

The Lived Experiences of Older Women in Alcoholics Anonymous

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ABSTRACT

The purpose of this study was to describe, analyze, and better understand the lived experiences of women age 50 and older in Alcoholics Anonymous (AA). Guiding this inquiry were the following research questions: 1) How do the older women participants experience the AA program? 2) What aspects of AA do older women consider beneficial? 3) What aspects of AA do older women consider detrimental? 4) What do older women consider as important conditions to succeed in the AA program? 5) How did these older women elicit meaning in their involvement with AA? and 6) How was the narrative aspect of AA experienced by the participants?

Fourteen older women from AA meetings in Southwest Virginia participated in two qualitative interviews. The results were represented by narrative descriptions of each participant's experiences and analyzed for common themes across the stories, which were presented and discussed. For these participants, the AA program was found to intersect with narrative therapy. AA, like narrative therapy, highlights deconstructing and re-authoring life stories through personal narratives. Storytelling itself proved to be among the most important traditions of AA and a core benefit to the storyteller (and to a lesser extent, the listener). Study participants found that telling their stories allowed for 1) a way to give back to the program, 2) a feeling of belonging to the group, 3) a welcome reminder to the speaker of her past struggles with alcoholism, and 4) a spiritual experience. Many of the women articulated their early concerns with publicly sharing at meetings, as well as their ongoing considerations of boundaries, over-sharing, and conflicts of interest in storytelling. Finally, in an unexpected finding, the women cultivated and maintained intimate friendships with other women in AA that addressed relevant issues *beyond* sobriety including everyday needs and life challenges. Social activities often transcended the boundaries of the meetings.

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CHAPTER ONE

Introduction

Alcohol abuse and dependence can devastate the lives of individuals and families of those who are affected. Despite common myths, alcoholism is not only an issue for younger adults. Along with a growth in the aging population comes an increase in alcohol-related problems for older adults. Between 2010 and 2050 the United States is predicted to have a large growth in its older adult population. In 2010, the number of Americans over the age of 65 was 40.2 million (Vincent & Velkoff, 2010). By 2050, that number is expected to increase to 88.5 million. The population of the United States will also be growing older in general, as nearly one in five adults will be age 65 and older by 2030. This growth is due in great part to the aging Baby Boomers who turned 65 beginning in 2011. More specific to the older female population, females are predicted to continue to outlive males. In 2050, it is estimated that among those 65 and older, 55% are predicted to be female, while among those 85 and older, 67% are predicted to be female (Vincent & Velkoff, 2010).

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2009) reported that of adults aged 65 and older in the past month, 9.8% said that they participated in binge drinking and 2.2% said that they participated in heavy drinking (up from 6.9% and 1.8% in 2004). In addition, 2-15% of noninstitutionalized older adults demonstrate symptoms of alcoholism, and one in every 10 older patients who is in a medical setting (i.e. geriatric mental health outpatient clinic, veteran hospitals) suffers from an alcohol problem (Sorocco & Ferrell, 2006). It is estimated that there are 2.5 million older adults in the United States who have alcohol abuse issues (Stelle & Scott, 2007; Virginia Department of Alcoholic Beverage Control, 2007),

and that 17% of Americans over the age of 65 (2.5 million) have alcohol-related issues (Virginia Department of Alcoholic Beverage Control).

While more limited information exists that specifically addresses statistics regarding older women and alcohol abuse, what we do know is that in a survey of primary care physicians, one in 14 (7%) of their older female patients (over the age of 59) was suspected of abusing alcohol. When applied to the general population of older women, nearly 1.8 million women (7%) were abusing alcohol. As the older female population continues to grow, mathematically it follows that the number will increase to 2.8 million by 2019 (The National Center on Addiction and Substance Abuse at Columbia University (CASA), 1999).

According to CASA (1999), in a physician survey, only 62% believed that substance abuse treatment is somewhat or very effective for older women. In addition, less than one % (11,000) of the 1.8 million older women (over the age of 59) who may need treatment for alcohol use or abuse actually receives it. As a result, women represent less than 1/3 of the individuals in treatment. Although limited in number, studies suggest that older women alcoholics can be successfully treated (Satre, Blow, Chi, & Weisner, 2007; Satre, Mertens, & Weisner, 2004). In chapter two, I will further discuss these studies and general guidelines for treating older women alcoholics. More specifically, Alcoholics Anonymous (AA), a common mutual support group for alcoholism, has demonstrated some success in treating older women (Matheson & McCollum, 2008; Sanders, 2006).

Problem statement

The limited amount of available information and research regarding older women and alcoholism is problematic as the numbers of older women who face these challenges grows. It is also unclear whether AA, the most common alcohol recovery program in this country (Miller &

McCrary, 1993), is an appropriate place to refer older female clients and patients who have alcohol problems.

Purpose of the study

The purpose of this study is to add to the limited body of knowledge about older women and AA, by describing, analyzing, and better understanding the lived experiences of older women age 50 and older in AA. My goal was to understand older women's beliefs and perceptions about AA by exploring the relevance (if any) of some general themes including the use of narrative, the role of sponsorship, and the experiences of being (a) female, (b) older, and (c) a older female in AA. Guiding this inquiry are the following research questions:

- 1) How do the older women participants experience the AA program?
- 2) What aspects of AA do older women consider beneficial?
- 3) What aspects of AA do older women consider detrimental?
- 4) What do older women consider as important conditions to succeed in the AA program?
- 5) How did these older women elicit meaning in their involvement with AA?
- 6) How was the narrative aspect of AA experienced by the participants?

The results are represented by narrative descriptions of each participant's experiences and dissected for common themes across the stories to be analyzed and discussed. The findings of this study will contribute to recommendations or guidelines for best practices that practitioners can use when considering whether or not to refer their older female clients and patients to AA. For those who do refer, these guidelines may also assist them in better preparing these women for AA so that they obtain the most benefit from their time in the program.

Because I investigated an area where little research currently exists, my study is exploratory. By utilizing the in-depth phenomenological approach inherent in qualitative inquiry,

I was able to investigate and ultimately better understand the lived experiences of the older women in my study (Rossman & Rallis, 2012). During interviews with the older women in AA, their stories were reconstructed and I was able to immerse myself in the meaning of their lives through their eyes (Seidman, 2006). Through the course of this meaning-making process, I have begun to set the stage for future research in this area.

Definition of terms

The following definitions will help the reader to better understand terminology related to this study.

- A) *Alcohol dependence/addiction* – The terms addiction and dependence are generally interchangeable. The DSM-IV-TR uses the word dependence (Van Wormer & Davis, 2008). Alcohol dependence is defined as a maladaptive pattern of alcohol use with three or more of the following criteria occurring in a 12-month period: 1) tolerance (the need for more and more alcohol to attain a desired intoxicated effect), 2) withdrawal (withdrawal symptoms and the need to drink more to diminish the symptoms), 3) drinking larger amounts for a larger duration of time than was intended, 4) persistent desire or unsuccessful efforts to stop drinking, 5) a large amount of time spent in efforts to obtain, use or recover from alcohol effects, 6) social, occupational or recreational activities altered as a result of drinking, 7) drinking continues despite knowledge of physical or psychological harm it has already caused (American Psychiatric Association, 2000).
- B) *Alcohol abuse* may be more accurately characterized by alcohol use and alcohol misuse (Van Wormer & Davis, 2008), and is less severe than dependence. These criteria include: 1) recurrent drinking that results in a failure to fulfill major role obligations at work,

school or home, 2) recurrent drinking in physically hazardous situations, 3) recurrent drinking-related legal problems, 4) continued drinking despite persistent or recurrent social or interpersonal problems that are caused or exacerbated by the drinking 5) Symptoms of drinking do not meet the criteria for alcohol dependence (American Psychiatric Association, 2000).

- C) *Biopsychosocial-spiritual model* – counseling professionals have a holistic view of addiction that considers the biological, psychological, social and spiritual components in its causation and consequences. Biological refers to the genetic components of addiction, psychological includes unhealthy thought processes that may encourage “escape” through substance use, social examines where the drinking activities are taking place and where (or for whom) the drinking impacts, the spiritual realm is often crucial in recovery and key to one’s sense of meaning. The components are often interactional and are intertwined in the addiction cycle. Treatment requires attention to each component that frames the whole person (Van Wormer & Davis, 2008).
- D) *Alcoholics Anonymous (AA)* – a mutual aid support group (sometimes called “The Program”) with no formal leaders and is open to anyone who has the desire to stop drinking. Membership is free, and there are more than 117,000 groups and over 2 million members in over 180 countries. The principles of AA are written down in what has euphemistically become known as, “The Big Book” (www.aa.org).
- E) *Older Women* – The definition of “older” varies across the literature, but Neugarten’s (1978) definition of the “young-old,” age 55 to 75 was slightly amended for this study to include age 50 and older.

Delimitations

This study was designed to explore the experiences of older women who are currently members of an AA group in southwest Virginia. Older women members of AA in co-ed and women-only groups participated.

Limitations

This study included a relatively small geographic area. Older females from a relatively urban area of southwest Virginia were recruited to participate. A qualitative study of a much larger geographic scope is necessary to obtain a greater demographic cross-section.

Also of note is the nature of AA and its focus on anonymity. Researching members of AA is anathema to the anonymous nature of the program, and included issues of garnering trust from a vulnerable population.

As is the nature of qualitative inquiry, data was self-reported and is therefore passed through the filter of self interest and self image. Participants may not have fully disclosed their true beliefs or perceptions to an unfamiliar third party. Despite my efforts to assure confidentiality and trust, there was always the concern that participants were guarded in their disclosures.

CHAPTER TWO

Literature Review

Chapter two presents a review of relevant literature related to the current study. It begins by describing the large numbers of older women in America who suffer from alcohol abuse, and the unique challenges they face that are specific to their population in biological, sociological and psychosocial realms. While research exists that examines older adults and alcohol, significantly less is published regarding older women and alcohol. The most common recovery program for alcoholism in this country is AA (Miller & McCrady, 1993). While originally created for men, this group has changed through the years to include women, despite criticisms that it still has not been inclusive enough of women's specific needs. AA has also made efforts to be more inclusive of various age groups including older adults. However, a review of the literature illustrates a dearth of information specifically regarding older women and AA. The purpose of this study, therefore, is to begin to illuminate this topic by describing and analyzing the lived experiences of older women during their time in AA. The results will be represented by narrative descriptions of each participant's experiences and dissected for common themes across the stories to be analyzed and discussed.

Unique characteristics of older women

Older women's unique characteristics must be taken into consideration when studying alcohol abuse. These characteristics are based on age and gender, and can be broken down into biological, social/societal, and psychosocial realms.

Biological.

Older women have an increased sensitivity to alcohol, and a decreased tolerance of psychoactive substances. As women age, their bodies lose lean body mass and water which assist

in metabolizing alcohol. The result of this loss is that the same amount of alcohol that was considered safe and moderate for younger women is identified as high risk for abuse and addiction for older women. In addition, liver enzymes which function to metabolize alcohol become less efficient, and the central nervous system sensitivity increases, as women age (Adams, 1995; Blow & Barry, 2002; Katz, 2002).

As compared to other groups of individuals, women experience alcohol-related issues sooner, and are more quickly addicted, despite consuming the smallest amounts of these substances. This phenomenon called “telescoping,” accounts for recommendations by the National Institute on Alcohol Abuse and Alcoholism that older women should consume no more than one drink per day, being cautious about even one drink (Katz, 2002). Blow and Barry (2002) further explain that alcohol use recommendations are lower for adults over the age of 65, and even slightly lower for older women than older men.

Another biological consideration is that older women have an increased sensitivity to over the counter and prescription medications. Older women are more likely to receive prescriptions for, and abuse, sedatives and hypnotics, particularly benzodiazepines, which are prescribed more frequently to older women than to any other population (Blow & Barry, 2002; Katz, 2002). This is supported by Brennan, Moos and Kim (1993) who studied the individual characteristics of men and women between the ages of 55 and 65. They found that women were more likely than men to report frequent use of antidepressants and tranquilizers. Although there is a scarcity of data, the mixing of prescription medications (like antidepressants) and alcohol could have detrimental effects (Adams, 1995; Blow & Barry, 2002; Katz, 2002).

CASA (1999) found that in general, older women (over the age of 59) are more likely to report feeling depressed than older men. Depression may be the result of declining health or

bereavement over the loss of a spouse, and women may begin drinking to alleviate negative feelings associated with these events. Ironically, alcohol abuse may exacerbate depression: female alcoholics are two times more likely to be depressed than female non-alcoholics, and four times more likely to be depressed than male alcoholics.

Societal.

Older women are sometimes dismissed as senile or else they are mistakenly imbued with only positive virtues. In a culture that is obsessed with youth and beauty, particularly with women, older women are particularly vulnerable to a negative view of aging. This negative view can influence both the health care workers and the women themselves (Katz, 2002; Pagliaro & Pagliaro, 2000).

Beliefs held by healthcare workers.

The beliefs held by healthcare workers about older women are often influenced by and mirror the attitudes of greater society. A health care worker may dismiss signs of a potential substance abuse problem because of pre-existing societal ideas that older women don't use or abuse substances (Pagliaro & Pagliaro, 2000). Therefore, they may not see the urgency in identifying, diagnosing, or treating a potential substance abuse problem in an older woman . Additionally, they may view alcohol as one of the older woman's last pleasures in life, and choose not to bother with treatment. They may erroneously believe that older women are incapable of change and that treatment will not be beneficial, or they may feel uncomfortable addressing such a personal issue with an older woman (Katz, 2002; Pagliaro & Pagliaro, 2000). The influence of prevailing attitudes may result in the health care workers ignoring or missing signs of alcohol abuse in older women (Katz, 2002).

Beliefs held by older women.

Katz (2002) explained that because of negative societal views towards women and aging, there might be a sense of shame or low self esteem that causes older women to hide their problem from their doctors or other health care workers. Many of these women formed their attitudes and beliefs before the 1950s, when the traditional gender roles influenced the common attitudes that girls with upstanding morals and values abstained from alcohol. Older women may underreport their alcohol abuse problems because of shame and perceived stigma. For these reasons, the numbers of older women with alcohol abuse is probably much larger than what is currently reported.

Psychosocial.

Older women experience decreases in their social networks due to death of spouses, family members and friends. Often these women, particularly those who are homebound, live alone with limited daily contact with other individuals (Katz, 2002). Additionally, older women may also experience a decrease in social contacts due to retirement. Their daily interactions may decrease drastically once they no longer have the interactions of co-workers.

However, having fewer social contacts is not always due to external factors like death or retirement. It is important to recognize that older adults, even those without significant losses may choose to have a smaller social network. The socioemotional selectivity theory (Carstensen,1993) explains how when individuals perceive their time left to live is limited, as is the case with many older adults, they shift their focus from information seeking sources (commonly found in relationships with unfamiliar people) to emotional regulating sources (most commonly found in already established relationships with children or other close family). Therefore, their social networks may decrease, but only because older adults are more selective

in who they include. Whether social networks shrink as a result of circumstance or choice, the result of these smaller networks is that substance abuse can easily go undetected and there are fewer systems in place to support treatment (Carstensen, 1993; Carstensen, 1995).

Impediments to screening and treatment

Limited expertise of all healthcare workers.

Brennan, Moos, and Kim (1993) found that women were less likely than men to seek help specifically for drinking issues, but more often sought help from a mental health practitioner for a personal or family problem. Since these personal or family problems can stem from a drinking problem, it is imperative that all health care professionals who come in contact with older adults be aware of the specific biological, societal/social, and psychosocial aspects of older women and alcohol in order to adequately identify and treat this population.

When doctors and or other healthcare workers are unaware of these aspects, they can mistakenly overlook symptoms of alcohol abuse. There are several alcohol related symptoms that mimic normal physical and mental issues in older adults like depression, dementia (Sorocco & Ferrell, 2006), memory loss, unsteady gait, confusion, disorientation, falls, complaints of insomnia or restless sleep patterns, irritability, heart palpitations, dry cough (Perkins & Tice, 1999), fatigue, chronic pain, and impotence (Morgan & Brosi, 2007). Health care providers who are untrained in gerontology could easily overlook these symptoms of alcohol abuse as part of the natural aging process (Stelle & Scott, 2007).

DSM criteria.

Another impediment to diagnosis and treatment of alcoholism in older women is that there is no clear definition of what constitutes problem drinking in this population. Health care workers may refer to the criteria for substance abuse in the DSM IV, but this does not

differentiate between older and younger women or between men and women. The DSM criteria is not necessarily designed to capture symptoms of alcohol dependence among older women, and may in fact not be an appropriate measure for health care practitioners to use with this population. For example, older women may not experience physiological dependence or withdrawal, two criteria identified in the DSM IV for alcohol dependence, but the problem may still exist (Katz, 2002; CASA, 2006).

Characteristics of older female alcoholics

It can be misleading when studies indicate that older women decrease their intake of alcohol as they age because the conclusion might then be made that older women do not have alcohol problems. Moos, Schutte, Brennan, and Moos (2004) sent a survey assessing alcohol consumption habits to a sample of 1,884 men and women age 55 to 65 who had consumed alcohol in the past year or shortly before. The same individuals were contacted again with mailed surveys at one and four years, and part of the sample participated in a seven year follow up. After ten years, the survey was completed by 1,291 individuals (529 women and 762 men). Results showed that while there was a significant increase in the proportion of individuals who abstained from alcohol between the baseline and the 10 year follow up for both women and men, women were slightly more likely to be among this group. Looking at individuals who continued to partake in alcohol, only women reported a modest decline in frequency of drinking alcohol. At the 10 year follow up, baseline alcohol consumption, smoking, friends' approval of drinking, and the use of psychoactive medications at baseline predicted drinking problems in women. The researchers accounted for the decrease in frequency by explaining that change in social circumstances for older women like a deceased spouse or a decreased likelihood of being present for social occasions where alcohol is served could decrease the amount of times a older woman

drinks. The decrease in amount of alcohol may be due to cohort effects of individuals who grew up shortly after the era of prohibition. Although prevalence of drinking declined with age, particularly with women, it is important to note that many of the adults in the study still reported drinking problems. In addition, few participants actually sought professional help for their drinking issues (Moos, Schutte, Brennan, & Moos, 2004).

The same authors conducted a 20 year follow up study and gathered data on 320 women and 399 men. Findings supported the idea that there is a slow decline in alcohol consumption among older adults as they move into their 70s and 80s. However, 27.1% of women and 48.6% of men age 75-85 still drank excessively in amounts associated with increased risk of drinking problems. Interestingly, men who drank excessively had a greater chance of experiencing drinking problems than did women who drank excessively. The authors suggested this may be accounted for because men tended to consume larger quantities of alcohol in a shorter period of time than women (Moos, Schutte, Brannan, & Moos, 2009).

Curtis, Geller, Stokes, Levine, and Moore (1989) studied 417 elderly individuals over the age of 60 at the Johns Hopkins teaching hospital and screened them for alcoholism using an in-depth patient interview and the SMAST (Short Michigan Alcohol Screening Test – Geriatric Version) or CAGE (a screening that follows an acronym in which the interviewer inquires whether the participant has ever tried to cut down on drinking, is annoyed by criticism about drinking, feels guilty about drinking, or uses drinks as eye-openers) as well as physician interviews. Results suggested that elderly alcoholics (60 years or older) were less likely to be identified if they were white, female, or had completed high school, stereotyping older alcoholics as black, male and less educated. These stereotypes impede doctors' ability to diagnose and treat older adults with alcohol abuse problems. In addition, the researchers pointed out that elderly

patients with alcoholism are less likely to be detected and treated than younger alcoholics. Supporting this are CASA's (1999) results that show that one out of four (26.7%) white women are current drinkers as compared to one out of six (17.5%) of older African American women and Hispanic women (17.2%). In addition, drinking is most prevalent and amounts of drinking are greater among older women with higher incomes (\$40,000 and above) as compared to those whose incomes are less. These results support the previous assertion that older women are particularly vulnerable to being overlooked as alcoholics.

Early vs. late onset

There are some differences in characteristics and prognosis between early onset and late onset alcoholism in older women. Early onset older female drinkers generally begin drinking before the age of 50 and often have a family history that includes alcoholism. The prognosis for these women is poor and many die before they reach 65. Late onset generally happens at age 50 or older and is often associated with a specific stressor – an event or life change like death of a spouse, retirement, or medical disorder (Pagliaro & Pagliaro, 2000). In fact, Adams, Barry and Fleming (1996) found that sometimes retirement may precipitate higher levels of drinking. In their study of 5,065 adults older than age 60, individuals aged 61 to 65 who were retired were more likely to consume more than 21 drinks per week and report binge drinking than individuals in the same age range who were not retired. Late-onset is more commonly found in older women, particularly those from middle or upper class socioeconomic groups. These women tend to more commonly suffer from psychological or medical disorders (Pagliaro & Pagliaro, 2000). As reported earlier, Brennan, Moos, and Kim (1993) examined the individual characteristics of 509 men and 195 women problem drinkers between the ages of 55 and 65 and again one year

later reaching 476 men and 195 women. They found that women who consumed less alcohol were more likely to be late onset problem drinkers than men.

While there are no studies that compare treatment approaches or outcomes of women with early versus late onset of alcoholism, some believe that late onset alcoholic women respond more positively to brief interventions. In general, they possess previous coping mechanisms that they were able to employ before they began drinking, and because of this, they are more likely to recoup these skills once drinking is no longer an option (Katz, 2002). Some other researchers explored early versus late onset drinking for both older men and older women. Atkinson, Tolson, and Turner (1990) compared 146 male military veterans age 60 or older with alcohol use disorders and separated them into three groups: early onset (before age 40), midlife onset (41 to 59 years) and late onset (at or after 60 years). The researchers found that onset occurred after 45 in nearly half the cases, refuting previous assertions that symptoms of alcohol use disorders were rarely displayed for the first time after the age of 45. Late onset drinking was milder, and associated with less family alcoholism, as well as somewhat greater psychological stability. Schonfeld and Dupree (1991) explored the records of 170 elderly alcohol abusers age 60 and older and divided them into three categories: 48 early onset (abusing alcohol before age 50) and 100 late onset (abusing alcohol after age 50) and 22 uncertain. Early onset older adults were intoxicated more frequently and experienced withdrawal symptoms more profoundly. In addition, they were more likely to drop out of treatment.

Can older women alcoholics be treated?

According to CASA (1999), in a physician survey, only 62% believed that substance abuse treatment is somewhat or very effective for older women. In addition, less than one % (11,000) of the 1.8 million older women (over the age of 59) who may need treatment for alcohol use or

abuse actually receives it. As a result, women represent less than 1/3 of the individuals in treatment.

However, in a review of the limited studies on older women and alcoholism treatment, results demonstrate that treatment can be effective with this population. Satre, Mertens, and Weisner (2004) utilized participants age 55 and older from two studies at the Kaiser Permanente Chemical Dependency Recovery Program in Sacramento, CA. These older adults participated in 12 months of treatment including supportive group therapy, education, relapse prevention, and family-oriented therapy. Patients were expected to attend 12-step meetings off-site. Baseline interviews were conducted in-person with 127 participants to assess drinking patterns and mental health. Follow-up phone interviews six months later yielded 92 interviews (25 women and 59 men). Findings at the six month interview, illustrated that older women had higher abstinence rates than men, but this was not statistically significant. Instead, greater length of stay in the managed care outpatient treatment setting, and regular attendance of AA meetings appear to be better predictors of abstinence – characteristics more commonly found in women. Further research is needed to understand why women are more likely to attain these outcomes. In addition, women reported better outcomes on measures that were not abstinence-based. Non-abstinent women reported that in the month prior to the six month follow up interview, they had eliminated heavy drinking (five drinks per occasion), and men reported that they averaged four heavy drinking days. The results of this study suggest that treatment for substance abuse can be beneficial to older women, and that they can attain success either through abstinence or drinking reduction.

Satre, Blow, Chi, and Weisner (2007) again looked at the 127 original baseline interviews in order to conduct a seven year follow up investigation. At the seven year follow up, 84 older

adults (25 women and 59 men) were interviewed. Results demonstrated that participants who reported abstinence at seven years reported greater 12-step group attendance at both the five and seven year follow up, although in this case there was no significant difference by gender. In contrast to the six month follow up, researchers found that older individuals generally did not utilize the 12-step groups at seven years. The study continued to support the results of the previous study that longer initial length of stay in treatment, a characteristic more common in women, was a better predictor of positive outcomes. Likewise, non-abstinent men reported greater frequency of heavy drinking (five or more drinks per occasion) than did non-abstinent women comparable to the six month follow up study.

Brennan, Moos and Kim (1993) found that older women may attempt to conceal or minimize their drinking problems, or be more apt to display more socially acceptable issues with depression or prescription drug use. Often, prescription drug use indicates self-medication and can signal that there might also be alcohol abuse occurring. As mentioned earlier, older adults are also particularly vulnerable to the negative effects of mixing prescription drugs and alcohol. For these reasons, treatment for older women should be made available to encompass multiple substance use, and depression, as well as take into consideration the variances between men and women.

Significance of gender in treatment outcomes.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2009), gender is not a predictor of retention in treatment for substance abuse, nor is it a predictor for treatment outcome and relapse rates. Likewise, as Satre, Mertens, & Weisner (2004) demonstrated, in mature adults age 55-77, gender was not statistically significant in predicting abstinence rates after treatment. However, greater length of stay in treatment and regular

attendance of AA meetings – characteristics more commonly found in women – were better predictors of abstinence in mature adults. In addition, after treatment, non-abstinent mature women reported that in the month prior, they had eliminated heavy drinking (five drinks per occasion), and mature men reported that they averaged four heavy drinking days.

Treatment suggestions for older adults.

Curtis, Geller, Stokes, Levine, and Moore (1989) suggested that if older persons are screened positive for alcoholism, they should be offered the full range of treatment options tailored for his or her age. Other special needs of older alcoholics during treatment include:

- Treatment staff must believe that older alcoholics can recover.
- Caring confronting may be more appropriate than a harsh approach.
- Elderly alcoholics may need to be guided to help them admit their problem and share their emotions.
- They may feel uncomfortable in a group with younger participants.
- Treatment staff should be taught about sensitive issues such as age factors which can impact on treatment success. For example, older people may not like to be addressed by their first name and may experience greater feelings of shame associated with alcoholism.
- Sensory losses may also require treatment adaptations.
- Social activities are an important part of treatment for older alcoholics (Virginia Commonwealth University, n.d.)

In addition, treatment must once again take into consideration the specific biological, social/societal and psychosocial aspects of being a woman and an older adult with alcohol issues.

Alcoholics Anonymous (AA)

AA was developed for and by alcoholics (Bill Wilson and Dr. Bob Smith) around 1935 as an approach to alcohol recovery. At the time of its inception, alcoholism was viewed as a hopeless condition by the medical community. Wilson and Smith borrowed some principles from the Oxford Group, a nondenominational Christian movement that focused on self-improvement through self-inventory, admitting wrongs, making amends, using prayer and meditation, and carrying the message to others (www.aa.org). Their ideas were eventually recorded in a book known as “the Big Book” with the 12 Steps of AA as its hallmark (Davis & Jansen, 1998). These 12 steps include:

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and, when we were wrong, promptly admitted it.

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 (Alcoholics Anonymous World Services, 2001, p. 59-60).

AA members meet in groups as often as needed and there are no fees or dues associated with membership. The only requirement is a desire to stop drinking. Their primary purpose is to achieve sobriety and help others to attain that goal. It is estimated that there are more than 117,000 groups and over 2 million members in over 180 countries. It is a fully self-supported group that does not accept donations from non-members, and individual members are limited to giving no more than \$3,000 per year. It is a completely anonymous group that strives to attain complete abstinence following the motto, “one day at a time.” AA meetings may be open - anyone is welcome to attend or closed – only alcoholics may attend (www.aa.org).

Sponsorship.

One aspect of AA involves sponsorship. The AA pamphlet on sponsorship explains, In AA sponsor and sponsored meet as equals...Essentially, the process of sponsorship is this: An alcoholic who has made some progress in the recovery program shares that experience on a continuous, individual basis with another alcoholic who is attempting to attain or maintain sobriety through A.A. (Alcoholics Anonymous World Services, 1983, p. 7).

Whelan, Marshall, Ball, and Humphreys (2009) investigated 28 AA sponsors to explore how they viewed their roles in helping the sponsored (sponsees). Results demonstrated three

main roles: 1) encouragement towards working the AA program, 2) support and 3) carrying the message of AA to alcoholics and newcomers. Studies have generally found positive effects both of being a sponsor (Groh, Jason, & Keys, 2008; Moos, 2008) and of having a sponsor (Johnson, Finney, & Moos, 2006; Moos, 2008; Witbrodt & Kaskutas, 2005). More specifically, Beckman (1993) found that women who reported positive amounts of social support from their AA sponsors were more likely to stay involved with AA. Sanders's (2006) study on how women "work" on the steps of AA within the context of feminist criticisms, also spoke to the value of having a sponsor in obtaining and maintaining sobriety, and indicated that having and being a sponsor "is one of the most personal and powerful parts of the AA experience, and women partake of it fully" (p. 26). Sponsorship played a key role for these women, allowing them to connect and form intimate relationships with other women.

Gomes and Hart (2009) surveyed 54 males and 24 females in a two year follow up study of recovering alcoholic patients in London, England who had completed a 4-7 month inpatient treatment that emphasized abstinence, spirituality, and the 12 steps of AA. The researchers investigated whether engaging in recovery practices endorsed by AA would result in lowered alcohol use and better subjective quality of life. Unlike previous studies, this study found that having a sponsor had no affect on abstinence from alcohol use, but did find that respondents who had sponsors also had lower levels of depression and higher levels of meaning and purpose in their lives.

An AA brochure on sponsorship explains how sponsorship benefits the sponsor:

Sponsorship strengthens the older member's sobriety. The act of sharing sobriety makes it easier for a member to live without alcohol. By helping others, alcoholics find that they help themselves.

Sponsorship also offers the satisfaction that comes from assuming responsibility for someone other than oneself. In a very real sense, it fills the need, felt by most human beings, to help others over rough spots (Alcoholics Anonymous World Services, 1983, p. 13).

Research is limited about the composition of the sponsor/sponsee grouping. In AA's brochure on sponsorship, the section, "Should a sponsor and a newcomer be as much alike as possible?" explains,

Often, a newcomer feels most at ease with a sponsor of similar background and interests – another physician or another homemaker, another church-goer or another agnostic, another Irish-American or another black. But many A.A.s say they were greatly helped by sponsors totally unlike themselves. Maybe that's because their attention was then focused on the *most important* things that any sponsor or newcomer have in common: alcoholism and recovery in A.A.

A.A. experience does suggest that it is best for men to sponsor men, women to sponsor women. This custom usually promotes quick understanding and reduces the likelihood of emotional distractions that might take the newcomer's mind off the purpose of A.A. (AA World Services, 1983, pp. 9-10).

The Narrative Process in AA.

The narrative process is integral to the AA experience (Cain, 1991; Humphreys, 2000; Jensen, 2000; Pollner & Stein, 1996). Cain explained that the narratives told in AA serve as a model, illustrating the definition and meaning of alcoholism to other members. An individual then uses that model as a vehicle through which to compare him and others in order to determine if he is an alcoholic. "As the AA member learns the AA story model, and learns to place the

events and experiences of his own life into the model, he learns to tell and to understand his own life as an AA life, and himself as an AA alcoholic” (p. 215). Likewise, Humphreys (2000) identified five types of AA story types including the “Drunk-a-Log.” This story describes a member’s “personal account of descent into alcoholism and recovery through A.A.” (p. 498) and accounts for a large portion of content the *Big Book*. As the member grows to better understand the AA process, his drunk-a-logs become constructed in ways that greater reflect and support the philosophy of AA.

AA and older adults

While there is a dearth of studies addressing AA and older women, there is a small amount of information that deals with AA and older adults in general. Satre, Blow, Chi and Weisner (2007) suggest that mutual aid groups (such as AA) are an important part of recovery and that older adults often underutilize them. Elderly alcoholics have traditionally not been represented well in AA, but that is beginning to change through outreach to senior centers and nursing homes (Washburn, 1996).

Mosher-Ashley and Rabon (2001) explored 160 adults (73 male and 87 female) who attended AA and reported that they were in recovery. Three groups (39 and younger, 40-59, and 60 and over) filled out a questionnaire and two standardized tests that studied depression, life satisfaction, emotional support, and loneliness. Results demonstrated that emotional needs were met among the three age groups, while feelings of loneliness were most prevalent among younger adults. The two older groups did not report being depressed, while the younger group did report being mildly depressed. The authors posited that perhaps depression was related to length of sobriety, since most of the older alcoholics in the study had been sober for a number of years. Measures of life satisfaction were higher in the two groups that did not report depression.

One major finding was the lack of participants in the oldest group. Out of the 160 adults found through area AA meetings, only 25 were over the age of 60. The authors questioned whether the needs of older adults were being met through AA and suggested that perhaps that accounted for the scarcity of participants in this population. These findings led the authors to suggest that perhaps other treatment options such as peer counseling would be better than AA for older adults (Mosher-Ashley & Rabon, 2001).

Washburn (1996) interviewed 3 men and 3 women between the ages of 60 and 82 to find out how the role of AA affected the lives of older adults beyond sobriety. The themes that emerged from these interviews included acceptance, the beginning of the problems, spirituality, sharing and hope, and AA stereotypes. Washburn pointed out that AA's support of each person's worth and dignity elevated the status of older adults in society, which in turn may deter this population from turning to alcohol.

Rathbone-McCuan (1988) explained that elderly alcoholics can benefit from group intervention as an effective aspect of their treatment and that "the most frequently encouraged form of group involvement is AA" (p. 143). The benefits of AA for older adults include the ease of participation, the low cost, and the personal support and socialization that is inherent in membership.

Homogeny in AA groups for older adults.

Since specialized treatments that serve older adult alcoholics are rare, a mixed age group AA meeting is often the first place where an older adult may turn for recovery. Schiff (1988) explained that some older adults did not like AA due to the unappealing myths and stigmas surrounding the organization. Older adults reported feeling different from "those alcoholics" in the group and were concerned for their anonymity. Once these individuals formed their own age

homogenous AA group however, the experience became a positive one. Similar aged groups might be the most successful for older adults since there is a disparity in perspective on life and types of issues faced between the younger and older alcoholics. In addition, older adults may also benefit from smaller groups (Satre, Mertens, Areán, & Weisner, 2004). Andrews (2008) studied substance abuse among older Latino adults. Her findings suggest that these older adults should be provided with age-specific, culturally appropriate substance abuse treatment interventions. These conclusions can be translated to older women as well: treatment approaches must be tailored to meet the unique needs of being both female and a older adult. Older alcoholics respond better to treatment in an environment with cohort peers who also suffer from alcoholism (Amodeo, 1990; Klein & Jess, 2002), and age-specific treatment groups have been demonstrated to lead to higher attendance and treatment completion rates for older alcoholics than are groups comprised of mixed ages (Sorocco & Ferrell, 2006). Slaymaker and Owen (2008) discussed their findings of participants entering residential treatment at the Older Adults Program at Hanley Hazelden in West Palm Beach, FL (now the Hanley Center). Based on the twelve steps of AA, the center provided treatment to adults 55 and older with alcohol and/or drug dependence. Results demonstrated that continuous abstinence was maintained by the majority of participants with improved emotional and social functioning. These positive outcomes continued over the course of a year post-treatment. These results further illustrate the high success rate of alcohol treatment programs that incorporate similar aged peers (Slaymaker & Owen, 2008).

AA prints a pamphlet specifically targeted towards older adults called, “A. A. For the Older Alcoholic – Never Too Late.” This pamphlet explains that late life losses or stressors can instigate or exacerbate alcoholism, and that some individuals drink continuously into old age. Within the pamphlet are the stories of a diverse group of four men and four women who joined

AA at the age of 60 or older, demonstrating a desire to reach older alcoholics (Alcoholics Anonymous, 2001). Practical barriers to AA meetings include lack of transportation, physical disabilities or feeling uncomfortable attending meetings in the evenings (Satre, Mertens, Areán, & Weisner, 2004).

Women and AA

CASA (2006) explained that historically, women's alcoholism was viewed as different from men's with different root causes. Women who suffered from alcohol abuse were stigmatized and treatment was not made available to them. Throughout time, alcoholism was viewed as more of a "sin" for women than for men (Nakken, 2002). This was the case during the early years of AA – some men were uncomfortable being at meetings with women, and even doubted that women could be alcoholics. Women in AA were forced to sit on the other side of the room from men, as those who were single or divorced were viewed as a threat by the wives of the men in AA. In the mid-40s, AA did acknowledge the existence of women and alcoholism, and special women's groups were created to deal with "women's issues." These women's groups were still stigmatized, however, and women were hesitant to join for fear of being negatively perceived (CASA, 2006). Even the original language of AA addressed men and included only masculine references. When women were mentioned, it was assumed that they were the wives of alcoholic men. Women were challenged to translate the overtly male-dominated messages of AA into something relatable to their gender. For example, while men's alcoholism may manifest itself in anger, violence, or abusive behaviors, women may demonstrate depression, anxiety or withdrawal from others. Women needed to somehow reconcile those differences in order to benefit from their experiences in AA (Nakken, 2002). The degree to which women were

marginalized in AA appears in an AA newsletter article from 1946 entitled, “Why Women Should Not Be Allowed in AA” which included “facts” such as:

1. The percentage of women who stay in AA is low.
2. Many women form attachments too intense – bordering on the emotional.
3. So many women want to run things.
4. Too many women don’t like women.
5. Women talk too much.
6. Women are a questionable help working with men and vice versa.
7. Sooner or later, a woman-on-the-make sallies into a group, on the prowl for phone numbers and dates.
8. A lot of women are attention-demanders
9. Women’s feelings get hurt too often.
10. Far too many women cannot get along with the non-alcoholic wives of AA members
(1946 AA newsletter, as cited in CASA, 2006 p.138).

To further enhance the accusation that AA is male-centric, Chapter 8 of the Big Book is titled, To Wives, and only addresses the problems associated with having an alcoholic husband. There is, however, acknowledgement added in later editions that women can also be alcoholics, indicated at the bottom of the page in small writing:

Written in 1939 when there were few women in AA, this chapter assumes that the alcoholic in the home is likely to be the husband. But many of the suggestions given here may be adapted to help the person who lives with a woman alcoholic - whether she is still drinking or is recovering in AA (Alcoholics Anonymous World Services, 2001, p. 104).

One of the earliest gender-specific programs for women alcoholics was established in 1956 at Hazelden's Dia Linn Farm. Through the program, staff learned that women benefitted more from a holistic approach than men, one that included attention to the emotional, relationship, family, social, economic and other issues as integral elements in the recovery process. This holistic approach was the model that influenced future women's treatment programs (Nakken, 2002).

As Nakken (2002) explained, AA's focus on powerlessness and ego deflation, illustrated by the first step of the 12 steps of recovery in AA (Alcoholics Anonymous World Services, 2001), sparked resistance and anger in women who came of age during the sexual revolution and valued a feminist perspective. As a result, in the 1970s and 1980s, women sought to create alcohol treatment programs that honored their value, potential, and personal power. Women for Sobriety (WFS) Inc. created in 1975 by Jean Kirkpatrick, was created in response to a perception of AA's focus on powerlessness when alcoholic women were already feeling powerless. (Katz, 2002). WFS's goals were to, "increase women's self-esteem, empowerment, and self-reliance and to reduce their sense of guilt and shame" (p. 20). This organization was founded on two assumptions: 1) "that women, societally disempowered, need a female setting to feel safe, and 2) " that they should not have to experience additional disempowerment by admitting loss of control" (p. 555). Another group called Secular Organizations for Society (SOS) was formed to avoid the concept of powerlessness. The prevailing philosophies behind both of these was the idea that addicts have the ability to take control over themselves, as opposed to the AA stance of dwelling in powerlessness (Katz, 2002). Women-only AA groups and other similar groups like WFS rapidly grew in the late 1970s and 1980s. However, by the end of the 1990s, few WFS groups existed (Katz, 2002), although Nakken (2002) stated that women-only AA groups are still

common across the nation. Some researchers still contend that women may also respond better to all-women's groups. It allows them to share experiences and identify with women who have similar stories – removing the stigma and shame that sometimes accompanies women alcoholics (Blume, 1991). Beckman (1993) also notes that anonymity plays a key role in why AA may be attractive to women because they do not need to tell family or friends about their involvement.

Some subtle but important changes have occurred over the past several decades in terms of AA and gender specific recovery needs. The core AA literature is now supplemented by materials written by women for women that address their unique needs. In addition, gender-neutral terminology is used when referring to a Higher Power (although original concepts like the Twelve Steps still use male pronouns to describe God) and literature addresses issues that are specific to being female (Nakken, 2002). Today, it is estimated that one-third of AA membership is comprised of women (CASA, 2006).

Pagliari and Pagliari (2000) note that while some believe that AA has great benefits for women, others today still question AA's tendency to individualize issues and emphasize Christian spirituality and the need to "surrender" to "powerlessness," particularly with already marginalized women like African Americans or lesbians. Other objections too AA include: an inherent gender bias, a sexist tone, and the outnumbering of women by men at meetings.

Matheson and McCollum (2008) addressed the issue of "powerlessness" and how 13 women in 12-step programs including AA experienced this feeling. They examined this concept through images, metaphors, similes, and analogies as it related to the first step of recovery: "We admitted we were powerless over alcohol – and that our lives had become unmanageable" (Alcoholics Anonymous World Services, 2001, p. 59), and also how the concept of powerlessness changed or remained the same over time for women in AA. Generally, women felt

that the concept of powerlessness was important to their recovery, although a few women believed it was not helpful. For those who did believe embracing powerlessness was useful to recovery, many saw it as having a positive outcome and associated it with long-term outcomes described as freeing and a relief. The process was transformative for many – as women progressed in recovery, early ideas of powerlessness as being oppressive and negative evolved into feelings of empowerment and peace. The women who saw little use for the concept of powerlessness contended that perhaps women do not have to fully accept the concept to be successful members of a 12-step program.

As discussed earlier, Sanders (2006) investigated how women “work” the twelve steps of AA within the context of feminist criticisms: the language of AA’s Twelve Steps (including the use of the word, “powerless”), the male-dominated culture, and the spiritual nature of the steps. The author surveyed 167 women who attended “women only” AA meetings in a metropolitan area in the Eastern US. Similar to what Matheson and McCollum (2008) found, these results suggest a relief in admitting powerlessness. In this case, the idea of powerlessness was specific to the inability to control the use of alcohol as opposed to a greater societal sense of a lack of power. The women in the survey also were discerning about what they perceived God to be, and were apt to create a personal conception of God that they felt comfortable with. Therefore, admitting powerlessness did not automatically assume acceptance of religion unless it was deemed appropriate to them. In addition, the male-dominated culture reflected in the twelve steps also did not prove to be an impediment in “working” the twelve steps to recovery.

Travis (2009) posited that the concept of surrendering power, as illustrated in Step 3 of The Big Book, “We made a decision to turn our will and our lives over to the care of God *as we understood him*,” (Alcoholics Anonymous World Services, 2001, p. 59) is easier for women to

accept than men, “AA rejected the masculine norms of egotistical competition, dominance, and self-aggrandizement that prevailed in the culture around them” (p. 184). Further, some researchers argued that AA is more likely to attract female members than male because the concept of admitting powerlessness over alcohol, lack of control over one’s own behavior, and a dependence on a higher power to achieve sobriety is a more comfortable position for a woman to adopt (Timko, Moos, Finney & Connell (2002). Women may have specific characteristics that are more congruent with several of the steps of AA like having lower self-esteem, more frequent drinking when perceiving oneself to be powerless, and having a more external locus of control than men or nonalcoholic women (Beckman, 1993). Beckman explains, “I now believe that AA, a fellowship originally designed by and composed primarily of men, appears to be equally or more effective for women than for men” (p. 246).

Summary and Research Direction

The topic of older women and alcohol is an immediate and growing concern. As the population of women increasingly age, they face unique challenges that must be taken into consideration when assessing appropriate screening and treatment options for alcohol abuse that are biological, societal, and psychosocial. Biologically, older women’s bodies process and handle alcohol differently than younger or male adults. In addition, women face greater societal issues - older female alcoholics may be ignored or stigmatized, and in turn, this view is reflected in how women negatively regard themselves. Finally, older women face losses in their social networks that can make finding support for alcoholism more challenging. Research does suggest that older women can be successfully treated for alcoholism, and specific suggestions were made as to how to tailor treatment for older women. Some research has evaluated AA as effective with older adults *or* with women, but few studies specifically address AA and older women. To fill

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that void, this study sought to understand the lived experiences of older women who attend AA through their narrative process. Participants explained their perceptions and beliefs regarding their membership in AA through two mostly in-person interviews.

CHAPTER THREE

Methodology

This chapter will describe the research, research methods, and data collection. In addition, I will explain how I recruited participants, as well as the ethical considerations required in conducting this type of research as described in the informed consent agreement. Finally, I will address how I conducted the data analysis with regards to credibility and rigor. The purpose of this study was to describe and analyze the lived experiences of older women during their time in AA meetings. The results were represented by narrative descriptions of each participant's experiences and dissected for common themes across the stories that were analyzed and discussed.

Research Methods

There exists a dearth of studies in the literature that address older women and AA, so this was an exploratory study that involved interviewing participants mostly in person twice for a maximum of two hours each time, to gather information about their experiences at AA meetings. The overarching questions that served as a guide for my interviews were:

- 1) How do the older women participants experience the AA program?
- 2) What aspects of AA do older women consider beneficial?
- 3) What aspects of AA do older women consider detrimental?
- 4) What do older women consider as important conditions to succeed in the AA program?
- 5) How did these older women elicit meaning in their involvement with AA?
- 6) How was the narrative aspect of AA experienced by the participants?

Interview questions emerged from these research questions, but were carefully considered in order to be certain that each question directly addressed a research question (Appendix J).

Rationale for Qualitative Research Design.

Through my research, I wanted to immerse myself in the lives of older women in AA so that I could understand their experiences. In order to achieve this, I also needed to understand the context in which the women were experiencing AA, including their backgrounds and individual circumstances that shaped these experiences. All information gleaned was filtered through my own interpretations and personal experiences. I am aware that my questions and observations were colored by my own experiences and the resulting meaning was reflexive (Rossman & Rallis, 2012).

Qualitative method was well suited to this study because it considers the collaboration between researcher and participant experiences. Qualitative research is conducted in the participant's natural setting and is interpretive, in that, "it assumes that humans use what they see and hear and feel to make meaning of social phenomena" (Rossman & Rallis, 2012, p. 6). The roots of qualitative research can be traced to phenomenology and hermeneutics (Rossman & Rallis). The researcher using qualitative method is attempting to understand how the participants make sense of events and behaviors that are occurring in their world, and how their understanding of these influences their behavior. Context also plays an integral role in qualitative studies, and the researcher seeks to understand the influence it has on the participants' actions. The "inherent openness and flexibility" (Maxwell, 2005, p. 22) found in this method allow the researcher to modify research design and focus as new areas are explored. While outcomes are important, qualitative method also values the process that the researcher undertakes, and results are experientially credible (Maxwell).

Data Collection

Interview process and structure.

Before the interviews began, I piloted two interviews to ascertain the quality of my questions. Each question was evaluated on the depth and breadth of information that it extracted from the participant. Any questions that did not assist in gaining meaningful knowledge about the participant and her experiences in AA would be discarded or re-written according to recommendations by the participant or my own assessment of the pilot interviews. My interview questions were deemed useful for the purposes of adequately addressing the research questions.

For all but one participant, there were two interviews of 14 women conducted within four weeks of one another. The participant who completed only one interview experienced a relapse between the first and second interviews and it was feared that further interviewing might compromise her efforts towards sobriety. All but three interviews were conducted face-to-face (see Limitations). The first interview contained two components: 1) demographic data gathering and 2) phenomenological interview, and the second was a follow-up phenomenological interview. Meetings took place at an appropriate time and location deemed acceptable by the participant. The initial contact with participants was done in person or via telephone or email by a confederate, who is an AA member and assisted with the recruiting of women who met the study's criteria: women must be age 50 or older, speak English, volunteer to participate in the study, and consider themselves to be active members of AA (regularly attend AA meetings weekly for the previous year). She followed a script to ensure all participants were recruited in a similar manner that highlighted the length of time of the interviews, confidentiality, and the purpose of the research (See Appendix A for recruitment script). After the women agreed to participate, I followed up with a confirmation letter and the Informed Consent sent via email or

mail (See Appendix B for confirmation letter; Appendix F for Informed Consent document).

After the first interview, I transcribed the recordings and send them to the participants to ensure that all information was accurate, giving the participants the opportunity to make any edits. This same process occurred again after the second interview.

There was no pre-selection process other than meeting the criteria for participation.

Thirteen women fit these criteria and one did not currently consider herself an active member, but had been previously. Women in this study were between the ages of 52 and 81.

Demographic data gathering.

At the first interview, I gathered background information from the women to assist in producing a description of the participants, and to aid me in better understanding and interpreting the data (see Appendix D for the demographic question list). The demographic questions were the only aspect of the interview that was structured.

Phenomenological interview.

Much like the meaning-making process of telling one's story in AA, I found that the process of interviewing participants enabled them to tell me their stories and impart the meaning of these life experiences. Since these women and I were strangers, I wanted to make the interview process as comfortable as possible for them. To meet that need, the majority of the first interview focused on asking participants to recreate their experiences in AA meetings in the least directive way possible. However, because our time was limited and valuable, I wanted to be sure that I was gathering the most relevant information to address the research questions. To this end, I used an interview guide approach (see Appendix E for the interview protocol for the first interview). Rossman and Rallis (2012) explained that in using this approach, the interviewer creates a few broad topics or areas to explore but is open to discussing other areas that the

interviewee pursues. The interview consisted of open-ended questions, followed by encouragement to elaborate, resulting in long, descriptive narratives regarding experiences as an older woman in AA meetings. As an interviewer, I was an integral part of the process of meaning-making that happened throughout the interview (Seidman, 2006). However, I was mindful that the interview should unfold according to participant's perspective and my biases or perspectives should not influence how that occurred (Rossman & Rallis, 2012).

With the exception of the brief demographic questionnaire, the first interview was an opportunity for participants to tell me their stories with minimal involvement on my part except to generally keep on track with the research questions and the interview guide. The second interview was more focused on reflection of meaning, and gave me the opportunity to probe some common themes that arose among the interviews. It also allowed the participant an opportunity to voice any concerns, questions, or comments regarding the interview process or the transcription of the previous interview (see Appendix E for the second interview protocol).

Field notes.

I took field notes throughout my interviews as a way to capture my observations of, “events, actions, and interactions” during the interview process that was not discernible on the audio recorder (Rossman & Rallis, 2012, p. 195). I recorded my perceptions both of what I saw (the running record) and my commentary of the running record (observer comments) (Patton, 2002; Rossman & Rallis). That assisted me in creating more accurate transcripts and augmented the quality of the research. As soon as was appropriate after each interview, I wrote down all of my observations to be typed later. These field notes did not contain participant names or any other identifying information other than pseudonyms that I assigned each woman, and were

shredded once they had been transferred to the computer. In addition, I kept an audit trail of activities I engaged in throughout the research process.

Participants

In selecting participants for this study, I tried to employ purposeful sampling. Ultimately my goal was to locate older women who could impart a depth and breadth of information about their experiences at AA meetings (Patton, 2002). I am aware that I was likely viewed as an “outsider” to the AA community, having never been a member. I had anticipated that I might be met with suspicion and lack of trust since I was a stranger to these individuals. Because AA is a volunteer-only organization, and I was only researching older women who were well over the age of 18, there were no formal gatekeepers from whom I needed to seek approval. Because of the closed nature of the AA community, a (previously mentioned) confederate, who is an AA member assisted with the recruiting of women who met the study’s criteria. This individual was who Seidman (2006) described as an informal gatekeeper, and held “moral suasion (p. 45),” encouraging others to participate.

Ethical Considerations

My proposed research involved recording and analyzing stories and experiences of older women in AA. Due to the personal nature of my examination, I adhered to Virginia Tech’s Institutional Review Board’s ethical standards set in place to safeguard the rights of human subjects. I made every effort to avoid compromising the integrity or physical and emotional safety of my participants.

Each participant was asked to sign an informed consent form to ensure that she was fully aware of all aspects of the research project and could make an informed decision about whether or not to participate (see Appendix F). The informed consent included the purpose of my

research, and the expectations of interviews (amount of time and number of interviews). In addition, the informed consent addressed the rights of the participants: participation was voluntary and participants may excuse themselves from any part of the process without fear of penalty or recrimination. The informed consent also described how the research would be disseminated – whether through publications of my dissertation or journal articles, or through conference presentations, as well as how to contact me or the local IRB with questions about the research or their rights. The informed consent also contained information regarding additional safeguards which are detailed below.

Confidentiality.

Due to the sensitive nature of the research, confidentiality is paramount. In addition to IRB guidelines and principles of good practice (Maxwell, 2005; Patton, 2002; Rossman & Rallis, 2012), I took particular precaution to ensure confidentiality when working with participants from AA. Inherent in the AA experience are anonymity and confidentiality, which could potentially be breached without proper researcher care. This could possibly result in compromising a participant's recovery. My primary means of data collection was in-person interviews, so I enacted several safeguards into place to ensure that participants' information remained private. Interviews were conducted individually at a location of the participant's choosing where she was most comfortable. In most cases, this was at the participant's home, but I also conducted several interviews in restaurants where I attempted to sit in areas where our conversation could not be easily overheard.

When transcribing interviews and writing any field notes, memos, or final reports, I used only pseudonyms of the interviewees that I assigned, so that even a casual observer could not decipher the real name. I further obscured the participant's identity by changing any identifying

descriptive information that might make recognizing the participant possible. I used two digital recorders during the course of my interviews. The recorder and any information regarding the participants' true names or contact information was kept locked in a secure location, separate from the other study materials, which was not accessible to anyone but me. When my research is concluded, the memory cards in the recorders will be erased and reformatted, and all papers with identifying information will be shredded.

Risks.

There are minimal risks associated with involvement in this research. As Seidman (2006) discussed, risks can occur during and after the interviews. There was a chance that participants might feel uncomfortable during the interview discussing personal information that involves their alcohol abuse or experiences in AA. Describing these experiences might also have invoked some unhappy or distressing memories and emotions. As was explained in the section about confidentiality, every reasonable effort was made to ensure complete privacy. However, as with any descriptive qualitative study, there is the remote possibility that participants' identities might be guessed when the research is published. If participation in the study has any adverse effects like depression, suicidal thoughts, or other mental health issues, I will provide the names and contact information of local counselors who can provide assistance, as well as alert the IRB Board.

Compensation.

A Barnes and Noble gift card valued at \$10 was provided to participants at the onset of each interview. Compensation was based solely on participation, and was in no way considered a reward for, or an evaluation of, the quality of information that participants shared. Every

participant was entitled to compensation for participating in each of the two interviews, regardless of the quantity or quality of information shared.

Limitations.

As a result of having a single recruiter within the AA community in a general area of the country that lacks diversity, this was a fairly homogeneous sample racially (white), socio-economically (upper-middle class), and geographically (living in and around a small urban community in southwest Virginia). In addition, three of the second interviews were conducted on the telephone due to lack of availability on the part of the participant, or illness on the part of the interviewer. The rationale was that it was better to be able to build on the momentum of the first interview by having the second interview within several weeks, than risk creating a disruption in rapport by allowing too much time to elapse between meetings in order to keep both meetings face-to-face. Ultimately, phone interviews did not appear to hinder the interview process as they were always second interviews when rapport had already been established in a previous face-to-face interview.

Data Analysis

Process.

Once I completed each round of gathering data, I transcribed all field notes and interviews, noting speech rate, pauses, sighs, and other speech characteristics, using the field notes to help me create “thick” descriptions of the data (Patton, 2002). More explicitly, data that was rich with descriptions and information about the participants’ experiences in AA. Immediately upon completing each round of interviews, transcripts and corresponding field notes were read meticulously and excerpts that reflect the meaning of the phenomena of interest were highlighted. Once interviews were concluded excerpts were later coded and then grouped into

categories and subcategories. These categories and subcategories were organized according to themes that addressed the research questions (Appendix I). As described earlier, the process of data analysis is reflexive, and I was also aware of how my knowledge, beliefs, and perceptions influenced how I viewed the data.

Throughout the course of data analysis, I utilized analytic memos as a means to organize my thoughts about, “emergent insights, potential themes, methodological questions, and links between themes and theoretical notions,” as suggested by Rossman & Rallis (2012, p. 291). These memos further assisted me in making sense of the data.

Credibility and rigor.

I aimed to create and carry out a research design that took into account researcher reactions, but could adequately and objectively result in descriptions of these older women’s experiences in AA. However, knowing that qualitative research is interpretive and lacks one clear “truth,” I put strategies into place to help ensure the credibility and rigor of my research results.

“Thick” descriptions.

Creating “thick” descriptions of my participants’ stories increased credibility (Creswell & Miller, 2000, p. 129; Creswell, 2013, p. 168). Patton (2002) defines “thick” descriptions as “rich, detailed, and concrete descriptions of people and places in such a way that we can understand the phenomenon studied and draw our own interpretations about meaning and significance” (p. 438). I imparted as much detail as possible to help the reader contextualize the women in the study (Creswell & Miller, 2000).

Triangulation of findings and data sources.

By utilizing findings and data source triangulation, Anfara, Brown, and Mangione (2002) explained that credibility, dependability, and confirmability are increased because each major finding is derived from multiple data sources. In the case of my study, I analyzed phenomenological interview transcripts from two separate interviews, demographic information, field notes drawn from my observations, and analytic memos. When I created categories, subcategories, and themes, I ensured that they were supported by multiple data sources. However, it is important to note that inconsistencies among the data were not necessarily indicative of weak findings, but can offer “opportunities for deeper insight into the relationship between inquiry approach and the phenomenon under study” (Patton, 2002, p. 248). Any major findings that were not supported by multiple data sources were deemed to have low credibility, dependability, and confirmability and were rejected from the study.

Recruitment consistency.

Because I had a third party serve as recruiter for women in the study, I needed to be certain that recruitment was done consistently, using the same verbiage for each woman. To that end, my recruiter was provided a script that she followed when asking women to participate in the study to ensure all participants were recruited in a similar manner that highlighted the length of time of the interviews, confidentiality, and the purpose of the research (Appendix A). In cases where she emailed her requests (about 75% of the time), she copied me and I was able to verify that she did use the provided verbiage.

Internal consistency.

My interviews consisted of a number of women who were interviewed twice. While each participant had her own unique story to tell, I checked for consistent themes across the women’s stories by comparing their experiences in AA. As expected, some components were experienced

by all of the women. On the other hand, some women experienced similar situations in different ways. Therefore, I also reported cases where there were exceptions to illustrate divergent viewpoints on various topics among the women.

Likewise, I looked for consistency from a participant throughout interview one and two. Just as with the case of comparing the various women's experiences, I expected that specific components would remain the same across interviews, and that a dramatic outlier may signal an inconsistency in truth and compromise credibility (Patton, 2002).

Prolonged engagement in the field.

Creswell and Miller (2000) explain how protracted involvement in the field can lead to higher validity. During my research, I met the participants on two occasions which were interviews that lasted anywhere from one to nearly two hours each. In addition, I communicated via phone, email or mail about the interview process, the women's impressions of the interviews, and dissemination of the two transcripts. The more time I communicated with participants, the greater the participant trust and comfort level, and likelihood that they imparted detailed, factual information. By our second interview, I was able to verify my "hunches" and compare my interview data with my observational data (p. 128).

Review by inquiry participants/participant validation.

As discussed earlier, I asked participants for "member checks" where participants gave me their feedback about the transcripts (Rossman & Rallis, 2012). Transcripts were sent via email or hard copy to participants within two weeks of each interview. Feedback from the interview one transcript was given to me at interview two or via telephone or email beforehand. Participants had the right to omit or clarify any information pertaining specifically to them. Occasionally,

participants would correct a word choice, or ask that a sentence be left out, but generally there were very few edits to the original transcript.

Peer debriefer/community of practice.

Through the cooperation of research committee co-chair, Dr. Penny Burge, my data and process of analysis including category codes, subcategory codes, and themes were reviewed. I wanted to confirm my findings were sound and reasonably free of bias or outside influence. Likewise, my community of practice (colleagues with whom I work) also served as a “sounding board,” by also reviewing my data process of analysis and findings to ensure that quality ideas were utilized in the research while less productive ones were discarded (Rossman & Rallis, 2012).

Summary

This chapter has been a description the methods I employed for my dissertation research. I illustrated my research topic and methodology, and clarified the process of gathering data through interviews and field notes. Next, I explained how I recruited participants, and the various ethical considerations that were weighed when interviewing my participants and disseminating the data drawn from our interactions. Later, I discussed how I analyzed the data being mindful of maintaining credibility and rigor.

CHAPTER FOUR: ARTICLE ONE

The Intersection of Narrative Therapy and AA Through the Eyes of Older Women

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Abstract

Alcoholics Anonymous (AA), a worldwide organization specifically designed to assist alcoholics to stop drinking, integrates the experience of members sharing their story with the group. The researcher conducted a phenomenological qualitative study including twenty-seven interviews with women age 50 and older in AA to explore these narrative processes in AA. Results suggest that the tradition of storytelling in AA reflects narrative therapy practices in two ways: 1) the use of a three-stage model, and 2) the characteristics of the story. The overlapping three-stage narrative therapy/AA model includes: (1) conceptualizing the alcoholic story, (2) recreating the story to incorporate an identity of strength and sobriety, and (3) sharing the success story with others in the program. Like those told within the context of narrative therapy, the AA stories themselves are not static, but rather, evolve continuously. Clinicians can benefit from examining the intersection between narrative therapy and AA when working with older female clients who have had experience with, or who are being referred to, AA.

The Intersection of Narrative Therapy and AA Through the Eyes of Older Women

Practitioners established narrative therapy under the umbrella of constructivism as a mode of shaping one's personal narratives by deconstructing and re-authoring life stories, creating meaning. Researchers further identified older women as a subgroup who, by virtue of their shrinking social networks, have fewer outlets with whom to share their story. In parallel, storytelling is paramount in Alcoholics Anonymous (AA), specifically, the story of the AA member's life from addiction to sobriety. This exploration is novel in that it filters the AA storytelling model through the constructivist lens of narrative therapy through the eyes of older women.

Constructivism and narrative therapy.

Constructivism, a post-modern framework that espouses the ideas that reality and knowledge are subjective, holds that truth is not absolute. Rather, it exists as relative, contextualized phenomena, invented or constructed differently by each individual (Berger & Luckmann, 1966; Sexton, 1997). Some constructivist clinicians employ this theory when they emphasize the meaning derived from the client's specific language and narratives shared in the counseling session. Behavior is examined through the client's personal narratives (stories) as opposed to specific thought processes, emotions, or acts, with the goal being to construct more adaptable and viable stories (Sexton, 1997). Since the client is responsible for actively constructing her social world, her history is not viewed as a record of the events and experiences in her life, but rather "a living representation of how one is experiencing life" (Hayes & Oppenheim, 1997, p. 25-26). The client's narrative is therefore constructed based solely on her lived experiences.

Under the umbrella of this constructivist paradigm, narrative therapy focuses even more heavily on attributing meaning through the use of stories or self-narratives. These self-narratives shape how individuals identify themselves, and stories provide a framework that allows individuals to interpret their experiences. When using the narrative approach in therapy, clients are encouraged to “*deconstruct*” and “*re-author*” their stories by examining the meaning behind certain narratives and creating new narratives that attribute different meanings to experiences within the broader context of their lives (White, 1995).

Deconstruction and re-authoring occur when problems are objectified and externalized so that they become an entity separate from the individual discussing them. This externalization of problems allows the client to remove herself from the dominant stories that have influenced her life. In this way, the individual can more readily separate from the problem, and ascribe new meaning to it from a more objective distance (White & Epston, 1990). For example, a negative childhood incident could be examined separately from the rest of an individual’s past experiences, and retold as a positive learning experience that influences successes in the future.

Women and narrative therapy.

Women are a good fit for narrative therapy practices. Lee (1997) discussed how from a feminist perspective, women can benefit from narrative therapy because it enables them to break down the prevailing gendered stories rife with misogynistic undertones, and assign new meaning to their experiences through alternative narratives that empower them. Further, narrative therapy can also be effective when working with middle aged women with body image dissatisfaction because it helps them “unpack” their unnatural body expectations and adopt new ones that focus on health (Duba, Kindsvatter, & Priddy, 2010). Finally, Draucker (1998) explained that women who suffered from sexual violence could benefit from narrative therapy by finding the unique

outcomes in their shared stories. These unique outcomes represent moments of strength that are otherwise buried in the tragedies of their life stories. Uncovering these moments of triumph can enable these women the possibility of building a new, stronger life narrative.

Role of the therapist and a third stage.

Morgan, Brosi, and Brosi (2011) adapt narrative therapy to older adult clients battling addictions by encouraging them to externalize and re-author their lives. However, the authors add one more task for clinicians: “To assist the client in connecting with people who will assist him or her in reinforcing the new story... the development of the new story empowers the older adult to take pride in the life that has been recreated” (p. 452-453). Gardner and Poole (2009) further discuss narrative therapy as (a) deconstructing the problem, and (b) reauthoring new stories—but like Morgan et al. (2011), they add a third stage which they call, “Making it real – Presenting and witnessing preferred way of living” (p. 603). For example, clinicians could help empower a client to focus on friendships that embrace her “new” story and avoid friendships that cause the client to dwell on negative conceptualizations of her old story.

Challenges associated with a third stage and older women.

In looking at the three-stage mechanism for achieving effective narrative therapy, the third stage may prove to be especially challenging for older women to attain (Morgan, Brosi, & Brosi, 2011). They may have difficulty finding available avenues and mechanisms for connecting with peers in order to present and reinforce the new narrative for a number of reasons. Older women frequently experience decreases in their social networks due to death of spouses, family members and friends. Often these women, particularly those who are homebound, live alone with limited daily contact with other individuals (Katz, 2002). Older women may also experience the decrease in social contacts that accompanies retirement; their daily social connections may

decrease precipitously once they no longer have the interactions of co-workers (Cornwell & Waite, 2009).

Older women may also experience feelings of shame and guilt around their alcoholism. They may perceive a societal disapproval of older women drinking, and as a result, they avoid contact with others in order to hide their addiction (Davis, 1997; Katz, 2002).

However, having fewer social contacts is not always due to external factors like death or retirement, and even those without significant losses may choose to restrict their social network. The Socioemotional Selectivity Theory (Carstensen, 1993) holds that when individuals, such as older adults, perceive a sense of limited time, their focus shifts from information-seeking sources (commonly found in relationships with unfamiliar people) to emotional-regulating sources (most commonly found in already-established relationships with children or other close family). In part because older adults are more selective in whom they choose to include, their social networks may decrease. The result of these smaller networks, whether decreasing as a result of circumstance or choice, is that attaining the third step in narrative therapy, presenting and reinforcing the new story, may be more challenging (Carstensen, 1993; Carstensen, 1995).

Alcoholics Anonymous (AA).

AA was developed for and by alcoholics (Bill Wilson and Dr. Bob Smith) circa 1935 as an approach to alcoholism recovery (Alcoholics Anonymous World Services, 2001). At the time of AA's inception, alcoholism was viewed as a hopeless condition by the medical community. Wilson and Smith borrowed some principles from the Oxford Group, a nondenominational Christian movement that focused on self-improvement through self-inventory, admitting wrongs, making amends, exercising prayer and meditation, and carrying the message to others

(www.aa.org). Their ideas were eventually recorded in a text known as “the Big Book,” with the 12 Steps of AA as its hallmark (Davis & Jansen, 1998).

AA members meet in groups as often as needed and there are no fees or dues associated with membership – the only requirement is a desire to stop drinking. Their primary purpose is to achieve sobriety and help others to attain that goal. It is estimated that there are more than 117,000 groups and over 2 million members in over 180 countries. It is a fully self-supported organization that does not accept donations from non-members, and individual members are limited to giving no more than \$3,000 per year. It is an anonymous group that strives to attain complete abstinence using the motto, “one day at a time.” AA meetings may be open (anyone is welcome to attend) or closed (only alcoholics may attend). In addition, meetings can be mixed genders or more specialized like all women or gay and lesbian individuals only (www.aa.org).

Women and AA.

The National Center on Addiction and Substance Abuse at Columbia University (CASA) (2006) explained that historically, women’s alcoholism was viewed as different from men’s with different root causes. Women who suffered from alcohol abuse were stigmatized and treatment was not made available to them. Throughout time, alcoholism was viewed as more of a “sin” for women than for men (Nakken, 2002). This was the case during the early years of AA – some men were uncomfortable being at meetings with women, and even doubted that women could be alcoholics. Women in AA were forced to sit on the other side of the room from men, as those who were single or divorced were viewed as a threat by the wives of the men in AA. In the mid-40s, AA did acknowledge the existence of women and alcoholism, and special women’s groups were created to deal with “women’s issues.” These women’s groups were still stigmatized, however, and women were hesitant to join for fear of being negatively perceived (CASA, 2006).

Even the original language of AA addressed men and included only masculine references. When women were mentioned, it was assumed that they were the wives of alcoholic men. Women were challenged to translate the overtly male-dominated messages of AA into something relatable to their gender. For example, while men's alcoholism may manifest itself in anger, violence, or abusive behaviors, women may demonstrate depression, anxiety or withdrawal from others. Women needed to somehow reconcile those differences in order to benefit from their experiences in AA (Nakken, 2002). While nearly one-third of all AA members are now women, the inherent male-oriented tenor of AA still exists in its language and in attitudes of some older male members in particular.

The narrative and AA.

The narrative aspect is an integral component of AA (Cain, 1991; Humphreys, 2000; Jensen, 2000; Pollner & Stein, 1996). Cain viewed the narratives told in AA as a model, illustrating the definition and meaning of alcoholism to other members. An individual then uses that model as a vehicle through which to compare her stories with others in order to determine if she is an alcoholic. "As the AA member learns the AA story model, and learns to place the events and experiences of his own life into the model, he learns to tell and to understand his own life as an AA life, and himself as an AA alcoholic" (Cain, p. 215). Likewise, Humphreys (2000) identified five types of AA stories including the "Drunk-a-Log." This story described a member's "personal account of descent into alcoholism and recovery through A.A." (p. 498) and accounted for a large portion of the *Big Book's* content. As the member grew to better understand the AA process, his drunk-a-log narratives became altered, and constructed in ways that greater reflected and supported the philosophy of AA using the model, "experience, strength,

and hope” and “what we used to be like, what happened, and what we are like now” (Jensen, 2000, p.11).

A literature review of narrative therapy and of AA brought to light some possible overlapping themes. By asking the research question, “How was the narrative aspect of AA experienced by the participants,” the researcher sought to better understand the processes involved in constructing narratives in the context of AA meetings, through the eyes of women age 50 and over.

Methods

Sample, setting, and procedures.

The interviewer utilized a qualitative approach and a phenomenological interview process. Much like the meaning-making process of telling one’s story in AA, the process of interviewing participants enabled them to share their stories and impart the meaning of these life experiences. Through this methodology, the researcher sought to obtain “thick,” highly detailed descriptions in order to best understand the women’s experiences through their own words (Creswell, 2013; Creswell & Miller, 2000; Patton, 2002). There was an established protocol for questions, but broad streams of inquiry were established as necessary to address the research question: How was the narrative aspect of AA experienced by the participants? Specifically, the interview questions, 1) “Have you ever told your story in AA? How did telling your story to the other members impact you?” and 2) “Do you share in meetings? What’s it like revealing parts of yourself in this way? How does sharing impact you?” coupled with a review of the literature describing the AA and narrative therapy processes assisted the researcher in discovering the parallels between AA and narrative therapy.

Fourteen older women in AA were interviewed for a total of 27 mostly face-to-face sessions over a one year period. The women ranged in age from 52 to 81. They greatly varied in the amount of time they had been sober in AA from one to 32 years, although nine of the women had been sober for 15 or more years. Eight women had at least one false start where they tried to attain sobriety but relapsed, and all women had been drinking for ten or more years before they found AA. Table 1 presents a detailed summary of participants' history of drinking. For all but one participant, two interviews were conducted. The participant who completed only one interview experienced a relapse between the first and second interviews and it was feared that further interviewing might compromise her efforts towards sobriety. The second interviews occurred within four weeks of the first. Typical sessions lasted one to two hours and were held in private homes, offices, and eating establishments to ensure that the participants felt comfortable and that privacy could be ensured. Three second interviews were held over the phone due to illness or scheduling conflicts.

Because of the closed nature of the AA community, a confederate, who is an AA member assisted with the recruiting of women who met the study's criteria. This was a fairly homogeneous sample racially (white), socio-economically (upper-middle class), and geographically (living in and around a small urban community in southwest Virginia). Eight participants were currently employed, five retired, and one in between jobs. Ten were married or had a life partner, nearly two thirds of the women had children, and one-third of the women had grandchildren. In every case, strict measures protected the confidentiality of interviewees. Participants ranged from 52 years old to 81 years old and all but one considered herself an active member of AA (regularly attended AA meetings weekly for the previous year).

The women were all forthcoming and interested in this research, and several viewed their participation in the study as a way of giving back to the program. Participants' interviews exhibited marked internal consistency, revealing an array of common themes in their experiences. However, divergent viewpoints were also noted as significant and acknowledged in the findings. All participants will receive a copy of the manuscript upon its publication.

Data analysis.

The researcher sought to attain detailed, illustrative descriptions of the data. At the completion of each interview, audio recordings were precisely transcribed by the researcher, adding additional notes with observations about the participants' nonverbal behavior and information about the setting from the researcher's field notes. Additionally, within four weeks after each interview the participant was given her typed transcript to review in order to ensure accuracy. After meticulously reading the transcripts (totaling over 300 pages), the researcher highlighted excerpts that reflected the meaning of the phenomena of interest. Later, a constant comparison method was employed to open code these excerpts, incorporating analogous and differing experiences, and then codes were grouped into categories and subcategories. These categories and subcategories were organized according to themes across the narratives that addressed the research question (Rossman & Rallis, 2012; Saldaña, 2009). Table 2 is a display of the detailed data analysis process. A review of the transcripts indicated strong internal consistency as evidenced by common themes throughout the participants' experiences. The transcripts were also reviewed by a second researcher to ensure the accuracy and adequacy of the codes and to help identify constructs, resulting in theme analysis agreement. The researcher adhered to all IRB protocols and participants signed the informed consent document before the

interviews occurred. All participants were ensured confidentiality by masking identifying information and assigning pseudonyms to the transcripts.

Findings

In developing the theme of intersection of narrative therapy and AA, two main categories emerged related to storytelling. First, women's descriptions of their stories in AA had three unique stages (subcategories). Members passed through these stages in order, discussing their lives while addicted (*despondence*), the movement towards sobriety (*recovery*), and finally, shifting the focus to sharing that success story with others (*retelling*). These stages coincided with the three-stage storytelling models that are commonly used within the AA meeting: (a) "What we used to be like (experience), (b) what happened (strength), and (c) what we are like now (hope) (Jensen, 2000, p. 11). The second category that emerged related to storytelling in narrative therapy and AA indicated a common characteristic of being ever-evolving and subject to change.

The three Stages of Storytelling in AA.

Stage 1: Despondence.

The women described their early days in AA as miserable -- mired in alcoholism and feeling worthless. These qualities were organized into the subcategory, *despondence*. Despondent women commonly felt fear, depression, hopelessness and failure, and their personal stories about this time reflect these emotions. Susan, 66, works in the medical field and has been sober for 34 years. She had attained the longest length of sobriety of all the participants, and when I met her after work at a local diner, she described the negative and powerful reaction she still has to retelling her early stories of alcoholism:

So we need to qualify and go back in there and re-experience our drinking, and that's what it does for me. It takes me back, reminds me, reliving it almost, of what it was like. I've done enough work it doesn't hurt me, but it can take my breath, sometimes, or make me sick to my stomach.

However, there is a purpose in the retelling of these difficult stories involving drinking. In particular, women discussed the heart wrenching precipitating incidents that led to their decisions to join AA (Table 1). Several women referred to situations involving their children. Ginny, 57, was living in a halfway house when I met her at a local park. She tearfully described how she was driving drunk with her son when she got into a major car accident, leading to her decision to seek help in AA. Likewise, Dianne, 69, a retiree with over 31 years of sobriety, told me a bit about her days of alcoholism, and how one of the significant events that persuaded her to join AA was when she blacked out and forgot to pick up her young son after school. She discussed how recalling these painful early experiences was an important step in the recovery process:

So in that sense, I think it (storytelling) really now lets me remember. And keeps me focused. And then an extreme amount of gratitude for the way things are now... a big piece of it is so you remember, you remember what the pain was like and how miserable it was.

For the women, describing their early stories of alcoholism, and the devastating experiences that accompanied that time was a necessary first step towards attaining sobriety. These stories illustrated *despondence*, the first stage of storytelling in AA.

Stage 2: Recovery.

In this stage, women shifted to speaking about their recovery process. This storytelling stage, also illustrated by the sub-category code, *recovery*, exhibited more positive terms, and personal stories were revised to highlight the strengths and successes that enabled them to resist drinking and illustrated their transformation to sober individuals. Betty, 64, a retiree with 25 years of sobriety, relished her relationships with many women in AA. She expressed her joy in being able to share her story of recovery with others: “Telling the recovery part is the fun part, it has work, it has sadness, but it’s fun.”

Dianne explained how over time her storytelling focus shifted from dwelling on past experiences with alcoholism, to describing the fortitude involved in gaining and attaining sobriety:

Because that’s really what you want to hear about. I mean, we all knew how to drink. We might have done it in different places and with different consequences and stuff like that, but basically we all knew how to drink too much and not be able to stop and that kind of thing. What you want to know is, how do I stop? And how do I get rid of that stuff inside me that’s just eating me up.

Discussion of the recovery process, involving the transition from alcoholism to sobriety, is another integral stage in storytelling for older women. Women expressed that this stage of storytelling allowed them to illuminate and articulate their transformation.

Stage 3: Retelling.

In this stage, women in AA focused on sharing their journey with others in the program. This sub-category, *retelling*, allowed women the opportunity to fully articulate their process of becoming sober individuals, but also to share current daily experiences with maintaining sobriety. Women discovered that sharing their stories of alcoholism and early struggles in AA

“qualified” them in others’ eyes to speak in AA, and gave a context for new members to identify with the stories. Meg, 61, has been sober for 15 years. She currently sponsors 13 women and is considered by many to be an icon in the AA community. She articulated the importance of telling her AA story so that others might relate:

In storytelling, that is the real benefit of meetings, in storytelling, is that somebody who’s 25 can come in and listen to somebody like me who’s 60, and I can say, “This is what happened to me,” or “I didn’t think it would ever happen to me, but this is where alcohol took me. And if alcohol is taking you to places you don’t want to go, you don’t have to keep going until you’re desperate.”

Recounting the story of one’s journey to sobriety was integral to the women because it helped to reinforce their positive self images and increased feelings of self worth. Beth, a 58 year old professional with over 4 years of sobriety, met me in her home. She was in the process of moving to another state to be closer to family, and lamented that her current job afforded her little time to connect with other women at AA meetings. She explained the power of storytelling in AA, and how sharing her story with the group helped to strengthen her new identity as a sober woman:

It just shows the progress you’ve made, where you were and how you were versus how you are currently...it’s great, it’s comfortable, it’s a learning process.

The three stages of storytelling in AA were clearly articulated by the women in the study. The difficult journey of moving from alcoholic to sober individual (*despondence to recovery*), and then the sharing of that transformation and of other current experiences in sobriety with the greater group (*retelling*), can be better understood through the women’s descriptions of their narrative processes in AA.

Evolving stories in AA.

Eight of the 14 women articulated a second category within the overlap of narrative therapy and AA: A continuously--changing narrative in their AA storytelling. As the women's perceptions of life events were altered, so were the resulting stories as told in the context of AA. Of particular note to the researcher, none of the interview questions mentioned the characteristics of the story. Over half of the women independently volunteered information regarding the continuously changing story as an important element in their storytelling. Hannah, 61 a doctor with 5 years of sobriety, met me in her busy office, and between patients, discussed the value of telling her story to the group. For her, storytelling was accompanied by discovery of a new insight or revelation about herself each time:

There's always something that's a growth experience when you get up and tell your story and it always seems to be a little different—I hope it's a little different—that I've learned something or had some different insight or experience at the time I'm talking... I hope it (the story) continues. I mean, I would be happy right now with what I've got, as static. But, being an alcoholic I want more.

Hannah reflected on telling her story in meetings as an opportunity to take stock in her life each time. Similarly, Ruth, 54, in the janitorial field with 17 years of sobriety, spoke about her story as evolving in the present and future, but static when discussing the past. She viewed her story as changing according to her personal growth, and that change as imperative to maintaining her sobriety.

As you continue to grow (the story) changes. I mean, what I was like doesn't change. And what happened doesn't change, but what it's like today is ever-evolving... I heard a speaker say one time that it takes the first five years to find your marbles and it takes the next five years to learn how to play with them (laughs). And then it's been about growing spiritually. That's the big thing is that we want you to continue to grow because if we don't, then we're going to go back to where we came from, chances are pretty good of that happening if we don't continue to grow.

Where Ruth and Hannah saw growth and evolution in how their stories changed over time, Linda explained that variations in her story are also attributable to changes in her life from day to day. She expressed how she may shift her focus or even how much she shares depending on her present situation and feelings at the moment:

I find that every time I tell my story it varies. Several things affect how that goes for me on any given day: where I am, because there's been times when I was going through a divorce and I'd be asked to share my story and I was really struggling emotionally about the divorce and how it impacts my daughter, and just all the things, the life changes that was going to create. .. So there's been times like that when I shared and I was like, "I don't really know if I've got much to share," and ultimately my story may sound a little different then. Like I may focus on some other aspect than I would have if I go up there and I feel like I'm in a really good spiritual place, and a really good place in my life and more confident.

One major feature of storytelling in AA was the idea of a continuously evolving narrative. As the women's lives changed, so did their accompanying life stories. These women had the self awareness to recognize that their ever-transforming identities were reflected in the continuously

evolving stories that they told. While every woman at the time of interview had obtained sobriety, not everyone made the connection between their ongoing evolution and the characteristics of their resulting stories.

Discussion

There is a clear intersection of experiences between a client sharing her story with a counselor in narrative therapy, and an older woman sharing her story in AA. A review of the literature of narrative therapy and of AA, as well as the women's responses to the research question, "How is the narrative aspect of AA experienced?" illustrate that as women work through the twelve steps of AA, there is overlap with narrative therapy in two distinct ways. First, the three-stage AA storytelling model that they follow mirrors the three-stage narrative therapy approach. The findings further suggest that by following this model, older women in AA experience three distinct stages: *despondence*, *recovery*, and *retelling*. Second, the continuously evolving story, a hallmark of narrative therapy, is echoed in the women's descriptions of their story narratives in AA.

Three stages of narrative therapy and the stages of AA storytelling.

Narrative therapy utilizes a three-stage process that is parallel to three stages of storytelling as explained by the women in the study. These three stages of narrative therapy (a) current feelings, (b) deconstruction and recreation of those feelings, and (c) shared new narratives, reflect the models commonly used within the AA meeting: (a) "What we used to be like (experience), (b) what happened (strength), and (c) what we are like now (hope) (Jensen, 2000, p. 11). In addition, the twelve steps of AA can also be placed into these same three stages reflecting both narrative therapy and the AA model. The women in the study reiterated this three stage process of AA storytelling through their descriptions of: (a) *despondence*, (b) *recovery*, and

(c) *retelling*. Table 3 presents the progression of these parallel processes tracing the three stages of: (a) narrative therapy, (b) the AA model, (c) the twelve steps of AA, and (d) the women's experiences in storytelling. Finally, the table gives an overview of what is addressed in the discussion section: how narrative therapy and the women's narrative experiences in AA intersect in each of the three stages.

The overlap of narrative therapy and women's narrative experiences – stage 1.

The beginning client in narrative therapy focuses on her present understanding of her current situation (White & Epston, 1990). Morgan, Brosi, and Brosi (2011) explained that in early stages of narrative therapy with substance-abusing older adults, the client is encouraged to define the problem of being a substance abuser and discuss how that has affected her life. Likewise, the AA storytelling model in this stage is focused on past alcoholic *experiences* and “what we used to be like” (Jensen, 2000, p. 11). In that same vein, older women in this study recalled early stories of unhappiness, desperation, and misery around their alcoholism. These experiences were labeled, “*despondence*.”

The overlap of narrative therapy and women's narrative experiences – stage 2.

As clients engage in narrative therapy, they are encouraged to externalize the problems, deconstructing and recreating them (White & Epston, 1990). Following the Morgan, et al. (2011) model, older adults should begin to separate their alcoholism from their identities and reshape their stories by focusing on instances when they were able to overcome desires to drink. Likewise, in the AA model, women “work” the steps of AA, demonstrating their *strengths* and explaining to others, “What happened” (Jensen, 2000, p.11). Older women in this study articulated feelings of pride and achievement in attaining sobriety, evidenced in their storytelling.

Their stories of strength and fortitude in altering their identities from alcoholic to sober were labeled, “*recovery.*”

The overlap of narrative therapy and women’s narrative experiences – stage 3.

Clients in narrative therapy shared their new personal narratives with others to reinforce new stories and empower the storyteller in “outsider witness groups” (Carr, 1998, p. 496; White & Epston, 1990). Morgon, et al. (2011) found that after overcoming substance abuse, the older client should connect with other people in order to reinforce the new story and to reduce a sense of isolation commonly experienced with older adults. AA specifically addresses the challenges that these older women faced in the third stage of narrative therapy by providing a critical venue (the meeting) for older adults to congregate and tell their stories. AA storytelling in this stage focused on sharing “what we are like now,” giving *hope* to others that they, too, can reconstruct their own stories to reflect this narrative therapy process (Jensen, 2000, p. 11). Women in this study shared a desire for their stories to be an example to others in their own struggles towards sobriety, and saw value in sharing their story, not just of their identity transformation, but of how they maintained their new identities as sober individuals. These experiences were labeled, “*retelling.*”

Linda summarized that the process of sharing her story with the AA group reinforced the entire three-stage process, by helping her to better understand and redefine herself:

(Telling your story) gets easier, and I think it crystallizes your journey. You know how you change and you don’t always see things until you’ve already changed, you know, like hindsight’s 20/20? So I think that’s one of the things that sharing does, and that idea of

redefining yourself. It gives you that opportunity to kind of look back after you tell your story, and that idea that as you redefine, looking back and getting a little clearer... And I think my story, my sense of what I've been through gets clearer having to put it into words.

Utilizing the AA storytelling model, women in the study followed the same three stage narrative model employed in narrative therapy. Their descriptions of the three stages, *despondence*, *recovery*, and *retelling*, reflect the same linear processes in storytelling that are evident in narrative therapy. The movement through these stages is considered integral to the AA program in achieving and maintaining sobriety.

Evolving stories in narrative therapy and AA.

The experience of living is by nature ever-changing and continually transitioning. Narrative therapy provides women with the means to explore, “a living representation of how one is experiencing life” (Hayes & Oppenheim, 1997, pp. 25-26). Therefore, it follows that the life stories generated by clients within the context of narrative therapy are not static, but rather fluid, responding to evolving life experiences. Just as the stories generated in narrative therapy are ever-evolving, the women in this study indicated that their narratives in AA are never static and change according to the variations in their lives. This is particularly important for women in AA who seek the program's services because of a desire to change. Ultimately through their stories, their identities as alcoholics can be deconstructed and recreated to give new meaning to their lives as sober, productive individuals. Thus, their stories change to coincide with their alterations in identity. The story elasticity also lends an additional sense of hope for positive future change as well.

Implications for Clinicians.

Examining experiences with AA through the lens of narrative therapy may be particularly beneficial for older women in two distinct ways. In terms of age, older women face unique challenges, among these being declines in health, decreased social networks, and the negative stigma of aging. As older women begin to evaluate their lives, narrative therapy can help to create a sense of meaning encompassing their past and present experiences. Narrative therapy allows older women the ability to deconstruct and recreate their life stories. Through this process, these women can construct new narratives that tell their life's "story" to the world (Kropf & Tandy, 1998).

From a strictly feminist perspective, "re-authoring" one's story is necessary in order to remove it from the "dominant gendered stories that are central in maintaining the social construction of femininities in contemporary society" (Lee, 1997, p. 2). The feminist narrative perspective gives women a "voice," allowing them to vocalize the injustices that they have faced within a larger society. They are encouraged to change their relationship with their problems and reconstruct new, preferred stories (Lee, 1997).

Finally, clinicians working with older women who have either had experience with, who are currently in, or may be referred to AA, may consider the overlap of narrative therapy and the AA storytelling model when deciding on appropriate treatment methods. In particular, narrative therapy processes may be complementary to the work that their clients have already done in AA, and will have some familiarity. For clinicians who refer their older-woman clients to AA, it may be useful to prepare these clients for the narrative traditions that are reflected within the AA environment. In these cases, clinicians who employ narrative therapy may wish to reiterate the AA model and verbiage in their practice by emphasizing: "Experience, strength and hope," and "What we used to be like, what happened, and what we are like now." Clinicians may also want

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to aid recovering older female clients in finding venues to share their new stories if they are not currently members of AA. For example, group therapy might be one arena where older women could share their stories. Another idea might be for older women to speak to others in retirement communities or nursing homes about their personal experiences. While these women suggested features of narrative therapy that can be found within AA, more research is necessary to ascertain the effectiveness of pairing individual narrative therapy with the membership and practices of AA.

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Table 1.

Study Participant History-of-Drinking Summary

	Age	Years sober in AA	False starts getting sober	Years drinking before AA	What prompted AA?
Meg	61	15	2+	33	Difficulty staying sober before annual blood work
Nancy	59	2	0	10	Nervous breakdown
Rose	64	27	0	21	Having to travel with husband's family sober
Susan	66	34	0	18	Joined a group with AA members in it
Beth	58	5	2	19	Didn't want to live the way she was living anymore
Betty	64	25	0	22	Work identified it and she went to treatment
Brenda	56	27	0	15	Friends dying
Dianne	69	32	0	20	Blacked out, forgot to pick up son
Ginny	57	1	1+	11	Car crash with son in car, drinking
Hannah	61	5	1+	14	Depressed, mandatory because of DUI
Linda	52	24	1+	16	Boyfriend's ultimatum
Louise	81	29	2	10	Realization that alcohol was killing her
Mary	58	6	1+	20	Lost job, mother died, taken to emergency room
Ruth	54	17	2	27	In psych unit, realized she had same disease as parents

Table 2.

Data Analysis Process

Research Question		
How was the narrative aspect of AA experienced by the participants		
Theme		
The Intersection of Narrative Therapy and AA		
Categories	A. Three stages of Storytelling	B. Continuously evolving story
Subcategories and Supporting Codes	Despondence Stage <ul style="list-style-type: none"> • Sadness in alcoholism • Desperation in alcoholism • Depression in alcoholism • Worthlessness in alcoholism • Fear in alcoholism • Physical injury from alcoholism 	New revelations <ul style="list-style-type: none"> • Insights/discoveries through storytelling
	Recovery Stage <ul style="list-style-type: none"> • Empowerment - recovery • Success - recovery • Fortitude - recovery • Work - recovery 	Shifting focus <ul style="list-style-type: none"> • Past stories static • Future stories changing • Benefits of evolving story
	Retelling Stage <ul style="list-style-type: none"> • “Qualify” to speak • Help others to relate through storytelling • Learning process through storytelling 	

Table 3.

The Three Stages of Narrative Therapy and Storytelling in AA

	Stage 1	Stage 2	Stage 3
Narrative Therapy (Theory)	Personal narratives reflect current feelings about situation	Personal narratives deconstructed and recreated	New personal narratives shared with others, reinforcing and empowering
AA (Theory)	Mired in alcoholism Experience What we used to be like	“Works” steps Strength What happened	Share story Hope What we are like now
AA's Twelve Steps	<div style="border: 1px solid black; padding: 5px;"> <ol style="list-style-type: none"> 1. Admitted we were powerless over alcohol—that our lives had become unmanageable 2. Came to believe that a Power greater than ourselves could restore us to sanity 3. Made a decision to turn our will and our lives over to the care of God as we understood Him 4. Made a searching and fearless moral inventory of ourselves 5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs 6. Were entirely ready to have god remove all these defects of character </div>	<div style="border: 1px solid black; padding: 5px;"> <ol style="list-style-type: none"> 7. Humbly asked Him to remove our shortcomings 8. Made a list of all persons we had harmed, and became willing to make amends to them all 9. Made direct amends to such people wherever possible, except when to do so would injure them or others 10. Continued to take personal inventory and, when we were wrong, promptly admitted it 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 </div>	<div style="border: 1px solid black; padding: 5px;"> <ol style="list-style-type: none"> 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 our affairs </div>
Storytelling (Findings)	Despondence	Recovery	Retelling
Narrative Therapy in AA (Discussion)	Personal stories reflect failure and hopelessness around drinking and alcoholism	Personal stories recreated to emphasize strengths and successes in abstaining from alcohol	Personal stories of journey to sobriety told in AA meetings, reinforcing the new story and helping others to reconstruct their own stories of sobriety

ARTICLE TWO

Importance of Storytelling for Older Women in AA

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Abstract

The researcher conducted a phenomenological qualitative study including 27 interviews with women in AA age 50 or older to explore how the process of storytelling affected these women. Alcoholics Anonymous (AA), a worldwide organization established with the goal of assisting alcoholics in sobriety, incorporates the experience of members sharing their story with the group. Results suggest profound impacts on the storyteller including: an avenue for giving back to the program, acceptance and feeling a part of the group, overcoming anxiety about public sharing, reminding the speaker of her past struggles, and having a spiritual experience, understanding boundaries, over-sharing and conflicts of interest in storytelling, and story focus. Impacts on the AA listener include learning from others in the program, and identifying with the speaker's story. Though storytelling is viewed by these women as primarily advantageous to the speaker, benefits to the listener are found to be a welcome, though secondary, "side effect." Mental health practitioners may discover that counseling techniques involving storytelling, particularly with the client as narrator, will prove effective when working with older women who suffer from alcoholism or other addictions.

The Importance of Storytelling for Older Women in AA

As we age, telling stories about our life and experience can be a beneficial process. Butler (1963) first introduced the idea of the life review process, and suggested its importance for older adults. He described it as a, “naturally occurring, universal mental process characterized by the progressive return to consciousness of past experiences” (p. 66), and contrasted it with the negative connotations associated with reminiscence, which he labeled, “fatuous” (p. 66). Haber (2006) further illustrated that Erikson’s (1950) eighth stage of psychosocial development, integrity vs. despair, was positively influenced by conducting life reviews, by minimizing despair and helping to acquire ego integrity. Gergen and Gergen (1983) identified that when configuring self-narratives, the storyteller must create, “coherent connections among life events” (p. 255). Parker (1995) found that although heavily researched, there had been no successful attempts thus far to solidify the concept of reminiscence into a theory, so she proposed applying Atchley’s (1989) Continuity Theory of Successful Aging as a theoretical framework when evaluating reminiscence. According to Atchley (1995), “Continuity Theory thus offers a parsimonious explanation for and description of the ways adults employ concepts of their past to conceive of their future and structure their choices in response to the changes brought about by normal aging” (p. 183). Parker suggested that memory recall through reminiscence is integral for an individual to maintain a sense of continuity. She asserted that, “individuals build these lifestories as they age, and these stories incorporate past events into an organized sequence, giving them a personal meaning and a sense of continuity” (p. 521).

Alcoholics Anonymous (AA).

AA was created circa 1935 as an approach to alcoholism recovery for and by alcoholics, Bill Wilson and Dr. Bob Smith (Alcoholics Anonymous World Services, 2001). At the time that

AA was established, alcoholism was considered a hopeless condition by the medical community. Wilson and Smith borrowed some principles from the Oxford Group, a nondenominational Christian movement that focused on self-improvement through self-inventory, admitting wrongs, making amends, exercising prayer and meditation, and carrying the message to others (www.aa.org). Their ideas regarding alcoholism and recovery were later conveyed in a text known as “the Big Book,” that highlighted the 12 Steps of AA. (Davis & Jansen, 1998). Initially, AA was created only for men. Early verbiage reflected male bias, echoing the predominant sentiment of the time that women could not be alcoholics. While some male oriented language still exists in classic AA literature, the composition of AA has changed to include one-third of women in its membership (The National Center on Addiction and Substance Abuse at Columbia University (CASA), 2006; Nakken, 2002).

The only requirement of AA members is a desire to cease drinking. Members meet in groups as often as needed and there are no fees or dues associated with membership. The primary purpose is to attain and maintain sobriety and assist others with that same goal. Currently in AA, there are more than 117,000 groups and over 2 million members in over 180 countries. The group does not accept donations from non-members, and individual members are limited to giving no more than \$3,000 per year. With anonymity being paramount, AA strives to achieve complete abstinence following the motto, “one day at a time.” AA meetings may be open (anyone is welcome to attend) or closed (only alcoholics may attend) (www.aa.org).

The Importance of narrative and AA.

The narrative is inextricably linked to AA (Cain, 1991; Humphreys, 2000; Jensen, 2000; Pollner & Stein, 1996). Narratives told in AA can be viewed as a model, demonstrating the definition and meaning of alcoholism to other members. An individual then determines if she is

an alcoholic by comparing her story with those of other alcoholics in AA. “As the AA member learns the AA story model, and learns to place the events and experiences of his own life into the model, he learns to tell and to understand his own life as an AA life, and himself as an AA alcoholic” (Cain, 1991, p. 215). Humphreys (2000) further described the AA narrative by identifying five types of AA stories including the “Drunk-a-Log.” This type of story, commonly depicted in the *Big Book*, described a member’s “personal account of descent into alcoholism and recovery through A.A.” (p. 498). As the member grew to better understand the AA process, her drunk-a-log narratives were reconstructed in ways that better articulated the AA philosophy using the model, “experience, strength, and hope” and “what we used to be like, what happened, and what we are like now” (Jensen, 2000, p.11). In much of the same way that Parker (1995) viewed reminiscence through the Continuity Theory, AA stories encompass a holistic view, incorporating past experiences into a meaningful present narrative.

By asking the research question, “How was the narrative aspect of AA experienced by the participants,” the researcher sought to better understand the processes involved in constructing narratives in the context of AA meetings, through the eyes of women age 50 and older. Primary findings of this paper focus more narrowly on the question of the importance of storytelling from the perspective of being the storyteller and being the listener, and how specific components of storytelling affect older women in AA.

Methods

In an effort to better understand what the narrative experience was like for older women in AA, the interviewer employed a qualitative approach and a phenomenological interview process. The interview questions 1) “Have you ever told your story in AA? How did telling your story to the other members impact you? “ and 2) “Do you share in meetings? What’s it like revealing

parts of yourself in this way? How does sharing impact you,” assisted the researcher in elucidating the importance that storytelling holds in the women’s AA experiences.

Participants.

Participants were recruited through the help of a confederate, a member of the AA community, who used a prewritten script to ask peers in AA who fit the study criteria (active members who regularly attended AA meetings weekly for the previous year, women age 50 and older, English speakers) to participate. Fourteen older women in AA were interviewed, and all but one considered herself an active member of AA. The women ranged from age 52 to 81 and were all of Caucasian decent. Participants’ highest levels of education varied: three completed graduate school, three completed some years of graduate school, two completed a Bachelor’s degree, one completed an Associate’s degree, three completed some college, one graduated high school, and one obtained a GED. About three-quarters of the women were single, and about two-thirds of the women had children and about one-third of the women had grandchildren. A little over half of the women were employed, and all but one of the remaining were retired (See Table 1 for more demographic information).

Limitations.

This was a fairly homogeneous sample racially (white), socio-economically (middle to upper-middle class), and geographically (living in and around a small urban community in southwest Virginia). And with the exception of one woman (81 years old), the demographic is more “young old” with the rest of the women ranging in age from 52 to 69.

Procedure.

A total of 27 mostly face-to-face sessions occurred over a one year period. For all but one participant, two interviews were conducted. The participant who completed only one interview

experienced a relapse between the first and second interviews and it was feared that further interviewing might compromise her efforts towards sobriety. The second interviews occurred within four weeks of the first. Typically interview sessions lasted one to two hours and were held in private homes, offices, and eating establishments to ensure that the participants felt comfortable, and to maintain privacy. Three of the second interviews were held over the telephone due to illness or scheduling conflicts, and the rest were held in person.

There was an established protocol for questions, but broad streams of inquiry were developed as necessary to address the research question. Both interviews were phenomenological in nature with the exception of a brief demographic survey given at the beginning of interview one. In every case, strict measures protected the confidentiality of interviewees. Approval was sought from the IRB before any interviews occurred, and the researcher followed all IRB protocols including ensuring that the Informed Consent Document that was signed by each participant and followed throughout the research. In addition, pseudonyms were used and all identifying information was obscured in order to preserve participant confidentiality. The women were all forthcoming and interested in this research as a way of giving back. Approximately one-third of the women expressed an interest in seeing the completed results.

Data Analysis and Quality/Rigor.

The researcher worked towards the goal of developing precise, detailed descriptions of the data. Following each interview, the researcher transcribed the audio recording, adding additional notes with observations about the participants' nonverbal behavior and information about the setting from the researcher's field notes. In addition, an audit trail was kept to ensure that the precise steps enacted within the data collection process were recorded. Within four weeks of each interview the participant was given a typed transcript to review for accuracy in both words

and overall meaning. Transcripts (totaling over 300 pages) were read meticulously, and excerpts that reflected the meaning of the phenomena of interest were highlighted. These excerpts were later open-coded using a constant comparison method to incorporate analogous and differing experiences, and then grouped into categories and subcategories. These categories and subcategories were organized according to themes across the narratives that addressed the research question (Rossman & Rallis, 2012; Saldaña, 2009). Table 2 gives a detailed description of the data analysis process. Participants' interviews exhibited marked internal consistency, revealing an array of common themes in their experiences. A second researcher also reviewed the transcripts and codes to ensure no important concepts were missed, and to help identify constructs.

Findings

In addressing the research question, "How was the narrative aspect of AA experienced by the participants?" the women explained the process of storytelling and articulated the various ways that they were affected by their participation. Emerging from this was the theme of the importance of storytelling from the perspective of being the storyteller (category 1) and being the listener (category 2). Thus, the primary findings of this research illustrated how specific elements (subcategories) of storytelling and of listening to others' stories affect older women in AA.

The Importance of Storytelling for the Speaker.

Twelve out of the 14 women reported that the act of telling their stories in AA positively affected them, one suggested that telling her story had no effect on her at all, and one projected a negative attitude toward sharing. A positive feeling about storytelling also indicated a sense that storytelling was important. Women further articulated subcategories regarding the important aspects of speaking to the AA group: (1) Fulfillment of a desire to give back to the AA program,

(2) Acceptance and feeling a part of something, (3) Transcendence beyond early feelings of anxiety or discomfort related to sharing and public sharing, (4) Remembrance of important past events, (5) A spiritual experience, (6) Understanding of boundaries, over-sharing and conflicts of interest in storytelling, and (7) Story focus. One woman also described enjoying the entertainment aspect of telling her story to the group.

A way to give back.

Some women noted a desire to give back to the AA program, and cited storytelling as an important way to achieve that goal. One strong motivator was sense of obligation. Of the 14 women interviewed, 11 women indicated feeling an obligation to give back without being prompted. Five specifically indicated that sharing their personal stories from alcoholism to sobriety with others is their way to repay that obligation. Some women also indicated a desire to “pay it forward” – they were grateful for having heard more experienced members’ stories, and now wanted to tell their stories to inspire others who may not be as far along in their sobriety. Along those lines, storytelling was also mentioned by some as a way to demonstrate service, one of the hallmarks of the AA program. Often, this storytelling was achieved through two common models: (1) “What we used to be like, What happened, and What we are like now,” and (2) “Experience, Strength, and Hope” (Jensen, 2000, p. 11).

The researcher met with Susan, 66, at a local diner for dinner. She had just finished a full day at her job and was still dressed in her work clothes. Susan had been sober for 34 years, so she was a long-standing member of the AA community. She discussed her harrowing experiences with alcohol, including a promiscuous period where she would leave her children at home and spend evenings with various men. She explained how sharing that story with others,

and illustrating how she attained sobriety, fulfilled a sense of obligation, and was a requirement of the program:

That's what we have to do in order to carry the message to stay sober... You have to give away what you've been given and someone carried the message to me. They were willing to be honest and tell me what happened to them and how they got sober.

Meg, 61, is a pillar in the AA community. Other women in this study mentioned her frequently as a mentor and friend. At our second meeting, Meg received a visitor – a young woman in AA whom Meg sponsors. It appears that Meg's influence in the AA community is large – she sponsors numbers of women and has an amazing ability to quote directly from *The Big Book*. A retiree with over 14 years of sobriety, she frequently alluded to how hearing others' stories in AA helped her achieve sobriety, and how she hoped to do the same for others through her storytelling:

It gives me the opportunity to give back... it's basically my way of being able to participate in AA as somebody who's been through the process, and it's the way I say thank you to the people who helped me get out of the hole...AA says, "Batter up!" and I just stand at the plate.

Rose, 64, is a close friend of Meg's with 27 years of sobriety. She was a very recent retiree from a prominent position as a political staffer, who was finding the transition from work to retirement challenging. Rose was stylish, funny, and sensitive, and was easily touched by emotion when discussing her gratitude towards AA. She expressed how the service aspect of AA can be met through sharing stories at meetings:

And meetings are also important for me now because it's part of my service... because I think that at 27 years it's a service to open your mouth and say what's going on with you so the people with one year can go, "oh, ok."

Hannah, 61, is a practicing doctor with five year's sobriety. She ushered me into her office where between back-to-back appointments, made time to speak to me because of her appreciation for the AA program and a desire to help illuminate the benefits of the program to others. Hannah rejected the idea that there was an obligation to use storytelling at meetings but rather emphasized that all elements of AA, including storytelling, were suggestions meant simply to help others:

You don't have to do anything. You don't have to sit for the whole meeting...you don't have to do anything. Nothing is required - ever. There are suggestions and some of those suggestions...like it's suggested that you pull a rip cord when you jump out of a plane.

You don't have to. Here's the program, here's some suggestions, here's what's worked for us, take it or leave it.

Whether motivated by a sense of obligation, a wish to pay it forward, an example of service to AA, or an altruistic desire to simply help others, storytelling was considered important by many women because it afforded them a way to give back to the AA program.

Acceptance and feeling a part of a group.

Many of the women expressed that a valuable benefit of storytelling in AA is that it gave them a sense of group acceptance and belonging. This occurred because of the actual act of sharing the story with the group, but also because of the positive feedback received from the group as a result of storytelling.

Rose tearfully explained that to her, the importance of storytelling is that it ultimately brought her a sense of community:

And so for me, sharing is a way to contribute and a way to participate and be a part of.

That's probably the most important because I'm sharing what's supposed to be coming through me, like when I'm up talking, not just when I raise my hand.

Meg illustrated how sharing her story was significant for her because of the positive feedback that it incurred. This feedback generated a sense of acknowledgment and validation in the group:

I've learned stuff about myself that I didn't know until I heard myself say it. But part of it is also being accepted and having people come up afterwards and say, "I'm really glad you shared that"... Sometimes it validates me.

Thus, storytelling can garner positive feelings of belonging simply through the act of speaking to the group, but also through the positive feedback returned by group members in response to that sharing.

Overcoming anxiety about public sharing.

Seven women described overcoming early feelings of discomfort or anxiety associated with sharing with the group. Early concerns centered on being judged or just a general sense of fear related to public speaking, but women expressed that they were able to conquer their fears and speak to the group with positive results. (An eighth woman was never able to overcome her anxiety.) Mary, 58, is working in the banking industry. With 6 years sobriety, the experience of becoming sober was still relatively recent. Like Rose, Mary also considered Meg a strong mentor and friend in the AA community. Mary described having had a strong sense of shame about her

alcoholism, and gave a powerful analogy to describe the process of how her nervous feelings the first time she told her story to the AA group gave way to relief at the positive outcome:

I could liken it to the first time feeling like I was stark naked in front of the group... Like, "Go ahead and look." And then me looking back like, "ok, they didn't leave the room, they didn't reject me, I think it's going to be ok."

Like Mary, Susan discussed the initial fear of sharing her story in public. However, she also acknowledged the benefits derived from overcoming these fears:

And so for me, when I got started it was scary... And what we're doing is sharing from the heart, and I've never found that anywhere else. Once I got acclimated to the fact that people weren't going to reject me or run me out of AA, it can be very rewarding.

Similarly, Linda, 52, a professional in the counseling field, articulated the benefits of overcoming her trepidation and sharing her story with the group. Being in the mental health profession, Linda's perspective was particularly interesting because often her comments appeared to be a merging of that of a recovering alcoholic, and that of a professional in the counseling field:

I guess I feel there's that piece of just doing something that's uncomfortable that's stretching that feels like I'm doing the right thing ...but inevitably it always ends up feeling good, and I always end up feeling like whatever comes out of my mouth was supposed to come out of my mouth sort of like this process (laughs). It always just feels like great afterward...: I guess one of the things is just being able to get outside myself.

For some women, fear of public sharing and an anxiety around how their stories would be received pervaded early storytelling experiences. Later, overcoming those fears, and the confidence and pride derived from sharing with the larger group were vital in achieving sobriety.

Reminding the speaker of her past struggles.

Seven women expressed the benefit of storytelling because it reminded them of their past struggles in alcoholism. This idea of being reminded is positively associated with feelings of gratitude, focus, progress, and humility. For some women, retelling the past was a way to acknowledge previous struggles but also to celebrate the ability to overcome hurdles. Hannah explained why it was particularly necessary for AA members to be reminded of their past experiences related to drinking:

It's nice to go back and review it. Like I said, we have quick forgetters and sometimes slow learners, but to remember how I felt, what hooked me in, the struggles I had, it's good to go back and review that...And it reminds you of who you are and where you came from...

Dianne, 69, was a retiree with over 31 years of sobriety. When we met in her home, Dianne told me a bit about her days of alcoholism, and how she constantly feared that she might black out and miss a call to come in to work. She echoed Hannah's sentiments when discussing why remembering and sharing these painful early experiences is so important to the recovery process:

So in that sense, I think it really now lets me remember. And keeps me focused. And then an extreme amount of gratitude for the way things are now...a big piece of it is so you remember, so you remember what the pain was like and how miserable it was.

The women in the study had strong sense that being mindful of the past was imperative in maintaining a sober present and future.

Enjoys entertaining.

The women discussed a number of benefits derived from the storytelling experience, but benefits for Betty, 64, were unique. I met with her, in her home that was filled with art – painting, pottery, and examples of crafting. Betty is a fun-loving retiree with a quick wit and

easy laugh. She spoke about having a large family with 11 grandchildren. At our second interview, we met at a restaurant where she brought her 8 year old grandson. She spoke candidly and frankly about her alcoholic past, despite the presence of her grandson, but in between stories she demonstrated her softer side by hugging him and remarking several times about what a well behaved boy he was. With 25 years of sobriety, Betty had a distinctive perspective – she relished telling her story because it allowed her to entertain others. Betty enjoyed making people laugh, and demonstrated her sense of humor when speaking to the AA group. She explained her style fusing a lighthearted touch with the serious elements of her story:

I probably have more fun than I should. I'm a bit of an entertainer. The old joke used to be I wanted to be a movie star, I wanted to be a rock star, be on stage, so now I am - Hi, I'm Betty, I'm an alcoholic!

Sharing at meetings allowed Betty the opportunity to express her sense of humor and fulfill her need to entertain others.

Spiritual experience.

Spirituality is a critical component of the AA storytelling experience. A number of women discussed acknowledging a higher power before telling their stories to the group in the form of praying for help and guidance. Prayer was mentioned in helping women choose what to say to the group or to quell anxiety about public speaking. One woman referred to sharing, and hearing what is shared, as her “spiritual medicine.” Susan mentioned spirituality throughout her interview; it was clearly of great importance to her within the context of the AA experience. Unlike the others, however, she expressed that the act of telling her story was in itself a spiritual experience, crediting her word choices to God:

Well for one thing it is a spiritual experience because I always pray before I talk, I don't try to plan what I talk, I never take notes, and I know it's God's thing...I don't know what he wants me to share. He knows who's there and what message they need to hear - I don't...So I don't have a canned talk. I'm open to the spirit and that's what my sponsor told me from the very beginning: "Let the spirit direct you."

For many women, spirituality was inextricably linked to the storytelling process. Sharing with the group was often accompanied by a spiritual component deemed integral to the AA experience.

Boundaries, over-sharing, and conflicts of interest.

The subcategory of boundaries emerged when women described their experiences as storytellers. While storytelling is paramount to the AA experience, seven women discussed the need to self-sensor when sharing with the larger group. Two of these women made a distinction between what is appropriate to share with the group versus what is appropriate to share with a sponsor. Two others, whose jobs involve working in the addictions community, identified conflicts associated with disclosing their full story to an audience that sometimes included clients. Dianne expressed her viewpoint about the need for boundaries when sharing, and drew a distinction between sharing appropriately and over-sharing:

Because revealing pieces of your thinking or what was going on in your head, or one thing or another, is not the same thing as having no boundaries whatsoever. I mean, you don't want to say everything that comes in your head. You can have a filter and still be open.

While storytelling is integral to the AA experience, many women believed that there still

needed to be some type of self-censoring, depending on the audience. Some stories or components of the story may not be appropriate for the larger group, and it is incumbent upon members to understand that distinction.

Story focus.

Another subcategory that emerged under importance of storytelling was the composition of the story and what aspects of the story were emphasized. AA members are encouraged to share their stories using the three stage model, “experience, strength, and hope” and “what we used to be like, what happened, and what we are like now” (Jensen, 2000, p.11). However, the women believed that each component of the model should not receive equal attention in the story.

Several women mentioned the idea of “qualifying” in storytelling. When women shared their past experiences of “what we used to be like” before joining AA, they considered this a way to demonstrate that they were “qualified” to speak publically about their story of the journey from alcoholism to sobriety with the group. Betty explained the purpose of qualifying in AA, “Some places they call that, ‘qualifying.’ I ‘qualify’ to be here. I ‘qualify’ to tell you.”

It appears that telling stories that focus on the past, or the qualifying elements, more commonly occurred to members with less time in AA. Dianne articulated how she told her story early on:

It used to be when I spoke, I would start at the beginning and go through to the end, and you never had enough time for recovery or the end.

She continued to express how utilizing smaller amounts of time to describe recovery was not just an issue with time management in storytelling, but also a reflection of what was most pressing in her life at the time. In her early days of AA, alcoholic experiences were still most

vivid, so her stories reflected that emphasis. Later on as she obtained more years of sobriety, Dianne's story emphasis changed:

So what I learned to do over the course of time is switch from "This is what it used to be like, to "this is what it is like now"... That's really what you want to hear about. I mean, we all knew how to drink. We might have done it in different places and with different consequences and stuff like that, but basically we all knew how to drink too much and not be able to stop and that that kind of thing. What you want to know is, how do I stop?

Like, Dianne, many other women discussed how their preferred focus in storytelling was about the recovery process and sobriety. Brenda discussed her storytelling emphasis on what her life is like now, "The thing where I really focus my story is how my life has improved."

Rose explained exactly how she allotted her time more heavily towards discussing her recovery when telling her story at AA:

"I usually do that (qualifying) in about five or ten minutes, if I ever talk, usually that's all I do. But it's getting into the steps and how it's impacted our life..."

Meg also had specific lengths of time set aside for the various parts of the story when she spoke to the group that favored details about recovery:

I tend to spend more time talking about the recovery process. So, If I've got 45 minutes, I might spend 5 or 10 minutes on who I am and where I grew up, and how I got to AA, and then a little bit, another 5 minutes on how that happened that I got to AA, but then I'm going to spend half an hour on what life in recovery is like, and what my experience is with the recovery process.

For these women, sharing stories about early alcoholic experiences was viewed as necessary to “qualify” as a worthy speaker, but they believed that the majority of the story should focus on how women attained and maintained their sobriety.

Importance of storytelling for the listener.

Six out of 14 women also discussed the positive effects that the narrative process of AA had on the listeners of these stories. Several themes emerged including what aspects they benefit from as listeners, and what they perceive others as benefiting from listening to them. These included learning from others in the program, and identifying with the speaker’s story.

Learning from others in the program.

Another important component of listening to others’ stories, was hearing what others members of AA had gone through in their road to sobriety. Besides offering them a sense of clarity and comfort, the stories also contained useful suggestions for attaining and maintaining sobriety. Meg explained how particularly newer, younger members can learn from the stories of more experienced, older members:

In storytelling, that is the real benefit of meetings, in storytelling, is that somebody who’s 25 can come in and listen to somebody like me who’s 60 and I can say, “This is what happened to me,” or, “I didn’t think it would ever happen to me, but this is where alcohol took me. And if alcohol is taking you to places you don’t want to go, you don’t have to keep going until you’re desperate.”

Likewise, Nancy expressed the altruistic desire for members to share stories in order to benefit others in the program, “I think there’s a general feeling within AA that you want to share in hopes that you might help someone else.”

Listening to others tell their stories in AA was important because it allowed women the

opportunity to hear the stories and perspectives of other members. In turn, women benefitted by learning from, and emulating others' experiences.

Identifying with the speaker's story.

Women understood the importance of identifying with the speakers' stories, and the value of the listener finding commonalities with the speaker. Similar stories of struggle and grief around alcoholism that ultimately culminate in successful abstinence and better overall quality of life, offer listeners a sense of relief and salvation. Mary expressed the relief she felt as a listener in AA, hearing another woman's story that resonated with her:

I preferred speaker meetings where I was hearing other alcoholics share their story and it gave me hope, a lot of hope. And it made me feel like, "oh my god, I'm not the only one who feels this way, or behaves this way."

As a speaker, Hannah hoped that someone like Mary might relate to her struggles and be roused to make positive changes like she had.

It is a big important part of giving back, hopefully to get someone to be attracted to the program by your story and your sobriety and to say that, "yes, I felt like you feel and that they have something that I'd like."

The sense of connection attained by hearing one's own experiences echoed by others is a valuable benefit of storytelling in AA. Being able to relate to others' challenges and triumphs through the stories they tell, is integral to the success of the program.

Benefit to listeners a welcome "side effect."

The women articulated that storytelling is utilized foremost as a tool to help them maintain their own sobriety. Having positive effects on the listeners is a welcome result, but that is viewed

as secondary in importance—as a “side effect” of sharing. Susan expressed this perspective in her description of speaking at meetings:

So that’s good for me, and if it helps somebody else, great. But you see it’s helping me to stay sober. That’s the whole point of telling your story; it helps that person to stay sober.

At age 81, Louise was the oldest participant – she was 12 years older than the next oldest woman in the study. We met at her home, filled with pictures of her three children. She lived alone, and looked and acted years younger than her age might imply. Louise offered a unique perspective because she spoke, not just as a recovering alcoholic, but as a woman who by virtue of her age, had years of life experience behind her. She discussed her early drinking experiences as a teenager, and several efforts to attain sobriety until the final time, 29 years ago. Like Susan, Louise also explained that the primary reason for telling her stories is to maintain her own abstinence from alcohol:

And I’ve done what I can, and if telling my story to you, pretend you were an alcoholic, if that helps you in some way not continue to drink, then I’ve done a good job... And it’s about helping me. About helping me get it out and laying it on the table and letting people see dirty laundry, so to speak.

While there is clear benefit to listening to others’ stories in AA, older women generally held the act of storytelling at a higher level of importance than listening.

Discussion

Parker (1995) considered Atchley’s (1989) Continuity Theory of Normal Aging an appropriate theoretical framework through which to examine the concept of reminiscence. She asserted that “lifestories” (p. 521) were critical in creating continuity for older adults. Likewise, AA’s narrative processes can also be understood as “lifestories” through this framework.

AA members utilize two overlapping storytelling models: “what we used to be like (experience), what happened (strength), and what we are like now (hope)” (Jensen, 2000, p.11). These models merge perceptions about the past and present (negative alcoholic experiences, positive feelings about successful abstinence from drinking,) and incorporate conceptualizations of a productive, sober future. Often, the resulting AA stories are actually life stories, since they encompass decades, and in many cases, nearly the entirety, of the participants’ lives. Constructing these AA life stories (reminiscence) allows older women to verbally arrange the events of their lives into a streamlined story, achieving a sense of continuity as described by Parker (1995).

With the original research question, “How was the narrative aspect of AA experienced by the participants,” I sought to better understand the ways in which older women conceptualized and utilized the narrative process within AA. After carefully considering the women’s responses to this research question, it became clear that many women were actually articulating the importance of the storytelling process. Their descriptions of the value of constructing and sharing stories in AA supported Parker’s understanding of reminiscence. For older women in AA, composing and retelling life stories was also a critical component in helping them to acquire and sustain their sobriety. This research supports Parker and further asserts that storytelling (reminiscence) in AA can also specifically benefit older women with alcoholism or other addictions.

Conclusions

Storytelling was a critical component of the AA experience for older women, and its importance was expressed from the perspective of both the speaker and of the listener. Generally, the women believed that storytelling in AA had a meaningful purpose and was vital to the

program for attaining and maintaining sobriety. The women described the value of sharing their stories without being prompted by the research questions. Through this storytelling they were able to give back to the program, garner a feeling of acceptance and camaraderie, overcome anxiety about speaking in public, obtain necessary reminders about past struggles, and achieve a spiritual experience. However, there was also evident benefit from hearing others' stories as well. And while this study demonstrates more support for the positive effects of storytelling for the storyteller, it is important to note that there is gain from being the recipient of storytelling in AA such as learning from other members in the program, and identifying with the speakers' story. Future researchers should address women with more diverse socioeconomic and racial backgrounds. A larger geographic area also needs to be canvassed to include urban and rural areas in other areas of the country. Moreover, with one exception of a woman who was 81, the older women in this study ranged from age 52 to 69. Additional researcher should seek to obtain more information about women in their 70s and 80s.

Implications for Counselors

From a mental health perspective, there is value in reminiscence and storytelling. Through the construction of an oral history, older adults have the ability to piece together disparate events in their lives into a unified whole. In particular, seemingly random or unhappy past situations can be applied to the greater story, imbuing it with an overall sense of meaning. This can assist older women accept the challenges of aging by inviting them to recall, and then draw upon, previously used strengths to help solve present issues. Therefore, constructing and then sharing one's story instills a sense of continuity into an older individual's life view. As older women in AA derived many benefits from the storytelling aspects of the program, clinicians may consider that techniques incorporating reminiscence or other similar ideas involving a life review process may

prove effective in helping older female clients with alcohol or other addictions achieve a sense of resolution and purpose. Clinicians may also wish to consider that hearing an applicable story from an individual in a similar situation may also serve as an effective strategy when working with older female clients with alcohol or other addictions. In this vein, group counseling practices may be beneficial as an avenue for both sharing stories and listening to others' stories. Aspects of storytelling as a counseling technique for older women with alcoholism and other addictions should be further explored.

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Table 1.

Study Participant Demographic Information and AA History

	Age	Schooling (NF=not finished)	Years sober in AA	Years drinking before AA	What prompted AA?
Meg	61	Master's (NF)	15	33	Difficulty staying sober before annual blood work
Nancy	59	Master's (NF)	2	10	Nervous breakdown
Rose	64	Law school	27	21	Having to travel with husband's family sober
Susan	66	Bachelor's	34	18	Joined a group with AA members in it
Beth	58	Bachelor's (NF)	5	19	Didn't want to live the way she was living anymore
Betty	64	Bachelor's (NF)	25	22	Work identified it and she went to treatment
Brenda	56	Master's (NF)	27	15	Friends dying
Dianne	69	Bachelor's (NF)	32	20	Blacked out, forgot to pick up son
Ginny	57	High school	1	11	Car crash with son in car, drinking
Hannah	61	Medical school	5	14	Depressed, mandatory because of DUI
Linda	52	Master's	24	16	Boyfriend's ultimatum
Louise	81	Associate's	29	10	Realization that alcohol was killing her
Mary	58	Bachelor's	6	20	Lost job, mother died, taken to emergency room
Ruth	54	GED	17	27	In psych unit, realized she had same disease as parents

Table 2.

Data Analysis Process

Research Question		
How was the narrative aspect of AA Experienced?		
Theme		
Importance of Storytelling in AA		
Categories	A. Telling story: Effect on storyteller	B. Telling Story: Effect on listener
Subcategories and Supporting Codes	Sense of obligation to give back <ul style="list-style-type: none"> • Guilt • Gratitude • Obligation • Pay back • Pay forward Acceptance <ul style="list-style-type: none"> • Community • Love • Community • Belonging • Positive feedback • Caring Overcoming anxiety <ul style="list-style-type: none"> • Nervous beginning, • Fear of speaking, • Fear of judgment • Relief Reminding of past <ul style="list-style-type: none"> • Memories • Past sadness • Grateful for past • Telling stories about past Enjoys entertaining <ul style="list-style-type: none"> • Telling story fun • Entertainer Spiritual experience <ul style="list-style-type: none"> • Pray for guidance • Pray for words • Speaking is spiritual Boundaries/Over-sharing/Conflicts of Interest <ul style="list-style-type: none"> • Self-censoring • Over-sharing • Appropriate sharing • Job/AA meeting overlap • Share with sponsor Story focus <ul style="list-style-type: none"> • Qualifying • Story focus – recovery • Story focus – drunk-a-log 	Learning from others <ul style="list-style-type: none"> • Clarity from listening • Comfort from listening • Suggestions Identifying with speaker <ul style="list-style-type: none"> • Identify (relate) • Hope • Similarities • Relief Benefit to listener “side effect” <ul style="list-style-type: none"> • Story for me • Listeners Secondary

ARTICLE THREE

Unexpected Social Benefits of AA for Older Women

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Abstract

For this research, twenty-seven interviews were conducted with 14 women age 50 and older in Alcoholics Anonymous (AA) to explore the participants' most beneficial and meaningful experiences in the program through a phenomenological qualitative study. AA, a worldwide organization specifically designed to aid alcoholics who want to stop drinking, integrates the concept of fellowship and social support into the core of its program. Although there is an inherent social component to the AA meetings themselves, findings from this study suggest additional valuable social benefits from participation in the program for these women including: forging new relationships with other women, a sense of comfort and security derived from social interactions in AA, support beyond sobriety, and common activities transcending AA meetings. Also explored was the phenomenon of AA and romantic relationships which proved to have both beneficial and undesirable outcomes, as well as women's perceptions of what they benefit from socially by being female as opposed to male. While social engagement has been generally shown to correlate with positive physical and mental health outcomes, results from this study are noteworthy because social networks are particularly difficult to cultivate and maintain in the older population.

Unexpected Social Benefits of AA for Older Women

“We’ve known you forever when you walk through that door.” – Hannah

Social interaction promotes healthy and successful aging, especially in women, yet, as women age their social circles shrink (Katz, 2002). The constriction of companionship circles may occur by circumstance (death of spouse) or by choice (disinterest in making new friends). Among older adult women active in AA, the interactions inherent in AA meetings may fill at least some of that companionship vacuum, but it is also the less-obvious extra-meeting socializing among the cohort that, this study will demonstrate, provides a meaningful and surprisingly robust social outlet. The researcher found strong bonds extending beyond the formal confines of AA meetings, and into roles typically filled through deep friendships, such as chauffeuring those who cannot drive, helping friends through illness and hospitalization, counsel and support beyond listening to friends’ problems centered on drinking, and co-attending everyday events like shopping and group dining. The outside-the-meeting friendship structure was found to be not only vital, but also nearly unanimous among those interviewed for this study.

Older Women and Decreased Social Interaction.

Older women frequently experience decreases in their social networks due to death of spouses, family members, and friends. Often these women, particularly those who are homebound, live alone and experience limited daily contact with other individuals (Katz, 2002). Older women also experience the reduction in social contacts that accompanies retirement because daily connections may decrease precipitously once they no longer have the interactions with co-workers (Cornwell & Waite, 2009). In particular, older female alcoholics may experience a sense of isolation due to feelings of shame and guilt around their alcoholism. They

may perceive a societal disapproval of older women drinking, and as a result, they avoid contact with others in order to hide their addiction (Davis, 1997; Katz, 2002).

Theories related to older adults and decreased social interaction.

Cumming and Henry (1961) established Disengagement Theory which posits that, “Aging is an inevitable mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social systems he belongs to” (p. 14). Moreover, as adults move from middle- life to an older-adulthood, they distance themselves from other people and alter their relationships (Cumming & Henry).

However, having fewer social contacts is not always due to external factors like death of family and friends or retirement. It is important to recognize that older adults, even those without significant losses, may choose a smaller social network. The Socioemotional Selectivity Theory (Carstensen,1993) holds that when individuals perceive their time left to live as limited, as is the case with many older adults, they shift focus from information-seeking sources (commonly found in relationships with unfamiliar people) to emotional-regulating sources (most commonly found in already-established relationships with children or other close family). Therefore, social networks may decrease, but only because older adults are more selective about whom they choose to include. Whether social networks shrink as a result of circumstance or choice, the result of these smaller networks is that substance abuse can easily go undetected and there are fewer systems in place to support treatment (Carstensen, 1993; Carstensen, 1995).

Social Engagement and Mental/Physical Health.

Theories related to older adults, social engagement, and successful aging.

There is substantial research to suggest that social engagement lends itself to a more positive aging experience. Contrasting the inevitable detachment of older adults from greater

society inherent in Disengagement Theory, Activity Theory, a model of successful aging, (Havighurst, 1953; Havighurst, 1961) is defined as: “The maintenance as far and as long as possible of the activities and attitudes of middle age” (Havighurst, 1961, p.8), and specifically includes behaviors and outlooks related to social engagement. This idea of successful aging linked to social engagement was later reiterated by Rowe and Kahn (1987) to demonstrate the connections between social engagement and positive health benefits. Rowe and Kahn (1997) later explained that successful aging can be viewed from sustained engagement in social and productive activities. Two subgroups of this are: “1) interpersonal relations, (which include) contacts and transactions with others, exchange of information, emotional support, and direct assistance and 2) productive activity, which creates societal value, regardless of reciprocation” (pp. 433-434).

Social engagement linked to better mental and physical health.

Cacioppo and Patrick (2008) described loneliness as causing an alteration of emotional balance, and reducing feelings of happiness normally felt by seeing others who are happy. Other studies have further suggested that social support and engagement are linked to positive outcomes in physical and mental health. Cohen and Wills (1985) noted that the association between social support and wellbeing may be either the result of the support (main effect model) or some type of buffering mechanism (buffering model) that protects the individual from stressful events. In a meta-analysis, Holt-Lunstad, Smith, and Layton (2010) reviewed 148 prior studies with more than 300,000 combined participants and found a statistically strong link between both morbidity and mortality. They determined that individuals with adequate social interaction have a 50% better chance at survival than those without, independent of age, gender, initial health status, and the eventual cause of the participant’s death. The authors equated the

importance of social relationships with other well known and influential epidemiological risk factors like smoking, diet, and exercise. This may suggest a measurable health benefit attributed to the kinds of deep and broad social interactions that the participants in this study reported.

Studies specific to older adults.

Lemon, Bengston, and Peterson (1972) linked social activity with friends to life satisfaction among older adults in a retirement community. Hooyman and Kiyak (2010) explained the potential outcomes of social supports for older adults: “physical and mental well-being, feelings of personal control, autonomy, and competence, successful aging, reduced negative effects of stressful life events (bereavement and widowhood), and reduced mortality risk” (p. 277). Unsar, Erol, and Sut (2009) found a positive correlation between increased social support levels of older adults and the quality of life scores. Buchman et al. (2009) highlighted that older adults who participated less frequently in social activities had a more rapid rate of motor function decline. The research clearly demonstrates a range of healthy aging decisions, which are all impacted by social supports.

Alcoholics Anonymous (AA).

AA’s primary goal is, of course, sobriety, but integral to the program are the group meetings that incorporate an inherent social component. AA may therefore serve a secondary function as a social outlet, and for this subgroup of older adult women, that secondary function may be particularly important. AA was developed circa 1935 as an approach to alcoholism recovery by alcoholics Bill Wilson and Dr. Bob Smith (Alcoholics Anonymous World Services, 2001). Common wisdom in the medical community at that time was that alcoholism was a hopeless condition. Wilson and Smith incorporated ideas from the Oxford Group, a nondenominational Christian movement that focused on self-improvement through self-

inventory, admitting wrongs, making amends, exercising prayer and meditation, and carrying the message to others (www.aa.org). Eventually, they described these ideas in a text known as “the Big Book,” that emphasized the 12 Steps of AA (Davis & Jansen, 1998).

The only requirement of AA members is a desire to stop drinking. They meet in groups as often as needed and there are no fees or dues associated with membership. Their primary purpose is to attain sobriety and help others to realize that goal. It is a fully self-supported organization that does not accept donations from non-members, and individual members are limited to giving no more than \$3,000 per year. AA is an anonymous group with an aim for achieving complete abstinence, upholding the motto, “one day at a time.” AA meetings may be open (anyone is welcome to attend) or closed (only alcoholics may attend). In addition, meetings may be mixed gender or be specialized for subgroups such as all-women or gay and lesbian. It is estimated that there are more than 117,000 groups and over 2 million members in over 180 countries (www.aa.org).

AA and Fellowship.

AA was viewed as a social organization from its onset. In the forward to the 1st edition of *The Big Book*, the AA group is labeled a “Fellowship” (AA World Services, 2001, xiii). In 1947, AA’s publication, *The Grapevine*, included “The AA Preamble,” further establishing the importance of socializing in the AA recovery program:

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism (www.aa.org).

Machell (1992) further identified fellowship as, “client perceived belongingness,” and discussed the importance of the concept of fellowship in AA (p. 1). His research suggested a

clear relationship between an individual's perception of fellowship and his successful treatment outcomes at a residential treatment center for alcoholism. Thus, AA members rely on one another's support and social interaction to attain and maintain sobriety and fellowship is a cornerstone of the AA program.

Women and AA.

Historically, women's alcoholism was not considered as legitimate as men's and was believed to have different root causes (The National Center on Addiction and Substance Abuse at Columbia University (CASA), 2006). Alcohol abuse was viewed as more of a "sin" for women than for men, and it was not uncommon for women who suffered from alcohol abuse to be stigmatized and denied treatment (Nakken, 2002). Early years of AA reflect this inequality. Literature illustrates that some men did not believe that women could even be alcoholics, and were uncomfortable being at meetings with women. To this end, women in AA were forced to sit on the other side of the room from men, and single or divorced women were viewed as a threat by the wives of the men in AA. The mid-1940s brought about some change, as the existence of women and alcoholism was acknowledged, and special women's groups were created to address "women's issues." These women's groups were still stigmatized, however, and women were hesitant to join for fear of being negatively perceived (CASA, 2006). Early language of AA addressed men and included only masculine references. When women were mentioned, it was assumed that they were the wives of alcoholic men. It was challenging for women to translate the overtly male-dominated missives of AA into language that could be applied to their gender. For example, an alcoholic male may exhibit anger, violence, or abusive behaviors, while women may demonstrate depression, anxiety or withdrawal from others (Nakken, 2002). In order to benefit from their AA experiences, women needed to somehow reconcile those experiential differences.

(Nakken, 2002). Although nearly one-third of all AA members are now women (CASA, 2006), chauvinism and male-dominated language still exists in AA's literature and in the attitudes of some of its older male members (Nakken, 2002). Some of the participants in this study expressed frustration at the dismissive brand of sexism that causes women to feel that their opinions and needs are less than those of the men in the group, and/or the predatory sexism inherent in unwanted sexual innuendo and advances. It should be noted that not all participants expressed the idea of sexism as commonplace in AA, and others suggested it to be fertile ground for dating.

Methods

The interviewer employed a qualitative approach and a phenomenological interview process to better understand the lived experiences of older women in AA. In particular, this study centered on the research questions:

1. What aspects of AA do older women consider beneficial?
2. How did these older women elicit meaning in their involvement with AA?

An interview guide was used to assist in exploring the research questions through the following interview questions:

1. What about the AA program is helpful to you?
2. How does being female affect your experience of AA?
3. How does being an older adult affect your experiences of AA?
4. I'm interested in hearing more about your experiences in AA in terms of meetings, sponsorship, fellowship and service. What aspects of AA are particularly meaningful?

Through these interview questions, the researcher discovered unexpected social benefits acquired through participation in AA which are the focus of this research.

Participants.

Fourteen older women in AA participated in the study. To be eligible, participants were required to be female, active members of AA (attended meetings on a weekly basis), and were age 50 or older. Women in the study ranged in age from 52 to 81 and were all Caucasian. They had varied maximum educational levels: three graduated from graduate school, three completed some years of graduate school, two completed a Bachelor's degree, one completed an Associate's degree, three completed some college, one graduated high school, and one obtained a GED. Many of the women had anemic family support: ten of the women had no spouse nor life partner, about one-third had no children, and about two-thirds had no grandchildren. Eight women were employed, five were retired and one was between jobs. In terms of salary and schooling involved, professions ranged from blue collar (custodian) to white collar (physician). In addition, all but one woman had attended at least one all-women's meeting, and two women currently only attended all-women's meetings. Table 1 gives a detailed description of each woman's specific experiences.

Procedure.

Fourteen women were interviewed in mostly face-to-face sessions over a one year period. For all but one participant, two interviews were conducted, for a total of 27 interviews. The participant who completed only one interview experienced a relapse between the first and second interviews and it was feared that further interviewing might compromise her efforts towards sobriety. The second interviews occurred within four weeks of the first. Three second interviews were conducted over the phone due to illness or scheduling difficulties. Typical sessions lasted one to two hours and were held in private homes, offices, and eating establishments to ensure that the participants felt comfortable, and that privacy could be ensured.

Because of the closed nature of the AA community, a confederate, who is an AA member assisted with the recruiting of women who met the study's criteria. This was a fairly homogeneous sample racially (white), socio-economically (upper-middle class), and geographically (living in and around a small urban community in southwest Virginia). In every case, strict measures protected the confidentiality of interviewees including assigning pseudonyms in the transcripts and obscuring all identifying information. The women were each forthcoming and many were interested in this research as a way of giving back, so study results will be mailed to all participants upon completion.

Limitations.

Because the women were all obtained through a single recruiter (who often recruited women she knew from fellow meetings)this sample was not particularly diverse in terms of race, socioeconomic background, or geographic area. Moreover, with the exception of one woman (81 years old), the demographic leaned more towards the “young old” as the rest of the women ranging in age from 52 to 69.

Data Analysis.

The researcher aimed to depict detailed and accurate descriptions of the data by personally transcribing the interviews (over 300 pages) from the audio recording, adding additional notes with observations about the participants' nonverbal behavior and information about the setting from the researcher's field notes. In addition, participants were sent a typed transcript for review within four weeks of each interview to preserve clarity and accuracy. After a scrupulous review of the transcripts, the researcher highlighted excerpts that reflected a better understanding of the research questions. A constant comparison method was later employed to open-code these excerpts with an eye for incorporating analogous and differing experiences. Next, these open

codes were grouped into categories and subcategories from which the researcher later developed broader themes that addressed the research questions (Rossman & Rallis, 2012; Saldaña, 2009). Table 2 gives a detailed explanation of the data analysis process (supporting codes, subcategories, categories, and themes) that directly address the research questions. The researcher sought to obtain “thick” descriptions of the data that were rich with detailed information about the participants and their experiences (Creswell, 2013; Creswell & Miller, 2000; Patton, 2002). Transcripts were also reviewed by a second researcher who confirmed that all important concepts were included and assisted with the process of identifying constructs. Finally, interviews with participants displayed similar themes throughout their experiences, indicating strong internal consistency. However, divergent themes were also recorded and noted as important when interpreting the findings.

Findings

A major benefit and mechanism for eliciting meaning in AA involved social interactions. Although the AA fellowship offered an inherent social component (AA meetings are social by nature with members converging in one room and chatting informally before and after the meetings,) the women discussed additional social benefits that they acquired from participating in the program that went beyond attaining and maintaining sobriety. Two themes emerged including (a) relationship benefits in AA, and (b) Unexpected support and activities beyond AA. Within these themes, categories cited by the women were (a) the value of forging new relationships with other women, (b) the sense of comfort and security derived from social interactions in AA, (c) the support not always associated with attaining and maintaining sobriety, but rather presented as an end unto itself, (d) the support instrumental in other areas like smoking cessation, health issues, and day-to-day ups and downs, (e) the engagement in social activities

with other members that exceeded the confines of the meetings, providing additional avenues for support, (f) the occurrence of romantic relationships in AA, and (g) their perceptions of social benefits for women versus men in AA. Detailed description of themes, categories, and supporting codes are presented in Table 2.

AA's role in forging relationships with other women.

While the importance of fellowship in AA was commonly discussed, five of the women specifically mentioned the significance of forming relationships with *other women* within the theme of relationships. They discussed the value of their female friendships in AA, many of which had been sustained for decades. In particular, the sponsor/sponsee relationship was cited frequently as an avenue of continual and vital female support. It was not uncommon for women to have come into AA without ever having obtained significant female relationships prior to joining. AA often provided the only avenue for women to finally forge essential female friendships that were described using familial terms like, "sisters in sobriety." Ruth, 54, met me in her home. She was working as a janitor with 17 years of sobriety in AA. Ruth's perspective was unique because she grew up in a home with two recovering alcoholic parents who were a part of AA. Ruth drank for 27 years before joining AA, and she discussed that once becoming a member, she was able to obtain valuable friendships with women that she had previously lacked:

Well, I can tell you that as a woman, I have changed a lot because before I got sober, I didn't have a whole lot to do with women. I was one of the guys, you know? Since I've gotten sober and I work with a lot of women, I've really gotten to really love women where I didn't before. They were competition.

Like Ruth, Beth, 58, also expressed her appreciation for the female friendships obtained in AA. Beth was a professional, had five years of sobriety, and drank for about 19 years before she

entered AA. When I met her in her home, she expressed frustration about her long commute to work which severely limited the time she would normally spend at AA meetings. She explained that unlike Ruth's situation, she did not drink with the "guys." Instead, she isolated herself and drank alone.

I am very grateful that I've had the women in AA. I have so many wonderful friends that are true friends — girlfriends...because as a woman who drank at home, finding friends in the fellowship was very important to get me out of the house and form relationships with other women that had a common bond with them.

For many women, the absence of early healthy relationships with other women was problematic. Linda, 52, a professional in the counseling field with 24 years of sobriety, explained that she did not have a particularly strong relationship with her mother, and began drinking as a young teen. She said that she was able to compensate for the lack of a close maternal relationship through friendships with older women in AA:

For me the meaningful thing is being able to have another woman that I can have a really honest and open relationship with. And I feel like some of those women it just so happens have been older and that's really helpful because I don't really have a great relationship with my mom, so having a place where I can have an opportunity to have that unconditional love from another woman...

For some older women in AA, there was an absence of strong female relationships upon joining the program. Women cited the ability to form and maintain new female friendships as major social benefit of participating in the AA program.

General sense of comfort and safety.

Through the AA fellowship, and the relationships established through this process, the women found more intimate feelings of comfort and safety. They discussed a certain level of security when meeting with their “home group,” and being welcomed at meetings by “smiling faces.” Rose, 64, a retired political staffer with a prominent career and 27 years of sobriety behind her, shared her happiness and relief upon running into AA members outside of the meetings as “little touchstones all over town.” Likewise, Louise, 81, a retiree with 29 years of sobriety, expressed this sense of security metaphorically, “Whenever I’m in a meeting I feel very safe, very comfortable, sort of like sitting on your mama’s lap.” Meg, 61, a retiree with over 14 years of sobriety, and a close friend of Rose’s, explained that the sense of security even transcended the boundary of the meetings:

It is interaction, so, if I just feel lonely, and there aren’t any meetings at that time that I can go to, I can call somebody up. And that’s just interaction, communication with another person who I feel comfortable with.

Likewise, Hannah, 61, a physician with 5 years sobriety, also mentioned being able to “pick up the phone” to speak with other members who “know exactly who you are.” Brenda, 56, a case worker, had maintained her sobriety for 27 years. We met at a restaurant where she articulated the uniquely intimate qualities of her friendships in AA:

There’s no sniping, there’s no insecurity, we’re comfortable with each other, and we’re at the stage in our lives where we really understand how much we need one another.

Participation in AA provided a sense of support and security that older women greatly valued. Knowing that supportive members were easily accessible in person or through the telephone at any time of day provided the women comfort and peace of mind.

Support beyond sobriety.

The AA fellowship provided support for attaining and maintaining sobriety, but the interactions in AA also offered support for other facets of the women's lives that were completely separate from issues of drinking. Louise talked about her AA group's assistance in helping her to stop smoking. Dianne, 69, a retiree with over 31 years of sobriety, was recovering from a bout with cancer that had rendered her bed-ridden for several months. She explained how difficult it was maintaining sobriety when she was physically unable to attend meetings. At the present, she had regained mobility, and was feeling better. She expressed gratitude towards the women in AA for supporting her when she was being treated for her illness:

And of course a tremendous amount of my support came from (the AA experience), and friends that I've had for years, twenty some years, stuff like that.

Dianne further described how her AA friends provided meals and visited her in the hospital. Other women cited obtaining support in AA through the day-to-day ups and downs. Rose explained:

“That group has been with me through parents dying, divorce, crazy sister, work stuff, hip replacement, all the life stuff...we sort of get to do life with each other, it's a real community.”

The support offered to the women through the AA fellowship exceeded the confines of sobriety and included support for many other life challenges as well. Women expressed their gratitude for this assistance, considering it another valuable social benefit of AA membership.

Common activities beyond AA meetings.

Women described their fellowship activities as extending beyond the rooms of AA. Most commonly mentioned was meeting for dinner, coffee, or dessert after an AA meeting. But

beyond that, the women explained that individuals who joined at similar times formed a “cohort” or “clique” and often socialized as a group outside of AA meetings. In Linda’s words:

But fellowship is huge, and when we were in (state) I think I told you that (daughter’s) dad was really connected and had gotten sober with this group of people about the same age and they became a really great support system and we all did stuff all the time together so I’ve been a part of that.

Betty, 64, a retiree with 25 years of sobriety, described going shopping with her “AA buddy” and more significantly, spending Christmas with AA friends listening to Christmas carols. Another, sometimes significant, obstacle that older women faced was accessing meetings, as some did not drive due to health issues. Once again, the AA fellowship exceeded the meeting boundaries as other members readily volunteered to pick older women up or take them home. Rose discussed going to dances and parties with AA friends, and Dianne mentioned camping and playing sports. She elaborated on the importance of extracurricular events with other AA members:

It helps, especially early on, it helps you connect...with safe people, something in common. Something with people you probably would be friends with anyway.

Louise maintained a relationship with a fellow AA member long after he moved to another state. She recalled that he still stops to see her on his way to visit family in the north. The relationship encompassed much more than support for sobriety, and Louise is close with his entire family.

While friendships may be initially developed because of the common AA meeting experience, many women’s relationships extended beyond the meetings into other social

activities. Women described the social benefits from these meaningful non-AA related social activities with fellow AA members.

AA and romantic relationships.

The women spoke of romantic relationships within AA in both positive and negative terms, with preponderance towards the negative. The most common grievance cited was a phenomenon called, “thirteenth stepping,” where men take advantage of a woman’s vulnerability (especially a new female member) by making advances towards her at meetings. Meg explained that an alcoholic woman in AA may erroneously turn to a relationship as a means to gain strength:

And when you’re vulnerable and you’re looking for power, it’s easy for someone to swoop into your life and try to exert power. And that’s not what AA is, AA is about a higher power, a non-human power.

Beth discussed how detrimental 13th stepping can be to the recovery process for a woman:

I guess the one thing that comes to mind, is that not all people who go to AA are decent human beings. A lot of men come to AA meetings looking for dates...it’s bad because when people come into AA, they’re at a low point in their life and they’re seeking help and they’re very vulnerable to someone who shows them affection or kindness and they can get hurt, and send them back out, where they could have improved their life and stayed in AA, they’ve gone away because of their experience.

Mary, 58, a professional in the banking industry with 6 years of sobriety, articulated the difficulty for some women in avoiding the 13th stepping:

My older sister was in AA for a while, and she would have been early 40s, maybe 40 or thereabouts. And I remember her telling me it’s constant getting hit on to the point where she was so disgusted.

However, while there are many complaints, it is important to note that this behavior did not occur every time in every meeting. Women explained that it was dependent on the presence of specific male members and the unique tenor of the particular meeting. On the other hand, several women acknowledged a benefit in a romantic involvement with a fellow AA member. Linda discussed having dated, and been engaged to, two men in AA. Dianne expressed the practicality of having a romantic relationship with a fellow AA member because of common goals:

And then when you were going to meetings, you were looking, too. Because you did kind of prefer to get in a relationship with someone that was in the program because there's a level of understanding if both of you are working the program.

While fraught with the complication of 13th stepping, there still appear to be some positive aspects associated with inter-membership dating in AA. Unlike the other subcategories articulated in this paper, romantic relationships can be viewed as both detrimental and as a social benefit. Moreover, the opportunity for a romantic relationship appears to be readily available if desired. For an older woman looking for a relationship with an individual with common experiences, AA may still be considered a likely place to find a partner.

Women's perceptions of social benefits of AA for women versus men.

Another category under the theme of relationships in AA is women's perceptions of the social benefits of AA for women versus men. These differences for women involved their emphasis on feelings, their relationship within the AA group, and their outcome of improved external relationships.

Women discussed that one difference between women and men is women's tendency to focus more on the emotional. Rose explained:

Women talk more about feelings...some of this comes from some of the guys at AA who say, “Yeah, and then we go to those meetings and those women they talk about their *feelings.*”

Susan elaborated on the idea of women’s emphasis on feelings, but noted that that emphasis may actually be a benefit to women in their quest to attain sobriety.

We are feeling people, so we are able to get to our feelings sooner than men. All of us drink so we don’t have to feel. We’re also talkers and we share, it’s easier for us to share than for a man.

Women also discussed the inherent relationship differences between men and women in AA. On balance, they believed that men generally were more competitive with one another while women had a more cooperative relationship. Meg noted these differences between men and women in AA. She likened these fundamental longstanding divisions as necessary due to biology:

Men are competitive, men are combative, and they have to be in able to be the providers and the protectors. Women are nurturers, we have to be, to keep the home fires burning, to put up with pregnancy, to take care of infants, until they can take care of themselves some. We are by nature more nurturing and the guys are more competitive.

Women perceived that another social benefit of AA that was unique to them as female was its link to relationships. Linda explained the importance of discussing relationship issues in AA, and that all-women’s meetings may offer her more opportunity to engage in that discussion than in mixed gender meetings:

I might talk about some of the challenges with using the twelve steps and using the program through more relationship stuff, and maybe more parenting as a mom. And just as

a woman in the workplace....so maybe that kind of information would become more relevant...my experience in the program, my work, as a mom...

Expanding on that, Beth viewed AA as a vehicle by which to ultimately improve her external relationships. She discussed lessons garnered from her own experiences, as well as from other women at AA; “I would say that as a woman being in AA the benefits are that it gives a woman more self esteem which would help in relationships – boyfriend, husband, mother, daughter.”

It’s important to note that not every woman perceived a difference in social benefits between the genders. Nancy expressed her belief that the male and female experience in AA is similar in most ways:

The journey that a man goes through and a journey that a woman goes through are pretty much the same of letting go of trying to control things and accepting life on life’s terms.

For many older women in AA, there is a perceived social benefit to being female versus male. Women viewed themselves as benefitting from being more emotionally connected to themselves and others, as well as from having a more cooperative relationship in AA than that of men. Their stories in AA had a focus on relationships, and the program also helped them to improve their external relationships. However, not every woman believed that there were uniquely female benefits to being in AA. Some contended that despite having different genders, the AA program could be understood as equally impacting men and women.

Discussion

Previous research suggested that older adults, particularly older women, encounter impediments to finding and creating social outlets. The reasons may be retirement, immobility, death of family or friends, or self-imposed isolation. Moreover, alcoholic women may have the

added stigma of embarrassment or shame that further isolates them. In parallel to these studies, many of the women interviewed are retired and discussed the losses in their lives from divorce or death of companions (of the 14 women, four were married or had a life partner). While they did not directly address how AA helped them remain engaged socially despite these losses, there was a universal sense of gratitude for their involvement in, and social benefits derived from, the program. Moreover, many social activities with non-AA adults involve alcohol, adding a challenge to friendships outside AA and putting a further premium on those inside the program.

Havighurst (1953; 1961) and Rowe and Kahn's (1987) research demonstrated links between continued social engagement in old age (Activity Theory) and successful aging. Supporting this, women in the study generally attributed physical health benefits (being sober) and mental health benefits (acquired coping mechanisms, self confidence and a feeling of acceptance) to their continued involvement with the AA fellowship. The relationships forged in the program were intimate, nourishing, and encompassed much more than just support for sobriety within the meeting boundaries.

As social engagement is linked to successful aging (Havighurst; Rowe & Kahn), AA provides older women a unique venue for not just obtaining sobriety, but for meeting their social engagement needs. In the interviews, women were not only universally grateful for the sobriety, but many were also happy for the friendships. The interviewer was surprised by the easy social nature of the women in the study. Many of them endured difficult personal histories before drinking, and each suffered the pain associated with the alcoholism itself. This, plus the research linking older women and shrinking friendship circles might otherwise suggest an introverted disposition among participants. Yet in interviews these women were at ease. With the exception of the one participant who relapsed before the second interview could take place, they were not

sullen, shy, or socially uncomfortable in the way one might expect in people with such life trauma. Nor did they express excessive levels of self-deprecation, self-consciousness, materialism or competitiveness. The researcher found the women to be at peace, positive, excited about their lives, enthusiastic for what the next day might bring, and kind to themselves. They possessed an unusual level of comfort to being open in discussing their lives, which might be a result of an AA program that puts a premium on sharing life stories in meetings.

Conclusions

The complexity and prominence of AA friendships in the lived experiences of older women in AA was not asked about or expected (or even suspected) but rather, grew organically, first from the interviews themselves, and then further crystallized upon interview coding. While the researcher probed the most important aspect of fellowship, it was not conceptualized as being a relationship beyond the confines of the meetings or transcending the topic of sobriety. Through the course of the interviews, it became clear that socializing among this population was not just a small advantage, but a core benefit of AA membership. These friendships are likely important across the AA demographic, but the research suggests that this particular population of older women (1) faces specific challenges to social engagement, and (2) garners social benefits from AA. Involvement in the AA program provided older women with avenues for social engagement that encompassed all aspects of their lives.

Although these women were all in a small urban area in Virginia, their experiences may resonate with women or men from other age ranges, and other geographical areas. Care, however, must be taken when generalizing the results of any qualitative study. Although these themes seem to have a universal element to them, they may only be representative of the participants in this study.

Future studies are recommended that follow up with a variety of geographical areas and/or studies that develop an instrument to conduct larger-scale surveys to discern if these themes are endorsed more broadly. Future researchers may wish to further explore the social benefits of AA for older women, and *start* with interview questions designed to measure and map friendships in AA. Participants reported uncomfortable moments in social gatherings with AA friends and those friends' non-AA spouses. Since AA meeting content is confidential, participants were not sure how much information to disclose to their friends' non-AA spouses for fear that they might breach a confidence. It may therefore be useful to compare the special circumstances of AA friendships with other friendships outside of AA. Because social engagement is linked to successful aging, it might be valuable to explore whether older women with the social benefits of AA are perceived as aging more successfully than other older recovering alcoholic women who are not affiliated with the program. Further, were data available, one might compare mortality and morbidity for recovering alcoholics in AA and compare them to data from recovering alcoholics outside group programs with an eye toward the benefits of socializing.

Gerontologists, social workers, and counselors addressing older women struggling with alcoholism might wish to discuss AA's social benefits and their links to successful aging. Further, care providers, educators, and students might emphasize the social benefits of other support groups (group therapy, Narcotics Anonymous) and encourage clients to actively pursue what might otherwise be a non-obvious opportunity for establishing friendships. Professionals engaged in group counseling, especially those associated with older women and/or addictions issues, might work to emphasize the social component of the group itself, *beyond the counseling realm*. Encouragement might be offered for members of the group to meet between or beyond therapy sessions. For those who are introverted, shy, or find socializing difficult, a "prescription"

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from a healthcare professional to seek friendships from within the group might ignite a friendship network that inertia would have otherwise stymied.

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Table 1.

Study Participant Demographic Information and AA History

	Age	Race	Married or life partner?	Number of children (* = partner's children)	Number of grandchildren	Years drinking before AA	Ever attended a women's only meeting?	Also attend co-ed meetings?	Career
Meg	61	White	N	0	0	33	Y	Y	Retired
Nancy	59	White	N	1	0	10	Y	N	Career counselor
Rose	64	White	N	0	0	21	Y	Y	Retired lawyer
Susan	66	White	N	3	6	18	N	Y	Patient care coordinator
Beth	58	White	N	1	0	19	Y	Y	Account Representative
Betty	64	White	Y	2	11	22	Y	Y	Retired
Brenda	56	White	Y	2 *	1	15	Y	N	Case manager and HIV testing in prisons
Diane	69	White	Y	1	2	20	Y	Y	Retired
Ginny	57	White	N	2	0	11	Y	Y	Laid off
Hannah	61	White	N	0	0	14	Y	Y	Doctor
Linda	52	White	Y	1	0	16	Y	Y	Social worker
Louise	81	White	N	3	7	10	Y	Y	Retired
Mary	58	White	N	0	0	20	Y	Y	Banking and management reporting
Ruth	54	White	N	0	0	27	Y	Y	Custodian

Table 2.

Themes, Categories, and Codes

Research Question		
What aspects of AA do older women consider beneficial/elicit meaning from?		
Article Title		
Unexpected Social Benefits of AA		
Themes	A. Unexpected Relationship Benefits and AA	B. Unexpected Support and Activities Beyond AA
Categories and supporting codes	Relationships with other women <ul style="list-style-type: none"> • Female support • Previous female friends • One of the guys • Relationship with mother Comfort and safety <ul style="list-style-type: none"> • Security • Touchstones • Feeling understood • Accessibility Romantic relationships <ul style="list-style-type: none"> • 13th stepping • Vulnerability • Common bond - romantic Perceived social benefits of women vs. men <ul style="list-style-type: none"> • Women – emotions • Women - cooperative • Men – hierarchical • Men – combative • Stories – relationships • External relationships - women • Women/men no difference 	Support not AA <ul style="list-style-type: none"> • Stop smoking • Health issues • Family Issues Other activities not AA <ul style="list-style-type: none"> • cliques • Holiday celebrations • Dinner/Coffee • Camping • Dances • Friendships outside of meetings

CHAPTER FIVE

Conclusions

The purpose of this study was to explore the lived experiences of older women in AA. I sought to better understand the experiences of being in AA with a particular focus on how the women understood the narrative processes inherent in the program.

In chapter one, I offered an explanation of the necessity of exploring a population which is nearly nonexistent in scholarly literature, and I also outlined my plan for addressing my research. Through my study, I am able to add to a very limited body of knowledge, hopefully setting the stage for greater understanding of older women in the AA program for health care professions and educators alike.

Chapter two provided a detailed literature review to help the reader better understand the concepts outlined in my research. Of greatest importance was the growing problem of older women and alcoholism, an overview of AA, what is currently known about older adults and women in AA, and the evident dearth of knowledge integrating the two. This absence of research supports my justification in choosing this topic.

Chapter three explained my choice of methodology. A qualitative approach was selected that employed a phenomenological interview process with the intention of garnering a detailed depiction of what being an older woman in AA is like in the women's own words. Two in-depth interviews were conducted to better understand how older women perceive their experiences in AA. Other concepts that were discussed were participant selection, ethical considerations, and the process of data collection and data analysis.

I authored three manuscripts to describe some of the findings of my research. The first article, *The Intersection of Narrative Therapy and AA Through the Eyes of Older Women*,

explored the parallels between storytelling in narrative therapy, and the narrative component of AA. Both utilized a similar three stage process, and also shared the characteristic of continuously evolving stories. Recommendations for clinicians who work with older women with addictions were discussed.

The second manuscript, *The Importance of Storytelling for Older Women in AA*, explored the ways that the narrative, an integral component of the AA program, is vital to older women, and the benefits derived from participation in that activity. Findings suggested that there are a number of benefits for the storyteller including an avenue for giving back to the program, acceptance and feeling a part of the group, overcoming anxiety about public sharing, reminding the speaker of her past struggles, having a spiritual experience, understanding boundaries, oversharing, and conflicts of interest in storytelling, and story focus. While listening to stories being told in AA was not deemed as valuable as speaking, it was still found to be a welcome “side effect” of the narrative process. Benefits to listeners include learning from others in the program, and identifying with the speaker’s story. Recommendations to clinicians were also suggested.

Finally, the third manuscript, *Unexpected Social Benefits of AA for Older Women*, explored the ways that older women derived social benefits through their involvement in AA beyond the inherent social qualities of the fellowship in meetings. These social benefits often exceeded the boundaries of the meetings themselves, and addressed issues beyond sobriety. They included: forging new relationships with other women, a sense of comfort and security derived from social interactions in AA, support beyond sobriety, and common activities transcending AA meetings. Also explored was the phenomenon of AA and romantic relationships, which proved to have both beneficial and undesirable outcomes. Findings are particularly significant because the older female population is one that often has difficulty obtaining and maintaining social connections.

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APPENDICES

Appendix A

Recruitment Script

Thank you for giving me a few moments to talk to you. I wanted to tell you about my friend, Lauren Ermann. She is working on her PhD in counseling at Virginia Tech and is doing research to find out more about how women age 50 and older experience the fellowship of Alcoholics Anonymous. Basically, she wants to hear about your program - meetings, sponsorship, fellowship and service. If you want to be a part of this study, she would meet with you two times in a location that is comfortable for you for about 60 to 90 minutes each time so that she could ask you a few questions, but mostly so she could listen. Counselors don't really understand what it's like for women age 50 and older in the AA fellowship – there has not been a lot of research done in that area. You would be helping Lauren gain new information so that counselors and others will have a better understanding of what AA means for women like you. I can assure you that every aspect of her research will be kept confidential – she won't use your real name or any other details that would identify you. She would be recording your interviews with an audio recorder so that later she could type out your conversation in a transcript to help her with her research. You would have the opportunity to review each transcript to make sure that you were comfortable with what is said. In addition, to thank you for participating, Lauren will be giving you a \$10 gift card to Barnes & Noble at the beginning of each of the two interviews.

Thank you for your consideration.

Appendix B

Confirmation Letter to Participants

Dear XXXXX,

Thank you very much for agreeing to participate in my study on older women and their experiences with Alcoholics Anonymous. I am looking forward to meeting with you and having the opportunity to learn more about what being in AA has been like for you.

Enclosed is an Informed Consent form for you to look over before our first meeting. It basically lets you know your rights as a participant in this study, and what you can expect during our time together. When we meet on (date), the first thing I will do is ask if you have any questions about this form. I will then give you a signed copy for you to keep.

I will see you on (day of the week) at (time). Please call me (540)-239-3968 or email me (lermann@vt.edu) if you have any questions. Thank you again.

Regards,

Lauren Ermann

Appendix C

Demographic Questions

- 1) What is your age?
- 2) What is your race?
- 3) What was the last level of school that you attended?
- 4) Are you married or have a life partner?
- 5) Do you have children? Grandchildren?
- 6) Are you currently employed? If so, what do you do?
- 7) How many years have you been in AA?
- 8) Was this time the first time you joined AA? If not, when was the first time you joined?
- 9) How long did you drink before you went to AA?
- 10) Can you tell me a little bit about what prompted you to come to AA?
- 11) Have you ever attended a women-only AA meeting?
 - a. If yes, have you ever attended a co-ed AA meeting?

Appendix D

First Interview Protocol

Thank you for being here today. To remind you, I want to learn more about the experiences of older women (age 50 and older) at AA meetings. This is the first of two interviews, and most of the time will be spent listening to you tell me your stories about AA. I will ask some questions to get the conversation going, but my hope is that you will share your experiences honestly and with as much detail as you can. I will also be audio recording our interviews that I will later type to help me remember all of the information that you give me. Remember that you do not have to answer any questions and can stop the interview at any time.

Do you have any questions for me at this point?

Before we begin, I want to ask you a few basic questions about you just for some background information. After that, we will begin the main part of the interview when you will do most of the talking.

First ask demographic questions – see Appendix D.

- 1) What's it like for you to be a woman at AA?
- 2) What's it like to be a older woman at AA?
- 3) What about the AA program is helpful to you?
- 4) What about the AA program is not helpful to you?
- 5) How does being female affect how helpful or unhelpful AA is?
- 6) How does being an older adult affect how helpful or unhelpful AA is?
- 7) What would you say it takes to be successful as an older woman in AA?
- 8) What advice might you give another woman of your age who was considering joining AA? Would this advice change if the woman was younger?
- 9) What are your thoughts about your sponsor being the same gender or age as you?

10) What are your thoughts about your spouse being the same gender or age as you?

Additional questions may be explored based on individual responses.

I want to thank you again for your participation in this study. After a week, I will be emailing/ mailing you a copy of the transcript from today's interview. Please make comments and/or corrections directly on the transcript in red font if emailing, and return in the envelope provided if you are mailing. You can also bring your transcript comments to our second meeting. Here is a gift card to thank you for your participation.

Appendix E

Second Interview Protocol

Thank you for being here again for our second interview about the experiences of older women and AA. Before we begin, I want to check in with you and see if you have any questions or concerns from our first meeting?

I sent you the transcript from our first interview and I hope you have had the chance to look it over. Do you have any questions or concerns about the transcript?

Do you have any questions, concerns or comments in general about this process in general?

1. I'm interested in hearing more about your stories. What aspects of AA are particularly meaningful for you?
2. What is it like telling your story in AA? How did telling your story to the other members impact you?

Additional questions may be developed by the researcher based on initial interview responses.

These questions would be used to clarify any initial responses from the participant and to elicit additional information as needed.

I want to thank you again for your participation in this study. As an expression of my appreciation, here is another gift certificate. I will be mailing you a copy of the transcript from today's interview and please make comments and/or corrections as you did for the first interview. If I do not hear from you within two weeks after I have mailed you the transcript, I will assume you did want to make any changes.

Appendix F

Informed Consent Document

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Consent for Participants
in Research Projects Involving Human Subjects

Title of Project: The Lived Experiences of Older Women in Alcoholics Anonymous

Investigator: Lauren S. Ermann

Advisors: Dr. Gerard Lawson
Dr. Penny Burge

I. Purpose of this Research

The purpose of this study is to describe and analyze the lived experiences of older women age 50 and older in Alcoholics Anonymous (AA). Guiding this inquiry are the following research questions: 1) How do the older women participants experience the AA program? 2) What aspects of AA do older women consider beneficial? 3) What aspects of AA do older women find challenging? 4) What do older women consider as important conditions to succeed in the AA program? 5) How did these older women elicit meaning in their involvement with AA? and 6) How was the narrative aspect of AA experienced by the participants?

II. Procedures

The researcher will conduct two in-person interviews with women age 50 and older. The interviews will take place at a site of your choice and last for approximately 60 to 90 minutes each. The interviews will be audio recorded and written notes will be taken during the interview. All data will be used for research purposes only. During the interview, you will be asked to be honest about your experiences at AA. The information collected will allow the researcher to investigate what it is like to be an older female in AA.

At the end of the first interview, a second interview will be scheduled. A transcript of the audio recording from the first interview will be typed and emailed/mailed to you to check for accuracy and for you to add any additional comments. The second interview will allow you time to reflect on your current experiences and add information pertaining to the first interview. You will also have the opportunity to read the second transcript in order to clarify any information.

After you have reviewed this informed consent form, you will have the opportunity to ask any questions. The researcher will provide you with a copy of the signed documents and the researcher will also retain a copy.

III. Risks

There are minimal risks associated with participation in this study. Participation in this study may result in some discomfort when recalling possible unpleasant past experiences related to AA. If this occurs, you may stop the interview or the specific question at any time. In addition, if participating in this study causes severe discomfort or trauma, the researcher can refer you to a counselor in your area.

IV. Benefits

By participating in this study, you have the opportunity to share your personal story. This process may be beneficial by allowing you to reflect on the meaning behind those experiences. There is no promise made to you that you will receive any benefits. It is the hope of the researcher that health care practitioners and educators who work with older women will benefit from the results and implications of the study.

V. Extent of Anonymity and Confidentiality

Every effort will be made to protect your identity during the course of this research. Only the researcher will know the identity of the interview participant. Pseudonyms will be used and every effort will be made not to reveal any identifying characteristics in this study. You may select your pseudonym if you choose.

Audio recordings of interviews, transcription of interviews, field notes and audit trail will be stored in a secure location. Only the researcher will have access to the tapes and transcribed interviews. The memory cards in the audio recorders will be erased and destroyed, and all papers with identifying information will be shredded upon completion of the study and its results.

VI. Compensation

A \$10 gift card from Barnes & Noble will be provided to each participant at the beginning of each interview as a token of appreciation.

VII. Freedom to Withdraw

Participants have the freedom to withdraw from the study at any time with no penalty. Participants have the right to refuse to answer any question during the interview. The researcher has the right to also stop the interview if it is deemed beneficial to the participant.

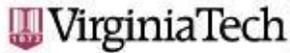
VIII. Subject's Permission

I have read the Informed Consent Form and details about this project. I confirm that I meet the criteria for participating in this study. I have had all of my questions answered. I hereby acknowledge the above and give my voluntary consent:

Participant Signature

Date

Appendix G
IRB Acceptance Letter



Office of Research Compliance
Institutional Review Board
2000 Kraft Drive, Suite 2000 (0497)
Blacksburg, VA 24060
540/231-4606 Fax 540/231-0969
email irb@ut.edu
website <http://www.irb.ut.edu>

MEMORANDUM

DATE: July 11, 2012
TO: Gerard Francis Lawson, Lauren Sheli Ermann, Penny Burge
FROM: Virginia Tech Institutional Review Board (FWA00000572, expires May 31, 2014)
PROTOCOL TITLE: The Lived Experiences of Older Women in Alcoholics Anonymous
IRB NUMBER: 11-630

Effective July 11, 2012, the Virginia Tech Institution Review Board (IRB) Chair, David M. Moore, approved the Continuing Review request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<http://www.irb.vt.edu/pages/responsibilities.htm>

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As: **Expedited, under 45 CFR 46.110 category(ies) 6,7**
Protocol Approval Date: **July 26, 2012**
Protocol Expiration Date: **July 25, 2013**
Continuing Review Due Date*: **July 11, 2013**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

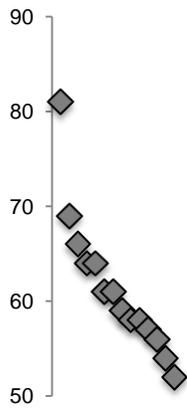
Invent the Future

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
An equal opportunity, affirmative action institution

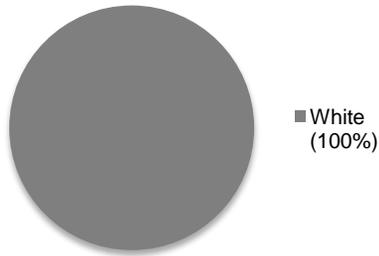
Appendix H
Demographic Information

Graphic Demographic Summary of Study Participants

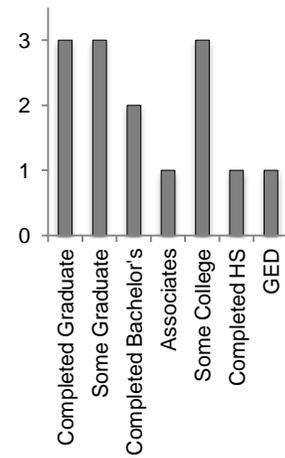
Age



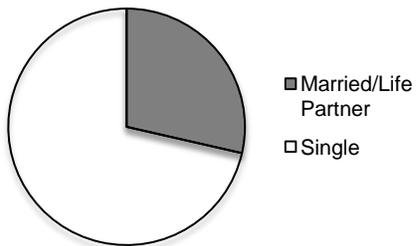
Race



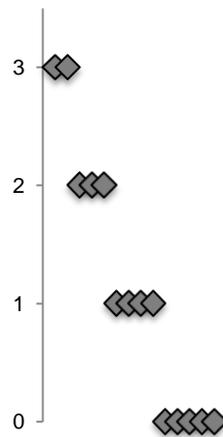
Highest Education Earned



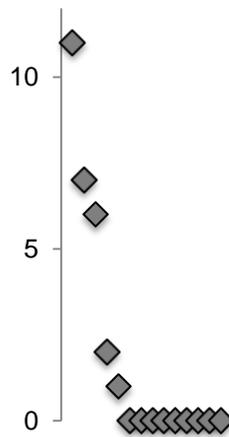
Marital Status



Number of Children

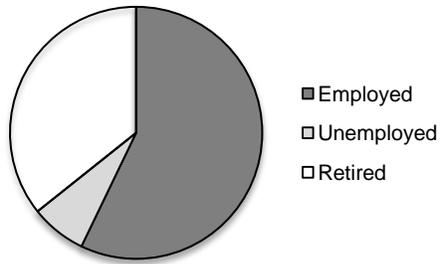


Number of Grandchildren



OLDER WOMEN IN AA

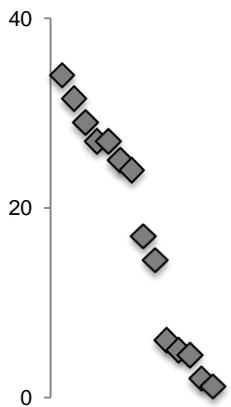
Employment Status



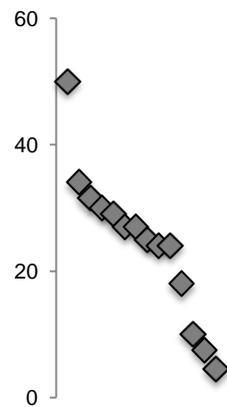
Job Descriptions

- Career counselor
- Lawyer
- Patient care coordinator
- Account representative
- Prison case manager
- Doctor
- Social worker
- Banking and management
- Custodian
- N/A (5)

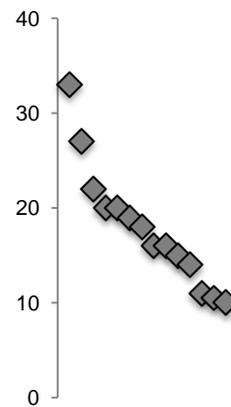
Years Sober in AA



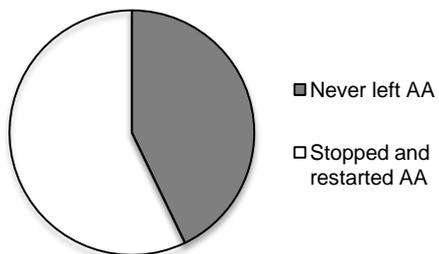
Years Since First AA Mtg



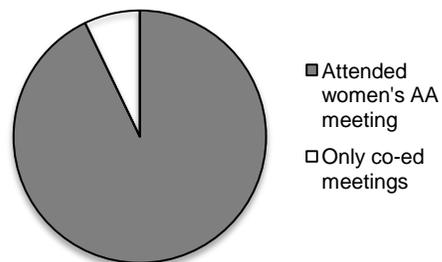
Years Drinking Before AA



Continuity in AA



Women-Only Meetings



Appendix I

Interview Questions Grouped by Research Questions

Study Purpose	
To describe, analyze, and better understand the lived experiences of older women in Alcoholics Anonymous (AA)	
Research Question	Interview Question
1. How do the older women participants experience the AA program?	<p>What is it like for you to be a woman in AA?</p> <p>What's it like for you to be an older woman in AA?</p> <p>What are your thoughts about your sponsor being the same gender or age as you?</p> <p>What are your thoughts about your sponsees being the same gender or age as you?</p>
2. What aspects of AA do older women consider beneficial?	<p>What about the AA program is helpful to you?</p>
3. What aspects of AA do older women find challenging?	<p>What about the AA program do you still struggle with?</p>
4. What do older women consider as important conditions to succeed in the AA Program?	<p>What would you say it takes to be successful as an older woman in AA?</p> <p>What advice might you give another woman of your age who was considering joining AA? Would this advice change if the woman was younger?</p>
5. How did these older women elicit meaning in their involvement with AA?	<p>How does being female affect your experience of AA?</p> <p>How does being an older adult affect your experiences of AA?</p> <p>I'm interested in hearing more about your experiences in AA in terms of meetings, sponsorship, fellowship, and service. What aspects of AA are particularly meaningful?</p>
6. How was the narrative aspect of AA experienced by the participants?	<p>Have you ever told your story in AA? How did telling your story to the other members impact you?</p> <p>Do you share in meetings? What's it like revealing parts of yourself in this way? How does sharing impact you?</p>

Red = 1st interview
 Blue = 2nd interview