



































































### *Perceived stress*

Results of perceived stress measured by SSP in the Swedish study-group showed that women displayed scale score close to the mean norm in Psychic trait anxiety, and about 0.5 SD above the mean norm in Stress susceptibility, Irritability, and Embitterment. Results indicated that women with 1 SD or more above the mean norm in Embitterment were more prone to have a treatment goal to “quit drinking” ( $\rho = 0.182, p < 0.05$ ) and to have been drinking more alcohol than the other women at the start of treatment (Mann-Whitney test:  $z = -3.389, p < 0.001$ ). The US women as a group experienced normal psychic stress, having mean raw scores close to female mean norm PSS scores. The women with PSS-scores exceeding 1 SD above the mean norm were drinking more alcohol than the other women at the start of treatment (Mann-Whitney test:  $z = 3.036, p = 0.02$ ), however there were no differences in alcohol consumption at the follow-up.

### *Experiences of treatment*

Subjects in both the Swedish and US study groups were very satisfied with particular aspects of treatment, and there were significant correlations between a decrease in percent drinking days at the end of treatment and treatment satisfaction ( $r = -0.31, p \leq 0.01$ ) versus treatment respect (the women’s perceived attitude from staff) ( $r = -0.22, p \leq 0.05$ ) among the Swedish women, showing that the women who were most successful in cutting down their drinking also rated treatment most empowering. Further, a significant relation was found showing that the Swedish women with high values in treatment satisfaction were more likely to maintain drinking below the risk limit ( $t = 3.253, p < 0.001$ )

## **Discussion**

This descriptive study compared two groups of women with drinking problems who received two different treatment approaches, each highlighting the options available. The main finding is that both groups of women demonstrated a decrease in alcohol consumption, as measured by grams per drinking day and percent drinking days. All women drank in excess of recommended guidelines; however the Swedish women drank considerably more per day. Interesting similarities between the groups were shown, despite the marked differences in length of treatment as well as different cultural contexts and healthcare systems. First, the women’s attitude to changing their drinking was important. Specifically, the Swedish women who selected abstinence as their goal were more likely to reduce their drinking. Among the US women, those in the “contemplation” stage of change were the least likely to reduce their alcohol use. Second, the women’s perception of treatment is an important factor for success. Third, the women’s experience of stress may play a role in the amount of consumed alcohol. Thus, highly stressed women could be a particular risk group of women who are vulnerable to developing alcohol problems.

#### 4.4 STUDY IV

##### **Women with alcohol problems – the possible significance of personality clustering for treatment planning**

###### **Aims**

The purpose with the present study was to establish possible differences in treatment outcome in terms of: (1) drinking outcomes (gram and number of drinking days); (2) perceived physiological health; and, use of treatment resources (length of time in treatment and number of visits) through an analysis of the data of 134 consecutive, treatment-seeking women with alcohol problems in a clinical context, based upon previously identified personality and psychological health clusters.

###### **Results**

###### *Personality and health variables*

A hierarchical cluster analysis was performed including: (i) Variables of psychological health from the Health Index, in which the total sample had a mean score for each variable below the mean norm (psychic energy, mood, nervousness, loneliness); and (ii) SSP personality scales, in which the total sample differed significantly from a female norm population (Somatic trait anxiety, Psychic trait anxiety, Stress susceptibility, Embitterment, Mistrust). The analysis resulted in two clusters (Cluster 1,  $n = 53$ ; and Cluster 2,  $n = 80$ ) with a residue of one patient, see Figures 4 and 5.

Further analyses of personality traits showed that the women in Cluster 1 were psychologically more vulnerable compared to the women in Cluster 2, in that they were less self-assertive (Lack of assertiveness,  $p < 0.01$ ), more withdrawn (Detachment,  $p = 0.019$ ), and more irritable (Trait irritability,  $p < 0.01$ ).

The self-rated over-all health (including both psychological and physiological health) at the start of treatment was different for the women in the clusters. Those in Cluster 1 having a lower over-all health status ( $M = 45.6$ ,  $SD = 27.8$ ) as compared to the women in Cluster 2 ( $M = 75.1$ ,  $SD = 26$ ),  $p = 0.004$ . Furthermore, those in Cluster 1 rated their problems with dizziness worse ( $M = 70.0$ ,  $SD = 26.5$ ) than those in Cluster 2 ( $M = 82.8$ ,  $SD = 23.2$ ),  $p < 0.0001$ .

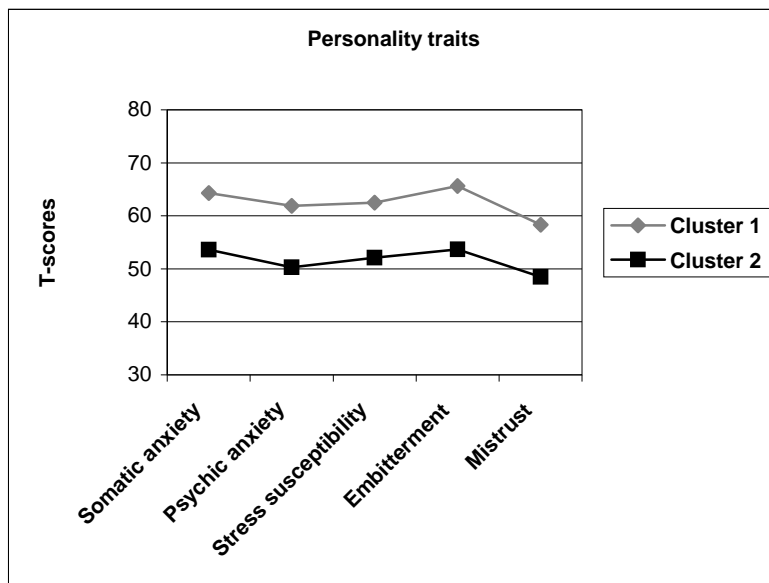


Figure 4. Self-rated personality traits at the start of treatment for female patients with alcohol problems, Cluster 1 (n = 53) and Cluster 2 (n = 80), where T = 50, SD = 10.

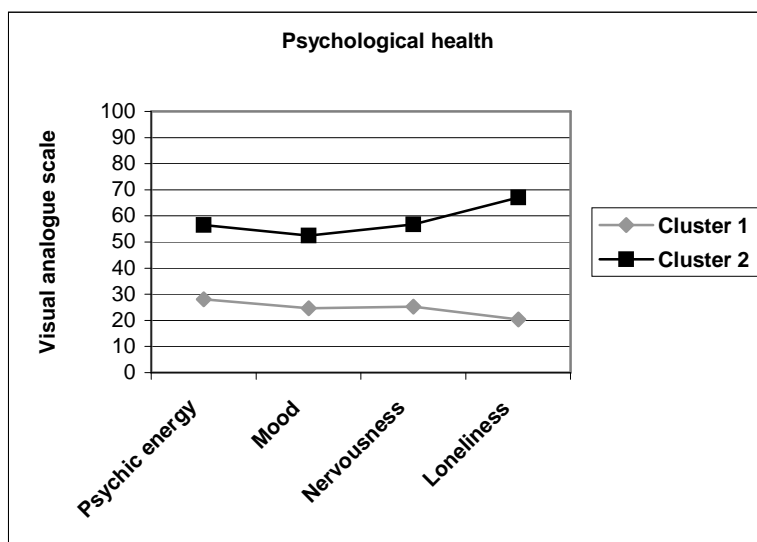


Figure 5. Self-rated psychological health at the start of treatment for female patients with alcohol problems. Cluster 1 (n = 53) and Cluster 2 (n = 80), presented in visual analogue scales (0 – 100) where low values indicates worse health.

#### *Alcohol consumption and consequences*

The consumption of alcohol was rather similar between the women in the two clusters, both at baseline (M = 90.1, SD = 43.5) and at the end of treatment (M = 45.2, SD = 49.0). No significant differences were found in the percent of drinking days at baseline (M = 0.36, SD = 0.29) or at the end of treatment (M = 0.14, SD = 0.20). The mean number of years the women reported that they had been drinking in this way was equal for the women in the clusters, about four and a half years.

All results were in favour of the women in Cluster 2 having fewer consequences as a result of drinking. Likewise, self-reported consequences of drinking in the AVI-R showed similar differences between the clusters in the primary scales of Decreased depression ( $p = 0.001$ ), Enhanced contact ability ( $p = 0.006$ ), Enhanced thinking ability ( $p = 0.03$ ), and Earlier family problems due to alcohol consumption ( $p = 0.022$ ).

#### *Treatment utilization*

In total, the women in Cluster 1 visited the clinic more times ( $M = 80.3$ ,  $SD = 8.1$ ) compared to the women in Cluster 2 ( $M = 56.6$ ,  $SD = 4.2$ ), indicating a significant difference between the clusters ( $t = 2.84$ ,  $p = 0.005$ ). The women in Cluster 1 stayed in treatment with a mean of 744.0 days as compared to the women in Cluster 2 with a mean of 622.5 days; however, there was no significant difference observed. Observing the number of cancellations, the women in Cluster 1 had more cancellations as compared to those in Cluster 2 ( $t = 2.18$ ,  $p = 0.031$ ).

#### *At the end of treatment*

At the end of the treatment the women in Cluster 1 still rated their health worse than those in Cluster 2, regarding most scales in the Health Index. The women in Cluster 1 were slightly less hopeful regarding their future handling of drinking ( $p = 0.065$ ) than were Cluster 2 women.

### **Discussion**

The main finding in this study was that two different clusters of treatment-seeking women were found. On the basis of scale-score in personality traits, and self-rated psychological health variables, two clusters of women were identified. Those in the first cluster (Cluster 1) had personality traits above the norm mean, and below satisfying self-rated psychological health. The women in Cluster 2 experienced normal health in the clustering variables. Enhanced values in the personality traits included in the cluster analysis could contribute to daily life problems. Furthermore, the women in Cluster 1 had worse physiological health than those in Cluster 2, both at the start and after treatment.

The consumption of alcohol was similar between the women in the two clusters, both at the start and at the end of treatment. Yet, the self-reported consequences were far more pronounced for the women in Cluster 1 as compared to those in Cluster 2. The women in Cluster 1 needed far more time in treatment to enhance a decrease in drinking that was compatible with the women in Cluster 2.

## 5 GENERAL DISCUSSION

The work in this thesis has focused on treatment-seeking women with alcohol problems. The main aims were to explore the women's underlying individual and psychosocial characteristics within a Swedish context, and to examine factors influencing treatment outcomes. This thesis was approached with an understanding of the development of alcohol problems as a complex interaction between several factors. The interactional perspective applied here suggests that the development of alcohol problems can depend on several factors, and their interaction, both from within the individual as well as from the immediate and extended psychosocial environment. Furthermore, an interactional perspective assumes that all individuals do not develop in the same way, as there is individual variation in development. Hence, a person-oriented method, creating an individual's profile, may be a valuable supplement to other methods in this area (Bergman & Magnusson, 1997).

Of special interest in this thesis are the factors that reflect individual differences and their implications for psychological and physiological health. Exploring a group of alcohol-treatment-seeking women from this starting point can provide valuable knowledge of how individual differences are mirrored in the development of alcohol problems, and can identify possible new directions for treatment planning.

### 5.1 MAIN FINDINGS

*Understanding the cultural context in which the individual is acting can contribute to understanding the drinking patterns and approach to treatment among women.* From this vantage point the results of perceived societal judgment found among the Swedish treatment-seeking women with alcohol problems strengthen the importance of taking cultural messages into consideration. This is of particular importance when interpreting the underlying psychosocial characteristics for the women of this study (DeMarinis *et al.*, 2009). Also Mäkelä *et al.* (Makela *et al.*, 2006) found clear gender differences in a study of European drinking cultures. In societies where drinking is surrounded by ideas about femininity/ masculinity, female alcohol drinking is often connected to feelings of guilt and shame over not being 'correctly' feminine and may be a hindering factor for seeking treatment (Kearney, 1997; Jakobsson *et al.*, 2008). A hypothesis generated through this study of interest for further investigation is that Swedish women seem to prefer a women-only treatment when optional (Dahlgren & Willander, 1989; DeMarinis *et al.*, 2009). It therefore seems of great importance to offer women-only treatment in the Swedish context, or of having the possibility to address explicitly the particular needs of treatment-seeking women in a mixed-sex treatment facility.

*Well established drinking patterns were found in this group of treatment-seeking Swedish women with alcohol problems.* This was expressed in that most women were qualified for the diagnoses of alcohol dependence, and that they could identify a set of specific behaviours surrounding a typical drinking occasion (drinking ritual). The typical drinking occasion was manifested by drinking alone and by having expectancies of change in mood by drinking (DeMarinis *et al.*, 2009; Scheffel-Birath *et al.*, 2009a). The women in general had a daily alcohol consumption corresponding to one bottle of

wine, seven days per week (Scheffel-Birath *et al.*, 2009a; Scheffel-Birath *et al.*, 2009b; Scheffel-Birath *et al.*, 2009c).

Despite this, the women were still functioning relatively-well socially, and most probably this cost a great deal of strain to maintain. Having developed an alcohol dependence in combination with a personality disorder is known to be difficult to treat (Fridell *et al.*, 2006). If women with such heavy alcohol consumption are not offered attractive treatment options at an early stage there is probably at great risk for even more serious consequences of their drinking. However, having treatment resulted in a significant decrease of alcohol, either having access to long term or short treatment (DeMarinis *et al.*, 2009; Scheffel-Birath *et al.*, 2009a; Scheffel-Birath *et al.*, 2009b; Scheffel-Birath *et al.*, 2009c).

*Several factors were influencing treatment outcome.* The most important factor seems to be the possibility of being offered any type of alcohol treatment. It was shown that both the US women treated by BI and the Swedish women that had long-term treatment did equally well in decreasing their drinking. Further, it was shown that treatment-seeking women in long-term services used the treatment to different extents. The more psychologically healthy women reached the same decrease in drinking with a significantly lower number of times in treatment as compared to the women with worse psychological health. This could indicate that short term treatment could be enough for women with risk drinking, women who are not actively treatment-seeking, or even for women with a more severe alcohol problem yet having relatively good psychological health. For women seeking treatment for alcohol dependence diagnoses and experiencing strained psychological health, it is important to have the opportunity for long-term, gender-informed treatment service as well as the possibility to influence the treatment process.

*The treatment-seeking group of women studied was shown to be a heterogenic group with respect to their personality profiles and perceived psychological health.* One of the most striking results from the studies is that almost half of the Swedish treatment-seeking women suffered from impaired psychological health and personality traits deviant from the mean norm (Scheffel-Birath *et al.*, 2009a; Scheffel-Birath *et al.*, 2009c). As the concept of personality could be described as partly grounded in genetic dispositions that could be reinforced or not developed during the lifespan, these women's problems can be a result of strains during their childhood (Watson *et al.*, 1994; Spak *et al.*, 1997). Most of the Swedish women in these studies were raised with one or both parents/stepparent having alcohol problems, and experiencing a negative relation to one or both parents. Being exposed to a family environment where alcohol frequently was used, as these women were, could bring with it an increased probability of experienced negligence or trauma. The experienced negative relation to parents is possibly linked to these experienced traumatic situations, and connected to the parents' drinking problems during the women's childhood. Together with an increased vulnerability for psychological distress, being exposed to abuse as a child would probably mean that this group of women had an increased risk for developing alcohol and/or other psychiatric problems, as well as more difficulties when coping with daily life situations and addressing problems. This group of women, it can be concluded, therefore needs longer treatment and accesses to diversified resources during treatment.

*The healthier group of women in the studies generally had experienced the same extent of parental drinking during childhood.* However, this group had a more positive attitude to receiving help and needed fewer times in treatment to achieve the same level of non-risky drinking as did the more psychologically burdened group. This brings up the issue of how long and intensive treatment should be to address these more or less healthy groups of women. This links to a new area of treatment research that has been generally focused on matching individuals to different treatment methods (Project Match Research Group, 1998; Read *et al.*, 2001; Miller & Wilbourne, 2002; Kaner *et al.*, 2007).

## **5.2 METHODOLOGICAL CONSIDERATIONS**

The overall limitation in the studies included in this thesis is that the Swedish data were collected from a selected group of treatment-seeking women with alcohol problems. The studies were performed at a clinic in a larger city in Sweden, and no control group was used. These facts limit the possibility to generalize the results to a larger population of women with alcohol problems.

From the whole population of 199 women we managed to collect complete data from 134 (67%) women. This may weaken the possibility to generalize to the whole population of treatment-seeking women with alcohol problems. However, there were no differences found between the women with complete data and incomplete data at baseline. Further investigation of the factors that contributed to the 33% of the women that chose to interrupt their treatment or to not answer the follow-up questionnaires would be important.

The sample sizes in study I and II were rather small and could affect the validity of results. In study I data collection and data analyses were performed within the parameters of a qualitative study protocol and thereby meeting the validity criteria of such. In qualitative analyses the work with validity and reliability is continual during both data collection, analyses and presentation of results (Tashakkori & Teddlie, 2003). In study II the statistical analyses were mainly performed on a qualitative data set where small populations usually are accepted. The data set was then converted and quantitized into indices in accordance with established procedure (Tashakkori & Teddlie, 2003).

The data collected from case journals, mainly used in study I, represent reflections and notations from clinicians, and no stringent way of writing down this information was established at the time for data collection to study I. However, as an effect of the findings in study I a template for recording case journal information was introduced.

Regarding study III there is a potential limitation regarding the included samples. The two study samples used were not directly comparable, where the samples consisted of (i) treatment seeking Swedish women for alcohol problems, and (ii) treatment seeking US women for medical problems, and having concurrent alcohol problems. The data from the two very different samples were not compared in the study, but rather

contrasted in order to problematize a number of different factors involved for examining the effects of different treatment methods on women with alcohol problems. A more optimal design would have been a more standard comparison of treatment options using comparable samples. Most optimal would certainly have been a randomized controlled trial (RCT) design if such would be possible, but performing such a study was outside the limits of this doctoral work. If one were to pursue such an RCT, both personality and health factors would need to be considered in the planning of the design. With these limitations well in mind, this study could be used as a pilot study for a closer investigation of the optimal number of times needed in treatment for women with different degrees of alcohol problems.

The instrument used for data about perceived psychological and physiological health is a health questionnaire, the Health Index. This index is influenced by instruments that have been tested for validity and reliability, but in its present form it has not been tested nor used in any other study. However, when comparing data from the Health Index and SSP in studies II and IV, congruence between these instruments was found that can be interpreted as a validation of the Health Index.

### **5.3 CONCLUSIONS**

The Swedish women included in this thesis were all treatment seeking at a clinic specialized for women with alcohol problems. They were all in need of help for addressing their developed alcohol dependence diagnoses. Despite drinking an average of one bottle of wine per day they still had a stable living situation, custody over their children, and a connection to the labour market (at work or on paid sick-leave). Maintaining function in these areas while at the same time consuming this degree of alcohol made many demands on their activity planning, time, and energy.

This group of treatment-seeking women for their alcohol problems was heterogenic. Two groups were found, with one group being relatively stable in personality and in perceived psychological health, and the other having personality traits above the norm mean indicating experiences of anxiety, stress susceptibility, and embitterment, as well as a less satisfying perceived psychological health. Both groups of women decreased their drinking significantly after the received treatment. However, the healthier group of women needed about half the treatment time that was required for the more burdened group of women in terms of arriving at the same level of non-risky drinking. This highlighted the importance of discussing length of treatment when planning treatment options.

Having the opportunity to receive treatment for alcohol problems is valuable. Most women included in this thesis could change their drinking habits after treatment to a non-risky drinking pattern irrespective of their different alcohol consumption levels before treatment.

## **5.4 FUTURE DIRECTIONS**

Using a cultural perspective for creating an enhanced gender profile when investigating women with alcohol problems, has been useful for gaining an increased understanding of: drinking patterns, feelings connected to drinking, and approaching treatment outcomes. Applying a cultural perspective for a better understanding of gender-specific areas associated with men's drinking might also prove useful and might thereby enrich the treatment options for both men and women, and for planning related couple and family strategies.

Further studies on treatment planning and treatment methods for women with alcohol problems aimed at matching treatment time and resources to women's psychological health would show if time and cost could be decreased for women who were more psychologically healthy, and less vulnerable concerning personality and daily life behaviour. This however needs to be addressed in future research.

## 6 SVENSK POPULÄRVETENSKAPLIG SAMMANFATTNING

Riskfyllt drickande av alkohol är på flera sätt mer skadligt för kvinnor än för män. De fysiologiska konsekvenserna av drickandet kommer snabbare för kvinnor bland annat beroende på en till vissa delar olika ämnesomsättning samt att fördelningen vätska/fett i kroppen är annorlunda för kvinnor än vad man ser hos män. Till de allvarligare fysiologiska konsekvenserna för kvinnor av alkoholförtäring hör bland annat olika cancerformer (till exempel bröstcancer och strupcancer), hjärt- och kärlsjukdomar och diabetes. De psykologiska konsekvenserna av drickande utgörs bland annat av en ökad risk för depression och självmord, vilket gäller både kvinnor och män. I takt med att kvinnors drickande har ökat, har även särskilda behandlingsalternativ för kvinnor etablerat sig. Svensk forskning har visat att kvinnor lyckades bättre i behandling om de får hjälp på en mottagning anpassad för kvinnor jämfört med om de får behandling på en mottagning som vänder sig till både män och kvinnor. Detta kan troligen ha berott på att behandling av alkoholproblem huvudsakligen var inriktad på den stora målgruppen för behandling, vilken tidigare utgjordes av män.

Avsikten med denna avhandling var att undersöka kvinnor som söker hjälp för sina alkoholproblem. Vi ville närmare studera underliggande individuella och psykosociala karaktäristika för kvinnorna i denna svenska grupp. Vi avsåg även att undersöka olika faktorer som kan påverka behandlingsutfall mätt i alkoholkonsumtion, nöjdhet med behandling samt upplevelse av stress i relation till alkoholkonsumtion för kvinnor i behandling för sina alkoholproblem.

I den första studien (Study I), en kvalitativ studie av de 20 första kvinnorna i kohorten, undersöktes journalanteckningar för att förklara hur kulturella faktorer påverkar kvinnors drickande i Sverige. Studien visade att kvinnorna kände sig stämplade på grund av sina alkoholproblem samt att de kände sig frustrerade över att de upplevde att samhället behandlar män och kvinnor med alkoholproblem på olika sätt. De flesta (95%) beskrev en problematisk uppväxt med upplevelser av misshandel förekom, såväl verbal, fysisk som sexuell. De flesta var också uppvuxna med minst en (1) förälder som hade missbruksproblem. Kvinnorna beskrev att deras eget drickande hade utvecklats sedan tonåren då de börjat experimentera med alkohol och sedan fortsatt med sitt drickande in i vuxenlivet. Vid studiens genomförande hade de utvecklat ett problematiskt drickande med både socialt drickande samt privat drickande i ensamhet.

Den andra studien (Study II) avsåg att undersöka det privata drickandet hos 50 kvinnor, dels avseende känslotillstånd och förväntningar på förändringar i känslotillstånden vid drickande, dels om deras upplevelse av relationen till föräldrarna påverkade behandlingsutfallet. I studien framkom att alla hade förväntningar på ett förändrat sinnestillstånd i samband med ett typiskt dryckestillfälle samt att det mestadels var negativa känslor som de avsåg att hantera med hjälp av alkoholen. Som grupp betraktat så minskade kvinnorna sitt drickande signifikant under behandlingen. Resultaten visade även att 82 % av kvinnorna var uppvuxna med alkoholproblem hos en eller båda föräldrarna. Endast 12 % tyckte att de hade en positiv relation till båda föräldrarna och det fanns ett statistiskt samband mellan att ha en negativ relation till sin mamma och

samtidigt ha två föräldrar med alkoholproblem. Det fanns även ett statistiskt samband mellan en upplevd negativ relation till mamman och ett relativt sämre behandlingsutfall än för övriga kvinnor.

I den tredje studien (Study III) undersöktes 134 svenska kvinnor som fick långtidsbehandling och 152 amerikanska kvinnor som fick en korttidsbehandling för sina alkoholproblem. Korttidsbehandlingen innebar att man endast fick några behandlingstillfällen som huvudsakligen fokuserades på att kartlägga drickandet, rådgivning om allvarlighetsgraden i drickandet, om hur man kan förändra sitt drickande samt hur man kan bli bättre på att uppnå resultat avseende minskat drickande. De svenska kvinnorna drack signifikant mycket mer före behandlingen jämfört med de amerikanska. Resultaten visade dock att båda grupperna av kvinnor minskade sitt drickande efter genomgången behandling både avseende gram alkohol/dryckesdag och procent dryckesdagar. Faktorer som påverkade behandlingsutfallet gynnsamt var för de svenska kvinnorna att ha som mål med behandlingen att bli nykter jämfört med att ”skära ned”, samt att vara nöjd med behandlingen. Framgångsfaktorer för de amerikanska kvinnorna var att antingen vara beredda på att förändra sitt drickande eller att inte ha reflekterat över att drickandet kunde innebära problem, samt att vara nöjd med behandlingen.

Den fjärde studien (Study IV) hade som syfte att undersöka om gruppen svenska kvinnor som frivilligt söker hjälp för sina alkoholproblem på en alkoholmottagning är en heterogen grupp avseende personlighetsdrag samt upplevd psykologisk hälsa. I studien undersöktes 134 kvinnor med hjälp av ett personlighetsformulär samt ett formulär för självskattad psykologisk och fysiologisk hälsa. Resultaten visade att gruppen kvinnor kunde delas in i två olika grupper (kluster). *Kluster 1* omfattade kvinnor som uppvisade personlighetsdrag (somatisk och psykisk ångest, stresskänslighet, bitterhet, misstro) som avvek signifikant från normalpopulationens medelvärden. De skattade även sin psykologiska hälsa under den senaste veckan (psykisk energi, sinnesstämning, nervositet, ensamhet) till en icke tillfredsställande nivå. *Kluster 2* omfattade kvinnor som uppvisade personlighetsdrag som inte avvek från normalpopulationens medelvärden: de skattade även sin psykologiska hälsa som relativt tillfredsställande. Kvinnorna i de båda klustren drack i genomsnitt samma mängd alkohol både vid behandlingens start och vid avslutning, dock behövde kvinnorna i Kluster 1 signifikant fler besök för att uppnå samma minskning som kvinnorna i Kluster 2.

Sammanfattningsvis så visar studierna i denna avhandling att kvinnor som söker hjälp för sina alkoholproblem är en grupp kvinnor med relativt sett allvarliga alkoholproblem då de utvecklade diagnosen alkoholberoende. Trots den höga konsumtionen av alkohol hade de ännu anknytning till arbetsmarknaden, bostad samt vårdnaden av minderåriga barn. Upprätthållandet av allt detta var troligen förenat med stora ansträngningar. Kvinnorna själva upplevde att de dessutom ansågs tillhöra en grupp med negativa förtecken i samhället och de kände skuld och skam över detta. Möjligheten att få behandling för sina alkoholproblem upplevde de som värdefull och merparten av kvinnorna minskade sitt drickande. De hade vid behandlingens slut antingen slutat dricka helt eller drack en mindre mängd alkohol, som kan anses riskfri avseende fysiologiska och psykologiska komplikationer.

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