalists. By the end of their participation, most of the women in recovery were willing to use digital technology (e.g. email, web discussion board), and this expanded their skill-base. Yet, few of the women engaged with supported anonymous personal expression or advocacy for women’s care via the internet through the RWR ‘blog’ (a website hosted through the university computer network to ensure anonymity and limit people and organisations selling products and services).
CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

Introduction: Meeting midlife women’s recovery needs

This chapter contains two main sections: a series of ten conclusions drawn from the seven year transdisciplinary participatory action research and five recommendations which are also made on the basis of that research.

Change in the lives of midlife women with AUDS is achievable through wise practice. Such wise practice must consider whole-person-healing-in-context and care focused on midlife female needs. It must enable, and support, a transdisciplinary community of practitioners that draws on contemporary women-oriented clinical and research-informed knowledge that is useable in practice.

Conclusions

Conclusion 1: Achievability

Whole-person healing through an abstinent recovery goal is achievable for midlife women with AUDs when provided with female-focused care and supportive ‘Recovery Development’\(^\text{266}\) to meet their specific needs. Outcomes are positive for women who enter early treatment for high-risk alcohol consumption, dependence and addiction.

The change from dependence, to intradependence, interdependence, ‘cooperative independence’ and independence (Chapter 5), identified in this study, can be enabled by cooperative support of women with AUDs to maintain abstinent recovery. This assistance must be prompt and appropriate, as the ‘Recovery Care’ threshold is met when women acknowledge a concern about alcohol use in their lives.

\(^{266}\) In this final chapter single quotation ‘marks’ are used to identify concepts created through the RWR study.
Conclusion 2: Whole-person-healing-in-context

The issues which women with AUDs deal include accumulated distress, adverse circumstances, and maladaptive development. Therefore, the recovery change process must work on the physical, emotional and spiritual aspects of women’s lives and must seek to increase their autonomy, authenticity and self-actualisation using healthy intradependence and interdependence to achieve cooperative independence (Chapter 5). Over time the women sustain recovery wellbeing through insight, adult experiential learning and supportive therapies. They come to engage in positive relationships, choices of principled transpositioning (changing identities, roles, and ways of being and doing), and a deeper understanding of affective experience. This is followed by the development of a mature adult patience, creativity, concentration, diligence and valuing virtue, i.e. personal and social good.

An important part of this healing is the development of a strengthened sense of self. The self-care and self-discovery associated with a strengthened sense of self can enable women to consider an identity shift, that is, from being a non-drinking woman to a woman in recovery and wellbeing. This may involve the belated learning of some key adult lifespan development processes, e.g. maturation of thinking, a sense of individual responsibility, self-determination and self-efficacy.

Conclusion 3: The role of practitioners

Since they play an important role in women’s processes of recovery, practitioners must be enabled to meet the developmental needs of midlife women with AUDs who are in ‘Recovery Care’. Practitioners must be aware that encouragement is needed for the women to take action to achieve abstinence, for example, any seeking of support by midlife women needs to be affirmed with non-judgmental follow-up telephone calls and appointments. Achieving abstinence also requires preventive monitoring in the form of encouragement to persist with the recovery process. In addition, the women and their practitioners need to develop a sense of joint partnership (supportive interdependence).

Practitioners and ‘Expert Volunteers’ can emphasise the important role of self-compassion and self-discipline as a feeling of being worthy of care may lead women to enter into earlier safe treatment. Practitioners must respond to negative thoughts, non-beneficial emotions and underlying beliefs by providing therapy opportunities.
This supports the women’s ability to accurately perceive other people’s emotional language, expressions and mannerisms, abilities which may not have been learned by women who have experienced trauma, even terror.

As commitment to self is a difficult hurdle for these midlife women, it is important for practitioners to help them establish realistic expectations of the pace of recovery. It may appear below women’s level of abilities to commit to a single direction, such as their abstinent recovery; however, expert volunteers and practitioners can provide many examples of this being an important and correct decision. Exploring several possible construals or interpretations of experienced events with a professional can support understanding and cognitive affirmation of a situation. Explanations from practitioners about why people may switch construals (their version of events) abruptly when recalling situations, as being a quick way to avoid unmanageable feelings that are connected to the situation, can be enlightening. The importance of practitioner support in revisions of construals (especially beliefs and values) can clarify objectives, avoid false expectations, introduce self-reflection, and enable self-monitoring.

As it is a major task for these women to form new affiliations through negotiation, recovery challenges are better served by a healthcare approach that is structured as a horizontal cooperacy or network. The network connects through being part of a common ‘Ecology of Recovery’ care system, rather than through a hierarchy of top-down controls.

The ongoing training of practitioners involved in women with AUDs recovery care and development is a necessary step to establish and retain the quality of long-term complex care needed to sustain abstinent recovery. Practitioners who are able to effectively work collaboratively with an integrated team of specialists that span the health, medical and welfare needs of the individual women’s programs are essential.

**Conclusion 4: The need for early identifiers**

More attention needs to be paid to early identifiers of AUDs in midlife women. To improve effectiveness, most practitioners need to learn much more about the ways in which midlife women with less severe symptoms of AUDs present for help (these being different from how men present).
Most women who are concerned about their drinking are, nevertheless, unlikely to engage in open discussion about their ‘alcohol problem’. The many subtle indicators of women’s risky drinking (Chapters 2 and 4) need to be more effectively recognised by practitioners. Common scenarios described by participants included: seeking relief from stress and feelings of anxiety and panic; having mood swings which they often related to feelings of having too much to do and also to pre-menstrual tension, peri-menopause or menopause; experiencing fatigue and having disturbing memories and difficulty sleeping, including dreaming of past trauma events; pain associated with menstruation; issues with food; and worrying about conflict in their relationships. All of these, and related scenarios may indicate alcohol misuse and abuse.

**Conclusion 5: The benefits of ‘Small r Recovery’ programs**

Engagement in ‘Small r Recovery’ processes and programs supports the volition of midlife women with AUDs to achieve abstinence and maintain an in recovery way of life. This requires recognition of their multiple burdens, including the difficulties the women face in fully embracing the recovery change process. The elements of ‘Small r Recovery’ (explained in Chapter 6) can assist practitioners to facilitate these women’s transformations based on women-specific needs. Recovery change is a dynamic process based on internal and external, and past, present and future considerations. Importantly, it involves both sudden and gradual processes that can lead to insights (‘aha!’ moments). In this way, through abstinence and recovery change, these women’s long-standing conflicts relating to attitudes and actions can be resolved.

‘Be-Come-Well’ is the recommended treatment that needs to be made available to midlife women with AUDs (see the ‘Recovery Continuum’, ‘I’m in recovery’ and ‘Complex Recovery’ in Chapter 4); it involves a continuum of core self formation of being a mature abstinent woman, and coming to conscious insight so that new options for living and constructive choices involving healing and learning in ‘Small r Recovery’ are possible.

Through safe, weekly appointments and sensitive interaction with women, health assessment is completed in a non-confronting way. Options for care are considered and agreed to in collaboration. Integrated treatment with facilitated daily living has,
at this point, begun (the ‘Recovery Triad and RCDs’, Chapter 5). Persistence and follow-up by the practitioner to bridge and reinforce engagement with, and for, the client is essential.

Preparation and paving of the way to support the women’s new lifestyle of early recovery without conflict with ‘concerned others’ is usually necessary; and its lack can be a critical block. It is an unfortunate, but common fact, that many women with AUDs are embedded in non-functional, often maladaptive, traumatising or violent relationships. A plan of care with changing familial relationships is necessary as a safety net for women; the ‘WmSpace’ program was created to meet this need, Chapters 4 and 5. Some simple tools such as mobile phone alerts can help women to care for self; and to contact others who understand their concerns and the importance of being and staying abstinent in difficult circumstances.

**Conclusion 6: The benefits of ‘Big R Recovery’ programs**

‘Big R Recovery’ highlights the transition and wellness process, from ‘Distressed Recovery to Wise Recovery’, that strengthens women’s commitment to her recovery and helps maintain abstinence (Chapters 4 and 5). Practitioners and patients, in partnership, focus on ‘Recovery Development’ and ‘Recovery Support’, particularly the metaprocesses of experiencing self and others (cognition with intention, affect with intersubjectivity and personal and sociocultural communication based on local working theories developed in RWR, Chapter 6).

Women in recovery need to be provided with factual information about the major changes that alcohol toxicity has on the physiology, neurobiology and metabolism of women. This provides them with an understanding of how their bodies are functioning; for example, why digesting food is difficult, the reasons their balance is lacking when sitting, standing and walking, and their ongoing feelings of irritability.

‘Big R Recovery’ includes processes suitable for midlife women to constrain their thinking (cognitive and affective) in order to alter and limit processes that may lead to drinking alcohol or ‘Non-recovery’ (Chapter 5), and then comprehend and enact new ways of living in recovery and wellbeing. Mindfulness and transformative learning are two techniques recommended on the basis of the findings of this research. It is important in the recovery process for midlife women to include pro-
active counselling for mental health, education on ageing and relationships with significant others, and contributions to their community as part of their ‘Chronic illness Recovery management plan’ (CiRmp).

Women with alcohol dependence are accepting responsibility in ‘Big R Recovery’ to participate in wellness activities to:

1. Sustain a resilient core self in midlife – creative autonomy

2. Relate as a mature woman with other people in daily life – ‘in the present’ affiliation

3. Develop identity/ies for chosen roles that are coherent and self-caring – authenticity in personal commitments


Retaining women in monitored treatment procedures that meet their needs (using suitable modes of care; outpatient clinic attendance, respite weekends, client-practitioner weekly therapy or monthly appointments for review, and the coordination of an agreed recovery plan including support from expert volunteers and peers in recovery) can increase the likelihood of positive long-term outcomes for more midlife women.

‘Big R Recovery’ includes working in groups or individually to safely reveal harmful or stigmatising events. Remembering and re-experiencing such history is difficult when in recovery treatment. For it to be beneficial – not destructive – the trauma therapy must involve preparing over many months for safe circumstances and acquiring suitable skills to come to terms with the post-trauma mental and somatic construal.

In ‘Big R Recovery’, women practise maintaining conscious, internal balance (a sense of calm and wellness) with a perspective of self-disciplined freedom of choice (Chapter 5 and 6). This integrated state of being encourages women to respond in useful and purposeful ways to life and its variations, and to changing environmental
and sociocultural contexts. The development of midlife life skills (self-worth guiding self-care activities, role selection suitable to self-identity), sound decision-making in money management, and pursuing vocational training and spiritual exploration are common features of maintaining recovery for midlife women with alcohol dependence.

Through such development, it becomes possible for these women to consciously redirect tension to act on unacceptable impulses through other outlets such as exercise, art, music-making and supporting other women, and most importantly to explore in a constructive way the nature of the ‘tension’ and resolve it rather than distract themselves or ignore it. This paradox of freedom of choice, by doing what has been learned by other women in recovery (providing some security and predictability), can result in ‘flow’ experiences (states of energised absorption) that lead-on to examining women’s existential wellbeing as part of their psychological and physiological wellbeing (Chapters 4 and 5).

‘Big R Recovery’ is possible for individual women through a negotiated healthcare partnership that is people-focused and involves developing reciprocal responsibilities of professionals and patients, treatment and services for co-occurring disorders, giving priority to abstinence, and providing human kindness as well as quality care. A meaningful and agreed recovery plan (if suitable a Chronic illness Recovery management plan’) incorporating these features is an essential tool to achieve sustaining abstinent recovery for midlife women (Chapters 5 and 6).

The integrated care, and continuing care, needs to include the following ten objectives:

1. Discussing physiology changes, including return of menstruation, fertility problems, intercourse, pregnancy, sexually-related health, and hormone-related conditions.

2. Monitoring multiple medication use for co-occurring illness (physiological and psychological conditions), as pharmaceutical substance dependence can occur, particularly opioids and benzodiazepines.
3. Reducing the bodily pain that commonly occurs as the many biological systems damaged by alcohol heal.

4. Establishing and maintaining housing, financial planning, transport arrangements, occupation at suitable levels, and education and training as vital components for sustaining recovery.

5. Building reserves of physiological and psychological energy (including mental volition-vitality levels) to prepare for treatment for comorbid disorders and associated chronic illness continuing care.

6. Working towards the development of a resilient core self, emotional wellbeing, improved mental functioning, coherent role-selection and social functioning.

7. Addressing midlife women’s sociocultural issues (intimate partner violence, parenting dependent adult children, discrimination in the workplace, addressing past familial abuse and neglect, and conflict and trauma history).

8. Arranging and encouraging connecting with people, as well as ‘experts through experience’; this includes peers (in ‘WmSpace’), friendships, interest group memberships, work colleagues, and neighbourhood-community involvement.

9. Attending agreed ancillary therapy, including AA, meditation and exercise sessions, developing leisure activities for relaxing encounters and enriching experiences.

10. Discussing family relations, with any action being based on the women’s specific needs; this involves agreements between the women and their practitioners concerning how to best meet their objectives of maintaining abstinence and accessing ongoing care for their long-term recovery (Chapters 5 and 6).

**Conclusion 7: Including contemporary research-based treatment principles, processes, and practices**

Healthcare professionals who focus on women’s abstinent ongoing ‘Recovery Change’ (ongoing due to the women’s dynamic life-course and the nature of the
chronic condition) can enhance their clinical practice through the application of contemporary research-based treatment principles, processes, and practices. As a contribution to such practices, the current RWR research, through knowledge translation techniques, has developed a tertiary education and professional training and development curriculum resource for practitioners, named, ‘Recovery Triad of Practice – Complex Action in AUDs Recovery Care and Development with Support’ (Chapters 5 and 6).

In addition, this research has ascertained that ongoing recovery change for women with AUDs is reliant on recognition of and facilitation by practitioners of four critical issues, summarised below (see detailed discussion of ‘Wise Recovery’ in Chapter 5 and Wise Practice in Chapter 6).

1. Protection (of the vulnerable adult, by providing knowledgeable contemporary care, and support for working with affiliation opportunities in a safe environment);

2. Productive and persistent efforts (develop the women’s volition for abstinence and introduce recovery activities to explore autonomy and individuation);

3. Purposeful exploration of potentials (to facilitate the women’s authentic transitions and reflection on useful capabilities); and

4. Prevention and empowerment (which can contribute to women’s effort and endeavours that increase vitality and voice to express their adult requirements in a self-disciplined manner).

**Conclusion 8: The importance of cognitive-affective development**

Midlife women’s cognitive-affective development needs must be met for the emergence of robust self-actualising and everyday sustainable abstinent recovery. Individual women can be enabled in this development for their home and work life and also, importantly, in leisure activities. Practitioners can select the 'Big R Recovery' pathway, particularly ‘Complex, Valued and Wise Recovery’ – for women with chronic alcohol dependence or, addiction and comorbid disorders, as distinct
from ‘Small r Recovery’ – for women with less severe dependence, i.e. no comorbid disorders.

Cognitive and affective faculty development is critical for achieving recovery change. This involves focused initiatives, sharing experiences, and practising new skills for sustained recovery. A more secure personal cognitive-affective orientation, with composed and thoughtful affect (including low over-activation), leads to developing and improving suitable attachment-relationship styles for social interaction. Meeting with peers in discrete local community areas (practicing recovery in the community) can provide the necessary social environments for autonomous self-actualising. This enables women to improve their affiliation skills and ‘be close’ in friendships with credible and caring people.

**Conclusion 9: Supporting abstinence means naming the resistance**

It is necessary to acknowledge the prevalence within present social and health systems of negative and cynical (including defeatist) stances on abstinence, as well as to question the polemic for harm minimisation as the dominant approach (Selman 2009). The ‘Recovery Care and Development’ approach can succeed, whereas the ‘detox, rehab and relapse prevention’ approach so often fails for women; my research provides many positive and optimistic examples of women successfully achieving long-term resilient abstinent recovery. This highlights the urgent need for implementing a systemic, action-based, women-oriented ‘Recovery Care’ approach for midlife women with AUDs, particularly in the face of their increasing numbers in Australian society. The benefits would include improved personal, familial, community, environmental and cultural health and wellbeing, social justice and economic functioning.

Another problematic belief that creates resistance to dealing with AUDs is the idea that intoxication is part of living life. As a result, relaxing and rewarding yourself with alcohol is considered acceptable and this acceptance has extended to purposeful intoxication as a social activity in Australia.

A further resistance that does not assist healing is an overemphasis on personal responsibility, and blaming the women for not recognising the illness and seeking
help. In these circumstances, compassion is required. In some circumstances, some of the people involved may prefer the women to remain dependent.

**Conclusion 10: Barriers to women’s recovery**

The most important barriers to women’s recovery – specific to the female gender – are:

1. Inadequate recognition of the severity of midlife women’s AUDs, and of the growing number of midlife women who are in need of AUDs treatment;

2. The absence of any plans for the provision of healthcare services to midlife women with AUDs either in Australian national alcohol strategy or among the main programs used in addiction medicine, mental health or women’s health;

3. A critical lack of contemporary knowledge about the specifics of midlife women with AUDs or abstinent recovery, coupled with sexist, ageist and classist care attitudes; and

4. Limited or no attention given to midlife women’s thoughts, feelings, opinions and decisions in medical discussions.

**Recommendations**

Based on my participatory action research I make the following recommendations (a summary of the RWR findings and recommendations was sent to the National Drug Strategy 2010-2015 consultations; Appendix 7.1). These are accompanied by the actions needed and the appropriate vehicles to carry out these actions, e.g. Ministerial Council on Drug Strategy; further details are on the DVD (contact Janice Withnall).

**Recommendation 1: Recognising midlife women with AUDs as a population in need of urgent medical treatment**

**Actions:**
1. Rectify the years of inaction by promptly establishing policy, strategies, plans
   and programs that recognise Baby Boomer and Generation X women as being
   at high risk.

2. Acknowledge, as a public health message, that midlife women’s AUDs is a
   serious concern; and that action must be taken to raise awareness of services
   that meet these women’s needs, including treatment for complicating physical
   and mental conditions, and the commonly associated complex personal and
   social distress. Importantly, public understanding that the women can become
   well and are not at ‘fault’ is essential for these women’s healing and recovery.

3. Upgrade women’s healthcare options for recovery from alcohol use disorders
   (neuropsychological disorders and physiological diseases), and encourage
   integration of primary health, community health, hospital and specialist
   services, and mutual-help groups to provide easy access and coordinated
   treatment for midlife women, while recognising that the lives of many are
   complicated.

4. Inform practitioners that their role must include providing ‘non-deviant’,
   realistic and hopeful health messages that emphasise positive, supported
   outcomes to reduce the women’s (and their families’) patterns of fear, shame
   and guilt, as these discourage seeking help for alcoholism.

5. Emphasise that women’s worthiness for healing and wellness can best be
   upheld by ensuring ongoing women-oriented AUD chronic illness
   management, including the monitoring of midlife women for emerging
   distress in recovery, and the need for respite and continued recovery care.

6. Campaign for cultural long-term attitudinal change to reach a position in
   which not drinking is a widely recognised legitimate choice at any time, and
   that non-drinking is socially acceptable.

7. Provide adult learning and midlife development courses designed for
   vulnerable women to resolve midlife emotional stress, role strain and
   estranged self-concept, especially for women with familial alcohol misuse and
   trauma backgrounds. AUDs are lifelong conditions requiring positive and
supportive approaches for women to be well, and to maintain long-term abstinent recovery processes. These processes can sustain wellbeing and resilient purposeful living.

**Vehicles:** National Drug Strategy (the National Alcohol Strategy is incorporated in this document), State and Local Government and approved Non-Government Organisations’ drug and alcohol services plans, the proposed National Addiction Knowledgebase, and the next National Health Survey asking questions on midlife women’s alcohol consumption

**Recommendation 2: Distribution of information to support Recommendation 1**

**Actions:**

1. Ensure that current information on alcohol’s effects on midlife women’s (different from men’s) bodies and minds is received by practitioners and is easily accessible e.g. by updating government (national, state and local government), health, welfare and medical web sites.

2. Meet the needs of women with alcohol use disorders and comorbid conditions through a recovery goal that can be shared with their peers, and within their families; with objectives that support abstinence, and ongoing quality care for women’s wellbeing in long-term recovery.

3. Make available user-friendly, practitioner and midlife women-oriented guidelines for recovery from alcoholism e.g. this study’s ‘Action into Abstinence’ and ‘Establishing Abstinent Recovery’ initiatives; and by making findings such as mine available in ‘popular’ forms.

4. Distribute to health promotion units, and public and commercial media outlets interesting life stories (case studies) and research results so that radio programs, feature articles and posters in gyms and libraries will begin to carry positive messages e.g. ‘have a break from drinking’; with contact details for counselling and mutual-help groups provided. Women who see this material can ask questions, gather more information, and begin to ‘have a break from drinking’.
5. Provide health education and appropriate information to spouses and children to enable support for women to be actioned in the home environment.

**Vehicles:** National Women’s Health Policy, Primary Healthcare Strategy, Health and Hospital Reform, Mental Health Strategy and Preventative Health Agency strategies

**Recommendation 3: Promotion of ‘Recovery Works for Women’**

**Actions:** Present recovery from alcohol dependence, in an open and positive manner, as images of people developing new abilities through professional care, mutual-help support groups and guided self-help to become fit and well in terms of ‘mind, body, emotions, living environment and the spirit’. Simultaneously, offering the general population a positive ‘to do’ message, of choosing ‘I’m not drinking alcohol today’, to develop over time a sociocultural norm of alcohol-free days and lower, non-impacting alcohol consumption.

**Vehicles:** The National Drug Strategy, NHMRC, the ADCA peak body, Australian Drug Foundation (ADF), and ANZRCP Addiction Medicine chapter, the Preventative Health Agency, Local Government, Better Health Channel and the Community Builders Network

**Recommendation 4: Supportive actions for increasing women's self-regard**

**Actions:**

1. Apply adult experiential learning techniques in midlife women-focused recovery development programs. These need to emphasise emotional wellness, capacity-building to share and belong, and to enable these women to plan for their ‘new life’ opportunities.

2. Support non-judgemental social network meetings in safe and pleasant community spaces, including AA; together with provision of training for in recovery mentors (expert volunteers) to support other women in need.
3. Support gentle personal care and acknowledging and planning the time
needed for understanding and accepting self, experiencing senses, feelings and
thoughts during times of turmoil and adjustments, and enjoying the freedom
and vitality of abstinence.

4. Support transitioning through negative and positive life events with
authenticity of mind, body, emotions and spirit, while meeting selected role
responsibilities, having a sense of belonging in chosen groups, and being able
to provide empathy and support for others when needed.

mmd1, Action Cycle 2, Women’s interview: Yes I do feel I am living a
meaningful life today. When I was drinking I didn’t want to live.

Today is a mystery which is wonderful. Most important is to just stay
positive and to not let other things influence this feeling of being alive.
The second most important thing is my ongoing relationships. I don’t
think it’s a journey you can do on your own. I think you need support.

My life purpose today is to give out as much as I can without wanting
too much in return.

Recommendation 5: Further research with women in long-term
abstinent recovery

Actions: Arising from this study, the following SIX research projects have been
identified to help limit women’s progression to AUDs, and to enjoy wellbeing in
sustainable abstinent recovery. Draft proposals are on the DVD:

1. Explore the characteristics and potential of ‘ecologies of recovery care’, such as
WmSpace for wellness, to embed women’s recovery development –
particularly for women with early alcohol misuse experiences – in a broader
ecohealth approach for sustainable community living. Draft proposal based on

2. Extend the current research to women in their 20s and 60s who are misusing
alcohol to identify ways to ease their emotional distress without alcohol

267 If a draft research proposal has been written based on completed RWR trials, it is noted as the last
sentence of the research descriptions.
consumption; using both emotional intelligence and ecological intelligence processes to reduce identity-conflict and role-strain, and to maintain a healthy core self. Draft proposal based on a RWR trial, ‘Action into Abstinence’: a negotiated, individualised recovery and mental health plan.

3. Identify intergenerational preventive care techniques for young women with deprivation and harm backgrounds through a trial using insights from, and mentoring by, women in long-term abstinent recovery; this needs to model healthy mentor relationships and share transformative learning experiences to encourage self-care and build resilience during anxiety-provoking situations. Draft proposal based on a RWR trial, ‘Active Mind Recovery Process’: Cooperative action for cooperative independence to maintain abstinent recovery.

4. Study women as career, family and community leaders, and document their experiences of womanhood and self-assertion in stressful work, home and leisure activities; to identify key characteristics and techniques that can sustain women’s wellbeing and effectiveness. Draft proposal based on a RWR trial, ‘Long-term recovery through seeking, achieving and flourishing’.

5. Explore women’s mentoring and leadership techniques for intergenerational cognitive-affective development and women’s ways to address complex long-term challenges to achieve a nominated purpose while maintaining wellness. Consider what this contributes to women’s sustainable abstinent recovery. Draft proposal based on a RWR trial, ‘Catalysts of Recovery Change’.

6. Identify ways to introduce, or revise, and strengthen emotional wellbeing and values discussion in professional education, training and development. Participatory action research with small groups of professionals (practitioners, health, welfare/community services, nursing and medical educators, policy and promotion advisers, and science communicators) and women in long-term abstinent recovery could provide a suitable framework and enriching process. Draft proposal based on a RWR trial – ‘WORC for Relationships’ (Women’s Ongoing Recovery Change for [satisfying] Relationships).
Limitations of the study

As a primarily qualitative (and not quantitative), participatory action research study the findings are subject to the following limitations (how these were addressed or taken into account follows each limitation):

possible bias related to the prior experience, understanding and conclusions of the researcher

I drew on my family’s experience with AUDs, the positive outcomes achieved with abstinence, and the ineffectiveness of ’harm minimisation’ approaches. However, I was open to the possible effectiveness of the latter and listened for this among those with AUDs and practitioners, and I did a comprehensive literature search relating to this area. For AUDs in midlife women, nearly everything that I found (especially in the most recent literature, and that by the most experienced researchers) confirmed the superiority of ’abstinence’ over ’harm minimisation’ as an effective life-span treatment.

Possible bias related to the self-selection of the participants
(midlife women with AUDs and practitioners)

Access to stigmatised populations (in this case, midlife women with AUDs) for research is difficult. To be able to conduct my survey, in 2007 I asked the State Governments of NSW, VIC, SA and QLD to have access to the midlife women who had recently received public health AUDs care, particularly to those still living within their communities one year after healthcare completion. This access was not granted. Because of this I decided to recruit these women through the media, noting that they needed to be willing to describe their current lives and how they purposefully stopped drinking alcohol. In Australia, at that time, no study of midlife women with AUDs, living within the general community, had been conducted and published. Consequently, the findings of my study are based on the experiences of these women.

The practitioners were recruited through professional associations and from contact at conferences. They were all professionals who had extensive experience with addiction, including AUDs; and they were not selected for any preference for approaches that emphasised ’abstinence’.
That abstinence was the focus of my approach and that the research did not investigate a comparable ‘harm minimisation’ or ‘control’ group.

Based on an extensive literature review and a preliminary trial in 2006 with midlife women with AUDs in a private hospital completing detoxification, rehabilitation and relapse prevention, I found that many of these women were also suffering from severe physical illnesses (such as Hepatitis C) and psychological disorders (such as Post Traumatic Stress Disorder); and that the accepted ‘harm minimisation’ treatments had provided poor outcomes for these women. In a conventional quantitative study, a comparison between the long-term health outcomes for midlife women with AUDs receiving either ‘abstinence’ or ‘harm minimisation’ treatments would be of interest. However, the scale, costs and logistics of such a study were beyond the possibilities of a PhD study by a single researcher with only support funding. Furthermore, because the literature and my preliminary study pointed to the clear superiority of ‘abstinence’ for treating midlife women with AUDs, I decided that most could be gained by carrying out a qualitative participatory action research study of the experiences of this group.
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RWR APPENDICES

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Trial report prepared as a journal article

Enabling women’s recovery from alcoholism: Exploring creativity, experiencing happiness and learning to change

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Abstract

This article outlines the qualitative research process and outcomes of a newly designed and implemented short intervention called CREATIVE RECOVERY. The therapy was piloted in 2004-2005 with mid-aged women in Australia who self identified as alcoholic women in need of medical care and support to remain abstinent and well. The therapy involved the women learning through multimedia explorations about themselves and the possibility of a happy, interesting and stimulating life in recovery. Results indicated that change through the therapy’s positive learning experiences enabled women to: recognise their abilities; enjoy challenging creative activities; succeed with self expression and group interaction; and all without the use of substances. Such outcomes suggest that this approach may further enhance women’s experience of becoming well and happy in sobriety.

Keywords

alcoholism, women, recovery, creative, Australia, happiness, change, adult learning, multimedia

WORD COUNT - 3300
This report of a pilot research project conducted in 2004-2005, is preparatory for a larger study of women alcoholics in recovery residing in Australia. It outlines the research process and outcomes, and is focused on mid-aged women who are self identified as alcoholic women in need of medical care to become abstinent and well, and who are learning through multimedia explorations about themselves. Results indicate that positive learning experiences can enable women to enjoy challenging creative activities, self expression and group interaction without the use of substances. Such outcomes suggest that this approach to CREATIVE RECOVERY may enhance women’s experience of becoming well and happy in sobriety.

“Creativity is the interaction among aptitude, process and environment by which an individual or group produces a perceptible product that is both novel and useful as defined within a social context” [1].

“Recovery finds itself in the internal experience of life and not purely through the external application of others” [2].

Review of the literature has revealed that there is a growing need to better understand what can help midlife women in Australia suffering through alcoholism to not only stop drinking but to progress to wellbeing and long-term recovery. In Australia, women are less likely than men to be identified and diagnosed with an alcohol problem. Mid-aged women are the fastest growing segment of alcohol misusers [3]. Women move more rapidly from alcohol abuse to dependence and they experience more severe sequelae conditions and morbidity than men of the same age group [4]. Women are also at increased risk for relapse. Gender specific treatment approaches are urgently needed [5, 6]. Including a variety of therapeutic approaches within a program is called for to address the multiple levels of women’s addiction [7]. It appears that older women benefit from treatment that encourages behavioural attempts to get involved in substitute activities and create new sources of satisfaction [8, 9].

The concepts that provided the foundation for this study are: a holistic approach to a healthy life [10, 11, 12]; recovery as part of a woman’s social ecology system of healing [[13, 14, 15] 16]; gender and art therapy from a feminist perspective [17, 18]; seeing sobriety in recovery as a positive state of wellbeing [19, 20]; being assisted through adult learning methods [21, 22]; to discover existing attributes [23, 24]; addressing self [25]; and to better understand self, purpose and recovery [26, 27]; and expressing [28] or communicating ideas and feelings.

This qualitative research draws upon a multidisciplinary understanding of alcoholism, a constructivist view of knowledge creation [29] and a framework of experiential learning [30] and action research [31, 32]. The position of the researchers and women volunteers is as participants in an enactive inquiry process whereby people manifest themselves, rather than represent themselves [33]. This way of studying a phenomenon suits the human creative process. Both the research and creative process cannot be isolated from the participants and the contexts within which they live. All participants are regarded as embodied, sensing, thinking, emotioning, acting, languaging beings. In this way the self becomes an instrument of understanding [34, 35]. Self reflexivity asserts its validity [36] and can therefore be challenged. The researchers nominate medical conscience, healing by first intention, as the ethical base of the study. Respect, safety and confidentiality are key principles of the methodology.
Research strategy

The midlife participants, all of whom were diagnosed as alcohol dependent, self-selected to participate in the study after hearing an explanation by the first author during their out-patient relapse prevention program at a private hospital in Sydney. Creativity, from a neurobiological perspective, is a highly distributed and integrated brain activity that comprises three overlapping phases of association-integration, elaboration and communication [37]. It draws upon all of a person’s life experiences. Recovery and this therapy [38] can be fun, educational, an inspiring experience and a process to reveal insights and skills and express true feelings and thoughts.

There were four 1.5 hour ‘CREATIVE RECOVERY’ sessions with a different activity at each session. No particular skills were needed. It was emphasised that no identification of the women was to occur and that notes on their comments about the sessions would be taken and reviewed for presentation and further study.

The six women were closely observed as they learned new ways of expressing themselves using humour and craft materials, paint and poetry, music and computer graphics. Everyone was able to do what was asked. Applying an interpretive phenomenology approach [39, 40] the participants anonymously contributed to recovery research by talking about what they created, how it felt for them and what they learned. Four analysis approaches were used: participant selection [41, 42]; visual analysis [43]; theme association [44]; and content analysis [45], grouping similar language regarding wellness and happiness. The researchers also used critical reflection [46] to identify the processes occurring in the sessions.

Method

The process outlined below was developed for the pilot study based on observation of creative therapies as a complementary medicine approach to the treatment of cancer and depression and anxiety treatment; reading the alcohol, drug and addiction literature; and self-testing of the techniques. The literature on psychiatric nursing practice, particularly the nurse-client relationship was especially useful. The themes of ‘being there’, ‘being concerned’, ‘establishing trust’ and ‘facilitating transition’ [52] were regarded as relevant to the women in this study and the researcher as facilitator.

Each 1.5 hour session was divided into four segments, introduction and focus, preparation and relaxation, doing an activity linked to the nominated theme, and talking about the outcomes and the process with a formal closure. At the beginning of each session the women were reminded of the group rules: if they could not attend a session, they must inform the researchers; after one absence, any further absence meant no further involvement in the research; each person was to be accepted, listened to and appreciated for themselves and their participation; there was to be no discussion of other people’s behaviour and responses outside of group time; if there were difficulties the women were to approach their support network, such as the relapse prevention facilitator who was aware of the session’s content; and every woman could leave the research at any time, without explanation.

The first author of this paper took the role of facilitator, and focused on encouraging the women to consciously express their thoughts and feelings through exploring and creating an object. It was reinforced that all people have creative ability and that self-acceptance, self-knowledge, self-nurturing and self-improvement can result
from engaging with such processes [53]. Also mentioned was that art is often born out of chaos, such as active alcoholism and stigma of the disorder, and the word therapy has a Greek base of ‘to be attentive to’ [54]. Each participant was asked to remember a time when an artwork stimulated their thoughts and feelings. The women listened to information about the theme of the session and the materials available. Response was asked for. If the response was a question, it was answered by the facilitator. A short focus exercise was completed and then the women were asked to begin. A five-minute ‘time to finish’ prompt was given and then the women were asked to stop and quietly review what had happened for them. A prompt of ‘describe what it is, how you felt and what you learned’ was stated. Women volunteered to speak. The others were asked to listen and when the woman was finished, could comment on their own response to the piece. It was emphasised not to comment on what the other woman said. At the end of the session the women were asked for a word or phrase that summarised ‘what it is like for you now’. The researcher then explained the learning style that occurred in the session. An explanatory message was given to close each session. This emphasised that these images could be used to work with forgiveness of themselves, increasing their self esteem, improving communication, letting go of stress, and healing [55].

Results

Mid-aged women in early recovery volunteered, participated and benefited from the sessions. They were guided in new ways to safely experience their creativity and explore imaginative ways of connecting with their feelings and thoughts about their alcoholism and life, trying new artistic and media practices and learning much about themselves as whole women [62], in relation to self, others, and their environment. For participant selection, the women nominated which session was the most positive for them. Below are their choices and comments (lightly edited for clarity) from that session.

Also displayed are the women’s art pieces which they nominated to be photographed and published. The dissonance of what can be said and what can be shown was noted and carefully considered. The researchers suggest that the ‘very’ personal at the time of the women’s creative therapy could not be made so public. As this tension became apparent, a woman was discretely asked singularly, “what is happening for you?” The responses included: fear of negative or embarrassing feedback from ‘someone’, self-doubt, lack of trust, and a strong concern of being exposed to hurt. Accompanying the art piece is a caption prepared by the researchers using visual analysis guidelines.

Note: The following six images and references can be emailed by contacting Janice Withnall j.withnall@uws.edu.au.

Woman 1 - Recovery, the computer session. “I didn’t want to stop. I put together the Travelling Willbury’s, “End of the Line”, then Nickelback, “I have been wrong: I have been down to the bottom of every bottle”, and then Red Hot Chilli Peppers, Zephyr song, “I live forever”. It was my story. I loved the alchemy patterns. You could go with the music and change the patterns when you felt you wanted to. I feel like I’m growing, learning the new things I need to be a sober adult. I have, deep inside me, a force that can help me. I can live a better life”.

IMAGE 1
Woman 2 - Rehabilitation, drawing. “I’m starting to see bits of the real me. It’s wonderful. I’ve got more energy to be with people and talk to them”. The drawing was not handed-in for photographing. The participant chose this piece for photographing.

IMAGE 2

Woman 3 - Recovery, computer session. “Recovery is my goal, it’s going to be hard but I can hang on. I’m committed and I can also enjoy it. I’m determined, so let’s go”.

IMAGE 3

Woman 4 - Rehabilitation, drawing. “I was confused and churning. I’m starting to find words for it. This helps. I’ve had some insights about myself and my issues. I have choices now about what I can do”.

AND

Resistance, animals. “I was scared that the others would think I was silly. I had my head full of you can’t do it. I was lonely, sad, lost. Then it changed. It was like playing again. It was fun. I felt good, satisfied, alive, even healthy”.

IMAGE 4

Woman 5 - Rehabilitation, drawing. “I sort of was empty then agitated, those feelings of shame, blame, guilt, poor me, why me. But I was aware of the feelings and I drew about my ideas. It can get better”.

And

Resilience, artwork. “I’m not alone or as confused and empty. It was safe and it was a chance to learn. I didn’t realise that I had this energy and could be creative. I was able to express myself and share it. It made me feel happy”.

IMAGE 5

Woman 6 - Journaling. “Initially horrible, terrible, I wrote pages about my deepest thoughts and feelings. And, after my mood improved, I had a more positive outlook. I could write without being drunk”. The woman selected this piece to be published.

IMAGE 6

Findings

The multimedia art produced by the women was a creative response to their experiences and the facilitation theme for the session: resistance, rehabilitation, resilience and recovery. The learning styles were selected to assist the women’s physical and mental understanding of the themes. The women’s verbal responses about their experiences were studied and similarities recorded. The researcher’s observation comments were added[63]. Interpretation of the similarities revealed a
The researchers named the processes occurring in each session as: embodiment, innate ecologies, de-catastrophising and self-healing. The processes which occurred during this therapy approach are explained below. It is suggested that they indicate the process involved for the women to rediscover their innate abilities of resilience, adaptability and transformability [64], and to integrate their tacit knowledge, ‘we can know more than we can tell’ [65] with their new understanding through the experiences involved in the therapy session. There appears to be a creative enactive flow [66] enabling discovery and conscious progress into recovery. The psychodynamic and psycho-social processes in context, a group of women [67, 68], appeared to enable and support positive change for the women. Lewin’s field theory that human behaviour is the function of both the person and the environment [69] was apparent.

Processes of recovery through the stages of the therapy were:

**Session 1: Resistance lowered using sensorial learning**

*Embodiment* – the women were able to express their feelings and ideas about recovery, engaging their soma, to produce a concrete form. They expressed surprise, no longer ‘poor, useless me’. They laughed nervously. They were complimentary about others’ ‘sculptures’.

**Session 2: Rehabilitation enjoyed through multiple-intelligences learning**

*Innate ecologies* – the women discovered talents that as part of their being they were creative and imaginative. Their work showed their relationships with their environments and others. The women were pleased and excited. They asked for further explanation from others in regard to the others’ work.

**Session 3: Resilience displayed using cognitive learning**

*De-catastrophising* – the women were attentive and asked questions of the facilitator. Their works showed clarity. They appeared to exhibit a changed perspective; that their life didn’t have to be a destructive drama, or chaos and suffering. They voiced their need for a positive life. Some commented on their actions around organising support. Others stated that they had to be responsible for living in reality. The women appeared confident and happy with themselves, even well.

**Session 4: Recovery explored through transformative learning**

*Self-healing* – the women were tentative and courageous in using the computer to express what they perceived as their recovery pathway. The women appeared to concentrate. Many “WOWs” were said. They were proud and joyful. Some women discussed God, a ‘higher power’, ‘a special something’ that would be with them in recovery.

**Outcomes**

Over the four sessions offered, a relatively brief intervention, it was apparent that the women moved from a sense of ‘nothingness’ and a body of emptiness to being vital women in the moment, present, with passion, reason and soul. They could
explore their intrinsic self and act with authenticity, showing and sharing their ideas and feelings with dignity. Through gaining a deeper understanding of who they are, the women opened to the worth of positive attitudes and relationships with others.

The research strategy was embedded in the experiential learning of ‘how to become well’. The tasks completed became a whole-person process [99] of ‘being’ happy in CREATIVE RECOVERY. It was felt as uplifting [100]. As conflicting feelings emerged, by using appropriate personal and group behaviour with multimedia, agitation was decreased and some meaningful resolution occurred. The women not only completed challenges but took away concrete reminders in their artwork, new skills, reawakened abilities, improving self esteem and recovery affirmations.

This study offers a piloted brief intervention, CREATIVE RECOVERY therapy [101], to the alcohol and drug field. The dialectical tension, mutually opposed (in contradiction) yet mutually necessary, is a feature that needs to be prepared for by practitioners as a force or energy required for people to engage with a change process of embodiment of reality, recognising innate ecologies, de-catastrophising and the beginning of self-healing.

Framed in adult learning techniques the four stages of change achieved were:

1. Resistance met with sensorial techniques and revealed the women’s embodied [102] hope. The women’s resistance was dismantled through their intentionally attending the sessions, sensing their enacting, perceiving their human rights and illustrating their significance.

2. Rehabilitation opened the participants to their multiple intelligences and they recommitted to their innate ecologies. The women learned more about their mind and body through fun-filled ways to learn and be in adulthood. Their creativity encouraged their evolving self, not their separate self that was prone to addiction. It was acknowledged that they were making honest attempts to express themselves with others.

3. Resilience enabled cognitive stretch so the women began to de-catastrophise (a mal adaptive style of coping) and enjoy positive excitement. They behaved in harmony with the environment, homeostasis. They valued their existing strengths and skills which were acknowledged as seeds of health [103].

4. Recovery was seen as possible through recognition of assistance, removal of blocks to self-healing [104] and resolving through encouraging transformations. Essential for wellbeing [105] is experiencing their vital energies [106], knowings of the heart, body, mind and the spirit and taking up the search for their essence [107, 108, 109] [our essence is that part of us which is unconditioned by our personal history]. This search is the purpose of recovery [110, 111].

Further Research

The therapy outcomes could be reinforced by adding three sessions: a further rehabilitation session introducing poetry [114], a second resilience session using digital photography, video and DVD movies; and a third recovery session on creating their own www blog. Another session focusing on resolve (intentionality and commitment) and praxis (informed, committed action), or as a specific section in
each session, needs to be piloted. Resolve in the women’s complex world could mean to intentionally and firmly decide to change: to alter in ways that enable them to find an answer or solution; or transforming dissonance to consonance. Perhaps further exploring music and sound effects [115] would suit this aspect of the therapy. A new evaluation form for the women to complete and a questionnaire for the rehabilitation or relapse prevention counsellors would also assist further refining this CREATIVE RECOVERY therapy. Trials of mid-aged alcohol and drug dependent women and women with a co-morbidity diagnosis are needed.

**Conclusion**

In this study the women worked with the anxiety of the risks associated with the activities and learned significant things about themselves. They appreciated the positive tension, perhaps excitement, of their creative processes and those of the other women in the group. They accepted that they were capable of expressing and integrating their ideas and feelings imaginatively. The women engaged with each other as people, and were proud of the skilful ‘artistic’ examples of their inner strength, abilities and humanness. Happiness was recognised as a personal and group experience, something to enjoy in sobriety.

The study’s outcomes may be used to support both mid-aged women attempting recovery and the clinicians working with them. We sincerely acknowledge the participating women’s courage. It has been inspiring. As one group member said, “yes, if it can help another alchie, I’ll do it”. The wellness concept could be improved by including more processes, such as multimedia exploration and communication, which encourage creativity, happiness and joy and therefore further facilitate a more positive recovery.
Appendix 2.1: The transdisciplinary literature search:  
Six methods of data exploration

The following six types of explorations were planned in RWR to gather and investigate1 new information for participants (and on myself): 1) the trial project discussed previously (see the Trial Report in Appendix a); 2) at each of the six Action Cycles (see Chapter 3); 3) while preparing for the meta-study using the preliminary results (see Chapter 4); 4) the secondary data (see Chapter 5); 5) while using the praxis method of study (see Chapter 6); and 6) during the final evaluation processes of RWR (see Chapter 7). The principles and techniques applied in the six types of explorations are summarised below.

1. Engaging with participants

The trial project, Action Cycle 0, Enabling Creative Recovery, used an adult action learning and critical reflection method of evaluating literature (see Chapter 1 Appendix).

2. Explorations during the Action Cycles

Four external data collection processes were completed in RWR to contribute to the participant data and find answers for RWR questions and issues: the first involved disciplinary and interdisciplinary searches and collection of relevant materials; the second focused on specific topic-oriented literature searches, e.g. the difficulties of shame and stigma and the vital benefits of peer conversation, and openness in practitioner-client discussions to support midlife women in recovery with AUDs. The third was concerned with transdisciplinary academic literature collection and analysis, as part of the dynamic nature of action research (Becker 2002, Jacobs & Frickel 2009). The fourth search focused on research methodology2, particularly literature that would help me design, develop and modify the RWR study. The products of all of the literature searches were referred to in the writing of all of the chapters of the thesis, to find information that might improve midlife women’s recovery.

“We recognised that in developing the framework (including socioeconomic determinants of health in medical practice guidelines) it was crucial to attend to the following issues:

- Problems of translating evidence based guidelines into practice and use of clinical judgment.
- Non-representativeness of populations studied in randomised controlled trials.

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1 These five explorations below were completed using the Transactive Participatory Methodology and multiple methods, particularly by cross-checking with the 10 groups of participants and back-checking (critical reflection by the researcher) in relation to the four Dynamic Lines of Inquiry running through the six Action Cycles.

2 The following description from the British Medical Journal (2003) is an apt list of what must be considered when working with complex research questions.
• Contribution of other types of evidence, including observational and qualitative studies.

• Appropriateness of, and difficulties in, conducting randomised controlled trials in all aspects of health (particularly modifying psychosocial conditions, health behaviours, and prevention).

• Difficulty of developing and evaluating complex interventions in health services research within randomised trials.”

(Aldrich et al 2003 p1283-1284)

3. Credible knowledge from secondary data sources

The sources of data for the RWR inquiry included more than just empirical sources (participant’s experiences and my observations) and the selected peer-reviewed research publications. Information from secondary data sources was included as there have been few published studies on ‘how to do women’s recovery’. I investigated cases where research partnerships with participants had occurred and were valued. As an example, the email discussions with the research team of the Australian Longitudinal Study of Women’s Health3 regarding the data selection from their demographic and sociographic information was best suited to the needs of my RWR study.

I examined the secondary data collected to understand more about the women’s recovery (the phenomenon studied in RWR). My analysis involved transparent construal (interpretation) and various reasoning approaches (formal analysis methods using induction for theory-building; Rappaport 1996, abduction; clinical abduction; Upshur 1997, and deduction as an adequate explanation; Lenzo 1995) to discover ‘likely answers’ to my ‘how to’ research question (see Chapters 3 and 4). My approach was influenced by mixed methods inquiry (Teddlie & Tashakkori 2012), realist synthesis (used in the RWR meta-study) and policy evaluation and development approaches (Head 2007).

An example of an influential secondary data source was the Alcohol Education and Rehabilitation Foundation providing estimates of the annual cost of the misuse of alcohol in Australia ($36 billion in 2010). A second example is my multiple searches of the databases4 of the Alcohol and Drug Council of Australia and the National Drug Sector Information Service for new studies on women’s recovery (last accessed 22 February 2013).

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3  The Australian Longitudinal Study on Women’s Health (ALSWH – 1995-2015) involved a survey of the health and wellbeing of three cohorts of women who in 1996 were aged 18–23 years (1973–78 birth cohort), 45–50 years (1946–51 birth cohort) and 70–75 years (1921–26 birth cohort). They were recruited using stratified random sampling from the Australian National Health Insurance database (Medicare), which includes all citizens and permanent residents (Powers & Young 2007). Their large sample was broadly representative of the Australian female population, although there was intentional over-sampling of women from rural and remote areas. Mailed questionnaires were used to collect self-report data on health and related variables every three years.

4. Meta-study explorations

Realist synthesis methodology (Pawson 2002) was adapted to enable me to review a large sample of community-based health projects in Australia (Hunter, Berends & MacLean 2012). The study drew on a highly varied sample of 127 community-based projects addressing alcohol and drug use problems that received funding from a national non-government organisation in Australia between 2002 and 2008. This led to the identification (from open and pattern coding) of 10 barriers and 9 enabler mechanisms that were influencing the outcomes. Eight case studies (four demonstrating successful implementation; and four demonstrating less than successful implementation) were further analysed to better understand the mechanisms involved. High level theories were developed, from these findings in Chapter 6.

I seized the opportunity to learn about meta-interpretation, an approach to the interpretive synthesis of qualitative research (Weed 2008). The synthesis is an ideographic (rather than pre-determined) approach. The focus is on ‘meaning in context’ and the emphasis (drawn from policy making and medicine on ‘what works?’ (Tranfield & Denyer 2002). In answering the ‘what works’ question, a second question is asked does this represent ‘a truth in context’, a truth in the RWR study.

5. Explorations while using the praxis method of study

Philosophical and methodological discussions continue to be debated in relation to knowledge systems, research paradigms, the nature of data and the adequacy of evidence-based approaches in health and medicine (see Chapter 3). In RWR, these discussions were monitored by setting database keyword ‘alerts’, with publication citations being regularly sent to my email. I followed the evolving ideas to provide an up-to-date framework for considering ways to improve quality health care partnerships, and guidelines for knowledge and action in mental health and alcohol and other drugs clinical practice.

One praxis method that influenced my approach in RWR involved attempts to integrate theory, research processes and practice into a cooperative inquiry for improving health care (Smith 2011, Newman 2008, Newman, Sime, & Corcoran-Perry 1991). The opportunity to use the collected data for theory building enabled a deeper understanding of women’s recovery as a desired outcome (see Chapter 6). In RWR praxis integrated new local working theory, participatory research and the practice of recovery by different groups in the community to introduce pragmatic ways to change.

“There is an emerging pattern of findings from the published reports of the praxis. (a) Research-as-praxis is transformative for the nurse and the client; (b) expanding consciousness is reflected in patterns of enhancing relationships, creating meaning, and changing patterns; (c) the authentic presence of the nurse in a caring partnership is essential; and (d) reaching a turning point (or choice point) facilitates freedom to choose and act.” (Smith 2011 p260)
6. Explorations during the final evaluation processes of RWR

The reliability of my findings concerning ways to improve women’s recovery is partly based on Confirmation Theory (created by Carnap [1950], and explained by Achenstein [2001] as being relevant to studies in the 2000s). RWR applied a mixed method inquiry strategy, and so I worked with qualitative data, quantitative data and secondary evidence (research paradigms). Confirmation Theory effectively validated each research paradigm\(^5\) used in RWR.

\(^5\) After learning about the new practice (as knowledge in the literature, participant experiences and discussion with experts and personal reflection) I had a positive attitude toward it (persuasion) and sort support from my organisational system (the university; UWS). This led to an intention to try the new method (decision) and the process of learning how to use it with participants in RWR (implementation). Upon experiencing success with the new approach (confirmation), the researcher integrated it into routine practice and may subsequently encourage its use by others.
Appendix 2.2: Academic literature presented to participants and professionals using knowledge translation techniques

Communication exchange – Researching with Women in Recovery – HREC 06/091

PHAA Annual Conference handout, Alice Springs, September 2007

Janice Withnall, Professor Stuart Hill and Dr Sharon Bourgeois, University of Western Sydney

Women and alcohol, more detail

The recovery from alcoholism numbers in women in Australia vary with age, with most of this study’s women entering recovery in their 40s. Other demographics are similar. Disadvantaged women, are not the largest group, non-disadvantage Australian educated, employed, urban mothers are the largest dependent group at 16 percent, for 45 to 55 year olds. This group was first identified in the USA in 1966 (Wood & Duffy). Today in Australia more women in ‘aged care’ are being recognised as non-recovery alcoholics cared for to an early death through brain damage and other organ disease. Apart from health and welfare costs, the cost of alcohol related accidents and absence in Australia is $79 billion a year (Pridd 2006).

Alcoholism is a recognised now as chronic brain disorder, the human mind is a highly emotional, cognitive and volitive organ. A person suffering from alcohol abuse has a complex predisposition, often with trauma-based developmental learning and behaviour. Alcoholism is still seen as a degenerative syndrome (Rea 1992) even though the physical and mental capabilities of people can return with abstinence and medical management.

In Australia intoxication is OK. In 2001, 62 per cent of alcohol was consumed in a harmful manner (Chikrithhs 2003). For women, drinking alcohol is seen as glamorous, it eases anxiety, is part of belonging in social situations and useful in the workplace. However, women with a drinking problem face a more hostile community than men. In Australia there is greater social stigma and disadvantage for women not being ‘good’. There are a greater number of women than men with comorbid physical and mental illness.

The disease has until 22nd century, little prevention strategies, poor diagnosis, ill-fitting treatment, with a prognosis of relapse, ongoing care in psychiatric institutions or no care and early death. Respecting the knowledge of women in recovery means findings ways for other women to enter recovery and perhaps prevent other generations from alcohol abuse. In the Health and Medical field in Australia enacting respectful relationships with people who are alcohol dependent, not mere lip-service for user-centred services is required to create and sustain the ecology of recovery space/place necessary for more women to live a happy and useful long life in recovery.
The Research

Drawing upon transdisciplinary knowledge, mixed method data collection and analysis, those involved are findings will be considered in the light of the large number of theories of addiction. Outcomes will be designed to assist the wide diversity of women overcome their alcohol problem and achieve equality in care and recovery with their needs and concerns addressed.

Treatment suggestions

Transformative learning (Mezirow 20001) can enable the women to be present and aware of their reality, and practice how to transition, from chaos to order, to home and work and persevere. Creating an ECOLOGY of RECOVERY space as part of community intervention draws upon the enacting of social ecology (Hill 2003), ecological health practices (Earls & Carlson 2001) and ecohealth (Townsend 2007).

Transformative learning processes and topics, offered in the ecology of recovery space, that may assist women into recovery include:

- Way of being in place (Cameron 2003), a loving attention to what is; a willingness to let go of negative mental and visual preconceptions and dream into a mutual relationship with country
- Sensory grounded experiences (Joselson 1996) that meet the desire to escape pain (Grof 1993), but replace substances and other addictive behaviours,
- Building capacity - living well and happy - exercise, food, rest, relaxation, spiritual exploration, simple family tasks, acceptance and practice of daily work routines
- Emotional and social learning (Weare 2007), relationship building and mutualism activities
- Creating awareness of intuition, free choice and decision making for self.
- Expressing inspiration, imagination and creativity through art, music, movement and animal therapy
- With co-morbid diagnosis, Dialectic Behaviour Therapy (Linehan 1992) of acknowledging mindfulness, tolerating distress, regulating emotions and interacting effectively

Women and alcohol, the damaging flow on effect

Care of children and older family members and financial assistance is necessary so that time and focus can be more assured for the suffering woman. Over 2 million Australians now live with alcohol induced brain damage (Lunn 2007). Billions of dollars can be saved annually through lost income, accidents, co-occurring physical and mental disorders and not recognised early illness which lowers functionality and increases mental, physical and emotional distress of family, friends and colleagues.
The increasing numbers reflect the younger age of hazardous drinking, a similar background of believing alcohol was a sexual disinhibitor, relationships with heavy drinking partners and the multi-role stress that midlife women are placed under without social, family and workplace acknowledgement and support. Midlife women are key ‘carers’ in our health system. The Baby Boomer and Generation X groups need a recovery space to contribute to stopping intergenerational addiction. Their seeking help, helps their daughters, sisters, mothers and grandmothers – all vulnerable to and active with alcohol abuse.

For further information (e.g. a reference list) contact Janice Withnall, j.withnall@uws.edu.au, telephone: 02 (612) 4570 1194, mail: UWS Hawkesbury Campus, Bldg G/IT, Locked Bag 1797, Penrith South DC, 1797, NSW, Australia
Appendix 2.3: An example of women and practitioners wanting to know more about recovery and AUDs

In each Action Cycle the data collection was checked for common topics. I provided research information on common topics via Newsletters and Updates and the topics influenced the data analysis and data collection in the next Action Cycles, e.g. the responses below (after Y) were checked.

Women’s Matters: Identifying and describing important issues for women in recovery from alcoholism, Australia, 2007

<table>
<thead>
<tr>
<th>CODENAME</th>
<th>POSTCODE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your response to the issues below can be – yes (Y), no (N), both yes and no (YN), not applicable (NA), a current matter for me (CM) AND an explanation. Feel free to express yourself. This information is confidential.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you would like to talk about the issue, perhaps you’re not sure how to answer it, please contact me, Janice, on 02 4570 1194 or 94302279@studentmail.uws.edu.au.

1. My roles eg in my family, at work Y these roles define who I am.

2. Care of child/ren and/or aging parent/s Y it’s a big factor on how able I am to get to meetings to get well. It’s also crucial to be sober to serve these family members in the way I believe God designed me to serve them.

3. Perception of myself as a woman Y as a drunk, it’s incredibly shameful as a women. The sexual risk alone is so degrading as a woman.

4. Self esteem Y crucial in all areas of recovery. Its in building up the self esteem that enables me to take care of myself the way recovery demands that I do.

5. Sexuality Y sober sex in a safe intimate marriage is the best sex there is. It enables me to define myself sexual and enables me to see the good in sex that God designed it for. Our world has such a sick sense of sexuality and it has hurt so many.

6. Hormones Y I still swing up and down each month but nothing like I did when I was drinking or in early recovery.

7. Menopause N no experience of this.

8. Unresolved grief Y old wounds constantly get triggered but each time I work through an issue with God’s help, I grow and heal and as I do I’m more able to help others on their journey. It can only be handled with God’s help.
Childhood experience/s Y so many old pains but all are healable in recovery and only with abstinence.

Co-dependent relationship/s Y a daily prospect to recovery from. I need to do a lot more reading around these areas.

Relationships Y by far the biggest challenge in recovery because of the number of buttons from the past they hit. None of us are perfect and we all struggle with the skills to learn to get along.

Safety within marriage/partnerships Y I’m blessed to be in an awesome marriage without which recovery would have been a lot harder road.

Feeling secure Y true honest authentic friendships do this for me and they get off the ground as I trust and rely on God.

Change and fear Y a daily challenge to overcome but I trust that God’s grace is sufficient for me in all these challenges.

Can alcohol misuse be prevented? Y in our culture probably not but than if we can make inroads on smoking maybe there’s hope with education.

Anger and alcoholism Y anger comes from the repressed emotions we had to bury with the alcohol use – its unavoidable but with the appropriate recovery tools it is manageable.

Truth and alcoholism Y without rigorous honesty we don’t get recovery from alcoholism. It is by being fully known and fully accepted that we can really know we are fully loved by God.

Resentment and alcoholism Y the number one offender. An alcoholic has to use the tools to overcome the resentments or they will not find peace. Alkies cant do resentments. It plays too much in their head.

Alcoholism is a genetic disease. Y possibly.

There are psychological and physical illnesses that go with alcoholism. Y it is such a misunderstood illness that really only the sufferer can fully know its extent.

Medications for alcoholism N no experience.

Other medications Y I found antidepressants incredibly helpful in the first 18 months of recovery.

I had to drink. Y the emotional pain was so intense that without the tools to live I had drink but I had to stop to find the tools and learn to live well.

The events/thoughts/feelings that changed my wanting to drink. Y meetings of AA and the awareness that it was an illness and it would get worse. Drinking was not the solution. That was the initial motivation to stop and than after time I had my thinking challenged by others in recovery and over time I got therapy to help me with the feelings. My alcoholism had disabled me from feeling feelings.
How I changed my life. Y motivation, discipline, grace, meetings, commitment to recovery and helping others recover.

The help I sought and why. Y AA and therapy. AA because it held the solution to abstinence and therapy because it helped relieve the pain.

People/groups that helped my recovery. Y trusted friends in AA.

Age when I first tasted alcohol Y teen years. My family sat up each night and had a single drink before dinner. I don’t do it with my family today.

Age when I wanted to drink Y teen years. I loved it.

Age when I knew I was an alcoholic Y late thirties.

Is your recovery through Alcoholics Anonymous (AA)? Y Yes.

What treatment/s or therapy/s was part of your recovery and which worked? Y aa and therapy. I've changed therapists over the years and this has also helped.

I wanted sobriety for myself Y in the end I needed it for myself.

People I love are resistant to my recovery. N people I love don’t totally understand my recovery but they do appreciate it.

My child/ren, parent/s, brothers/sisters has an addiction/s. Y I believe there are many in my family who are ‘dry drunks’ i.e. they don’t drink but they exhibit the alcoholic behaviour.

I am happy with my life today. Y indeed most days when I work the AA program I am happier than I believed possible.

Is there a difference in the way Australian society views women alcoholics to men alcoholics? Not sure but I wouldn’t be surprised if there was thank you.

Next stage

A letter showing your interview details and discussion board access code and instructions will be sent to you shortly. Results of this Q58 Issues and the complete My Recovery Questionnaire results will be compiled and also sent to you. Please confirm or complete these details –

- Interview by telephone number email
- Your mail address for the results is
- The name of your health professional and their role, e.g. GP, counsellor are –
- I need to fill in an Informed Consent Form
• I want an Information Sheet

• I want RWR Questionnaires/Newsletters/ Updates (crossout what item you do not want to receive)

**More participants**

Also, you may know other women or practitioners who could participate, so please pass on my contact phone number or email address: Janice Withnall, University of Western Sydney **02 4570 1194** or **94302279@studentmail.uws.edu.au**

**NOTE:** This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval Number is 06/091. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (tel: 02 4736 0883 or 02 4736 0884). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 2.4: Comparison of addiction theory, therapy theory and RWR recovery theory

I studied what West’s Prime Theory of Motivation (motivation) and Carey’s Methods Of Levels (perception; MOL) could contribute to women’s recovery (volition) and this is shown in Table 1.

**Table 1: From illness to women’s wellness in recovery**

<table>
<thead>
<tr>
<th></th>
<th>MOTIVATION</th>
<th>PERCEPTION</th>
<th>VOLITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Compulsion and instrumental and Pavlovian learning as responses</td>
<td>Generating conflict (as feeling or action); focusing on the basic disruption underlying the conflict is fundamental to many dynamic therapies</td>
<td>Seeking volition to act as an intradependent self (LWTR1 discussed in this chapter)</td>
</tr>
<tr>
<td>2</td>
<td>Potentially competing impulses and inhibitory forces (sometimes felt as urges), perhaps desires</td>
<td>Shifts in attention noted and questioned; could be an image or an auditory perception just as much as a thought or feeling</td>
<td>Finding Integration of Self and Current Life (LWTR2)</td>
</tr>
<tr>
<td>3</td>
<td>Generating motives (sometimes experienced as feelings of want or need) attached to a mental image of something</td>
<td>Patients supported to shift their awareness, observe these disruptions and with support direct attention more fully to this occurrence</td>
<td>Freedom from seeking dependence (LWTR3)</td>
</tr>
<tr>
<td>4</td>
<td>Involves generating evaluations (beliefs about what is right or wrong, beneficial or harmful, pleasing or displeasing)</td>
<td>Interruptions to the person’s dialogue noted and discussed so that reorganisation can begin to alter their perceptual control system</td>
<td>Midlife adult development supporting maintenance of abstinent recovery (LWTR4)</td>
</tr>
</tbody>
</table>
West attempts to explain human behaviour in terms of a multilevel motivational system, in which higher levels evolve later and can only influence behaviour through lower levels (similar to Carey’s, 2006). West sees addiction metastasising into the whole motivational system of people; a system of forces that energise and direct people’s actions. “Because of the causal links between different elements in the motivational system, there will be many cases (probably the large majority) in which the distortion in priorities involves multiple levels. The treatment program (for addiction) needs to involve multiple components targeted at all the modifiable distortions in the motivational system. Because addiction will usually involve distortions across the whole system, the treatment program needs to address all elements that can be affected, for as long as is necessary either to achieve a cure or to suppress the addiction… We are seeking to reshape the addict’s motivational system – to change the addict as a person. In some cases this may go to the root of his or her being” (West chapter proof 2007 and viewed webpage 2008).

### Discussion

West draws the distinction that, in everyday language, such plans are referred to as rules. Sustaining that behaviour change requires the rule that we set to generate sufficiently strong wants and needs at relevant moments to overcome all the old sources of motivation that will continue to rise. West has a long history in the addiction area, in particular smoking, and he draws on all of that previous data, as well as his knowledge and work in addiction to set this prime Theory of Motivation. He mentions that the second feature of these rules, if they are to be effective, is how well it fits with what might be called deep identity. He refers to deep identity as our self-conscious and that, from this, we generate profound pleasure, satisfaction or discomfort. It has the power to evoke strong wants and needs. If there is a profound identity change, this can help to be a potent driver before behaviour change but, more commonly, he puts that maintaining the new behaviour, sticking to the rule requires self-control. That is, doing things that we should or ought to do. And this is reliant on our deep identity and requires mental effort. He puts that therefore individuals with a strong coherent sense of self, with good reserves of mental energy,
with intelligence and support necessary to organise the environment to minimise competing motivations and a strong commitment to a rule with clear boundaries will be better equipped to put into effect an attempt at behaviour change. And that's a big ask for people that are in active alcoholism. However, it is doable. I would suggest that this is, in part, a form of the recovery, care and development processes suggested through my research and that there is modification in regard to women in midlife and the process that they require, which is driven from seeking dependence to seeking recovery.

**Therapy**

Carey (2002) described Perceptual Control Theory (PCT: Power's work from 1973 to 2004), as when living things control, what they control is an internal signal called perceptions. A person lives in a state of perceiving (that is comparing what is with what it's best state of being is, a reference signal) and then taking action to meet that gap. The action is in response to a perception. Without a stable core-self people live with unstable perceptions and more often are living in fear and anger. If women are perceiving a fearful situation, they will respond to that and try to take actions that would stop the fear, and that is the fear itself, not necessarily any causal factor in a sensory reality. What is important for the women’s recovery change process is the notion that living things control their perceptions. Human being’s ability to understand ‘true’ cause and effect in their life has been questioned by many (Dewey 1894?). Powers replaced this notion with the explanation that people strive to maintain perceptual experiences in preferred states.

The basic MoL therapy principle (which also acknowledges age, gender, birth cohort and individuality) is to help reveal the misperceptions that underlie women’s thoughts, feelings and actions that have led to alcohol dependence and addiction. In midlife this is a long-term process as there are layers of disruption that need to be identified and treated as a process of recovery change (engage-transition, embody-transformation and enrich-transposition, discussed in Chapter a). Method of Levels can assist women with AUDs to identify the internal distress and help to open the way to altering perception; women shifting their awareness and attention through safe experiences and learning new ways of taking action (including not acting) on an issue.

Women’s lives with AUDs can stop being a seemingly constant, desperate struggle of control to overcome threatening conflict. It can be taken a step further and used for recovery development. I illustrate this by applying language the women use in recovery to the MOL therapy. The therapy as part of the recovery process involves locating and identifying relevant background feelings and thoughts and bringing them to the foreground for closer consideration. By bringing the background material forward, higher level mental functions can be applied to the material. As they are being inspected in a recovery session these background thoughts and feelings link to other thoughts and feelings. By discussing the perceived reality in a safe situation, the women’s attitudes, beliefs and values surrounding the thoughts and feelings are expressed. It is through this constructive questioning and discussion that the recovery process of developing an authentic self can continue and emerge for women.
Recovery

Maintaining recovery when people's lives transpire as intended, self-disciplined choice is seamless and continuous. When people find themselves struggling, anxious or distressed, i.e. having to exert a great deal of effort to plan and perform tasks, internal conflict may be present rather than 'external' conflict. As women maintain recovery, unease becomes familiar, although never pleasant. They can associate symptoms such as worry, as indicating a low level of internal conflict; an incompatibility of goals with self and situation being a mid level concern and the more chaotic feeling and difficulty expressing the nature of the tension, being the highest level of internal conflict which can lead to drinking alcohol and relapse. I equate the MoL approach with transformative learning and perspective shifting. Trying to regulate or control this distress is largely futile because these efforts have little effect on the nature and place from which the conflict is being generated. Mansell and Carey, (2009), continue to research and explain the notion of Perception Control Theory and their Methods of Levels Therapy. This approach can assist women to progress to a robust independence in parallel with needed comorbid treatment e.g. for mood disorders.

The multi-layered nature of women’s AUDs in midlife requires a multilayered application of care that moves beyond an unsatisfactory result of the absence of mental illness. The iterations of the Local Working Theories of Recovery are holons (joined hierarchies: Wilbur 1985, Pribham 1991) to support women to reach mental health from dependence and addiction (the most severe form of dependence). The theories describe the care, development and socio-cultural support necessary for wellbeing in sustainable abstinent recovery.

Theory references used in the following Chapters

Chapter 3


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Chapter 4


Bradley, EH, Curry, LA & Devers, KJ 2007. Qualitative data analysis for health services research: developing taxonomy, themes, and theory, Health services research, vol. 42, no. 4, pp. 1758-1772.


Caudillo, DE & Buckley, M 2011. Making the body relevant: Using attachment theory to conceptualize effective treatment for midlife women coping with dissolution of an intimate relationship.


**Chapter 4**


Chapter 5


Lyons-Ruth, K 1991. Rapprochement or approchement: Mahler’s theory reconsidered from the vantage point of recent research on early attachment relationships, Psychoanalytic Psychology, vol. 8, no. 1, pp. 1-23.


**Chapter 5**


Examination of Participation in Community Groups.


**Chapter 5**

Appendix 2.5: Models of care and treatment publications

Chapter 2 – Key Influences


he neuropathology of alcohol-related brain damage, Alcohol and Alcoholism, vol. 44, no. 2, pp. 136–140.


Chapter 3 – Transactive Design


Chapter 4 – Transactive Results


Lester, B-A 2009. 'A health promotion model for facilitation of self-care of women in midlife to support them in the attainment of wholeness', Doctor of Literature and Philosophy, University of South Africa, Pretoria, South Africa.


**Chapter 4 (a)**


**Chapter 5 – Findings**


**Chapter 5 (a)**


Chapter 5 (b)


**Chapter 6 – Practice and Theory**


Reifsnider, E, Gallagher, M & Forgione, B 2005. Using ecological models in research on health


**Chapter 7 – Conclusions**


**Preface**


Appendix 2.6: Engaging with care

I searched for longitudinal studies (see below) that considered how to improve healthcare of women with chronic illness. The information was included in questioning participants, discussing ideas with the Participant Reference Group and investigating connections with the RWR data.


WHA 2005. The Australian Longitudinal Study on Women's Health (Report 24 - June 2005), Report for the Australian Government: Department of Health and Ageing (DoHA), Women's Health Australia (WHA), Callaghan, NSW.

WHA 2005. The Australian Longitudinal Study on Women’s Health: Data book for survey 4 of the mid-age cohort 2004 (53-58 years), Women's Health Australia (WHA), Callaghan, NSW.

WHA 2005. Women's Health Australia Newsletter 2005, Women’s Health Australia (WHA), Callaghan, NSW.

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Non-Australian longitudinal studies


Appendix 3.1: New approaches to midlife women overcoming AUDs through abstinent recovery

New Approaches to Midlife Women Overcoming Alcohol Dependence: Sustaining recovery

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Abstract

How do midlife women sustain long-term recovery from alcohol dependence? Researching with women in recovery, and the practitioners who care for them, was the participatory action inquiry strategy for this Australia-wide study. Preliminary findings of the first four cycles of our seven-cycle research process are presented here to contribute to identifying and further developing appropriate health and medical care for the ‘hidden’ Baby Boomer and Generation X women who are misusing alcohol. Exploring the lived experiences from active alcoholism to abstinent recovery of participants revealed that a growing number of midlife women misuse alcohol, and also identified what women need in order to reduce the length of time in active alcohol dependence and relapse episodes. We have also endeavoured to explain how female physiology, psychology, and various social and environmental factors contribute to alcohol misuse during midlife. The difficulty of not drinking with this chronic illness is amplified by the Australian culture of ‘drinking for belonging’ and ‘comfort’ (especially women), and the high social-stigma and self-stigma of women’s addiction, which is often an unacknowledged comorbid mental health disorder.

Keywords: alcohol dependence, women, midlife, recovery, substance-related disorder

Our Australia-wide study, ‘Researching with Midlife Women in Recovery from Alcohol Dependence’, was designed to better understand how these women came into recovery, how they sustain their recovery, and what needs to happen to more effectively enable such sustained recovery? The lived experiences of this largely neglected group of women from 35 to 54 years, and of the practitioners who care for them, were documented from 2005 to 2009 in our action research [1, 2] study. All participants gave informed consent and remain anonymous. Like Laudet [3], we were confronted with stories of complexity, complication and paradox from survey and interview responses: and of the many challenges faced by these women, as they embarked on their journey toward recovery, and as they repeatedly had to make life-saving decisions as they grappled, often alone, with this chronic illness [4].

In 2005, as a midlife woman, the first author became acutely aware of the high incidence of high-risk drinking among her peers, and she began to search for explanations. Information available validated her concerns and revealed extensive misuse of alcohol by midlife women. Data showed that the drinking habits of midlife women in Australia had risen from 5 percent in 1986 [5] to 8 percent in 1996 [6], to 10 percent in 2001 ([7]) and 13 to 16 percent by 2004-2005 ([8], [9]), a tripling of this behaviour in just 20 years. Increasing numbers of women were drinking more, rather than fewer women drinking more. Most of these, largely non-disadvantaged, women had become risky and high-risk drinkers in their mid-20s, and had continued to increase their alcohol misuse in their late-30s, becoming alcohol dependent in their 40s and 50s. Our observations of this upward trend in older women have also been documented in the reports of the Australia Longitudinal Study of Women’s Health [10], and the Report of NSW Chief Medical Officer [11]. In a preliminary study ([12]), some of the personal and social negative ramifications for this important group of women suffering from alcohol use disorder have been identified and described; and in our ongoing study we are seeking further clarification to the following common questions.
1. What are the main issues associated with midlife women becoming alcohol dependent?

The following five factors provide a starting point for understanding this phenomenon:

1. Women in Australia experience alcohol misuse differently than men [13], and their illness development and recovery needs are also different [14]. A woman’s body is rapidly damaged by lower amounts of alcohol than previously understood [15], and the ‘telescoping’ effects of alcohol [16, 17] on women’s mind and body is greater and more rapid than for men.

2. Women from 35 to 64 years score ‘very high’ [sic] for psychological distress [18]. There are currently two generations of ‘midlife’ women (Baby Boomer and Generation X) who, faced with multiple-burdens, are often drinking for relief. This becomes chaotic coping with complex changes [19, 20].

3. Because research on the female experience of alcohol dependence has been limited [21], there has been a lack of recognition of this growing problem over the past 20 years. Most health, medical and community services workers are inadequately aware of the female-specific data on physiological, psychological, socio-cultural, environmental and genetic factors [22, 23] that can increase a woman’s risk of alcohol use disorder and hinder recovery.

4. In Australian society, where alcohol consumption is widely regarded as the norm, drinking has a higher impact on women than where this is not so culturally acceptable. Nutt [24] has argued that whereas men have a 70:30 ratio of genetic to environmental influences on alcohol dependence, in women the ratio is the opposite, 30:70. As women have become more highly educated, and have received higher incomes, they have become increasingly able to buy their own alcohol.

5. Australian society treats drunken older women as deviants (much more so than men, and than younger women). This is a major barrier to them seeking help ([25, 26], and for appropriate help being available for them. Consequently, many older women with alcohol problems tend to hide this perceived ‘moral ill. There is generally a lack of gentle intervention and supportive care messages for mature women with alcohol-related problems within our public health institutions [27] community services [28], and within General Practice care [29].

One of our older women participants, who is in recovery and has been abstinent from alcohol for many years, related a story about a lady called Ginger Betty from the 1950’s in a suburb, south of Sydney. Ginger Betty turned up to an AA meeting, but the group decided that females were not proper alcoholics. Not being recognised as ‘the real thing’ – an alcoholic – has been a major obstacle to obtaining help for women in Australia. Betty, however, as many of the women in our study, was not deterred. She so wanted to be sober that she would sit outside the meeting and listen through the window. This socio-cultural barrier has been further confounded by the emergence of the ‘super mum’ and ‘sex and the city’ career woman expectations.

Taking on new roles, as well as traditional women’s responsibilities, makes life very complicated and hectic, with much energy and effort having to be spent performing additional tasks. As a self-reward for a job well done, a drink is, at least initially,
perceived as a reasonable option. As a sedative, it works to bring relief from heightened stress, at first by enabling the woman to continue, get the jobs done, and even ‘sparkle’ while doing them. It also masks when her allostatic load [30] is reached, and the associated damage that the alcohol does to her body, mind and spirit initially goes unnoticed.

The other barrier for most midlife women in Australia is that over the past 20 years, unlike Ginger Betty, they have been drinking in a ‘hidden and private’ way. By speaking with these older women (55-65 years) we have come to better understand why this occurs. As their mothers’ and grandmothers’ did before them, they kept such “bad, wrong and nasty” behaviour secret. There was silence and ignorance around such unpleasant, shameful and ruinous family matters. Most women in Australian society are desperate to avoid being identified as having any problems with alcohol. Our colonial history is replete with stories of women being labelled as whores, ‘god’s police’, and as hysterical—mad women [31, 32, 33]. Taboos and moral judgements can undermine all efforts to seek help for alcohol dependence and alcoholism (even when this is euphemistically referred to as alcohol misuse or just an alcohol problem). We are now experiencing a situation in Australia in which three generations of women in a family can be alcohol dependent, and all want ‘the drinking’ to stop. These women are willing to contribute to improve the situation so that other women may avoid such suffering.

2. Why are these women having alcohol problems?

They have been exposed to sufficient risk factors to generate an addiction. This is what must be recognised, rather than labelling it as an ‘alcohol problem’. Although this may have begun relatively simply, invariably it becomes increasingly complex over time. Most alcohol dependent women are unaware that they may have a predisposition towards such dependence, and of the ongoing nature of gene-environment interactions [34] and they have little understanding of the role of family and community [35], also of the ways in which traumas can activate such predispositions [36]. Sadly, very few are aware that two standard drinks is the recommended maximum consumption, and, when confronted, most will doubt the documented damage that four drinks can have on the female body [37, 38].

Predictably, this is resulting in growing social and economic problems, particularly when we include the costs that untreated alcohol misuse create. Happily, an increasing amount of help is now being provided for teenagers and young adults who are drinking to intoxication. However, as the increasing number of women in their 20s drink larger amounts more frequently, growing numbers of them will predictably be likely to join the vulnerable midlife women that we have been studying. Few of these midlife women have had access to the type of education and early intervention services that are available to today’s youth. Most do not know that health care is available; and, among those who are aware, most tend to resist help because of the real and perceived difficulties associated with beginning treatment. These are the women that are seen most frequently in General Practice consultations, family counselling, and who visit mental health professionals. It takes many months, and often years, for a woman to understand that alcohol dependence is real. It is difficult to persuade a person who has ingrained in them their need to ‘care for all others before themselves’, to ever seriously consider treatment.

As these women drink secretly at home, on work trips, (paradoxically) at health retreats and over ‘recovery’ weekends, their family, work and community lives start
to unravel and crises escalate. The stage is set for them to eventually lose their home, children, marriage, career, finances and transport; and, ‘it is [widely regarded as] their own fault’. So, in addition, they take on the blame and guilt associated with this situation. Sadly, many reach the stage evident in the expression ‘I can’t stop and I want to die’ [39]

Many of the women in recovery commented on the relative ignorance of most health and medical professionals about issues related to women and alcohol use. Counterfactual thinking and emotional distress are major factors affecting the most vulnerable women [40, 41], with a number of medical practitioners being unaware of, or not taking into account, the complex interrelated factors that are involved in this disorder. Women in recovery were able to significantly raise their GPs knowledge and skills base as they recovered through AA; and to provide their drug and alcohol counsellor with important new research information. A critical block for progress is that alcohol dependence contradicts the dominant assumption in Australia: that the ‘disadvantaged have the greatest potential for illness’. We found that most of the women who were alcohol dependent were not disadvantaged. One of our participants, with over 20 years in recovery, recalled that doctors laughed at her brave suggestion that she might be drinking too much, stating, ‘nice ladies like you don’t have that problem’. Such medical denial is still experienced today by highly educated and salaried women. Others who are partnered to heavy drinking males, and who ask for help because they can no longer ‘keep up’ and meet social and business commitments with their husbands, commonly receive the same treatment. For some husbands, it is more convenient to leave the ‘tipsy’ wife at home, whereas the women are more likely to go to their doctor to talk about intimate relationship problems [42], anxiety [43], depression [44] and the issues of transmenopause [45]. Additionally, we were told of violent rages by the women, sometimes with the police and ambulances being called.

3. What treatments are these women receiving, and not receiving?

The intervention process today is still predominantly ad hoc. The women in recovery in our study had been subjected to a great range of treatments over many years. Participants who have been abstinent for 30 years reported that they still required support for their alcohol dependence, emphasising that ongoing support and continuity of care [46] is a necessity for living a long and contented life in recovery.

Most women have to struggle to get the kind of effective help that they can incorporate into their functioning life. Unfortunately, for many this is not provided until their abuse of alcohol escalates to requiring emergency care with legal constraints [47]. For most women, early intervention in midlife is prevented because of the expectations on them to care for others, before themselves. Enabling these women to care for themselves is a core challenge; and the community and their health practitioners must work with women, and Australian society, to meet this sociocultural need. Senior practitioners in our study critically observed that in Australian society today, women are still working out how to be ‘their own woman’, rather than striving to meet the expectations of others. The difficult nature of being a women in Australia has been clearly raised through the 1977 Royal Commission on Human Relationships [48], the first National Women’s Health Policy [49], the Senate Committee of Review of the Inebriate Act 2001 (Alcohol Taxation) and now the review of the National Women’s Health Policy being conducted in 2009 by the Department of Health and Ageing. Whether one is a teenage girl, career woman
wanting a family, a perimenopausal woman, or a new widower, it is still difficult being female in Australia.

It is clear from the women and practitioners in our study, and our extensive, transdisciplinary literature review and secondary data analysis, that midlife women need much more support to effectively transform [50], in specific stages, from unhealthy dependence to healthy independence. By analysing the results from three action research cycles of data [51], we recognised that the experiential and reflective change process is extensive and commonly involves three stages of recovery, with specific types of care being needed during each stage. For convenience we have labelled these stages the 3 Es: Engagement (in the early stage of recovery), Embodiment (during the maintaining recovery stage), and Enrichment (throughout the sustaining recovery period). Similarly, encouraged by the women's preference for textual naming, we used the following 4 Bs to refer to the personal work the women must become engaged in throughout this process: Bonding, Belonging, Believing and (feeling) Better. We summarised their parallel psycho-socio-emotional learning as involving the following 5 Rs: developing Reciprocal relationships, Rightful respect, Responsibility, Respite and complementary Roles. A deep perspective shift seemed to occur during the late early and maintaining recovery phase of Embodiment. For the participant women in recovery, actualising the Es, Bs, and Rs was achieved through an evolving process, integrating individual work with such external support as AA and counselling. It was costly for these women and their loved ones in more than financial terms [52]

It is essential to understand the realistic amount of time that recovery in midlife requires to reach positive outcomes. If you have been drinking for 10 to 30 years it takes time to transition, often a number of times [53, 54] to achieve sustained recovery; certainly more than a few weeks, or even a few months. We found that achieving early recovery can take 3 to 5 years; maintaining a recovery lifestyle develops over 3 to 12 years; and sustained recovery, a whole-being life-change, occurs after 8 to 21 years abstinence. Alcohol dependence is a chronic illness, an evolving lifespan event. The women participants in our study, who were engaged in new long-term therapies and rehabilitation programs, had been in recovery for 7 to 32 years. It also became clear that other illnesses (comorbid diseases and disorders [55]) can complicate the lives of midlife women with alcohol dependence. Recovery then becomes a dominant theme for the remainder of life in many of these multi-diagnosed abstinent women, and it is likely to become their ongoing approach to living life well.

Indeed, it is unusual for dependence to be a singular diagnosis. Counselling for ‘other women’s issues’ [56, 57] must support and not undermine commitment to improve coping skill and self-change development for continuing long-term recovery from dependence. Age and number of years drinking is particularly significant from a woman’s 40s onwards; when it may feel more difficult to participate again in the school, church, community, and work, recreation and family leisure without drinking. Being with in-recovery peers assists with integration and provides new opportunities to socialise. Such experiences contribute to motivation, and to a sense of hope that ‘older’ women who are alcohol dependent and not drinking can have a happy and useful life into the future.
4. What are the clinicians/practitioners providing, and not providing?

Most clinicians emphasise an individual harm reduction and harm minimisation approach. Based on our research, however, we strongly recommend that enabling abstinence [58] be the primary goal. It should be noted that the women in our study came to this abstinence goal themselves. Women talked about the distress, confusion, frustration and lying associated with ‘controlled drinking’ [59, 60]. Many had used detoxification and rehabilitation facilities, and also AA [61]. Whereas most relied on a combination of AA, medical therapy and counselling, others began with AA, ‘progressing’ to their own approach or a Salvation Army (or like organisation) program. Very few of our participants were able to do it themselves [62]. All stated that the time it took to establish their recovery pathway could have been reduced, with relapse episodes fewer and shorter in duration (some women had no relapses), if there had been better public and expert understanding of a woman’s life concerns; and of the ‘commonly accepted and powerful’ place of alcohol in Australian culture.

The on-going changes involved in women’s recovery demand that support for respite, rehabilitation and ongoing chronic illness management [63, 64] are recognised as important requirements for midlife recovery. Many women noted the need for access to better help when they were starting to feel ‘not themselves’, and for understanding the causes of this.

The complexity of this alcohol dependence was evident in most of the stories and suggestions for improved support. When the women suspected that they were drinking too much they were able to identify likely precipitating factors, such as: not sleeping or eating properly (even using alcohol consumption to sleep and lose weight); needing a holiday or a change of job or husband/partner; difficulties dealing with teenagers, deaths and caring for aging parents at the same time; becoming work stressed, exhausted and tearful; often feeling tense, impatient and angry; not wanting close contact and intimacy and needing space; and not feeling happy or enjoying social activities. Their discussions relating to such issues with practitioners and friends resulted in diverse diagnoses and treatments. Feeling fearful, withdrawing to a small ‘place’ alone, avoiding or pushing ‘help’ away, forgetting and making mistakes, and demanding that events and circumstances happen on their terms were common scenarios as these women’s level of drinking increased. At this stage, women may ‘choose’ to manifest a mental condition or curable dire illness in preference to the possibility of being labelled as having an alcohol problem, and of losing the one thing that they have come to rely on to ease their desperate pain and blackness, a drink. In this state, they believe that life could not be lived without a drink.

These women often spent many hours (and dollars) changing their doctors and counsellors; and many talked of difficulties finding a practitioner who could help them, and provide the support and expertise needed for their particular stage of recovery (early, maintaining, or sustaining recovery [65]). Cost of recovery was also a critical issue. Examples included simple things like buying vitamin B1, paying for yoga classes, arranging time off work (home and career), child-minding for self care, and allowing extra time to take public transport to group therapy, other meetings or doctor’s appointments. Access to ‘the family income’ is essential at this time, and that such access is not denied.

The need for access to a choice of gender-responsive, women-oriented midlife places was mentioned by all participants over the three years of the study. We called this a WM (Women in Midlife) living space that could support their ‘ecology of recovery’
Within this ‘ecology’ are people that will support the women to form a healed identity, practice positive socioemotional relating [66, 67] and reach self-managed care. This care is enabled through compassion, credibility and commitment, the most needed 3 Cs. Some told of feeling ‘undeserving’ of this within particular health, medical, community and family settings. The stigma of a woman with an ‘alcohol problem’, which by midlife in many women has also become a self-stigma [68], is a major barrier to seeking treatment. Many women participants spoke of ‘not ever wanting to be like …their mother, their father…’. Even with hindsight, for the women with a genetic predisposition and family history of alcohol misuse, their feeling of failure was paralysing. Another major barrier is the role and performance expectations for most midlife women – who must be ‘seen to be doing it all successfully’ – even doing recovery well. This is a particularly strong and destructive message for many Baby Boomer and Generation X women.

Ongoing access to a WM space for respite can enable these women to deal with the practicalities of life in the face of unrealistic expectations. They also need special places for family and peer education and support. The women participants closest to Generation Y characteristics, more than others, noted that the work to become abstinent, and to become a woman in recovery, was very difficult. This aligned with the 26 to 34 year-old women in recovery who showed an interest in the study and are willing to contribute to further studies. The staged approach was essential, as were reminders of monitoring ongoing physiological effects, and developing relationships with professionals and recovery peers [69]. The process of conversing [70], changing assumptions, attitudes and perceptions of broader life contexts, coping with personal and family circumstances, and self-caring all become more recognisable and doable over time; as does a woman in recovery re-entering family [39], work and study environments, and establishing themselves in their recreation groups and communities as well, capable and mature midlife women.

The two issues that Cycles 4 and 5 will focus on, drawn from the results of cycles 0 to 3 [71], are:

1. midlife women’s feelings of isolation, fear and despair in relation to admission to most emergency care units [72] and detoxification clinics; illustrating Australian society’s embedded false stereotypes and discriminatory reaction.
2. the focus, in some private and public rehabilitation programs, on younger people’s dependence issues, and relative neglect of older women, possibly due to an education gap around the complicated nature of midlife alcohol dependence and the need for abstinent recovery care for women.

Practitioners, GPs and specialists in the field are being asked to consider the suggestion for a change of emphasis from rehabilitation to ‘recovery education and development’; and a participatory care model that evolves through maintaining recovery to sustaining recovery over the long term [73, 74]. These are examples of aims of this transdisciplinary research being enacted.

Based on our study, we are also questioning the diagnostic value of the term alcohol abuse, and its place in the diagnoses spectrum of the syndrome [75, 76]. Perhaps it should be reserved for describing the self-harm type of drinking that some of the women in our study identified and described. Finally, with the National Alcohol Strategy and the National Women’s Health Policy being reviewed, translating these research results into informed advocating for midlife women with alcohol dependence is on the agenda for this ongoing action research.
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Appendix 3.2: The RWR media information engaged journalists and with coverage more people volunteered

Staged media placement – RWR Withnall (UWS HERC 06/091) – November 2010

1 Early Indicators 2 Advocacy Approach

1. Early Indicators – Providing quick answers for simple December feature

Give 'Early identifiers Women Matter' which is in the 'Give Your Mind and Body a Break' approach [JW – women need to learn a self-care break, that doesn’t use alcohol as a reward]; and the important messages below: 1, 2 and 3.

1. There are government and non-government alcohol services that are capable of supporting midlife women, by considering and acting on our research recommendations, but the support currently being provided is inadequate. AA is currently offering the best support.

Advocacy – There needs to be positive action by women to go to their GPs, and to addiction, mental health and community health services and make the point that they need support. This is very difficult for midlife women who have AUDs; most need other women to support them in seeking help. We can provide a simple ‘pathways to seek help information box’, and the ASK acronym from our women with over 25 years experience of abstinence.

ASK: Action into abstinence; Seek safety and support; Keep-on asking for help from knowledgeable people

2. Ask practitioners to contact us for more details and provide them with two of our research profile websites: RADAR and ROAR. For responsible action to be taken (old ways=old, few positive, results), practitioners need to become aware of our Conclusions, Barriers and Recommendations. These can also be released via bodies such as ADCA, APSAD, DANA, NADA ANDF lists, and via our Portal and Alert research sites.

3. Intergenerational female change: Finally, we could also emphasise the NHMRC 2009 guidelines to indicate that all women need to follow the recommendations to stop intergenerational alcohol dependence. Introduce the – 'one, two drinks and no drink limit' [JW – 1 drink day 1, 2
drinks day 2, 0 drinks day 3, because of progressive neurotoxic damage] and the 'single and next question assessment' guide [JW – 4 drinks in the last six months?, and ask to talk about 'Women Matter and Give Your Mind and Body a Break' and make a next appointment]. **However, we currently have nearly 500,000 women (35 – 59 years) in Australia with a high-risk drinking problem now.**

2. **Advocacy Approach – More exciting, and can get better ‘on the ground’ results for women**

Go with 'Early Indicators’ with the proviso of a January, February and March 2011 feature–supplement. This would provide more help for the January 2011 drinking crises i.e. the magazine is responsibly supporting with a real women’s matter through a contemporary, women-oriented, pragmatic approach (based on our research).

I am also considering a more targeted approach via sector leaders e.g. Professor Margaret Hamilton and Professor Ingrid Van Beck (who spoke with me at the ANCD seminar). They might put their viewpoint on the need for women’s targeted support, and for our current research outcomes to be applied and continued.

DANA is moving to upgrade their guidelines for alcohol and other drug specialist nurses; I have indicated that we can help with current research results. Also, we are contributing (in a simple way) to the new Association of Participant Service Users Guide for Providers of AOD Care.

There is the National Alcohol Strategic Plan for 2010-2015, which is in 'nowhere land' due to its critical review, and the federal election.

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See the Media folder on DVD for more examples
Appendix 3.3: RWR stories of human experiences attracted the media and more Australians learned about how women recover with AUDs

CAREER-oriented women who consume alcohol to keep up with male colleagues are increasingly finding themselves battling drinking problems.

A survey of drinking habits conducted by the University of Western Sydney has found career drinking among young women is behind a large increase in the number of middle-aged women reporting problem drinking.

The ongoing study, based on interviews with 120 women over three years, found a dramatic difference in the “alcohol life cycle” of women and men.

Are you drinking more because of work? Tell us below.

It suggests the number of alcohol dependent middle-aged women has been underestimated.

Researcher Janice Withnall said a kind of “supermum syndrome” among women aged 35-55 means many were drinking in private, denied the extent of their drinking habits and were reluctant to seek help. Australia’s drinking culture and feminist movement are partly to blame, she said, with women reporting drinking to keep up with peers in the workforce as the beginnings of their problem.

“In the early 1980s we saw more women entering management areas,” Ms Withnall said.

“A lot of business started to be conducted at lunches, dinners and after hours. A lot of career women in their 20s think they need to drink like the boys to get ahead. Suddenly they hit their 30s and realise they are not in control.”

She said environmental factors played a bigger role in women’s drinking life than men’s.

Over a glass of wine at a lunch meeting in the city yesterday, finance workers Linna Tran and Angela Davis, both 31, said alcohol was present during at least two work-related functions a week.

“You might be out of place if you don’t drink,” Ms Davis said.

National figures suggest 16 per cent per cent of women in the mid-life group suffers alcoholism, but Ms Withnall estimates the figure is closer to 25 per cent.

Appendix 3.4: Summary of the study and information sheet
file attached

The following six types of explorations were planned in RWR to gather and
Researching with Women in Recovery - HREC No 06/091

JB Withnall, University of Western Sydney, NSW, Australia

Summary of the study – Cycles 1, 2 & 3: How Midlife Women Achieve
Early Recovery from Alcohol Dependence

and INFORMATION SHEET

For Cycles 4, 5 & 6: How Midlife Women with Alcohol Dependence
Maintain and Sustain Recovery

This transdisciplinary, qualitative action research was initiated in late 2006 to
explore why the number of midlife women diagnosed alcohol dependent in Australia
had risen from 8% in 1996 to 16% in 2005, with most being non-disadvantaged
women. In mid-2008, with completion of the research cycles 1, 2 and 3, we will
make recommendations for the implementation of more holistic and gender-
sensitive ways for addressing and preventing any further increase. These
recommendations will be based on the experiences of both women who have
achieved abstinent recovery in Australia and qualified health and medical
practitioners who provide care and support for midlife women with this complex
and ongoing disorder. Following on from this foundation, research cycles 4, 5 and 6
now being conducted are designed to detail how women with alcohol dependence
can more effectively maintain and sustain ongoing recovery.

Australian Background

The annual cost of alcohol misuse in Australia, in days lost only, is $1.2 billion
(Collins & Lapsley 2002). In 2007 the Australian Longitudinal Study of Women’s
Health noted the rise in hazardous drinking in 45 to 50 year old women. The stigma,
misinformation, lack of specific research and refinement of treatment for this
particular population of midlife women (Lynskey 2005) combines to discriminate
against them. The complicated midlife period for women as ‘Baby Boomers’ and
‘Generation X’ is a stressful tipping point. A major issue is our societal paradox of
outwardly accepting female drinking, yet condemning women who drink too much.
Women are affected by alcohol differently to men, with more damage occurring at a
quicker rate (Mann 2005). The upward trend in diagnosis of alcohol dependence is
continuing, with the flow on effect of more younger women drinking more, and the
fact that less than one woman compared to three men with this problem enter
treatment during midlife (Cohen 2006, Green 2007). Healthcare and ongoing
recovery for midlife women can assist children, teenagers, older relatives, their
community and the economy. There are family examples in this study of three
generations of alcohol dependence, with intermittent harm reduction.
A brief summary of what has occurred in Cycles 1, 2 and 3 of this study

Our action research methodology (Reason & Torbert 2001) is employing multimethods of data collection from women in recovery with more than two years abstinence, and from qualified practitioners who work with women with alcohol dependence. So far it has involved three cycles of contribution and dialogue. This depth and breadth has enabled us to explore the complexities and processes of the women’s reality and lifeskills and the practitioners’ strategies and concerns.

In these cycles of the study few health and medical practitioners and women were up-to-date with the current understanding of women’s drinking life course and its difference from men’s. The particular biomedical and psychosocial distinctions that occur as ‘tolerance’ and ‘withdrawal increase’ was not identified in early stages of women’s alcohol misuse. In the general population as well, most people were largely unaware of women’s genetic predispositions and of the environmental risk factors for alcoholism, which are different from men’s. Nutt (2006) considers that for women the influencing factors are up to 30 % genetic and 70 % environmental, and that genetic/environment interaction continue and change throughout one’s life. There was limited appreciation of feelings of ‘isolation, fear and despair’, and of the particular barriers for women seeking access to effective health treatments and support, and retention in those services (Cohen 2006, Green 2007). Barriers include stigma and ‘undeserving’ attitudes towards ‘older female drunks’. For most women, functional difficulties such as travel time, childcare, carer respite, extended leave, stable accommodation and social support need to be addressed. Paradoxically, in our ‘intoxication is OK’ culture in Australia there is also a prevalent moral viewpoint about alcoholics being ‘bad’, even though alcoholism is a recognised disease by the World Health Organisation and a disorder by mental health diagnostics.

Our proposed neuropsychoemotional-bioecosocial (NPE-BES) model of ‘How women live recovery in Australia’, derived from this research, highlights the need for a suitable recovery environment, supportive collaborating practitioners from related fields, time to transition through stages of recovery and accompanying shifts of identity achieved through transformative learning (Hill et al. 2004). The model focuses upon a life course change needed for recovery through a safe, nurturing place with time to focus on the women’s self engagement, embodiment and enrichment (Withnall, Hill & Bourgeois 2007), and respectful therapeutic and peer support (including such programs as AA). This enables women to establish a ‘healthy’ self, build resilience and progress towards self-managed long-term recovery. Ways of seeking counselling for ‘other women’s issues’ (Niv & Hser 2006, Greenfield 2007) is also a necessary component to ensure positive coping skill development for continuing long-term recovery.

Our language analysis of the data set supports the value of more careful communication when screening women from their 20s onwards, establishing early intervention indicators (such as two questions; Vinson et al. 2007), lifespan progress and lifestyle evaluations for midlife and older women, and a more collaborative developmental, including behavioural, approach to maintaining abstinence and achieving sustainable recovery.
Cycle 4, 5 and 6 of this study

In Australia, the extent of physical and psychological damage to women, families and communities, and the apparent inability of the health system to adequately identify and initiate a healing process for midlife women, is distressing and changeable. The women in recovery, and the overworked professionals representing their communities of practice participating in this study, insist that there is hope for change and that improvement must occur. So the study continues with cycles 4, 5 and 6 to identify ways to maintain and sustain women’s recovery for this chronic and relapsing illness in midlife.

This research is not only about collecting empirical data, but also about exploring of the qualitative information relating to the life experience of those involved. The people invited to volunteer to participate are women with more than 7 years in abstinent recovery, practitioners with more than 20 years experience in the field in Australia, and professionals in selected disciplines that focus on midlife women’s health and wellbeing. A group of participants from cycles 1, 2 and 3 are also collaborating, as is the study’s Expert Panel established through the Human Research Ethics Committee, as recommended by the study’s supervisors. As occurred previously, at each cycle of the study, practitioners review a summary of women’s responses, and the women review a summary of the practitioner’s responses. Provided to participants, along with questionnaires and response sheets, is an overview of cutting edge research and clinical materials for consideration. Expressing insight, reflections on ways to improve the current status quo, and creativity are encouraged.

The details of this research, its transaction philosophy and methodology, results and findings, will be published in thesis form. Outcomes of the study include: evidence-based information on midlife Australian women and their recovery from alcohol dependence for health and medicine education and training curricula; helpful suggestions for early intervention and ongoing management for practitioners; information for women and families concerned about a possible drinking problem, especially intergenerational dependence; media information; and current Australian research conclusions focused upon midlife women for consideration by policy makers and alcohol dependence and addiction researchers.

References available from Janice Withnall, Researcher – PhD candidate

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The Research Supervisors are Professor Stuart Hill and Dr Sharon Bourgeois, both of UWS

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval Number is 06/091. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (Tel: 02 4736 0883 or 02 4736 0884). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 3.5: Confidentiality and anonymity was carefully maintained using the appropriate RWR Ethics Guidelines

University of Western Sydney          HREC               06/091
Dear                                      Date

Women in Recovery from Alcoholism – Participatory Action Research

Through your responses to the My Recovery Questionnaire, and to the Question 58 Issues document we have been doing what is called ‘communication of the first kind’, in which you have generously been providing information about your reality as a women in recovery.

Through the study’s next stage of an Interview and, if you wish, the Web Discussion Board, the research process now progresses to ‘communication of the second kind’, where information is better understood and new knowledge comes about. As part of this research, such knowledge can be used to help women alcoholics in Australia, both active and in recovery, as well as practitioners and the health system.

This stage is exciting for us as we look at complex situations and seek fresh responses based on your reflections on both your lived experiences, and those of others. Thank you for contributing.

Your suggested Interview time

Please check the details below and if they are incorrect please let me know by phone or email.

Date    Time    Your Telephone Number

Place

Please note that the Interview questions are attached to this letter for you to consider before our meeting time.

Web Discussion Board Access

The Web Discussion Board is a private University site on the Internet that has been set-up as a confidential space for only women primary participants of this research. Through this site women participants, using only codenames, can explore recovery amongst themselves and with the researcher. There are a number of topics on the Web Discussion Board that can be used as a starting point. You are very welcome to contribute your own ideas for discussion.

How to access and use the Discussion Board

Please be assured that you cannot harm the Discussion Board. Play with the features on the site and if you have any questions please call Janice on 02 4570 1194.
In a Search Engine such as <google.com>, type <uws.edu.au>, (don’t type <>)
Under the site called University of Western Sydney – Home, click on E-Learning
Then click on Login to E-Learning
Login using your codename as your Login ID AND use your codename again as your PASSWORD
Your codename is

Click on Women in Recovery
Click on Web Discussion Board Topics and read this information
Then click on whichever Topic you would like to contribute to
Click on Compose Message

If you would like to start your own discussion topic, just use the words NEW
TOPIC with a few words of explanation in the Subject line
Describe your ideas further in the message box
Click on Preview and then Click on Back
Make any changes and Click on Post

You need to log out when leaving the Discussion site by clicking on Log out which is in blue text at the top right corner near Help

To exit from E-Learning and UWS Home use the Back button.

You are welcome to read the other documents on the Discussion Board relating to a Creative Recovery study completed in 2004 and 2005.

Thank you for your caring, participating, and especially for sharing your experiences and important ideas. We will continue the study by sending Practitioners Comments on Women, Alcoholism and Recovery in Australia to you.
Please consider the comments and your response will be a great help in further understanding the recovery from alcoholism experience.

Yours collaboratively

Janice Withnall

PS: If there are errors, please let me know, thank you

For further information please contact Janice Withnall, Researcher-PhD candidate.
Telephone: 02 4570 1194  Fax: 02 4570 1190
Mail: UWS, Hawkesbury Campus, Building G/IT, Locked Bag 1797, Penrith South DC 1797.
Email: 94302279@studentmail.uws.edu.au

The Research Supervisor is Professor Stuart Hill, University of Western Sydney.

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval Number is 06/091. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (Tel: 02 4736 0883 or 02 4736 0884). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 3.6: A blue flower was used in reporting Action Cycle 4 outcomes at the International Women’s Mental Health Council Symposium in Melbourne, Australia, 2008

Intoxication Risk Estimation from Proportion of the Past 30 years. (Wagner & Bunnell 2000)

Additional information to support the graph is as follows:

- A blue flower was used in reporting Action Cycle 4 outcomes at the International Women’s Mental Health Council Symposium in Melbourne, Australia, 2008.
Appendix 3.7: For the telephone interview, participants chose from a list of questions what they wanted to be asked

Script for use with telephone interviews Action Cycle 2 Women

Please read the Stage 2 Set a and Set b questions. The woman has been sent a copy.

Technology

Plug in cassette recorder to power. Check cassette tape is in the correct way. Put in headphone ear jack. Practice.

Lie the cassette recorder on its side. This helps it not pick-up white space noise. Adjust volume dial to midway.

Push the recording button and dial the telephone number. Put the earpiece to the microphone in the cassette recorder. You should be able to hear in your headpiece what is being taped. Speak towards the phone. You can put the listening piece near the microphone and the speaking piece upwards to you.

Press stop and rewind tape and play back the recording. Adjust volume. Set counter to 000.

Interview Script

When you ring the number, identify yourself as Abigail from the University and ask for the woman by first name only. Do not tell anyone else what the call is about. If it is someone else, just say you will ring back.

Once you have confirmed it is the correct participant, check which question set she has chosen. Assure her that everything will be OK and support her to answer the way she wants to. Emphasise the information is confidential and anonymity will be maintained.

Remember to keep addressing the woman using her codename or first name only.

Clearly state that the woman can stop the interview at anytime, and the interview can also be rescheduled. Emphasise that you will ask the question and carefully listen to the answer but you will not engage in conversation. The woman can say whatever she wants and the first thing that comes into her head when the question is asked is what we need. Elaborating on her answer is also what we need.

Equipment check

Explain that you must first test that voices can be heard on the tape. This checking will take a few moments and you will talk the person through. Do not use any question in this checking. When this is worked out - Check the woman is ready start.
**START**

Introduce yourself and ask the identifying and approval information. Clearly say the question number and question.

Encourage by saying ‘yes, aha, we can hear you, keep speaking in a strong voice’.

Keep saying which number question you are asking. Ask if the woman is ready to move onto the next question. She is also welcome to add some more...

Also, assure her she can take a break by asking to stop after a question. Stop the tape and make sure the woman is OK and then check the tape and continue recording the interview. Keep explaining what you are doing (remember you can’t be seen).

If she says ‘she doesn’t understand or, is this that what you want, or, is this right’, just keep encouraging her that what she is saying is exactly what we want.

**SAFETY**

If something very strange happens, ask if the woman is OK. And if really you become concerned ask if she needs help and who you can ring to care for her. (Call me of Stuart Hill if this happens)

**FINISHING**

When finished, thank the participant and state that you are stopping the tape. Ensure that the woman knows she will be mailed results and that her participation is a great help for other women with drinking problems.

Say goodbye pleasantly, rewind the tape and label it with the codename – then transcribe.
Appendix 3.8: A heuristic of data collection and analysis
Key: A heuristic of data collection and analysis

The basics of collecting experiences, observations, relevant external data and exploring and analysing ideas are illustrated in the figure above. The Action Cycles are on the left of the diamonds, the data collection methods is shown on the four sides of the diamonds (representing the four Dynamic lines of Inquiry), the small diamonds represents the participants’ responses to result summaries and the levels of analysis (trials) on the right of the diamonds.

Trials of analysis, interpretation and evaluation techniques were also shared with participants as was knowledge translation information. The factors that made a major difference in RWR were the shared:

1. Questioning, evaluating, interpreting and distilling of meaning;
2. Constructing connected understandings; and
3. Continuing to communicate to find agreed ways to express the results and findings.

The RWR research design was inclusive; all participants had choices on how they preferred to contribute. Participants’ responses and queries were part of the next Action Cycle questions to be asked. For participants and readers of the work the goal was to be transparent and provide access to comprehensive information on the data collection and analysis processes used to establish preliminary results, results summaries, preliminary findings and conclusions (Sandelowski 2002).

The processes of cooperative analysis (Schultz 2004, Lipsey & Wilson 2001), collaborative sense-making (Wideen, Mayer Smith & Moon 1998), the continuing use of multiple lenses (Peshkin 2001) and concept maps (Suri & Clarke 2009, Pettigrew & Roberts 2006) was included in the complete Diamonds Action Cycles and Pearls diagrams. In RWR I purposefully integrated data through the participants initially and then with the use of NVivo (8 and 9; Symth 2006), feedback from experts (contacted by email), supervisors and select groups of participants, e.g. Participant Reference Group.

Reflexivity

Reflecting upon, examining critically, and exploring analytically the nature of the research process, during the research, began with the attention tradition, ‘logic-in-use’ (Kaplan 1964). Reflexism (Denzin 2001, Mauther 2003, Daley 2010) is now encouraged; that is engagement with one’s own research actions (reflection in action Schon 1983, 1987) and with others in a self-reflective way. Reflexivity is often employed in change management processes (chronic illness; Kralik 2004, AOD; Australian Government 2005, addiction; McKay 2005, recovery; White 2006, self-management; Price 2007, dual diagnosis; Drake 2007, substances; Hofemeister 2009, integrated care; Greenfield 2010). A researcher, with practice, can be aware moment-to-moment of emergent behaviours, and – through reflection and research – of their possible consequences, connection to past events and underlying explanations. Developing this ability enabled me to quickly improve the research process as needed. Testing my perceptions, and developing new skills and theories of action (as reflexism) were informing techniques of RWR.
Appendix 3.9: The Tri-thread feature expanded the RWR Knowledge Production Framework

The Tri-Thread was incorporated within both the RWR Transactive Participatory Research Process, and the RWR Knowledge Production Framework, as a critical integrator of the research design. Published research on midlife women with AUDs and recovery is minimal (as outlined in the Literature). I needed to employ an iterative and coherent group of methods over the seven cycles of RWR to explore the topic in a collaborative manner. The intricacies of TPRP, and the Tri-Thread, enabled me to facilitate and manage an expansive and holistic inquiry. Together with the participants, I pursued the pragmatic premise of the trial study: ‘That alcohol-dependent midlife women can stop drinking and sustain abstinent recovery, and that this complex change process – from active alcoholism to abstinent ways of living – can be understood, explicated and translated for everyday use’.

Figure 1: Three strands in the Tri-Thread of RWR TPRP and the Knowledge Production Framework (KPF)
The solid (spiral) line in the represents the Tri-Thread perspectives and techniques used to assist the processes involved in research knowledge production (situated, people-oriented and generative outcomes) throughout the study.

The Tri-Thread was designed to accommodate changes during my study of women’s recovery topics as they were identified, prioritised and developed within the research process. The spiral aspect of the Tri-Thread illustrates the characteristic of self-reinforcing energy and progression, while accommodating exploration of paradox, ambivalence, and pluralism with human change (Eisenhardt 2000). The Tri-Thread inputs were concurrent and continued throughout the study as a rigorous, yet flexible, element of input to the research overall, knowledge production and the transactive participation in the RWR methodology. Response to the Tri-Thread inputs also influenced the selection of methods, and the design and management of the instruments of data collection, analysis and reporting of results and findings.

**Tri-Thread process enabling exploration of complex issues**

Within RWR the women’s and practitioners’ complex recovery, the issues raised by the women and practitioners were considered as potential sources of ideas for better understanding the processes involved (know-what^), and the women’s lived experiences of addressing them (know-how^); this involved utilising TPRP and KPF for Mode 2 knowledge production (MacLean, MacIntosh & Grant 2002). Using the Tri-Thread helped me to identify, articulate and develop actionable knowledge for change (Adler, Shani & Styhre 2004); relating to women transforming from active alcoholism to long-term recovery.

An example was exploring a topic that emerged through my observation of recovery in the community: how power affects women’s recovery, how it is applied by women with AUDs, and how it is used by practitioners, e.g. ambivalent power (Etaugh & Bridges 2006), and replacement of ‘power-over’ by mutual empowerment (Miller 1997, 2003, 2010). The roles of power in the RWR spiral Tri-Thread (which is self-referencing) are summarised below, and discussed further in the following chapters:

- Systems and ecological thinking can nurture ideas about, and the application of, ‘distributed power’ (Torbert 1991); by raising awareness that acknowledges the mutual interactions of the main agents in the system (initially, the practitioners and clients). Positive adult recovery care emphasises and enables the development of perspective, mutuality and adaptability, rather than control, coercion and punishment. Within a paradigm of knowledgeable action, adults can work towards integrative objectives, using power to question and broaden issues raised in discussion (Walker 2010), to achieve something more like a just environment with inclusive patterns of living. Advocating for rights of representation for clients and supporters in a just health care system also means assisting, through recovery care, with processes that enable clients

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1 Feminism as predictors of relationship health, results revealed that having a feminist partner was linked to healthier relationships for women. Additionally, men with feminist partners reported greater relationship stability and sexual satisfaction in the online survey (Rudman & Phelan 2007).

2 Self in relationship (Crowder 2012) with the connection and importance of empathy and self-compassion in how we come to understand the ‘self’.
to develop autonomy, self worth, and better negotiation skills for decision-making.

- Transdisciplinarity offered methods of bringing power as strength and healing to vulnerable women (Jordan 2010) by maintaining a continuum of connection with other people in recovery. Throughout the study, I continued to provide new and supportive information for those interested in seeking positive associations and affiliation leading to healthy relationships. The contributions broadened my explanations of the perceived ‘problems’, and of the ways of change, including the need for a place for healthy opposition in relationships. My role as facilitator included offering contemporary research literature to practitioners for considering possible falsehoods in professional information, e.g. interventions that were assumed to be evidence-based, such as West’s (2005) Transtheoretical (Stages of Change) Model, and Longabaugh’s (2007) mechanisms of change.

- Because communicative exchange commonly involves an exercise of power in our society, it was important to help the women to identify the ideological workings of language (Fairclough 2001), and become better communicators. The women and practitioners who had found effective ways for creating and co-ordinating acceptable and competent change (power with people; Walker 2010) provided rich responses in RWR; these provided models for other participants, and approaches to knowledge translation that I, and others, could use with broader audiences. Sharing the positive experiences of women’s self-expression, and appreciating tranquil outcomes of power being used in the service of positive values, encouraged participants to reflectively consider their own and others’ beliefs, and others’ opinions and advice. Communicative activity also provided broader choices for women when making accountable decisions for maintaining self-care, establishing new affiliations and supportive links to improve their recovery.

The recursive nature of my study, and the feedback responses from participants, helped me to achieve my research aim of empowerment; by the study processes of the participants contributing to the RWR. Importantly, the research processes assisted in revealing the ways in which power operated in the knowledge production process itself. I encouraged an understanding of the benefits of participating in the research experience. Participants’ growing awareness (and their learning) increased their capability to identify and contest questionable ‘knowledge’, and then to suggest, or negotiate, alternative improvements to the processes involved in women’s change and recovery.

An ongoing benefit of the RWR research design was its ability to expose and enable discussion of issues such as ‘power’, prioritise and create new understanding from responses, and present draft results for feedback during each research cycle. Cohort differences (Baby Boomers and Generation X3) in understanding ‘power’ were revealed as a care issue to be addressed. Important for Generation X women was receiving enabling care for developing self awareness, acknowledging the benefits of safe living in the present, and accepting voicing identity as an adult. As a researcher,

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I was able to use this information for providing better intergenerational support for both Generation Y and Millennium women.

Baby Boomers needed encouragement to identify, feel and prioritise their personal choices for managing their own recovery development (beyond parenting and carer-based choices), accepting assistance with their hesitant learning of new skills in early recovery, and taking time for valuing their specific personal characteristics and needs. The Baby Boomers experience could be helpful in addressing the needs of the growing number of Silent Generation women consuming alcohol. In both cohorts, role modelling and encouragement (rather than practitioners just assuming and expecting that midlife women are likely to be resistant, in denial and non-compliant) was able to assist the women in exploring their abilities, and in expanding their capabilities for experiencing and communicating the benefits of ongoing recovery.

**Action of RWR processes and frameworks producing knowledgeable change**

The Tri-Thread provided a monitoring tool (through RWR TPRP and KPF) for understanding the ways of change experienced in midlife women’s recovery that embodied and integrated the cognitive, reflective, affective (Ardelt 2004), and existential dimensions of midlife people’s lives. The nature of the spiral and the Tri-Thread over the seven cycles included various forms of knowledge, enabling the researcher rich detail to explore. The relationships between participation, action and research (action research in healthcare; Hughes 2008), and conscious transactions of RWR, offered ways of change, and new integrations and syntheses that acknowledge the importance of remembering, when considering complex relational systems (Shiell, Hawe & Gold 2008), that ‘the whole is not all’ (Meadows 2008). Being open to the uncertain and unexpected aspects of recovery, within the design of the study, required my knowing and accepting that both I and participants were co-producing living changes as interactive, yet relatively autonomous, ‘self-eco-organizing beings’ (stet, p113 Morin 2008). Participants in RWR were all a ‘human becoming’ (Parse 1998).

The use of enriched knowledge (knowledge-for-action) for developing effective interventions in social work is based upon cooperative ‘hybrid’ knowledge production (a development from the work of Gibbons 1994, Huttemann & Sommerfield 2008). Using components of knowledge from participants (the term ‘components’ is commonly used when discussing interventions in nursing and social work; Spillane et al 2007), as a supplement to that from the literature, and the RWR research process itself, is an example of this form of knowledge use. The research design reinforced the importance of scholarly qualities and their relevance to everyday practice, a quality that interventions need to contain. Throughout the study, much attention was paid to cross-checking the data and analyses, particularly when drafting iterative concepts and constructs, expanding preliminary ideas into models, and when removing earlier constructs. This required maintaining the iterative data, recordings of discussions, and of the field notes that generated and provided new combinations.

As the study evolved, the significant knowledgeable changes were recorded and presented in the three main features of the Tri-Thread model; examples are shown below.
Figure 2: Systems and Ecological Thinking (SET) was an encompassing way of thinking to assist in meaning-making (Thurston & Vissandje 2005) in relation to the recovery process.

The circles represent important aspects of people’s lives; personal, environmental (home, work, neighbourhood) and social. Women with their healthcare team can nominate an issue that is a goal in each aspect of their lives and their recovery, e.g. resolve personal needs, take responsibility, live with others in a respectful manner. Practitioners can enable women to pursue such goals in a safe recovery manner, by discussing the intersections, the common issues involved when women take recovery action towards such goals.
Transdisciplinary Spectrum (TS) provided relevant connections (Tuffin et al. 2001) from other fields that could be used to increase understanding and improve ways of achieving abstinence and wellbeing.
Figure 4: Communicative Exchange (CE) enabled participants to express their lived experiences in detail (healing moments; van Lerberghe 2009), particularly the personal priorities of the women and practitioners.

Women and practitioners can, using the RWR Results, make their own Matrix. It is a tool for communication. Above represent what happens for women during their Complex Recovery phase of recovery (see Chapters 4 and 5). The top row are the content categories, the next row down is the personal actions to be learned, the third row is the interpersonal actions to be learned and some of the topics and tools for effective interactions. The final row is women living a whole-person recovery in wellness.
Appendix 4.1: Multi-methods of analysis in the Diamonds and Pearls methodology

My analysis approach was founded upon seeking agreed meaning to summative results as a way to make initial sense of contextualised actions/experiences. Sense-making by all participants was encouraged and the research provided a space of convergence for respectful, discursive practices in which participants could explore women's recovery with the goal of understanding and providing useful assistance, e.g. targeted methods of healing, healthcare and development interventions for midlife women with alcohol dependence was necessary for recovery to be long-term and lead to wellbeing. I outline below the analysis elements (the thinking tools) used initially in all methods of analysis to constructing an initial meaning, then specific methods of analysis were applied.

Abduction, retroduction, clinical reasoning

Abduction (Pierce 1958) emphasises logic of discovery over the logic of justification (Miller 2003). The collection of information on recovery experiences highlighted discovery of meaning discovery and the abductive and retroductive thinking. Both forms of reasoning is used in clinical reasoning and evaluation (Upshur 1997).

Example of abduction and retroduction

Abductive reasoning involved considering data and exchanging ideas on ‘what might be’ (Miller 2003, Dunne & Martin 2006). In the analyses I incorporated a spiral of ‘abductive reasoning’ (Dunne & Martin 2006) that moved between deduction and induction (Adler 2008). This was based upon an exchange of responses amongst participants (through crossover documents, RWR Update letters and emails), the iterative and recursive design process (including back-checking) and the goal of cooperative analysis. The exploring and reasoning processes continued throughout the research, particularly when outliers and difficult ideas and situations were encountered. Intuitive interpretation, such as abduction, can take the researcher into unanticipated theoretical realms; this is of importance and of value when identifying the how and why people's actions (particulars of the what, who, when and where).

Retroduction (Upshur 2007) is the finding of abrupt ‘jumps’, and reviewing what was a prior construct or characteristic that indicated either a flexible boundary, a finish point or a connection to a complex system. Retroduction can be similar to hindsight, of seeing the detail, links and intricacies of a seemingly chaotic event, and identifying the important features both within and external to the process. Discernment of constructs and characteristics within the accumulating data and multiple readings of rich description assisted in identifying distinctions and clarification of what characteristics belong to each (boundary, finish or system), e.g. isolation and terror and rage or alienation.

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1 Intuitions are defined as “affectively charged judgments that arise through rapid, non-conscious and holistic associations”. It is conceivable that intuitive judgments are envisaged on a continuum in which the non-conscious cognitive processes that support the interpretation of the relevant environmental cues are matched with an extant affect pattern. The detection of a mismatch is noted when the decision maker recognises that something is ‘out of kilter’, or simply ‘doesn’t feel right’
Clinical reasoning

Polkinghorne suggested using phronetic reasoning in psychotherapy (2004). He explained how action choices are embodied and involve emotional and cognitive processes which draw upon a full life of experiences. Women in Recovery participants were tentative with reasoning and logic, and wary of causative thinking. Phronetic reasoning which considered what action will be the best one was more inviting. I selected ideas put forward by participants in the Special Cases groups (see Transactive Methods, Analysis RWR Results chapter). Abductive logic (the logic of what might be; Adler 2008), creative and integrated thinking to assist produced applicable explanation statements (Dunne and Martin, 2006).

Phronetic reasoning in RWR enabled careful examination of the features of dependence and abstinent intradependence for engaging in self-care. Following was explaining the transition through a safe liminal space of professional care to embodying abstinence and interdependence (self, peer and professional) in early recovery in the community. Adequately represent the RWR results which identified transforming to an independent woman through a volitional seeking of self-actualisation (perhaps flourishing). Womanhood and recovery, as with life, involved a vital ongoing process of being stable and well during uncertainty (normal tension and stress) and seeking support when in distress or at times of profound change.

As an example in Cycles 5 and 6 I combined data re-coding and cognitive semantic analysis with transactional discursive activities involving myself and with the Participant Reference Group and Special Case groups. The activities involved considering drafted outcome-oriented ideas developed in RWR. Two example ideas were of a promotion acronym, ASK and a more complex issue, ecology for recovery:

1. The ASK acronym, developed by women in recovery research participants to promote continued abstinence and living well without alcohol, is a positive reminder that not drinking is doable: ASK: Action into abstinence; Seek safety and support; Keep-on asking for help from knowledgeable people.

2. That an integrated healing process needs a special place – a ‘do-able’ ecology of recovery. This includes a supportive female-friendly safe place to re-establish core ordering processes and engage in a triadic purposeful process (see the Findings Chapter) to a recovery self. The safe healing environment supports being safe with our self, safe with selected others, and safe in the world today. A woman can then learn and practice embodying an integrated self, be a woman able to deal with life, without disappearing into disorder. The destructive actions are replaced with enriching action and a sense of being a happy female adult, a woman with choices and abilities for a content life.

Interpretation and integration

Interpretation of the data collected from each Action Cycles, in pairs, triplets and together (Bradley, Curry & Devers 2007). An example of interpretive themes is below.

The five themes drawn from the dataset that suggested wellness and well being were: connection; transformation and evolution; relationship and kinships; meaning for living and being; and resolving challenges. The ideas, feelings and actions around the themes assisted in understanding wellbeing in recovery:
1. **Safe connections:** The importance of interconnection and disconnection, deconstructing and disconnection from the drinking self, and constructing interconnection with core-self, new identities and new people; and

2. **Transformation and transposition:** Changing core beliefs, exploring multiple identities, positioning oneself in new roles; and experimenting with pleasure activities;

3. **Relationships and kinships:** Facilitated relatedness through new friends, mentors, teachers, and kindred spirits by attending to heritage, acknowledging supporters and contributors and accepting family;

4. **Meaningful living:** ‘Being present’ frameworks of a midlife, non-drinking woman, with emphasis on her values; developing new principles; and contributing through work, recreation and community; and

5. **Resolving challenges:** Taking into account the relationships between people, issues of social justice, spirituality, the environment and whole-person long-term healthcare.

**RWR Results from integration of preliminary results**

The challenge of integrating data was considered in the research design, and RWR processes for integration were reviewed formally at Action Cycle 3 and Action Cycle 6 and changed as a result of the review (Charles 1998, Tashakkori & Cresswell 2007, Castro & Coe 2007, van Kouwen, Schot & Wasslen 2008, Castro et al 2010, Teddlie & Tashakkori 2010, Bazeley 2010, 2011). The overall aim was to deliver a thorough representation of participant responses through suitable research parameters (Onwuegbuzie, Johnson & Collins 2011, 2012). Studies using multiple methods of analysis, which are both iterative and recursive, require detailed documentation of the process to investigate the depth and breadth of complex issues (Johnston & Baumann 2007; Onwuegbuzie et al 2009). My decision to use multiple analytical perspectives yielded a more comprehensive picture of women’s recovery than was possible from one perspective alone.

“Integration using different but complementary sources best occurs at the stage where results are being composed, well before the final conclusions are made.” (Bazeley & Kemp 2011 p4)

The integration also included the Action Cycle pair outcomes, Action Cycle triplet outcomes and Reviews (examples are below) developed throughout the research (see RWR Pearl figure for detail later in the chapter). The RWR Pearl Analysis (below) shows the particulars of how the RWR multiple source research data was studied and integrated through a Level of analysis focus, over the six Action Cycles and four Dynamic Lines of Inquiry. The integration work with the RWR data resulted in my total immersion with the material and participants. The Pearl Analysis also provided a fully integrative research analysis and interpretation plan for meta-analysis (Dreher 1994, Schulz 2004, Hanson et al2005, Creswell 2005, Bryman 2007).

Text, in all forms, hold ‘latent structures of sense’ (Kohlbacher 2006). Changing meaning (different participant groups sometimes differed in their meanings and understanding of topics) was noticed through multiple reading of Cycle data and this informed the meta-study and knowledge translation process (see praxis Chapter).
The back-checking clarified significant ideas and assisted with knowledge transfer techniques (Campbell & Oei 2010). Knowledge co-generation and transfer is word play (play on meanings) and can invigorate the mind e.g. alliteration (Fairclough 2005, Shannon 2007, Shoshana 2011). Word play (power of words and affect; Panksepp 2008) can assist with people being receptive and open to new ideas (Reicherts 2007).

Action Cycle 2, Women’s Interviews, meg1 – “Yes, abstinence was hard work, well it was for me. I tried to do it for a long time; I thought I could just ease my drinking, (but) it wasn’t going to work. ...sobriety is acceptance. Abstinence is to constantly think about not picking up that drink. With sobriety you don’t even think about not picking up the drink. That’s how the two different things work with me in explaining those words. It’s only the last three years that hasn’t been a battle.”

Action Cycle 2, Women’s Interviews, pen1 – “Its self-awareness and finding what makes me tick.”

**Theory and data**

Working ‘up’ from data is often presented as what qualitative research is especially about. It is done in many ways: building new understandings from ‘thick descriptions’; reflecting on and exploring data records; discovering patterns and constructing and exploring impressions, summaries, and pen portraits. All such efforts have theoretical results. They produce new ideas and new concepts, which are sometimes linked and presented more formally as new theories. Most approaches to qualitative research also work ‘down’ from theory. They incorporate, explore, and build on prior theoretical input, on hunches or ideas or sometimes formal hypotheses. Many also stress the testing of theory derived from the projects’ data.

Computers provide assistance in the management of complex data. They can also be used in the discovery and management of unrecognised ideas and concepts, and the construction and exploration of explanatory links between the data and emergent ideas, thereby establishing fabrics of argument and understanding around them.
Appendix 4.2: Practitioner Questionnaire Action Cycle 2

University of Western Sydney HERC 06/091
Researching with Women in Recovery Study

Women’s Matters for Consideration by Practitioners

Your Codename

October 2007

Below are the matters women selected from 57 questions as being the most important to them as a sober woman - in recovery. Look at the information below from 1 to 12. Considering your experience of caring for mid-aged women dependent on alcohol, nominate its importance to your work today from the four responses listed below. You are welcome to also write about the issue.

YES this is important  POSSIBLY important  NOT important  N/A
YES                  POSSIBLY               NOT NA

Please answer questions a & b before 1 to 12.

a) From your experience, what is the best way of helping women into recovery?

b) If you could have whatever you needed, what would you do or how would you help women dependent on alcohol to stop and maintain not drinking?

1 ‘I’m a woman, I’m an alcoholic and I don’t drink.’
2 ‘My own sense of security today, is good.’
3 Change and fear – ‘I am working with it, dealing with it.’
4 Can alcohol misuse be prevented? – ‘yes, perhaps, no.’
5 Medications for alcoholism – known about, but not seen as helpful.
6 Age when first tasted alcohol – from 4 years to 15 years – younger age linked with abuse.

7 Age when I wanted to drink – majority from 12 years.

8 Age when I knew I was alcoholic - 60 % from 25 to 45 years – 30 % late adolescence to early 20s.

9 People I love are resistant to my recovery – 80% had an immediate relation negative about the woman's recovery.

10 My relation/s has an addiction – 85 %

11 I am happy with my life today – 90 %

12 Is there a difference in the way Australian society views women alcoholics to men alcoholics? This was the most written about question. A summary of the writings are below.

**It is somehow more pathetic and morally wrong**

*Women are so vulnerable ... seem to be viewed with disdain ... what is particularly horrifying – a drunk mother ...*

*Society sees it more as a moral issue if it’s a woman*

*... it’s not suppose to happen if you’re a mother*

*People don’t see the worst side of women alcoholics ...*

*We are labelled as tarts ...*
They look down their nose at women ...

I feel there is still a stigma for women

Yes, definitely

Thank you

PLEASE fill in the Informed Consent Form, remembering to nominate your codename for the study. With your completed Informed Consent Form return this document to Janice at UWS by mail.

Practitioners’ descriptions are being looked at by the women. We will analyse the responses, let you know the findings and suggest what might be done about them. We look forward to your response.

Janice Withnall

DATE

94302279@studentmail.uws.edu.au

UWS Hawkesbury, Bldg G/IT, Locked Bag 1797, Penrith South DC 1797

Telephone: 0245701194

Principal Supervisor: Professor Stuart Hill
Appendix 4.3: Participants contributing to Action Cycles preliminary results

Basic cooperative analysis procedures were repeated in each Action Cycle, and I used a mindful approach (involving continuous organising to enable wise action; Weick & Putnam 2006) to complete the process with participants. See figure below.

Key

Q3 + 1  Questionnaire 3 + 1 for practitioners

WM  Womens Matter questionnaire for women and practitioners (core-participants )

I - Interviews  Interview (semi-structured / face to face ) and telephone interview trial (choice of questions and topics based on women's selection)

T - TEE  Telephone calls to Experts about subject matter
           Email contact with Experts about preliminary results
Key:

The **Infinity symbol** inside the Diamond is the action research process. Women (W) and practitioners (P) were given my summary (R) of Action Cycle 1 preliminary results as ‘crossover’ documents called First review. The women were sent the practitioners’ questionnaire summary, and the practitioners were sent the women’s questionnaire summary; both were returned to me with participant responses.

The **crossover** (Small 2011) was a managed participatory data collection and analysis tool; shown as the horizontal dotted line of learning.1

‘**First Review**’ refers to my summaries of preliminary results; these included a few prompt questions and/or statements (see Table below) that participants could consider in their review. Participants provided a mix of their personal comments and critical information in response to the analysis prompts.

<table>
<thead>
<tr>
<th>Basic cooperative analysis prompts for all participants</th>
<th>Identify important content, perhaps similar and opposite</th>
<th>Describe the circumstances (context) of women and practitioners in the recovery process</th>
<th>Which terms don’t make sense; and are there more important experiences &amp; ideas not mentioned?</th>
<th>What do you interpret from the summary that can support improvement in women’s recovery care?</th>
</tr>
</thead>
</table>

**The outcomes** included the communication of RWR information to possible contributors through media releases and interviews, website reports and conference presentations.

**The dotted line Diamond** at the top of the shape represented the internal cooperative analysis2 that became part of the data for the ‘formal’ Pearl analysis.

**The Pearl** at the top of the Diamond contained circles that indicated the number of integrated analysis and Action Cycles (2, 3, 4, 5, 6) being studied.

**Pearl JW** represented the part of the critical reflection that I completed in relation to the Links and Levels.

**Link to Action Cycles** refers to my decisions to include new comments to the next Action Cycle as a feed-forward process.

**Levels of Analysis** represented selecting new, contentious and complicated material that I wanted to study further, i.e. by using meta-analysis technique.

**An example of what outcome the Basic cooperative analysis process produced**

The women and practitioners reviewed the Action Cycle 1 summary of preliminary results. The women highlighted struggle, stress and strain, and despair as key aspects. The practitioners included in their responses the clients’ denial and

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1  The Diamond and Pearl participant learning was based on exchange of Action Cycle information. From the learning process came identification of what the participants wanted to know more about. The researcher identified unknowns and gaps that needed to be followed up to respond to the participants and contribute to the RWR process.

2  The research process became an experiential learning environment (Kolb & Kolb 2005), with the formation of social bonds, social learning and social roles (Boeri, Sterk & Elifson 2006).
resistance. I considered their review comments, and provided the participants with information on social emotion3 communication (a particular type of interaction) to assist in mutual understanding and provide tools to enable the women (and practitioners) to engage more effectively.

The Basic cooperative analysis (within the Action Cycles) offered an opportunity to trial my analysis techniques. To consider possible new ideas, I experimented with a variety of forms of content analysis (Mayring 2002, 2003, Krippendorff 2004), ways of establishing meaning of colloquial phrases (Doran et al 2008, Nelson 2008), theme analysis (Black & Rubinstein 2004, Abraham et al 2007), and studying data using abduction (Miller 2003, Dunne & Martin 2006, Upshur 2007). These trials contributed to finding suitable ways of thorough meaning-making (van den Heuvel & Demerouti 2009), integrating data (van Kouwen, Schot & Wasslen 2008) and synthesising data (Suri & Clarke 2009). My unobserved observation of recovery in the community and professional practice also contributed to understanding participants’ data (Hess-Biber & Yasser 2004). Serendipity experiences during the study were also noted for possible inclusion (Plunkett 2001).

“... the meaning of acting, meaning of reflecting and meaning of relating.”
(Biong & Raundal 2007 p 246).

**Personal reflection**

Mature adults (Maslow 1968) are able to reflect on situations they select and on particular topics under discussion with others. Reflection is not a simple matter of thinking rigorously (e.g. just concentration). Reflection-on-action (Boud & Walker 1992, 1998) is absorbing thought, often for a particular purpose, on what can be named or experienced. During the study, on many occasions my reflection was neither positive nor negative, but rather ‘a state of perplexity, hesitation, doubt’ (Dewey 1933). Personal reflection (self-reflection as the focus) has also been described as part of experiential learning (Kolb 1984, Dewey 1933). The reflecting experience itself might include being in a non-time and place ‘moment’ or ‘space’ during which thinking about the action, related feelings and sensations of the event are recognised and reconsidered for the agreed purpose.

Reflection is not solely a cognitive process; emotions are involved (Feen-Calligan, Washington & Morley 2008), as are the other components of affect (mood, motivation and memory). The expression of feelings, and recognition of affective dimensions of reflection, was accepted and emphasised as legitimate in the RWR study. I was prepared for (through discussions with my supervisors), and able to deal with any effects of ‘intrusive’ thoughts, ‘re-experiencing’ events (Ehlers, Hackmann & Michael 2004) and trauma ‘memory’ (van der Kolk 2003). I informed participants (all women with a minimum of two years abstinence) concerning this matter at each interaction, and suggested that self-care was a priority, and to discuss matters of concern with their health care professionals during their participation in RWR. A list of authorised ‘help-lines’ were provided with Informed Consent forms

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3 Social emotions (e.g. elevation; Haidt 2003) contribute to fulfilment and mentoring. Elevation is triggered by witnessing displays of compassion, courage, loyalty and almost any other virtue. Elevation typically involves warm and open feelings in the chest, and it motivates people to want to rise to their own potential.
Merging of personal reflection for participants and research reflection for the study

I designed personal reflection opportunities for all participants in the research strategy. My responsibility was to create a climate of open research, with participants determining what they engaged with (incorporating reflection) and whether they wanted to respond. As an example of including reflection in the research methods: Participants decided on what methods of response they preferred, e.g. a telephone interview or a face-to-face interview. With the method type selected, participants then chose a particular question set (usually a ‘set a’ or ‘set b’); they were then encouraged to consider and choose a response approach. Both question sets contained the response approach options of ‘conversation on the topic’, ‘reflection on the topic’, or a ‘question-answer’ on the topic. Time for participants to consider the way of responding before the interview was included in the research plan. To begin each interview, I checked which approach participants had selected. The choices contributed to an empowered position for the participants.

People do often experience intrusion into their ‘life world’ (Habermas 1987) by institutions, through their work, social club, and educational experiences. In RWR, intrusion on the participants’ ‘vulnerability’ was not acceptable. Participants’ experiences were regarded as personal, and in the hands of the individual to share. Emotional disclosure does create its own challenges in research. Experiences of inappropriate disclosure, matters of great personal sensitivity, confidential information, unethical behaviour or crimes were all possible in RWR. I focused upon not overly intellectualising reflection, and not leaving people in emotional disarray. No ethical dilemmas arose in RWR; however, I was well prepared through requirements of the UWS Human Ethics Research Committee approval, including establishing an RWR External Expert Panel that my supervisors could contact when they deemed necessary, and to whom plans and outlines of progress were provided.

Critical reflection

Exploration of presuppositions that people hold about themselves and the world is a focus for CR. My role as a researcher was to identify and bring forward worldviews and values that influence, or that are a reason for change, in human actions (Mezirow & Dirx 2006). Engaging in CR meant my becoming aware of a level of personal dissonance in others, such as a person feeling frustrated with seemingly ‘unchangeable’ social situations. I would then seek time to reflect and confer with literature and people concerning the circumstances and attitudes that may assist desirable change to occur within the people involved. This was documented as part of the cycle analysis process.

My Critical Reflection, as ‘researcher’, did sometimes limit empathy and, on occasion, it was necessary to place some mental space, at least during gathering of data on ‘events of excess’ and with experiences of suffering. I did not conduct CR directly after demanding data collection. To record my Critical Reflections, I used the forms of diarising: critical reflection journaling (Kitchener & King 1994), fieldwork memos-to-self; and sketches and models for meaning-making.
Appendix 4.4: An example of meaning-making using cooperative analysis

Interpretations of the functions of emotions and purposeful recovery

Participants’ shared their ways of recovery in Action Cycles 0, 1 and 2, answering questions about ‘what happened?’ Responses to ‘what happened to hinder recovery?’ were also contributed by participants. Their responses enabled my investigation at a deeper level of how women’s thoughts, feelings and actions (Damasio 1999) to perceive the detail of women’s recovery and why the processes succeeded. Women’s recovery involved the meaningful discovery of an aware non-drinking ‘me’, finding mature ways to work towards joy (emotion science; Moses & Barlow 2007), peace and wellness (Myers, Sweeney & Witmer 2000) through highly valued long-term abstinence (Vaillant 2005, Fein et al 2006, Dawson, Goldstein, & Grant, 2007, Grant 2009, Laudet 2010). Critical to the process was women and significant others learning about emotions and how structural, anticipatory, and consequent emotions (power and status process of emotions; Kemper 2008) have effects on oneself, and on one’s ability to relate to others (social emotions; Frewen & Dozois 2011) and live a personal and comfortable work, leisure and social life.

In Action Cycles 3 and 4, analysing the participant responses about emotions revealed an important lack of knowledge and skill; being aware of and able to initiate the human process of signalling emotional and physical availability for social communication (De Leo 2008). Women in recovery coming to understand their guilty feelings, the releasing of shame (Corrigan et al 2006, Price Tangney, Stuewig & Mashek 2007) and reclaiming worthiness were critical recovery development processes. However, women’s capabilities of interaction and transactions (e.g. social expression of an autonomous self) in recovery were critical for wellbeing. Aware interdependence strengthened the women’s volition (post-intention action; Sneddon 2006, Schwarzer 2008) to remain in recovery and develop dignity and ways to sustain wellness with other people in their life.

My role was to follow-up on participant requests for information, ways to learn about gendered emotion (Shields et al 2006), and practice the language of emotions with helpful peers. Providing relevant and current evidence-based studies on interventions provided choices for women to take knowledgeable action for individual as well as collective recovery. Actions informed by understanding and experiences of emotion (and memory, mood and motivation) built women’s agency through the release of helplessness and reclaiming personal power (Kemper 2008). A midlife woman learned to build autonomy and authenticity through facilitated release in early recovery (the first six years of abstinence) of personal disturbance or trauma (fear; Lowenstein & O’Donoghue 2006, McLean & Anderson 2009). Also, with the provision of informed therapeutic care and peer support, women’s identification of anger (expressing the feeling; Rime 2009) assisted the reclaiming of a self-reflective mature identity (Hartman & Zimberoff 2004) and skills of critical reflection, for mental, emotional, physical and spiritual comfort.

In Action Cycles 4, women making abstinence and recovery decisions regarding multiple identities and roles required discussion with informed and trusted peers and practitioners (James 2002, White et al 2003, Padilla-Walker 2008, Stephens 2009). The process provided an experience of adult dialogue learned in the context
of safely experiencing emotional and physical healing (Bargh & Williams 2007), mental health and eventually wellbeing (Cummins 2008) of the mind, body and spirit. Women's beliefs and attitudes (Marich 2010, Jorgenson 2010) were better gently explored with knowledgeable people (with occasions of painful exploration), along with discussion of agreed recovery direction, intentions and actions for adult effectiveness (Thase 2006). In Action Cycles 5 and 6, it was agreed that developing a robust sense of self that was able to determine optimal actions in recovery (self-concept maturation; Corte & Zucker 2008) was a challenge for 35 to 59 year old women. Priorising self care (physical health, reflecting on possible transitions, considering existential life purpose with mental and emotional coherence Mauss et al 2005), and a sense of belonging in the community with connection to peers in recovery took self-management and relationship skills. Sustaining recovery required the women to enact over time their perceived worth and hope, self-awareness and presence in everyday activities, social adjustment (Attridge & Ghali 2011), sharing collective efficacy and with earned resilience (including emotional sobriety; Dayton 2007), effective personal response to uncertainty and new experiences.

**Practitioners assisting in identifying and strengthening the values and action combination**

This Complex recovery phase is essential, as lifelong recovery requires pleasure and development of robust skills, an inquiring mind and resilience. As explained by participants, the women’s important life matters were staying sober (action), fear of drinking (motivation), losing their families and themselves (volition; Scholz et al. 2008) and dying (risk awareness). Being happy and useful in recovery was talked about as personal wishes (yearning and seeking). Practitioners can facilitate the women’s initiatives to seek and ‘accept help to not drink’ with firstly expression of needs, beliefs and values surrounding such drives to action. Desirable, effective and respected actions can then be planned, discussed and implemented with review.

Actions and skills contribute to building volition (translating intention into principled behaviour) can be assisted by EEE. Women’s personal beliefs and values purposely guide the action, so that when completed recovery is improved. The women’s efforts in thinking positive ‘mental acts’ (i.e. in that they visualise, but not physically act) will not assist their volition for non-drinking, or be a challenging objective. Neither (on its own) will talk about necessary and desired actions for recovery result in recovery occurring in body, mind and spirit.

**Leads to volition**

With AUDs, bodily and mental functions must be working together to promote understanding and congruence at the level of core-self and consciousness (Radin 1997, Carlson 2002, Bernstein 2005) that which women are developing through changing their identities and roles. The important support for feeling personal truth, trust, resonance and clarity needs to be experienced and expressed to build self-trust (Brewereton et al. 2011), with realistic reviews of personal capabilities and objectives. People that are learning to trust (Covey 2009) can begin by sharing the positive feelings around the act of not drinking in their visualising. This becomes an ‘aha’ moment, and when acted upon women can distinguish more clearly what the feelings and thoughts are in the recovery experience. More experiences can improve the process and refine ways to achieve positive outcomes through developing the skills of complex and valued recovery.
**Appendix 4.5: Checking and updating the coding scheme**

<table>
<thead>
<tr>
<th>Definitions of the RWR participant-researcher coding scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>My reading of the participant responses of the Action Cycle, and making notes on first impressions, also provided possible topics and codes for analysis (RWR Coding Schemes are found in Appendix A).</td>
</tr>
</tbody>
</table>

**Example definitions of codes:** A condensing of information provided by participants, i.e. descriptions, and examples, of repeating topics in the data

**Self-aware adult:** “Who am I?” phrases, references to the self and identity exploration, personal beliefs and commitments, accepting new challenges and uncertainty, working on effectiveness in stressful situations, discussing with selected people emotions, memories and conflicts, exploring friendships

**Adult roles and responsibilities:** Maintaining a job, tasks such as gaining financial independence (paying one’s own bills), and beginning to make informed choices (saving for home and holidays), learning about human interactions and reviewing and rebuilding contact with family and friends, and participation in higher education and training

**Concept:** The researcher compiling memos on the Action Cycle (a mental operation) for participant discussion

**Construct:** A complex idea resulting from data analysis and theoretical concepts, reviewed by participants

**Theme:** A subject or topic with formative elements in the participant responses

**Participant Groups responses:** The features of the groups and issues needing to be resolved

**Cluster:** Groups of ideas that illustrate recovery processes; these were named by the researcher for evaluation by participants, e.g. recovery care, recovery development, recovery support, catalysts of recovery change

**Outcomes:** Titles of the outcomes were taken from the interview transcripts; the words reflected the recovery language used by participants

**Result trend:** Subjects raised in multiple Action Cycle data

**Small Diamond Basic cooperative analysis cross-over documents:** A summary of participant responses concerning other participants’ preliminary summary, e.g. the women viewing the practitioner summary of responses

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**Back-checking to assist in finding and confirming new codes/categories**

I formalised a data analysis and management technique in Diamonds and Pearls called ‘back-checking’ with the view of trialling meta study techniques; this was applied to each Action Cycle’s data to help to identify confusion or misunderstanding over the use of words and phrases (e.g. sober), difficult issues (e.g. violence), and controversial matters, e.g. usefulness of craving medication. This process provided a means to acknowledge tension of participants unsure of subjects,
disagreements and sometimes also strong passion in participant responses around words and issues, e.g. love, mother, harm minimisation. I separated this information and completed trials to explore, with the participants’ agreement, the meaning and circumstances (often paradoxes) that contributed to their reactions, using a Web Discussion Board (Cycle 2), then through emails, RWR Update letters and RWR Newsletters.

Example of back-checking

A recovery theme in the data was valuing sobriety. The participants contributed information on distinguishing abstinence and sobriety and the ‘dry drunk’ phenomenon (Nixon 2005). Participants wanted a greater emphasis on abstinent recovery over harm-minimisation policies and services, and more social marketing (Rytel 2010) to transform Australia’s cultural acceptance of intoxication (determined drunkenness; Measham 2006). Participants agreed that most medical and health professionals were significantly unaware of the rapid increase of alcohol dependence among women, with the consequent complex and chronic mental and physical illnesses (Wilhem 2008).

Action Cycle 2, Women’s Interviews, jan4 – “I think I tackled that one by saying abstinence means not drinking, being sober, but not having sobriety. I think sobriety is the peace of mind that I now have – that I can deal with life without alcohol. That’s more than just not drinking; that’s learning to handle life. So that’s what I consider to be the difference. Being sober or having sobriety is peace of mind. Being able to cope with life as life dishes it out to me, and not needing you giving me alcohol or anything like that to getting me over the various day-to-day life.”

Action Cycle 2, Women’s Interviews, meg1 – Yes, abstinence was hard work, well it was for me. I tried to do it for a long time; I thought I could just ease my drinking, (but) it wasn’t going to work. …sobriety is acceptance. Abstinence is to constantly think about not picking up that drink. With sobriety you don’t even think about not picking up the drink. That’s how the two different things work with me in explaining those words. It’s only the last three years that hasn’t been a battle.”

Action Cycle 2, Women’s Interviews, pen1 – “Its self-awareness and finding what makes me tick.”

Action Cycle 5, Practitioner Questionnaire, 3Q9 – “Abstinence is essential to recover. Recovery is a long slow process.

“I think midlife women need extensive competent therapy. We heal through relationships once we are abstinent. The process of recovery requires we rebuild trust. Thus, the competence of the counsellor is crucial.”

“Education of the damage alcohol causes, and education as to how and where to get help. The local GP is generally not aware of the disease of addiction, and suggesting moderation to an alcoholic is frankly useless.”
Appendix 4.6: Participatory multiple transactive analysis methods

Transactive analysis

The study of RWR data became a discerning spiral of analysis, with participants’ experiential learning and critical reflection for the RWR inquiry to progress to the next cycle and not block emerging ideas. My process of transactive analysis was a combination of direct influences for meaning-making from the contextualised action/experiences offered by participants, the practicalities of the inquiry itself and the research design combining triangulation and ways of clarifying and extending understanding to co-generate actionable knowledge. I followed initially the recommended steps for managing the flux and flow of the research (Anderson 1996) to bring the collective resources of the study to become understandable:

- To establish a framework that emphasises meaning – making construction as the target for all methods
- To nominate methods that reveal onsite the material practices of, in this case, research participants in natural settings
- To recognise the phrases, ideas or related information revealed through TWR were themselves the product of the framework.

Triangulation embedded and enhanced through participation

Triangulation in the RWR study involved myself and participants converging on similarities and noting difference. Importantly TPRP, DLI, Cycles and transactive methods also assisted participants moving in similar directions, with intersections of ideas and a crystallisation approach (Richardson 2000) across the DLI and the Cycles as the study evolved. Confirming a repeating pattern through methods and Cycles in the study was useful. The crystallisation occurred through a continuum of dynamical patterns, of so-called ‘simple’ systems (Lewin 1999), indicating more complex patterns. The patterns and their emergence can be understood through the properties of the system itself (Lewin 1999 p202-203). These involve:

- interaction among people brings mutual affect and emergence
- small changes can bring large effects
- emergence is certain, however, it is not certain what form it will take.

A technique I used to assist in identification and stying with a lengthy process as ideas became understandable was ‘back-checking’. Critical ideas and the words used by participants were collected and recorded as ‘valued terms’ (coding). I explored the terms through a transdisciplinary literature search to identify categories and themes in the growing database. Terms were collected from all responses, not any particular methods. The words as selected ‘units of meaning’* were loaded in the NVivo 8 program which contained all of the words of the study. The back-check of the terms produced reports on where they occurred in the different cycles e.g. in answers in the women’s My Recovery questionnaire, Practitioner’s questionnaire, the women’s Cycle 4 interviews, and the Expert’s
discussion in Cycle 6. Drawing on repetition to focus on what ideas dominated participant groups was one outcome; another was examining responses by people who used the term and the surrounding ideas. This information was incorporated in the next Cycle for clarification.

**Research discovery using iterative joint action**

I drew on the fundamentals of cooperative inquiry (Heron 1996); the ‘pursuit of practical knowledge in the service of human flourishing’ (Heron & Reason 1997, 2001); and an extensive study of participatory inquiry (Reason and Bradbury 2008, 2006, 2001). RWR aimed to offer an opportunity for local people to exercise their recovery voice, to interpret their current situation, and to improve their approach to development through action. In RWR, I balanced between the orientations of action for advocacy, and inquiry based on ecohealth and participatory research (Mertens et al 2005). Because strong opinions have been expressed in PAR, to achieve this balance I held opinions lightly so that I could consider others’ views and the questioning of my own.

I reviewed the participatory research work that had been conducted in health and medicine (Taylor 2003, Stephens 2007, Cargo & Mercer 2008, Wright 2009); particularly the community-based research (Hughes 2003, 2008). I discovered in Hughes’ work the evidence-based information cycle (assess, ask, acquire, appraise and apply; Hayward 2005 www.cche.net/info.asp), from which I explored possible cycles of action, and employed ‘analysis through appraisal’ in my RWR. The study of emotions, information processing and appraisal in women’s AUDs recovery particularly interested me (Scherer, Schorr & Johnstone 2001, Wright & Fitzgerald 2007, Garland, Gaylord & Park 2009). Further understanding of stress (physical reactivity) and seeking safety, perception and emotional distress (Herald & Tomaka 2002) with women’s dependence and abstinence were significant factors to explore in midlife recovery.

Life enhancing relations amongst research participants emphasised that the principles of democratic and collaborative study is well illustrated when investigating chronic illness and care (Koch and Kralik 2002). The RWR study included ways of operationalising results and findings to facilitate practitioners’ understanding of how to contribute and progress with AUDs clients towards chronic disease self-care management. PAR in mental health nursing also considers the wellbeing of practitioners (Sabin-Farrel & Turpin 2003, McLindon & Harris 2011). At the same time, the continuity of participants asking key questions of me as researcher throughout the study ensured a focus on midlife women’s needs and equity of outcomes: Who owns the knowledge? Who can define the reality? and, For what purpose?

**Linking the Cycles - *Action Inquiry***

I combined the developments I explored in Action Inquiry (A-Inq; also developed and modified by Torbert 1981, 1991, 2001) with Action Science for my particular RWR context. The A-Inq approach highlighted addressing in-depth people’s desired outcomes: each person’s own conscious awareness of their own behaviour-in-action to achieve their goals and outcomes. Action Inquiry is ‘consciousness in the midst of action’ (Torbert 1991 p221), yet it acknowledges that it is difficult to discover mistakes-in-action. Women and practitioners can, however, heed dissonance and
contradictions (in AA terms recognised as being ‘restless, irritable and discontent’) as signals to take self-care actions. The actions include developing alternative recovery actions for individuals through receiving appropriate advice and support, with cooperative monitoring of practice of the new processes being learned. Collaborative review and evaluation by clients and practitioners involved in the care team can provide ‘evidence’ to continue to improve interventions.

The four dimensions that characterised A-Inq and AS in RWR (Withnall modifying Chandler & Torbert 2003) were a focus on: 1. worthwhile practical pursuits; 2. democracy and participation; 3. many ways of knowing, and 4. emergent developmental forms. Furthermore, to move beyond unsuccessful ‘mechanisms of change’ in my addiction research, I focused upon the AS Line of Inquiry in RWR (containing A-Inq and AS). By considering ‘knowledge about’, theories-in-action, and the beliefs underlying the action, more informed treatment processes could evolve. Producing ‘actionable knowledge’ through AS in a socially responsible manner in RWR opened the exploration of local theories-in-use from Cycle 3 onwards. In the 2000s, applying ‘frames’ in AS to assist in characterising the meaning-making (the perceived reality) inherent in people’s actions (Friedman, Razer & Sykes 2004) emerged, and I used this technique in analysis for theory-building. Individual and group actions represent ‘meaning-making-in-living’ in most adult activities (including women in recovery).

**Pearls**

The features of Action, Enaction, Interaction and Transaction imbued the analytic activity of the study with the RWR TPRP and the co-production of knowledge. I use the word analytic or analysis as a generic term for close scrutiny, investigating or examining. The Pearls represent the basic ways of interpreting the information received and establishing the criterion for the next cycle. Three Levels of Analysis were designed in the Dynamic Lines of Inquiry, Basic, Level 1, then Level 2 and Level 3 as described in the Research Design chapter and detailed in the chapter in pages following. Analysis is also a process in the Cycle of Action research and action learning.

Suitable analysis methods to understand the characteristics parameters and processes of women’s recovery healing and development for wellbeing were studied and explained. They are discussed below and significant results were derived through them. The pearls were people-oriented and clarified discovery and identification of patterns, exploring the dimensionality of ideas and actions (e.g. time, place, people orientation and values), describing and explaining context and acknowledging different worldviews and needs. I emphasised that the ‘pearls’ analysis of the research supported:

- recursive study with self-referencing to limit repeating dead-ends, checking details and considering when closure of the investigative process was appropriate
- progressive research accepting multi-methods as offering ways to understand complication, complexity (holographic inquiry) and profound simplicity to reveal as much of the whole that is practical
• the experiential combination with a people-focus as participation provided the thrill of the present dynamic energy to consider future options and accepting what had passed through expressing thoughts, feelings and beliefs

• the need for calm and separation (including the researcher) and critical reflection on the singular, the comprehensive and the synergistic.

I worked through and with the Pearl analysis process in each Cycle, which included term and theme analysis, studying data using cognitive semantics, abduction processes for reasoning, progressive focusing to identify and detail ideas and synthesising depending on what types of information and detail were in the responses. RWR analysis techniques are discussed later in the chapter. What also occurred was the development of internal Cycle process as described in the second level of analysis (2nd level).

Importantly the negatives of participant information and outliers were recorded. Maintaining six Action Cycles of study, continuing with suitable Levels of analysis that revealed intricacies, ephemerals and information connected to the context of the study was a major challenge. The summarised results went to core participants and where appropriate (with anonymity for the participants) presented to communities of clinical and research practice through articles and posters, women in recovery with over 15 years abstinence being interviewed by journalists (with anonymity agreed), as public information through media reports on RWR and my Expert Panel for response. I reflected on the responses and recorded ideas and issues through self-memos, concept mapping, and writing of documents (e.g. long-form abstracts) for my supervisors. Then, returning to single loop feedback to prepare for the next Cycle, knowingly influenced by prior research Cycles experiences and results.
Appendix 4.7: Recovery and alcohol dependence: What works for midlife women in Australia

Final Phase Outline of *Researching with Women in Recovery from Alcohol Dependence* – a PhD study (UWS HREC 06/091) Dec08

**Janice WITHNALL, Professor Stuart B HILL and Dr Sharon BOURGEIOS**: University of Western Sydney, Australia

The aim in this participatory, transaction research is to enable all alcohol-dependent midlife women in Australia to experience recovery and achieve self-managed, sustained wellbeing. Currently only 1 woman in 3 dealing with this chronic illness, and its comorbid conditions, seeks assistance. Preliminary findings of our Australia-wide transdisciplinary study is showing that transformative learning in women-oriented, safe and tranquil recovery environments can support a combination of appropriate medical, alcohol and other drug, mental health care and community self-help approaches (including AA) to meet the needs of midlife women. This would include supporting women to sustain their recovery through adjusting on a deep level to their changing world and creating a robust way of keeping well. Living the paradox of being a mature alcohol dependent woman, yet choosing to abstain from drinking in Australia, is achievable with healthcare, supportive peers and self-care.

Midlife is a powerful and responsible time in most women’s lives. Midlife women are a diverse group with tumultuous and wonderful experiences, erratic work histories due to parenting and caretaking, and many are faced with the challenges of interdependence through lack of independent money, accommodation and socioeconomic status. Many midlife women in Australia also feel ‘oddly invisible’. For those who become alcohol dependent, in 2008 the estimate is 16%, a rise from 8% in 1996, life also becomes much more complicated and soul destroying. Alcohol dependence is a complex physical, mental and social illness, with differences for females in all areas, from the experiences of males.

**Cycles 1, 2 and 3 Outcomes**

Based on analysis of data, the lived experiences of alcohol dependence and recovery in Australia, contributed by research participants, women in recovery and healthcare practitioners.

**Transformative Learning and Sustained Recovery**

Helping women to change through experiential transformative learning can enable a ‘positive’ identity shift (Billett & Somerville 2004) and prevent relapse. For sustained recovery, women need to be enabled to explore and develop their identity, attitudes, values, purpose, relationships, and their potentials and opportunities. *It is about improving performance, not just changing behaviour*. We have found that women’s emotions and anxiety can motivate and/or create barriers to change as can the practical needs such as childcare and transport.

Within a supportive (liminal) space, skilled practitioners from contributing fields (biomedical, psychosocial, alcohol and other drugs, mental, public and community health) can help women to do the needed work to stop drinking and begin recovery. Recovery involves the ‘three Es’ of Engagement, Embodiment and Enrichment.
Maintaining recovery is about overcoming ‘multiple burdens’, simplifying life, and enabling pleasure. It involves accepting help in managing this chronic illness, and taking increasing responsibility for enriching and sharing one’s life. Long-term health management, peer support and life-long learning are central to achieving sustainable abstinence-based lifestyle for female adults with alcohol abuse and dependence disorders.

**A Responsive Recovery Environment**

By using a social ecology and holistic health framework to study the lived experiences of midlife alcohol-dependent women, and the practitioners who help them, both the environments in which alcohol dependence develops and the characteristics of the dependent women have become more definable. Our study has highlighted the importance of early identification of alcohol use disorder and perceived personal, relationships and social need to enter high quality ‘places’ to support recovery. Quality here refers to landscape, sociocultural and politico-economic features, all of which must be considered when working with complex health disorders and healing. Having access to women-oriented settings, non-judgemental understanding, and practical resources is essential for the design of effective programs for recovery from alcohol dependence. Access to such ‘liminal’ safe spaces minimises the chances of negative outcomes such as early exit and relapse. Lack of supportive access has been a sociopolitical, economic and cultural disabling factor, especially for women with a genetic predisposition and a high-risk environment that includes such factors as anxiety, depression, trauma and relatives with alcohol and drug-use problems.

**Targeting Treatment for Midlife Women and Intergenerational Change – Cycles 4, 5 and 6**

A special population of women misusing alcohol in Australia, comprising middle-aged Baby Boomers and Generations X need targeted high-risk healthcare. Societal and cultural expectations of the ‘nurturing super woman’, which tips women into anxiety and depression spirals, illustrates one complication of the illness of alcohol dependence and its context. Help for midlife women needs to be prioritised so that the disparities of health status and health outcomes are righted. The ‘Women in Australia 2007’ report points out that alcohol dependence is linked to suicide and other acute mental and physical illnesses for women in the midlife age group. Recovery through abstinence is necessary to break intergenerational alcohol abuse. Recovery from dependence through natural remission appears to occur, however this data about midlife women in Australia is lacking. Currently, our study is working with families with three generations of alcohol dependent women.

**Working Hypotheses**

Based on our analysis of collected data from cycles 1, 2 and 3, the final phase of this study will examine:

- the complexity of the female, personal nature of the disorder
- the anomie of the social and organisational network as the context of the disorder
- the communicative aspects of interactive change
• and a ‘triadic’ (versus ‘dyadic’) care model suitable for the Australian culture, its environment and time.

**Targeting Treatment**

We will also explore and refine treatment themes– with women with more than five years experience in recovery, and qualified professionals with more than seven years practice:

• the four Bs: bonding; belonging; believing; and (feeling) better.

• the five Rs: reciprocal relationships, rightful respect, responsibility, respite and complementary roles.

Women’s attitudes to social role, midlife psychological and hormonal change, body and personality stereotypes, eating, sexual and shopping maladaption are critical matters for which the final phase is also seeking explanations focused on Australians in 2008. Such explanation can contribute to informing screening and assessment, policy, professional development and prevention strategies. All actions are investments for Australian women and their families, friends, colleagues and communities.

**Invitation to participate in the RWR Final Phase Meta-study**

Those who we invite to participate in this final phase of the research are:

• women with more than five years in abstinent recovery

• qualified practitioners with more than seven years experience in the field in Australia

• senior professionals in disciplines that focus on midlife women's physical and mental health and wellbeing.

A group of participants from cycles 1, 2 and 3 (previously called stages 1, 2 and 3) are also collaborating, as is the study's Expert Panel established through the UWS Human Research Ethics Committee. As occurred previously, at each cycle of the study, the practitioners review a summary of the women's responses, and the women review a summary of the practitioner’s responses. Along with questionnaires and response sheets, participants are provided with an overview of cutting edge research and clinical and therapeutic materials. Expressing insights, reflections on ways to improve the current *status quo*, and creativity are encouraged.

**Contact Janice Withnall, Researcher – PhD candidate, for participation information**

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Research email: 4302279@student.uws.edu.au

Mail: UWS, Hawkesbury Campus, Building G/IT, Locked Bag 1797, Penrith South DC 1797 NSW, Australia

**The Research Supervisors are Professor Stuart Hill and Dr Sharon Bourgeois, both of UWS.**
NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval Number is 06/091. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (Tel: 02 4736 0883 or 02 4736 0884). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 4.8: Participants contribute feedback

Feed-forward and Feedback loops

**Feed-forward**

Using critical thinking to analyse data ideas that were repeating, outlier or curious ideas were placed in the next Cycles for discussion in a suitable method to clarify its meaning and significance to the study. Information from my synthesis of transdisciplinary literature and meta-analysis of secondary (government) data records were also included in the feed-forward technique.

The ongoing participant contact took an informal feed-forward approach (participants sending me material they had discovered whilst maintaining confidentiality. The ‘qualia’ of these transactions were recorded in my field notes as well as responses transcribed verbatim into the participant database. The qualia nuances I noticed was women’s sensitivity and concern for others, vulnerability with strength, humility, courage and hope, bearing witness to both tragedy and wellbeing, and relating to existential or spiritual/uplifting notions such as peace, a high power, the cosmos, nature, kindness, joy and harmony.

**Feedback loops**

The idea of successful feedback loops with learning, action research and therapy work is critical; as is the forward momentum (e.g. feed-forward as information which formed topics participants wanted studied) towards the next Cycle. What I experienced in RWR was the needs to not only be efficient with feedback loops but more effective through back-up loops of practice and reflection and the need for development through education and training as people age. The women and practitioners illustrated with further practice of new techniques, language and developmental concepts (Nesbit & Adesope 2006) similar characteristics to life-long learning for long-term recovery (Oakes 2008). Wellbeing and resilience was possible, as well as ‘an uplifting’ energy and joy. Mid-aged vulnerable people can build capacity and learn ways to undergo a wide range of shocks, tension and disturbances with peer-support and informed people in their ‘close network’.

**Feedback:** critical, contrast (exceptions), similarities and extension

Finding conflicting ideas and possible paradoxes also occurred with careful study of ideas. I extended the use of triangulation (Meetoo & Temple 2003) through the feedback processes in the seven Cycles, using the four Lines of Inquiry, as well as the multiple methods. Three examples of the process were, in keeping with TPRP: 1. the Participant Reference Group members confirmed that the exchange of summaries of results (between practitioners and women in recovery) occurred and new insights made; 2. action science revealed useful leadership, management and marketing concepts that I and participants could identify as useful for recovery; and 3. in Cycle 5 as reciprocal exchange, participants received transcripts of their long-form open
An example of information sent to participants for feedback

Practitioners’ approach to helping women dependent on alcohol in Australia – 2008

Practitioners from three areas of support were asked what were the three ways they would help women abusing alcohol. Below is a brief summary of input

1. Drug and Alcohol

First
Offer support, encouragement, and motivation to do a rehabilitation program

Second
Offer psychological support through detoxification and assist them to join a support group in the community

Third
Arrange for follow-up care, encourage contact with AA and a sponsor and arrange transport to AA

Extra
Family or carer involvement in the process, ensuring a safe environment (home, hospital or rehabilitation facility) and good nutrition.

2. Mental Health

First
Provide information on risk levels of drinking and offer counseling

Second
Public media campaign about risk levels for drinking

Third
Support through access to a withdrawal unit and follow-up women only rehabilitation unit

The long-form open interviews were conducted with participants volunteering for three groups: as senior practitioners with more than 20 years experience; women with more than 15 years of recovery; and women with more than 25 years of recovery. I provided criteria for checking the analysis notes (e.g. fairness, relevance, accuracy and ‘do no harm’) and open response welcome. In this process many ‘terms’, ideas and contradictions became meaningful and useful.
Extra

Seriously look at alcohol advertising and stop the push for mixer drinks as a fun and a healthier way to drink.

3. Regional Drug and Alcohol

First

Provide a medically supervised detoxification, check risk levels and look at reasons for self medicating

Second

Support through D&A nurses counseling with GPs, possibly prescribing Campral, or discuss rehabilitation unit admission or relapse prevention strategies

Third

Provide funds for access to local services including childcare, build self esteem and motivation through counseling to change alcohol being the answer to problems

Extra

Take a warm and sensitive individual approach, maintain regular contact and encourage peer support such as AA, start a long-term plan of help as it usually is a complex situation with abuse, relationship issues, financial pressure and comorbidities

What is your response to the practitioners’ comments?

Flow-on from crossovers

With the crossover of information participants reported talking with other people about the study. New participants were recruited using the interest in the crossover as ‘snowball sampling’ from the RWR activities. Also of importance was that the participants provided their social group or networks with understanding of the RWR experiences. Interestingly feedback of such activities highlighted negative association or affiliation outcomes e.g. being more aware of networks that allowed masking of critical comments by humour, accepting false or negative actions (hidden agendas and manipulation) or exclusion practices. The comments revealed that values upheld by the support networks needed to be equivalent to the values of the women and the practitioners involved in recovery for positive outcomes. Some networks supported norms and directions that were undesirable or detrimental to people with AUDs and did erode the progress that the women had made. The unsuitable norms created further barriers to limit recovery: contribute to a return to drinking; and increase or severe negative physical complications with mental, emotional and economic consequences.

Feed forward: paradox

Paradox is described as the instantaneous existence of two inconsistent states (Eisenhardt 2000) such as between collaboration and competition, new and old,
active alcoholism and abstinence. Mature adult mentalising (Fonagy) assists not only compromising or agreeing on something between the two items, a person can learn more and make a more appropriate decision in the context of their lives by holding both instantaneously and working through the tensions (Beech et al. 2004) that it creates. The process of understanding offers more fully the range of choice that’s available and being able to consider what would be the best fit for a person, particularly a midlife woman, to act upon in acknowledgment of their healthcare situation and their support structure. There is inherent pluralism in midlife living.

My process of critical reflection was part of the triangulation process as it occurred for each cycle. I included appraisal of my actions, my self – memoes of free-form mapping of thoughts and on achieving research goals. Critical reflection assisted in monitoring interpretation leaps and I was particular in maintaining a ‘devil’s advocate’ check on ‘bewares’ (Anderson 1996). Beware of:

- assumptions, beliefs and background as nested theory
- invisible protocols of research social practices
- recognition becoming an explanation
- implicative action.

Referring to my notes on a critical discursive perspective at each Diamond and Pearl assisted in RWR meaning discovery, meaning assimilation and meaning understanding. Knowing yourself was a useful if not essential understanding for the investigation [a leverage point]. Accepting that the research experience would ‘change’ me took the length of the research to comprehend ‘How’.

During Cycles 2 to 3 the need for a progressive focusing process* became apparent and I responded with more use of systemic thinking (Marshall 2004) and critical reflection as transformative learning (Brock 2009). Progressive focusing (discussed below) ran in parallel with the diverge-converge way of work based on the ‘Next Stage’ comments of participants. “Next Stage’ was in the last section of each research form e.g. questionnaire or last interview question. Participants were asked what ideas were generated for them in the process and asked if they wanted the idea-issue to be part of the next cycle and/or wanted research information on the topic sent to them e.g. a current journal article on the topic. What the ‘Next Stage’ Cycle involved was described and participants were asked if they wanted to continue to the next Cycle and what method of inquiry they preferred e.g. interview or three question email they were willing to share their experiences. Update letters gave information on preparation for the next Cycle and items of interest. Participants’ responses were used as data for Cycle Links 2-3, 3-4, 4-5 and 5-6.
Appendix 5.1: Details of analysis levels and RWR meta-analysis

The Pearls represented the ways of analysing and interpreting the information received in RWR and establishing or confirming the objectives for the next action Cycle, the topics to raise and appropriate questions. The ways of analysing had evolved over the research Cycles and had four features by the end of action Cycle 6: Levels, links, trials and reviews which are explained below. In the research design I planned to study the participants’ contributions using a structure (four levels for analysis) with the focus on ways of change. Each Level was another process that contributed to the mixed methods triangulation. The Cooperative Basic Analysis (completed in the Small Diamonds in each Action Cycle) was the initial identification of recovery characteristics. The following three Levels’ focus were: meaningful discovery using 1st Level techniques in Cycles 0, 1 and 2; meaningful assimilation using 2nd Level techniques in Cycles 3 and 4; and meaningful and agreed understanding using 3rd. Level techniques.

Analysis techniques (Table 1 below) chosen for discovery, assimilation and agreed understanding were modified to meet the needs of participants, research objectives and the type of data collected in the Cycle responses. The Levels and techniques assisted in thoroughly investigating the data to prepare and integrate preliminary results summaries and then a metasummary of concepts (Sandelowski & Barroso, 2007). It was the metasummary that indicated potential recovery constructs for further exploration in the planned Meta-study.

The four levels of analysis, Basic (outlined earlier in the Chapter), 1st, 2nd and 3rd Levels were possible because of the amount and richness of the data provided by participants, the participant numbers increasing, my ongoing observations of practice in the Community and Communities of Practice and studying related transdisciplinary research, longitudinal studies and secondary data of Australian Bureau of Statistics material. The Levels also assisted in ordering, checking and documenting the research flow, searching for further information required by participants, conducting analysis trials and critical reviews; which all enabled understandable and useful outcomes (an extended pragmatism stance; McIntyre-Mills 2006).

The focus and processes of the three levels also related to features of the research design:

1. 1st: the discovery of new ideas through the four Dynamic Lines of Inquiry; this included the processes of wondering and generating (Somerville 2008) to begin to describe in detail recovery characteristics important to women

2. 2nd: the investigation of the complex nature (Morin 2008) and context of midlife addiction and recovery; data was assimilated through the Tri-thread and encompassed results integration where appropriate

3. 3rd: the emerging of concepts, processes and explanations through Diamonds and Pearls Methodology that supported, were parallel or opposed women’s healing practices, wellness and understanding of recovery (physical, emotional, spiritual and mental health and wellbeing; AHMC, COAG 2008).
The four levels of analysis provided actionable knowledge, to which I applied knowledge transfer techniques (Campbell & Oei 2010). Examples of actionable knowledge (detail in the following Praxis Chapter) through the Levels are introduced briefly below. An example of knowledge co-generation and transfer is word play (play on meanings) to invigorate the mind e.g. alliteration (Fairclough 2005, Shannon 2007, Shoshana 2011). Humour (Myers, Sweeney & Witmer 2000; fun and leisure; Hood 2003, Fullagar 2008) and word play (power of words and affect; Panksepp 2008) can assist with people being receptive and open to new ideas (Reicherts 2007).

Through the Level analysis techniques I was aware that RWR participants were expressing in their responses different ways of communicating information. There were many acronyms, rhetorical statements, parodies, metaphors and analogies to consider as representations of participants’ lived experience. Examples of the word play, adventure and serious play (used for personal integration and individuality; Kjolsrod 2003), and my awareness of language and figures of speech such as metonymy (Putnam 2004, Vaara & Riad 2010) opened opportunities for oblique analysis. Participants’ use of words appropriately influenced interpretation of the data, and assisted in the ongoing translation of technical jargon and vernacular slang terms using the Levels process. The meaning-making outcomes of Basic through to 3rd Level interpretation were useful information to improve women’s recovery care and development:

Examples of word play outcomes are listed here and discussed with Level interpretation below:

2. Level 2: ‘WE’ and EMBER; assimilation of women’s recovery change options and the complex nature of midlife interventions
3. Level 3: ‘I’ self care for recovery change; integrated meaning-making producing substantive and agreed upon outcomes.

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1 Metonymy is a reductive figure of speech (a trope) that uses a word that in a sense is different from its literal meaning, e.g. ‘the bottle’ in place of ‘drinking alcohol’. The technique, a common discursive resource, contributes to microlevel communication to initiate emotive frames, stereotypes, evocative imagery and can be used with wit, irony and threat. People feel dissonance or resonance (more subtle than persuasive argument) with metonymy's use, as illustration about difference, identity (Cornelissen, Haslam & Balmer 2007) and sense of belonging, e.g. stranger danger. Metonymy and metaphor (Lakoff & Johnson 1980) can combine and differ as the metaphor being the blossom and metonymy the bud.
Table 1: Ist Level focus was self discovery, decision making, and recovery development for a stable ‘me’.

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<tbody>
<tr>
<td>Meaning discovery</td>
<td>Focus; Extended content &amp; concept analysis (Hsieh &amp; Shannon 2005)</td>
<td>Outcome: Recovery development and decisions</td>
<td>Outcome: Integrated health care</td>
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Participants’ sharing their ways of recovery in action Cycle 0, 1 and 2, ‘what happened’, enabled my investigation at a deeper level of how women’s thoughts, feelings and actions (Damasio 1999) contributed to women’s recovery and why the processes succeeded. Women’s recovery involved the meaningful discovery of an aware non-drinking ‘me’, finding mature ways to work towards joy (emotion science; Moses & Barlow 2007), peace and wellness (Myers, Sweeney & Witmer 2000) through highly valued long-term abstinence (Vaillant 2005, Fein et al 2006, Dawson, Goldstein, & Grant, 2007, Grant 2009, Laudet 2010). Critical to the process was learning about emotions and how structural, anticipatory, and consequent emotions (power and status process of emotions; Kemper 2008) affect oneself, relating to people (social emotions; Frewen & Dozois 2011) and living a personal and comfortable work, leisure and social life.
Example of 1st Level discovery, analysis and interpretation

Through the action Cycles 0, 1 and 2 women participants had experienced neglect, deprivation, adversity and alienation demanding high emotional work (Strazolins & Broom 2004) in their life course. Not being able or comfortable to identify or express emotions in an adult manner was a common obstacle of women participants before abstinence and less so in recovery. Through Cycle 1 and 2 I was discussing with participants the ELA construct: the name given in RWR for adult understanding of Emotion, Language and Action. ELA assisted women to care for self and share the care for others (Langer, Rudd & Syrjala 2007).

Analysing the participant responses about emotions, an important lack of knowledge of a useful recovery skill was identified; being aware of and able to initiate the human process of signalling emotional and physical availability for social communication (De Leo 2008). The acronym ELA became a reminder of the women developed capabilities of expression interaction and transaction in recovery. Women who were aware of connections of ELA strengthened their volition (post-intention action; Sneddon 2006, Schwarzer 2008) to remain in recovery and develop dignity and ways to sustain wellness with other people in their life.

Women in recovery coming to understand their guilty feelings, the releasing of shame (Corrigan et al 2006, Price Tangney, Stuewig & Mashek 2007) and reclaiming worthiness. Recovery, with my follow-up on participant requests for information confirmed a recovery action was more effectively completed through women learning and practicing the language of emotions, with information on gendered emotion (Shields et al 2006). Actions with understanding and experiences of emotion (and memory, mood and motivation) built women’s agency through the release of helplessness and reclaiming personal power (Kemper 2008). A midlife woman learned to build authenticity through facilitated release in early recovery (the first six years of abstinence) of personal disturbance or trauma (fear; Lowenstein & O'Donoghue 2006, McLean & Anderson 2009). Also, with knowledgeable and therapeutic support provided, women’s identification of anger (expressing the feeling; Rime 2009) assisted the reclaiming of a self-reflective identity (Hartman & Zimberoff 2004) and skills of critical reflection and relaxation.

ELLA, E (Emotion) L (Language) L (Linked) to A (Action), extended the ELA understanding. Actions of humans are often forms of communication aimed at building connections (links) with other people and maintaining significant, intimate, and supportive social relationships. In active alcoholism the links between emotion, language and action disconnect (emotional non acceptance; Gratz et al 2007) through distress and extensive physiological and psychological change (Taylor et al 2004, McEwan 2007, Sinha & Li 2007, Sinha 2009). Women when abstinent can begin to learn how to reconnect to their sense of self, express emotions through ‘language’ (learning about discourse, discursive practices and dialogue; Anderson 1996) and use conversation for ‘talking about’ intended activities. Nikander (2007) studied and emphasised emotion in communication when meeting people, when watching, listening, hearing or reading contemporary life and media. From a neurophysiologic perspective active alcoholism and early abstinence can limit: people’s recognition of facial expression (Foisy et al 2005); and affect prosody can be reduced (recognising emotional valence in voices; Monnot et al 2001). Neurocognitive function and cognitive proficiency (Glass et al 2006) are impaired which all contribute to ineffective, limited or no communication.
ELLA helped me to observe and explain preferred women-oriented communication about recovery, and my highlighting useful information for practitioners with the objective of explaining the importance in the agreed understanding; ‘meaning of acting, meaning of reflecting and meaning of relating’ (Biong & Raundal 2007) in women’s healthy recovery.

The paragraph below is a summary of 1st Level recovery discovery results (detailed later in the Chapter) which was presented in RWR newsletters and at professional conferences (Appendix a).

Developing a robust sense of a core-self in recovery (and self-concept; Corte & Zucker 2008) was an agreed challenge for 35 to 59 year old women particularly prioritising self care (physical healing, examining embodied consciousness, mental and emotional coherence Mauss et al 2005), and a sense of purpose (and place) in the community. Making abstinence and recovery decisions regarding identity and roles (James 2002, White et al 2003, Padilla-Walker 2008, Stephens 2009) was learned in the context of safely experiencing emotional and physical healing (Bargh & Williams 2007), mental health and eventually wellbeing (Cummins 2008) of the mind, body and spirit. Women’s beliefs and attitudes (Marich 2010, Jorgenson 2010) were better, gently explored in recovery (with occasions of painful exploration) along with discussion of agreed new direction, intention and action for adult effectiveness (Thase 2006). Sustaining recovery was the process of enlivened discursive activities leading to cooperative independence, through interdependence and intradependence. Being a mature woman entered the awareness of women in recovery: the women enacted over time their perceived worth and hope, self-awareness and presence in everyday activities, social adjustment (Attridge & Ghali 2011). The sharing built a collective efficacy and with earned resilience effective personal response to uncertainty and new experiences (including emotional sobriety; Dayton 2007).

Meaningful assimilation in RWR was drawn from translational science (Hiatt 2010), a transdisciplinary approach to problem solving and concilience. Consilience (Wilson 1998, Kellermann 2010) is achieving an integrated agreed understanding using a multidirectional, continuously feeding back to earlier inquiry processes to answer new questions or seek refinements. The process can accommodate the convergence of lines of argument from the diverse subdisciplines and the ability of different disciplines to support each other, and thereby to advance knowledge.

The RWR research design was structured to accommodate the process as was participants’ sharing significant lived experiences and providing ongoing contribution to the research process itself, e.g. cross over document review and feed-forward and back. The outcomes of consilience reveal links to a larger gestalt (Naess 1989). A similar process of discovery, assimilation and application is used in cancer research with feeding back to genomics, clinical practice (from medicine, social work to urban planning) and public health message research (Krasny 2009). My and participants understanding deepened with the Cycles and was enabled by maintaining human dignity (Fukuyama 2002) with all transactions of the research.

Recovery is the practicing of new knowledge to transition and transform to adaptive living that enables an adult to recognise and cope with change in appropriate ways. All women commented that they didn’t truly understand the basics of living a ‘good’ (healthy, principled) life before recovery, including loving oneself and others. They had observed life as a chaotic process, only one feature of life’s organised complexity.
Table 2: 2nd Level Recovery assimilation results, interpretation process and example

The 2nd Level focused on ways women develop a robust self and recognition then assimilation to a group and society; ME included in WE; and the recovery care catalysts and support which makes this possible

<table>
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<th>Pearls 2nd Level</th>
<th>Progressive focusing</th>
<th>Conversational activity</th>
<th>Paradox &amp; gestalt</th>
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<tr>
<td>CONCILIENCE</td>
<td></td>
<td></td>
<td>(psychodynamics; Doyle 2003)</td>
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<tr>
<td>Focus: Transformative paradigm (Mertons 2003, 2005, 2007)</td>
<td></td>
<td></td>
<td>Outcome: Complex and chronic illness management</td>
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<tr>
<td>Outcome: Recovery support and self-care</td>
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Combining action Cycles 3 and 4 results at the 2nd Level provided an opportunity to search for plausible alternatives for improving recovery based on women’s lived experiences of recovery. I was influenced by the critical discursive perspective\(^2\) (Kolobov 2010) which I practiced with participants and during Unobserved Observation. The information collected from participant responses provided leads to search the literature based e.g. seeking more examples particularly from longitudinal studies\(^3\). The women’s experiences and explanations of practicing recovery change for health and wellness (Liden & Antonakis 2009) also directed me to what was offered by intervention science and translation research (Heyman & Smith Slep 2009).

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\(^2\) The critical discursive perspective studies how social actions are ordered during personal conversations, particularly noting socioculturally relevant features being acted and accomplished in context. Social actions and inference in conversation highlight features of groups and communities with whom the person associates with and is part of their socio-cultural identities.

\(^3\) I searched for studies that followed people with AUDs for longer than two years abstinence and contained information related to women (three years, Bottlender & Soyka 2005; five years, eight years, Timko, Finney & Moos 2005, Mann et al five years, 10 years and 15 years).
The women copied what they could discretely discern (sense or perceive) from others but had not fully experienced the lived gestalt. The copied learnings were without a depth of understanding, especially human interactions as a whole person experience. Being with like people in recovery who are further along the development process was very useful for women in recovery as was working with healthcare practitioners with appropriate knowledge and expertise. Women reaching their own transposition, capable of intradependence, interdependence and independence as an authentic midlife woman.

**Example of 2nd Level analysis and interpretation is ‘EMBER’**

EMBER is an integration of results at the close of Cycle 4. The EMBER acronym is memorable and embeds a learning memory process with research-based detail. The five letters of EMBER represent the particulars of developmental processes that women in recovery personally experienced and found to be effective. EMBER’s list of important concepts was detailed with RWR data and related studies for practitioners and supporters to intervene and be part of transformative learning for recovery. Further detail is in the Cycle 4 results in this Chapter:

- **E** encourage, educate, embody and enrich
- **M** myself, me caring for me, memory and emotions, moods and motivation
- **B** basic healing, body exploration and personal boundaries, building and bridging for belonging
- **E** evaluating environments and engaging with social exchanges, establishing a personal recovery ecology
- **R** recovery development and respite, responsibility and appropriate roles, respect and relationships

At Cycle 4 catalysts for care to enable women’s recovery change were understanding sex and gender differences, considering cohort characteristics and sociocultural and environmental context, knowledge of developmental lifespan events (starting with women’s perception and memory), and acknowledging the critical knowledges and practices of risk and resolve in recovery.

Generally a gestalt is a structure where the whole is greater than the sum of its parts. From this, Næss (1989) developed the concept where not only is the whole greater than the sum of its parts, but also each part is greater as a result of the whole. From this, we can deduce that phenomena may only become fully visible when studied as part of the gestalt to which they belong (Kerr & Key 2012). If we study things in isolation, we will miss seeing their full nature.

Gestalt is the term for acknowledging organised complexity, understanding configuration, and pattern or organised whole. Wieg (xxxx) explains gestals as structured wholes, capturing the interdependence of parts and the context of a certain part-whole relationship. A vexing question is whether part-whole relations are transitive and that reasoning about gestalts is better understood as a sequence of cognitive transformations.
### Table 3: 3rd Level Recovery agreed understanding results, interpretation process and example

**Meaningful understanding for agreement**

**Interpretation, Integration and Meta-analysis of Cycle Results (T for E, M, B & N for E & R)**

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<td><strong>TYPE 2 THINKING</strong></td>
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<td>Outcome: Considering Double Helix Spiral model (Mendlinger &amp; Cwikel 2008)</td>
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<td>Focus: Explicative meta-summary (Sandelowski &amp; Barroso 2007)</td>
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<td>Outcome: Critical knowledges</td>
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**THE 3rd LEVEL FOCUSED ON:** RWR participants (including the researcher) acknowledged ‘as dynamic & complex adaptive systems’ sharing understanding and abilities to enact, embody and self-sustain recovery change (discussed later in this Chapter)

Individuals seek to find self meaning in life and to develop a lifepath accepting that change is likely. Critical knowledges to learn and practice type 2 thinking (fluid intelligence) and a positive curiosity and diligence. Practitioners needed to consider the context of women’s recovery needs, including womanhood and wellbeing in long-term recovery. Supporters mentoring can challenge old beliefs, and encourage practice of new skills and tasks to sustain women-oriented recovery.

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4 Exploratory activities (Robinson 2011 of the full spectrum of possible relationships between analytical themes within qualitative data. All of which can act as meaningful links among themes/codes/categories/parts within an extended analysis.
Self actualisation is a sociopsychological process in which an individual seeks to find meaning in life and to develop oneself through enhancing experiences (Rogers 1995) needed for women in midlife development. Enhancing experiences includes attitudes, affect and cognition particularly cognitive decoupling and complex affect; affection exchange beginning with friendship and an intimacy how to powerfully communicate opinion.

The obstacles, recovery intervention strategies I nominated, and the symptoms (in the broadest sense) were based upon the needs of midlife women and informed by the participants’ contributions to RWR, along with academic literature and discussions with experts.

The Level’s techniques also combined first through assisted in identifying a richer understanding of women’s recovery including uncertainties, differences and similarities in the data. Perplexing information was studied using multiple approaches and on occasions revealed the paradoxes involved in women living in abstinent recovery and wellbeing with alcohol use disorders.

“Embedding is a form of mixing in mixed methods research, where secondary forms of data is lodged within a larger study with a different form of data as the primary database. The secondary database provides a supporting role.” (Cresswell 2009 p229)

Example 3rd Level analysis and interpretation

Women changing from dependence (addiction) to abstinence and recovery: a RWR heuristic. The preparation for the trial project set a broad starting point: AUDs recovery change involves facing a problematic situation (Checkland & Scholes 1990) to be worked through, resolved or removed. By cycle two of the major study, concepts below in bold were highlights of the analysis. Transdisciplinary literature reviews revealed similar concepts. The numbered points below from numbers three to six illustrated my ‘unknowing’, which was then pursued for improved understanding with the objective to find ways practitioners and supporters could better assist in women’s positive recovery experience.

The women’s journey into AUDs abstinence and recovery change (Withnall, Hill, Bourgeois 2008, 2009, 2010) involved:

1. **Women Changing** through seeking self: healing into a women’s body as self, and accepting care and support from knowledgeable peers and practitioners

Lasting health behaviour changes began with women’s critical self appraisal and small steps led to an identity shift (Kearney & O’Sullivan 2003). Making a behaviour change(abstinence) that lasted more than six months involved a critical reappraisal of self and situation, which was the first turning point that led to small changes in recovery, not dependence living. If this small change was successful, it produced positive indicators of a possible new identity, which led to more behavioural changes over time. The initial turning points seemed to be: Distressing accumulated evidence that was essentially incongruent with personal goals and values

2. **Making Choices** (recognising the personal ability to do otherwise) to safely experience and learn how to act as an adult effectively in an abstinent, self-
care manner: becoming well, expressing self and sharing in support as a well and a mature adult.

Over time people learn adaptive responses, some internalised as values and motivations, and others as external norms and roles to meet social and cultural expectations. People seek purposive interaction with other people with similar self-schemas (Corte 2007). Empathy from another person (with similar self-schema) seems to be important in learning to safely self-soothe, restore emotional equilibrium and help strengthen the self (Greenberg et al 2007).

3. Developing **Self-Concept** in an authentic, adaptive and strengthening sense: generating emotions and establishing equilibrium in thought and action.

Emotional and cognitive structures are highly integrated and that these affective – cognitive or cognitive–affective structures (Davidson, Scherer & Goldsmith 2003) are the important targets of treatment. The adult meaning construction process includes emotional ‘qualia’ which supports making sense of experience as crucial or more ‘influential’ than the initiating experience.

4. Continuing to **Communicate to Connect**: relating as self through informed decisions and practice of personal and interpersonal skills

Women with AUDs are likely to be unaware of the underlying important connecting processes involved in chats and conversations. Women will need guidance to begin to associate, appraise, and affiliate in a midlife human female manner. A particular goal can be friendships and, with time in recovery, intimate relationships which are valued achievements of a healthy adult. Women expressing to bare and bear the uncertainty (‘It is what it is’) places abstract sensations into a daily grounded reality. Women’s communication (to themselves and others) in recovery is no longer a circle that closes upon itself, but is movement, an expression of living that remains open, mostly satisfying and unfinished.

5. **Coordinating** recovery monitoring, care and development action is assisted and extended by team care and peer support, particularly advice and discussion to safely engage with and understand (interrelate with) other people

Desynchronies or incongruence between cognition, emotion and physiology occur in early recovery and need to be healed through time and routine e.g. taking thiamine tablets, attending support groups. Affect disorders (anxiety, depression) and PTSD may emerge and need to be further processed in therapy to promote safe change. Particular at this time in early recovery (two to six years abstinence is early for RWR participants) women reconsider changes (i.e. accept, or modify), particularly emotional development and interpersonal effectiveness. Choices on exploring new roles and expanding opportunities to achieve wellness begin to be planned with beliefs, relationships and life events also reviewed.

6. **Considering and clarifying** self-identities, life purpose and exploring existential matters in midlife bring possibilities for wellbeing. Persistence and commitment to abstinence brings long-term recovery into consideration for women. Arousal becomes awareness, sharing change when necessary is doable, as is attending to difficult matters. Assessing, accepting and growth
occur with happy and sad life events. Abstaining is more than self-discipline but self-worth and enriching living in recovery.

Identifying concepts, processes and particular details used by women as recovery catalysts, including facilitation and monitoring by practitioners and mentoring by supporters, provided a rich source of techniques to study and understand. What techniques were suitable for practitioners and supporters to meet their needs?

The changes and learning required to continue and thrive in recovery included:

- learning from developmental neuroscience to aid cognition and affect to reach an agreed objective (Goldsmith, Pollak & Davidson 2008)
- the relationship between emotional intelligence and four aspects of psychological wellbeing; (self-acceptance, life satisfaction, somatic complaints and self-esteem (Carmeli, Yitzhak-Haley & Weisberg 2009)
- interventions that consider sophisticated emotions and appraisal (judgment explanations used in evaluation; Long & Godfrey 2004, influence of emotion on judgment; Panksepp 2007)
- facing life’s reality living in secure spaces and supportive relationships for women’s mental health (Blehar 2006)
- ceasing problem-seeking, and focusing on personal perception and principles, concentrating on roles, rights and responsibility to participate in health decision making, strategising and negotiation (Mantere & Vaara 2007).
Appendix 5.2: Discussing ideas with participants in Action Cycle 5 and 6

PCT as a working theory of how midlife women are helped to recover from alcohol dependence

Perception Control Theory is at present not used in the alcohol and other drug field. Having reviewed applicable theories, this seems to fit the data of the study, with one reservation – the place of emotion in women’s recovery (and control shifting to mindfulness). I look forward to discussing its application with you.

Scenario based on Tim Carey’s explanation of PCT (2002 p30-31)

“... your lover being late for a romantic dinner might disturb your perceived state of a loving relationship. Calling your lover’s mobile telephone may provide you with information that will restore the state of your loving relationship to its previous condition.”

If I posed this scenario to our women in recovery their answer would be similar to this:

A woman addicted to alcohol would become anxious, angry, afraid and physically distressed. She would order another drink and ruminate about her lover being with another woman. Her imagination would picture a dazzling ‘other woman’ and catastrophising would begin about ‘divorce’ and then revenge on the lover and his new partner. All past discrepancies of her lover with other women (real or imagined) would re-present. She would explain to the wait staff how she is being wronged and that she didn’t deserve such treatment. She would perhaps cry, go to the ladies room, drink in the ladies room and... either a heated row or cold disdain on the arrival of her ‘no longer’ lover. She would leave the restaurant in a fury. It would escalate further with more alcohol and the woman, if fortunate, be in hospital emergency or at a police station ... or worse ... and there would be blame, shame, guilt or no memory of the event.

The woman’s perception of reality governs her actions. Those perceptions are alcohol effected. Unfortunately for women with alcohol dependence this ‘acting out’ occurs even without drinking. In more dangerous ways the acting out is internalised by women as they drink in secret and only the bizarre or depressed and alienated behaviours are observed.

‘Action not Behaviour’ has kept imposing on me over the past three years of the study. This is understandable from my research design and the experiences and descriptions of the participants in the study. Women with alcohol dependence are distressed, they react, but not necessarily to external stimuli:

“The behaviour that we observe in others results as a by-product of people controlling their internal perceptual signals.” (Carey p 29)

PCT is a living theory, not a behaviour theory. I prefer the Powers (1998) not the Glasser (1998) approach. PCT is counter intuitive which also attracted me as I believe women’s AUDs is counter intuitive as is human addiction being a paradox. I can argue for PCT also applying to the women’s recovery response. They are learning
about themselves (their perception) and other ways of doing life – purposefully choosing and using combined feeling, thought and intuition, and the spiritual, to act in an informed way in regard to their new ‘real’ lives.

PCT is about control, and addiction for the women is about the only control they come to believe they had left for them to survive – drinking to stay alive; which in reality is drinking to death.

Prior to the dependent use, the women all talk about the escalating need to ‘control’ every aspect of their and their loved ones’, work colleagues’, netball team members’...lives. For many years they appeared remarkable with onlookers not aware of the internal effort needed to control, often using maladaption eg lying to achieve results. Finally the distress becomes traumatising and chaos overtakes them with ‘I couldn't do it anymore”...”I just didn’t care (about me living) anymore”. They drink more alcohol to not know, feel or remember.

PCT fits with the transdisciplinary combination of data collected and analysed such as:

- **Physiological** – homeostasis/allostatic load
- **Psychological** – neuroscience, biological psychiatry, discursive psychology, community and positive psychology trends
- Woman talking about ‘coming to’ having abstained and beginning to perceive another world and learning to live in this newly perceived world of non-drinking. The women are truly amazed at their new existence: “How come I didn’t know about this?”, ‘I grew up thinking everyone else had a ‘how to live’ instruction book. In recovery its my life I’m living now.”
- Socially mediated nature of alcohol misuse. Initial actions fit the perceived drinking world and early need to change their marginalisation, ‘a feeling of being different, an outsider’ – an alien.
- Ecological relationships and medical understanding of gene-environment interaction, socialisation and basic seeking of a special place of safety for oneself.
- Feminist and transformative adult learning and development perspective
- Holistic healing, harmony and wellbeing preferences

PCT is circular and fits the paradox notion of addiction and recovery. PCT explains how people can ever only control their perceptions and change their perceptions. This is a tenet of the AA program. AA also puts changing the action to change the perception, with the ways of thinking and the feelings eventually changing with practice and time. Transformative learning also employs perception change, as does DBT and Schema Therapy, perhaps in a more cognitive way.

Thanks also go to Warren Mansell at Manchester who I contacted about PCT and he referred me to Tim Carey at Canberra University. I read their work. Tim and I then had an exciting telephone chat which resulted in these pages.

I am most interested in n participants’ ideas about this concept and if they have lived similar experiences.
Appendix 5.3: Methods of collection: Secondary data sources

I collected, accessed and studied the quantitative data below for further understanding of the RWR data. This data contributed to integration, abstraction and theorising processes.

Data cubes and statistical information


HDSC 2008. National health data dictionary version 14, cat. no. HWI 101, Australian Institute for Health and Welfare (AIHW): Health Data Standards Committee (HDSC), Canberra, ACT


Filters and alerts

ACA 2008. Counselling Australia, Volume 8 Number 1, Australian Counselling Association (ACA), Grange, QLD

ADF *Community Alcohol Action Network*, Australian Drug Federation (ADF), viewed 21 September, 2011


AGPN 2009. Chronic disease management: Prevention, early intervention and self management, Chronic Disease Newsletter Issue 3, Australian General Practice Network (AGPN), Forrest, ACT

AHDGP 2007. Newsletter: August 2007, Adelaide Hills Division of General Practice (AHDGP), Mt Barker, SA

AIPC 2009. The professional counsellor, Issue 3, Australian Instituted of Professional Counsellors (AIPC), Fortitude Valley, QLD


CASA 2009. Newsletter: Issue No 31, Counselling Association of South Australia (CASA), Kent Town, SA


Portals


DANA About, Drug and Alcohol Nurses of Australasia (DANA), viewed 7 September, 2011, <http://www.danaonline.org/?page_id=16>


Appendix 5.4: Extended understanding as meta-synthesis was completed

**Group 1: A woman’s abstinent midlife self**

*PAR Discussion* on self concepts, emotionality and emotional intelligence; ‘we’re over being midlife victims’

- Discuss core-self and emotion
- Women, emotion and language
- Women, mood and habit memory
- Women, from dependent attachment to interdependent affiliation

**Group 2: Experiencing recovery – wellness with illness**

*Unobserved & Observed Observation Discussion* on Communities of Practice and ‘Wm Space’; relationships, risk and resilience

- Experiencing self and other – affect and cognition
- Women, heedful interaction through conversation (chat)
- Difficulties with familial relatedness
- Social connection developed through experiential adult development
- Peer group belonging
- Friendship and closeness

**Group 3: ‘Be Come Well’ in recovery**

*Critical Reflection Discussion* on establishing gender-specific recovery and maintaining biomedical and psychosociocultural wellbeing; the meaningful choices

- Identities and roles
- Women and motivation – volitionism – being and believing
- Creativity, critical choice and commitment
- Responsibility to self and selected people
- Resilience over the lifespan
Group 4: How women transformed and sustained fulfilling lives

Expert Exchange Discussion on consciousness, complexity and ‘Recovery Development’; systems and networks that provide ecohealth

- Discursive development: problem as paradox
- Values - attitudes and actions
- Transition, Transform and Transposition
- Sustaining community connection

Group 5: Researching recovery as praxis and communicative action

Participant and Action Science Discussion of knowledge translation of evidence-based recovery action for professional practice, education curricula and mediation for public health promotion and prevention
Appendix 6.1: Of substance contribution: Midlife women maintaining enriching recovery from alcohol dependence

JB Withnall, Professor SB Hill, Dr SR Bourgeois

University of Western Sydney, New South Wales, Australia

MetaAnalysis Results from Researching with Women in Recovery - HREC No 06/091

This transdisciplinary qualitative action research was initiated to explore why the number of midlife women diagnosed alcohol dependent in Australia had risen from 8% in 1996 to 16% in 2005, with most being non-disadvantaged women. The aim is to propose more holistic and gender-sensitive ways for addressing and preventing further increase based on how women have already achieved long-term recovery in Australia.

Alcohol dependence is linked to suicide and other acute mental and physical illnesses of women in middle-age (Women in Australia 2007). The design of the study enabled dialogue among professionals, women and researchers which raised awareness of care needs for midlife women with alcohol dependence and that maintaining and sustaining recovery was possible (Rickwood 2006). Our action research methodology (Reason & Torbert 2001) and mixed methods of data collection from women in recovery with more than two years abstinence and qualified practitioners who work with women with alcohol dependence, occurred over three cycles. This depth and breadth enabled us to explore the complexities and processes of the women’s reality and practitioners’ strategies. Concepts, descriptions and explanations were continually refined through feedback loops, literature review and modelling. We were able to develop recommendations for improvement and theorise in a pragmatic manner the profound women’s experiences of ‘alcohol dependence and abstinence’, being ‘sober and living in recovery in Australia’, and of being ‘supported and treated’.

Results

Briefly, inductive, abductive and deductive analysis of the rich empirical data highlights the need for a greater emphasis on recovery over harm minimisation policies and services, and on the need to alter Australia’s ‘cultural acceptance of intoxication’. Dominant recovery themes identified from the research included: valuing personal perception; consciousness, cognisance and emotions; appreciating self-awareness; women mentors; secure living spaces; financial security and supportive relationships. All of this was achieved through the individualised recovery pathways of the women and embedded through experiential learning (Baker 2005) and transformative learning (Mezirow 2003). The recovery pathways created a nurturing ‘space’ for deep change over time to occur. We found that most medical and health professionals were significantly unaware of the rapid increase of alcohol misuse and abuse among women (in their 20s and 30s), and alcohol abuse and dependence by women in their 40s with the consequences of complex and chronic mental and physical illnesses (Wilhem 2008). Also, within this group of practitioners, there was little understanding of ‘the fear’ and particular barriers for
women seeking access to effective health treatments and support and retention in those services (Cohen 2006, Green 2007). Barriers include the stigma and discriminatory attitudes towards ‘female drunks, especially mothers’.

Few practitioners and women were up-to-date with the current understanding of women’s drinking life course and its difference from men’s and also the biomedical and psychosocial distinctions that occurred for women. Assuming behaviours, attitudes and emotions were common amongst midlife men and women in Australia was detrimental to care and support. Across the professional groups involved in the research, there was little integration of valuable knowledge such as: alcoholism as a chronic brain disorder; alcoholic neurobiology (Harper 2005); the physical telescoping effect for women; midlife co-morbidities; women’s dimensions of health (Stern 1998); interdisciplinary approaches combining epidemiology, developmental and biomedical knowledges (Ben-Shlomo & Kuh 2002) and newly presented stress and trauma contributors. There was little consideration given to women’s genetic predispositions and environmental risk factors for alcoholism being the reverse of men’s. Nutt (2006) works on the ratio of up to 30% genetics and 70% environmental contributions for women and that genetic/environment interaction continues and changes over the lifespan. Importantly, the professionals were open to understanding the specifics of women’s midlife addiction, viewing new theories, considering strategies of adult intradependence (Corte & Stein 2007) and taking into account mental health advances (Oades 2006). Both women and practitioners saw the urgent need to inform Australians about midlife alcohol dependence and the positive outcomes of recovery.

Our proposed neuropsycho-biosocial model of ‘How we live recovery in Australia’, derived from this research, highlights the need for a suitable recovery environment, supportive collaborating practitioners from related fields, time to transition through stages of recovery and accompanying shifts of identity achieved through transformative learning (Hill et al 2004). Our model also provides a way to improve professional practice by emphasising development loops of reflection, creative practice, acknowledgement of compassion fatigue, increased peer and supervisor guidance and essential continuing education. It illustrates the whole lived experience needed for recovery through a safe, nurturing place with time to focus on the women’s self engagement, embodiment and enrichment (Withnall, Hill, Bourgeois 2007), and respectful therapeutic and peer support (including such programs as AA). This enables women to establish self, build resilience and progress towards self-managed long-term recovery. A healing environment guides the women in establishing stable eudaimonic and hedonic abilities (Ryff 2004), experience emotional and social learning (Weare 2007), and a deeper sense of interdependence, meaning and purpose, which some describe as greater ‘spiritual’ awareness, and happiness. Ways of seeking counselling for other ‘women’s issues’ (Niv & Hser 2006, Greenfield 2007) is also a necessary component to ensure positive coping skill development for continuing long-term recovery. Our language analysis of the data set supports the value of more careful screening of women from their 20s onwards, establishing early intervention indicators such as two questions (Vinson et al 2007), lifespan and lifestyle progress evaluations for women, and a more collaborative developmental, including behavioural, approach to abstinence and sustainable recovery.
Discussion

At cycle 1 of the study the priority was the context and characteristics of the women, their chronic illness in the Australian environment and health system. Women’s equality is a re-emerging issue in Australian society in response to neoliberal government policy, and a silent societal expectation that women ‘just do it - all’. The complex and complicated midlife period for ‘Baby Boomers’ and ‘Generation X’ is a stressful tipping point, as is the societal paradox of outwardly accepting female drinking, yet condemning ‘wives and mothers who drink’. The current intervention focus in Australia is upon teenage drinking, with relative neglect of midlife and older groups who are equally in need of recovery support for alcohol dependence. Unfortunately, the ‘islands of professions and organisations’, health and medical structures and local, state and federal governments involved in substance use disorders seems to dissipate care efforts. Theory exploration and modelling the phenomena began to take on importance during cycle 2 of our research. Applying the significant data to theories such as integral (Eliason & Amodia 2007), allostatic load (McEwan 2007) and self-determination (Wild 2006), along with the women’s illness and continuing recovery (Mueser 2004), deepened our understanding of the women’s recovery experience. In cycle 3, the emergent knowledge about the process of recovery and the reality of alcohol dependence in Australia for women and practitioners was refined and checked for authenticity and utility.

The situation appears to be an overwhelming scenario: the personal tragedies and the extent of damage to families and communities; the apparent failure of the health system to adequately identify and initiate a healing process for midlife women; and the non-response to ‘restricting alcohol availability’ calls to policymakers from the addiction field, even with the evidence that the cost of work days lost due to alcohol misuse for Australian society was estimated at $1.2 billion2 per annum (Pidd et al 2006). Yet the women in recovery, and the overworked professionals representing their communities of practice, insisted that there was hope; and changes for the better were happening3 such as: the National Health and Medical Research Council 2007 proposal for lowering the number of drinks consumed per week for men and women to remain healthy, and its strong recommendation that people under 16 years and pregnant women should not drink alcohol at all. Even the perceived isolation of the alcohol and other drugs field in Australia from mental health, general and specialist practice (Outram et al 2004) and primary and acute care was beginning to be addressed through related issues such as foetal alcohol syndrome and emergency care overload. This, then and now, necessitates alcohol-related illness to be identified.

References available from Janice Withnall

1 Our research is currently moving through cycle 4 as the final reiterative phase of the action, and this will enable the completion of this PhD research study.
2 I believe new costs of alcohol misuse are being released.
3 Professor Webster has made further announcements today (15 April 2008).
For further information please contact Janice Withnall, Researcher-PhD candidate.

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Mail: UWS, Hawkesbury Campus, Building G/IT, Locked Bag 1797, Penrith South DC 1797 NSW Australia

The Research Supervisors are Professor Stuart Hill and Dr Sharon Bourgeois, both of the University of Western Sydney.

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval Number is 06/091. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (Tel: 02 4736 0883 or 02 4736 0884). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 6.2: Long-term interventions suitable for midlife women’s recovery

Few AUDs interventions (e.g. AA and particular psychotherapies) are designed for lifespan application. Practitioner professional development to improve care by using interventions that are suitable for long-term recovery is currently lacking. Three approaches (I call them ‘interventions’) that meet women’s long-term abstinent recovery needs are described in the table below: Spiral Dynamics (Beck & Cowan 1996); AA’s 12 Steps (1939 to 2010); and Transformative Learning (Mezirow 1978 to 2003). The common premises of the interventions that benefit women are:

- People can change based on volition (motivation based on recognised personal values) to ‘be well’ in the world; through taking action in which the focus is to attentively experience their life situation and to use a deliberate approach (e.g. such interventions as those described below) to question values, beliefs and attitudes underlying personal actions and self-identity. There is a growing awareness (often amazement) and acceptance of the complexity in midlife and elder living. The women’s part in the multi-dimensional and dynamic processes of maturing and belonging is indicated through their actions of appreciating others, their willingness to relate and the processes they apply to develop personal relationships.

- Women aim to connect with the process of living in a ‘whole-person’ manner (mental, emotional, physical, psychological and spiritual); and this involves reviewing the values implications of all new circumstances (including three levels of values: surface values, hidden values, and deep values; Cowan & Todorovic 2000). Through this, often enjoyable, process women identify changing conditions and can reconsider the context of their personal recovery and be willing to interact with others about complicated matters. Ease of interaction, including intimacy, and self-reflection to improve clarity for decision-making and determination in difficult matters, continues to indicate ‘self-in-wellbeing’ throughout a sustaining abstinent recovery process.

- Adult development continues through life, including cognition and affect integration, leading to maturing and refining of ‘intelligences’ and abilities. The frameworks for engagement offered by the interventions encourage progress in a continuum of change, while highlighting disturbing personal characteristics that may require attention. Guidance and facilitation (from practitioners and volunteer supporters) can help women focus upon individual objectives and goals, with awareness and exploration of critical factors, including the ‘whys’ of a situation. Women can be enabled to proceed with the ‘whats’ of the matter and the ‘hows’ to succeed in endeavours or, importantly, to cease activity and connection in unhealthy circumstances.

Three suitable long-term recovery interventions for women

Spiral Dynamics (Beck & Cowan 1996, modified by Withnall with reference to Kahveci 2003, and Hay 2005) is a personal and organisational (e.g. education and business systems) staged development that meets core human needs. Spiral Dynamics is a model of an emerging ‘self’, and it maps the Spiral journeys through the intrinsic psychological, social, and organisational development of the individual. The Spiral has several quanta (i.e. distinct levels); and Beck and Cowan postulate...
that their Spiral Dynamics model shows ‘waves of existence’. The Spiral is not symmetric; to meet dynamic, ongoing change, development is progressive and recursive, as needed. This model was inspired by the work of Graves (1970) who over 20 years earlier had developed a dynamic map of the developmental stages of human consciousness, value systems, and worldviews. He described a number of behavioural systems, based on the biological, psychological, and social interactions and relationships that he considered to be essentials of all ‘biopsychosocial systems’.

“Briefly, what I am proposing is that the psychology of the mature human being is an unfolding, emergent, oscillating, spiralling process marked by progressive subordination of older, lower order behaviour systems to newer, higher-order systems as man’s existential problems change.” (Graves 1974 pp 72–87)

The Spiral is also a meme and holon system; described by Kahveci (2003) as a belief structure, with organising principles for a mode of living that progresses (enacts or transcends) while including its predecessors. Kahveci suggested that moving between the levels of Beck and Cowan’s Spiral Dynamics model involves an interactive progression based on learning styles (for meeting ‘Problems of Existence’ and using appropriate ‘Coping Systems’ that can be effective in the host environments). Hay (2005) considers that the Spiral Dynamics group effect can help our current ways of living to become ecosynchronous. This Spiral framework reveals how the multiple personal experiences of the unfolding of self [becoming] and being aware of events in the environment are meaningfully related [through synchronicity]. The recognition of people belonging to a ‘spiralling’, dynamic progression of a synchronous human ecology can become part of a supportive process for intentional development of more sustainable communities.

The AA program of recovery involves ‘working’ through the ‘12 steps’, and accepting the principles of the program of recovery in daily life. I have included with these steps, Schwartz’s (1992) ‘Universal Values Types’, which illustrate the gap between addiction-oriented living and ‘preferred’ midlife adult values and motivations. The comparison provides a sense of the depth of healing that the midlife women commit to as they progress in the steps. Being able to see this helps the women to sustain their process of abstinence recovery. With respect to the spiritual component of the AA program, the choice of what spiritual approach is taken is up to the individual. Galanter (2007) notes the similarity between AA and positive psychology’s exploration of life purpose and meaning, and social network support (Valentine, Gallaher & Moutappa 2004). In my research, participants’ values and beliefs played an important part in long-term abstinence recovery, with abstinent women talking freely about their faith in God, or in a positive energy of some kind (e.g. nature), or the spiritual nature of the AA program itself (Carrico et al 2007).

The UKATT report (Orford et al 2006) called for treatment options based on a complex system of mutually supportive parts, and that considered the client’s social and cultural values. I recommend that in clinical practice, and in long-term psychotherapeutic relationships, the ethical values of practitioners – respect, responsibility, integrity, competence and concern – need to be openly demonstrated (through role modelling) and discussed (Plante 2007). My study also identified that for addiction and chronic illness practitioners, not just palliative care specialists, an awareness of spirituality and religiosity in healthcare training is needed. The desire for wellbeing, is likely to develop through exploration of the existential, the experiencing of a conscious ‘self in recovery’ and focussing more on inner psychological, emotional and spiritual matters (Maiteny 2000).
Mezirow’s (1978) transformative learning, as a 10-step adult education process, can be used to increase women’s engagement with active recovery through their becoming more aware of: contexts of a sociocultural democracy; engaging in discourse on worldviews with others; and applying reflective judgment to planning and action. Many practitioners and researchers have commented upon transformative learning; I have selected Taylor’s (1993, 1998, 2007) and Brock’s (2009) contributions as being the most useful for women’s recovery. Taylor highlights the recursive nature of the transformative learning models to illustrate the ways in which people return to the ‘meaning structuring’ process when experiencing disorienting dilemmas in relationships; cultural and socioemotional disequilibrium (i.e. when trying new roles); the need to revise life interpretations through critical contemplation due to change in life context; and readiness for meaning-making at important life transitions.

Brock’s (2009) study was the first to quantify the 10-precursor steps to experiencing transformative learning. The results emphasise the importance of learning about the critical reflection process, and being open to the use of intuition, empathy and other ways of broadening knowing; awareness of these processes and factors can also help practitioners to be more effective in enabling transformative learning in their clients. Critical reflection involves exploring our presuppositions about ourselves and the world. Boud and Walker (1992) suggest that the level of personal dissonance indicates the need for adult’s to engage in critical reflection; and Kovan & Dirkx (2003) suggest that to be effective such reflection should be extended beyond the cognitive realm to the emotional, spiritual and situational dimensions.

Mezirow (1998) did acknowledge that the term critical reflection in relation to his Transformative Learning theory (TLt) might have better been called perspective reflection or subjective reframing. I recognise that TLt does have clear links with perception control theory and schema therapy. Critical reflection is a form of experiential learning (Kolb 1984), which occurs when people in daily activity allocate a time and place (a mental and emotional creative space) to still themselves to become aware of and explore false assumptions in relation to their own experiences. This faculty is also useful to practitioners who are working with reflective practice (Schon 1983, Brookfield 1995). Importantly, for women in recovery, critical reflection can be used to identify and support fruitful personal recovery action: through perceiving and exploring a deluding belief; questioning acceptance of a description as a fact; responding reactively to a frustrating ‘unchangeable’ social situation; or carefully considering a transpositioning to enrich a living and learning future in recovery (Braidotti 2009).

<table>
<thead>
<tr>
<th>Spiral Dynamics</th>
<th>AA 12 Steps Program of Recovery</th>
<th>Transformative Learning</th>
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**Beige, express self instinctively and automatically for biological survival**

Beige is not listed in the levels of interactivity because at that level, intentional learning hardly occurs. This could be associated with an active alcoholism level.

Active alcoholism

Developmental movement from an externally presented problem (‘I drink because’ – blame of ‘others’ or events) to a self-generated problem or a problem with dimensions framed by the individual, reflects the women’s current capacity (King & Kitchener 1994).

Externalising often indicates what higher care needs are required e.g. for midlife women it is often more time in a safe place

(a) a disorienting dilemma

King and Kitchener (1994) noted that developmental movement provides the individual with the ability to recognise and respond to ill-structured problems. Ill-structured problems are characterised by uncertainly and more than one correct answer.

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The first six stages are subsistence levels and people at these levels think in ‘first tier ways’ which involves that their worldview is correct and they do not appreciate that other worldviews can exist.

**Beige to Purple**

Awakening of a sense of dependent self in a mysterious and frightening world to find safety/kinship/harmony/reciprocity

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

The paradox of dependence through maladjusted seeking of independence

Self Direction

(Independent thought and action)

Freedom, self respect, creativity, independent, choosing own goals, curious

(a) a disorienting dilemma

I suggest distress and despair continues for an extended time for women in early recovery. As an indicating paradox, health is returning for women, they are thinking of themselves and not just others.

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**Purple, sacrifice self to the wishes of the elders and the ways of the ancestors to placate the spirits**

The forms of learning: paternalistic teacher; step by step sequences, rituals and routines; small group nests; use of magic and fantasy.

**Purple to Red**

Awakening of an egocentric self determined to break the shackles of the family or tribe and become independent

2. Came to believe that a Power greater than ourselves could restore us to sanity. (A book published by AA called Steps and Traditions gives more detail on ‘working’ each step.)

Stimulation

(Need for variety and stimulation)

An exciting life, a varied life, daring

(a) a disorienting dilemma

Self-examination confirmed or informed in community, self-definition begins
| Blue level, sacrifice self now to the one true way and obey rightful authority so as to deserve reward later (social hierarchies; paternalistic; law and order; religious/puritan; absolute right and wrong) | 3. Made a decision to turn our will and our lives over to the care of God – Higher Power as we understood Him (it). 
Hedonism (Pleasure or sensuous gratification for oneself) Pleasure, enjoying life, self-indulgent |
| --- | --- |
| Blue to Orange 
Awakening of an independence-seeking self who challenges higher authority and tests possibilities | (b) self-examination with feelings of guilt or shame 
*Shared feelings or perceptions as validation. Feelings of others acknowledged and respected.* It may be a sudden change in perspective or a more subtle reframing of the world. Supporters are encouraged not just to celebrate the sudden ‘a-ha’ type of learning but continue to stimulate the more gradual change of framework that occurs over time. |
| 4. Made a searching and fearless moral inventory of ourselves. 
Achievement (Personal success through demonstrating competence according to social standards) Ambitious, influential, capable, intelligent, successful | (c) recognition that one’s discontent and the process of transformation are shared and that others have negotiated a similar change 
*Critical assessment of assumptions (objective and subjective).* |
**Orange level, express self calculatedly to achieve what self desires, but so as not to arouse the ire of others**

(individual truth and meaning; objective/experimental/deductive; rational; achievement oriented; materialistic; belief in the marketplace).

The forms of learning: explore feelings and learn by watching others’ actions; share here and-now experiences to enhance interpersonal skills.

Orange to Green

Awakening of a sociocentric self who strives for belonging and acceptance to discover inner harmony

| 5. Admitted to God-Higher Power, to ourselves and to another human being the exact nature of our wrongs. Power |
| (Attainment of social status and prestige, and control or dominance over people and resources) |
| Social power, wealth, social recognition, authority, preserving my public image |

| (d) exploration of options for new roles, relationships, and actions |
| *Discovery of options. Explore options using self-defined criteria.* |
| Four levels of transformative learning are woven into the 10 precursor steps: an elaboration of existing frames of reference, learning new frames of reference, transforming a point of view, and transforming what Mezirow (2000) calls “habits of mind”.

**Green level, sacrifice self now, to obtain now, for self and others**

(communitarian; ecologically sensitive; networking; freeing the human spirit/relationships; value communities; consensus decision-making; egalitarian; pluralistic relativism)

The forms of learning: self-directed access to knowledge and materials; individual develops without compulsiveness or fear; eclectic and diverse interests.

People at the start of second tier thinking are more able to step back and perceive a ‘big picture’, are aware that what occurs is in context and look for the links across different situations and ways of thinking and being

Green to Yellow

**Awakening of an inquiring, interdependent self who no longer needs approval yet can collaborate**

| 6. Were entirely ready to have God (a Higher Power) remove all these defects of character. Security |
| (Safety, harmony and stability of society, of relationships and of self) |
| Sense of belonging, social order, national security, reciprocation of favours, family security, healthy, clean |

<p>| (e) a critical assessment of assumptions |
| <em>Planning a course of action with emphasis on concrete actions and goals. Planning action guided by a philosophy, rationale, belief or value.</em> |
| (f) provisional trying of new roles |
| Role examination was another important characteristic in fostering transformative learning, specifically disorienting dilemma about social roles and tried on new roles. |
| <em>Provisional occupation of role and authorship of role.</em> |
| Baxter Magolda (1999) found four stages of growth in the transformative learning process: absolute knowing, transitional knowing, independent knowing, and contextual knowing. The passage is from certainty about one’s knowledge to the ability to question in the last stage, which can be likened to critical thinking |</p>
<table>
<thead>
<tr>
<th>Yellow level, express self as self desires, but never at the expense of others or the earth (holarchies; natural flows; group sensitivity; good governance), a more integrative approach is possible</th>
<th>7. Humbly asked Him – Higher Power to remove our shortcomings. Conformity (Restraint of actions, inclinations and impulses likely to upset others and violate social expectations or norms) Politeness, self-discipline, honouring of parents and elders, obedient</th>
<th>(g) planning of a course of action (h) acquisition of knowledge and skills for implementing one’s plans Acquistion of concrete knowledge and skills. Knowledge and skills inventoried and assessed. Additional knowledge and skills, if required, is sought.</th>
</tr>
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<tbody>
<tr>
<td>The forms of learning: interaction with whole-Earth networks to expand awareness and explore diverse ways of being and thinking; intuitive learning. Yellow to Turquoise</td>
<td>Turquoise level (universal holism and Wilbur suggests integral transformation (2000) The second tier thinking focuses upon, flex and flow and global views (Kahveci 2003). Values and lifestyle choices are considered In turquoise arises the individual’s awareness that the people can and should contribute to this interconnected living system</td>
<td>8. Made a list of all persons we had harmed, and became willing to make amends to them all. Tradition (Respect, commitment and acceptance of the customs and ideas that one’s culture or religion impose on the individual) Respect for tradition, moderate, humble, accepting my portion in life, devout</td>
</tr>
<tr>
<td>(i) building of competence and self-confidence in new roles and relationships Emotional competence (Duffy 2006) can be explored through critical reflection. Building self-confidence and competence, into a self-authorising self</td>
<td></td>
<td></td>
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<tr>
<td>Coral level of the Spiral is suggested. I recommend co-operative inquiry with participation of people across levels</td>
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<tr>
<td>There are people in the same society living at different levels of the spiral. Anderson (2000) described three groups in USA as:</td>
<td></td>
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<tr>
<td>Cultural creatives (progressives), Moderns and Traditionalists. Moderns are the dominant culture and Traditionalists are conservatives, supporting religion, family and patriarchy (Hay 2005).</td>
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</tr>
</tbody>
</table>

| 9. Made direct amends to such people wherever possible, except when to do so would injure them or others. |
| Benevolence (Preservation and enhancement of the welfare of people with whom one is in frequent personal contact) |
| A spiritual life, meaning in life, mature love, true friendship, loyal, honest, helpful, responsible, forgiving |

| 10. Continued to take personal inventory and when we were wrong promptly admitted it. |
| Universalism (Understanding, appreciation and protection for the welfare of all people and for nature) |
| Equality, inner harmony, a world at peace, unity with nature, wisdom, a world of beauty, social justice, broadminded, protecting |

| 11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out. |
| 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs. |

| (j) a reintegration into one’s life on the basis of conditions dictated by one’s new perspective |
| Competence and self-confidence affirmed or transferred. |
| Transformative learning continues as a person is struck by a new concept or way of thinking and then they follow through to make a life change |

| Mutual respect and trust are values of participatory research and provide a foundation for integrating multiple perspectives into a project, allied interpretations and credible outcomes – Cargo & Mercer (2008) |

| 4. validating a new belief by an empirical test of the truth of its claims, when feasible, or by a broad-based, continuing, discursive assessment of its justification to arrive at a tentative best judgment; |
| 5. coping with anxiety over the consequences of taking action; and |
| 6. taking reflective action on the new validated belief. |

| 11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out. |
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| 5. coping with anxiety over the consequences of taking action; and |
| 6. taking reflective action on the new validated belief. |
Although AUDs is a difficult and highly stigmatised mental health issue, research findings are emerging on the possibility of achieving greater social compassion and community inclusion around addiction and recovery; increases in social capital and the benefits of community amenity were observed when less people were actively intoxicated (Mooney 2005). Practitioner compassion fatigue, and ways to address medical complacency (Fahy 2007), are new perspectives that are also being reported in the alcohol and other drug literature. Community awareness of alcohol dependence in older populations, family experiences and Australian statistics of the sociocultural fact of Australians consuming more alcohol from 2000 to 2010 (calculated for every person over 15 years), are all being more openly discussed (Chikritzhs et al 2010). An evidence-informed recovery-change process can enable more women to progress from being vulnerable to the primal drives involved in active alcoholism to the seeking of a stable self (Panksepp 1998, Damasio 1999, Berridge & Robinson 1998) and wellness. This is more effectively achieved as the number of knowledgeable people – who are open to experience transforming illness into wellness through abstinent recovery, and focused women-oriented care – increase.

**Expressing values, supporting social justice, critiquing healthism and consumerism are important for women sustaining recovery**

Identifying the values that are involved is important in praxis-oriented research. A researcher’s selection of ontology, epistemology, and methodology is indicative of their values; and this may determine the Ethics Committee’s approval of the study. Gunnells (2008) focused on professions and professionals (choosing the counselling field as a case study) to explore the intersection between values, social justice and equity from three management perspectives: practitioner education and development; a workplace perspective; and from the participants (clients) using the services of the counselling organisation. The role of spirituality was found to be important, especially for adult females; and it helped to progress counselling beyond the level of ergoic conflicts. Gunnells proposed that social justice issues could be worked through by focussing on equity of services and enabling a ‘greater good’ (at a spiritual not material level) to become more inclusive and to facilitate ethical (values-based) conduct of all involved.

The main themes that encouraged productive and satisfying counselling work practices and outcomes, including participant’ satisfaction, were the ideas of: connection; relationship and kinships; meaning, as in frameworks for living and being; transformation and evolution; and resolving challenges.

Elaborating further on these six themes indicates their potential application to midlife women’s AUDs recovery:

- Connections. The importance of interconnection and disconnection, deconstructing and disconnection from the drinking self, and constructing interconnection with core-self, new identities and new people

- Relationships and kinships. Facilitated relatedness through new guides, mentors and teachers, and kindred spirits, with honouring heritage, legacies and family
• Meaningful living. 'Beingness' frameworks of a midlife, non-drinking woman, with emphasis on her values; developing new principles; mottos and affirmations

• Transformation and evolution: of changing core beliefs, and positioning oneself in new roles

• Resolving Challenges. Taking into account the relationships between people, issues of social justice, spirituality, and whole-person long-term healthcare, including the development of a respectful and responsible life-course plan

• Neoliberal politics and healthism. Questioning and rethinking the driving forces that place much of the responsibility on the individual with chronic illness to achieve a level of health, while avoiding ill health.
Appendix 6.3: Practitioners, Expert Volunteers and Supporters providing integrated care for stressful times

High-risk events

Stressful events that take days or weeks to resolve will require the women in recovery to learn, practice and develop their personal capacities to address issues as they arise, and to manage any associated stress. Examples of such issues provided by the women included caring for an adult child or an ageing parent with addiction, and various crises with their intimate partner (Reynolds et al 2010, Taylor 2008). From analysing my meta-data, the following eight useful development processes, to be introduced as part of stable recovery rather than in response to a crisis, were identified. The aim was to find effective techniques that would be of interest to the women and so provide them with more advanced skills to enable them to deal with difficult events. The eighth process is best provided by specialists in discussion with the women:

1. Establish clear personal boundaries (differentiation of self; Knauth, Skowron & Escobar 2006) and explore self-worth (Kaiser, Major & McCoy 2004, Ford 2008);

2. Identify and renew protective factors (Brady & Ashley 2005), such as the women realising their personal educational aspirations (especially if they have experienced familial dysfunction that has limited their adult education and personal growth);

3. Identify stress buffers that can contribute to optimal health; such positive psychosocial functioning (playing sport) can provide time-out for realistically construing and reflecting on their setbacks and successes (Nierop et al 2008);

4. Enhance pro-social capabilities (Rime 2009) by making available a range of techniques for improving emotional coping in recovery: such as those involving emotional discharge (Kohn, Mertens & Weisner 2002), emotional balance (Austenfeld & Stanton 2004), positive affect (Folkman & Tedlie Moskowitz 2004), and emotional intelligence (Saklofske et al 2007);

5. Increasing awareness of the nature of the interactions between personal and system dynamics (developing a small and big picture perspective), and of the need for a strategic focus to contribute to personal volition and the achievement of positive outcomes (Scholz, Nagy & Schu˝z 2008);

6. Being willing to delay personal action plans, and to pace one’s efforts and energy for self-efficacy and mastery (Scholz et al 2007);

7. Encourage the exploration of spiritual (meaning of life) beliefs (Sutherland 2009, Hartman et al 2009) and generative activities, such as mentoring other women in recovery, and contributing to the wellbeing of one’s family, the community and the biosphere (Stokels 2003); and
8. Raising trauma awareness through informed intervention (Olff et al 2007).

From analysing the participant data the following five imperatives were identified as being important for practitioners to consider:

1. Take into account all stakeholders’ diverse ways of knowing;
2. Help build capacity for ongoing change;
3. Create a space for interactions and bridge relationships;
4. Pursue practical and inclusive solutions to issues of pressing concern; and
5. Provide a protective factor for the expression of distress and exclusion.

These five factors can be accommodated when assisting with women’s recovery goals and new capabilities.

Creating actionable knowledge

Identifying the personal capabilities aligns with action theory accounts of studying both life-limiting and life-enhancing projects (Graham et al 2008). To achieve life goals, people who are goal-directed utilise, as necessary (often daily), capabilities such as foresight and planning (as discussed xxxx). Exploring and making personal discoveries about themselves was a goal of many of the participant women in recovery. Participants spoke about the essential and unpleasant reality of being informed, as women in early recovery, of how unwell their body-mind was. The explanations assisted them in setting appropriate objectives and working with realistic expectations.

Some of the difficulties experienced by the women during the first five years of recovery can be better understood when they have access to information concerning the slow regeneration of the brain with abstinence (OLITA – Outpatient Long-Term Intensive Therapy for Alcoholics; Bartels et al 2007), and on the ways in which the recovering brain can affect physical abilities, such as balance (ataxia: Rosenbloom et al 2007). Participants were eager for more ‘brain information’, and their continuing discovery and development of goals. I reviewed recent research on brain function, particularly concerning fluid and crystal intelligences, and distributed working memory. Working memory is connected to the different intelligence constructs. Verbal memory is related to crystallised intelligence and fluid intelligence is connected to visuospatial memory.

Fluid intelligence is defined as the ability to reason under novel conditions and crystallized intelligence is related to performance based on already learned knowledge and experiences. More specifically, fluid intelligence is said to reflect an ability to induce abstract relations, whereas crystallized intelligence is said to reflect scholastic achievement and cultural knowledge. High fluid intelligence tends to predict high

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The five principles central for guiding such trauma care are: i) a sense of safety and confidentiality, ii) a calming environment, iii) a sense of self – and community efficacy to support the women, iv) connectedness, and v) hope (Hobfall et al 2007).
crystallized intelligence, if educational opportunities are available.
(Haavisto & Lehto 2004 p 2)

Describing to the women early in the recovery process how memory works (through networks of information processing and storage systems that respond to sensory input) is helpful, because most of them have significant fears concerning their memories. Trying to avoid memories (the pain surrounding events, including shame, terror and rage) is a common reason given by women for ceasing treatment: ‘it’s just too painful’. Memory can be affected by psychological trauma (Brewin et al 2007), alcohol-related brain damage (Harper 2009), and by the normal forgetting that commonly occurs as a defensive response to disruption at the time of the initial registration of information. One’s understanding of past events can become distorted as a result of repeated intrusive memories and abnormalities in neurotransmitter systems (Ries et al 2009). Misinterpreting events in the present can be linked to mood and emotion, which in turn can be affected by ‘unconscious’ memory (Kelly & Masterman 2008). Negative memories, such as difficulties experienced resisting the distraction of irrelevant information (Durazzo et al 2008), can become ‘old triggers’ for current feelings of arousal and agitation, which can lead to comorbidities (e.g. persistent anxiety).

To minimise the negative effects of such memories, the women need to be reassured of their safety if memories intrude; and be assured that recall-remembering will not be required during initial AUDs treatment and early recovery. Participants emphasised that assuring women that any questions about memory would be answered was necessary and needed to be repeated throughout the initial treatment process. Providing the women with brief comments about the different types of memory (verbal, episodic memory, visuospatial and working memory) is useful to prepare them to accept that professional help will be available later on in the recovery process. This enables them to deal with their negative memories. Also, it is important to make clear to them that during withdrawal and early recovery their memory reserves are likely to be low, and what has recently been learned may not be well remembered, so ‘staying away from alcohol’ at this time is especially important. With continued abstinence, ability to plan and change attitudes, which requires high use of working memory, improves (Hoffman et al 2009).

**Conflict in relationships**

In the course of a life lived together, it is likely that conflict will occur (Kernberg 2012). Actively repairing relationships and continuing recovery development is a major obstacle and challenge for most women. The social perception abilities of women with AUD’s are low or not well developed for adult circumstances (Blood in Roffey 2012). Commonly, the women seeking support for dealing with critical life

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2 It is difficult for women to speak about the traumatic events in their lives, as these dangerous situations at the time of the event, limited their verbal memory, visuospatial and temporal memories. Also, misperceived ‘aggressive faces’ can be unknowingly linked to negative past events, and this can trigger current feelings of high anxiety. Neuropsychologists are revising our understanding of working memory and executive functioning (Pitel et al 2009) through the use of brain imaging technologies (Chanraud et al 2010). Research is being conducted on individual differences, e.g. personality and higher education (Hoffman et al 2008), with thought and memory (intrusion and suppression) links to intelligences. Improved understanding of our psychoneuroendocrine system (Brewin & Beaton 2002) is providing new ways for drug practitioners to work with trauma, brain and central nervous system function in their AUD clients.
events involving people are often confronted with old beliefs about the need for self-reliance; and they find that interacting with both the people involved and those able to assist is very difficult. Fortunately, their old coping mechanism of drinking is also recognised as detrimental.

### Conflict

- Resolving conflict in families (Gabb 2009) A useful learning about the following:
  - Recognition that conflict and healthy relationships can and do co-exist; conflict is normal and does not necessarily lead to dysfunctional patterns or personal harm.
  - Acknowledgment that no amount of positive thinking will completely eliminate conflict; rather, we need to accept and respect the endemic nature of conflict and expect that insight can assist in shaping conflict into a potentially positive force in relationships.
  - A search for positive feelings and behaviours that can mitigate the unpleasant and undesirable aspects of conflict can be helpful.
  - The cultivation of positive character traits that reinforce healthy, effective human relationships in which we tolerate and even grow and thrive under conditions of conflict.
  - A distinction between healthy conflict, where differences are expressed and common understanding discovered, and destructive conflict that is overly critical or hurtful, and undermining of power and self-esteem.
  - An explanation of how healthy conflict can make a positive contribution to healthy human relationships through providing means for negotiating and balancing power and influence.
  - Affirmation that people do use the techniques arising out of positive psychology, as well as broader spiritual-religious practices, to enhance their skills and modify their relationships to decrease the frequency, intensity and destructiveness of conflict.
  - The integration and use of multidisciplinary theory and research evidence for developing effective personal and professional practices.

The possibility of clarification of what the conflict is about (e.g. what are we debating, arguing or fighting about?) and resolution carries with it the possibility of further strengthening and deepening relationships (Covington & Surrey 2000). However, if it emerges that one cannot expect a positive, resolution and mutual re-commitment, there exists the need to acknowledge and, in the end, accept the situation. Most women with AUDs will need developmental education or therapy to be able to appropriately respond to adult relationship problems and conflict.
Recognising the signs of conflict and developing the skills to repair harm in the aftermath of conflict and wrongdoing are essential for individuals, families, organisations and communities. Conflict can take an emotional toll on those involved, and it needs to be managed in a way that the dignity and well-being of those involved can be restored and maintained. It also requires that the responsible parties are accountable for their part in the incident, and that they take effective action to make amends (Josselson 2003).

**Empowerment in relationships**

When women are stable in abstinent recovery, with appropriate nurturing and development of personal interaction abilities in a secure environment, the careful exploration of personal relationships (Biegel et al 2006) can be very beneficial. Women participants agreed that progress on sharing authentic self-concept in social interactions was both difficult and beneficial. The women’s preference for creating relationships incorporated acknowledging that people develop relational competence as life unfolds, and that relational understanding can be created in mutual empathy, and it can foster mutual empowerment (Armstrong 2008). Feeling effective in valid connection encouraged the women to further represent their needs for wellbeing, while considering the needs of others.

Both the practitioners and the women explained that comfortable association (Stets 2003, 2005) with people is better developed in selected groups, e.g. AA, or a local book club. Women and practitioner participants advocated enabling slow change, with the support of a peer mentor, therapist or GP, including discussions during which they could express their thoughts and feelings and receive feedback. Associating effectively with others (including work colleagues) involves understanding and applying the important ability of affiliating (Covington & Surrey 2000, Josselson 2003, Masters & Carlson 2006, Longabaugh 2007), then developing and maintaining friends, and contributing and receiving warmth in family membership (affection exchange; Bourke & Hared 2005, Robinson, Smith-Loven & Wisecup 2006).

*CBS6, Action Cycle 4, New women interview: “I have real relationships today. And whilst they can at times be more confronting than the ones I had before, they’re infinitely more rewarding and of more value to me. This is really important in my recovery because they provide me with proof that my life is better today than it was when I was drinking.”*

The women participants described and explained their difficulties with relationships (seeking trustworthy associations3), and the need for focussing on the process of relational recovery to enable the intergenerational changes needed to prepare for risk and focus on stable developments. The blocks they had to overcome, including those relating to their past relationships, were reported by the participants; these included treating other people with indifference or denial and having to withhold aspects of the self in order to maintain their primary relationships (a common relational paradox; Miller & Stiver 1997). The women’s preferred ways for engaging in relational and robust recovery is detailed in the Valued Recovery phase of the continuum (see Chapter 4).
jah1, Action Cycle 2, Women’s interview: “I think defiantly while I was drinking at my strongest. I started drinking at twelve and by the time I was fifteen I was in and out of different hostels to live in. I spent from fifteen to just before I turned twenty one, living on the streets or in the back of a car or whatever it might have been. Throughout that whole time I was drinking. My strongest memories are of things that happened during that time. They are not good memories they are quite strong bad memories and it encompasses so many things. Between just the physical effects of drinking, to assaults that happened with people, to a girl that committed suicide and I found her. I think it’s important to remember that stuff. But at the same time it’s important to get some distance from that and a different perspective on it”.

In their life course, the women participants had experienced neglect, deprivation, adversity and alienation, all demanding high emotional work (Strazolins & Broom 2004). During their recovery process their personal needs and actions included seeking informed understanding and discussion of gender (Van Gundy, Schiemans & Kelley 2005, Well & Dearing 2006), sex differences in community healthcare (Ringwalt 2004), and ways to contribute to child, youth and young adult support (Tracy & Martin 2007). The women pursued caring for self, and also sharing the care for others (Langer, Rudd & Syrjala 2007).

Being engaged in mutual endeavours with others and groups in the community can support the women’s development of realistic empathy and support (Morse 2001). However, a lack of meaningful midlife social networks for the women to enrich their recovery living was identified as being needed in most Australian communities. The women did not want more networks just concerned with ‘finding a partner’. The social networks needed were for developing mutual respect in midlife relationships, and ways to identity and express oneself while the other person is clearly recognised and responsive. The social interaction desired was an appreciation of the wholeness of the other person, with a special awareness of the other’s, and of one's own, subjective experiences (Souvaine et al 1990).

“... true independence means both asserting the self and recognising the other.” (Gent 1992 p 33)
Appendix 6.4: Guidelines for sustaining recovery drafted by Action Cycles 5 and 6 participants

Sustaining long-term recovery using selected lifespan interventions

Women’s resilience and wellbeing in long-term abstinent recovery must emphasise women’s self-differentiation skills and the protective factors of scholastic competence and spiritual (meaning of life) beliefs (Sutherland 2009, Hartman et al 2009). Gender differentiation of self has been identified as a developmental process (Knauth, Skowron & Escobar 2006); this is halted, however, if women use drugs or alcohol in place of learning adaptive coping mechanisms. Midlife women in recovery require extended support with self-esteem, problem solving abilities, and interpersonal skills for building resilience; particularly helpful are weekly psychosocial therapeutic, educational and experiential sessions designed to support and strengthen women’s existing and new coping and protective strategies (Brady & Ashley, 2005). High self esteem is a significant protective factor in high-risk environments. Enabling midlife women to realise their educational aspirations (especially if they have experienced familial dysfunction) can increase their self worth and prosocial coping abilities (Biglan & Hinds 2009).

Improvement in holistic healthcare for ongoing chronic illness can occur with the application of sustainability principles (Greenhalgh 2005, Sattmann-Frese & Hill 2008). Alcoholism is a chronic illness (Randolph 1950, White et al 2002, Krampe et al 2006) and alcohol consumption is a major risk factor for most chronic illnesses (Australian Institute of Health and Welfare 2006). Social and ecological sustainability is utilised to improve disease self-management (Glasgow et al 2000) as well as sustainable health and wellbeing (public health; McMichael 2006, mental health; Parkinson 2007). For midlife women in AUDs recovery, wellness with chronic illness (Lindsey 1996) is achievable through the adoption of such societal ethics and values as the following five orientations (p9 SANZ 2009):

1. Placing great importance on non-material sources of happiness.
2. Removing the perceived linkage between economic growth, material possessions, and success.
3. Affirming the deep interdependence of all people. The associated community values include a robust sense of mutual respect, fairness, cooperation, gratitude, compassion, forgiveness, humility, courage, mutual aid, charity, confidence, trust, courtesy, integrity, loyalty, and respectful use of resources.
4. Affirming the value of local community, with associated benefits of reduced environmental footprints and increased cooperation between people.
5. Valuing nature intrinsically through knowing that human society and its political economy are integral and interdependent components of nature and the biosphere.

Through his work at the Australian National University, Professor McMichael stressed in the Lancet (2006) and in the European Journal of Public Health (2006) the need to maintain the complex systems that support health and life: “Population
well-being and health, understood thus, become the real bottom line of sustainability” (European Journal of Public Health 2006: 2). Parkinson (2007), in his report on the Scottish mental health system, identified the need for women to reduce alcohol consumption by sustaining individuality (autonomy) within a larger social context, and seeking a sense of self determination and personal authority. My research has similar findings concerning the needs of women in abstinently recovery for independence, social inclusion and assistance to initiate, develop and sustain mutually satisfying personal relationships.

Additional strategies need to be developed and provided by the various alcohol and other drug services in Australia (considering living environments, life goals, support context and co-occurring disorders; Coyne et al 2007, Neto 2008) to enable women to prevent relapse and to focus on lifespan development (Schulenberg & Magg 2007). No longitudinal studies have been completed on women’s recovery after formal treatment. Men’s long-term recovery (male sex only) has been studied (Vaillant 1966 & 2003, Ojesjo 2000). Research on long-term outcomes of treatment, without male/female differentiation, has occurred (Mann et al 2005). A trial on post recovery treatment outcomes for women in a women-only recovery group is in progress (Greenfield et al 2007). Long-term recovery has been discussed and studied, e.g. in 1989 with the appraisal of a study of the recovery course of abstinent alcoholics:

“It was suggested that keys to full recovery in alcoholics are abstinence and time, which are necessary for recovery from a protracted withdrawal syndrome and brain dysfunction, for the repair of social relationships, for vocational rehabilitation, and for abstinence itself to become stable.”

(De Soto, O'Donnell & De Soto 1989 p 693)

Developing protective factors, especially in women with AUDs and comorbid illness, can draw upon the practices of mindfulness (Weick 2006, Waters et al 2009) or integral recovery (Dupuy & Morelli 2007). The work of Oades and colleagues (Oades 2005, Andresen, Caputi Oades 2007) on patient’s experiences of recovery from serious mental illness in Australia, and the development of a collaborative recovery model can begin to meet women’s AUDs recovery needs. This model provides an integrative framework combining (i) evidence-based practice; (ii) manageable and modularised competencies relevant to case management and psychosocial rehabilitation contexts; and (iii) recognition of the subjective experiences of consumers.

Current research findings that meet the needs of midlife women’s maintaining recovery, and can improve women-focused treatment aimed at long-term abstinent recovery (White 2009) include:

- mental functioning, mood preparedness and positive affect to facilitate insight and creativity (Kounios et al 2006, 2008, Subramaniam et al 2009)

- wise judgment, using meme and holon concepts for discerning appropriateness of response and levels of engagement (Fry & Kriger 2010)

- combining personal risk analysis and affect stabilising techniques with support for considered individual life choices and decision-making (Slovic 2007, Rivers, Reyna & Mills 2008, Appelt et al 2010).
Maintaining a positive mood (with less anxiety) can support preparedness for solving problems as shown with brain activity imaging (Subramanian et al 2009). Preparedness uses an insightful and analytical process. Women in recovery often have the ability of rapid observational processing, developed through fear of threat. This can be put to good use with guidance and practice to consciously lower affect and channel such mental functioning into productive and novel work. Insight involves a more global, diffuse detection of multiple associations, and a rapid ‘switching of attention’ activity to more preferable ‘paths’, rather than problematic paths, to provide more complete (and unexpected) solutions to emergent challenges. The ‘Aha’ of insight also generates positive affect and motivation in the women to not give up when faced with difficult tasks. Midlife women’s volition of in-recovery living can be strengthened by having access to this capability.

Practitioners will find worth in exploring the sociocultural, complex adaptive living systems concept of ‘memes’: a meme is defined as a pattern of behaviour, values, language or technology (Csikszentmihalyi 1993). It was described first by Dawkins (1976; 2nd edn 1989) in his book ‘The Selfish Gene’. Memes as a ‘structure of thinking’ in cognitive science, sociocognitive science and memetics (Castelfranchi 2002) is now supported as an explanation for cultural knowledge transmission (either practical, deontic or factual; Sartika 2004). Memes as beliefs and norms are shared in groups of people for adoption by those ‘chosen as belonging’, and not shared with those chosen to be rejected. With the emergence of cultural birth cohorts (e.g. Baby Boomers, Generation X and Y; sociocultural self-organising; Mittelton-Kelly 1997), it is an important part of a person’s self-organising process (Leydesdorff 1993) that contributes to their social identity. This concept can assist midlife women to understand their prior feelings of exclusion, and why their confusions concerning various common social practices. In recovery, women can use this information to begin to engage more effectively with their birth cohorts. The recovery networks that are developed in this way can help them to maintain their health and sense of wellbeing as they age.

Humans can be well when living in accord with others; and they can learn that they can nurture their own and others wellbeing as holistic individuals in ‘holons’ (self-reliant beings of living systems embedded in joint hierarchies or holarchies; Koestler 1967, 1979, Wilbur 1985, 2000, Pribram 1991, Wade 1996). According to Koestler (1967), human beings are ‘Janus-faced’ holons, looking inwards to their own integrity, and outwards to the sustainability of the wider system (social, ecological and economic) of which they are parts, on which they depend, and which they map out for themselves through communal and individual beliefs and meanings. We are multiple holons, with access to wisdom in all of our domains of being: bio-physical, psychological, cultural and spiritual, both individually and socially.

The factors that influence choice making (Appelt et al 2010) include individual differences in cognitive ability, motivation (specifically social desirability, motivated self regulation, and epistemic motivation), and personality (specifically, empathy and traits of the Big Five personality model; Johnson & Krueger 2004). In ‘real-world’ decision-making, people use (often in unaware ways) a framing process for considering their options. The framing process includes the ordering of choice options and the adult requirement of choice justifications, which are based on a consideration of the circumstances of the situation. Such consideration of an individuals’ circumstances are, for women in recovery, prioritised by personal risk of return to drinking and retaining emotional wellbeing, along with the usual time pressure, cognitive load, and social context (Weber & Morris 2010). Enabling women in recovery to take on this process for engaging in wise middle and late adult
life choices and decision-making is critical for developing self-managed long-term recovery. However, a strong proviso of no loss of chronic illness health care and support (Price & Cheek 2007) must occur to maintain women's equity as they age and engage in life-course change.

**Analysing and theorising processes for complex data analysis**

My analysis approach was founded upon seeking agreed meaning to summative results as a way to make initial sense of contextualised actions/experiences. Sense-making by all participants was encouraged and the research provided a space of convergence for respectful, discursive practices in which participants could explore women's recovery with the goal of understanding and providing useful assistance, e.g., targeted methods of healing, healthcare and development interventions for midlife women with alcohol dependence was necessary for recovery to be long-term and lead to wellbeing. I outline below the elements involved in the constructing process completed through the study.

Research in mixed methods and participatory studies are not linear. Researchers need the design, methodology, methods and tools to look at alternatives, record multiple directions and changes. Of particular importance is analysis management that includes: data cleaning, data entry and database access - flexibility to jump from one code to a conceptually related one (to explore theory) or to a factually related one (to explore patterns in the world the research is about). The prepared databases maintain and exploit theoretical links between concepts along with the real-world facts about and links among people, place, actions, and so on, not just explore textual links between codes. This is because the process of constructing an understanding is tentative, involving the exploration and testing of hunches at all grain size levels, hanging onto them if they look good for now, throwing them away when they no longer fit, while maintaining the rest of the growing structure.

**Theory and data**

Working 'up' from data is often presented as what qualitative research is especially about. It is done in many ways: building new understandings from ‘thick descriptions’; reflecting on and exploring data records; discovering patterns and constructing and exploring impressions, summaries, and pen portraits. All such efforts have theoretical results. They produce new ideas and new concepts, which are sometimes linked and presented more formally as new theories. Most approaches to qualitative research also work ‘down’ from theory. They incorporate, explore, and build on prior theoretical input, on hunches or ideas or sometimes formal hypotheses. Many also stress the testing of theory derived from the projects' data.

Computers provide assistance in the management of complex data. They can also be used in the discovery and management of unrecognised ideas and concepts, and the construction and exploration of explanatory links between the data and emergent ideas, thereby establishing fabrics of argument and understanding around them (NVIVO 7, 8 and 9 was used in RWR analysis).

**Further exploration**

Different researchers have different methods (and terms) for the exploration and understanding of rich data; production of ‘thick descriptions’ (Geertz, 1973, p.26);
discovery and uses of patterns; construction of new concepts and testing of old; linking of these into theoretical frameworks, explanations, and models; and validating impressions and conclusions. These, it must be noted, are not unchanging. Theory testing is emphasised increasingly, even in recent writings in the ‘grounded theory’ tradition (Glaser & Strauss, 1967; see also Strauss & Corbin, 1990), which is often, in our view, mistakenly presented as the dominant approach to theorising in qualitative research.

All these processes involve the recognition of categories in the data, generation of ideas about them, and exploration of meanings in the data. Because the categories and meanings are found in the text or data records, this process demands data management methods that support insight and discovery, encourage recognition and development of categories, and store them and their links with data. Ease of access to data is important to support recognition of the surprising and unexpected, construction of coherent stories, and exploration of sought-for patterns, as well as construction and testing of hypotheses (Bogdan & Taylor, 1975). But those methods also must not get in the way, by distorting rich records, diluting ‘thick descriptions’, or demanding routines that destroy insight.

But the challenge remains to adapt it to ways of recording, linking, exploring, testing, and building cumulatively on the insights derived from data. To draw on a distinction first made by Turner (1981), theory emergence in qualitative research is interlinked with processes of theory construction. Ideas, concepts, and categories discovered in the data are woven by researchers into fabrics of theory.

**Creative theorising**

Theory construction in qualitative research (the exploration and linking of theoretical and other organising and explanatory concepts and statements) is creative, not merely mechanical. The data-handling tasks associated are thus highly complex. And theory testing is usually part of theory construction, not a subsequent stage. Concepts are captured; links are explored, created, and tested; ideas are documented and systematically reworked, in textual memos, models, and diagrams demonstrating the specification, explication, and elaboration of theories.

So the dichotomy that matters is not descriptive-analytic versus theoretical: All data management methods involve theorising. Rather, in assessing what computers contribute we need to distinguish textual-level operations from conceptual-level operations. Whereas code-and-retrieve as we have described it is a textual-level operation, codings and retrievals are guided by theoretical interests, are used to shape and test theory, and (inevitably) put theoretical blinkers on an individual’s access to the text. Textual-level operations are theoretically relevant, but they do not construct or operate on theories.

And so the web – of code, explore, relate, study the text – grows, resulting in little explorations, little tests, little ideas hardly worth calling theories that nevertheless need to be retained as wholes, to provide further data for further study. Together they link together with other theories and make a narrative, the understanding of the text. The strength of this growing interpretation lies to a considerable extent in the fine grain size and tight interconnectedness of all these steps; and the job of qualitative data handling (and software) is to help in the development of such growing interpretations.
This network of concepts, evidence, relations of concepts, coordinations of data, of hierarchies of grain size where the theory/data/explanations chunks of one grain size are the data for the work of the next grain size up, is a good fractal-like model of people’s explanatory belief systems (belief systems are explanation systems). This is how a person (e.g. a social scientist) reflectively constructs an explanation, a story, for and from data.

The process is not all bottom-up, however. At each stage, the researcher uses expectations, prior theories, hunches, experience, and a good education (as with the theoretical determination of textual codes). The network builds up from the bottom, guided by a vision of the structure of a larger-scale network into which these small empirical gleanings must fit. When one gets there, the larger-scale structure is more likely to be different in many ways from the earlier ghostly vision; were it not so, the constructed theory would be quite unempirical, quite unconditioned by one’s data. And if one’s prior ideas are wildly out, then that will show up in the increasingly procrustean strains of trying to build the anticipated larger structures from the small, heavily data-conditioned ones.

And because, in that recursive fractal-like way we have described, the partial results and little theories become part of the data for the next move in the analysis, software would then treat the analysis/explanation material added to the database as more data alongside the original textual material. The very analytic structures, the explanations, become more data. Indeed, the very process of analysis (the computations) should be fed back into the data. That is, we want to save as data the theory/data/explanation chunks of one grain size so they can be explored as data for explanations at the next level up. Methodologically, this is known as system closure: Results obtained about the system, analytical techniques used on the system, become part of the system. A hallmark of qualitative social science research (but not of physics) is that the data being researched in a project are closed over its own techniques and results. System closure is the software feature needed to support directly the conceptual process of data-theory bootstrapping; but not sufficient – system closure will not necessarily give you a leg up to direct conceptual-level software operations).

**Action Science, experiential learning and social learning**

The Action Science Line of Inquiry provided a focus on the personal, social and environmental combinations (the context) that affect a women’s recovery. Not drinking in the same midlife environment with the same people will require women to change. The study examined actions such as learning about core-self and not drinking when interacting with people in everyday tasks. Not engaging in patterned behaviour and replacing the behaviour with a mindful completion of a task enabled the women to change and progress in recovery. Recognising that actions can be changed with thought and action based on commitment (to abstinence) was a continuing way of learning about ones’ ability to stop unhealthy actions and continue with practice to heal.

**Example of adult learning**

The research-based information of interest to the women was the human experiential development (personal information), social learning (social information) and the Peele addiction ideas (environmental information). Participants were asked to read and consider the information over Cycles 1, 2 and 3,
and in Cycle 3 and 4 they shared their related experiences and opinions on the material.

**Personal**

Humans develop through experiential learning (Kolb 1984, Schon 1987, Boud, Cohen & Walker 1993) and by adapting to current circumstances (Lewin 1951). Similar to other survivors of trauma (Brison 2002), women in early recovery learn to accept the situation and work to revision who they are, which commonly involves, often with assistance, the development of a personal set of rules to guide them. Learning ‘new ways of being’ also means expecting resistance, struggle, and even defiance. That resistance may not necessarily originate from the women, but from those with whom she lives, works and socialises. Providing bodily, intellectually, emotionally, spiritually and institutionally safe and firm health care can ‘hold’ and nurture women’s healing and recovery (Josselson 2003, Jordan 2004). A difficult and distressing situation, and daunting contexts and circumstances, may require ongoing support and action at agreed times. Women with alcohol dependence can explore self-development and restructuring relationships based on the non-drinking self (Corte 2007).

C2womintwyn3 – “Yes I do feel I have meaningful and purpose in life today: Learn how to love and be loved in return. Simply to be me and contribute my unique gifts, to keep myself well (mentally, physically, emotionally and spiritually) and help others (my family and my community) to do the same.”

**Social**

Engaging with social transactions and social knowledge in all parameters, from bonding, social attachment, socioemotional development (Sanchez & Pollack xxxx) to effective social roles (Boeri et al 2006) is essential learning for midlife. Social interaction, dialogue and consensual validation (valid by the process of discussing it) among people enables them to realise that they are not alone and, with time, that they belong. The conversation and dialogue is particularly important to establishing authentic relationships, autonomy and the development of trust. The midlife period in women’s lifespan is characterised by a complex interplay of multiple roles (Lachman 2004). Integrating knowledge of culture, values and social awareness is an ongoing process. Midlife adults find ways to enact their sense of social, cultural and environmental responsibility; this strengthens their capability for meaning-making, purposeful living and action in social crises. Learning about social and institutional structures (the local neighbourhood, clubs, workplaces, medical systems) also heightens peoples’ ability to consider life domains and life course decisions (Lamb & Sampson 2003, Agnew 2005), with an understanding that extends from local to global scales.

C2womintVixl – “I have also learnt to say, ‘That’s not okay, that’s not acceptable’, then to separate myself and walk away at times. And that can be a real challenge.”

P.I. – “Partnership is about a link and a personal relationship for me... [it] took a lot of learning how to negotiate. Now I guess that in general I
didn’t have a very good handle on it prior to getting into AA. Those are the things I had to learn how to do.”

Environment


“The addictive experience is the totality of effect produced by an involvement. It stems from pharmacological and physiological sources, but [underneath these ‘drivers’, it] takes its ultimate form from cultural and individual constructions of experience. The most recognisable form of addiction is an extreme, dysfunctional attachment to an experience that is acutely harmful to a person, but that is an essential part of the person’s ecology, and that the person [feels they] cannot relinquish. This state is the result of a dynamic social-learning process in which the person finds an experience rewarding because it ameliorates urgently felt needs, while in the long run it damages the person’s capacity to cope and ability to generate stable sources of environmental gratification.” (Peele 1986 p97)

C4newwomintCBS6 – “But look, you know, what I’ve learnt are simple things that help me maintain a level of emotional sobriety. I’ve learnt things that I just didn’t know when I was drinking or didn’t have the capacity to do. You know, I learnt that when things come up that make me feel uncomfortable, I need to address them. I’ve learnt that, um, I don’t have to say yes to everything or say no to everything. I’ve learnt that I teach people how to treat me and that it’s okay to have boundaries. That’s just something that I wasn’t fully (indistinct) about.

“And I’ve learnt that I need to have some level of respect for myself if I want to expect anyone else to have it for me.

“What I learned in recovery is that if I want something to change, I have to change it. That I don’t get to experience change in my life just because I want it. I’ve learnt in terms of some of those, you know, maturity things, and being an adult then; that there’s some hard work in (in) life that’s on offer in terms of the good things that are also on offer. I can only speak from my own experience and say that I’ve learnt to have a more balanced, less extreme approach to everything over time.

“I’ve actually learnt to enjoy and seek out opportunities to be by myself.

“So I’ve learnt about those things over the last few years and learnt to value them. I didn’t - I didn’t get that at the beginning of recovery.”
Appendix 6.5: ‘Big R Recovery’: RWR tertiary education materials

‘Big R Recovery’ includes working in groups or individually to safely reveal harmful or stigmatising events. This process is similar to AUDs treatment for women. Prior to this role play and tutorial work, prepare by reading, Alcohol dependence: from molecular physiology to addiction behaviour (Spanagel 2009).

Remembering

Such history, remembering and re-experiencing it, is difficult therapy; it is only begun with maintained abstinent recovery and the women’s comprehensive understanding and agreement. For it to be beneficial – not destructive – the therapy must involve preparing over many months for safe circumstances and acquiring suitable skills to constrain and come to terms with the post-trauma mental and somatic construal. This might occur in an agreed respite place with known non-drinking supportive peers, and the monitored use of anti-depressants and anti-anxiety medications.

Affect, the multiple factors that influence judgment: Circular affect processes and alcohol abuse

An essential education and discussion topic in early recovery for women with AUDs is the confusing affect adjustment; this can be eased through knowledge and support. The highest positive affect can occur after neutral discussion, a sharp decline in positive affect after conflict discussion, and, surprisingly, an equal level or further drop in positive affect after happy discussion. Residual negativity effect from previous events is commonly brought to elevated moments (happiness), especially following (unconsciously) perceived threats (conflict or opinion discussions). This confusion lessens with the women’s increasing awareness and recognition of low levels of ‘real’ threat, as an abstinent adult in recovery.

For women in recovery, positive affect can begin to contribute to engaging with difficulties and working in an analytic and creative way to solve a problem. It broadens women’s scope for attention and sensitivity to insight. A more neutral affect, rather than negative affect, can also improve outcomes as people are better prepared to detect and switch to a ‘correct’ association, and eventually a ‘correct’ solution enters their awareness. A negative affect with experience of maintained abstinent recovery can also remind women of past suffering and their ability to now adjust appropriately. This ability reassures and confirms the benefits of recovery.

Circular affect processes

A combination of the features of affect, emotion, mood, motivation and memory can be used to facilitate cognitive processes such as attention, perception, strengthening memory and goal attainment. Why it is difficult to achieve such facilitation? Recent affective science studies (discussed in Chapter x) of mood and memory, and interactions with emotion, confirmed that dependent people suffer from impaired affect regulation, and have a lower confidence in their ability to self-regulate.
negative moods. Dependent people also experience greater fear of high-affect intensity. This reaction lowers emotional control and triggers physiological distress indicators that affect mood expectations. Negative mood influences affect memory recall, with more negative events being recalled. This lowers motivation expectancies, which, in turn, lowers mood. This process happens rapidly, and it takes conscious attention and practice to prevent this from happening.

Positive mood elevates brain activity as people prepare for new activities, and when they are being introduced to new ideas. Positive mood motivates engagement. A negative mood has a somewhat opposite effect. The effect of positive and negative events on mood is well known, with positive events having a positive mood effect. Positive mood, however, has a shorter duration than negative events and negative moods (e.g. six hours compared to nine hours discussed in Chapter x). Alcohol use increases the length of negative mood, as well as cognitive and behaviour distortion. There are more subtle effects of negative mood and alcohol-related memory processes being studied, and this may eventually assist in mood adjustment.

**Motivation becomes volition through transformation in ‘Recovery Development with Recovery Support’: Self-disciplined freedom of choice, recovery-oriented communication and supported social interaction in ‘WmSpace’**

**Motivation becomes volition for women’s evolving INTRAdependence, INTERdependence and INdependence**

With women’s cognitive-affect integration skills developing, the Chronic Illness Recovery Management Plans are reviewed to encompass evolving values-based purpose and objective outcomes. The energy of volition (motivated commitment to achieve objectives) facilitates transitions towards intradependence, transformation to interdependence and independence, and sustaining long-term recovery through transpositioning (discussed in Chapter x), which can be achieved with time and Recovery Support to meet each woman’s particular circumstances.

**Motivation has multiple constructs, and in ‘Big R Recovery’** it is grounded through women’s commitment to value-oriented action to achieve individual objectives; particularly ‘Seeking’ intradependence, interdependence and independence of self as an adult woman in abstinent recovery (see Chapter x). Volition (value-oriented, motivation with commitment to action) is initiated through the healthy ‘Seeking’ process of ‘Small r Recovery’; and by the women achieving the objective of intradependence, demonstrated by no further self-harm through drinking, acceptance of abstinent recovery and the application of ASK. ASK was developed in collaboration with the women in recovery in this study (i.e. women having a minimum of 15 years abstinence). ASK was embraced as a memorable acronym by the women in early recovery – Action into abstinence; Seeking a safe and secure self; and Keep-on asking knowledgeable people for advice and assistance. Interdependence and adult independence through Recovery Development with Recovery Support uses volition in learning how to commit to longer-term objectives (cognition with intention), and to effectively complete tasks involving making wise choices. Interdependence acknowledges the need for advice and assistance (which highlights personal affect and intersubjectivity) and receiving such support through supported social interaction (e.g. AA, speaking with a trusted practitioner, and engagement in a ‘WmSpace’). Emerging independence is expressed through abstinent recovery with personal integrity and individual style; and it is applied with
volition to objectives in a larger sociocultural scenario e.g. recovery-oriented communication in selecting new roles, and completing training and education for these roles.

Transformative learning techniques can also assist with motivation becoming volition for difficult independent actions, such as changing perspectives to be able to meet demanding circumstances and remain abstinent. Learning involves taking in ‘prehending’ concrete experiences (details in Chapter x), and then reflecting upon and experimenting with related affect and alternate ways to reason and produce more effective outcomes. It is a recursive process to discover fresh possibilities, including change of attitudes, and developing more acceptable ways (often more appreciative, robust and reality-based) to achieve chosen outcomes. Women can reconsider their assumptions about living, assess new options, and replace, revise and consolidate points of view to guide actions.

Practitioners can support this experiential action through discussion, and the provision of sensitive challenge and constraint; the women need to experience safe relationships to be able to consider such changes. To lower the risk of returning to drinking (relapse), practitioners need to identify any further support that may be required, and refer the women to suitable preventive and active treatment therapies that place abstinent recovery as a priority, such as Dialectical Behaviour Therapy, Acceptance and Commitment Therapy, Schema Therapy, and AA attendance. Comorbid (co-occurring) disorders (psychological and physiological) can influence the choice of treatment. The therapies more suited to midlife women with alcohol dependence, who are often diagnosed with depression and/or anxiety disorders, are discussed in Chapter x.

Recovery Development with Recovery Support

Self-disciplined freedom of choice

In ‘Big R Recovery’ women practise maintaining conscious, internal balance (a sense of calm and wellness) with a perspective of self-disciplined freedom of choice (see Chapter x). This integrated state of being encourages women to respond in useful and purposeful ways to life and its variations, and to the changing environmental and sociocultural contexts. Development of midlife life skills (self-worth guiding self-care activities, role selection suitable to self-identity), sound decision-making in money management, and pursuing vocational training and education enrichment are common features of maintaining recovery for women with alcohol dependence. Through such development, it becomes possible for these women to consciously redirect tension to act on unacceptable impulses through other outlets such as exercise, art, music-making and supporting other women, and most importantly to explore in a constructive way the nature of the ‘tension’ and resolve it rather than continue to distract or ignore. This paradox of freedom of choice, by doing what has been learned by other women in recovery (providing some security and predictability), can result in ‘flow’ experiences (states of energised absorption) that lead-on to examining women’s existential wellbeing as part of their psychological and physiological wellbeing (see Chapter x).

The process of women explaining their choices to practitioners, and like-minded people, makes real the unconscious and conscious ways these women evaluate their position in abstinent recovery, and consider the rich spread of information from which to plan and take coherent personal action to achieve clear objectives. In
addition, developing this process of self-discipline is helped if the women are enabled to:

1. Acknowledge and inhibit strong, but unwanted, habitual reactions and emotional impulses that damage abstinence and recovery attitudes and actions.
2. Be present and maintain core-self consistency, with ‘aware and able’ checks of available options to initiate and complete tasks and meet selected role responsibilities.
3. Appraise situations by using a ‘one-step back’ perspective and ‘what if’ consequence checks; these can also help to gauge the women’s level of hypersensitivity (if this is rising the women can attend to this by taking time to return to an internal balance).
4. Transform ‘old reactions’ into the preferred responses and actions of an authentic-womanly self when positive, negative and unexpected events occur (take notes of the process and principles followed as a form of progress check).
5. Maintain realistic and responsible self-actualising goals and objectives in the face of distracting internal and external stimuli (a return to basics such as ASK is always appropriate).

**Recovery-oriented communication facilitates interaction with self and others**

Recovery-oriented communication is a necessary part of maintaining women’s abstinence, health and wellbeing. Communicating using selected language via spoken words, facial gestures or emailing is a human metaprocess that involves cognition and affect. Communication abilities are often falsely assumed and often require adult education (and re-education) support. Midlife women with a developing abstinent, authentic core-self may be initially inhibited (affect pathways) and confused (cognition pathways), and may require assistance and patience to communicate effectively. Education and treatment can assist with four types of talk (see Chapter x) that can be introduced, role played and modelled for women:

1. conversation (necessary social small-talk)
2. discussion (of viewpoints and opinions held)
3. dialogue (closely working together on matters of mutual concern), and most important
4. self-talk (attention to this can bring women into the present and their own world of meaning).

Sharp words (in conversation), assertion of opinion through debate (discussion), lengthy complex argument (dialogue) and self-denigration (self-talk spoken, written [diary notes] or silent) are often misconstrued by women with AUDs as conflict, threat and proof of unworthiness. The parameters of adult communication for personal expression need to be explored by abstinent women, rather than avoided, resisted or just imitated. Activities such as daily check-in by telephone with a respected person are important techniques to gauge genuine (and in-the-present)
listening and speaking, as well as adult reliability and consistency. The phone calls, as well as sharing at AA meetings and through group therapy, help to develop response-ability, and avoid the triggering of hyper-reactions to words, tone of voice and visual cues. Replacing women’s unrealistic self-demand for perfection when communicating with other people, by offering the ‘best effort at the time’ is an important indicator of progress.

**Careful social interaction**

Women’s capacity to connect with self and selected others while heeding the need for self-care requires practice. Women with long-term in-recovery experience can facilitate, model and encourage this critical ability in others; and this can help to expand intrapersonal and interpersonal abilities of self-acceptance and self-actualisation. Understanding healthy social attachment, especially social emotions, such as fun and shame, can be learned as an adult. Adult interdependence also broadens experiences and knowledge about what is involved in functioning as a ‘whole person’ who can enjoy abstinent social interaction.

The vicissitudes of human relatedness, particularly the capacity for trust, are particular challenges for midlife women in recovery. Gentle nurturance through ‘Big R Recovery’ to facilitate valuing women’s sensory perceptions and intuition begins the process. Encouraging prompt communication of their thoughts and feelings (however faltering) with other knowledgeable women is initially difficult to do, and as it is embraced as a worthwhile life-long practice. By observing respected peers in recovery (‘experts through experience’) and practitioners, women with AUDs slowly build their confidence in others and themselves. Mutual respect and reciprocal support in relationships such as peer friendship provide opportunities for experimentation with levels of personal expectations and responsibility, experiencing hope and disappointment, managing difficulties and reaffirming commitment to recovery.

Misunderstanding ‘affectionate communication’ is a common difficulty in recovery. It is a complicated matter with midlife women, as it can be a trauma-inducing process (i.e. flooding hormone release). Offering ‘safety net’ options (what to do if a personal situation becomes stressful) is a pragmatic starting point for practitioners. Intense and confidential care and support to enable midlife women’s abstinent Recovery Change and Recovery Development in intimate relationships to be affirmed (often considered as taboo-talk by midlife women even with other women) is a critical matter; it was highlighted in my research results and findings as being insufficiently supported. Careful consideration of patient needs and requests should guide this important therapeutic area. Further study on intimate relationships in midlife women with alcohol dependence is needed. Simply applying perimenopause, menopause and post-menopause research findings is inadequate, and was reported as being both confusing and detrimental.

**‘WmSpace’ for midlife women’s safe interaction**

A ‘WmSpace’, as described and developed in this research (see Chapter x), is a place in the community (perhaps a pleasant, discrete room in a public building) where midlife women in recovery can gather, and learn from ‘experts through experience’ about options for remaining abstinent in everyday situations. Participants in the study emphasised that abstinent recovery was a ‘24/7’ process of living, and that recovery was cumulative, as was alcohol dependence. Women with AUDs verbalising
their concerns with other women, perhaps two or three times a week (similar to physical exercise requirements), provided non-medical time to gather a sense of coherence of being midlife women in recovery in their local communities. Access to such spaces can improve the women’s emotional wellbeing and mental health within their own neighbourhoods. Women with alcoholism (even when practising abstinence) are still often marginalised; many examples were given by research participants of losing friends and family when their alcohol dependence was revealed.

From this research, it was clear that midlife women need more accessible processes to create a bridge for them from out-patient groups, mutual self-help groups and therapeutic communities to a safe and understanding place in their communities. GPs and counsellors, in the main, have not provided this extensive support. However, combined with their routine appointments, ‘WmSpace’ can support the shifts and transitions that have been revealed and established in therapy. The ‘WmSpace’ can also represent non-threatening, acknowledgement by the community (cultural and institutional acceptance and support) for midlife women needing to heal, not just of their roles as mothers in children’s playgroups and after school activities, or carers of partners or parent with a disability. It offers extension of care in a social network, and a positive ‘in the neighbourhood’ beginning for increasing community reconnection.

Importantly, it can also be a space for negotiated practitioner training and development (through observation) in midlife women’s ways of recovery from vulnerability to vitality. Professionals might observe and absorb discursive practices, women's construals and interpretations, and the matters and attitudes important to their recovery, such as developing midlife comprehensibility, manageability and meaning in abstinent in-recovery living. ‘WmSpace’ also provides places where health and welfare support agencies can help meet these midlife women’s needs. This may also overcome the women’s common mistrust of these services. Women participants detailed their experiences of being left aside in healthcare and welfare settings (including telephone helplines), and of being labelled as ‘burdens’, ‘undeserving’, ‘too damaged’, ‘non compliant’ and ‘difficult’.

Community (non-governmental organisations), government services, following confidential care and support without judgment principles, and existing mutual-support group activities (AA, SmartRecovery) can be part of ‘WmSpace’. The practicalities of informing women of their existence (perhaps a responsibility of primary health care, addiction and mental health services and community noticeboard systems), and the cost and block booking of a midlife women’s meeting space (e.g. two hours in a room for 15 people, three times a week with a morning, afternoon and evening session) is doable.

**Negotiation of ‘Recovery Development’ partnerships and responsibilities**

‘Big R Recovery’ is possible for individual women through a negotiated healthcare partnership that is people-focused and involves: developing reciprocal responsibilities of professionals and patients; treatment and services for co-occurring disorders, giving priority to abstinence; and providing human kindness as well as quality care. A meaningful and agreed Chronic Illness Recovery Management Plan is an essential tool to achieve sustaining abstinent recovery for midlife women. The elements of the plan are drawn from the research results (see Chapter x) and
emphasise continuing care that is supportive and addresses the suffering involved in women with AUDs and their co-occurring illness. These elements may be grouped under the following three headings:

1. People partnerships for agreed process and objectives
2. Women-oriented care for maintaining abstinent wellbeing
3. Chronic complex illness care requiring reciprocal responsibility and kindness.

**People partnerships for agreed process and objectives**

Research participants (women in recovery and practitioners) agreed that alcohol dependence, and its related conditions, is a complex chronic illness that requires cooperation and effective contributions from knowledgeable professionals to meet the individual's specific healthcare needs. The reality of midlife women’s AUDs demands an organised alliance across medicine, health and welfare services of specialists and ancillary health professionals with addiction knowledge who agree on holistic patient-focused continuing care principles. A lead practitioner is essential for ‘Recovery Care and Recovery Development with Recovery Support’. This individual can negotiate with each woman concerning her specific health and wellbeing objectives, treatment approaches, selection of cooperating professionals, priority of care, importance of routine monitoring by experts, and involvement of ‘experts through experience’.

Practitioners and women following a Transition, Transformation and Transpositioning overview (see Chapter x) for abstinent recovery are better able to provide extensive and focused healthcare for midlife women with AUDs. The partnerships of Chronic Illness Recovery Management Plans provide a knowledge-generative collective for insights to be discussed, applied and evaluated, and records kept on which to base treatment for more women. Two essential features of successful midlife women’s recovery in the research findings were: the need for active healthcare to reduce risk of further chronic illness (women with alcohol dependence in recovery are at higher levels of risk for most ‘ageing diseases’); and continuing treatment for Recovery Care and Recovery Development.

**Women-oriented care for maintaining abstinent wellbeing**

This study’s research findings provide a starting point for midlife women’s lifespan care and development in an individual Chronic Illness Recovery Management Plan. The integrated care needs to include the following 10 objectives:

1. Discussing physiology changes, including return of menstruation, fertility problems, intercourse, pregnancy, sexually-related health, and hormone-related conditions.
2. Monitoring multiple medication use for co-occurring illness (physiological and psychological conditions), as pharmaceutical substance dependence can occur, particularly opioids and benzodiazepines.
3. Reducing the bodily pain that commonly occurs as the many biological systems damaged by alcohol heal.
4. Establishing and maintaining housing, financial planning, transport arrangements, occupation at suitable levels, and education and training as vital components for sustaining recovery.

5. Building reserves of physiological and psychological energy (including mental volition-vitality levels).

6. Working towards the development of a resilient core-self, emotional wellbeing, improved mental functioning, coherent role-selection and social functioning.

7. Addressing midlife women’s sociocultural issues (intimate partner violence, parenting dependent adult children, discrimination in the workplace, addressing past familial abuse and neglect, and conflict and trauma history).

8. Arranging and encouraging connecting with people, as well as ‘experts through experience’; this includes peers (in ‘WmSpace’), friendships, interest group memberships, work colleagues, and neighbourhood-community involvement.

9. Attending agreed ancillary therapy, including AA, meditation and exercise sessions, developing leisure activities for relaxing encounters and enriching experiences.

10. Discussing family relations, with any action being based on the women’s specific needs; this involves agreements between the women and their practitioners concerning how to best meet their objectives of maintaining abstinence and accessing ongoing care for their long-term recovery (see Chapter x).

**Chronic complex illness requiring reciprocal responsibility and kindness**

Assertive follow-up by practitioners to establish extended aftercare for women’s Recovery Development can also help to identify related co-occurring conditions, both physiological and psychological. There is also an opportunity with midlife women in care to begin a prudent process of developing with those in the healthcare partnership, firstly by agreement with women, a ‘responsible wellness with multiple chronic disorders’ approach. These women, in consultation with practitioners, begin to take on a more reciprocal responsibility for their wellness, while accessing care for their multiple disorders and engaging in therapeutic relationships.

Acknowledging and affirming women’s developing authentic self-care, their ability to consider knowledgeable advice and committing to and completing actions for abstinence as positive living experiences, brings to the fore discussion of eventual self-management objectives (e.g. further education, career change, changing residence, and financial and aged-care planning). Such discussion signals progress and provides evolving satisfaction for all people involved in ‘Big R Recovery’ processes. It can also create a new stressor – the women’s thoughts and feelings of being left without access to care. Reassurance drawing upon whole-person healing expertise, which has been exhibited through prior care, can reinforce a sense of security in a continuing and changing therapeutic relationship.

Recognising the subjective experiences of both the client and practitioners can also emphasise the humanity involved and the important ‘soft outcomes’ of partnerships
in Recovery Care and Recovery Development with Recovery Support. Unfortunately, a cooperative partnership working with a respectful (and difficult) process for all involved (including the client and ‘experts through experience’) in the healthcare system is currently rare. Kindness in these difficult caring situations is significantly remembered, and was reported by many of the research participants. Social justice requests by research participants who did not experience quality care were also reported by many of the participants.

**Complex and continuing treatment for long-term abstinent recovery**

Seeking wellness advice from practitioners and supporters begins a ‘self-management of my wellbeing’ objective (see Chapter x). Maintaining wellness in recovery, and then working towards increasing self-management of wellbeing is best done through a Continuing Chronic Illness Recovery Management Plan that emphasises mature adult processes to reach agreed objectives (the illness is not cured), with ongoing monitoring. Long-term abstinent recovery care, development and support have been subjected to limited research and documented clinical practice.

**Sustaining abstinent recovery requires the women’s recognition of any emerging comorbidity** (e.g. return of depression) and ability for pre-emptive response e.g. communicating their concerns promptly to appropriate practitioners and supporters. Keeping records and respectfully facilitating midlife women’s continuing recovery wellbeing is a valuable resource. The critical factor for the lead practitioner is to maintain resilient medical, health, welfare and ancillary care partnerships that can accommodate appropriate change, maintain ease of access, and adjust to new collaborations for patient-centred wellbeing care. Such a healthcare plan (hopefully, also as e-records) can form a tribute to the many people involved. Professional responsibility in offering medical, health and welfare care options for women in recovery is demanding, as is the high level of capability and commitment required for managing and leading partnerships across health sectors.

**Sustaining abstinent recovery**

Women were grateful for the assistance they received in their despairing and difficult times. They wanted to contribute by sharing their understandings and knowledge for wise (whole) caring actions, such as principled mentoring of women across generations to enable others to establish and maintain abstinent recovery. I described their substantial knowing as being similar to that described by Brown (2009), and also Emmons, Petersen and Seligman, Czikszentmihalyi and colleagues (discussed in Chapter x). The women took action (striving for responsible wellness) with the support of wisdoms from Eastern and Western philosophical traditions, and concepts of spirituality from AA to Gaia. Many of the women were enabled to embark on their journey of change with support, education, often career and relationship change, and most importantly (as often repeated) with the priority of abstinence.

The proposition that addiction (substance abuse, and alcohol dependence) is a replacement for relationships has been discussed for many decades, and even centuries (see Chapter x; and in particular the work of Brown [xxxx], Covington [xxxx], Matto [xxxx] and Kellogg [xxxx]). Understanding the cumulative effects of
the damaging, interpersonal and social relationships that contribute to alcohol misuse by women can provide a wealth of knowledge to help other women in an in-recovery support relationship to become well. A long-term perspective is needed. Fortunately more longitudinal studies are in preparation, and are incorporating addiction and relationships questions, e.g. the Healthy Aging of Women Study (Anderson, Anderson & Hurst 2010).

Women and practitioners agreed that sustaining abstinent recovery could be achieved through a negotiated focus on the women’s transformation, becoming robustly well, and contributing their transpositioning experiences (from active alcoholic to honourable positions) for the wellbeing of other women with AUDs. Women in long-term recovery are committed to self-care, and to entering into worthwhile endeavours while continuing to seek wise counsel. The women participants described overcoming many recovery challenges and near relapse experiences that were fulfilling and were examples of vital living with AUDs, e.g. psychological, physiological and spiritual ‘flow’ events (see Chapter x).

The practitioner participants acknowledged that for women with AUDs, establishing abstinence and then a recovery way of living is a very difficult process. The goal of bringing women with alcohol use disorders to abstaining from drinking is the start of the initial protective task of exploring with women how to establish a healthy core-self. Intradependence, followed by productive recognising of emotions and beliefs, is then regarded and experienced as a useful resource. Practitioners described how the women developed awareness and perception that attitudes (their own and those of others) can be misleading, and are challengeable in a respectful manner. The integration of cognition and affect to produce desired personal action was a substantial achievement. Perspective-shifting capabilities that help to stabilise ongoing identity and role selection and development followed, and often the women sought therapy to help them confront this more difficult process. In abstinent recovery, with support through treatment and peer networks, including AA, women can reach a point of seeking, not dependence, but independence and its associated self-worth, achievements and wellbeing in mature womanhood. Both the practitioners and the women viewed safe healing as an ongoing process, and nominated specific areas that required attention. These may be grouped under the following subheadings.

**Physical**

Further work on women’s biosocial characteristics and functions (cardiovascular, neuroendocrine and immunologic) beyond stress and allostasis is needed. In particular, studies on the multiple aspects of intimacy in relationships (emotional, sexual, intellectual, and recreational). I have examined the longitudinal findings of the MIDUS (Midlife in the United States) study, which began in 1994 under the leadership of Carol Ryff. Ryff and colleagues focused upon a combination of emotion, social relationships and health research. The teams leading the Whitehall II study in the UK, and the Australian Longitudinal Study on Women’s Health, are being lobbied to include questions on socioemotional factors that can have positive (and negative) effects on health.

**Psychological**

Healthy mental functions that assist with vital engagement in everyday life and the abilities to develop a good life were primary objectives of the midlife women.
Attention, being present in the moment, and enjoying involvement in selected activities were emphasised, and that encouragement is necessary. Being able to adjust to circumstances, including distractions, accept and continue on in a creative way were of particular importance. Satisfaction from focusing on mid-term and then committing to meaningful long-term goals were some of the difficult challenges achieved and reported by the women. Challenging personal states of being surprised the women, as did the benefits of considering attitude changes, such as being in harmony with other people, working and feeling whole in the world, and experimenting with pleasing processes.

**Spiritual**

A positive state of being, with awareness and openness, was discussed by the women who had experienced considerable recovery time (eight years or more). Most spoke of a way of recovery living that was more loving and supported by spiritual beliefs. They found abstinence and spiritual beliefs fulfilling and enriching. In most circumstances, they could be calm and contented and able to offer comfort and compassion. They spoke of being less reactive and demanding, with appreciation of the world, gratitude, happiness with or without people, and peace of mind previously not experienced. The practices of reflection, meditation and prayer were used often. These practices enabled the women to concentrate (gently), perceive more acutely with their senses, and understand more about themselves with clarity. The resulting uncluttered and still mind compared favourably to their previously noisy and scattered or spacey and empty mind.
Appendix 7.1: Midlife women: A special recovery population and key to intergenerational alcohol use change in Australia

The study’s final phase explores with women in recovery, practitioners and leaders in related fields, the issues listed below: Have your say today by filling in our survey or leaving contact details. Participants with experience of alcohol dependence & its care are important in this transactional research.

1. Alcohol has a different biopsychosocial effect for women, especially as they grow older. Women suffer more damage, more quickly with less alcohol. This information must be translated into medical and healthcare education and practice in Australia for alcohol dependence levels in three generations of women in Australia to lower from current estimates of 16 to 23%. Alcohol use disorder needs to be identified earlier in women, preferably by their mid 20s, using the Vinson three questions approach. Screening at particular health consultations is necessary. Women want particular recovery treatment (Withnall, Hill, Bourgeois 2008). Each extra three to five years of drinking for women dramatically reduces the possibility of recovery without major illness, brain damage and long-term rehabilitation. Co-morbid psychological and physical disorders increase and death by 50 is more likely in women. Suicide in midlife women related to alcohol is a leading cause of death (Women in Australia, 2007).

2. Midlife alcohol dependence in women needs to be treated now as a special population problem. New techniques for treatment that are identified by women in recovery and qualified practitioners through this study can meet the complex midlife adult needs of women. Discriminating circumstances for women needing treatment was re-identified in 2001 through the Federal Government Senate Committee Drinking Act inquiry. The rise in the number of women misusing alcohol was first documented in 1986 in Australia in regard to heart disease. Women’s alcohol use disorder needs in Australia were studied with a number of published research outcomes from 1994 to 1998. We have today an alarming upward trend of alcohol dependence in 35 to 55 years old women and only a small number in treatment. The estimate is now 1:3 cases. This non-treatment is cascading to younger generations of Australian women. Policy and program change in the upcoming NATIONAL ALCOHOL STRATEGY needs to happen for today’s female ‘Baby Boomers’ and ‘Generations X and Y’.

3. Age, time and context matter in alcohol misuse. We know young women drink equal amounts or more alcohol than young men AND this is the tip of the iceberg of female alcohol misuse in Australia. Career drinking in the 20s and 30s, secret/unseen/undiagnosed midlife alcohol dependence and aged women with alcohol-related dementia shows a life course health problem with alcohol and women in Australia. The number of women who drink more after child bearing is growing. The number of women who career drink and do not have children is growing. The number of women who begin drinking after 55 years is growing. Women participating in the research are from 25 years to 65 years of age.
4. Alcohol dependent midlife women need a woman-sensitive recovery environment for respite and healing. The Australian environment is a high risk factor for women with genetic and life history pre-dispositions for alcoholism. Reaching midlife means few women able to limit or ‘control’ the amount they drink. If women were able to limit drink in adulthood, especially with childcare, parent-care, partner-care, home-care, business-care, low self-care and career development pressure there would not be as many alcohol dependent women in Australia NOW. Abstinent recovery is the clinical approach needed, not harm reduction, for this special population. Our intoxication culture and the social ‘invisibility of midlife women’ have resulted in a Baby Boomer ‘alcohol bubble bursting’ with continuing intergenerational damage. Even women who perceive the need for help are not coming forward until distress and crisis is happening in their life due to the cold stigma of adult female alcoholism and public ignorance of the disorder and its reality as a chronic illness. Appropriate treatment for 35 to 55 year old women to abstain and maintain recovery must begin in Australia. To come forward, to break the intergenerational chain & myth of a lower socioeconomic disease’, women must be assured of safety, independent accommodation, finance and education assistance and childcare. With women in recovery, increasing the number of men in recovery may follow.

A list of references for these statements is available – contact Janice Withnall.

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Midlife WOMEN in RECOVERY survey - final input

UWS HERC 06/09  (Withnall 08APSAD)

In your experience with alcohol dependence, tick the words relevant to women in Australia seeking help and receiving help. Write what the line of words mean to you under each line. Please provide your name and contact details if you would like to see the results of this final phase of Researching with Women in Recovery. Janice Withnall can be contacted on – 02 4570 1194 or j.withnall@uws.edu.au

Relevant = tick

- resistance
- neuroscience
- consciousness
- perimenopause
- stay stopped
- my meaning
- reality
- allostasis
- safe care
- limbic system
- learn
- my meaning
- relationships
- anomie
- cognition
- self-recovery
- transition
- my meaning
- responsibility
- chaos
- chosen role
- triadic
- belong
- my meaning
- robustness
- identity
- commitment
- socioemotional