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Rumination and Self-Medication Among Women with Posttraumatic Stress and Alcohol Use Disorders

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Abstract

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MS, Walden University, 2014

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Women with posttraumatic stress disorder (PTSD) often develop alcohol use disorders (AUD) resulting from the use of alcohol to self-medicate from negative affect. Research supports the relationship between comorbid PTSD and AUD, and studies with women additionally identify the role of rumination, or excessive thinking about distress and its causes, as a precipitating aspect leading to self-medication. Female-based data is sparse, however, regarding specific thought patterns and factors which trigger the need to self-medicate with alcohol. Numerous researchers have studied the relationship between stress, anxiety, and alcohol use, although, there exists a need for qualitative studies providing thick, rich information. Applying the self-medication model and rumination theory, the purpose of this study was to use a transcendental research framework as a lens to explore and describe the phenomenon of how women with comorbid PTSD and AUD make sense of their dual disorder. Qualitative data were gathered from in-depth interviews of 12 women who participated in Alcoholics Anonymous groups in a large Southeastern city. The women collectively described their lived experience with the phenomenon as an internally-focused strategy premised on the notion of a "Higher Power." They reported using this strategy to manage thoughts, feelings, and behaviors which triggered negative self-assessment and the need to self-medicate with alcohol. This research contributes to the literature by offering a more detailed understanding of comorbid PTSD and AUD. Positive social change can be achieved with a better understanding of the etiology of female trauma and the factors that trigger alcohol relapse in women with PTSD.

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Dedication

This work is dedicated to the brave women who took part in this study. Their voices can help us better understand the relationship between abuse and alcohol use. Let their courage, strength, and fortitude expedite the development of treatment programs which can better serve a female population with this dual disorder.

Acknowledgments

First, and foremost, thank you God for guiding me on this journey, even though at times I may have questioned the path I was on. Thank you so much to my husband, Joshua, who supported me through this entire process and encouraged me to push forward. Without him, this would not have been possible. Thank you to my son, Joshua, and his wife, Allison, for giving me a reason to finish. Last of all, thanks to Chi Chi and Nala who licked the tears from my eyes when the women's stories made my heart ache.

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Chapter 1: Introduction to the Study

The use of alcohol to manage thoughts and feelings resulting from past trauma is a known phenomenon, as clinicians commonly diagnose posttraumatic stress disorder (PTSD) and alcohol use disorder (AUD) as comorbid conditions (Battista, Pencer, & Stewart, 2013; Ciesla, Dickson, Anderson, & Neal, 2011; Jayawickreme, Yasinski, Williams, & Foa, 2012). Recent studies indicate that comorbid PTSD and AUD is no longer solely a condition resulting from wartime trauma; rather, it is a significant concern for physically and psychologically abused women whose trauma may have begun as early as childhood (Bailey, Webster, Baker, & Kavanagh, 2012; Foster et al., 2014; Hellmuth et al., 2013; Huang, Schwandt, Ramchandani, George, & Heilig, 2013). Typically studied among men who have experienced combat, PTSD and AUD research has expanded to include women who have been victims of childhood and adult physical and sexual violence (Simpson, Stappenbeck, Varra, Moore, & Kaysen, 2014). Research reports a significant number of females develop AUDs because of continuous negative reflection post trauma, which reinforces a cycle of alcohol relapse to self-medicate from negative affect (Battista, et al., 2013; Ciesla, Dickson, Anderson, & Neal, 2011; Jayawickreme, Yasinski, Williams, & Foa, 2012). There exists a need, therefor, to better understand PTSD and AUD symptomology for early detection with women seeking therapy.

In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V; APA, 2013), PTSD is defined as an extreme stressful reaction to an experienced trauma, or the witnessing of a disturbing occurrence; trauma manifestations

include emotional, physical, and psychological responses. Diagnostic criteria for PTSD include (a) exposure to an event that threatens death, severe injury, or sexual violence; (b) intrusive symptoms resulting from a traumatic event such as distressing memories, dreams, flashbacks, or prolonged stress; (c) continuous avoidance of any stimuli related to the traumatic event; (d) changes and worsening in cognitions and mood; and (e) alterations in arousal such as anger, hypervigilance, exaggerated startle response, difficulty concentrating, and sleep disturbances (APA, 2013). Although a diagnosis of PTSD cannot be attributed to a medical condition or the effect of substance use and abuse, 80% of those diagnosed with PTSD meet diagnostic criteria for an additional mental disorder, with alcohol abuse reported as highly comorbid (APA, 2013). These findings support the need to better identify and understand the relationship between trauma and alcohol abuse in females.

Alcohol abuse is one of the most common psychiatric conditions diagnosed in the United States. The DSM-V (APA, 2013) defines AUD as (a) a problematic pattern of increased alcohol use; (b) tolerance to higher amounts of alcohol to achieve intoxication; and (c) withdrawal as manifested through the need to continue using alcohol to avoid unpleasant side effects. The lifetime risk of developing alcohol dependence is approximately 15% (APA, 2013). Clinicians have typically reported higher rates of alcohol dependence in males than females (APA, 2013). More recently, researchers have begun to consider genetic and physiological factors regarding women and children which contribute to a comorbid diagnosis of PTSD and AUD (APA, 2013).

Researchers have found evidence of differences in how men and women turn to alcohol to relieve trauma affect; however, much of the research has been conducted with male populations (Foster, Hicks, Iacono, & McGue, 2014; George, et al., 2014; Hellmuth, Jaquier, Young-Wolff, & Sullivan, 2013). Exposure to a traumatic event is quite common, and substance use to manage post trauma affect is the most prevalent comorbid condition for those diagnosed with PTSD (APA, 2013). Previous studies indicate that approximately 35% of patients with PTSD seek additional treatment for substance abuse (Gielen, Krumeich, Havermans, Smeets, & Jansen, 2014). This suggests the need for thorough assessments for women reporting alcohol abuse with trauma histories.

Several pathways have been proposed for the link between PTSD and alcohol, with alcohol used to self-medicate from past trauma recollections the most highly received (Crum et al., 2013; Fitzgerald & Long, 2012; Gaher & Buchkoski, 2014; Haller & Chassin, 2013; Simpson et al., 2012). In formulating self-medication theory, Conger (1956) posited that individuals use alcohol to block out or forget about past trauma. This means that traumatic memories are continuously repressed for those with cooccurring PTSD (Conger, 1956). Alcohol used to repress memories contrasts PTSD treatment recommendations that propose the need to uncover traumatic memories and replace negative cognitions with positive thought strategies. This presents an issue for those with comorbid PTSD, however, as alcohol is used as a moderator to reduce PTSD symptoms, any additional attention to stressful memories will only trigger a greater need for alcohol (Berenz, Rowe, & Schumacher, 2012; Gielen et al., 2014; Simpson et al. 2012).

Although current integrated treatment strategies for PTSD and AUD appear to provide the best outcome for this dual disorder, very few substance abuse facilities offer this type of treatment approach (Gielen et al., 2014). Researchers have noted that cooccurring PTSD and AUD present more severe clinical profiles with lower rates of treatment completion (Berenz et al., 2012; Gielen et al., 2014; Tull, Gratz, Coffey, Weiss, & McDermott, 2013). Prolonged exposure (PE) therapy, is recommended to treat PTSD, however, this form of therapy contradicts recommended treatment for alcohol addiction (Berenz et al., 2012; Simpson et al., 2012; Tull et al., 2013). PE advocates postulate that PTSD symptoms are the result of negative cognitive thoughts and that avoidance of these thoughts is what perpetuates PTSD symptoms (Berenz et al., 2012; Simpson et al., Tull et al., 2013). Clinicians who offer PE treatment address reoccurring distressful thoughts through psychoeducation, breathing techniques, imagination, and in vivo exposure (Berenz et al., 2012). The conflict with comorbid AUD arises when professionals uncover and address negative cognitions, as these are what alcohol is used to suppress (Berenz et al., 2012).

Due to the difficulty of treating both disorders simultaneously, very few treatment facilities in the United States offer an integrated approach to PTSD and AUD therapy. Many individuals are treated only for substance abuse without acknowledgement of PTSD symptoms they may have (Gielen, 2014). Researchers have reported the need for a better understanding of the phenomenon of how women make sense of their dual diagnosis of PTSD and AUD (Grupp, 2008). There is also a need for a deeper understanding of how traumatic memories might trigger alcohol relapse. To address this

gap in research, I conducted this phenomenological study to provide a detailed description of posttraumatic thoughts and experiences that provoke self-medication with alcohol.

The need for dual treatment strategies among women is beginning to gain acceptance in current literature, although attention is still warranted to uncover a better understanding of specific memories that seem to trigger alcohol relapse (Caselli et al., 2010; Ciesla et al., 2011; Tait, Brinker, Moller, & French, 2013). In addition to better understanding how women describe comorbid PTSD and AUD, there is a need for more thorough diagnostic interviews of women presenting with AUD (Brady & Back, 2012; Huang et al., 2012; Schwandt, Heilig, Hommer, George, & Ramchandani, 2013; Smith, Smith, & Grekin, 2014). Clinical interviews need to address childhood and early adulthood with women presenting AUD, as neglected diagnoses of early life trauma may indicate PTSD (Bailey, Webster, Baker, & Kavanagh, 2012). If the source of this trauma continues to be misdiagnosed, the need to self-medicate with alcohol will also continue (Bailey et al., 2012; Foster et al., 2014; Hellmuth et al., 2013; Huang et al., 2013).

To address the need for a better understanding of comorbid PTSD and AUD with women, this chapter begins with background information on my study problem, which includes my rationale for conducting additional research in this area. The essence of the study is introduced and the research questions I used to collect data from participants is presented. I include the theoretical framework I used to clarify the relationship between my study and my research questions. Potential limitations of the study are also addressed. In closing, this chapter provides a greater understanding of this research from

a social change standpoint, by acknowledging the necessity to better understand the phenomenon of comorbid PTSD and AUD in women.

Background of the Problem

A greater understanding of the phenomenon of comorbid PTSD and AUD among women is needed. Research shows an intimate relationship between psychological suffering and AUDs among women, with studies on anxiety sensitivity indicating a positive association between stress and alcohol use (Battista et al., 2014; Fitzgerald & Long, 2012; Harwell, Cellucci, Loverling, & Iwata, 2011; Johnson, Heffner, Blom, & Anthenelli, 2010). Analyses from substance abuse treatment facilities report that a dual diagnosis of PTSD and AUD occur in over 30% of their patients, 30-59% of whom are female (Heffner et al., 2011; Jayawickreme et al., 2012). PTSD and AUD are twice as common among women, and some research indicates that females have a greater likelihood of alcohol dependence compared to males (Sannibale et al., 2013). Studies reveal a detailed female perspective regarding stress and alcohol use has received little attention, despite studies recommending future research is needed to better understand the presenting differences in women regarding trauma and triggers provoking alcohol relapse (Hruska et al., 2011; Johnson et al., 2010; Lehavot et al., 2014). This would suggest the need to further understand and identify specific characteristics presented by this group of women.

A comprehensive understanding of the underlying factors for why women diagnosed with comorbid PTSD use alcohol to cope with trauma memories. Most researchers have examined whether there is a correlational or cause and effect

relationship between anxiety and alcohol, and have not undertaken a deeper investigation of the actual differences between men and women experiencing this phenomenon (Foster et al., 2014; George et al., 2014; Hellmuth et al., 2013). Researchers who have delved more extensively into the types of trauma suffered by women have found that a significant number of females report posttraumatic stress symptoms (PTSS) and PTSD resulting from childhood and lifetime physical and sexual trauma (Bailey, Webster, Baker, & Kavanagh., 2012; Foster et al., 2014; Hellmuth et al., 2013; Huang et al., 2013). Researchers conducting gender-based trauma studies additionally reveal that rumination, or continuous focus on past negative events, is more common in women and plays a significant role in alcohol relapse (Battista et al., 2013; Ciesla et al., 2011; Jayawickreme et al., 2012). Because rumination is linked to alcohol relapse, it is important to better understand how the cyclical pattern of negative thoughts initiates the need for alcohol use to dampen the memory of a past situation or event (Caselli et al., 2010; Ciesla et al., 2011; Tait et al., 2014). My aim in conducting this study was to contribute a greater understanding of how female victims of trauma describe their use of alcohol to self-medicate from post trauma memories.

Problem Statement

Even though research has begun to report gender differences with individuals presenting comorbid PTSD and AUD, a problem exists with a gap in the literature on how females experience these conditions. Few researchers have explored factors specific to women's alcohol abuse, specifically how they use alcohol to cope with trauma recall (Lehavot et al., 2014). It is important to note that more women experience AUD post

trauma whereas men often report AUD both prior to and post trauma (Jayawickreme et al., 2011). Grupp, in 2008, specifically stated the need to address the gap in research from a female perspective of this comorbid disorder. Yet, little research has been done since then to explore how women make sense of alcohol to avoid their feelings post trauma. More importantly, research shows that women tend to ruminate on past trauma (Battista et al., 2013; Caselli et al., 2011; Harwell et al., 2011). Despite identifying rumination as a contributing factor to alcohol use, there is a lack of substantive studies on how women identify and describe what thoughts and feelings tend to trigger alcohol relapse (Ciesla et al., 2011; Tait et al., 2013).

Research further indicates differences in how men and women use alcohol as a means of self-medication. According to longitudinal research findings, PTSD and AUD commonly concur, although diagnoses vary by anxiety type and subgroup based upon gender (Crum et al., 2013; Dvorak & Simons, 2014). Studies report differences between men and women when it comes to how each gender responds to trauma situations such as combat, physical, sexual, and childhood traumas, in addition to acknowledging inconsistent findings between gender differences most likely occur due to lack of female studies (Brady & Back, 2012; Foran, Smith Slep, & Heyman, 2011; Hassija, Jakupcak, Maguen, & Shipherd, 2012; Hellmuth et al., 2013; Johnson et al., 2010; Lehavot et al., 2014). Lack of female studies on comorbid PTSD and AUD present the reason for this study.

Purpose of the Study

The purpose of this study was to explore the phenomenon of self-medication and rumination in a sample of women with comorbid PTSD and AUD. Women from 12-step Alcoholics Anonymous groups were asked to describe their lived experiences of alcohol use as a means of self-medication to help manage posttraumatic memories.

Research Questions

I sought to answer two central research questions:

RQ1. What are the lived experiences of women diagnosed with PTSD and AUD as described by them?

RQ2. How do women diagnosed with PTSD and AUD describe how their diagnosis can be better understood?

In addition, I wanted to answer the following sub questions:

1. What is the overall essence of thoughts, feelings, and behaviors described by women with PTSD and AUD prior to self-medicating with alcohol?
2. What is the overall essence of the physical settings described by women diagnosed with PTSD and AUD when they self-medicate with alcohol?
3. How do women with PTSD and AUD describe their unsuccessful experiences when they succumb to self-medicating with alcohol?
4. How do women with PTSD and AUD describe their successful experiences when they refrained from self-medicating with alcohol?

Theoretical Foundation

A theoretical foundation is the basis of a research study, and this study is reinforced by two theoretical foundations. The proposed theories which support this research are tension reduction theory (Conger, 1956), and rumination theory (Nolen-Hoeksema, 1991). Conger's (1956) tension reduction theory postulates alcohol use in response to a desire to self-medicate from negative trauma affect. Rumination theory proposes reoccurring negative thoughts lead to alcohol cravings and subsequent alcohol relapse (Nolen-Hoeksema, 1991). Both theories relate to the research questions of this study which ask women with comorbid PTSD and AUD to describe their lived experience with alcohol relapse and how they feel their experience can be better understood by professionals who work with dually addicted women. A further discussion of the theoretical foundation for this study is discussed in Chapter 2.

Nature of the Study

A qualitative approach with a phenomenological research paradigm was selected for this study. This approach was chosen because a better understanding of the use of alcohol as a means of self-medication required a deeper description of the participant's personal experience. Phenomenological research, which emphasizes the participants lived experience, provides a greater understanding of how this sample of 12 women described their dual-diagnosis of PTSD and AUD, along with memories that triggered their use of alcohol to deal with the anxiety from trauma recall. This approach was selected to further understand a female perspective to PTSD and AUD as participants experienced and described. Thus, addressing the lack of literature providing detailed

information regarding women who have lived through this phenomenon (Berenz et al., 2012; Duranceau, Fetzner, & Carlton, 2014).

A transcendental research framework (Moustakas, 1994) was selected to explore how female participants made sense of their lived experiences, as well as the lived experience of the group as a whole. This approach was chosen for its ability to derive a description of the totality of the experience presented by participants, rather than an explanation or analysis of data found typically in quantitative research. The meaning women gave to their experience of self-medication with alcohol in response to trauma recall was the phenomenological basis of this study, and a transcendental framework was particularly appropriate. Moustakas (1994) felt the "only thing we really know for sure is the conscious" and the conscious lived experience of the participants was the focus of this study. A more thorough explanation of this research foundation is discussed in chapter 2.

Definitions

Alcohol use disorder (AUD): Significant adverse consequences resulting from obsessive alcohol use when an individual becomes unable to control or stop their drinking. Tolerance to greater amounts of alcohol is present over time, and withdrawal symptoms are triggered when there is an attempt to cease drinking. (APA, 2013).

Alcohol cravings: Physical and psychological symptoms and sensations that produce a strong desire for alcohol (Jayawickreme et al., 2012).

Anxiety sensitivity: The fear of becoming anxious and the symptoms that accompany anxiety (Dixon, Stevens, & Viana, 2014).

Comorbid diagnosis: A diagnosis of two mental disorders simultaneously (Gielen et al., 2014).

Integrated treatment: Treatment strategies that target two disorders simultaneously (Gielen et al., 2014).

Negative affect: Experiencing negative emotions and poor self-concept (Harwell et al., 2014).

Negative reinforcement: Alcohol used as a learned behavior in response to negative affect (Harwell et al., 2011).

Posttraumatic stress disorder (PTSD): A stressful emotional, psychological, or physical reaction to a personal trauma, witnessing a trauma, or knowledge of a trauma, resulting in distressing memories, dreams, and flashbacks, and avoidance of stimuli related to the past traumatic event (APA, 2013).

Rumination: Obsessive reflection on negative thoughts and consequences (Nolen-Hoeksema, 1991).

Self-medication theory: Using alcohol as a means to avoid negative thoughts and emotions (Conger, 1956).

State anxiety: A short-term heightened fear to perceived dangerous situations (Sung, Lee, Song, & Kim, 2011).

Tension-reduction hypothesis: Associated with Conger's (1956) self-medication theory. The use of alcohol to cope with reoccurring negative symptoms resulting from stress and anxiety.

Trait anxiety: A long-term genetic inclination to worry or stress (Read, Merrill, Griffin, Bachrach, & Khan, 2014).

Transcendental phenomenology: Uncovering the meaning individuals give to their lived experience with a phenomenon (Moustakas, 1994).

Assumptions

All research begins with a certain set of beliefs or assumptions. Based upon the voluntary nature of this research, the participants meeting the criteria of this study were fully willing to participate. Participants answered questions accurately and honestly, to the best of their knowledge, based upon their experience with the phenomenon under investigation. This was assumed, as those offering their participation had difficulty with alcohol relapse as the result of reoccurring traumatic thoughts, feelings, and memories from past trauma. These assumptions, in turn, were necessary to reflect the purpose of this study, which was to collect information as to how women with comorbid PTSD and AUD describe their experience with alcohol used to self-medicate from trauma memories.

Scope and Delimitations

This study was designed to address the gap in research of how women with comorbid PTSD and AUD describe the phenomenon of ruminating thoughts that trigger the need to self-medicate with alcohol. The scope of this study, therefore, involved female participants who had been diagnosed with both PTSD and AUD. A phenomenological research paradigm was selected to gather a thick, rich collection of information, and while no phenomenological study will produce the same information,

the descriptive data can be transferable to both individuals experiencing this phenomenon, as well as professionals who treat them.

The participants were recruited from a sample of women from Alcoholics Anonymous (AA) groups in the city of Richmond, VA. Participants were at least 18 years of age, presented a minimum of one-year post traumatic experience, and had at least one year of continuous sobriety. The number of participants selected for this study was 12, which was chosen based upon similar peer-reviewed qualitative studies that indicate this sample size to be adequate for reaching saturation.

This study describes a limited number of experiences from women who attend Alcoholics Anonymous meetings in a mid-size southeastern city. The sample size, therefore, restricts the degree of generalizability to the greater population of women with comorbid PTSD and AUD. As previously stated, the purpose was to explore the experience of the participants of the study, and not to generalize the information to a wider population. This does not, however, mean insights gained from the study cannot be applied to those who have similar characteristics of the participants in this study. Importantly, however, is that this sample of women described a spiritual solution to their alcohol cravings, based upon the nature of the 12 steps of Alcoholics Anonymous.

Limitations

All studies have limitations, and the following addresses potential restrictions of this study from a sample, researcher, and methodological perspective. Sample size is much smaller than with quantitative data, which limits the amount of information used for analysis and the transferability of information to the greater population of women

with comorbid PTSD and AUD. Despite phenomenological studies using smaller sample sizes, the data gathered is highly parameter specific and presents a richer, more explicit description of the experience rather than analyses of significant relationships. Due to the lack of qualitative studies regarding this phenomenon, the unearthing of valuable information may possibly be incorporated into more successful individualized treatment strategies moving forward. It should be noted, that additional qualitative research is still very much needed in this area.

While the selection of a very well defined population is a benefit, the accounting of experience through the interview process might be seen as a potential limitation due to subject inaccuracies in memory recall. In other words, the description of the women's experiences must be taken at face value. There is always the possibility of selective or distorted memory with a population interviewed at minimum one-year post-trauma. The one year cut off point, nevertheless, was deemed necessary to avoid any potential harmful recall if subjects had not received initial therapy or were not able to process trauma information without potential distressful consequences.

In phenomenological research the instrument of measure in the interview setting is the researcher, which can also be a potential limitation of the study. This type of study used the researcher to collect, analyze, and report the essence of the data using self-analysis. This means there is potential for a biased and prejudiced interpretation of the phenomenon under study as seen through the researcher's eyes. The possibility of these limitations was addressed through the research methods framework, later described in chapter 3, and the use of audio-taped interviews for constant accounting of the actual

descriptions obtained from participants. Follow-up with participants was also conducted upon data collection and analysis, to assure for an accurate accounting of the essence of the experience as reflected in the information gathered from participants.

Significance

The main significance of this study was to conduct research that could contribute to positive social change through a better understanding of comorbid PTSD and AUD in women. Social change calls for research based upon a female understanding to competently understand, address, and design treatment strategies that may decrease alcohol dependency for women with PTSD. This is necessary, as alcohol used to self-medicate from trauma continues to rise, especially among women. This cooccurring diagnosis no longer belongs only to men suffering from post war trauma and alcoholism, but now includes a significant portion of the population comprised of women. This research can help fill some of the gaps in the literature that specify the need to better understand how women make sense of their use of alcohol to deal with thoughts, feelings, and emotions resulting from traumatic experiences. The necessity to approach a female perspective is especially relevant, since men and women indicate differences in both their trauma histories and their approach to alcohol use. Jayawickreme (2011) reports many women do not have difficulty with AUD until post-trauma when they have turned to alcohol to self-medicate. Therefore, a better understanding of episodes that trigger relapse is vital.

The importance of this study also relates to the lack of literature from a qualitative standpoint which addresses the lived experiences of women with comorbid PTSD and

AUD. Most of the current research provides limited statistical data found in quantitative studies. This qualitative research can expand beyond an understanding of how women think and feel about their experience, and contribute to additional awareness for women suffering from this disorder. Finally, detailed and explicit experiences provided by participants can help create expanded insight and understanding for professionals treating women with this dual diagnosis who have difficulty treating PTSD and AUD simultaneously (Stevens, Andrade, & Ruiz, 2009).

Summary

This qualitative study was conducted to present a better overall understanding of the phenomenon of alcohol used to self-medicate from trauma recall. A population of 12 women with cooccurring PTSD and AUD was chosen due to the scarcity of research studies from a qualitative female perspective (Grupp, 2008; Hruska et al., 2011; Johnson et al., 2010; Lehavot et al., 2014). While the association between trauma recall and alcohol use is nothing new or original in psychological research, a deeper interpretation into gender-based studies warrants attention. Current literature increasingly shows a significant relationship between PTSD resulting from physical and sexual attacks, with more and more women reporting the use of alcohol to deal with the aftermath of childhood and adult trauma symptoms (Cohn et al., 2014; Painter, & Scannapieco, 2013; Peter-Hagene, & Ullman, 2015). Negative reflection, or rumination, regarding such types of circumstances has been reported as a major factor influencing relapse with women, however, there exists a gap in studies identifying and describing commonplace memories or situations that trigger alcohol use and relapse. Self-medication theory, however,

dominates current gender research explaining why women use and abuse alcohol to deal with trauma recall (Crum et al., 2013; Cohn et al., 2014; Hruska, & Delahanty, 2012; Smith, Smith, & Grekin, 2014).

This study moves beyond identification of the relationship between alcohol abuse and PTSD symptoms from a theoretical perspective to an accounting of how women described their conscious thoughts, feelings, and emotions prior to using alcohol to deal with or dampen such thoughts and memories. The overall essence of what these women thought and felt prior to alcohol use, abuse, and relapse provides a deeper understanding of their experience of the phenomenon. This information, in turn, can be useful for both women diagnosed with this comorbid condition and individuals treating this population through a better understanding of reoccurring themes and patterns that trigger the need for self-medication.

In Chapter 2, I review the most recent relevant literature regarding what has been reported on comorbid PTSD and AUD. Further detail is included from a neurodevelopmental perspective of anxiety, as well describing both internal and external factors that play a role in the development of anxiety and anxiety sensitivity. Theoretical models regarding the use of alcohol to relieve symptoms of anxiety are presented and the self-medication model is described through tension reduction theory. This chapter also includes the most recent research on female studies that indicate PTSD often occurs with women from a non-military etiology of childhood and adult physical and sexual abuse. A female perspective to trauma symptoms is presented and includes a discussion on how rumination is often a factor for women with reoccurring negative memories and affect.

Chapter 2 closes with implications of how the information obtained from this study may promote social change by expanding research that is predominantly male based. This may help women to better understand their condition, as well as aid professionals who design simultaneous treatment strategies specifically for women with comorbid PTSD and AUD.

Chapter 3 introduces the design and methodology of this study. A qualitative research approach with a phenomenological research strategy used one-on-one in-depth interviews to better understand how women diagnosed with comorbid PTSD and AUD turn to alcohol to self-medicate from trauma memories. In conclusion, this chapter presents the parameters of the population studied, ethical implications, and data collection procedures regarding the research.

In Chapter 4, a transcendental research framework (Moustakas, 1994) was applied to interpret and disseminate the findings. My role as the researcher is discussed and the overall essence of the female participants' experiences of the phenomenon is presented through a detailed accounting of how they described it. The findings outline an internal and external description of what is presented from a conscious perspective of the participants of this study. These structural and textural descriptions are then united and presented into an overall description of the essence as described by the group as a whole.

Chapter 5 presents a summary of the findings in response to the research questions designed to study the phenomenon of self-medication in response to trauma memories. Implications for the research gathered is presented regarding how the essence of the participant's descriptions can be used to better understand their experience.

Chapter 5 further addresses implications for clinical practice involving this population, and recommendations for future research.

Chapter 2: Literature Review

Introduction

Clinical researchers outline the link between trauma related anxiety and alcohol abuse. Based on my review of the literature, however, there is a lack of descriptive gender-based research to aid in the development of combined treatment strategies for individuals seeking relief from both PTSD and AUD. The relationship between anxiety and alcohol can be quite complex, with suggested therapy for each condition to occur independent of one another. Therapies for each disorder contradict each other, which results in poor treatment prognosis for individuals diagnosed comorbidly (Berenz et al., 2012; Gielen et al., 2014; Tull et al., 2013).

Despite contrasting treatment approaches, dual treatment strategies must involve a comprehensive examination of the multiple factors that contribute to PTSD and AUD (Beseler et al., 2011; Cohn et al., 2014; Cacciola & Nevid, 2014; Dvorak & Simons, 2014; Fitzgerald & Young, 2012; Gillihan et al., 2011; Harwell et al., 2011). These factors include brain chemistry, individual traits, internal and external stressors, motives for drinking, gender, type of trauma experienced, and coping ability (Beseler et al., 2011; Cohn et al., 2014; Cacciola & Nevid, 2014; Dvorak & Simons, 2014; Fitzgerald & Young, 2012; Gillihan et al., 2011; Harwell et al., 2011). The purpose of this study was to further explore the phenomenon of comorbid PTSD and AUD in women, through participant descriptions of factors which triggered alcohol use to self-medicate from trauma memories.

This chapter contains an analysis of current peer-reviewed literature on comorbid PTSD and AUD. A brief review of the brain and anxiety discuss internal and external factors which lead to anxiety disorders and PTSD. Both short-term and long-term anxiety are outlined, and rumination is noted as a contributing aspect among women diagnosed with comorbid PTSD and AUD. Theoretical models describing the relationship between PTSD and alcohol are discussed, and support is provided for the self-medication model of alcohol use (Conger, 1956) as the best explanation for why women turn to alcohol post trauma. Types of trauma most often reported by women are included in this chapter, along with a discussion regarding childhood physical and sexual abuse as a catalyst for PTSD and later alcohol abuse and dependency. Trauma recall ties into rumination theory and the idea that women often continuously rehash past trauma memories. This rehashing of memories is what precipitates alcohol use, abuse, and relapse (Nolen-Hoeksema, 1991). Thus, presenting the need for a better understanding of how women describe specific internal and external factors that trigger self-medication with alcohol.

Literature Search Strategy

The search of literature used electronic psychology and health sciences databases including PsycARTICLES, PsychINFO, ERIC, SAGE Premier, and CINAHL Plus. Numerous search terms of *posttraumatic stress syndrome (PTSD)*, *alcohol use disorders (AUD)*, *comorbid, gender*, *rumination, anxiety*, *anxiety sensitivity*, *self-medication*, *negative affect*, *trauma*, and *treatment* provided a comprehensive search of supportive literature. The search began with multiple combinations of search terms. I then used one

or two word combinations to achieve saturation of information on women with cooccurring PTSD and AUD. The articles were assimilated electronically and reviewed to obtain the most up-to-date accounting of current peer-reviewed literature on comorbid PTSD and AUD from a female perspective. Additional texts supplemented the literature search and provided detailed information on the use of self-medication regarding tension reduction theory (Conger, 1956) and rumination theory (Nolen-Hoeksema, 1991) . Both theories were the basis for my theoretical foundation.

Theoretical Foundation

Theories vary regarding the use of alcohol in response to trauma. Theoretical models point to several patterns surrounding the connection between PTSD and AUD with most adhering to some type of self-medicating model for the use of alcohol to cope with feelings and emotions post trauma (Crum et al., 2013; Fitzgerald & Long, 2012; Gaher et al., 2014; Haller & Chassin, 2013; Simpson et al., 2012). Alcohol to deal with stress has been identified for years with the origination of the tension reduction hypothesis first introduced by Conger in 1956 (Beseler, Aharonovich, & Hasin, 2011). Tension reduction theory postulates alcohol is used to deal with fear and tension resulting from trauma and a comorbid diagnosis of PTSD and AUD commonly occur when alcohol becomes the predominant means of coping with post-trauma symptoms (Gillihan, Farris, & Foa, 2011; Hruska & Delahanty, 2012; Kaysen et al., 2014; Morgan-Lopez et al., 2014). While there are many variations of the self-medication hypothesis, a more recent model specifically pertaining to the frequent occurrence of comorbid PTSD and AUD is Khantzian's (2003) self-medication theory. This theory posits the discomfort from PTSD

symptoms is reduced when alcohol is used as negative reinforcement (Simpson et al., 2012).

The negative reinforcement model recognizes negative affect (NA) as important to alcohol cravings and cravings are a key predictor of continued problematic drinking (Beseler et al., 2011; Cohn, Hagman, Moore, Mitchell, & Ehlke, 2014; Frone, 2015; Hruska, & Delahanty, 2012; Kaysen et al., 2014; McLean, Su, & Foa, 2015; Simpson et al., 2012). Rumination theory helps to explain the relationship between reoccurring negative thoughts, alcohol cravings, and subsequent alcohol relapse that reinforces the self-medication hypothesis postulating alcohol use as a coping strategy to control negative affect. Important to note, however, this means of relief to persistent self-focused depressive and distressful attention on past traumatic events is reported more often with women diagnosed with PTSD and AUD who use alcohol to self-medicate from trauma memories (Brozovich et al., 2014; Casselli et al., 2010; Ciesla et al., 2011; Goldwin, Behar, & Sibrava, 2013; Harwell, et al., 2011; Tait et al., 2013). The combination of both theories, therefor, provides the backdrop for the research questions that seek to explore how women make sense of a dual disorder of PTSD and AUD. Chapter 2 further provides additional information pertaining to both self-medication and rumination theories in relationship to the purpose of this study.

Literature Review

Comorbid PTSD and AUD

PTSD is an anxiety disorder that results from experiencing or witnessing a traumatic event (APA, 2013). Symptoms of PTSD can vary significantly from person to person, though one of the predominant symptoms is severe anxiety from reliving or thinking about reliving memories of past trauma (APA, 2013). PTSD can occur at any time during one's lifetime. Researchers are beginning to investigate the effect of PTSD resulting not only from adult trauma, but also from childhood trauma (Huang et al., 2012; Johnson et al., 2010; Painter & Scannapieco, 2013; Zinzow et al., 2012). Current studies indicate the need for psychological professionals to pay closer attention to childhood histories with individuals presenting PTSD symptoms.

Researchers have noted that early life trauma could be the basis for a PTSD diagnosis despite a more recent traumatic occurrence (Bailey et al., 2012; Huang et al., 2012; Schwandt et al., 2013). According to existing research, childhood trauma resulting from sexual, physical, or emotional abuse can exist over a long period of time, and may be a risk factor for future adult traumatization and additional mental health diagnoses (Brady & Back, 2012; Zinzow et al., 2012). This finding is present in neurobiological studies which show that changes in brain structure and function in victims of childhood abuse present a link to comorbid mental health diagnoses and subsequent episodes of traumatization (Birn et al., 2014; Painter & Scannapieco, 2013; Rinne-Albers, van der Wee, Lamers-Winkelman, & Vermeiren, 2013). Thus, the need for professionals to conduct more thorough psychological assessments of clients presenting PTSD

symptomology to detect if the etiology of their condition is from a more recent trauma or whether it is the result of a past trauma that may have begun in early childhood (Alexander, 2014; Schwandt et al., 2013).

In addition to childhood trauma, research reports anxiety disorders highly cooccur with substance abuse issues (Capone et al., 2013; Hruska & Delahanty, 2012; Read et al., 2014). Alcohol, which is the most highly abused substance, is reported in over 24% of those diagnosed with PTSD, and those with PTSD are over five times more likely to develop AUDs than the rest of the population (Bailey et al., 2011). AUDs result from the self-medicating benefits that alcohol has when individuals attempt to dampen negative feelings experienced when thinking about past trauma (Duranceau et al., 2014; Gaher et al., 2014; Haller & Chassin, 2013; Hruska & Delahanty, 2012; Read et al., 2014; Simpson et al., 2012). Not all individuals diagnosed with PTSD will develop AUDs, however, as multiple mediating factors play a role in comorbid AUD development (Beseler et al., 2011; Birrer & Michael, 2011; Harwell et al., 2011; Mohr et al., 2013). An examination of factors contributing to a cooccurring diagnosis of AUD are discussed throughout the remainder of this chapter.

Understanding Anxiety and the Brain

Anxiety can result from many factors. These include brain chemistry, the environment, substance abuse, or multiple combinations of stress inducing situations. Describing anxiety is not as easy as saying it is an underlying uneasiness and apprehension regarding a real or imaginary outcome. This is because anxiety characteristics can run the gamut from mild worry or concern to extreme psychiatric

disorders of panic attacks, compulsive behaviors, and PTSD (Battista et al., 2013; Fitzgerald & Long, 2012; Harwell et al., 2011; Johnson et al., 2010). Anxiety disorders do not exist in a vacuum and are often found to coexist with many other psychological disorders such as alcohol abuse. Although researchers have substantiated the connection between anxiety and AUDs, they have noted the complexity of the relationship and the need to examine multiple factors that play a role in the etiology of each disorder separately as well as conjunctively (Battista et al., 2013; Fitzgerald & Long, 2012; Harwell et al., 2011; Johnson et al., 2010).

As with most psychological disorders, risk factors for the development of anxiety disorders or PTSD can be explained in terms of both physiological and environmental aspects due to the complexity of brain maturation and the effect on several internal and external experiences. One major risk factor identified in the development of comorbid PTSD and AUD in women is trauma history. Preclinical research shows a strong connection between psychological trauma and psychopathology as indicated in brain abnormalities detected from trauma exposed children and adults (Rinne-Albers et al., 2013). In fact, childhood maltreatment is considered one of the major risk factors for PTSD later in life (Daniels, Lamke, Gaebler, Walter, & Scheel, 2013; Painter & Scannapieco, 2013; Rinne-Albers et al., 2013).

PTSD is considered a trauma and stress-related disorder, or a hyperarousal response to previous trauma exhibited in exaggerated startle response, flashbacks, difficulty sleeping, feeling on edge, and increased irritability or anger (APA, 2013). PTSD in children, while still considered a trauma-related disorder, can also be considered

developmental in nature as stress-related anxiety and fear create alterations to the brain and central and autonomic nervous systems during crucial developmental years (Painter and Scannapieco, 2013).

Neurodevelopmental studies indicate brain modifications resulting from prolonged exposure to childhood trauma and abuse have been linked to depression, PTSD, and alcohol dependence (Birn et al., 2014). These modifications can result in anomalies throughout multiple areas of the brain including the hippocampus, corpus callosum, and prefrontal and sensory cortexes (Birn et al., 2014; Rinne-Albers et al., 2013). The limbic system, which partly includes the hypothalamus, hippocampus, and amygdala, is responsible for memories and emotions. The hypothalamus represents the regulation system of the brain, or thermostat, responsible for balancing feelings as well as physiological bodily functions such as blood pressure and breathing. The function of the hippocampus relates to memory and cognitive ability and the conversion of short-term memories into long-term memories takes place in the hippocampus. The HPA axis, consisting of the hypothalamus, pituitary gland, and adrenals, is a major part of the neuroendocrine system involved with controlling reactions to stress and research shows stress-induced hyperactivity of this axis is linked to reduced grey matter in the hippocampus (Lu, Gao, Wei, Wu, Liao, Ding, Zhang, & Li, 2013). Known as the storehouse for memory, the hippocampus is believed to play a role in anxiety disorders and panic attacks (Painter & Scannapieco, 2013). Studies substantiating this relationship indicate stress-related alterations to the hippocampus have been associated with

symptoms of PTSD resulting from increased activation of emotions and the inability for fear extinction (Birn et al., 2014; Painter & Scannapieco, 2013).

In addition to the hippocampus, the amygdala indicates vulnerability as well, as this is where fear conditioning and the ability to recognize threat take place (Painter & Scannapieco, 2013). The amygdala plays a key role in the processing of emotions and research indicates a significant link between abnormalities in the amygdala and PTSD (Birn et al., 2014). Neuroimaging studies of adult sufferers of PTSD suggest irregularities in communication between the hippocampus and amygdala result in exaggerated response to fear, in contrast to studies that show resiliency to childhood trauma and better connectivity between the hippocampus and amygdala (Birn et al., 2014). Disconnect happens during times of extreme stress whereby the body responds by releasing hormones that can damage brain cells. As a result, inaccurate storage of traumatic events can occur with an overreaction to triggers resulting from earlier memories (Painter & Scannapieco, 2013). Childhood studies most noticeably show a weakening of the prefrontal cortical pathways making it difficult for the extinction of fear (Birn et al., 2014). Interesting to note is age, as it appears to make a difference as to the amount of disconnect between the amygdala and prefrontal cortex with white matter degeneration in this area resulting in lower anxiety in older adults (Clewett, Bachman, & Mather, 2014).

Meta-analyses studies show changes in brain matter also plays a part in childhood trauma exposure and later life diagnoses of PTSD. Grey matter, which serves as a means of thinking and memory storage, was found to present structural changes in adults

diagnosed with PTSD (Daniels et al., 2013; Lu et al., 2013). White matter, although more challenging to study, shows indication of communication breakdowns between different brain areas (Daniels et al., 2013). In response to the lack of white brain matter studies, Daniels and colleagues (2013) tested individuals with co-existing anxiety and PTSD, as well as conducted a comprehensive review of white matter in trauma-exposed children. The corpus callosum, which houses the largest amount of white matter, is responsible for sending messages from one side of the brain to another. The authors found corpus callosum areas were significantly reduced in PTSD groups in comparison to healthy groups, with sexual abuse as the strongest predictor of reduced corpus callosum in girls (Daniels et al., 2013).

The Development of Anxiety

Trait and State Anxiety

A better understanding of the brain and physiology clarifies how anxiety affects the body and where anxiety comes from. Research indicates internal and external factors play a role in the development of anxiety disorders and PTSD and can be examined by the length of an anxiety episode. This put in psychological terminology refers to anxiety from a state or trait perspective. State anxiety is the short-term heightened fear to a specific dangerous environmental stressor that creates an increased response to threat (Sung et al., 2011). This response results in a highly anxious, sometimes incapacitating emotional state (Sung et al., 2011). The fear of heights, for example, is a common type of state anxiety. In this instance an individual, who has developed the fear of heights, will experience feelings and symptoms of anxiety when in situations that expose them to

high places. This is only temporary, nonetheless, as once the height element is removed the anxious symptoms will begin to dissipate. Importantly, state anxiety should not be considered a lesser form of anxiety due to its shorter duration, as symptoms of distress can be quite profound and debilitating during the period leading up to and during the threat exposure (Sung et al., 2011).

Trait anxiety, on the other hand, reflects genetics, individual personality, and non-shared environmental factors that result in long-term discomfort from worry or stress (Sung et al., 2011). Trait anxiety is the reflection of a build-up of anxiety and those who suffer from this type of anxiety are relatively stable in their anxious response to perceived threatening situations over their lifetime. In other words, trait anxiety is developed as a long-term conditioned response to life, leaving those with high rates of trait anxiety easily stressed and anxious during times of state anxiety and during less stressful times as well (Sung et al., 2011). An individual who is generally fearful a great deal of the time and tends to worry about stable environmental situations would be an example of trait anxiety, as often the situations that create anxiety for these individuals would not present anxiousness in the general population.

Research indicates both state and trait anxiety play a role in AUDs, meaning it is important to better understand the cause of the discomfort and the motives behind alcohol use to deal with thoughts and emotions resulting from anxiety (Sung et al., 2011; O'Hara et al., 2014). Interestingly, while trait vulnerability indicates the same direction of the relationship between anxiety and alcohol, the effect of PTSD symptoms on traits can result in alcohol use or misuse rather than the PTSD symptoms themselves (Read et al,

2014). Current literature expands the differences between state and trait anxiety by digging deeper into the motives underlying the need for alcohol to moderate the negative affect of stressful events. For some, a stressful event may bring about increased alcohol consumption for a short duration, while others may feel the need to continue using alcohol to moderate symptoms of continuous anxiety and stress.

Epidemiological data notes long duration stress, such as that resulting from physical and sexual abuse, presents a strong relationship with alcohol for those diagnosed with PTSD who use alcohol as a means of self-medication (Johnson et al., 2010). Research shows childhood abuse and trauma exposure has been linked with severe alcohol dependence in later life (Copeland, Magnusson, Goransson, & Heilig, 2011; Enoch, 2011; Magnusson et al., 2012; Schwandt et al., 2011). Cross-sectional studies point to a relationship between childhood sexual abuse and alcohol use (Smith et al., 2014). Studies on childhood trauma also show a significant link to AUDs in both early and later life, with some supporting the connection between the two as stronger in females (Painter & Scannapieco, 2013). Additionally, negative affect resulting from early life trauma exposure links negative affect to alcohol cravings, thus supporting the continuous use of alcohol to reduce anxiety symptoms (Simpson et al., 2012).

Anxiety Sensitivity

Negative affect can result not only from thoughts of earlier trauma but also from thoughts of re-experiencing anxiety symptoms. Anxiety sensitivity (AS), or the actual fear of anxiety and its accompanying sensations, has been found to be a factor in the creation of anxiety disorders (Dixon et al., 2014; Gillihan et al., 2011; Harwell et al.,

2011). Studies address the concern that thinking about feelings resulting from anxiety may be enough to trigger the need for alcohol to deal with anxiety symptoms (Dixon et al., 2014; Gillihan et al., 2011; Harwell et al., 2011). In this case, it is not the remembrance of a specific traumatic event but the accompanying symptoms of anxiety, such as elevated heart rate and trembling for example, that create fear and the need to self-medicate with alcohol. Research suggests individuals with AS believe that anxiety sensations may be a catalyst to bringing about catastrophic consequences (Dixon, 2014). Distinct from anxiety, AS is also specified as a risk factor contributing to the onset of AUDs (Harwell et al., 2011).

Concern lies with the hyper-focus on physiological symptoms creating anxiety disorders (Gillihan et al., 2011; Harwell et al., 2011). Individuals who experience trait anxiety have been found to suffer from higher rates of AS due to their experience of ongoing anxiety symptoms (Bardeen, Fergus, & Orcutt, 2014; Dixon et al., 2014; Harwell et al., 2011). In other words, those who experience ongoing long-term anxiety become more fearful of anxiety symptoms such as increased heart rate, perspiration, and shaking, which are perceived by the individual as the threat (Dixon, 2014). AS has been identified in publications as a reason for increased alcohol use, with individuals high on anxiety sensitivity scales presenting higher rates of anxiety disorders (Gillihan et al., 2011).

Studies show AS moderates the relationship between the negative affect and alcohol use, meaning negative emotional periods indicate higher alcohol use with those presenting AS (Harwell et al., 2011). Additionally, there exists strong evidence that AS

is associated with drinking and those diagnosed with anxiety disorders and PTSD may be more vulnerable to AS and the need to use alcohol as a means of reducing symptoms of anxiety (Gillihan et al., 2011). This evidence is further outlined using theoretical models describing why individuals turn to alcohol to deal with anxiety and anxiety symptoms.

Theoretical Models of Alcohol Use for Anxiety

Motivational Models

It is helpful to examine the role of alcohol to reduce symptoms of anxiety with positive and negative reinforcement models of behavior. While both positive and negative reinforcement relate to alcohol misuse and addiction, it is important to clarify each definition. Behavioral in nature, positive reinforcement refers to the implementation of a strategy that results in positive reward. For example, the Motivational Model of Alcohol (Cooper, Frone, Russell, & Mudar, 1995; Cox & Klinger, 1988) states individuals use alcohol because they believe the positive effects of alcohol will make them feel better. For instance, the individual who believes a drink or two at the end of the day will help them unwind from anxious or intense emotions. For some individuals this may work, however, for others the positive effect of alcohol may lessen over time and require more alcohol to achieve the desired result. In this case, evening cocktails may begin as an enjoyable ritual but turn into a means of coping if the need for more alcohol to relax and de-stress increases over time.

Motivational models of alcohol use are particularly relevant for identifying whether someone is using alcohol to cope or as a reaction to avoid intrusive memories (O'Hara et al., 2014). The importance of both positive and negative reinforcement

regarding drinking motives is seen in the Motivational Model of Alcohol Use (Cox & Klinger, 1988). This model proposes expectations surrounding alcohol use are positive in nature, thus believing alcohol can decrease levels of anxiety (Cox & Klinger, 1988). Support of a motivational model is also extended by Cooper and colleagues (1994) who present a four-factor model of alcohol use through social, coping, enhancement, and conformity dimensions. This model extends the concept to include both internal and external positive and negative reinforcement strategies, further identifying specific factors that can influence alcohol use and abuse.

While positive reinforcement from alcohol would refer to the use of alcohol to bring about a pleasurable feeling, negative reinforcement would imply alcohol is used to remove an uncomfortable feeling such as anxiety. Behavioral analyses indicate this negative relationship when considering AS and alcohol use through the negative reinforcement model. In this case, alcohol would be used as a learned response to alleviate feelings of anxiety. Opposite in nature to positive reinforcement, which incorporates the addition of alcohol to relieve anxiety, the negative reinforcement model uses alcohol as a means of taking away symptomatic thoughts, feelings, and emotions of anxiety using alcohol (Gillihan et al., 2011; Harwell et al., 2011).

While both positive and negative reinforcement models indicate different theoretical underpinnings, research presents varying settings for how they are used. Studies show positive reinforcement drinking is more often seen in social settings where individuals drink to enhance their mood and forget about their concerns. Negative reinforcement drinking, on the other hand, is more closely associated with drinking alone

or in a solitary setting (Cooper, 1994; Mohr et al., 2013). This ties back into the idea of drinking motives and whether an individual is drinking to enhance their mood and take their mind off of stress, or drinking as a means to cope with stress. Negative reinforcement relates to a self-medication theory of alcohol that posits alcohol use to alleviate feelings resulting from anxiety. Support for the self-medication model is best described through Conger's Tension Reduction Theory (1956) that posits alcohol is used as a process of reducing negative thoughts and anxiety.

Proposed Theories of Comorbid PTSD and AUD

Tension Reduction Theory

Conger (1956) proposes people learn to drink to avoid negative thoughts and emotions (Beseler et al., 2011). In other words, the tension relating to psychological distress is diminished by the stress dampening effects of alcohol used as a negative reinforcement (Hruska & Delahanty, 2012). This hypothesis is in line with Khantzian's (1985) theory of self-medication that posits individuals with psychological disorders seek relief from symptoms using substances (Haller & Chassin, 2013). The self-medication model continues to be linked to comorbid PTSD and AUD in military populations, with the need for alcohol to help individuals cope with re-experiencing avoidance and hyperarousal symptoms (Capone et al., 2013; Schumm & Chard, 2012).

Further noted is research that addresses tension reduction theory for victims of childhood and adult sexual abuse to regulate posttraumatic stress (Cohn, et al., 2014; Kaysen et al., 2011). Studies on comorbid PTSD and AUD report PTSD symptoms typically precede the onset of alcohol use and the greater report of symptoms, the greater

urgency to self-medicate with alcohol (Gaher et al., 2014; Haller & Chassin, 2014). Despite the self-medication models support for comorbid PTSD and AUD, there lacks a comprehensive analysis of individual factors that contribute to the need to self-medicate (Smith et al., 2014). An extension of the tension reduction hypothesis is presented in the following model.

Stress Response Dampening Model

The Stress Response Dampening Model (SRD) presents an expansion on Conger's theory of the tension reduction hypothesis. SRD states the expectation of anxiety is the motivation for drinking, rather than the actual anxiety itself (Morris, Stewart, & Ham, 2005). Per SRD, negative effect is reduced with alcohol use for those suffering from long-term anxiety disorders such as generalized anxiety disorder (GAD), PTSD, and panic disorders, thus, reinforcing the motivation for continued alcohol use. This model posits the idea that individuals learn to use alcohol to reduce overall anxiety without attention to the specifics of what created the anxiety. It is important to note, when applying this hypothesis, that anxiety and fear are two distinct processes and while alcohol may alleviate stress it may not reduce actual fear (Hefner et al., 2013).

Fear versus anxiety in response to alcohol use has been extensively studied in laboratory research when it comes to startle potential. Reports addressing the relationship between anxiety and SRD note experiments on startle potential, in imminent versus certain threat situations, found alcohol could significantly reduce startle potential during uncertain threat but not during imminent threat (Hefner et al., 2013). This seems to mean alcohol moderates uncertain longer lasting threat rather than short-term

imminent threat. This relates back to state and trait anxiety with those who experience ongoing ambiguous anxiety presenting higher rates of alcohol use disorders than individuals who turn to alcohol to self-medicate during specific short-term anxiety producing instances. It would appear the differences between anxiety symptoms seems to indicate the need to better identify etiological factors that produce ongoing negative thought processes which elevate the potential for negative reinforcement drinking.

The High-Risk Hypothesis

Studies show the self-medication hypothesis does not always explain the relationship between PTSD and AUD, with research noting the abuse of alcohol can place individuals at risk for experiencing traumatic events. The high-risk hypothesis states individuals who abuse substances may place themselves at additional risk for experiencing traumatic events (Chilcoat & Breslau, 1998; George et al., 2014; Roberts & Fillmore, 2015). This is more frequently reported in gender studies with populations physically and sexually abused while under the influence of drugs or alcohol (Alexander 2014; Haller & Chassin, 2014; Schwandt et al., 2013). More recently, research addresses the high-risk hypothesis for victims of childhood abuse and trauma who re-experience subsequent trauma in adult life (Bailey et al., 2012).

The Stress Vulnerability Model

The stress vulnerability model further proposes a twist to the self-medication hypothesis. This model stresses that not all individuals experiencing PTSD turn to alcohol, but rather there must exist specific personal characteristics that create vulnerability for some individuals, but not all (Hruska & Delahanty, 2012). The theory

behind this model further adds credence to the need to study potential risk factors for the development of comorbid PTSD and AUD through a better understanding of how women report their experience with trauma. This means not only current trauma must be better understood, but also potential early life trauma must be examined to understand the phenomenon of self-medication as a complete construct, and not only that from a specific period in one's lifetime.

The Role of Trauma

Original research on PTSD symptoms and cooccurring alcohol use was primarily linked to military men and combat trauma. Studies report impaired ability to function was often found with male soldiers experiencing flashbacks resulting from combat exposure, death, and injury (Capone et al., 2013; Foran et al., 2011; Hassija et al., 2012; Johnson et al., 2015; Maguen et al., 2012; Schumm & Chard, 2012). Current research extends trauma flashbacks associated with military personnel to include enlisted women with comorbid PTSD and AUD resulting from combat and military sexual trauma (Schumm & Chard, 2012). In fact, subsequent studies on women show PTSD symptoms have been found to account for elevated alcohol use more so than the traumatic event itself (Capone et al., 2013).

A growing body of evidence reports multiple forms of violence and abuse extends PTSD symptomology and diagnoses in non-military settings (Cohn et al., 2014; Kaufmann, O'Farrell, Murphy, Murphy, & Muchowski, 2014; Smith et al., 2014). This research acknowledges a PTSD diagnosis can also result from numerous forms of trauma exposure expanding from childhood to adulthood forms of physical, sexual, and

emotional trauma (Simpson, Stappenbeck, Varra, Moore, & Kaysen, 2014; Sigurvinsdottir & Ullman, 2015). One prevailing type of trauma reported in women's studies is rape, which indicates an estimated lifetime prevalence of 12% to 18%, with nearly a quarter of these women developing PTSD (Zinzow et al., 2012). Studies regarding women in the military demonstrate female veterans are consistently showing higher rates of PTSD from military sexual trauma and rape (Maguen et al., 2012).

In both military and non-military research, underlying factors for trauma flashbacks and PTSD symptoms are sparse regarding the relationship between negative affect and alcohol use, especially resulting from childhood sexual and physical abuse (Foster et al., 2014; Hassija et al., 2012; Hellmuth et al., 2013; Maguen et al., 2012; Zinzow et al., 2012). Most abuse research, thus far, has focused on rape as the mediating factor and lacks additional categories of abuse in their analyses. Early childhood trauma, nonetheless, is becoming more prevalent in PTSD and AUD comorbidity research with studies reporting the need to better understand the role of early life trauma and susceptibility to AUD (Brady & Back, 2012; Huang et al., 2012; Schwandt et al., 2013; Smith et al., 2014). Literature emphasizes the need to better understand factors triggering alcohol abuse with women having experienced trauma, as this population is reported to have one of the most severe clinical profiles and worse treatment outcomes in comparison to women who experience PTSD or AUD singularly (Berenz et al. 2012; Duranceau et al., 2014; Tull et al. 2013).

Research is beginning to uncover the importance of coping motives in relationship to multiple types of childhood and adult trauma and cross-sectional and

longitudinal studies present a strong association between female childhood abuse and alcohol disorders (Kaufmann et al., 2014; Smith et al., 2014). Coping motives incorporate the idea of alcohol cravings that can lead to relapse and reports suggest alcohol relapse is often experienced more often on days with greater alcohol cravings (McLean et al., 2011; Simpson et al., 2012). While the self-medication theory proposes a direct path from PTSD symptoms to alcohol use, some studies show the path as indirect with PTSD symptoms effecting personal traits that trigger alcohol use (Read et al., 2014). This suggests the role of individual vulnerabilities needs further examination for a more comprehensive understanding of the potential comorbid connection between the two.

Rumination Theory

Rumination theory (Nolen-Hoeksema, 1991), a response styles theory, helps explain why some women turn to alcohol to cope with negative affect resulting from past trauma. Rumination refers to the excessive self-focus on negative thoughts regarding possible causes and consequences of symptoms of distress, rather than solutions to such thoughts (Nolen-Hoeksema, 1991). Ruminative thoughts are cyclical in nature with a continued re-hashing of possible reasons as to why certain things happen, rather than attempting to relieve negative associations (Nolen-Hoeksema, 1991). While decades of research have shown the connection between rumination, negative affect, depression, and alcohol use, more recent studies are sharpening the association between rumination, alcohol disorders, and alcohol relapse, with a better understanding of how rumination is used as a coping strategy to deal with negative affect (Battista et al., 2013; Brozovich et al., 2014; Caselli et al., 2010; Goldwin et al., 2013; Harwell et al., 2011; Jayawickreme et

al., 2012; Teismann et al., 2014). Alcohol use or abuse to cope with re-occurring negative thoughts is outlined in the literature through two distinct pathways. The first takes a direct path of alcohol used to relieve thoughts brought about by attempting to control ruminative thoughts, and the second involves an indirect approach, with rumination increasing depressive symptoms that trigger alcohol use (Casselli et al., 2010).

A Direct Path

Research pointing to rumination as a coping strategy to control negative affect states the use of continuous negative self-reflection on past events or behaviors is a means to cope with negative feelings (Casselli et al., 2010, Frone, 2015). In this case, individuals purposely re-evaluate past adverse events hoping to bring about relief from negative affect. Self-questioning regarding what may have caused an event, as well as the consequences of the event, are typical for women suffering from anxiety, depression, and alcohol abuse (Brozovich et al., 2015; Ciesla et al., 2011; Jayawickreme et al., 2012). Goldwin (2013) looked at the repercussions of rumination on negative thinking in a population of both those with and without posttraumatic stress symptoms. The authors evaluated two key cognitive conditions of verbal linguistic versus imagery-based thinking and abstract versus concrete thinking. Verbal linguistic thinking, or the use of words to describe thoughts or memories, seemed to interfere with emotional processing and was more often found in participants who experienced depressive rumination without a traumatic event, while imagery-based thinking, or the ability to turn thoughts and

experiences into mental pictures, was present more often in participants having experienced trauma (Goldwin et al., 2013).

Cognitive models show those with PTSD who visually experience past trauma are more likely to see these images in relationship to a current threat they must avoid (Birrer & Michael, 2011). In this case, rumination is used to avoid the visual memory, when in turn, rumination is triggering more traumatic images through the reinforcement of each memory recall of the event (Goldwin et al., 2013). For those with AUDs, this process can be quite dangerous as continuous reflection on past trauma has a high probability of leading to alcohol relapse (Caselli et al., 2010; Ciesla et al., 2011; Epkins, Gardner, & Scanlon, 2013; Frone, 2015; Harwell et al., 2011).

An Indirect Path

An indirect path suggests an unconscious occurrence of past negative or traumatic memories leads to the cyclical nature of rumination (Caselli et al., 2010). This is typical of those suffering from traumatic flashbacks. This group of individuals feel the need to find a way of erasing such thoughts, and often turn to alcohol as a means to self-medicate (Caselli et al., 2010). While research indicates obsessive negative thoughts typically exacerbate already existing stress and anxiety, it would then place rumination as a factor that creates negative affect rather than a coping strategy (Teismann et al., 2014). Rumination, therefore, represents a risk or vulnerability for individuals with AUD as reoccurring thoughts relating to past negative events is highly associated with alcohol relapse (Tait et al., 2013). This is especially true for individuals who ruminate over traumatic experiences. This group of individuals is not necessarily looking for a means

to solve depressive thoughts, but rather a means to dampen the occurrence of these recollections all together (Battista et al., 2013). This relates back to self-medication theory and the use of alcohol to cope with negative thoughts and feelings.

Gender-Based Research

Thoughts and feelings pertaining to gender differences exist in studies on alcohol use. History expresses the use and abuse of alcohol has been better tolerated when seen in male contexts as opposed to female (Tait et al., 2013). Current research reports the percentage of women with AUD continues to rise and awareness in gender differences outline the need to conduct additional research on women with comorbid PTSD and AUD. Recent studies indicate women are much more susceptible for getting stuck in a pattern of negative thoughts regarding past situations to which they self-medicate with alcohol (Ciesla et al., 2011; Tait et al., 2013). Gender variations are also reported based upon the type of thought or rumination, as it appears men and women exhibit depressive and angry rumination quite differently in reaction to negative affect. Ciesla (2011) found higher rates of angry rumination led to higher weekly drinking with women but not so with men, although worry based rumination showed less weekly drinking with women yet no differences with men.

Gender differences have also been linked to post-event processing similar to rumination. Post-event processing, or a maladaptive means to respond to distressing symptoms, is described as dwelling on one's past performance regarding a situation and the meaning and causes of particular negative consequences (Nolen-Hoeksema, 1994). As previously discussed, women report higher rates of rumination, therefore, the need to

examine factors of rumination requires future attention. Battista (2013), when examining gender in relationship to alcohol use and post-event processing, found women who consumed more alcohol reported less post-event processing than women consuming less alcohol. Men, on the other hand, reported more post-event processing with higher rates of alcohol compared to men consuming lower rates of alcohol (Battista et al., 2013). This study not only reinforces gender differences, but also strengthens reports that women who consumed higher rates of alcohol found some relief from continuous rehashing of negative events.

While women tend to ruminate more often than men, gender differences can be found with women in response to alcohol abuse and rumination. One mediating factor being under the influence of alcohol during time of assault. Statistics report approximately half of rapes involve women under the influence, and this population also reports greater percentages of developing PTSD (Zinzow et al., 2012). Studies support the possibility women under the influence not only place themselves at greater risk for victimization but also respond differently to sexual situations than non-victimized women (George, 2014). Higher rates of dysfunctional beliefs and rumination are reported as effecting a woman's belief in herself and safety in the world around her (Matos et al., 2013; Turliuc, Măirean, & Turliuc, 2015). Shame additionally plays a role in instances regarding women who were drinking at time of assault. Many of these women partially blame themselves for their inability to ward off an attack while intoxicated, and ruminating about what they could have done exacerbates PTSD symptoms (Matos, Pinto-Gouveia, & Costa, 2013).

The Need for Comprehensive Treatment

The above-mentioned factors touch on some of the most imperative points to consider when treating women with cooccurring PTSD and AUD. Although, much more gender-based research is needed due to the difficulty in treating both disorders simultaneously. Epidemiological studies report the majority of women in substance abuse treatment centers meet a diagnosis of cooccurring PTSD, with those presenting comorbid psychopathologies being less compliant to treatment strategies (Hein et al., 2012, 2015). Treating both disorders concurrently presents a challenge with many believing that an individual's alcohol addiction must first be conquered prior to working on PTSD symptoms (Gielen et al., 2014). While this seems plausible, many women report difficulty in getting sober due to ruminating on past-traumatic thoughts and memories that continue to place them at risk for relapse (Battista et al., 2013; Ciesla et al., 2011; Jayawickreme et al., 2012). To deal with this conundrum, integrated treatment strategies are beginning to gain momentum with a variety of designs.

One method of combined treatment places emphasis on the past with trauma-based techniques in conjunction with relapse prevention strategies. This integrative approach explores trauma thoughts and memories to reduce alcohol cravings, in addition to implementing prolonged exposure (PE) techniques to work through PTSD symptoms (Mills et al., 2012; Sannibale et al., 2013). Present-focused strategies, on the other hand, limit the exploration of trauma-based memories using cognitive-behavioral strategies to improve current functioning and coping strategies (Hein et al., 2015; Najavits & Hein, 2013). Whether the design be past or present focused, research acknowledges the need to

address both diagnoses simultaneously for the best possible treatment outcome (Hein et al., 2015; Mills et al., 2012, Najavits & Hein, 2013; Sannibale et al., 2013). One present-focused dual strategy gaining momentum in PTSD literature is Seeking Safety.

The dual integration strategy of Seeking Safety is the most empirically-based PTSD and AUD treatment strategy, thus far, showing higher rates of program completion (Morgan-Lopez et al. 2014). Using a present-focused cognitive-behavioral approach, Seeking Safety addresses the safety of the client in a way that does not ask them to delve deeply into emotionally disturbing trauma narratives. The approach deals with the here-and-now, teaching clients how to apply successful coping skills to present daily life. Seeking Safety balks conventional trauma therapy, such as PE, noting individuals with substance abuse have difficulty working through trauma recall without turning to alcohol for relief (Hein et al., 2015). While the program reports higher rates of treatment completion, PTSD and AUD symptoms have not shown significant improvement when it comes to relapse prevention (Berenz et al., 2012).

Contrary to solely present-focused strategies, like Seeking Safety, are those that place importance on uncovering and working through past trauma while still staying focused on the present. Lazarus and Folkman (1984) identify two types of coping strategies as problem-focused (PF) and emotion-focused (EF) coping. PF coping strategies directly attempt to eliminate or reduce issues or stressors, while EF strategies are designed to manage emotional distress resulting from trauma states (Majer, Droege, & Jason, 2012). Programs such as Seeking Safety look more towards managing and coping with day-to-day stressors, a form of EF coping, rather than delving into the deep

abyss of the trauma that creates PTSD symptoms. On the other hand, strategies such as prolonged exposure (PE), representative of PF coping, seek to uncover the basis for distress to work through traumatic memories and illuminate stressors.

Surprising to many, Alcoholics Anonymous (AA) is a program that deals with both past and present recovery strategies and AA's 12 steps of recovery are the most widely used program in substance abuse facilities (Witbrodt, & Dlucchi, 2011). Recent research reports some of the strongest longitudinal gender findings for individuals with AUD who use the 12-steps of recovery for alcohol abstinence (Majer et al., 2012). While structured as a program for alcoholics, gender studies report many women seeking help from AA also present comorbid PTSD (Gielen et al., 2014). In addition to the 12 steps, AA emphasizes many tools with the power of story-telling of one's painful past acknowledged as a key factor to sustained sobriety. This story-telling, in form, presents some similarities to PF coping. Honestly sharing one's painful story became the cornerstone for AA recovery, as first told in 1934 between Bill Wilson and Dr. Bob Smith the co-founders of AA (Alcoholics Anonymous, 2001). AA still emphasizes this as part of the fourth step, whereby a newcomer to AA meets with an old-timer to share their story of alcoholic destruction. For many, this may be the first time they tell someone else the source of their drinking which, for women, often results from childhood or adult physical or sexual trauma (Bailey et al., Foster et al., 2014, Hellmuth et al., & Huang et al., 2013). It is important to note, the AA member on the receiving end most likely has not received any formal training in therapeutic techniques, yet through the process of listening and sharing their own personal story, provides safety and relief for

the newcomer. The program of AA recommends uncovering the past to work through painful thoughts and memories that drive individuals to drink. This recounting, along with a present-focused action plan to cope with daily stressors, is a source of aid for many women recovering from trauma histories and simultaneous alcohol abuse.

Summary and Conclusions

Uncovering explicit factors of trauma history is beneficial in long-term sobriety, although there lacks qualitative research that describes specific thoughts and emotions typically experienced by women who suffer from comorbid PTSD and AUD. This gap exists not only within AA research, but across all domains of comorbid PTSD and AUD literature. Without a better understanding of trauma-related triggers of alcohol use, women experiencing a dual diagnosis will continue to present high rates of treatment non-compliance, relapse, and alcohol destruction. It is the hope of this study to present a deeper understanding of how women describe the phenomenon of cooccurring trauma and alcohol use to help those with comorbid PTSD and AUD better understand their diagnosis. It is also hoped this information may someday be helpful in the development of more effective treatment protocols designed to meet the independent need of each client.

Chapter 3: Research Method

Introduction

This qualitative study responds to the following gap in research literature: to explore the phenomenon of comorbid PTSD and AUD in women. Qualitative research allows the researcher to investigate a phenomenon to better understand the meaning an individual or group attributes to a problem (Creswell, 2009). I used a qualitative strategy to address the lack of gender-based studies which provide detailed information of comorbid PTSD and AUD (Hruska et al., 2011; Johnson et al., 2010; Lehavot et al., 2014). Therefore, a better understanding of how participants describe their experience with rumination and self-medication was uncovered. This information may help explain some deficiencies in prevailing research regarding the role of rumination and self-medication in relationship to alcohol relapse.

This chapter includes a detailed description of the research design, my role in the research process, and the methodology for the study. A rationale for the choice of design is outlined, as well as the logic used to define the population for participant selection. This chapter further details the instrumentation used to collect data. I further explain data analysis procedures and the dissemination of my findings. Finally, Chapter 3 concludes with a review of ethical procedures needed to support the earnestness of this study.

Research Design and Rationale

A qualitative phenomenological research paradigm provides a way to increase individual and public understanding of how participants described their lived experience with alcohol use to self-medicate PTSD symptoms. Qualitative methods are especially

effective for studying phenomena that lack sufficient research (Creswell, 2009). They are also a process for generating additional questions for future qualitative and quantitative studies of a phenomenon. Although purely descriptive in nature, this study may present new information which can be used in future qualitative and quantitative research on this topic.

The research questions for a qualitative study are based upon the study's purpose (Creswell, 2009). The lived experiences of the women of this study detail how women with comorbid PTSD and AUD describe their use of alcohol to self-medicate PTSD symptoms. The research questions prompted a description of the overall essence of participants' cognitive and physical understandings of their experiences. This information emerged through two broad interview questions that asked respondents to describe their lived experience with a diagnosis of PTSD and AUD, and how they felt their diagnosis could be better understood. A deeper understanding of the phenomenon surfaced through sub questions that probed the overall essence of participants' thoughts, feelings, and behaviors prior to self-medicating with alcohol. The sub questions also inquired the typical physical settings when participants self-medicated with alcohol, their unsuccessful experiences when they self-medicated with alcohol, and their successful experiences when they refrained from self-medicating with alcohol.

Moussakas' (1994) transcendental phenomenological approach (1994) provided a means to gather detailed information on how participants described their experience with cooccurring PTSD and AUD. Originally outlined by Edmund Husserl (1931), transcendental phenomenology is grounded upon subjective openness. This was often

criticized during Husserl's time, however, today this approach is highly regarded when the need to gather more explicit information about a phenomenon is necessary (Moustakas, 1994). The word phenomenon means to flare-up, show itself, to appear. Moustakas set out to design a transcendental approach to bring to light that which is held in the consciousness of an individual based solely upon descriptions provided by participants (Moustakas, 1994). To do so, however, requires some cautious preparation by the researcher.

Role of Researcher

In phenomenology, the researcher is the instrument used for data collection. This makes it necessary for the researcher to relieve themselves, as much as humanly possible, of any previous preconceived ideas regarding the phenomenon (Moustakas, 1994). Biases or prejudices of the phenomenon under investigation must be addressed prior to the collection of data and the transcription of text for analysis (Moustakas, 1994). Husserl termed the abstinence of ideas as the "*epoche*", that to him meant a means of purifying one's consciousness (Moustakas, 1994). Moustakas (1994) eloquently describes the process of the epoche as the need for the researcher to prepare for new knowledge by "bracketing out" any previously held thoughts and beliefs to enter into a new consciousness apart from the world. Within this new reality, the researcher can listen to participants describe their experience with the phenomenon as if it were being heard for the very first time. While a daunting task indeed, this process requires unwavering attention and presence, with a so-called humbling of the researcher to resist ego and any previously held notions regarding the phenomenon (Moustakas, 1994).

While perfect adherence to this practice is unlikely, it is imperative for the researcher to reveal any personal and professional relationships that may influence this process of data collection.

As a researcher, it is important for me to disclose my experience with this phenomenon, as this could potentially bias the findings if not continuously monitored. To begin, I have been a member of AA for 18 years and I have volunteered with women in recovery for 17 of those years. As part of AA's 12-step program, it is suggested that individuals complete what is called a fourth-step inventory. This process basically outlines any resentments, fears, and bad behaviors which, if not overcome, could continue to trigger alcohol relapse. While some complete this process in an abbreviated fashion, the format is quite detailed. It requires a good deal of time spent with the newcomer to AA revealing their past thoughts, feelings, and behaviors to a seasoned member of AA. I was fortunate, during my early days in the program, to work with an AA veteran who was taught the 12-step program from the original co-founders Bill Wilson and Dr. Bob Smith. While this process continues with AA today, the thoroughness of the early design has fallen somewhat by the wayside. It is the original meaning of the forth step that I presently teach in classes and utilize in my volunteer work with women in AA. Due to my past, I have listened to many women with AUD describe their experience with alcohol and relapse, and important to note, many of these stories also include a comorbid diagnosis of PTSD resulting from physical and sexual trauma. While it would be assumed my experience with the phenomenon could bias my thoughts, it has made me a better listener. Knowing that everyone has specific variations

in their story of alcohol dependency helps me remain open to their personal experience. I understand the vulnerability with this population and the need to proceed with care when discussing such private matters. My role as researcher, however, is much different for this study in comparison with my work with AA members. In the capacity of this research, I was there strictly to gather information and not to provide counsel, however, protocol was implemented for cases requiring any therapeutic support.

Methodology

Participants

The sample of participants for this study comprised 12 females presenting comorbid PTSD and AUD, with diagnoses received from accredited practicing psychological professionals. Parameters for participant selection outline a minimum age of 18, current attendance of AA meetings, a minimum of one-year post traumatic experience, and at least one year of continuous sobriety. Participants were excluded who had not received treatment from a practicing professional for PTSD and were not currently working with an AA sponsor. Regarding the context of the study, the sample size selected was based upon review of previous literature that reflects the "rule of thumb" for appropriate sample size for qualitative studies. While there is no set number specifically allocated for sample size in qualitative research sampling, the research depends upon several factors to support the study's purpose (Patton, 2002). One major factor is that of saturation, or the point to which no new information produces a change in that already detected (Guest, Bunce, & Johnson, 2006). Being that this study is based upon specific criterion of a homogenous group of women, I selected a sample size of 12,

as indicated by numerous studies and authors as adequate for reaching saturation in similar qualitative research (Creswell, 2013; Guest et al., 2006; Patton, 2002).

The participants were secured through flyers placed at numerous women's AA meetings throughout the city of Richmond, VA. Potential participants contacted me directly by a phone number exclusively for this study. A brief phone meeting of 15 minutes was conducted for prescreening each potential participant, as well as to discuss the purpose of the study. At this time, informed consent and confidentiality was outlined, and participant protection from potential harm from the study was discussed. Twelve women were selected from the above-mentioned criteria who agreed to participate in the study. The women were scheduled for sixty to ninety-minute one-on-one interviews, in addition to a ten-minute debriefing session post-interview. A phone number for a professional counselor was also available in case any participant became distressed and could not reach their personal counselor or AA sponsor.

Data Collection

Upon receiving Walden University's IRB approval number of 09-20-16-0339515, participants were interviewed over a two-month period. All women signed informed consent and confidentiality forms prior to being interviewed. These forms also included permission to audio tape interviews. Recordings of the interviews were transcribed verbatim for uncovering reoccurring themes and patterns regarding participants' use of alcohol as a means of self-medication from past trauma. All interviews were conducted face-to-face in a neutral private office setting over a sixty to ninety-minute time frame. This allowed for anonymity of participants, as well as enough time to uncover the

essence of their lived experience with comorbid PTSD and AUD regarding alcohol abuse and relapse. The following details the open-ended interview structure including two main questions and four sub questions:

Main Questions

1. What are the lived experiences of women diagnosed with PTSD and AUD as described by them?
2. How do women diagnosed with PTSD and AUD describe how their diagnosis can be better understood?

Sub Questions

1. What is the overall essence of thoughts, feelings, and behaviors described by women with PTSD and AUD prior to self-medicating with alcohol?
2. What is the overall essence of the physical settings described by women diagnosed with PTSD and AUD when they self-medicate with alcohol?
3. How did women with PTSD and AUD describe their unsuccessful experiences when they succumb to self-medicating with alcohol?
4. How did women with PTSD and AUD describe their successful experiences when they refrained from self-medicating with alcohol?

Data Analysis

A phenomenological analysis, based upon the transcendental philosophies of Husserl (1931) and Moustakas (1994), was conducted from the data collected at interviews. From these philosophical viewpoints, the intentionality of this research was

to study the conscious lived experience of women with comorbid PTSD and AUD. That which appears in the participant's consciousness being the phenomenon under investigation. Intentionality, or consciousness, is comprised of a "*noema*" and "*noesis*" according to Husserl (1931). The noesis consists of the mind and spirit, or that which is perceived, thought, or felt, and the noema being that which is physical, is the recollection or remembrance of an experience through consciousness (Moustakas, 1994). The relationship between the noema and noesis represents the intentionality of consciousness (Moustakas, 1994).

This process began with the epoche, or the bracketing out of previously held judgements, biases, and knowledge, to prepare myself to see each participant interview from a fresh perspective. Once all interviews were conducted and transcriptions of the interviews were complete, the transcripts were entered into the software program of NVivo (QSR Int., 2015) to aid in data coding and analysis. NVivo was helpful for storing, sorting, and coding the vast amount of information gathered during participant interviews, and allowed for all data to be contained in one location compatible with Microsoft Word. It is important to note, similar themes and patterns of the research were detected and reported, as well as all outlying or discrepant descriptions when disseminating my findings.

Once the data was entered, sorted, and categorized, I began the process of phenomenological reduction, or the task of recounting what was seen in the transcripts from a textural or external standpoint. The process of phenomenal reduction required multiple times of looking and describing the information until it was reduced to what is

considered horizonal and thematic. Horizonal refers to the endless possibilities of the experience of the phenomenon from a conscious perspective, while incorporating textural descriptions for each possibility (Moustakas, 1994). Once this was complete, imaginative variation was implemented to arrive at structural descriptions of the phenomenon, or the underlying factors or perspectives that brought about that which was experienced (Moustakas, 1994). In addition to using NVivo to organize and code the information from each interview, I also hand coded transcripts for review. I felt this would make it easier for me to gain a deeper understanding of the content of the raw data. This coding was then compared to that from NVivo to gain more intimacy with thematic outputs.

Once both textural and structural meanings were derived, a synthesis of meanings and essences was created into a unified statement revealing the essence of the phenomenon as a whole (Moustakas, 1994). This does not mean the statement of the essence is completely exhaustive, as there may be an infinite number of possibilities yet to be uncovered. At this point, I included my own influential experiences regarding the phenomenon, that were previously set aside at the beginning of the study. Regarding the personal nature of this research, the information presented in this study is only representative of my personal analysis based solely upon a particular time and place. This information might, however, provide an outline to a method that can be re-examined with future data in multiple types of settings.

Trustworthiness

Trustworthiness relates to reliability and validity of research, although these terms are quite different in qualitative as opposed to quantitative studies. Qualitative research

applies a naturalistic approach to understanding a phenomenon without the use of statistical methods of measurement (Creswell, 2009). With this in mind, the reliability and validity of qualitative research must be redefined or, or according to the actual nature of this type of research, it would be deemed both invalid and unreliable (Creswell, 2009). The trustworthiness of qualitative research depends on the exactness of the information gathered, or in other words, does the data collected from in-depth interviews of participants reflect the true purpose of the research? In response to the challenge of trustworthiness in qualitative research, I used specific techniques developed to verify the authenticity of the findings relating to the qualitative counterparts of reliability and validity. This is outlined through the following aspects of credibility, transferability, dependability, and confirmability.

The credibility, or whether the findings of this study are accurate and believable, involved both researcher and member checking. This process included a precise review of all audio tapes and hand written notes. Transcripts were checked multiple times for correctness against tape recordings of the interviews. Once complete, a follow-up appointment was scheduled with participants for the process of member checking. At this time, participants reviewed their transcripts for accuracy and cleared up any miscommunication that might have occurred during the interview process. This was also a time for participants to add any additional information they felt was relevant but neglected during the first interview. Once this information was verified, the transcripts were entered into NVivo and checked again for accuracy against existing sources of data. Checking for credibility did not end at this point, and was continuously reassessed during

the entire process of text analysis until reaching the point of data saturation. Peer review was also utilized to increase the validity of the study. The next step was to assess transferability.

Qualitative research uses smaller sample sizes, making it more difficult to demonstrate the application of findings to other situations. To combat this dilemma, I utilized thick, thorough descriptions involving the phenomenon under investigation. Thus, making it easier for the research to be transferable to other populations and settings. Transferability should be approached with caution, however, making sure replication of a research strategy is chosen from studies that provide an adequate description for transferability. This study did so, by providing rich descriptive information regarding the population, boundaries of the study, the interview, interview questions, and all information pertaining to data collection and analysis.

The dependability of this study is reflected through the process of determining if this work were repeated in the same manner as described, similar results would be produced. It is for that reason; a detailed accounting of all processes is documented allowing for the replication of future research with other populations using the same methods. The execution of this study is explicitly presented through a detailed description of the entire process from start to finish, including an audit trail to trace the course of the research regarding the culmination of the overall essence of the study.

After checking for dependability, the last point of trustworthiness in qualitative research concerns confirmability, or to ensure the findings are representative of the experiences of the participants, rather than the biases and previously held beliefs of the

researcher. A transcendental research framework helped to bolster the objectivity of this study by using the epoche previously described. A second audit trail reflected the theoretical framework of the research, allowing me to constantly check my own objectivity regarding the phenomenon. Once again, conformability was enhanced through a continuous process of checking and re-checking data.

Ethical Procedures

Informed consent and confidentiality requirements of Walden University's Institutional Review Board (IRB) were adhered to prior to conducting all research for this study. Informed consent forms were signed by each participant prior to interviews that clearly stated information pertaining to the study. The form provided (a) a description of the study, (b) information regarding myself as the researcher, (c) the purpose of the study, (d) the process used to gather information, (e) the voluntary nature of the study, (f) risks and benefits of the study, (g) the right to privacy of the study, (h) dissemination of findings, and (i) the right to withdraw from the research at any time. Due to the sensitive nature of this study, participants were aware that a licensed mental health professional would be available in case they experienced any adverse effects and their personal therapist was not available.

Prior to participants signing a confidentiality agreement, the issue of confidentiality was discussed at length, stating participant rights to privacy of information disclosed during the interview process. This form outlined all efforts put in place to make sure participant information was protected, including notation that unauthorized disclosure of this information can have legal ramifications for the researcher.

Participants were aware all transcripts and tape recordings were anonymously coded, rather than labeled with the participants' name, and were to be stored in a locked cabinet in my residence for the period of five years. It was also discussed all data gathered on my personal computer would be password protected, with only the subjects code and not their name. Participants were also informed all information will be removed from my computer and stored on disc in participant files upon completion of the research.

Summary

This chapter provides a synopsis of the research intent in conjunction with the purpose of this study, in addition to the research questions designed for data gathering. The role of myself as the researcher was intimately disclosed and the methodology implemented for participant selection was fully detailed. This chapter also outlines steps taken for data collection, analysis, and dissemination of findings, in addition to ethical procedures implemented for participant protection. This chapter concludes with a discussion of the trustworthiness of this study, and its relationship to future research

Chapter 4: Results

Introduction

The purpose of this study was to explore the phenomenon of self-medication and rumination among women diagnosed with comorbid PTSD and AUD. The topic addresses the gap in gender-based literature reflecting a female point of view. Two broad research questions guided data collection on how participants describe their lived experience with comorbid PTSD and AUD, and how they feel their cooccurring diagnosis could be better understood by professionals. Sub questions gathered more specific participant descriptions including their thoughts, feeling, and actions prior to alcohol relapse. Sub questions additionally prompted participant descriptions of their successful experiences with alcohol abstinence and unsuccessful experiences of alcohol relapse.

Chapter 4 begins with an accounting of the setting where the interviews took place. I also include information on relevant demographic characteristics of the participants. The procedures for data collection and analysis are outlined, along with an examination of the study's trustworthiness pertaining to credibility, transferability, dependability, and confirmability. Results are addressed through seven overarching themes which emerged from the data. An overall synthesis of the themes was developed into a textural and structural meaning of the participants' experiences using a transcendental phenomenological framework (Moustakas, 1994). This chapter concludes with a summary of the combined group experience, or overarching essence of the

participants' lived experience with the phenomenon, and how it relates to my research questions.

Setting

The method for recruiting participants placed flyers at five women's meetings of Alcoholics Anonymous (AA) in Richmond, Virginia. Flyers included the title and purpose of the study, eligibility criteria, a disclosure that participation would be voluntary and confidential, and an email address and telephone number to contact if interested in participating in the research. Thirty-two potential applicants responded to the flyers and were pre-screened to ensure that the eligibility requirements were met. Requirements included being (a) female, (b) 18 years or older, (c) English speaking, (d) dually diagnosed with PTSD and AUD, (e) a member of AA with at least 1 year of continuous sobriety and a program sponsor, (f) at least one year post trauma experience, and (g) past difficulties with alcohol relapse.

Demographics

Participants for this study ranged in age from 38-60 with an average age of 56. All 12 participants self-identified as Caucasian, and reported being a current members of AA. Years of sobriety ranged from 5 to 18 years for participants, with the average length being 10 years. All but one participant had been married at some point in her life. However, 10 of the 12 participants married reported that they are now divorced from their first husbands; four of them said they had remarried, and six were single. Trauma histories of the participants span physical, sexual, and psychological abuse covering time periods of early childhood through adulthood. Eight of the participants came from

households with one or two alcoholic parents. Of the remaining participants, two said that their parents were heavy social drinkers. One described occasional social drinking by her parents, and one participant reported a household where neither parent drank.

Data Collection

From the 32 potential respondents, 12 participants met my eligibility requirements. Interviews took place over a 9-week period from October 29, 2016 to December 29, 2016. A private, neutral office location protected participant anonymity**.** All participants read confidentiality agreements, read and signed informed consent forms, and agreed to having their interviews audio-taped. The format of the interview consisted of nine open-ended questions and participants were instructed to answer each question as honestly as they could with as much detail as they were comfortable with. Participants were given 90 minutes to respond to questions pertaining to their alcohol use history; thoughts, feelings, and behaviors surrounding their alcoholism; and how they felt their diagnosis could be better understood by practitioners treating comorbid PTSD and AUD.

The interviews ranged from 45-75 minutes, with most interviews averaging around 60 minutes. All interviews were audio-taped, transcribed, and placed in a file created for each participant, which also included biographical data gathered from the interviews, informed consent forms, confidentiality agreements, interview transcripts and hand-coded notes. Each participant selected an alias to secure her anonymity, and case numbers were assigned from 1 to 12. Written documents and audio tapes will be stored for a minimum of five years in a locked file cabinet at my residence, and my computer is

password protected. All data was collected as planned, with no unusual circumstances presented during data collection.

Interview Questions

Nine interview question were developed to address two main research questions. Data from interview Questions 1 through 5 looked to understand and describe the participants lived experience of comorbid PTSD and AUD:

1. Can you describe for me your history of alcohol use?
2. What were the circumstances surrounding the time you began using alcohol as a means to self-medicate or escape?
3. Can you describe for me your typical physical surroundings during times of relapse?
4. How would you describe the thoughts that came to mind prior to relapsing?
5. How would you describe what you were physically feeling prior to relapsing?

Interview Questions 6 to 9 addressed how participant's felt their diagnosis could be better understood and treated by professionals:

6. How would you describe your behaviors and actions prior to relapsing?
7. What thoughts and/or behaviors were most likely to lead you to alcohol relapse?
8. What thoughts and /or behaviors have been the most successful to help you refrain from alcohol?
9. How do you feel your diagnosis of PTSD and AUD can be better understood by professionals who treat women with this dual disorder?

Data Analysis

The transcendental philosophies of Husserl (1931) and Moustakas (1994) are the basis of data analysis for this study. Transcendental phenomenology allowed me, as the researcher, to move past what I may have typically believed or experienced about the phenomenon to be open to endless possibilities of experiences as described by participants. This philosophy provided the back drop to investigate the phenomenon of comorbid PTSD and AUD from a fresh, new perspective.

Moustakas' (1994) model of phenomenological reduction of data includes (a) epoché, (b) horizonalization, (c) clustering of themes, (d) textural description of the experience, (e) structural description of the experience, and (f) textural-structural synthesis of the experience. Through these steps, the noema (or, phenomenon) and the noesis (or, meanings) gave definition to participants' meanings of their experiences with the phenomenon. While keeping in mind a self-medication model for alcohol use, as well as Conger's (1956) tension reduction theory of stress through alcohol use, I continuously worked to remain open to endless possibilities of participant descriptions of their experience with the phenomenon. This allowed the data to unearth a full, rich textural description from both an individual and group perspective.

The Epoché

To look at the phenomenon of comorbid PTSD and AUD with a fresh outlook, I first had to set aside any previous predispositions regarding the phenomenon. This is called the epoché (Husserl, 1931) or state of suspended judgement. This process allows seeing the experience with a new pair of glasses, so to speak. Ideas, attitudes, and

experiences become detached from my previous perception of the phenomenon. This setting aside of preconceived ideas and notions began early on with this study by writing and recording my personal exposure with the phenomenon and my previous experience listening to women diagnosed with comorbid PTSD and AUD. I also recorded my personal thoughts and experience on the phenomenon after writing the literature review, knowing additional research and knowledge may have potentially altered my preceding belief system. This process helped to clear my mind, knowing my personal biases and ideas were recorded for later reflection. Moustakas (1994) states new knowledge is an experience in itself and I attempted to stay grounded in the essence of what new knowledge was uncovered with each participant. While it is impossible to completely remove all preconceived judgements, prejudice, and understanding, continuous reflection and practice of the epoché increased my competency to remain fresh during the process of data reflection and analysis.

Phenomenological Reduction

Phenomenological reduction includes the process of (a) bracketing out the topic or question, (b) horizonalization, (c) clustering horizons into themes, and (d) organizing horizons into a textural description (Moustakas, 1994). Audio taped interview data was transcribed and input into NVivo (QSR, 2015) software to code and analyze data by clustering information into specific re-occurring themes. In addition to using NVivo (QSR, 2015), I personally hand coded copies of interviews and compared them to codes developed in NVivo (QSR, 2015). This process checked and assured all codes or horizons and themes were captured. In bracketing out past experiences, I focused the

research away from my previously held conceptions with the phenomenon to remain firmly rooted in the experiences of the participants and the research questions (Moustakas, 1994). The processes of bracketing, horizonalization, and clustering into themes was ongoing during this phase of phenomenological reduction and continuous review and reflection of the data involved a conscious effort for myself to remain transparent while I reviewed and coded data. Bracketing out the topic helped to move the research away from me so that I could interact with the data from the participants' perspective.

Through multiple readings and analyses, I coded the interviews into significant statements or topics, with cross coding of interviews allowing for the emergence of similar descriptions and statements among participants. From the codes and themes an overall textural meaning of the phenomenon was developed. This is what Moustakas (1994) refers to as the "what" of phenomenological reduction, or what one sees through the interaction of the relationship of the internal conscience of experience of the phenomenon (Moustakas, 1994). Specific quotes provide vivid accountings of participant experiences with comorbid PTSD and AUD. These descriptions are written verbatim from transcripts including both individual and composite textural descriptions of participant experiences with the phenomenon.

Imaginative Variation

While phenomenological reduction composes the textural description of the data, the structural definition is achieved through the process of imaginative variation, or the means to arrive at divergent possibilities using imagination and endless perspectives

(Moustakas, 1994). The structural definition in phenomenological data is what Moustakas (1994) defines as the "how" of the data, or how did the experience of the phenomenon become what it is. To arrive at a structural definition for the data, continuous reflection on the information from perspectives of time, space, cause, and relationship was implemented. Thus, acknowledging the idea there would be more than one single road to the information before me, in fact, this process would uncover an endless list of possibilities (Moustakas, 1994). The examination of internal or conscious experiences were limitless, however, continuous reflection brought meaning and understanding to each individual textural definition, as well as an over-arching structural essence for the group.

Synthesis of Meaning and Essences

The final step in data analysis was the synthesis of a universal textural-structural meaning for the lived experiences of the phenomenon as described by participants. This combined the overall essence of individual textural descriptions emerging from the written transcripts with the individual structural descriptions of the experience evolving through the process of free imagination and intuition. The combination of both the textural and structural descriptions makes up the over-arching essence of the group's experience with the phenomenon of comorbid PTSD and AUD based upon a particular time, place, and vantage point of myself as the researcher.

Emergent Themes

The 12 verbatim interview transcripts were extensively analyzed with hand coding and the use of NVivo (QSR, 2015) software. The first step was to read through

all data and broad code significant statements. This gave me an overall sense of the data, along with some meaning behind it. Based upon the phenomenological nature of my study, I then proceeded to go back through the data and code for finer themes to place into nodes, or groupings. I initially coded 709 meaningful statements within 57 nodes. A continuous process of reading and re-reading each node began, removing any duplicate information. I then coded at multiple nodes and utilized word search queries, which helped to reveal patterns throughout the data. Some of the most frequently occurring words or statements coming out of detailed nodes include "anger", "anxiety", "depression", "drinking to escape", "drinking to forget home life", "I felt worthless", "I wanted to die", "I was afraid", "low self-esteem", and "sadness". Nodes were then combined within appropriate themes containing parent nodes and child nodes. Child nodes, or sub nodes contain coding to finer themes found under the parent node, or greater theme. After numerous times of working through each node, patterns appeared resulting in the following seven significant themes made up of 189 statements.

Theme 1: Alcohol and Trauma

Theme 2: Difficulty with Thoughts

Theme 3: Self-Medicate from Feelings

Theme 4: Behaviors Prior to Relapse

Theme 5: Subsequent Abuse

Theme 6: What Works

Theme 7: What Professionals Need to Know

Discrepant Findings

Discrepant findings were in the minority of the participants' descriptions of their lived experience with PTSD and AUD. Any variations to the major themes are addressed following each of the seven themes.

Evidence of Trustworthiness

Several steps establish the trustworthiness of this research in areas of credibility, transferability, dependability, and confirmability. Credibility is found with persistent review of the verbatim transcripts to identify meanings and emerging themes. Each transcript was checked and re-checked against the audio-taped interviews, as well as having a peer review of each transcript against audio-taped recordings. In addition, participants reviewed typed transcripts of their interviews to acknowledge their information reflected the essence of their experience. Once transcripts were entered into NVivo (QSR, 2015), I once again checked for accuracy. I thoroughly outlined the research process involved in this study to make it easier to transfer this research to other populations and settings. Qualitative research typically uses small sample sizes, so to make transferability possible, I used rich, thorough, and descriptive information regarding the population, boundaries of the study, interview setting, and all information pertaining to data collection and analysis. The dependability of this study is found through a detailed accounting of all processes necessary to conduct a replication of this study in the future. The last point, or conformability of the study, helps to ensure the findings of this research are reflective of the participants and not of myself as the researcher. The transcendental framework of Moustakas (1994) helped to bolster

objectivity of this study using the epoché, as well as continuous use of "bracketing out" my personal thoughts and biases to remain open to the essence of the participants' experiences with as much clarity as possible.

Participant Profiles

Participant 1 (Heidi)

Heidi, age 48, grew up in a household with an alcoholic father and angry mother. She began drinking in her mid-teens to escape her feelings of fear. Her PTSD diagnosis dates to her childhood, when her father would habitually threaten suicide. Heidi began heavily using alcohol in her early teens, and attempted suicide at age 16. She suffered additional trauma from an abortion she had from a pornographically addicted man she dated in college. She has been divorced twice, and is now in a healthy marriage. She has 11 years of sobriety.

Participant 2 (Tanya)

Tanya, age 55, began drinking alcoholically in her childhood to escape the volatile relationship between her alcoholic parents. Her PTSD diagnosis results from a rape in high school, in addition to three subsequent rapes occurring in her twenties. She used alcohol to self-medicate because she blamed herself for the rapes. Tanya suffered additional trauma from a former boyfriend who stalked her and threatened to take both of their lives. She is now married for the second time, and has been sober for 18 years.

Participant 3 (Lin)

Lin, age 54, began drinking at age 11. She grew up in a household with a violent alcoholic father. Her PTSD diagnosis dates to childhood with her father's beatings, and

was further triggered by two rapes. One rape occurred in childhood and the other rape in her teens. Trauma triggered from one of the rapes resulted in a suicide attempt. Lin began using alcohol as a child to escape her home life and her negative self-image. She has been sober nine years and married to her only husband.

Participant 4 (Victoria)

Victoria, age 60, grew up in a religious household and did not begin drinking until age nineteen. Victoria knew her father hid his alcohol and her mother was addicted to prescription pills. Victoria was more of a binge drinker and did not drink heavily until age forty-three to self-medicate from feelings of loneliness. Her PTSD diagnosis stems from her first marriage to an abusive husband who threatened her and her parents for three years. She is currently remarried and has been sober for seven years.

Participant 5 (Stacy)

Stacy, age 42, began drinking at age 16. Her household growing up was free of alcohol, however, the tension was high with a controlling, angry mother and an absent father. Her PTSD results from childhood and her mother's verbal and physical abuse. Stacy was further abused by two emotionally and physically abusive husbands, with the second sexually abusive as well. She almost died from one of the assaults. Stacy is now divorced, and has been sober for five years.

Participant 6 (Rose)

Rose, age 54, began drinking at age 14. She reported a fairly happy childhood home, although she felt very lonely as a kid. She found alcohol was a great way to self-medicate from loneliness and her drinking and subsequent drugging continued into

adulthood. Rose's PTSD diagnosis stems from her only marriage to a husband who was emotionally, physically, and sexually abusive. After contemplating homicide and suicide, she divorced her husband and got clean. She in now single, and has been sober for 13 years.

Participant 7 (Tina)

Tina, age 56, began drinking at nine years old. Her PTSD results from her childhood, with a verbally and physically abusive alcoholic father and a sexually abusive brother. Tina was hospitalized at age 15 following a suicide attempt. It was during this hospitalization, when she confessed her brother's sexual abuse. She continued to be traumatized during her brother's arrest and court proceedings, resulting in his conviction. Tina has never been married, and has remained sober for the past 17 years.

Participant 8 (Susan)

Susan, age 55, began drinking at age ten, and believes she became alcoholic at age 16. She grew up in a dysfunctional household with a father addicted to alcohol and cocaine. Her PTSD results from her childhood and her verbally and physically abusive dad. She later married a verbally and physically abusive husband. While no longer married, she has been re-traumatized through her daughter's addiction to self-mutilation and alcohol. She remains single and has 14 years of sobriety.

Participant 9 (Cathy)

Cathy, age 51, began drinking alcoholically in high school. Her home life was good, although she reported some disconnection with her parents. Her PTSD is the result of a rape and beating in college. She was later sexually assaulted by a professor who was

helping her process her feelings from the rape. She was further traumatized working at an internship with children who had been sexually abused. Cathy is currently going through the process of divorce from her alcohol and drug addicted husband. She has been sober for eight years.

Participant 10 (Kristen)

Kristen, age 38, started drinking at age 17 to escape her mother's alcoholic abuse. She got married after high school to her first boyfriend, hoping she could build a happy family life unlike the chaotic household she grew up in. Her PTSD was diagnosed from her mother's emotional abuse during Kristen's childhood, and she became re-traumatized during her marriage. Kristen's husband was verbally, physically, and sexually abusive and she lived in fear for herself and her children. With the help of her father, Kristen and her kids escaped their abusive home and she has been sober for five years.

Participant 11 (Patricia)

Patricia, age 40, took her first drink at age 12. She grew up in a household with an alcoholic father who abused her sexually by the way he talked to her and touched her. Her PTSD diagnosis comes from her childhood, not only from her father's sexual abuse, but also sexual abuse which occurred with her father's friends. Patricia was later molested by an older man in college, and attempted suicide at 22 because she felt like she was becoming like her father. She is currently divorced from her second husband and has six years of sobriety.

Participant 12 (Rae)

Rae, age 50, began drinking in early in childhood when her parents would give her alcohol to put her to sleep during long car rides. Coming from a family of heavy drinkers, alcohol was a way a life with Rae's family. Her PTSD stems from her verbally and physically abusive mother, and subsequent trauma when she was raped and choked by an unknown assailant while in college. She used alcohol to escape from life at an early age. Rae is divorced from her only husband, and has been sober for 10 years.

Results

Theme 1: Alcohol and Trauma

The first theme emerging from participants includes a description of the beginning of their drinking histories and the etiology of their PTSD diagnosis. Re-occurring patterns were found in (a) the age of first drink, (b) living in an alcoholic household, and (c) early life trauma. The respondent's time of first drink ranged from ages nine to 19. Two participants could not remember the exact time, however, knew it was sometime in childhood. Living in a home with one or more alcoholic parents was a dominant theme found in 10 of the 12 participants, in fact, participants use of alcohol at an early age was described as the beginning of alcoholic drinking with 10 of the 12 women. These 10 women reported turning to alcohol to escape their childhood. Additionally, paramount is nine of the 12 participants received a PTSD diagnosis resulting from childhood emotional, physical, or sexual abuse.

Tanya and Rae could not remember the exact age they started drinking, but describe their first drinks as young children. Both women recount their childhood homes

as “highly volatile” with parents who were “heavy drinkers.” Tanya began drinking heavily in college indicating “this is when I started drinking and partying more, getting away from the stress of the home I grew up in.” Tanya described being raped three times in her life, although her original PTSD diagnosis points back to the first time she was raped in high school by her best friend’s ex-boyfriend:

> I must have passed out, because I remember trying to get away and then I don’t remember anything else. I never saw this as rape because I figured it was my fault for getting so drunk.

Rae’s PTSD stems from her mother’s emotional and physical abuse. She recalls drinking at an early age when the family would go on road trips:

> When I was small my parents would throw me in the backseat of the car to go on trips and the first stop was to the liquor store where they would buy me those pre-mixed screw drivers. I would drink two of those and pass out. I think their motivation was to put me to sleep because I was very talkative. They thought that was OK.

Tina grew up with a verbally abusive alcoholic father. She began drinking at age nine reporting her first black out episode while she was with “my so-called boyfriend at the time; I was eleven and he was twenty-one.” She says she remembered the two of them sharing a bottle of bourbon. The next thing she recalled was waking up in the back seat of his car with him on top of her. She states, “I blacked out and that was at age 11.” This was not the original source of her PTSD diagnosis, however, which came from sexual abuse by her older brother who repeatedly raped her from ages three through 15:

> I was sexually abused by my brother starting from when I could walk. He started training me right from the beginning. He trained me to pull my shirt up and pull my pants down. They called it show-and-tell in the woods for his friends. All the little boys would laugh. He started off that way and then as he grew and learned about different sexual things, he would do those to me, all the way to taking my virginity. He did anything. He did me in the back end, and just anything you could imagine.

Susan got drunk the first time at age 10, but did not start drinking until age 13. She described growing up in an explosive household with an alcoholic, cocaine-addicted father:

> It was that household where God was my father. I had nothing else in my life. He was it, but you never knew his rules. You only learned the rules after you broke them and after you were punished. But you didn't know why you were being punished, because you didn't know what you did, because you didn't know the rules.

Lin began drinking at age 11. She described her childhood trauma resulting from her father's emotional and physical abuse:

> Dysfunctional, highly violent house, four kids, a bipolar alcoholic father, and I was the target. When I would say something that tripped his trigger he would drag me away from the dinner table and beat the shit out of me.

Lin experienced additional trauma having been molested by an uncle in childhood and raped by her best friend's father in high school. The culmination of this abuse presents the beginning of her PTSD diagnosis.

Patricia began drinking at age 13. She grew up in a household with a sexually abusive father. Her dad would have friends over to the house to drink and they would sexually abuse Patricia, touching her and talking to her in provocative ways:

> I hated my dad and I hated his friends, especially when they were around the house drinking. They would give me drinks, I think, to get me drunk. I never really understood all of this until a friend of mine was over and they started acting sexual around her. She asked me what kind of things they would do to me, and I told her I couldn't always remember.

Heidi started drinking at age 15 because "drinking could help me forget about my home life" which included numerous suicide threats from her father:

> It was awful. My mother and father would get in these terrible fights. My mom would be throwing things, breaking things and yelling at my dad. I don't know if she was yelling at him because he was drunk or what. My dad would head down into our basement, where he kept his rifle, threatening to kill himself. I would be running down behind him begging him not to do it.

Kristen was 17 when she first started using alcohol to escape her "raging alcoholic mother." She recalled "my mother got jealous when my dad would spend time with me." She described her mom as "constantly screaming about something she wanted

done or something that wasn't right." Kristen left home immediately following graduation to get married.

Rose came from a family where both parents drank socially each evening, but she did not consider them alcoholic. Rose said she started to use alcohol at an early age to "black out" or "zone out", escaping from age 14 on because she was "lonely" and "sad." She began drinking and drugging every day "because that was just the thing to do." Unlike many of the participants, PTSD for Rose came later in life from an emotionally and psychologically abusive husband.

Victoria grew up in a strict Baptist home and drank for the first time when she was 19. While her parents made it look like they complied with the church's insistence of abstaining from alcohol, she described having alcohol in her childhood home:

> My alcoholic father kept a liquor cabinet in his bedroom and alcohol in the half bathroom, and my mother I'm not sure what she consumed. I know she liked prescription drugs, she liked pills.

Victoria, like Rose, was diagnosed with PTSD from her first marriage.

Cathy began drinking in high school, but did not describe in much detail her parents. She recounted her house as the "party base" noting "I don't know what was going on with my folks about not having any clue, but on the weekends we would have parties, bongs, beer, and whatever else." She described her diagnosis of PTSD resulting from a rape in college:

> I had just broken up with a boyfriend. I just didn't want to see him anymore and of course I wasn't thinking clearly when I was walking home. I was attacked with

> a knife and drawn into the bushes and told he was going to kill me if I screamed or did anything. I tried to run. He grabbed me and beat me to a pulp. Slammed my head up against a brick wall, punched me, black and blue everywhere, and then he raped me.

Stacy differed from the other participants, being the only one who was not raised in an alcoholic family, except for Cathy who did not describe her family's drinking. Stacy did, however, grow up with a highly controlling mother noting "what she said went, and that was that". She described having to "play by her rules, and unfortunately some of the time the rules would change but we didn't know it." Indicating both parents as "demanding" and "demeaning", her PTSD stems from her mother's emotional abuse. Stacy was the oldest and was placed in charge of her younger siblings. She was often told she "was never good enough", and felt like a "victim" at an early age.

Theme 2: Difficulty with Thoughts

An emergent theme found in the data was the difficulty participants had identifying thoughts which occurred prior to alcohol relapse. Most participants paused and took some time recounting thoughts, stating they had difficulty describing what they might have been thinking about before they relapsed. Often times, participants would begin with a description of one thought and, almost immediately, their description of thoughts switched to descriptions of feelings elicited from the thought they just described. While both thoughts and feelings are part of an experience, respondents strained describing ideas which they believe led them to relapse, thus indicating the difficulty this population of women have identifying the thoughts occurring as the root

cause to their feelings. Interesting to note, the women who were better able to describe distinct thought patterns were those who reported more extensive therapy over the course of their sobriety. Despite the difficulty respondents had in identifying thought patterns, notions of "death", "suicide", and "worthlessness" dominated participant descriptions.

Thoughts of Death

Nine out of 12 participants recounted thoughts of wanting to die, with five of them attempting suicide at one point during their life. Repetitive statements of "suicide", "wanting to die", and "wanting to kill myself" were woven into the fabric of 10 respondent descriptions. Despite most women recollecting they wanted to end their life, a recurring theme for not executing a plan had to do with the fear of leaving their children behind, therefore, they felt they would postpone suicide until their children were older. Kristen recalled:

> I was so depressed and wanted to die but I couldn't leave my kids. I figured I would just keep them safe until they got out on their own and then I could die. I couldn't imagine how I would get through this whole mess without drinking but my drinking had crossed the line and I couldn't stop once I started.

Rose thought about executing a plan to take her life, as well as her children's lives:

> When I was 41, I really wanted to kill myself. I thought that was a good idea, and to take my children with me. I thought maybe I should check out some other options, and the counselor I chose to see just kind of suggested that I wait until next week. My neighbor, however, did follow through on taking her life and her

children's. I got to watch this first hand and realized maybe this was not such a good idea, you know, for all the people that were left behind.

For the five respondents who decided to execute a suicide attempt, they all described negative thoughts regarding themselves. Tina, who was sexually abused by her brother at an early age, stated "I wanted to kill myself because I knew something wasn't right." Not until she understood her brother was abusing her did she realize why she was so depressed.

Heidi remembered her first suicide attempt at age 16:

> My boyfriend, at the time, was in Florida on vacation with his parents. A guy I had a crush on my freshman year was in town and took me out for my birthday. I got really wasted and almost slept with him. I felt so bad afterwards. I felt really guilty for betraying my boyfriend. I took a bunch of No-Doz and alcohol. I threw up a lot, but the family doctor felt I would be OK. I didn't sleep for three days and it scared me pretty bad.

Victoria attempted to take her life by drinking herself to death. This was after having a conversation with her boyfriend's best friend who told Victoria he couldn't understand why his friend was dating her:

> I was on vacation with a boy in St. Thomas and he had a friend who was a real estate developer who had a boat, so we were going to go to some uninhabited cays. That was our plan and there was going to be alcohol involved. So anyway, when I was there I asked him to be honest with me. I should not have done that. He said to my boyfriend "who is this? You know your previous girlfriend is a

> beautiful model and this person doesn't have any resemblance to the person you used to date." My boyfriend told him "I was a diamond in the rough". I wanted to die, so I got really wasted and sort of wandered off into the cay and laid down in the underbrush just hoping they wouldn't find me. I hoped I would die from the alcohol poisoning.

Patricia attempted suicide at age 16 with an overdose of sleeping pills and alcohol:

> I hated my life. I just hated my life and I had nowhere to go. I couldn't stand being in that house any longer. I was so sad and I just wanted to stop feeling. I don't even know what set it off at the time, but I remember listening to music and being very sad. If my friend wouldn't have checked up on me I would probably have died. I remember wishing I would have.

Lin recalled the conversation with her therapist of attempting suicide although not remembering she did so:

> One night I woke up in a bathtub submerged up to my nose and I never take a bath. This was when I was traveling. I think I did it, you know, as a way to commit suicide without causing too much suspicion about it. I called my therapist and asked if she was going to do anything if I told her something and she was able to tell me what I guess you are supposed to, which is if you have a plan I have to do something. Otherwise, talk to me. I told her about it and she understood how really desperate I was.

Stacy remembered her thoughts around the time she had become sexually promiscuous. Her drinking relapses left her with thoughts of wanting to die:

> I no longer wanted to be around anyone. I hated myself and what I had become. I was no secret either. We lived in a small enough town that people knew the kind of person I was. For a long time I wore it as a badge of honor. I was kind of like, so this is what I have become as the result of nobody loving me. I was in bad shape. I was too afraid to kill myself, so I thought I would just drink myself to death.

Tanya described similar sentiments:

> I was always angry at myself for drinking so much and not being able to handle my behaviors. I felt cheap and dirty after the rapes, and I'm still not comfortable calling them rapes because I blame myself. It seemed as though every time I drank too much I said or did something stupid that I would regret. This would start a vicious cycle of drinking to forget about what I did when I was drinking the last time.

Susan, Cathy, and Rae were the only cases in which suicide or thoughts of death were not described, however, Susan did state "not wanting to be here" resulting from shame-based behaviors prior to relapsing. Rae, did not describe wanting to end her life but knew "alcohol was killing her" and that was "how it was."

Thoughts of Worthlessness

Thoughts of worthlessness dominated patterns of all participant accountings in areas of marriage, family and work. Participants described "feeling worthless", "not

being good enough", "unlovable", "not liking oneself", as well as thoughts of being a "bad wife and mother." Six participants described thoughts of "worthlessness" or not thinking they were "good enough" regarding their relationship with their husband or significant other. Heidi had thoughts of worthlessness stemming from failed relationships with men. She recalled these thoughts following what she described as "men treating her badly." Tanya reported two separate incidences when she felt worthless as a wife. The first was when she found out her husband was cheating on her with both men and women. The second time, Tanya's thoughts of worthlessness came from when she found out her husband was helping his daughter with her résumé for the same position she herself was interviewing for. Tanya states "I typically always felt worthless when it came to men, and this would be a big trigger for me to drink."

Stacy described her thoughts following an episode with her first boyfriend who she eventually married:

> He got so mad and stormed out. I didn't see him and he didn't call for a week. Finally, I begged him to take me back and told him I would do anything he wanted. I think this reminded me of my parents getting mad at me for not doing the right things. When he yelled at me I felt worthless and unlovable, so I agreed to do what he wanted because then I thought I would be loved. At least I wouldn't be alone.

Rose, who was emotionally and sexually abused by her husband, described her thoughts of not being "good enough":

> The nights I couldn't or wouldn't have sex he had a bag, a huge set of pornography. A huge set in a big old trunk. He had a "go bag" that he took on any of our trips. It wasn't a very good marriage. This made me feel less than, not good enough. Those are my "go to" feelings. Whatever it is I'm doing it's not right. I'm not sexy enough, or I'm not pretty enough. He was always trying to change me. He wanted me to have breast enlargements. He did convince me, actually he insisted, that I have some liposuction. Which I did. I did not want to do that. The doctor knew that. It is what it is, because he just kept badgering me. He was like a kid in a candy shop. I need it, I've got to have it. Things like that, it was easier in the end to just say yes.

Kristen recalled thoughts of worthlessness stemming from her abusive relationship with her husband:

> My husband, well ex-husband now, was abusive. Physically and verbally abusive. Well, sexually abusive as well at times. It started out with him punching or slapping me every now and then when he would get angry with me. This was if I did something he didn't like. This got worse over the years and at times he would kick and punch me. He enjoyed making me feel like I was worthless. He enjoyed this with the kids as well. I tried to keep the kids away from him as much as possible so that they wouldn't do anything to upset him.

Lin described her overarching thoughts of worthlessness regarding her husband, family, and occupation:

> I almost never got attention the way I wanted, which was someone being warm, fuzzy, and caring. It was more someone trying to kick me in the ass and telling me what a worthless person I was. That kind of thing, and yet I kept doing it. Later, towards the end of my drinking, I drank to escape the misery I felt by being a fraud in the job I was in and by being a shitty mother. I didn't connect with my kids at all and I had a relationship outside of my marriage.

Tina described her thought patterns of feeling like she was "a bad person" through the analogy of a tape recording:

> It would be lots of thoughts. I'm a bad person. I have what I call the "bad-person syndrome." I'll get a tape in my head and it just runs over and over if I do something wrong. It's when I feel my PTSD has been triggered, I'll get this tape inside my head. It goes over and over, repeating that I'm a bad person. I can't get it out of my head. Or, I'm stupid because I did something wrong. Nobody loves me because I'm dumb. I can't do nothing right. If I were to think about my mother, my father or my family, or any of the abuse that would come up in my head, there would be thoughts that could trigger drinking.

Patricia described thought of "feeling worthless as person" based upon her sexual promiscuity:

> Talk about feeling worthless as a person. I disgusted myself. The whole sex thing with my dad growing up made me turn to older men to feel like I was loved. I never had a father figure and I guess I was always looking for one. I was very

promiscuous. Not much of a care or concern. I drank a lot and slept around a lot. I didn't care what happened. I hated myself.

Victoria and Rae described "not being good enough", even though they had both achieved accomplishments in life. Victoria described having her Master's degree and a full-time job and still feeling like she "wasn't good enough" in her boyfriend's eyes. Rae described her thoughts of worthlessness arising from her childhood, specifically her attempt to be someone her parents would be proud of:

I was never loved growing up and I did everything I could to get my parents to love me. Constantly achieving things so they would love me and never receiving it.

Susan and Cathy were the only cases which did not fall under descriptive themes of worthlessness or death and dying when it came to thoughts prior to alcohol relapse. Susan related thought patterns prior to relapse as having difficulty knowing what to do in certain situations. This difficulty, she felt, was due to her dysfunctional childhood:

Growing up my role models were The Brady Bunch and The Partridge Family. That was what I thought it was supposed to be. TV and Walt Disney screwed everybody up. There is no knight in shining armor. I thought there was. So, for me after a while, you just say screw it I'm done. You just throw in the towel.

Cathy stated her thoughts prior to drinking would involve anger towards her husband, but did not articulate detailed information concerning specific thought patterns.

Theme 3: Self-Medicate from Feelings

All participants described using alcohol to cope with their feelings, stating their feelings were most likely the result of rehashing past or present negative thoughts, and thus the catalyst for relapse. Most participants described the need to self-medicate to deal with day-to-day circumstances. Alcohol use was most often to escape from feeling "fearful", "sad", "angry", and "anxious". While participants described multiple feelings prior to relapse, "fear" in conjunction with "afraid" was described by all 12 participants. Nine respondents reported feeling "sad", nine "anxious", and eight "angry".

Fear

Fear is woven throughout all 12 of the interview transcripts describing participant experiences with the phenomenon of living with comorbid PTSD and AUD. Fear was not so much the result of memories or flashbacks from past trauma, but more so the fear of living life on a day-to-day basis. Fear, also synonymously used by participants with afraid, was the most defining theme throughout all interview transcripts, although described somewhat differently. The following will attempt to pull apart the participants' meanings of fear and afraid to better understand the overall experience of fear for this group of women.

Fear is defined as a "response to a real or imagined threat", as opposed to afraid, which is defined as "being fearful" (*Merriam-Webster Dictionary*, 2011). While all participants mentioned "fear", this was mostly in reference to specific fears. When discussing "being afraid", the women used more general terms. Fear was most often noted as (a) fear of husband, (b) fear of past thoughts of trauma, and (c) fear of what

could happen to their children. Seven participants described fear of their husbands regarding either physical or sexual abuse. Stacy recalled fear of her husband:

> Without getting into specifics, my husband liked S and M and was pretty rough with me. Sometimes when we had had too much to drink he would turn angry and ugly. This would happen if for some reason, I wouldn't be feeling good or he was hurting me with something he was doing and I would say no. This would set him off. He back handed me a few times. You just couldn't tell with him, I mean, when he was going to turn ugly. This had me pretty fearful all of the time, feeling like I had to perform exactly like he wanted.

Rose, as well, feared her husband:

> I had some fear around my husband, I still do, but I had a lot of fear at the end of our marriage. He would punch holes in the wall and I would get scared. But again, it wasn't like I got scared and called someone. I got scared and I got high. I wouldn't think about it anymore because he would patch it up really quick and say "see there's nothing there, no worries."

Kristen recalled her husband's abuse:

> My husband, well ex-husband now, was abusive. Physically and yeah of course verbally abusive, well sexually abusive as well at times. It started out with him slapping me every now and then when he would get angry with me. This was if I did something he didn't like. This got worse over the years and at times he would kick and punch me.

Fears resulting from past trauma were reported by four of the women. Rae described feeling fearful regarding the outcome of her rape. She recounted her fear of moving to the city where her assailant was going to be up for parole:

> There was another girl on my college campus who had my same name. She received death threats after this guy went to prison. He got four years for my rape, although he raped two other girls that same night before he was caught. I don't know how much time he got for those rapes. We knew who he was because he lived in the same apartment complex. When I got a new job in the same city where he was in prison, I knew I needed to change my name. That's why I got married.

Heidi described her feelings of heightened fear resulting from an old boyfriend who stalked and threatened her:

> I remember a time when he came to my apartment and I wouldn't answer the door. He left, but shortly after the phone started ringing. I knew it was him because he would let it ring and ring. This was before we had answering machines and cell phones. I knew I had to get out of there, and felt it was safe while he was still at home trying to call me. I grabbed my purse and headed out the door. I opened the door and there he was. He left the phone ringing at his house and drove back over to my apartment. I started screaming and the neighbors called the police. The police gave him a warning. He continued stalking me until I started dating someone who told him he would kill him if he didn't leave me alone.

Tanya described remaining somewhat fearful present day:

I've always been hyper-vigilant of my surroundings. Always watching and frightened of someone watching me or following me. I think this comes from a couple of other traumatic times in my life. One was when a high school boyfriend got angry at me and shoved my upper body through a glass door and then tried to choke me. The other was this creep who started stalking me at my job after college. I worked at a major department store and weekly I would get a red rose delivered with a cryptic note. This went on for weeks. I was always frightened walking to my car, not knowing if someone could be out there. We never did find out who it was.

Tina recalled her fear of being alone as a child:

I would be fearful if I would think about being at home alone on the weekend. This was when my mother and father would be gone fishing all day from sun up to sun down. I wasn't really sure if they came home at night or not. I would be scared because my brother and sister would leave the house and I would be there alone. I remember sitting on the couch. I would sit there and freeze with the TV at night, and be too afraid to go into the other parts of the house. There was an attic door that the suction of the house, the air flow, would make the door move. I would be frozen thinking it was somebody on the other side of the door trying to open the door, and be terrified half to death as a little kid.

Fear of what could happen to their children was described by four of the participants, however, not only fear from living in an abusive household, but also fear

surrounding their use of alcohol and its effect on their children. Lin stated, "I had little kids and they were afraid of me." She described what happened when she relapsed:

> There were things I promised myself that I wouldn't do when I picked up that first drink that I did within twenty-four hours. All of them. I wouldn't drive with my kids drunk, I wouldn't drink at work. The list was long. I did them all.

Victoria was fearful of being home alone because that is when she would drink. Her husband travelled a great deal and she was home with her daughter. She recalled their relationship:

> I had a kid who was now a teenager, with all the challenges that come with that. My daughter is very socially outgoing. I'm an introvert. She's very, very social. She knows everybody, you know very, very connected to what's going on. Not afraid of anybody. A quick, beautiful, adorable young woman and very, very determined. You know, if she wants something she really, really wants it. It was really a challenge to manage her behavior when she was a teenager living with me, so I would drink to help myself feel better. I felt very sorry for myself. Here I am this little introvert all alone with this really beautiful extroverted daughter who is very, very willful. What am I gonna do? Well I'm just going to cook, clean house, do laundry, and drink.

Susan recalled the emotional abuse she and her children suffered from her husband:

> Throughout my marriage, there was a huge amount of fear. Coming out of the marriage as well. The psychological and the emotional threats. I would say

> physical too, but that happened twice, that is, almost getting punched happened a few times. I think coupled with the fear of what might happen to my kids in that situation was wrapped into that fear too.
>
> Kristen described her fear of leaving her kids:
>
> Having to work and deal with the kids was very stressful for me. I had a lot of anxiety about leaving the kids, even though they were older. I didn't know what would happen if they came home and pissed off my husband.

Afraid

Being afraid was most frequently described by participants in a general sense resulting from (a) fears beginning in childhood and (b) feelings relating to self. Five respondents described "being afraid" as an ongoing sense of fear, which began in childhood. Tanya recalled "I began being afraid of alcohol when I was a kid", further noting "I was afraid of what would happen to me if I drank too much." Lin described her overall sense of being afraid as "I am afraid of something and afraid I'm always going to feel this way." Further stating "afraid I'm going to get worse, and afraid that this is beyond my limits, my tolerance." Stacy recalled "I was afraid of everything from the time I can remember." Heidi spent most her childhood being afraid her dad would die from his alcoholism or kill himself. She described waiting up for her dad to come home from work:

> From an early age, I worried about my father making it home from work every night after drinking. I couldn't sleep until he was in the house. I remember standing at the picture window in our living room waiting for him to pull in the

> driveway. It was always dark because my dad worked until 11:00 p.m. and then would close the bar down at 1:00 a.m. I would see him pull in the driveway and I would jump back in bed and listen until I knew he was in the house and in bed. Then I would go to sleep.

Three women described being afraid they could not handle life or take care of themselves. Tanya recalled "I was afraid of what would happen to me if I drank too much and I would tell myself I would only have a couple of drinks just to take the edge off, but that never worked." Tanya further stated "Once I started I couldn't quit and that would lead to black outs."

Stacy described being afraid of drinking again:

> I think I was afraid of what would happen to me when I drank again after being stopped. I drank a lot at home by myself. I think I drank the most at home when I relapsed because it was the safest place for me. As my drinking progressed, my space got smaller. The first relapses would be out in public when I was with friends and family, but at the end I was hiding in my closet drinking. This was partly due to hiding my drinking from my husband, but even when he wasn't there this is where I drank. I was incredibly frightened and paranoid. I would drink in there until I blacked out and went to sleep.

Tina recalled being afraid of killing herself if the time ever came when she would have to stop drinking:

> The second time I relapsed, I was really going to try and stop drinking. It was very scary because, if I feel this bad inside, how am I going to feel if I don't have

> my alcohol? It was so terrifying, the thought. If I feel like dying, with being able to drink and escape those feelings, what am I going to do without the alcohol to escape from those feelings? I was afraid I would end up killing myself because I wouldn't have my escape.

Patricia described being afraid, however, her fear involved men resulting from her childhood and sexual abuse:

> I was afraid of men, I hated them. But even though I hated them they were the only thing I knew, the only place I had to turn to. I couldn't stand to think about anything, I didn't think about anything. That was the plan, not to think. But I needed someone there to take care of me. Strange, even though I was afraid of them, I found some safety in the relationship.

Sadness

Feelings of sadness or depression were pervasive as described by nine of the women in this study. Sadness was chronicled most often as an overall feeling that their lives were not turning out the way they wanted them to be. Tanya described sadness regarding her past behaviors, and Heidi, Lin, and Rose chronicled sadness they felt began in childhood. Victoria was no longer having success with prescription medications to treat her depression, so figured "alcohol would be the answer." Stacy also described turning to alcohol to treat her sadness:

> A lot of the time I would drink to help me with my feelings, but then the alcohol would make me feel even worse, so I would drink more and more until I just blacked out or went to sleep. It wasn't like I felt bad and then the alcohol made

> me feel good. A lot of the time it made me think even more about the things that depressed me and then I would have to drink more. I would always wake up feeling worse because I spent the whole night drinking and thinking about things that made me feel sad.

Tina described how alcohol helped her feelings of sadness, resulting from what she believed to be her loneliness:

> I know when I got into my house, I was in an apartment for two years, loneliness, depression, and sadness set in. I didn't want to feel, so the brain tells me to reach for the alcohol because it will make me feel better. I know the doctors were saying it is a depressant so it was making me more depressed, but in my head I was saying no. I know you all say scientifically it is a depressant, but I am so depressed and feel so bad inside the alcohol makes me feel better.

Susan recounted how alcohol helped her with the "craziness" and "sadness." She described her drinking after her first child was born:

> I went crazy after the baby was born. I remember saying, somewhere in my life, I will stop drinking when I have children. Then the kids were born, I was breast feeding, and I said I will stop drinking when my youngest starts walking. I remember she came walking into the room, toddling into the room with my fish-bowl size wine glass, bringing it to me.

Tanya described her sadness because of the things she did while she was drinking:

> Sadness was a big part of my drinking. I was always very depressed. I don't think I realized it at the time, but I think my depression was a big part of how I

> felt about my excessive drinking. While everyone found the things, I did while I was drinking funny, they made me feel horrible. It was embarrassing. Then I would drink over what I did while I was drinking.

Kristen described the sadness she had regarding the end of her marriage, as well as sadness beginning in childhood.

> Maybe because I was so sad it turned out the way it did. I really loved my husband at first and I wanted to make the marriage work. I couldn't understand why he wanted to hurt me. It seems like I went from one hurting relationship to another. Here I thought I was escaping the anger getting out of my parent's home, and then I went from that to not long after having it with my husband. At least my mom didn't hit me, but she was very verbally abusive. I guess you could say I drank in high school to escape that because I was sad a lot of the time. I hated going home.

Three participants described childhood sadness as well. Heidi stated, "I know, for as far as I can remember back in my childhood, I was always very sad." Further noting "I would have to say in my youth I would drink because of sadness from feeling alone." Lin described her second relapse resulting from feelings surrounding her childhood abuse:

> So the next time I relapsed, four-and-a-half years later, I was so sad. I'm sure the DSM would have said I had major depression, but it was mainly centered around the work I was doing with my psychologist. I even said to her, I think this is too much, I think we need to back off and we did, but I was already on a role. I was

already moving downhill fast and I couldn't make it stop. I didn't think anyone else could either.

Rose described herself as a "sad person" beginning in her childhood and continuing into adulthood:

I spent a lot of time alone in my teens because my parents were at work a lot. That's how I escaped, I used. Later, I found that drugs were easier to get for me, so that's what I would do. I escaped all the time except when I went to work. That was only so I could earn money so I could afford to escape.

Anxious

Feelings of anxiety prior to relapse were also reported by nine of the participants. Four women described an overall sense of anxiety prior to relapse, as well as still needing to work on feelings of anxiousness. Two of the women described their anxiety as greatest after their rapes. Cathy recalled "the anxiety was so overwhelming I was in shock." Kristen reported anxiety was always what she was feeling prior to relapse:

I was very anxious, a lot of nervous energy. I've always had this. When I drink I'm not anxious. When I drink, I am calm. I am OK.

Heidi, as well, described anxiety as her most prevalent feeling prior to relapse, and she admits still feeling anxious today:

Anxiety would probably be the number one feeling prior to relapse. Always feeling like something bad was going to happen. I was always anxious. I still am today, I just don't drink. My startle reflex is still very prevalent. I have had it since childhood and it continues. Loud noises still bother me at times. When I

> used to get really nervous, I would feel as if I couldn't breathe and I was going to pass out. I didn't drink to get happy. I drank to cope. Alcohol was what I used to calm me down.

Tanya was also very descriptive when she discussed her feelings of anxiety prior to alcohol relapse:

> I felt a lot of anxiety and nervousness. The feeling I was going to crawl out of my skin if I didn't get a drink. Irritability, very irritable. Lack of patience, especially when it came to other people. Cold sweat, pounding headache, rapid heart-beat and trembling. I would feel sick to my stomach until I could have a drink. I think I would say there was a great adrenaline rush prior to relapsing. Knowing that the alcohol would calm me down.

Victoria reported using both alcohol and Xanax to control her anxiety. She described this experience:

> I had a friend who was a physician and he gave me a big bottle of Xanax samples he had collected. He told me I would probably like them. I didn't know until decades later that the effects of this medication are closely related to alcohol. When I was anxious I would take the Xanax. I wouldn't drink while I took the Xanax, but eventually I used up all the pills. I wasn't seeing the doctor anymore, so I started drinking again.

Stacy described her anxiety when it came to other relationships, especially those involving men:

> I was always very anxious and nervous about life in general. Afraid of everything. Afraid of men especially. Afraid of getting hurt. I didn't want to trust anyone and I still don't really want to trust anyone. People are fallible. I'm fallible. I just don't want to go through anything like my past again. I'm not good at relationships with men and I drank so I could be around men. I'm still very jumpy today. Don't try and scare me or sneak up on me because I might hall off and blast you with something. Men don't get this.

Patricia also recalled a great deal of anxiety she had around men in general, and is still having today:

> I get very anxious around men today because I don't trust them. I find it hard to believe what they're saying, thinking they have some sexual motive to what they want. That's why I stay away from them. That's all I knew, men wanting something sexual out of me. Yes, I take responsibility for putting myself in those situations later on in life, but as a kid I didn't know better. That's how I learned to get attention, to get what I wanted.

Two respondents described their anxiety, prior to relapse, stemming from their proximity to other individuals in their work environments. Lin was a highly successful executive, however, described the anxiety she felt from feeling like a "fraud":

> I was in a very high pressured job unlike anything else I had ever been involved in before. I oversold myself and ended up in an environment where I was surrounded by people whose degree of brilliance, excellence, and character were far beyond anything I had ever experienced. I realized, pretty early on, I was a

> fraud and I was going to do everything I could do to fool them. My thoughts and my accomplishments were total polar opposites. I just kept thinking it's only because I am a woman that I'm getting the promotions, despite having numbers in front of me to show me that that wasn't true in terms of sales and revenues actually brought in. But, that didn't matter. I felt the reality was wrong and the second time I came into AA after I relapsed, I believe this is what made me drink.

Susan reported feelings of anxiety when she got out into the work force. She recalled difficulties when dealing with her peers:

> I had feelings of anxiety being with these people because I was still a screw-up. They were lawyers and doctors and successful business people. What is my place here? I never figured out. Everybody had to like me, so I felt there was always the same anxiety to be fast on my feet, so to speak.

While Lin and Susan described their anxiety relating to their work life, they both stated their feelings of anxiety stemmed from their childhoods. Lin remembered her anxiety resulting from her father's treatment:

> When I was 13, 14, 15, my father would look me in the eye and say "you are shit, you're a piece of shit", and his actions enforced that. He broke a fraternity paddle hitting me. He broke my nose and my cheek hitting me in the face once. He hit me dead on with a phone book that he flung. It kept reinforcing, over and over again, that I was just a piece of crap.

Susan described feeling anxious about handling herself in the world. This, she believed, came from growing up in a home with parents who were unable to teach their children life skills:

> Being raised by people that didn't know how to handle things it just kind of, nobody addressed anything, nobody said anything. It was, you can't tell your grandparents and you can't tell the neighbors about this. Neighbors can't hear the screaming, that's all. It was just like I could feel the anxiety welling up.

Anger

Eight of the 10 participants described feelings of anger during some part of their interviews. Two women stated "resentments" and "anger" were what kept them drinking. Victoria recalled "anger, resentments, and more anger" were what she felt prior to drinking. Susan acknowledged her feelings prior to relapse with "a lot of irritation and anger, and I would just have to drink". She described her physical sensations of anger prior to relapsing:

> Waiting, like I cannot wait until that first sip. That's the only way I can explain it. It's like when it hits your gut and goes through your veins, and then you keep chasing that. Towards the end, I would get a lot of irritation and anger thinking I needed a drink because I can't get through this. I can't deal with any of this right now. I have to get one because I can't deal with this. It was like it tapped on every sensation. Your eyes hurt, your head hurt, and even though my gut hurt, I didn't care because I knew when I would drink it I would feel better.

Four respondents described the difficulty they had with anger, noting this feeling is something they still work on today. Lin shared how she struggled with anger for the first couple of years in sobriety, stating "about a year-and-a-half after getting sober I had such anger that I would say to people when is this going to go away?" She said she was "very slow physically to get sobriety after her relapse."

Three of the participants felt they carried a good deal of anger towards themselves, feeling like they allowed pain to continue in their lives which they should have stopped. Tanya blamed herself for the times she was raped, stating "I was drunk and felt anger at myself for being so stupid to put myself in such dangerous places."

Stacy described her anger resulting from resentments she had towards her parents:

> Anger, I had a lot of anger. I still have a lot of anger that I work on today and I know it's my fault. I have accepted the fact that I may always hold some type of resentment towards my parents. I know the program of AA says I have to rid myself of resentments or I will drink. I know I tried to fool myself into believing I had let go of my resentments early in sobriety, and drank again with a vengeance when they popped up. I had to get real that they were probably going to take a long time to let go of.

Rose described some of the anger she still carries towards herself for staying in a sexually abusive marriage for as long as she did:

> I've worked on anger now for about 3 years and that seems to have helped. I didn't realize how angry I was. I was an angry bird. Mostly, my anger was at me

> for letting it all happen. I kind of got set up for some of it, but I let it progress. It didn't really need to be there, but it was. I had some anger at him, some anger at my kids, I had other anger. Identifying some of that anger has helped. Knowing that when I say cutting remarks it hurts other people. Sarcasm can be funny if I place it on me. I did that a lot when I was a kid. That's how I learned, you know the coping mechanisms from my childhood.

Heidi described her anger coming from her childhood and felt this emotion stemmed from feeling like she never had anyone to take care of her:

> Anger would be the number one reason for me to drink, although I now know my anger was coming from fear. I guess I was always afraid of being on my own. This comes from my childhood and feeling like I didn't have parents to take care of me. Later on, I think I used anger as an excuse to drink. The anger was the result of men mostly, who had treated me badly. I always seemed to hook up with men who cheated on me.

Patricia also described anger resulting from her childhood, which later fed her need for alcohol to self-medicate:

> I was always so angry. Angry about my life, my home, my parents and angry I was still alive. When I was in my early 20's I tried to commit suicide. It didn't work, and I was angry at that. I drank because I was angry. I was rebellious and angry as a kid and that carried on into my adulthood. My therapist says my anger most likely comes from fear in my childhood. Fearing my dad. It was reinforced in my teens and when I got married.

Theme 4: Behaviors Prior to Relapse

Behaviors prior to relapse, like thoughts prior to relapse, were more difficult for the respondents to recollect and describe, although "isolation" was the most re-occurring behavior reported by nine of the 12 participants prior to relapse. Periods of isolation were times in which participants would dwell or ruminate on fears, resentments, and bad behaviors. In addition to finding isolation as a common pattern with the participants, being with the wrong group of people was described by six participants, and six women identified their promiscuous behaviors as a reason for relapse.

Isolation

Alcoholics like to isolate, in fact the rooms of AA call it the "curse of the addict." While it is not good for a person in recovery to be alone, periods of isolation lend themselves to negative thinking, which becomes repetitive. As was previously described in the earlier theme of "thoughts prior to relapse", participants described ruminating thoughts of death and worthlessness, which led to feelings of "fear", "sadness", "anger", and "anxiousness." The following participant descriptions help illuminate the role isolation played regarding negative thought and alcohol relapse. Eight of the women recalled the times they would isolate prior to relapse. Heidi stated the behavior most likely leading her to relapse was isolation:

> I was frightened about real or imagined things. Mostly about my husband coming to get me or the kids. I was frightened he would kidnap the kids and take them somewhere I couldn't find them, although they were older when I moved in with my dad. I was overwhelmed, wondering how I was going to get it together and

> take care of my family. At the end, I was hiding in my closet drinking. This was partly due to hiding my drinking from my husband, but even when he wasn't there this is where I drank. I was incredibly frightened and paranoid. I would drink in there until I blacked out and went to sleep

Tanya described the need to isolate to "get away from people." This would tend to happen after having an argument with a significant other:

> People made me nervous and I felt safer when I was by myself. I would also be emotional in some way before I drank, usually involving a lot of crying. I wasn't one who would drink when I was happy, maybe because I never was very happy. Possibly yelling or getting into an argument with someone. This would be if something would happen which would trigger an old emotion to a traumatic event. Unable to sit still until I could calm myself down with alcohol. Mainly I think I would isolate and be very frightened prior to relapse.

Lin sent her family away for a week, which ended in relapse after staying at home alone. Victoria wanted to be alone, but couldn't, so she spent time locked in her closet. Stacy stated the times she spent alone led her to repetitive "thoughts of self-pity" leading her to relapse:

> I spent a great deal of time, I guess. feeling sorry for myself for how others treated me. I know now that I had myself to blame, I guess I knew that. Yes, I was angry at myself for getting myself into certain situations where I would get hurt. Not so much did I blame myself for my childhood. I tried to be a good kid. I tried to make my parents love me. That I know was not my fault and started me down the

path of a negative self-image and self-loathing.

Tina discussed times, when isolating, when she would have re-occurring thoughts of how she saw herself:

> I would beat myself up for being so bad, like my father when he convinced me I was a piece of shit, I can't do anything right, and nobody likes me. If I could find a way to love myself and not try to find happiness through other people, then you know maybe that's it.

Cathy recalled her isolation as a period of "disconnection", stating her relapses would occur after a period of "trying to do everything in my own mind" primarily regarding her home circumstances living with an alcoholic husband.

Kristen would also spend time in isolation with thoughts of blaming herself for being "a lousy wife and mother", as well as thoughts of "being a lousy kid" based upon her mother's treatment of her:

> I always tried so hard to do things right. Like I tried to be a good kid and wanted and tried to be a good wife. I didn't know it at the time so much, but looking back I can see how many things I tried to do perfectly for my husband. I know it was for me to feel like I had worth, like keeping a good house, cooking, being a good mom, but the thing is that stuff changed to doing it to keep my husband's abuse down. That was really the switch to drinking more as a coping mechanism.

Familial Factors

Behaviors reported from family encounters was also a significant pattern reported by participants. This makes sense being most participants came from alcoholic and

abusive families, or were married or dating abusive men. Five of the participants recalled relapses resulting from episodes involving family. For three of the women, relapse occurred after arguments regarding resentments towards their husbands. Heidi relapsed at a family wedding when she realized family photos were being taken and she was not included. When she asked her husband why she was not in the picture he ignored her:

> I had been sober for about 3 months, which was the longest time I had put together in many years. I was actually feeling better and my anger was under control. I was being helpful at the wedding and spending time visiting with my husband's parents. I thought everything was going quite well, when I noticed they were taking family pictures and did not ask me to be in them. After being blown off by my husband, I went right to the vodka and drank two large glasses straight, one after another. I had never done this before. We got into a terrible fight on the way home in front of my son. I was very frightened at how crazy I got. From then on my drinking stayed hidden at home after my son went to sleep.

Tanya reported relapsing after an argument with her husband about one of his daughters from a previous marriage, feeling "he would always place the girls wants" before hers. Cathy stated "vacation with her husband and family" were when she would tend to relapse. This, she felt, came from resentments she had towards her husband who drank alcoholically:

> So, my thought processes were just basically thinking things towards my husband. Yes, definitely because I didn't get the support I needed from him and I'm having to deal with the kids and everything even on vacation, and so I said screw it.

Parents are often a trigger for alcoholics in recovery, even if only induced through memory. Lin recalled a family reunion which triggered relapse. Despite her AA sponsor stating, "you are walking into a hurricane and there is no calm in the center of it", Lin went anyway. She relapsed after being compared to her father by her favorite uncle. She hated her father because of the emotional and physical abuse she experienced from him as a child. Lin recalls a later relapse during a time she spent at the beach with a group of friends. She said someone said something that reminded her of her childhood and she was off to the bar for a drink. She said she did not "remember what it was", but it "was not more than one sentence" that set her off.

Rae stated she had to drink when her mother would come to visit because she "hated her so much and I couldn't stand to be in the same room with her" if she wasn't drunk. Cathy described her times of relapse resulting from family events, however, she described feelings of anxiety rather than anger:

> My family was very disconnected and if we had to be together we drank. I would drink because I couldn't handle them. Whenever I would go to my ex-husband's family I drank because I couldn't handle them either, because I didn't know what to do. I didn't know how to act. It was so anxiety ridden.

Bad Behaviors

Six participants described "bad behaviors" as a reason for relapse, with Tanya, Lin, Rae, and Heidi reporting they relapsed over infidelity. Rae stated she didn't cheat on her husband because she cared for someone else, but cheated because "I wanted someone to buy me drinks."

Tanya recounts cheating on her husband because she heard rumors he was bi-sexual and liked men as well as women:

> What a blow to hear, so I figured I would cheat on him to get back at him. Unfortunately, this was not the only man I was serious with that I heard gay rumors about. I wondered what is wrong with me? Why do I attract these men?

Lin described her infidelity later in her marriage, and how thoughts of the affair led her back to a drink:

> I had a relationship outside of my marriage which is what I really wanted. I didn't want my marriage. That was in the forefront of my mind, and I drank because of it. That didn't work, because it was still there.

Heidi recalled the time when she realized she was the first to cheat on her boyfriend of many years:

> You know I blamed my high school boyfriend for many years for screwing up my life and leading me down the path of many failed relationships and drinking binges. My story was that he was the love of my life and I wanted to be with him for the rest of my life. I blamed him for my drinking and depression for so many years because he cheated on me with another girl in high school. Our relationship was on-again off-again for many years, and later we married and divorced because of his infidelity. Not until I got sober did I realize that I was the first one to cheat on him, although he didn't know it, and I cheated on him quite a few times during our relationship. I honestly didn't realize this until I was about three years sober. I had completely blocked it out.

Sexual behavior, like Heidi's, was also reported by Stacy, Patricia, and Rae who drank over what they considered "promiscuous" behavior. Stacy recounted relapsing over her sexual behavior:

> If I would get myself involved in something I shouldn't be involved in, usually if I was out with friends or other people. I would say I wasn't going to drink but I would get involved with some guy and drink and do things I wasn't proud of. I didn't feel comfortable around other people when I was drinking because I knew it would lead to something I didn't want to do, or was trying not to do. You know, sex.

Patricia described relapse resulting from her promiscuous behaviors which she discussed occurring from the time she was quite young:

> I felt ugly and dirty and alcohol helped me feel better about myself. I drank through middle school, high school, and college, and went from not wanting to be touched by any guy to wanting to be touched a lot. I drank a lot and slept around a lot. I was very promiscuous, with not much of a concern about how it looked.

Rae recalled similar sentiments to Patricia regarding her behaviors, and how they fed into her drinking:

> So much of my drinking and sexual history goes hand in hand. I lost my virginity and I didn't even know it. I don't remember who it was. Looking back, I think that was the beginning of my "I don't care" attitude, because after that I become very promiscuous. I would steal people's boyfriends. I would do ugly things,

constantly looking for a fix. I used sex as a tool because I didn't care and I could get what I wanted. Drinking helped me do that.

Theme 5: Subsequent Abuse

Subsequent abuse or revictimization was a predominant theme throughout participant descriptions of their experience with the phenomenon of comorbid PTSD and AUD, with 10 of the 12 participants describing re-occurring episodes of abuse. Victoria and Rose were the only participants who did not report subsequent abuse, although each suffered years of victimization from their abusive husbands. Initial PTSD diagnoses of childhood trauma was described by six of the participants, followed by two participants abused in their early teens and two in their late teens. Sadly, only two of the ten women who received a PTSD diagnosis for their childhood and teen years were diagnosed within a year of the event. The remaining eight participants went undiagnosed, until years later, when they were in counseling for their alcohol addiction. Victoria and Rose, as well, did not receive a PTSD diagnosis until sometime after their experience, albeit they did not have to suffer as long without treatment as compared to the eight participants who were traumatized in their earlier years.

PTSD from Childhood

Heidi grew up with an alcoholic, suicidal father, and went through two subsequent traumatic experiences. One was after high school when she was choked and thrown through a glass door, and the other in college when she had an abortion. Heidi described how she felt her childhood trauma led to numerous "bad" relationships with men, saying "I felt like I couldn't survive on my own" because "I was so dependent on my

relationships with men." Heidi noted "I can still feel like that today at times, it's engrained so deeply in my mind."

Stacey, as well, felt her childhood with a physically and emotionally abusive mother played a role in her adult relationships. She was so intent on leaving her parent's home, she put herself in several abusive relationships. While her initial PTSD diagnosis came from an abusive mother, Tanya was raped twice in college and once in her late twenties:

> I put myself in some very dangerous places. Actually, setting myself up for something to happen. I didn't really care if it did. I didn't care if I lived or died. I felt like I did when I was a kid. That I wasn't good enough.

Lin grew up with an emotionally and physically abusive father, in addition to being raped by a family member as a child. She was subsequently raped in her teens by her best friend's dad. She recalled how the memory of her second rape triggered a relapse after being sober for a few years:

> My PTSD was triggered by the death of a guy in prison. He raped me and his daughter is my best friend. She has been since I was 18, and will hopefully always be, although I'm struggling with that right now. He died in prison, and she told me about that and shortly thereafter I started having these flashbacks. It got bad enough I had to be medicated and it took a while to get the medication right. I was having delusions and hallucinations for about 5 or 6 months before I started to drink again.

Susan grew up with an emotionally and physically abusive alcoholic father, and later went on to marry an emotionally and physically abusive husband. Susan recalled the similarities she felt growing up with her father's behavior and then later the behavior of her husband. She said she still has feelings from the past even though she has difficulty knowing what the feelings are:

> Teenage years were amplified with my father's addiction to cocaine. It was more of the psychological and the emotional abuse, you know, having to go through that kind of stuff. I think some of it, I don't know what it's from because I don't remember what it was, has kind of resurfaced. You don't know but something was there. Some demon, some entity, something happened but you don't know what it is. Then through my marriage, there was a huge amount of psychological and the emotional threats.

Kristen's PTSD stemmed from her volatile childhood home with an emotionally abusive mom. She couldn't wait to leave home, and married her first boyfriend when she graduated from high school. She was so happy to be free from her alcoholic mother, she didn't realize she was moving from one jealous and abusive home to another:

> There was no love at home, at least that's what I felt. There were times when things were good with my dad, like maybe he would spend some time with me, but I think my mom would get jealous because we were doing something fun, and she would make him stop.

Kristen described her husband's jealousy as well:

> He was jealous. This was a surprise because I wouldn't have guessed he had such a temper. He thought I was flirting with a guy, or thought I paid too much attention to what he had to say. That was the first night he hit me and threw me around. I never really spoke to guys after that, well men, because I was afraid of what he would do.

Rae also grew up with an emotionally and physically abusive mother, who told Rae "she would end up fat, pregnant, and living in a trailer." She was later re-traumatized in college when she was raped. She remembered calling home to tell her parents:

> When I called home to tell my mom and dad about the rape, they said they wanted nothing to do with it and that I probably deserved it. My mother was the mouth piece. In my family, the father took care of the boy and the mother took care of the girl. She beat me. She beat me a lot. She beat me when she got drunk. I was her anger outlet.

Patricia grew up with an alcoholic father who was sexually abusive. She described how her father and his friends used to "rub up against her" and talk to her in a sexually charged manner. She was later victimized at college when a salesman stopped by:

> It was this old guy selling candy. He looked like he was in his seventies and completely harmless. I remember I was home alone and had just gotten out of the shower with nothing but a robe on. I was going to buy some candy so I invited him in while I went to get some money. We lived in apartments so it wasn't like

there weren't any people around. After I paid him he put his arm around to thank me and grabbed my breast. He then told me how excited I made him and wanted me to grab his crotch. I couldn't get him to leave. I freaked out.

Of the six participants reporting PTSD resulting from childhood trauma, Tina was the only one who did not report subsequent major life trauma. Tina's abusive father and brother affected her so badly that she has never had a serious relationship, never married, and has lived alone for 20 years. She best sums up her childhood abuse with this statement, "I was just a little kid and I didn't know."

Abuse in Teens

Tanya and Cathy reported their PTSD diagnosis resulted from rapes occurring during their late teen years. College was a tough time for Cathy because this was when she was raped and beaten. Her assailant was a stranger who came out of the bushes when Cathy was walking home alone from her boyfriend's house. Cathy recalled alcohol and emotions impaired her thinking, so she was somewhat defenseless to the attack. She discusses stuffing her emotions from the rape for a year before processing her feelings with one of her male professors. It was during this time she was re-traumatized when her professor took advantage of her vulnerability. She stated, "I started processing it with my French professor who stuck his tongue down my throat."

Tanya began drinking in high school, and shortly thereafter she was raped during a black-out episode. Tanya was later raped two more times in college and once in her late twenties. She described her abuse resulting from her inability to handle alcohol:

> I was a blackout drinker. I drank fast, always wanting to get wasted, and when the alcohol hit me it hit me hard. I almost always threw up and would occasionally pass out. I had a lot of blackout episodes during my drinking in college. This I know because my friends would tell me the things I would do and I would have no memory of them.

Theme 6: What Works

Being that all respondents are members of AA, it was not surprising to hear 10 of the 12 participants describe how having a higher power in their lives has been the most important factor to their continued sobriety. Having some sort of spiritual connection, however, isn't always easy as Rose described:

> I was really miserable and I had people in AA telling me turn it over to God. These were the first five years of my sobriety. The first five years sucked. It was miserable, it was awful, but I kept on doing it because I saw other people do it.

Lin stated she "reached a point of complete desperation where I said to a higher power, I had never believed in before, help I can't do this myself". Cathy described how "having a spiritual life" and "going to church" were most important for her continued sobriety. Patricia described how she "appreciated that AA's higher power did not have to be a religious God like the one she grew up with, because that God didn't work for her." Heidi also described how the God of her childhood didn't work for her:

> I believed in a God back then but he never worked for me. Nothing I prayed for ever happened. I know how to pray today and that is to ask for guidance. AA has given me a relationship with a higher power. God is the most important thing in

> my life. Whenever I feel like I'm getting fearful I have to pray and remember I'm not alone. I didn't do this when I was drinking.

Stacy also acknowledged the guidance she gets from her God:

> I have a God today and that has been the thing that has really saved my butt. I must stay in touch with God all the time, or else I'm screwed. I can get nervous, fearful, and overwhelmed very easily, but if I pray and believe, God will give me good guidance and direction and help me calm down.

Victoria described how she thinks of God in what she used to recall as "coincidences." Today she feels she is connected to a higher power:

> You know, there is a saying "Is it odd or is it God?" People I trust say there are no coincidences in this life, and I'm just amazed. I'm eager to find out what each new day is going to bring. What is the next "Is it odd or is it God?" experience? I look forward to that.

Having a God, to whom they can pray, was also described by most participants. Kristen reported having to "pray a lot, if not I will get crazy." Rose noted "I have to pray to God for a plan because the plan is not mine." Tanya described prayer as "number one for my sobriety:"

> Whenever I feel frightened or overwhelmed I pray. I pray for guidance and to have my fear removed. I also pray when I get angry. I try to remember hurt people hurt people and most individuals aren't trying to harm others. I try to put myself in their shoes and not make it all about me. Getting out of my thoughts is a good way to feel better as well.

> This is why I pray to have the thoughts removed and have God direct me to a different way of thinking.

In addition to a God of her understanding, Rae described how the program of AA has helped her by giving to others what she has received:

> The compulsion and obsession of alcohol was removed from me and I didn't ask for it. I knew this had to be an act of God. From that day forward, to take another drink would be like slapping God in the face. Throwing myself into the program and working with others keeps me sober and it's what I'm good at.

Tina and Susan did not directly mention their relationship with a higher power as most important to their sobriety, however both women were similar to Tanya feeling the program of AA helped them develop compassion for other people to help relieve them of selfish feelings. Susan described her job dealing with individuals whose loved ones were dying, by obtaining their permission for organ donation:

> One of the gifts, I think for me, was my job for 10 years doing organs. People died, wow, you saw some stuff. What helped me was being non-judgmental. It was non-judgmental and non-assuming taken to another level. I really believe that having that job and seeing the perspectives of people and their thoughts and their understanding of what they are going through really opened my eyes to understand it ain't all about me.

Tina, as well, recounted a thought process she has developed which keeps her from wanting to pick up a drink:

> I finally came up with this tool that I would use that when I really get up in my brain. If I think I want to drink, I tell myself the first thing that you've got to do is remember why did you want to stop drinking? I had my reasons. The main thing is that I was drinking and driving in blackouts. I know the odds are I'm going to end up in jail, which that's not the worst thing for me, it's that I'm going to be in a car accident and either kill myself of someone else.

Theme 7: What Professionals Need to Know

Therapy is Beneficial

Respondents were asked to describe their thoughts on how psychological professionals could better understand the lived experience of women diagnosed with comorbid PTSD and AUD. All 12 of the respondents had, at one or more times in their recovery, seen a professional therapist or counselor. Six participants were still seeing someone. Six women discussed getting a therapist was one of the best decisions they made when they got sober. Cathy stated, "there have been other traumas in my life, besides the rape, but I've sought help." Four participants expressed how important their therapists still are to their overall well-being. Patricia said, "there is no way I would be here without the help of my therapist." Of the participants who discussed still seeing a therapist, Lin, Rose, and Susan described how psychological professionals helped them identify feelings. Lin recalled a time in sobriety when she was having trouble dealing with her feelings from a past rape:

> I worked with my psychologist who helped me focus on what I was feeling and when I was feeling it. Even though I've been seeing this woman for 15 years, I

> don't look at it anymore as a weakness, that I've been seeing her for that long. I look it as something that has been helping me stay sober and sane.

Rose first went to a counselor prior to getting sober because she wanted to stop feeling suicidal:

> I just wanted to stop feeling like I wanted to kill myself. You know that was the reason I started seeing a counselor, because my neighbor did that. She killed herself and her child. I thought about it, and I thought what a great idea, what a great executed plan. But I got to see the whole thing up front and close, and thought maybe that isn't that great of a plan.

Susan began her sobriety with a therapist who helped her identify feelings which she never understood:

> I constantly had to be proactive in getting the help I needed to identify what I was feeling? I remember in out-patient there was a poster with faces and expressions, like this is what embarrassment looks like. I remember looking at that going wow that's what that is. I was either homicidal or ecstatically happy. There was very little in between. If there was an in between, I didn't know what it was because I couldn't identify it. I remember picking up the phone and saying to people, this is what is going on. This is how I'm feeling. What is that?

A Better Understanding of Comorbid PTSD and AUD

The women of this study were very insightful when describing their experience working with psychological professionals, however, despite participants' acknowledgement that psychological professionals helped them identifying feelings, the

respondents described many areas they felt professionals still needed help. Nine participants outlined the need to better understand alcoholism and PTSD symptomology with women, with four respondents further noting the need to better understand why women use alcohol to self-medicate from the past. Tina and Patricia felt it would be beneficial if professionals attended more AA meetings to better understand this cooccurring disorder. Tina described how she thinks AA meetings could give therapists a better sense of alcoholism:

> I would suggest some AA meetings to listen to alcoholics. Hear what they're saying. There's no better way to learn. Here are real people living and telling you what they deal with day in and day out. What their thoughts are. What better tool than to hear it from the horse's mouth. Then you'll have the experience, you'll have the knowledge to better handle a client because you've listened to what they are dealing with.

Victoria stated, "alcoholism is only a symptom of a bigger, underlying problem", to which Patricia further describes the problem as "me:"

> The problem is me when it comes to my alcoholism. Yes, things happened to me that weren't good and I drank over them, but I wasn't drinking over the actual things that happened I was drinking over how I felt about myself. Thinking these things must have happened to me because I'm a bad person, or I must have done something to deserve it.

Heidi described how she felt the majority of people do not understand that PTSD comes from many types of trauma:

> Most people think PTSD comes from combat. I know so many women who are alcoholics who also have a diagnosis of PTSD resulting from rape, incest, sexual abuse, and domestic abuse. Professionals need to understand this is a significant problem especially if you are prone to alcoholism and you're a woman.

Stacy richly described the need for professionals to better understand alcohol from a lived-experience, rather than strictly a scientific perspective:

> You know I really think the counselors out there need to learn more about alcoholism. I think they like to talk a lot about how alcohol works on the brain but they have no clue about what we really go through. Not that it's their fault, but I really think they need to learn more about alcoholism. I have pretty much given up on counselors because the steps of the program and working with my sponsor have given me so much more than I have ever gotten from a professional. My sponsor will spend hours at a time working through some critical issues. When you're with a professional you have one hour, sometimes shorter than that. You can't get anything done in that short amount of time. If I would have had to wait to get better with all of the appointments I would have needed with a counselor I would be dead.

Rae, as well, described her work with her AA sponsor produced more positive results than her work with a counselor:

> When I did go to counseling, I feared judgement most, along with misguidance and lack of understanding. I would rather talk to a woman who had the same

> experience rather than a woman with just a degree. They are not going to understand.

Tina was also very intuitive when she described what she felt professionals needed to know when treating women with comorbid PTSD and AUD:

> The obvious thing is to know the behaviors, the symptoms. Know all the information you can on PTSD and on alcoholism and how it effects women, because I have been to a lot of different psychologists and they don't know. They know how to skim the surface, but they don't know in-depth behaviors, symptoms, and reactions of PTSD or alcoholism. So, they might be treating me for depression, or I'm scared that I don't want to go out of my house, but they think it's because I'm depressed or something. They don't understand that I'm having a reaction with the PTSD, and it's an overreaction that I don't want to go out around people. So, for them to learn all they can of the ins and outs of the symptoms and reactions of PTSD and alcoholism would help.

Rose went to see a counselor for her PTSD, and recounted the amount of time it took the counselor to address her alcoholism:

> My counselor waited nine months before addressing my alcoholism, and she told me she was an alcoholic in month four of me seeing her. I was still using. I was drinking while I was seeing her.

Kristen also discussed the need for alcoholism to be addressed in response to PTSD triggers:

> I think working on the alcohol part needs more attention. This wasn't talked about at first when I was trying to leave my husband. I guess I thought it would get better if I could get away, and not until I was without him did I realize I still needed to drink. I thought my drinking was just because I lived in that house with him but it was more than that. I get it that the PTSD had to be addressed right away, and still does, but there could have been more attention to my drinking. So, I guess there needs to be more of a focus on addictive behaviors for women who are suffering from PTSD.

Detecting Past Trauma

A re-occurring pattern for professionals to probe or ask questions regarding potential trauma history was described by seven participants. Here are some thoughts from Susan:

> The fact that anybody is even addressing both disorders is huge. It wasn't even a thought process I had, that PTSD was involved in that whole thing, my drinking. It's like their probing and their questioning helped me find out. They wouldn't let me blow off something that I said. Don't let me negate what happened. That's a big thing with women. They negate or minimize it because there are more important things to do. Going back to see if there is any inkling or memory of it to say, you know it's OK if you don't remember, but you had something happen and it was bad.

Rose described the need for counselors to get the truth out of alcoholics:

> I think for me, I used alcohol to cover up all the drastic things that were happening to me that I didn't want anybody to know about. Even though I thought everyone was doing them, really weird, so I had a lot of shame and guilt coming into counseling. I had been to a lot of counselors before, but I didn't give them the whole tale. The other thing if the client isn't going to be honest, and I don't know how they tell that, but it's really hard to get to it if the person isn't going to be honest. I had seen counselors and I only gave them half of it, not even half. They need to know alcoholics lie.

Five participants recalled their PTSD occurring in childhood or early adulthood but not being detected until much later in their lives. They described how helpful it would have been if professionals did a better job of uncovering past trauma as well as identifying children of alcoholics. Heidi stated, "therapists need to do a better job at detecting trauma histories in their patients."

Tanya noted the need for early identification of trauma history, recalling her past history with counselors:

> Many of the professionals I worked with overlooked a lot of my life that I think should have been talked about and dealt with. Not one of my therapists in my late teens and twenties asked any significant questions about my childhood or my time in college. None of the abuse or rapes were brought up until after I got sober the last time. I was almost 40 years old. I do believe, if they wouldn't have been brought up with someone in AA, I would have never received the PTSD help and I would probably still be drinking. No, I'd be dead.

Patricia recalled how long it took for her took get a PTSD diagnosis which resulted from childhood trauma:

> Early trauma played a huge role into my alcoholism, and despite having gone to therapists since age 18, I wasn't diagnosed with PTSD until my early 40's. So much of what happened in my childhood had to do who I am today, and no one talked about it. Therapy was always about what was happening right now, and even if that situation cleared up, the initial reason for my drinking was never addressed.

Tina felt past trauma could be better identified if professionals asked more questions regarding alcoholism in the family. She described her thoughts that alcoholism in the family may been overlooked when treating individuals with alcoholism:

> It's important to see if they were a child of an alcoholic. That has different symptoms for the child that becomes the alcoholic. It's the active alcoholism that they have, but they also have traits and reactions because they were raised in an alcoholic family. Professionals should definitely go into full detail about alcoholism in the family. If they don't look into it, they are missing a lot of the therapeutic tools to help the person.

Lin also felt her past history with trauma had been neglected by some of the professionals she had seen over the years. She described what it was like when the abuse surfaced:

> I had totally blocked it out, totally. One day Pandora's box opened, like in the Raiders of the Lost Arc when they opened the box and everyone melts. It hit me

like that. If my therapist had tied that together with my alcohol abuse, that she already knew about, that would have made more sense.

Treat Both Diseases Simultaneously

Most respondents described the need for both disorders to be treated simultaneously, with seven participants providing further insight into their dual condition. Cathy stated symptoms of both disorders must "come together" and the mental health professional must "understand what a substance abuse problem is and they all don't." Feeling there needs to be a better understanding and treatment of comorbid PTSD and AUD is also discussed by Tanya:

> I don't think they completely understand how difficult it is to stay sober when so many memories bring about triggers which make it really hard to stay sober. It's so hard to go from using alcohol to help deal with triggers to using nothing at all. The alcohol used to blur the thoughts and feelings to help me cope. My therapists have either wanted to work on only the alcoholism or only the PTSD, but not the two together. It's practically impossible to control both at the same time.

Stacy described her thoughts of a potential therapeutic strategy which might help women with alcoholism and PTSD:

> There needs to be a better understanding of alcoholism for those with PTSD and maybe some type of treatment that can work more in depth than just an hour appointment once a week. It's hard staying sober when you've experienced trauma. Maybe there could be some in-patient treatment that specifically addresses alcoholism and PTSD where women could go for a period of time until

they felt safe enough so that they didn't have to drink. I think I would have liked to go somewhere like that. Someplace to feel safe.

Heidi described how she thought women who had been diagnosed with both disorders would be helpful as professionals:

I think there needs to be more female professional psychologists who also have PTSD and alcoholism. Just like in AA, those who have experienced the disease are the best at helping others with the disease.

Patricia's counselor is a recovering alcoholic who was also diagnosed with PTSD. She described how helpful this has been to her recovery:

Oh, my gosh, I am so blessed. I don't know what I would do without my therapist. Oh, and I have a great sponsor too. This is the first therapist I have ever had that understands me. We talk about everything. My sponsor is great too. She gets me, she knows me, I'm sure better than my therapist. Knowing I can pick up the phone, at any time, and call either one helps my anxiety.

Group Textural-Structural Description

All participants interviewed for of this study are women diagnosed with PTSD and AUD, often stemming from childhood emotional, physical, or sexual trauma, or a combination thereof. All women are active members of Alcoholics Anonymous and work the 12 steps of the program. Now sober, the women described their lived experience with cooccurring PTSD and AUD, and their early abuse of alcohol to self-medicate from negative thoughts and feelings. Textural descriptions of what was experienced by the participants were somewhat diverse, although most of the women

described growing up in alcoholic homes, where the father was predominantly the alcoholic and abuser. Over half of the women outlined their initial traumatization resulting from a physically abusive alcoholic parent, with the rest of respondents reporting rape or sexual molestation as the episode evoking a PTSD diagnosis. Despite most women describing their traumatic experiences occurring in childhood, many were not diagnosed and treated for PTSD until adulthood after their drinking escalated to a dangerous point. For several women, their initial victimization was not their only life trauma, with over half of them re-victimized more than once. During these times of subsequent re-traumatization, alcohol was described as a mitigating factor. Most women reported thoughts of "wanting to die" and feeling "worthlessness", as well as feeling "afraid", "sad", "anxious" and "angry." Re-occurring behaviors prior to alcohol relapse were predominantly detailed as placing themselves in dangerous situations or attending gatherings where certain abusive family members were present. The women also described "bad behaviors" as a reason for relapse, with such behaviors most often depicted of a sexual nature, when they felt they were being "promiscuous" or allowing their significant others to conduct demoralizing sexual acts.

The structural understanding for this research lies in the participants' description of how a diagnosis of comorbid PTSD and AUD can be better understood by professionals who treat them. Most women felt psychological professionals needed to better understand both PTSD and AUD in women, especially when they co-occur. The women discussed the need for professionals to better understand how each disease reinforces the other and that treatment for both disorders must occur simultaneously if

there is ever a change for long-term sobriety. Two-thirds of the respondents described the need for professionals to better assess for childhood trauma, noting there lacks a thorough investigation of childhood history when first meeting with psychological professionals. Several of the women described the need for professionals to better understand the program of AA and how the alcoholic mind works, especially in response to rehashing or ruminating on thoughts, feelings, and behaviors from past trauma. The participants further described having a "higher power" or "God" in their life as being the most important factor in their continuous sobriety, in addition to the work they do with other female alcoholics in recovery.

The essential textural/structural experience for participants is the understanding most participants experienced their initial trauma and PTSD diagnosis from childhood or early adult victimization, usually involving an alcoholic family member, spouse, or acquaintance. Most participants developed low self-worth following their traumatization, which eventually led to the use of alcohol at an early age to mask feelings of fear, sadness, anxiety, and anger. Being that many participants were not diagnosed with PTSD until later in life, they continued to place themselves in dangerous situations, resulting in re-victimization. To deal with these circumstances, they turned to alcohol to self-medicate. All participants did not get sober until many years later, with Alcoholics Anonymous and the belief of a "Higher Power" acknowledged as the number one factor for their continuous sobriety. The women expressed a desire for the psychological community to better understand both PTSD and AUD in women, especially for those who suffer from both disorders. They outline their desire for more detailed childhood

histories, which could uncover early abuse, as well as more thorough histories of alcohol use which could detect the possibility of potential alcohol abuse.

Summary

Chapter 4 concludes with the identification of 189 meaningful statements resulting from verbatim transcripts of participant interviews. From these meaningful statements, seven overarching themes surfaced including: alcohol and trauma, difficulty with thoughts, self-medicate from feelings, behaviors prior to relapse, subsequent abuse, what works, and what professionals need to know. From the seven themes, a group textural-structural description analysis describes the essence of women living with comorbid PTSD and AUD and how they feel their disorder could be better understood. Despite the overwhelming similarity of the experiences of these women, their circumstances did vary and were included and described within each of the over-arching themes. Implications of these findings will be discussed in the following chapter.

Chapter 5 includes a discussion regarding the implications of the findings, the limitations of the study in regard to the greater population of women with comorbid PTSD and AUD, social change implications resulting from the research, and future recommendations. The chapter concludes with my personal reflections on the research and findings.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This purpose of this study was to apply a qualitative approach with a phenomenological research paradigm to better explore how women with a dual diagnosis of PTSD and AUD describe rumination and the use of alcohol to self-medicate from trauma memories. This approach addresses the lack of detailed descriptions of what women with this comorbid disorder experience, as well as how they feel their diagnosis can be better understood by professionals. To help close the gap in existing literature, a qualitative study was conducted and guided by two main research questions:

RQ1. What are the lived experiences of women diagnosed with PTSD and AUD as described by them?

RQ2. How do women diagnosed with PTSD and AUD describe how their diagnosis can be better understood?

I implemented a transcendental research framework (see Moustakas, 1994) to describe the thoughts, feelings, and behaviors relating to their comorbid diagnosis. I also asked participants to explore the role of psychological professionals who diagnose and treat women with this dual diagnosis. Nine open-ended interview questions were used to gather rich, thick descriptions of the participants' experience with the phenomenon. I then transcribed the audio-taped interviews, hand coded the information, and input the data into NVivo for further analysis of patterns. After a thorough and repetitive analysis of the interview transcripts, seven overarching themes emerged: alcohol and trauma,

difficulty with thoughts, self-medicate from feelings, behaviors prior to relapse, subsequent abuse, what works, and what professionals need to know.

Analysis revealing the essential nature of the participants' lived experiences relating to their comorbid diagnosis of PTSD and AUD can be described psychologically as a "Higher Power," or internally focused entity, the women used to help manage thoughts, feelings, and behaviors which triggered negative self-assessment and the need to self-medicate with alcohol. Respondents acknowledge the importance of psychological professionals in their recovery to help uncover and understand feelings regarding their disorders. However, in their interview responses, they discussed the need for professionals to better understand PTSD and AUD. The women described their work in AA as most beneficial to their overall recovery.

Interpretation of the Findings

A vast number of women with PTSD develop alcohol disorders because of continuous negative rumination post trauma (Battista et al., 2013; Ciesla et al., 2011; Jayawickreme et al., 2012). Although researchers are just beginning to conduct gender based studies on women with PTSD and AUD, some researchers report a vast number of women suffer from childhood and lifetime physical and sexual trauma (Bailey et al., 2013). Exposure to a traumatic event is quite common in populations diagnosed with AUD, and several theories have been proposed as to why this occurs. In developing self-medication theory, Conger (1956) posits that alcohol use was a means of dampening negative cognitions. This finding is borne out in my interview data. Participants said they used alcohol to repress negative thoughts and feelings.

Current research lacks a detailed perspective for women diagnosed with comorbid PTSD and AUD, even though this condition is twice as common in women than men (Sannibale et al., 2013). The findings from this study describe childhood history fueling early alcohol use. The women also recollect the thoughts, feelings, and behaviors, from early life, that continued to feed their alcohol use later in life. The interpretation of findings concludes with a discussion of the participants' explicit thoughts regarding what has helped them stay sober, and a description of how professionals treating women with comorbid PTSD and AUD can better understand this population.

Theme 1: Alcohol and Trauma

Researchers have reported that PTSD can occur at any period during one's lifetime. Current researchers place greater emphasis on early life trauma and a PTSD diagnosis (Huang et al., 2012; Johnson et al., 2010; Painter & Scannapieco, 2013; Zinzow et al., 2012). Based on study data, I concluded that early trauma was a cause of PTSD for many of the women I interviewed; this trauma was mostly from growing up in an alcoholic environment. Seven of the 12 participants had received a PTSD diagnosis resulting from childhood emotional, physical, or sexual abuse from a parent; each of the abusive parents also identified as alcoholic. This data concurs with researchers' findings that early life trauma is often the basis of a PTSD diagnosis, especially with women (Bailey et al., 2012; Huang et al., 2012; Schwandt et al., 2013).

Of the 12 participants, Heidi, Lin, Tina, Susan, and Patricia were abused by alcoholic fathers, and Kristen and Rae by alcoholic mothers. Tanya grew up with an alcoholic father; however, her PTSD stemmed from a rape in high school. Kristen and

Rae were raped during their later teens. Ten of the 12 respondents had a PTSD diagnosis before age 20. Only two of the women interviewed were traumatized in their 30s. One of the two reported that both of her parents were alcoholic, while the other described both parents as heavy drinkers.

Participants provided extended information about their early victimization and when they began using alcohol. They also described how their disease progressed over their lifetime. Most respondents recounted using alcohol at an early age to deal with thoughts and feelings resulting from parental abuse. Ten of the 12 participants described their relief when they found out that alcohol could numb them from what they were feeling. Respondents who had been victimized by nonfamily members provided similar accountings of how they began using alcohol to escape their thoughts and feelings.

The women's descriptions of alcohol to self-medicate from feelings was like an injured patient's description of how morphine could decrease their pain. Lin was 11 when she first started drinking and stated she "loved it immediately." She described her experience "when I took that first sip, that first swallow, it was immediately going to start to give me relief." Tanya described "the pain and anxiety was so great I knew as soon as a had a drink it would subside." Kristen recalled "I couldn't believe what alcohol did for me, I could breathe again." Susan was most descriptive "taking that first sip when it hits your gut and goes through your veins."

Theme 2: Difficulty with Thoughts

Rumination theory (Nolen-Hoeksema, 1991) is addressed in the literature to explain why some women turn to alcohol to cope with negative affect resulting from past

trauma. Based upon my research, this theory is supported by the participants of this study who described repetitive negative thought patterns as the catalyst to alcohol relapse. The two most repetitive themes discussed by this population of women included thoughts of death and dying and feelings of worthlessness. Nine of the respondents had repetitive thoughts of wanting to die. Victoria stated, "I so badly wanted to kill myself" and Stacy and Rae both recalled thinking "I would just drink myself to death."

Despite many who may believe thoughts of those suffering from PTSD most often occur from flashbacks of trauma experiences, these women described repetitive thoughts reflecting their negative opinion of themselves. Participants described both direct and indirect paths to rumination. The findings suggest, a direct path resulting from rehashing negative memories, and an indirect path resulting from an unconscious flashback of thoughts (Caselli et al., 2010). Direct paths were described as thoughts of worthlessness, with six of the women continuously rehashing negative thoughts of their role as a wife and mother. Rose felt "worthless as a wife" because her husband had to turn to porn to relieve his sexual cravings. Victoria described her worthlessness as a mother because she didn't know how to handle her "challenging teenager." Descriptions of indirect paths were described by others, such as Tina, who provided an explicit description of a time when her father made her feel worthless. She noted how "this thought comes up from time to time today when I feel I can't do anything right". Lin also described flashbacks of "being a piece of shit" which is what her father continuously told her as a child.

An extension of the literature presented in Chapter 2 was the difficulty these women had staying on tract when describing thoughts prior to relapse. A thought

typically turned to a feeling, and then feelings dominated their discussions. My findings support this data with most respondents having difficulty identifying thoughts. Those receiving the most therapy, however, could best describe their thoughts prior to relapse. Neurodevelopmental studies indicate brain modifications resulting from prolonged exposure to childhood trauma and abuse have shown anomalies in multiple areas of the brain (Birn et al., 2014; Rinne-Albers et al., 2013). One are of the brain affected by trauma is the hippocampus which is responsible for short and long term memory. This may support studies indicating irregularities of the hippocampus resulting from trauma and alcohol abuse can trigger emotions or feelings which may over-ride the actual thoughts or memories of an event (Birn et al, 2014; Painter & Scannapieco, 2013).

Theme 3: Self-Medicate from Feelings

Symptoms of PTSD can vary significantly, although anxiety from reliving or thinking about past trauma is most often apparent (APA, 2013). This would make sense, as PTSD is categorized as an anxiety disorder (APA, 2013). Existing research identifies the link between anxiety and alcohol use, especially with Conger's (1956) tension reduction theory. Conger (1956) proposes that people drink to avoid negative thoughts and emotions. Research describes both state and trait anxiety in response to PTSD, with state anxiety being a short-term heightened fear to a specific environmental stressor, and trait anxiety being an ongoing highly anxious and incapacitating emotional state (Sung et al., 2011; O'Hara, et al., 2014). While reflections of both state and trait anxiety were described by most respondents as one of the major reasons to self-medicate with alcohol, nine women described ongoing anxious states. These women recalled a long-term

anxious condition to life as the reason they self-medicated with alcohol. This would support research which links trait anxiety and AUD (Sung et al., 2011). Trait anxiety seemed especially predominant during periods prior to alcohol relapse for most participants, although the women indicated they still dealt with anxiety in sobriety. Tanya described being a nervous child and is "still very nervous today." Lin reported "feeling like I'm going to crawl out of my skin at times", and Tina noted "there are still times when I feel a light tremble all over my body."

In addition to state and trait anxiety, anxiety sensitivity or the fear of anxiety and its accompanying sensations, is also found with those diagnosed with PTSD (Dixon et al., 2014; Gillihan et al., 2011; Harwell et al., 2011). Studies address the concern that thinking about feelings resulting from anxiety may be enough to trigger alcohol use (Dixon et al., 2014; Gillihan et al., 2011; Harwell et al., 2011). This is supported in my research as described by one of the participants. Heidi recalled how thinking about being anxious made her more anxious, stating "I'm fearful of situations because I don't like how they will make me feel." She further stated "just thinking of how I'll feel makes me nervous." Anxiety stemming from an early age would support the development of trait anxiety, so it seems, especially for participants who grew up with an alcoholic abusive parent.

Extended findings, per respondents, reported additional feelings which provoked alcohol relapse. Participants equally described feelings of fear, sadness, and anger as often as anxiety when recalling what they were feeling prior to relapse. Fear, or feeling afraid, was described by all 12 of the participants resulting from ruminating on thoughts

most often involving their husband and children. While one may think that fear would typically result from thoughts of past trauma for individuals diagnosed with PTSD, this group of participants described fear most often in general terms of daily life or imagined projected fears. Stacy described her fear as "always feeling like something bad was going to happen", and Victoria described the feeling as "I felt scared a lot." Feeling afraid, however, was described by participants most often in terms of specific or real fears.

Sadness was also discussed by many respondents, most often beginning in childhood. Loneliness was described as a reason for sadness by Tina and Lin, with both women spending a great deal of their childhood home alone without their parents. Heidi also described loneliness over the way things were at home with abusive parents. Many of the women recounted their feelings of sadness continuing into their adulthood. Often, this sadness was felt over something they did that reminded them of how they felt as a child. For instance, Kristen discussed the end of her marriage stating, "I really loved my husband and wanted to make the marriage work." She said, "I seemed to go from one hurting relationship to another" when she compared her childhood home to her adult home.

Anger was also a predominant feeling described by eight women of this study. This concur with a study by Ciesla (2011) who found higher rates of angry rumination with women more so than with men. Two women reported anger as what kept them drinking, and many reported the need to keep their anger and resentments in check as a high priority today. Stacy recalled "I still have a lot of anger today" and Patricia

described herself as "an angry rebellious kid and adult." Susan felt her anger "tapped on every sensation" of her body. Anger was also portrayed as being a feeling participants felt towards others, but often they described feelings of anger directed towards themselves. Rose described anger towards herself for letting her sexually abusive husband "take things as far as he did", and Tanya recalled her anger resulting from getting herself into "dangerous situations."

Theme 4: Behaviors Prior to Relapse

Recalling behaviors prior to alcohol relapse extended existing research discussed in Chapter 2. Current studies predominantly identify thoughts and feelings, however, do not provide descriptive information regarding typical behaviors prior to relapse. AA includes identification of so called "bad behaviors" in their 12-step process, which helps alcoholics understand patterns of behaviors which have led them to alcohol relapse in the past. While thoughts and feelings of the behaviors are reported by participants as what provoked their alcohol relapse, the ability to identify behaviors which led them to these feelings has proved indispensable in their recovery. The participants described two over-arching patterns of behavior, with isolation described by nine of the 12 participants, and negative encounters with family members reported by five of the women.

Periods of isolation were the most described behavior prior to relapse, with respondents recalling this time as one when they withdrew from friends, family, and healthy lifestyle activities. Isolation was also described as a time when participants would ruminate on fears, resentments, and what they considered inappropriate behaviors. Tanya described "pulling away from everyone" and "stopped answering the phone" as

isolating behaviors. Cathy said she would isolate and get up in her head and "try to figure everything out" by herself, and Kristen said, "I would isolate and be fearful." For the respondents who recalled placing themselves in situations where they had no business being, Tina noted she needed to "stay away from friends and places where there would be alcohol." Susan described staying away from family because "this would be the time when things would happen that I wouldn't know how to deal with." Lin noted it was best for her to "stay away from family gatherings" to avoid negative encounters.

Theme 5: Subsequent Abuse

The need to uncover past histories of trauma and alcohol abuse is acknowledged by the women of this study. This supports current literature presenting the need for professionals to pay closer attention to early trauma and alcohol histories (Bailey et al., 2012; Huang et al., 2012; Schwandt et al., 2013). Childhood trauma from emotional, physical, or sexual abuse is reported as a risk factor for adult traumatization (Brady & Back, 2012; Zinzow et al., 2012). Ten of the 12 participants in this study received their PTSD diagnosis resulting from childhood trauma, and of these 10 women, all suffered additional traumas later in life. Research supports victimized women respond to sexual situations differently than non-victimized women (George, 2014), and the high-risk hypothesis (Chilcoat & Breslau, 1998) states individuals who abuse alcohol may place themselves at additional risk for trauma. The responses of the women in this study would be supportive of that idea. This is not to say these women purposefully placed themselves in dangerous situations, but rather periods of intoxication masked potential danger. Statistics report approximately half of rapes involve women under the influence

of alcohol (Zinzow, et al., 2012). This is confirmed by all women in this study who described being raped, with each of them under the influence at the time their rapes occurred.

This study additionally support Matos and colleagues (2013) findings that women tend to blame themselves for a rape if they are under the influence when they are raped. All but one of the participants raped described taking some sort of responsibility for what happened. Heidi stated, "I never saw this as rape because I figured it was my fault for getting so drunk." Cathy, who was raped and beaten in college, recalled "I knew it was partially my fault for walking home alone." The exception was Tina, who was only 11 at the time of her rape. This group of women felt the detection of a PTSD diagnosis and treatment earlier in life, may have saved them years of alcohol abuse and subsequent trauma.

Theme 6: What Works

The need for gender-based research and comprehensive treatment strategies are gaining momentum in current literature, specifically for the need to treat symptoms of PTSD and AUD simultaneously (Mills et al., 2012; Sannibale et al., 2013). Current research reports statistics on women with comorbid PTSD and AUD continues to rise, and women are more susceptible for getting stuck in a pattern of negative thoughts (Ciesla et al., 2011; Tait et al., 2013). All women of this study support the need for psychological professionals to treat both disorders simultaneously. Current research identifies the need for programs which simultaneously address PTSD and AUD, such as those which deal with both past and present recovery strategies (Witbrodt & Dlucchi,

2011). Alcoholics Anonymous is a program that deals with both and has been a highly successful means to recovery reported by all the women in this study.

The use of the 12 steps is described by participants through uncovering and dealing with past resentments, fears, and bad behaviors through the development of a "Higher Power" or spiritual entity. Many of the women described having a "Higher Power" helped them deal with their thoughts and feelings, as well as kept them from relapsing. This is not surprising, however, being that all 12 participants were active members of AA. The program of AA indicates that there will come a time when the only thing that exists between a person and a drink will be their "Higher Power" (AA, 2001).

This seems to have been the case with the women of this study, as all describe relapsing until they developed a meaningful relationship with a "Higher Power." Lin recalls reaching out to something she never believed in before stating "help I can't do this by myself." Patricia described how having a "Higher Power" kept her from feeling fearful. Stacy noted "I can get nervous, fearful, and overwhelmed, but if I pray it will calm me down." Tanya described turning to her "Higher Power" to rid herself of anger. These are all feelings, by the way, which were previously described by participants as precipitory factors to alcohol relapse.

Theme 7: What Professionals Need to Know

Epidemiological studies indicate the difficulty in treating women with comorbid PTSD and AUD (Hein et al., 2015; Hein et al., 2012). Treating both disorders has historically been a challenge, with many women reporting their struggle to remain sober when dealing with ruminating thoughts of negative memories (Battista et al., 2013; Ciesla

et al., 2011; Jayawickreme et al., 2012). All participants reported seeing a therapist at some point in their recovery. Half of the women, still see a professional. All participants discuss how beneficial therapy was to their recovery, especially when it came to identifying the feelings they had which led them to relapse. Uncovering feelings was reported as the most beneficial aspect of therapy, and having someone to help make sense of their feelings and talk about them was reported as one of the best decisions they made in recovery.

The women of this study support what is already presented in current literature, that being the need for comprehensive treatment strategies addressing PTSD and AUD simultaneously. Research acknowledges an empirically based treatment strategy of Seeking Safety, as the most beneficial to date (Morgan-Lopez et al., 2014). Seeking Safety, however, does not delve into trauma narratives, but rather works on successful coping skills for the here and now. Seeking Safety reports high rates of treatment completion, however, shows no improvement with relapse prevention (Berenz et al., 2012). One of the parameters set for this study was to listen to women who have had difficulty with alcohol relapse, as they describe their difficulty remaining sober. This, they described, was mostly due to early life trauma or alcohol use which was never uncovered or discussed. Victoria stated, "alcoholism was only a symptom of a bigger underlying problem." Patricia noted "I wasn't drinking over the actual things that happened to me, I was drinking over how I felt about myself." Feelings and stressors leading to relapse were prevalent in the discussions of participants, rather than descriptions of flashbacks resulting from actual trauma experience. Research notes

successful strategies help to reduce stressors in conjunction with treatment designed to reduce emotional stress (Majer et al., 2012). It would, therefore, seem that comprehensive treatment strategies for this population of women should address both early and current life stressors which trigger alcohol use, in addition to providing ways to manage current stressors. This implies that proper assessment strategies have already been implemented to detect past and present stressors leading to alcohol use and abuse.

Proper assessment of this population, and the need to detect trauma and alcohol histories was reported by most respondents. Current research indicates the need for professionals to pay closer attention to childhood histories for women presenting PTSD (Bailey et al., 2012; Huang et al., 2012; Schwandt et al., 2013). Research also reports the need to for professionals to be more thorough with PTSD sufferers when it comes to alcohol use, with close attention to when they began to use alcohol as a means to cope with anxiety (Duranceau et al., 2014; Gaher et al., 2014; Haller & Chassin, 2013; Hruska & Delahanty, 2012; Read et al., 2014; Simpson et al., 2012). Rose and Susan discussed the need for therapists to get to the bottom of the problem, which may be difficult because alcoholics "lie." Rose described telling numerous therapists only part of what was going on and not revealing "the whole story." Patricia's PTSD and AUD was not diagnosed until her early 40's despite going to therapists since she was 18. She recalled "therapy was about what was happening right now" and her alcoholism and trauma went undiagnosed for years. Many of the participants were raised in households with alcoholic parents and recounted the need for professionals to dig deeper into childhood histories for

abuse and trauma. Tina described having symptoms of alcoholism and being a child of an alcoholic "was overlooked" in therapy.

Extended information presented by the participants of this study include the need for professionals to better understand PTSD and AUD symptomology, especially when dually diagnosed. Nine women expressed the need for therapists to better understand PTSD symptomology, especially its presentation in childhood. Tina and Patricia felt professionals could better understand this comorbid disorder if they spent more time in women's AA meetings listening to individual stories. Many of the women also stated therapists needed to better understand the repetitive cycle of alcohol use in response to negative thoughts and feelings, and how the drinking cannot stop until the negative thoughts stop. Understanding what "drives the alcoholic to drink" was reported by Heidi, and described in detail when the participants discussed their work in AA. All respondents felt AA was what helped them stay sober, which is the issue most identified in comorbid PTSD and AUD literature. It is not the notion that this population cannot get sober, it is that they have such difficulty staying sober. Individual vulnerabilities need to be identified to gain a comprehensive understanding of the connection between the two disorders (Read et al., 2014).

Limitations of the Study

Smaller sample size can be seen as a limitation of qualitative research and phenomenological studies. The small sample size and strict parameters of this research limits the amount of information transferrable to the greater population of women with comorbid PTSD and AUD. The findings, however, provide a rich accounting for this

specific population of women who present success with alcohol abstinence. Despite the small sample size, this study provides explicit descriptions of participant experiences with the phenomenon, which lacks in current literature. Constant checking and re-checking of participant transcripts provides credibility to this study, and a detailed accounting of data collection and analyses provides an outline to perform similar research in the future. This study, though limited in size, unearths valuable information which can be incorporated into a better understanding of how women diagnosed with comorbid PTSD and AUD describe their experience with alcohol relapse. Additionally, the findings reported by the women of this study indicate the need for professionals to better understand comorbid PTSD and AUD in women. While this research uncovers only a small piece of what still is unknown with this population, it presents a strong argument for future research to better understand the phenomenon of cooccurring trauma and alcohol abuse with women.

It is important to note, the parameters of this study required participants to be at least one-year post trauma, with at least one-year of continuous sobriety. Therefore, there exists the potential for inaccurate memory recall on behalf of participants. The descriptions provided must be taken at face value understanding distortions in memory may be present recounting childhood memories and early life trauma. Myself, as the researcher, can also present a potential limitation to this study, being that phenomenological research uses the researcher as the instrument and the means to collect, analyze and report the essence of the findings. The potential for researcher bias

was continuously addressed through the process of the epoché, to help myself remain as neutral as possible throughout the course of this study.

Recommendations for Further Research

The importance of these findings address the need to better understand comorbid PTSD and AUD with women. Research reports 30%-59% of patients presenting comorbid PTSD and AUD are female (Heffner et al., 2011; Jayawickreme et al., 2012). Current literature on this comorbid condition is heavily male in perspective, and deals with PTSD symptomology based upon combat trauma. Research shows men and women with cooccurring PTSD and AUD are different in their response to trauma situations and alcohol use, and studies report a bias towards a male perspective (Brady & Back, 2012; Foran et al., 2011; Hassija et al., 2012; Hellmuth et al., 2013; Johnson et al., 2010; Lehavot et al., 2014).

This study describes the essence of a small group of women suffering from both disorders. It is clear to see their trauma most often results from childhood emotional, physical, and sexual trauma, and their alcohol use and abuse typically corresponds to a similar time frame. These women also recounted how their PTSD diagnosis took many years to be uncovered, as they continued to self-medicate with alcohol to avoid negative ruminating thoughts. During this time of an untreated diagnosis, they continued to place themselves in dangerous settings resulting in subsequent trauma. This would suggest further research and investigation into current intake strategies for women is necessary, especially to uncover alcohol and trauma histories.

Many participants of this study reported a significant time frame before their alcoholism was diagnosed and the connection was made between their PTSD and AUD. These women described how professionals could better serve this population through more thorough interview strategies. Inquiry into childhood histories of potential abuse and alcohol use as well as family histories of alcohol abuse, must also be assessed. The women of this study described anxiety as a precipitating factor to relapse, similar to current research findings, but also recalled fear, sadness, and anger as equally provoking. Research on anxiety is abundant, however, further studies on the role of fear, sadness, and anger could prove beneficial. The difficulty respondents had in identifying thoughts, prior to relapse, could as well benefit from additional research, as thoughts led to feelings which triggered alcohol relapse.

Implication for Positive Social Change

The importance of these findings from a social change aspect can be found in generating a broader description of the phenomenon of PTSD and AUD with women. There exists the need to better understand that PTSD no longer results strictly with men in combat situations, but also with women presenting abusive childhoods. Social change requires research based upon a female understanding to competently address appropriate treatment strategies for women. No longer is it suitable to treat women with this dual diagnosis founded upon research conducted on predominantly male populations. Despite the limited number of participants in this study, this research provides a deeper understanding of the thoughts, feelings, and behaviors as described by the women of this study, as well as how they feel their diagnosis can be better understood and treated. This

information can help fill some of the gaps in research and hopefully entice others to take deeper consideration into this phenomenon. The voices of these women give credence to the need to design more appropriate treatment strategies which simultaneously treat both disorders. Their suffering through years of abuse and alcoholism deserves attention to better comprehend the underlying factors which contribute to alcohol abuse and the difficulty this population has remaining sober. Participant descriptions can hopefully expand the insight and knowledge of professionals who treat these disorders, and motivate them to better understand both PTSD and AUD symptomology as it is described by the women who live with it.

Researcher's Reflection

Phenomenological research has taught me the importance of being able to bracket out my personal thoughts and biases to better understand the lived experiences of others. This will continue to be an effective tool as I work with individuals in the field of clinical psychology. The ability to see every individual for the first time with a fresh perspective will be valuable in both assessment and treatment. From a personal standpoint, this study has provided me a wealth of information and understanding which I can take into my volunteer experience with women in AA. While the past 17 years of working with women in recovery has taught me much about this dual disorder, this study has provided further insight and clarity to the overarching themes of women suffering from this comorbid condition.

From a personal sense, this study exemplifies a triumph of both personal and emotional growth that I may not have recognized in myself up to this point. Being part of

this population of women, I realize we are all here to rejoice in the battle of our lifetime, that being the ability to overcome our past trauma and live sober and productive lives. As a woman and a mother, I need to remain in constant pursuit of a better understanding of my relationship to the phenomenon, and join these women in a quest to aid others who suffer from this comorbid diagnosis. I will not say this was easy, as many of the interviews were painful to hear. The women of this study, however, provided great courage in the face of adversity as they continue to deal with their emotions and pursue a lifelong path of continued sobriety. Their journeys will forever touch my heart, and I will always be indebted to their honesty and humility.

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