

Women's Experiences of Recovery from Alcohol Dependency

in Tohoku Region, Japan:

Their Views of Needs for Recovery

By

Junko Kameta

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfillment of the requirements for the degree of

MASTER OF SOCIAL WORK

Faculty of Social Work

University of Manitoba

Winnipeg, Manitoba

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Abstract

This study uses a phenomenological methodology to understand Japanese women, living in Tohoku region, Japan, who have the experience of alcohol dependency and recovery. Moreover, the purpose of the study was to understand what would be the most effective ways if supporting women in rural communities. Six women were interviewed to obtain the meanings they attach to recovery. Nine themes emerged. It was found that the women had common turning points prior to beginning their recovery, and had adopted various changes in their process of recovery. For all women in the study, the essential meaning of recovery was *to live* and *to live fully*. Recommendations are presented regarding the advocacy required to create the conditions necessary for women to live fully. This involves greater education of the community at large about alcohol dependency and the creation of supportive environments for individuals in recovery and their families.

Acknowledgements

I would like to acknowledge everyone who has supported me throughout my academic years. Thank you to my advisor, Dr. Tuula Heinonen, for providing academic guidance, continuous support, and encouragement. Thanks also go to my committee members, Dr. Kendra Nixon (Faculty of Social Work) and Dr. William Lee (Asian Studies), for their expertise and feedback.

Thank you to my editors, Elizabeth Krahn and Nancy Clyde, for their help to improve my writing.

To my friends, Claire Fleet, Makoto Monobe and Johnny Marlow, thank-you for your friendship, laughter, and support during the last stages of working on this thesis; and to Stanley W. Kipling for your friendship, encouragement, and wisdom throughout my academic years in Canada.

Special thanks go to my parents, Tadami and Yoko, for understanding my educational goals, providing financial support, and for all of your teachings.

I also extend thanks to colleagues and clients at Main Street Project, and to the women's self-help groups in Iwate prefecture, Alcoholics Anonymous and Danshukai. Most of all, thank-you to the women in this study! You taught me so much about what it is like to experience recovery from alcohol dependency, and about being a woman with a voice. Thank you all very much! 皆さんありがとうございます。

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CHAPTER 1

INTRODUCTION AND RATIONALE

The number of females dependent on alcohol in Japan has increased in recent years (Higuchi, Matsushita, Maesato, & Osaki, 2007; Kimura 2006; Masui, Kawano & Mori, 2006). It can be easily predicted that alcohol consumption and the problem of alcohol dependency among women will continue to increase if no action is taken. There has been little qualitative research that has attempted to gain a deeper understanding of female alcohol use problems and recovery. Therefore, little is known about their experiences from the view point of the women who have experienced the phenomenon. Furthermore, due to stigma attached to the problem of alcohol dependency, those women who are affected by it are often silent.

Learning about the differential factors affecting men and women living with alcohol dependency caused me to wonder: How does a social worker help a female client when the client has a problem with alcohol use? What does a woman with an alcohol addiction think about her current situation? And, how do these women survive with the problem when social resources are limited? This study explores the reality of Japanese women in Tohoku region who have the experience of alcohol dependency and recovery by using a phenomenological approach and methods.

Originally, I planned to interview the women in Iwate prefecture, a part of Tohoku region; however, there were not sufficient participants so the research area was expanded to the whole Tohoku region. At the end of the study, I discuss what the phenomenological experience of alcohol dependency and recovery means to these

women through the lens of social work and, on that basis, what would be the most effective ways if supporting women in rural communities.

Rationale

I have worked with people who live with the problem of substance abuse in Winnipeg, Canada. Working at a detoxification unit at the Main Street Project made me wonder how Japanese women living with substance addiction would survive. Moreover, I wondered what it means to live with the problem in Japan, how are women experiencing it, and do they have as much support available and accessible to them as their Canadian counterparts.

Although I am interested in learning about the issue of substance addiction in general among women in Japan, my research will focus on the problem of alcohol dependency. The reason is that it will be very difficult to locate women who have the experience of substance misuse, particularly the women who have been using illicit drugs such as cannabis, cocaine, and methamphetamines. Obviously, these substances are illegal to use and even to possess, while alcoholic beverages are a legal substance. So an individual who misuses illicit drugs would not have likely come forward to participate in this study even though the researcher carefully planned to protect their privacy. Nonetheless, it would have been challenging for the researcher to disguise the identity of participants and, therefore, to protect their privacy in a small study setting like Iwate prefecture. When I was researching topic for this thesis, I found that the Iwate Mental Health Welfare Centre dealt with only two cases that also involved drug related problems in the 2007 fiscal year (Iwate

Mental Health Welfare Centre Annual Report, 2008). I discovered through my literature review that no treatment facility for alcohol dependency exists in Iwate even though it is well documented in the literature how much alcohol dependence adversely affects not only one's health but other areas of one's life (Forth-Finegan, 1991; Higa, 2000; Ishiguro, 2006; Masui et al., 2006). As mentioned earlier, there are few options available for these women to receive help, as it has been pointed out that community social resources are limited for alcohol dependency (Kimura, 2006; Masui et al., 2006; Mizusawa, 2007; Shirakura, 2004).

In North America, "it was not until the 1980s that treatment professionals began to recognize that the backgrounds and needs of women with addiction problems were quite different than those of men" (Reed 1987, as cited in Kearny 1998, p. 496). Kearny (1998) continued stating, "Since that time, woman-specific treatment settings have begun to address women's need for support with child care, parenting education, job training, self-actualization issues, gender roles and relationship concerns, and the impact of childhood and adult violence and victimization" (p. 496). Although the author writes about North American society, I believe that the needs of women in Japan who have experienced alcohol dependency have some similarities to those of North Americans. Gotoh (1994) describes, "Women [in Japan] are considered to be secondary people, dependent upon men and obedient to their fathers and husbands" (p. 953). It may be that the roles of women in a patriarchal society as mother, wife, and daughter are quite similar despite cultural

differences. Therefore, Japanese women's needs for support are comparable to those of women in North America.

While reviewing the literature on female alcohol dependency, I found that there is a lack of research that has studied women's experience of alcohol dependence. What is more, less attention has been paid to women's experiences of recovery through qualitative research. The literature also examines the effective approaches from the viewpoint of practitioners but, not from the eyes of women who have experienced addiction and recovery. Without direct experiential evidence it is difficult to capture the essence of women's experience of alcohol dependency. Despite the gradual acceptance of evidence-based practice (EBP) in Japan (ASW, 2007), little research has been conducted to determine what services and treatment options were most helpful to women with alcohol dependency problems. Japanese social workers, medical practitioners, and researchers have described in their writings the desperate need for women-specific recovery programs (Higa, 2000; Ishiguro, 2006; Kawaguchi & Oosawa, 1984; Masui et al., 2006; Takiguchi, 2007). However, little has been done to explore what is effective for helping these women and what these women say about the support they need.

Purpose of the study

In this project, I have decided to adopt a qualitative methodology to learn about women's experiences of alcohol dependence and their recovery. None of this has been fully explored in Japan. The main purpose of this research is to explore the question: "What is recovery for you?" My intention for this research is to understand

the experience of recovery that women with alcohol dependence go through. My questions in this qualitative research are: “What is it like to experience alcohol dependence as a woman in Iwate Prefecture or in Tohoku region, Japan?” and “How do women experience recovery from alcohol dependency?” The subsequent purpose of this research is to learn from the participants: “What would be needed to help their recovery from alcohol dependence?”

In order to learn about the phenomenon, I will identify themes in women’s experiences of alcohol dependence from data collected from interviews with the research participants. The targeted user audience for this research will be mainly social workers as well as professionals working in the health or mental health fields who work with women who have problems with alcohol use. I will share the findings from this study with the participants. Moreover, I am intending to share the women’s stories and findings of this study with people who are presently suffering from alcohol dependence and struggling to recover.

There are three subsequent purposes for this study:

1. To explore what a woman thinks to be the most helpful or supportive resources to recover from alcohol dependence. Were needed supports available, and if so, what were they? If such experiences were considered as helpful or supportive, how did participants experience this? What experiences did women consider as critical to their gaining and maintaining a process of recovery?

2. To learn how these women remain in a process of recovery. The questions that will be asked of the subjects are: What kinds of support are you currently utilizing to help you retain a healthy life style?
3. To hear the voices of women who are often silenced due to the stigma attached to the problem of alcohol use. While stigma continues, an unknown number of women are not getting the support that they might need to help themselves recover from alcohol dependence and its related problems. Karoll (2002) states that women with alcohol problems are not appropriately referred to places where they receive the help that they need. Karoll discusses about the importance of gender-specific screening and assessment. Without hearing about what it is like to live with alcohol dependence and its related problems, these women might remain silent and continue to suffer. Their continuing alcohol dependence could result in them living a shorter than average life span (Shirakawa, 2009).

By conducting this study, I would like to consider how social workers can effectively work with women in order to support them. I would like to explore what barriers there might be for women who seek help. I would also like to know what types of social resources are needed for the women in Iwate prefecture and/or Tohoku region so that they are able to live life in a healthy way, and the way that they wish to live, without being silenced, discriminated against, and/or marginalized.

CHAPTER 2

LITERATURE REVIEW

Alcohol-related issues and facts in Japan

According to the Japanese Statistics Bureau, the estimated population in Japan was 127,760,000 in November, 2011 (Ministry of Internal Affairs and Communication, 2011). Ishiguro (2006) stated in his study of gender differences in alcohol consumption that 70 percent of males and 40 percent of females consume alcoholic beverages in Japan. As reported by researchers, there are at least 2,300,000 alcohol dependent people in Japan (Akahoshi, 2008; Enomoto, 2000; Shirakura, 2004). Shirakawa (2009) reported that there are 8,600,000 excessive drinkers of alcohol. Among those, there are 800,000 people with alcohol use disorders. Higuchi et al. (2007) indicated in the review of alcohol use in Japan that “the percentage of current drinkers among females has increased markedly” (p. 1852). As noted in the report, “a public poll survey conducted in 1968 showed that the percentage of current drinkers was 76 percent for males and 19 percent for females, while corresponding figures were 84 percent and 64 percent in the 2003 national survey”(Higuchi et al., 2007). The lack of Japanese longitudinal data makes it difficult to determine the severity of alcohol consumption, and its associated social costs (Higuchi et al., 2007).

Kimura (2006) states that epidemiological studies exploring the reality of alcohol dependency have not been conducted in Japan. Higa (2000) also stated in her literature regarding female alcohol dependency that there is no epidemiological

research available to capture the number of females dependent on alcohol. The only source available for the number of alcohol dependent females is an annual report of intakes in medical clinics and hospitals. Despite the shortage of data, Higuchi et al. (2007) report, “From a global perspective, per capita alcohol consumption remains relatively high in Japan; therefore, the level of alcohol-related problems is also estimated to be high” (p. 1859).

Kimura (2006) warned that the number of alcohol dependent females will increase because of the changes of life style and the changes in values and attitudes toward drinking. Alcohol brewing companies and their advertisements are also playing a role by promoting drinking alcoholic beverages for women as positive images (Gotoh, 1994, Higuchi et al., 2007). Ishiguro (2006) wrote that alcohol dependent females are likely to differ from male counterparts in various ways. According to Ishiguro, women face different and unique consequences when drinking becomes a problem. Those consequences can be physical, social, relational, and mental (Higa, 2000; Ishiguro, 2006; Masui et al., 2006). A number of studies suggest that women with alcohol dependence are likely to have a history of abuse problems (Forth-Finegan, 1991; Karoll, 2007; Kearny, 1998); a lack of help seeking behaviour compared with males (Karoll, 2007; Masui et al., 2006); and the tendency to have complications with eating disorders, depression, other mental illnesses, and other substance or process addictions such as shopping and gambling (Akahoshi, 2008; Forth-Finegan, 1991; Higa, 2000). Study results indicate that women with alcohol dependency consistently have low self-esteem (Forth-Finegan, 1991;

Kawaguchi & Oosawa, 1984). Therefore, a substantial amount of literature suggests that there is a need for specialized treatment programs for women with alcohol use disorder (Higa, 2000; Ishiguro, 2006; Kawaguchi & Oosawa, 1984; Masui et al., 2006; Takiguchi, 2007). Kimura (2006) stated that a gender specific treatment program seems to be more effective for women because alcohol dependent women tend to be victims of violence by males.

Shirakura (2004) reported that there are 270 facilities delivering either specialized programs treating alcohol dependency or programs accepting alcohol dependent individuals. In Iwate Prefecture, where I conducted my study, there are no facilities with treatment programs, specialized alcohol treatment wards, or social skill training centres (SST). According to a 2005 report by The Japanese Mental Health Welfare Research Association (2007), there is one alcohol treatment unit in a psychiatric hospital in Iwate. The ward has ten beds for alcohol-related patients (The Japanese Mental Health Welfare Research Association, 2007). A social welfare worker at Iwate Prefecture Mental Health Centre, Mr. Oomukai, stated that there are no social resources available for people with alcohol dependency, such as local organizations, non-profit organizations (NPOs), or rehabilitation programs, in Iwate except the centre and two self- help groups, Alcoholics Anonymous and *Danshukai* (personal communication, September 25, 2008). According to an annual report of the Iwate Prefecture Mental Health Centre, in the 2007 fiscal year, there were 80 cases of alcohol-related problems, including drop-ins and phone calls coming to the centre. Three other counseling sites exist within Iwate. The Iwate Mental Health Welfare

Centre (2008) reports 197 cases as the total number of people receiving counseling and consultation for alcohol-related problems in the 2007 fiscal year. Including all forms of services, the centre served a total of 277 cases in the same year. The total excludes cases where individuals went directly to hospitals, clinics, or community health centres to seek help. Statistics by The Japanese Mental Health Welfare Research Association (2007) indicated that by June 30th, 2005, Iwate had reported 273 patients hospitalized due to alcohol use resulting in mental and behavioural disorders.

A statistical count of alcohol-related cases does not indicate whether alcohol use is a serious social issue in Japan, particularly in Iwate. As Iwate is the focus of my study, I question why there are no programs or treatment facilities specializing in treatment for alcohol dependency available in Iwate except one hospital. The Japan Social Worker Association for Alcohol-related Problems (ASW) (2008) notes alcohol-related problems are mainly treated at general hospitals, particularly in psychiatric units. Matsumura (2004) stated, "Psychiatry as a medical specialty came into existence during the Meiji period (1868-1912) as part of the state's mission to increase Japan's economic and military capacity through the large-scale adoption of foreign institutions and practices" (p. 901). Even today, treatment of alcoholism in Japan generally takes place in hospitals and clinics, in which health care professionals, such as doctors and nurses, mainly provide care even though it is clear that an alcohol dependent individual requires more than medical help to recover from alcohol misuse. *Danshu no Sanbon-bashira* means "the three mainstays for quitting

drinking." *Danshu no Sanbon-bashira* is the most common method of treatment used for alcohol addiction treatment (Akahoshi, 2008, The Japanese Mental Health Welfare Research Association, 2007; Kaneku, 2008). The three mainstays are 1) taking medications, such as Disulfiram and Cyanamide to prevent drinking alcohol (Akiyama, 1997); 2) attending self-help meetings; and 3) visiting a hospital or clinic program for treatment of alcohol problems on a regular basis.

Higuchi et al. (2007) reviewed alcohol-related articles in Japan and stated that "Cross-sectional data suggest that alcohol consumption is associated with serious health and social consequences" (p. 1849). The estimated social cost of alcohol abuse in 1987 was 6.6 trillion yen which is equivalent to 60 billion US dollars (1 US\$ = 110 yen). No other reports regarding the social cost of alcohol use disorder are available in Japan.

Alcohol dependency is not only affecting the individuals who have the problem, but it also adversely affects family members (Kaneku, 2008). Mr. Oomukai at the Iwate Prefecture Mental Health Centre reported that the centre mostly works with family members of individuals with alcohol use problems (personal communication, September 25, 2008). He stated that the main reason for this is that denial is a common characteristic of alcohol dependency. As a result, individuals with alcohol use problems are often reluctant to seek help.

An alcohol dependent person is often called *Al-chuu* in Japanese. Etymologically, this word is a shortened version of the word alcoholics in Japanese and it has a contemptible connotation. It was once commonly believed that alcohol

dependency resulted from one's weakness and laziness (Akahoshi, 2008). The essence of alcoholism as a problem is that it is caused by one's personal defect and the lack of ability to control alcohol intake. That is, alcohol dependency was seen as their immorality and caused by their deviant personality. This is still widely believed in Japanese society (Akahoshi, 2008) even though years have passed since 1963 when Kurihama Hospital established its first alcohol unit in Japan to treat alcohol dependent people based on principles from a disease model.

Historically alcohol had been used only in traditional ceremonies, events, and rituals (Akiyama, 1997; Higuchi et al., 2007, Takada, 1999). As Higuchi et al. (2007) wrote, "[I]n these early years it was not used by individuals for enjoyment on a daily basis" (p.1849). The well-known proverb *sake wa hyakuyaku no chou*, which is written in an ancient Chinese book, translates into English as "liquor is the best of all medicines." It is widely believed drinking the right amount of alcoholic beverages is beneficial for one's health because it reduces tiredness and enhances appetite (The Japanese Mental Health Welfare Research Association, 2007). In fact, there is another part of the sentence after this; "but it causes thousands of diseases." Yet, "the number of people in Japan who believe that *alcohol is good for health* probably outnumbers those who believe that *alcohol is bad for health*" (Higuchi et al., 2007, p. 1858). Over time, alcoholic beverages became more available to the general public and are now used for socialization (Enomoto, 2000) and individual enjoyment. In addition, since 1897 (in the Meiji era), Japan has moved to greater industrial development and taxation on liquor became a significant income source for the

Japanese government (Takada, 1999). The total amount of taxable income from alcoholic beverages in 2008 was 15,320 million yen (National Tax Agency, 2009).

Compared with other countries, it can be said that Japanese society is more tolerant towards drinking alcoholic beverages (Masui et al., 2006) and public drunkenness. In modern Japanese society, alcoholic beverages are served on various occasions, such as business gatherings and family events (e.g., funerals and weddings). Furthermore, drinking alcoholic beverages with others plays a role in the building of relationships and is also used as a tool for better communication (The Japanese Mental Health Welfare Research Association, 2007; Yoshizawa, 1995).

The legal drinking age in Japan is 20 years old. Compared to North America, there is less restriction on the sale of alcoholic beverages in Japan (Higuchi et al., 2007). For instance, vending machines with alcoholic beverages are located in public areas while in many other countries this is not allowed. There are also alcoholic beverages in grocery stores and convenience stores that are open twenty-four hours a day, seven days a week. Furthermore, Higuchi et al. (2007) state that the price of alcoholic beverages has been decreasing over the years. It can be said alcoholic beverages are more accessible in Japan compared to North America.

Since World War II, “the conditions surrounding alcohol have changed dramatically” (Higuchi et al., 2007, p. 1849). Today it is culturally acceptable for women to drink alcoholic beverages, whereas “traditionally [it was only] middle-aged and older males [who] drank alcohol” (Higuchi, et al., 2007, p. 1849). Although it has become quite acceptable for women to drink alcoholic beverages in

public, women who drink excessively are still criticized by saying that that kind of behaviour is “unlike a woman” (Masui et al., 2006, p. 1). In modern societies, alcohol dependency and addiction are still shameful problems for women (Forth-Finegan, 1991). Shimizu et al. (2004) pointed out that the culture of drinking alcohol has a double standard in Japan; it is allowed for men to drink and be drunk, but it is not for women.

Definition of alcoholism, alcohol use disorder, alcohol dependency

Karoll (2002) explained, “Alcohol-use disorders are commonly framed in terms of abuse and dependence” (p. 338). There are various names for the problem of alcohol misuse and the person who has the problem; for instance, alcoholism, alcohol addiction, alcohol misuse, alcohol abuse, or alcohol dependency, to name a few. The person with an alcohol use problem will be called alcoholic, alcohol dependent, alcohol addict, and *al-chuu* (in Japanese). Karoll (2000) indicated that “the terms *alcoholism* and *alcoholic* have stigmatizing effects on women” (p. 339). According to Beck (2008), “[S]ome experts want the DSM-V – the new edition now being compiled – to combine abuse and dependence into a single ‘alcohol-use disorder’ that ranges in severity, taking into account harmful drinking patterns and other symptoms” (p. 2). Although the term, alcohol use disorder, is widely used among social workers and is also commonly written in Japanese literature to refer to problematic drinkers and alcohol dependent persons in general, it is a medical diagnosis. When women do not seek help at medical settings, they will not be given the diagnosis. That is, unless she sees a doctor and is given the diagnosis, she will

not know, or will not consider that she has alcohol use disorder. The term, alcohol use disorder, lacks the broader sense of alcohol use problems. Moreover, it could be considered as a label. For these reasons, I use the term alcohol dependency throughout the thesis, as this term has the broader meaning of not only a medical problem but, also, a bio-psychosocial problem. The term alcohol use disorder will be used only when I quote an author directly.

Like the terms above, various definitions of the problem of alcohol misuse exist (Enomoto, 2000). For instance, The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (hereafter referred to as DSM-IV-TX) sets the criteria for substance dependence (including alcohol dependence) as follows:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by either of the following: (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect; (b) markedly diminished effect with continued use of the same amount of the substance
2. withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances); (b) the same (or

- a closely related substance) is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended
 4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
 5. a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
 6. important social, occupational, or recreational activities are given up or reduced because of substance use
 7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption). (p. 197)

The American Society of Addiction Medicine (ASAM) and the National Council on Alcoholism and Drug Dependence (NCADD) developed a definition of alcoholism. "Alcoholism is a disease characterized by continuous or periodic impairment [of] control over drinking, preoccupation with the drug alcohol, use of

alcohol despite adverse consequences, and distortions in thinking, most notably denial” (O’Brien, Cohen, Evans and Fine, 1990, as cited in Banneman, 1993, p. 9).

According to Higuchi et al. (2007), the Kurihama Alcoholism Screening Test (KAST) is the most commonly used scale in Japan (Kurihama Alcoholism Centre, 2008). KAST was originally made as a self-check (Takada, 1999). KAST has specific questionnaires for men (KAST-M) and women (KAST-F). There are eight questions in KAST-F. The test is scored by giving one point for each *yes* answer. A score of more than three points is considered likely to be alcohol dependency. Other scales used in practice are CAGE (the Cut-down, Annoyed, Guilt, and Eye-opener), DSM, and AUDIT. The AUDIT scale “was translated into Japanese and the validity and reliability of the Japanese version have been evaluated” (Higuchi et al., 2007, p. 1853).

The definition of recovery

It has been a widely accepted idea that a person with alcohol dependency will not be “healed”; yet, she or he will be able to “recover from it” (Matusda & Mizuno, 2000). When an individual becomes alcohol dependent, she or he is not able to gain control over their alcohol intake (The Japanese Mental Health Welfare Research Association, 2007). Acknowledging the problem and maintaining sobriety is a part of the process of recovery.

At the Japan Social Worker Association for Alcohol-related Problems (hereafter referred to as ASW) Conference, held from November 14 to 16, 2008, I asked the question: “What is the definition of recovery?” to four social workers who

have been experts in the field of alcohol dependency for years. Each person had a different view on recovery and the ASW association had no definition of recovery at that point. They argued that establishing the definition as an association can result in limiting its capacity to help clients and that this may impose the risk that a person in need might be excluded from receiving necessary help from a social worker. At the same time, they claimed, the definition did not have to be clearly stated nor was a label needed for who is a person in recovery and who is not. It was noted at the conference that it might be time for the ASW association to have its own definition of recovery from a social work perspective without such labeling. A retired social worker stated that, when one uses the word “recovery” for illnesses like flu and cancer, it means simply recovery from the illness. So she or he can say, “I am recovered” (personal communication, November 15, 2008). Yet, recovery for an alcohol dependent person means not only terminating problematic alcohol use by stopping drinking completely. It also connotes a personal growth throughout a process of recovery. Unlike other illnesses, people in a process of recovery will be alcohol dependent for the rest of their lives due to the widespread and accepted idea that “no recovered alcohol dependent exists” even if they have refrained from drinking for years.

I also reviewed the literature to find a definition of recovery from substance abuse. Adams and Grieder (2005) stated, “Recovery, the term and concept frequently used in the alcohol and drug self-help and treatment fields, does not have any single definition” (p. 17). I found that there are a variety of definitions available. Matsuda

(2000) stated, “The process of recovery means that one makes decisions to stop drinking and then she or he voluntarily expands her or his freedom and opportunities along with mental and physical recovery from what she or he had suffered due to alcohol use” (p. 38). He further stated that true recovery is when one gains back one’s self-respect during the process of recovery in the environment which one chooses not to drink alcohol (Matsuda, 2000). Kearney (1998) wrote that “Descriptions of recovery have included internal reshaping or reclaiming self-concepts and external lifestyle rehabilitation in which social interactions, pastimes, and environmental conditions were altered” (p. 496). Paris and Bradley (2002) stated that “[r]ecovering alcoholics become increasingly able to disengage from alcohol use as a way of avoiding painful realities. They are able to construct a new, sober identity that acknowledges that alcohol has let them lose control of their lives” (p. 649). Adams and Grieder (2005) noted that “[I]t is viewed as a process, a new way to live one’s life beyond mere abstinence from alcohol and/or other drugs. Recovery defines how one lives life today, implying hope, healing, and restoration” (p. 18).

In sum, recovery from alcohol dependence contains not only the absence of drinking alcoholic beverages but also contains the meanings of physical wellbeing, self acceptance, social inclusion, personal growth, gaining back the control necessary to make healthy choices, and having hope. According to Adams and Grieder (2005), “Wellness, resiliency, and rehabilitation are among many other terms often used interchangeably [with recovery]” (p. xxi).

Women's status and roles in Japan

Japan is a patriarchal society. Lebra (1992) stated, "In Japan's political economy, women's minority status is more firmly established than in the post-industrial West" (p. 197). For instance, the ratio of women in parliament in Japan is 11.3 percent, whereas the ratio of women in Canadian parliament is 24.7 percent (Lower House) (Inter-Parliamentary Unions, 2011). Women's wages in Japan were 65.9 percent that of men in 2006 and 66.8 percent in 2007 (Ministry of Health, Labour and Welfare, 2008). Mackie (2003) stated, "In most families, women still carried the major burden of childcare and domestic labour and it would have been fruitless to argue for changes to the sexual division of labour in the home while Japanese men worked the longest hours of any advanced country" (p. 182). For women to achieve equity in Japanese society there are many barriers to overcome.

Hasegawa (2005) wrote about the social conditions for women in Iwate in the Showa era (1926-1988). People in Iwate faced numerous obstacles, one after another, in the early Showa era. There were economic crises in 1930 and 1932, poor harvests in 1931, 1934 and 1935, a tsunami in 1933 and WWII. As an example of the impact of these crises there were 7,298 *Dekasegi* women in a period of three months in 1934 because of poverty. *Dekasegi* is translated as seasonal labour in English and it means when women work outside of their home towns, forcing them to live away from their family members. Some farmers sold their daughters to survive. Others migrated overseas. The employment opportunities for women had expanded gradually since Meiji era (1868-1912); yet, women's wages were 50 to 60 percent that of men.

Despite the increased number of women acquiring higher education, women were discouraged about their opportunities for achieving more education because they had to work to support their families and because it was believed that women did not need education to survive (Mikami, 1990). Marriage was the only option for the majority of women to survive in those days.

Mackie (2003) noted that, despite women receiving the right to vote in 1945, “In postwar Japan, women were positioned as gendered subjects whose ability to engage in public, political behaviours was restricted by legal, institutional and ideological structures” (p. 9). Mikami (1990) collected letters and journals that were written by women in north eastern Iwate from which he later published the periodical, “Working Mothers.” One woman wrote about her life where she has no money left for herself after spending money on her family. Others wrote of their endless work in the fields and at home. When their husbands and sons went to do seasonal labour, *Dekasegi*, during a period of high economic growth after WWII, women remained at home and took on extra responsibilities. When the breadwinners were away from home, these women ran the households by farming, taking care of domestic duties, caring for children, and looking after elderly family members. *Dekasegi* partially supported Japan’s high economic growth as well as supporting the poorer families in Iwate. On the other hand, it resulted in family breakdown, suicides, and divorces in some families (Mikami, 1990). Maruyama (1980), who studied women in farming villages in Japan, described women in those villages as having lower status and farmers’ wives taking more responsibilities and duties compared to wives in urban

areas. The standard of living for those women, particularly in Tohoku district, which includes Iwate prefecture and also Aomori, Akita, Miyagi, Yamagata, and Fukushima, was extremely poor in the early Showa era due to the feudalistic economic system in farming villages.

Kawaguchi and Oosawa (1998) stated that there has been a trend in Japan in which women are expected to play a role beyond their traditional one. In 1986, the *Equal Employment Opportunity Act* became effective (Mackie, 2003). *The Act* "refers specifically to sexual discrimination ...based on a philosophy of 'equality of opportunity' rather than 'equality of result' and is not backed up by affirmative action programs" (p. 184). Since "[T]he housewife's presence at home and care giving are part of a package in the employer's investment in her husband" (Lebra, 1992, p. 201), a considerable proportion of working women engaged in part time positions (Mackie, 2003). Even today, Tama (2001) presumes that most of the unpaid caring work is on women's shoulders in Japanese society. Mackie (2003) further states that "[T]he taxation system and employment practices in the current system make it disadvantageous for married women to engage in full-time employment, thus conditioning their 'choice' to engage in part time work" (p. 9).

A new policy, Basic Laws for Gender-Equal Society, was approved in 1999 and implemented in 2000 (Sugimoto, 2008). This policy aims to reduce inequality between men and women. It includes improving the employment environment, child nurturing support, a new pension distribution system for divorced couples and so on. The policy continues to be amended to meet the needs of societal and economic

changes (especially targeting the falling birthrate, *shoushika*). However, Sugimoto (2008) notes that these policies are re-examined and continue to change in order to meet labour and financial needs rather than aiming to achieve “gender equality”.

Although there are changes in family structures, such as the decline of the traditional family, and increased longevity, the “current Japanese social welfare system is structured based on [the] traditional family type [in] which the family consists of the male breadwinner, housewife and children even after this traditional type of family has been decreasing” (Sugimoto, 2008, p. 15). Today, as stated by Takeda (2008), “Japanese women are being required to make a hasty leap ... to a more self-steering idea of the individual” (p. 196).

Characteristics of women who have a problem with alcohol use

Alcohol dependent women have tended to face more discrimination and stigma compared with their male counterparts (Karoll, 2002; Kimura, 2006; Masui et al., 2006). It is due to a double standard between men and women of drinking alcohol in Japanese culture (Shimizu et al., 2004). Higa (2000) and Shinoda (1997) stated that the increasing risk of alcohol dependency is associated with life stages. Women are more likely to develop alcohol dependency during the following life stages: in adolescence, when their care giving role ceases, and when they reach a stage of building a career to achieve economic independence (“career women”) and/or when they become what might be termed, “kitchen drinkers” or housewives who drink secretly while family members are away during the day, “empty nesters” or women who become free from caring for their children, and elderly women.

Yamakawa's (1989) study, which explored "what life events lead women to drink alcohol," involved 1,650 women in Kusatsu-city, a place that is located in south western Japan. The population of this city is approximately 120,000. According to the study, life events such as entrance into post secondary school, employment, social activities, divorce, re-employment, and marriage promoted alcohol consumption. In marriage, women with husbands who were regular alcohol drinkers were themselves attracted to drinking. On the other hand, life events such as retirement, child birth, and serious illness controlled women's drinking. Due to entrenched stigma, the problem of alcohol use is likely to remain at home because family members are not willing for women to obtain help from the outside world. Indeed the problem of alcohol use is considered an issue of the family as a whole and it is seen as a great shame. Therefore, the woman is likely to be isolated without getting the help she needs beyond her family (Masui et al., 2006). When a husband has an alcohol dependency, his wife is likely to support her husband to stay sober; on the other hand, a husband whose wife has an alcohol dependency is less likely to be her support (Gotoh, 1994; Hashimoto, 2007).

In the study of women who participated in self-help groups, a woman shared her experience of prioritizing her family needs even when she herself needed help (Katamaru & Kageyama, 2008). A national representative sample survey revealed that 5.6 percent of women in the past year and 29.8 percent of women in their life time had been advised by others to either quit drinking alcoholic beverages or to reduce their amount of alcohol intake (Shimizu et al., 2004). These "others" include

1) female friends and acquaintances; 2) colleagues or bosses at work or school officials; and 3) husbands or partners; the percentages are 6.2 percent, 6.0 percent, and 5.6 percent respectively. In the same study, 0.8 percent of the women (seven women) considered seeking help and six of them actually sought help for their problems. In contrast, when a husband has a problem with alcohol use, his partner or wife most often encourages him to seek help. This study shows that outsiders are more concerned about women's drinking problems than are their husbands or partners.

Even after she seeks help from outside the family, she faces further obstacles. I attended *Kita-Tohoku* (North of Tohoku region in Japan) Alcoholic Anonymous meetings on October 25th and 26th in 2008. I had an opportunity to participate in a women's only open meeting. After the meeting, some women expressed that they sometimes felt self-conscious among male participants in AA meetings. They stated that they hesitated to say what they really wanted to share in the meetings because the majority of the participants were male. Indeed, women in AA meetings are a minority and it is uncommon for AA to run a women-only meeting in rural communities. In the case of Iwate, there are no women's only AA meetings. *Danshukai* runs one women's only group in Morioka-city which may not be easily accessible for women who live in other areas of Iwate. As previously mentioned, there are limited social resources available for alcohol dependency in general, let alone female-specialized programs.

Kawaguchi and Oosawa (1984) identify some characteristics of “women alcoholics” (p. 81) through literature reviews. Women are likely to become alcohol dependent over a shorter period of time from consuming smaller amounts of alcohol compared to men (Kawaguchi and Oosawa, 1984). It is known that women have a poor prognosis due to male-centred treatment programs, lack of support from their spouses and family break-up, and the tendency to have mental illness such as emotional disorder, depression, or other substance abuse (Kawaguchi and Oosawa, 1984); yet, Braiker’s study revealed that this is a myth (Forth-Finegan, 1991). Compared with males dependent on alcohol, females dependent on alcohol have the tendency to become alcohol dependent as a result of experiences that cause them psychological stress (Kawaguchi & Oosawa, 1984). These include loss of parents or separation, loss of child(ren), becoming an *empty nester*, miscarriage, and/or gynecological surgery. However, the authors also pointed out that women characteristically connect their problem of alcohol use with these experiences in order to rationalize their problematic drinking behaviours. Because of stigma attached to not only problematic drinking, but also having mental illnesses in general, women often seek support from mental health centres or community health centres rather than going to mental health hospitals or clinics (Kawaguchi and Oosawa, 1984).

Shimizu, Kim, and Hirota (2005) studied the connection between domestic violence and alcohol misuse. When a woman has alcohol-related problems, she is more likely to be a victim of domestic violence (Shimizu, Kim, and Hirota, 2005).

Women who are regular or excessive drinkers are likely to be abuse, to experience control of their social networks, or to experience financial abuse (Shimizu, Kim, and Hirota, 2005). On the other hand, women who are excessive drinkers are also likely to present violent behaviours towards their partners. The authors state that it is impossible to conclude that alcohol-related problems are a cause of domestic violence; yet, the two are in connection with each other. Shimizu (2007) stated that the connection between domestic violence and alcohol-related problems cannot be ignored for prevention of and protection of domestic violence.

Treatment and rehabilitation programs

After WWII, the problem of alcohol use started to be treated in hospitals in Japan. Today the main sites to treat alcohol dependency in Japan are general hospitals that have alcohol treatment units, and private clinics. Gradually, the treatment approach for alcohol dependency has shifted from hospitalization to outpatient programs (Enomoto, 2000). The Kurihama Alcoholism Centre has played a leading role in developing a way of working with patients with alcohol dependency, conducting research in the area, and training and educating practitioners such as doctors, nurses, and social workers (ASW, 2008). In some districts, especially in urban areas, there are specialized treatment facilities and programs available (Enomoto, 2000). Recently there has been a trial to facilitate alcohol day and night care programs, skills training programs (SST) for alcohol dependent people, and group homes. The first SST for alcohol dependents was opened in Tokyo in 1992 (Tokunaga & Yoshioka, 1997). Today medical treatment of alcohol dependence is

characterized by a variety of alternatives (Enomoto, 2000). Furthermore, these places offer support for family members (Kaneku, 2008). Additionally, cognitive behavioral therapy (The Japanese Mental Health Welfare Research Association, 2007) and group therapy (Nagano, as cited in Yoshioka, 1997) is being utilized for alcohol treatment practice. Forth-Finegan (1991) state that family therapy is effective for working with alcohol dependents; however, it is not common in Japan (ASW, 2009).

Even today, there are no resources to support people who suffer alcohol dependence in some communities (ASW, 2008). Particularly in Iwate, a sufficient network has not been built in the community when it comes to supporting these people. A medical social worker indicated in a report (ASW, 2008): “The help exists as a point, not a network” (p. 61). Resources for alcohol use problems are not only limited, but are not connected in Iwate.

Besides treatment programs, there are two major self-help groups; one is Alcoholics Anonymous (AA) and the other is *Danshukai*, which is also known as the Japan Sobriety Association (Higuchi et al., 2007). AA, which is known as a 12 step program, was formed in the USA in 1935 and came to Japan in 1975 (NPO AA General Services, 2007). *Danshukai* was founded in 1953 and “it was greatly influenced by Alcoholics Anonymous” (Ookawara, as cited in Yoshioka, 1997, p. 166). One significant difference is that, while Alcoholics Anonymous members identify themselves by a nickname, *Danshukai* requires a member to reveal her/his identity by name and other personal information. An AA membership survey indicates that the ratio of male and female AA members is 3:1 (NPO AA Japanese

General Services, 2007) in Japan; yet, there is no women's only AA group in Iwate, as mentioned earlier. When I attended Kita-Tohoku AA meetings, there was no female member from Iwate. On the other hand, "a *Danshukai* in Morioka-city, Iwate has 10 regular female members in a women's only group and some in mixed groups" (Mr. Narishima, personal communication, March 6, 2009). Mr. Narishima states that *Danshukai* is family-oriented in that all family members are welcome to attend a meeting. Yet, this approach has a disadvantage because some members who have no family support tend to withdraw from a group due to "jealousy" towards members who have support from their partners. Alcoholics Anonymous, on the other hand, is more individualized and it has a separate group, Al-Anon, for family members. In the case of Iwate, it can be said that *Danshukai* is more accepted for women in Iwate due to the fact that individualism is not characteristic of Japanese society, particularly in a rural community. Although the two self-help groups are run in slightly different ways, the goal of the two self-help groups is the same, abstinence from alcohol. The two distinct self-help groups are playing major roles to support alcohol dependent individuals and their families in Japan. Despite their contributions for helping alcohol dependent women, I wonder how non-AA or *Danshukai* members maintain their sobriety.

It is clear that a majority of alcohol treatment programs in Japan adopt ideas from North American models and approaches such as AA, cognitive behavioural therapy, and motivational interviewing, to name a few. This trend had begun after WWII whereas Japanese psychiatrists were largely influenced by German psychiatry

before the war (Suwaki, 1985). Suwaki (1985) described that “the big tide of American psychiatry washed over Japan, influencing Japanese psychiatrists in various fields such as dynamic psychiatry, psychopharmacology, and the behavioural sciences. These historical trends have inevitably affected alcoholism research and clinics as well” (p. 128).

Suwaki (1985) wrote that *Danshukai*, Cyanamide, and Naikan Therapy (Introspection Therapy) seem to have had great impact in terms of the development of alcoholism treatment in Japan. For instance, “Naikan Therapy is a unique individual psychotherapy derived from a Buddhist training method in Japan and is now administered in several alcoholism treatment hospitals” (p.130). He explains that:

Clients of Naikan Therapy examine closely the relationships with their family members and other important persons one by one and recognize the affectionate bonds of love, which they have heretofore disregarded through the length of their alcoholism. Naikan Therapy effectively strengthens the motivation for abstinence in alcoholics. (p.130)

Social work for alcohol-related problems

The Japan Social Worker Association for Alcohol-related Problems (ASW) was established in 1986 (ASW, 1995). In spite of the achievements that ASW made in micro and mezzo levels of social work practice with alcohol-related problems, less attention has been paid to the macro level of social work, such as prevention through education of the general public (ASW, 2008). Nishikawa (as cited in ASW,

2008) emphasized the significance of advocacy for clients' human rights in social work. In today's practice social workers are not involved in working towards political and societal changes. She suggested that ASW should raise their voice and challenge all levels of government to change policy, regulations, the political economy, and medical system. For instance, ASW could demand removing alcoholic beverage vending machines from public places. She also stated that macro-level social work needs to be done.

Social workers in Japan have also said that there are scarce social resources available for alcohol dependent clients (ASW, 2008). For this reason, social workers in general are heavily reliant on self-help groups, such as AA, as a primary means of help for recovery (Mizusawa, 2007). Sugimoto (2008) pointed out the Japanese social welfare system is deeply rooted in a structurally discriminatory society based on sexism. Therefore, Japanese social work education and practice that applies feminist theory and approaches has been delayed although a substantial proportion of clients and social workers are women. She notes the urgent need for a re-examination of the social welfare system from a feminist perspective.

Study setting: Iwate Prefecture

Iwate prefecture is located in the northeast of the Japanese main island. It is 15,279km² and 60.5 percent of its land is forests (Government of Iwate Prefecture, 2008). Iwate has the second largest land area in the country. The population of Iwate is approximately 1,375,000 in 2008 and the size of its population is ranked 31st out of

47 prefectures. The main industries in Iwate are manufacturing, service industries, farming, forestry, and fishing.

Iwate has been described as the “Tibet of Japan” (Mikami, 1990; Ueda, 2005) because of its mountainous terrain and its location far from the centre of Japan. It also means that Iwate is undeveloped and its standard of living is poor due to low incomes compared to other districts in Japan. Today, it takes only two and a half hours to travel from the centre of Iwate, Morioka city, to the capital city of Tokyo by the bullet train, *Tohoku Shinkansen*. However, many communities in Iwate are still considered remote or rural because of the inadequate transportation system.

Currently, there are no statistics indicating the number of people with alcohol dependency in Iwate. According to one statistic, total consumption of alcoholic beverages in Iwate was 97,025 kl in 2007 (National Tax Agency, 2009). Iwate is ranked 11th out of 47 prefectures for alcohol consumption. It can be said that alcoholic beverages became more accessible due to removing sales restrictions, the widespread use of personal vehicles, and an increase in the number of convenience stores.

CHAPTER 3

METHODOLOGY

Introduction

I have chosen phenomenology as my methodology for this project because it will help me to gain a deeper understanding of participants' experiences of living with alcohol dependency and their recoveries. Baker, Wuest, and Stern (1992) state that the phenomenological researcher understands the deeper meaning of the phenomenon in the context of the whole of human experiences by borrowing from other people's experiences. Creswell (2007) writes, "The phenomenological study focuses not on the life of an individual but rather on a concept or phenomenon, such as how individuals represent their illnesses and this form of study seeks to understand the meaning of experiences of individuals about this phenomenon" (p. 94). From the view of phenomenology, a researcher treats the participants as women who have an experience of living with alcohol dependency, but not focusing on their identity as alcoholics or addicts; furthermore, it is not considered as "a life story of alcoholics" because the word "alcoholic" has a stigmatizing meaning (Karoll, 2002). This approach avoids labelling the women in the research since "[t]he labelling process can have devastating effects, causing severe stress, guilt, fear, anxiety and a host of other emotional social problems" (Heinonen & Spearman, 2001, p. 125). In this way, the researcher focuses on the phenomenon and respects their experience without labelling the participants as alcoholics. Few social work studies in Japan have focused on learning how the women themselves experience the

phenomenon. As Zakrzewski (2004) states, “In phenomenological analysis, methods are non-inferential, there are no hypotheses to be tested, and there are no specific methods or strict analytic requirements” (p. 66).

Max van Manen’s approach is to analyze data by using the selective or highlighting technique (van Manen, 1990) and then to write the sections of findings and discussion by referring to his book *Writing in the Dark* (2002). He states, “... phenomenological inquiry has formative consequences for professional practitioners by increasing their perceptiveness and tactfulness” (2002, p. 8). Practically, I used *phenomenological reduction* as a research method to reveal the essential meaning of the participants’ experiences. Reduction is explained by van Manen as “the technical term ... [t]o come to understanding of the essential structure of something we need to reflect on it by practicing a certain reduction” (p. 185). In this research I utilize the five processes to obtain the existential meanings (Ueda & Yamamoto, 2009). The method is explained in Step 5, analysing data in detail.

Method of Data Collection and Analysis

There were several steps involved in this project. These included (1) selecting a theoretical framework; (2) bracketing; (3) recruiting participants and interviewing; (4) transcribing each interview; (5) analyzing data; and (6) writing the report. These will be detailed.

Step 1: Selecting a Theoretical Framework

The first critical step was to select a philosophical framework (Drisko, 1997). The theoretical perspective guiding this study draws on concepts from feminism and a

person-centred (or consumer-centred) approach. Additionally, the concept of empowerment is central to both a consumer-centred approach and feminist theory. The two theories will be explained.

Feminism. First of all, I reviewed articles written by North American authors to understand what feminist researchers consider as problems in research and practice, and how these problems impact on women's lives. Forth-Finegan (1991) claims the "cultural message has been playing a subtle but powerful role to make women powerless" (p. 18). Male-centred scientific views have resulted from a perpetuated culture of patriarchy and male hierarchy. It is particularly notable in the mental health and the medical field (Forth-Finegan, 1991). Fraser (2004) states that "'ordinary' women ... are liable to be omitted from many research projects" (p.184). From a feminist perspective the available knowledge is based on research that has studied male participants and has been analyzed from male-dominated perspectives. In the women's health movement, it has been pointed out that mainstream medicine has been built on male-centred perspectives (Forth-Finegan, 1991).

Karoll (2002) states, "Key research indicates that there is substantial evidence of the existence of several significant gender-specific differences in relation to alcohol-use disorders and that all social work practitioners need to recognize these differences. The existing barriers to screening, assessment and treatment and the improper diagnosis of women with alcohol-use disorders need to be overcome." (p. 349).

This paper addresses women's experiences of recovery from alcohol dependency in Tohoku region, Japan. In Japan, there are more rehabilitation programs available for men than women in medical facilities (Masui et al., 2006). Is it because there are more men with alcohol dependence problems? Sugimoto (2008) points out that social work research from the view of feminist theory is exceptionally lacking in Japan. As much research has indicated, compared with men, women often have different needs in areas of physical, mental, psychological, and social problems related to alcohol use. So it is not adequate to address only their problems of alcohol use when working with women with alcohol dependence, as "feminist theory stresses the need to identify and 'name' those attitudes, expectations, language, behaviors and social arrangements that have contributed to the oppression and marginalization of people" (Couchonnal, Snodgrass, & Becker, 1998, p. 94).

Indeed, it is hard to imagine that a woman in Japan could speak about her problem with alcohol use in public due to shame, stigma, and her need to protect her family as a mother, wife, or daughter. I grew up in Iwate prefecture and went to study in the central part of Japan, near the capital city of Tokyo. I have experienced the difference of living in two regions and this experience has made me aware that my home town in Iwate has more of a traditional and conservative atmosphere and culture than that of the central region. For this reason, it is not hard to imagine the environment of women with alcohol dependence in Iwate prefecture. What is more, I can imagine how difficult it would be for those women to say out loud, "I am an alcoholic," "I have a problem with alcohol use," or "I want to quit drinking" in that

environment where traditional stereotypes of women like “good wife and wise mother” are maintained. For this reason, I cannot understand women’s experiences fully without approaching the problem from a feminist viewpoint.

Heinonen and Spearman (2001) describe two important concepts in feminist social work. One is empowerment in which women are “able to take control and ownership of their lives” (p. 208). The other is validation described as “a step towards empowerment.” In this process, a woman’s experiences and views are respectfully heard, valued, and listened to. In this study, my aim was to hear women’s experiences and views of alcohol dependency and by doing so I hope that this experience can result in steps towards their empowerment.

Person-Centred Approach. Drake et al. (2001) described that in current practice in the USA, “Accurate information regarding illness, treatment options, effectiveness, and risks is rarely offered; patients are often considered incompetent to make such decisions and subjected to involuntary treatments; and providers operate from an outmoded paternalistic model” (as cited in Adams & Grieder, 2005, p. 6).

Similarly, I found this to be the reality of alcohol dependent women in Japan, as I discovered through conducting my literature review, personal communication with professionals, attendance at conferences and at self-help group meetings. Today, when women in Japan seek support for alcohol dependency, they are likely to have limited choices for treatment and social support. At hospitals, they are told to quit drinking completely (Shirakawa, 2008) and are encouraged to attend a self-help group (Mizusawa, 2007) where they are also told to refrain from alcohol completely.

When they go to such a group, they are often in the minority in the group unless they are fortunate enough to have access to a women's only group in a nearby community.

Sociologist Jean Kirkpatrick argues that AA's 12 step program takes power from women and makes them powerless when they actually need to develop a self identity (White, 2007). When women admit that they have a problem with alcohol use, they are diagnosed with an alcohol use disorder in hospitals and they have to label themselves as "alcoholic" in self-help meetings. Once they start a journey of recovery, they have to be in a process of recovery for the rest of their lives because there is no such thing as a "recovered alcoholic." It is a widely used practice model in Japan. Some less fortunate women are missed in the process of screening and assessment as there are existing barriers for women to be properly screened and assessed (Karoll, 2002). Since a lower priority is given to these women's needs in Japanese society, in medical and mental health care systems or at home, they might struggle with their duties of caring for others and they may not be able to speak about their struggles for the sake of protecting their family.

Heinonen and Spearman (2001) say the consumer-driven approach "starts with the deeply held value, closely related to self-determination by themselves without interference from professional helpers" (p. 217). A "person-centred approach places emphasis and focus on understanding the goals, hopes, wishes and strengths of the individual and family in terms of their own self-defined identity and related cultural concerns" (Adams & Grieder, 2005, p. 72).

In a person-centred treatment plan, one can make her own plan, not necessarily stating her goal for abstinence as a practitioner often expects when “[i]n addictive disorders field, the emphasis has been on personal and peer experience as a primary therapeutic tool and on sobriety as an outcome” (Adams & Grieder, 2005, p. 5). By using this approach, a woman is able to set her own goals and she is the one who takes the initiative for her journey of recovery.

In a person-centred approach a woman has the right to choose what she needs to help herself from alcohol dependency instead of following a practitioner’s expert advice based on knowledge put forth by male-centred perspectives. Indeed, the women are the experts of their lives from the view of a person-centred approach as well as a feminist approach. What is more, a person-centred approach allows me, the researcher, to ask questions of women who have rarely had the opportunity to voice their opinions, especially in a relationship with a “professional.”

Step 2: Bracketing

Bracketing is the other significant step in phenomenology. As noted by Creswell (2007), Moustakas, who is a phenomenologist, admits that bracketing is seldom perfectly achieved. However, Creswell (2007) suggests it can be possible by embracing “this idea when they begin a project by describing their own experiences with the phenomenon and bracketing out their views before proceeding with the experiences of others” (p.60). According to van Manen (1990), bracketing is “the act of suspending one’s various beliefs in the reality of the natural world in order to study the essential structures of the world” (p. 175). He states:

The problem of phenomenological inquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much. Or, more accurately, the problem is that our 'common sense' pre-understandings, predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question. (p.46)

In this research, I bracketed by identifying my social location, the prejudices and the knowledge that I had accumulated while growing up in Japan, as well as during my experience working with clients at social service agencies in Canada.

In this section I provide information about myself. The reason for this is to let readers know how my experiences and values influenced my analysis of the data. I state my experiences as potential biases and prejudgments prior to conducting the interviews. There are three experiences that I thought might affect this research.

1. My personal view of recovery: I have a tendency to view recovery as a goal for people with alcohol dependency due to my working experience with homeless people in Canada.
2. My image of women in Tohoku region, Japan: I believe that woman in Tohoku region, especially in the northern area, are less assertive and, therefore, patient compared with women in Canada and in urban areas in Japan.
3. My understanding of the status of women in Tohoku region: I believe that women in Tohoku region may have more hardships and struggles when they have problems with alcohol use.

Each of the above will be explained in more detail.

My personal view of recovery. My tendency to see that abstinence is equal to recovery is a result of my experience in working with clients with addiction issues in Canada. I became interested in addiction after I started a career as a social worker in 2003. I worked at Main Street Project in Winnipeg, a social services agency that provides a variety of services for people who are homeless and who have addiction issues. There is a detoxification unit where clients who have problems with alcohol and/or drugs stay for ten days to be detoxified and to receive support to be able to go back to their communities. Primarily they rest and eat to gain their physical strength back. Secondly, during a stay in the unit, the client is obligated to participate in self-help group meetings. The detox client attends a self-help group two or three times a day. As a crisis worker at Main Street Project, I talked with each client and provided services such as information on housing, referral to rehabilitation programs, and welfare assistance. Unfortunately, in my four year career at Main Street Project, there were some “regular clients” who repeatedly utilized the program. The number of deaths I encountered was significant.

For this reason, abstinence is the main goal I strived for when working with clients in my practice, because I have learned that survival chances increase as long as these clients stop drinking. Most importantly, sobriety means that they will not die and they might find support to alter their problems. Additionally, I tend to see a person who is in a process of recovery as an achiever. Moreover, I have an image and a hope that a client will “be able to live *happily ever after*” once she quits drinking alcohol.

My image of women in Iwate prefecture, Japan. I was born and raised in Iwate prefecture, Japan. I was educated in Iwate until graduating from high school. Then I moved to a central region of Japan to go to university. At the age of 22, I returned to Iwate for my first employment. From this experience, I prejudged Iwate prefecture as conservative compared with urban areas. I also had a biased image of women in Iwate prefecture that they seem to be more patient and less assertive than women in Canada and urban regions in Japan. In other words, these women hardly voice an opinion in public because it is not expected. When one does not voice her opinion, especially when encountering a problem, incident, or opportunity, she often then has to endure the situation that follows. Additionally, comparing the two countries, I have seen many differences. I especially see the differences in the lives of women in the two countries. In my view, women in Canada have more assertiveness and, therefore, more voice in society compared to their Japanese counterparts.

Growing up, I felt that the role of the wife in a big family, in a rural farming area, seemed to be one of the hardest roles as a woman because she has many duties as wife, mother, and farmer. For example, there is a family custom that all relatives get together for the *Bon Festival* (in honour of departed spirits) in August and in the new year. The place we gather is at a *chonon*'s, which in Japanese means the oldest son in a family. He has special duties and responsibilities in exchange for benefits in the patriarchal system. At this feast, men sit down, talking at the table, while the women cook and prepare meals for all the guests (more than 30 people). Most of the time, the oldest male child *chonon*'s wife takes the initiative to provide meals. It was

an enjoyable event for me as a child, but I thought it must have been tough for my aunt to be the wife of my uncle who is a *chonon*. She has many other daily tasks and responsibilities as a *chonon*'s wife. Furthermore, expectations of the *chonon*'s wife are greater than for her other female counterparts. She has to take the initiative to run the family by supporting her husband. Moreover, due to the Japanese traditional family model, the *chonon* and his wife are expected to take care of extended families financially and emotionally. The paternal side of my family is following this tradition as my father comes from a farmer's family in a rural and small community in Iwate.

My understanding of the status of women in Tohoku region. Women with alcohol dependency in Japan are a minority; women who live or have lived with addiction issues in rural areas are even more of a minority. For this reason, it may be that those women in a rural area may have difficulty in seeking help for their problems. Because I knew through growing up in Iwate prefecture that the communities in Iwate have a tendency to be conservative and gossip is easily spread, I would imagine it would be very difficult for a woman with addiction issues to find support within her own community due to prejudice. This belief has become more firm after I have experienced living in Canada where there are a variety of supports, such as formal resources in the community available for people with addictions.

In summary, I am aware that bracketing my beliefs, values, and prejudices may not have been perfectly achieved (Creswell, 2007). However, I have kept these three

prejudgments in mind and strove to set them aside during the whole process of this study.

Step 3: Recruiting Participants and Interviewing

Criteria for research participant. In phenomenological studies, the number of participants range from one to twenty-five (Creswell, 2007). However, Dukes (1984) suggest that three to ten is appropriate for this approach (as cited in Creswell, 2007). Baker et al. (1992) do not suggest any exact number, but they suggest keeping the sample size small enough to illuminate the richness of individual experiences.

I have defined women's recovery from alcoholism as a process where a woman acknowledges her experience of alcohol dependency and its adverse consequences, and has refrained from drinking alcoholic beverages for at least six months. There is no clear definition of length in recovery in Japan; therefore, I set my own criteria. Recovery means not only completely cutting off drinking alcohol, but is also recovery in bio-psychosocial ways, where a person regains her ability to make healthy choices for her well-being. I also set criteria to be that a participant has support that she can turn to when she experiences some difficulty in her life. No diagnostic materials were used to verify their claims: if the participants self-reported that they had alcohol dependency or experienced having a problem with alcohol use at some point in their lives that brought adverse consequences in any area of their lives, then they were included in the study.

Recruitment process. The Research Ethics Protocol was submitted to The University of Manitoba Research Ethics Board (hereafter referred to as REB) at the Office of

Research Services. Once the research was approved by REB, I began recruiting potential participants by contacting two newspaper companies and self-help groups. I also planned to place an advertisement in a third local newspaper to recruit participants; however, my request to place the ad was not approved. The reason that was given to me was the newspaper had no previous experience of placing such ads. I did not take further action to place an ad. I approached the leaders of two self-help groups in Iwate prefecture to ask their permissions for me to attend self-help group meetings and to recruit possible participants for my study. Eventually six women agreed to be interviewed. Originally, I had intended to interview women with a history of alcohol dependence in Iwate prefecture; however, there were not enough participants. In fact, I wrote in my proposal as follows:

[T]here is a concern about finding enough participants when it comes to a sensitive problem like alcohol dependence. Since the problem is often stigmatized and is viewed as shameful in Japanese society, it may be difficult to find enough participants, perhaps even locating one potential participant. I will expand the targeted area for recruitment if there are not enough participants in Iwate who fit the criteria for this study. In this case, I will include women who live in the north of Tohoku region, which includes the nearby prefectures of Akita and Aomori (See Appendix 1). Iwate is part of Tohoku district, and this grouping is similar to Canadian geographical groupings (e.g., Pacific, Central, Prairie, or Atlantic). Although each prefecture has unique customs and characteristics such as weather, food, and

dialect, to name a few, there are similarities such as history that I mentioned earlier. Moreover, the three prefectures share many similar characteristics, such as population, population density, life expectancy, and annual income which are below the national average. If I interview women who live in other areas than Iwate prefecture, I will change the title of this study and will include information of the prefectures in the literature review.

For this reason, I included Kita-Tohoku area and found one participant in Aomori prefecture. Unfortunately, I was not able to find more participants there. I reported the recruitment situation to my academic advisor and committee members. They discussed this issue and then approved my plan to include women from the rest of the prefectures in Tohoku region, such as Miyagi, Yamagata, and Fukushima.

After my plan was approved, I contacted an AA group member in Iwate. He suggested that I inform group participants of the research opportunity in an annual round-up meeting. I was given an opportunity to speak about the research in front of AA members from all over Japan. After my speech, four women came forward to show their willingness to participate in my study. Three of the four women finally agreed to be interviewed.

Interviewing. Altogether, I interviewed six women who identified themselves as persons with a history of alcohol dependence in Tohoku region. To protect each participant's privacy, the interviews were conducted in a private room, such as a private space at a community centre, a *Karaoke box*, or a participant's home. (The term, *Karaoke box*, is an anglicized Japanese reference to a very tiny room

containing karaoke machines which can be rented on an hourly basis by two or three people who wish to get together in privacy to sing).

There are three types of interviews: structured, semi-structured, and non-structured (Hirayama, Ou, Takeda, Fujii, & Lee, 2007; Takeda, 2004). Data for this study was collected by using non-structured in-depth interviews. However, as a beginner in conducting research, I used a list of probing questions. Participants were allowed to talk as long as they needed and wanted to share their experiences of the phenomenon. All the interviews were tape-recorded with permission and then transcribed. During the interviews all participants were asked the same questions: “Have you had the experience of alcohol use disorder? If so, could you tell me about your experience?”, and “What is *recovery* for you?” Participants were free to talk as long as they liked about each question. The interviews lasted approximately one hour to two hours and ten minutes. A questionnaire guide was used to elicit further information (see Appendix 4.1 and 4.2).

After the interviews, all participants were offered 2,000 yen (equivalent to \$23 Canadian dollars as of June 13, 2009) in appreciation of the time contribution to the study. Creswell (2007) states “giving back to participants for their time and efforts in this project—reciprocity—is important” (p. 44) although their contribution cannot be measured by an amount of money. Two women declined to receive the financial appreciation and I respected their decision.

Ethical Considerations. As mentioned earlier, it is a sensitive issue for women, particularly in rural areas of Japan, to discuss their misuse of alcohol and the

recovery process. As part of the recruitment process, there was an ethical responsibility to take into consideration the significance of women's needs to protect their families and to keep their alcohol problems quiet. I discussed with them any concerns or questions they had in order for them to make a decision for their participation in this study. Also, I adhered to the ethical principles of human subjects' research. The following steps were taken to ensure the ethics of this research and the rights of participants.

Each potential participant was provided with the opportunity to ask questions regarding the research, and was informed that she was free to withdraw at any time. Furthermore, as one author remarked, "The importance of self-reports in data collection was emphasized so that the research participant felt his or her contributions were valued as new knowledge on the topic and as an illumination of meanings inherent in the question" (Moustakas, 1994, p. 110).

The women were given an explanation of the research purpose and process. The researcher informed each participant of the potential risks of participation as well as the benefits. Moreover, I ensured that each participant understood the concept of confidentiality and their rights (Hirayama et al., 2003, p. 46). I also ensured that the participants knew how to make a complaint to the University of Manitoba Research Ethics Board (REB) by providing them with a contact phone number and email address. With the permission of the participants, the interviews were audio-taped and all data was stored in a secure place. The names of participants were disguised and could only be identified by the researcher. The researcher changed all

personal information (names, ages, locations, etc.) and descriptions that could identify participants to others. When I receive my MSW degree, all collected data will be destroyed including a history of contacts with participants stored in my electronic devices. Recorded audio tapes will be deleted. Written data, such as field notes and transcripts, will be shredded. Furthermore, I informed the participants prior to the interviews that I have an obligation to report to authorities any information they provided that contained threats of violence, commitment of crimes, or suspected child abuse.

After all these steps were taken, written informed consent was obtained from the women enrolled in the study. When the participants understood and agreed to participate in the study, an informed consent form was signed by all participants and the forms were collected from them. They all received a copy of their own signed informed consent (Hirayama et al., 2003; Moustakas, 1994.)

Validity and Rigor. I recorded the interview with an audio recorder. The recorded interview was transcribed as accurately as possible. Creswell (2007) states the importance of “using multiple strategies which include confirming or triangulating data from several sources, having our studies reviewed and corrected by the participants and having other researchers review our procedure” (p. 45). I took observational notes right after the interviews, which were used for analysis in order to increase validity. All the interviews and transcriptions were in Japanese, with one transcript, translated into English, provided to my advisor to review. Zakrzewski (2004), citing Giorgi (1970), said that “the validity of a phenomenological study rests

on whether it accurately depicts a first person description of the phenomenon and whether a reader can adopt and agree with the researcher's interpretation" (p. 66). In order to increase the level of rigor, I acknowledged my biases in the report as "bracketing" and presented it for readers so that it offers transparency (Hirayama et al., 2003).

Step 4: Transcribing interviews

All interviews were tape-recorded and transcribed verbatim by the researcher. Fraser (2004) suggests that doing transcription on your own benefits the researcher despite it being a time-consuming effort. The main reason for transcribing your own tape recordings is that the researcher is able to get close to the stories (Fraser, 2004). Therefore, I transcribed all interviews on my own. As mentioned earlier all the interviews and transcriptions were in Japanese, with one transcript, translated into English, provided to my advisor to review. Moreover, transcripts of interviews should "be read to fully understand a sense of the whole" (Baker et al., 1992, p. 1358). I have read the printed transcripts several times to capture the meanings of their experiences.

Step 5: Analyzing data

Data analysis requires several steps such as organizing data, reading through transcripts and notes, coding data, highlighting 'significant statements', sentences, or quotes that provide an understanding of how the participants experienced the phenomenon" (Creswell, 2007, p. 61). It also involves developing themes and drawing relationships between these themes (Creswell, 2007). Furthermore, I use a

five step approach, involving five processes, to obtain the existential meanings of recovery (Ueda & Yamamoto, 2009).

Process 1. This step involves presenting a phenomenon (or text) by writing down exact words spoken by participants.

Process 2. This step involves listing objective facts. The researcher points out participants' facts such as their profile, information about psychosocial factors, and illness and disabilities that participants face. In this process, I used van Manen's selective or highlighting approach using "phrases that stand out" (2002, p. 94) to analyze the data. After selecting the text that is notable, "the researcher" then analyzes the data by reducing the information to significant statements or quotes and combines the statement into themes" (Creswell, p. 60).

Process 3. At this stage, I rewrite pieces of text and merge them into a whole. It is not necessary that it make sense at this point (Ueda & Yamamoto, 2009). In this study, the themes are organized in order to understand the women's experiences; moreover, these themes are considered as objective facts as well. Then the context is rewritten.

Process 4. This is the process of reduction: the existential meanings are obtained from the context in Process 3. In Chapter 4, I present a segment of one participant's interview (process one) and demonstrate the steps that lead to reduction (process four). I then continue using this process with each of the other participants' interviews and then move on to process 5.

Process 5. At this stage, I describe “the existential condition” based on the existential meanings. The study was written up and ended with recommendations for future research. In this research, *Step 6 Writing* is considered as *Process 5*. van Manen (2002) states: “Phenomenology not only finds its starting point in wonder, it must also include wonder. For a phenomenological text to ‘lead’ the way to human understanding it must lead the reader to wonder” (p. 5). Additionally, I used some of the participants’ anecdotes in the writing in order for readers to understand the experiences of these participants.

CHAPTER 4

FINDINGS

Introduction

The purpose of this phenomenological study is to understand the essence of women's experiences of recovery from alcohol dependency. In order to obtain the existential meanings of each participant, the five process approach for reductions, explained in Chapter 3, was used. Once I had acquired the existential meanings, I followed with written hermeneutic phenomenological reflection. Participants in this study have unique backgrounds and experiences. At the same time, they also have similar experiences. To take all the findings into consideration, I rewrote a story of their experiences of recovery from alcohol dependency, focusing on the existential meanings.

In this chapter, profiles of the participants are described first and, following this, I present findings from each participant's interview. This was done by identifying significant statements in the interviews using van Manen's approach (1990) and arranging the formulated meanings into clusters. This resulted in four phases and nine themes. The example of reduction is shown and explained and, finally, I rewrote the participants' lived experiences "in a way of explaining their existential condition vividly for readers to understand and to experience for themselves what these women have gone through in life" (Ueda & Yamamoto, 2009, p. 48)

Results

Profiles of Participants

Six women were interviewed. They are residents in Tohoku region, two from Iwate prefecture, one from Aomori prefecture, one from Miyagi prefecture, and two from Fukushima prefecture. The age of participants ranged from 45 to 62 at the time of the interviews. The average age was 54 years. Two women were members of *Danshukai* and the rest were members of Alcoholics Anonymous. Five of the six women were married (one was a widow) at the time of the interviews. Another was single. Five of the six women lived with their families, and one woman, who was single, lived alone. Two women had experienced divorce.

The women were working in a variety of occupations: medical professional, self-employer, farmer, employee at a social service agency, and health care provider. One woman was employed, but did not mention her occupation. Five women had children. The five women who were married had moved in with their husband's families immediately or later in their marriages. It is a common living arrangement for Japanese families. One woman had experienced living with four generations of family.

Some women stated that they drank beer, whiskey, *nihon-shu* (Japanese rice wine, also known as sake), and/or cooking-wine. One woman stated that she had drunk a combination of these beverages at first. When her drinking became excessive to the point that she became totally preoccupied with alcohol beverages, she changed to drinking only packs of *nihon-shu* because it was convenient to purchase and to easily discard the packaging. The others did not specify what kind of alcoholic

beverages they were drinking. They spoke of drinking *osake*, the term used to describe alcoholic beverages in general.

Themes Identified

Significant statements were identified in the interviews. I organized them into a timeline, dividing it into four phases: (1) the past: living with alcohol; (2) turning point(s); (3) the present: changes in the process; and (4) the future and goals. Themes were found in phases 2, 3, and 4. This was done to learn objective facts of the participants in order to work on phenomenological reductions in Phase 3 and 4 of the five step approach. Each phase will be organized and explained chronologically.

Phase 1 - The past: living with alcohol. At the beginning of each interview, I posed the following question: “Please tell me about your experience of living with alcohol dependency.” The participants began talking about when they started drinking alcoholic beverages and when it had become a problem. They also talked about relationships with their families, their employment, feelings and values, and illness and difficulties they had faced in the past. Some of them provided reasons for their drinking. What follows are their experiences shared in the interviews.

The women stated that they experienced difficulties in completing household duties such as cooking and cleaning. One woman stated, “I could not stand in the kitchen [to prepare meals for the family] without drinking” and “Alcoholic beverages were *chikara-mizu* [energy water] for me.” In employment settings, some women were told that they smelled like alcoholic beverages by employers. One woman stated that she could not write properly because of “shakes.” Some missed work

regularly as their alcohol intake progressed, and eventually they resigned or got fired. All women who were mothers expressed the difficulties of raising and caring for children. For instance, one woman was not able to make lunch for her children. Another woman stated that she was not able to communicate with her son due to his violent behaviours and it resulted in increasing her alcohol intake. Another woman stated that she took money from her child allowance to buy alcoholic beverages. Two women stated they used medication inappropriately by taking alcoholic beverages and sleeping pills simultaneously. Some had experienced physical abuse from their family members. One woman stated:

My husband drinks [alcohol beverages] with supper [but he doesn't want me to drink]. He punched, hit, and kicked me when I was sleeping in our bedroom when I was drunk. He was saying, "I told you to quit drinking!" He punched my face with his fist. Yes, it continued for months and then I was hospitalized once when he kicked my thigh. It got bruised badly, so I was hospitalized. Well, I didn't dare to tell my doctor that it was caused by my drinking; I found another reason to tell the doctor what happened.

All women stated that they were drinking in the morning. Various experiences included: incontinence, passing out outside on a rainy day, drinking cooking wine, drinking on the street to hide from one's family, hiding bottles of whiskey in a futon and/or in a closet, and searching for bottles that the family had hidden in the snow. A few women reported that they had even been secretly drinking alcoholic beverages while they were in hospital for physical or mental health issues due to their alcohol

misuse. A few stated that they lost some memory because they were disorganized due to drunkenness. The majority of them were drinking secretly. One woman stated, “My mother-in-law believes women should not drink alcoholic beverages,” so she could not drink when other family members were around. These women had to drink secretly. For this reason, it took a while for family members to discover that a woman had a drinking problem. It was obvious that all participants made an extreme effort to hide their problem; furthermore, they denied it when their families pointed it out.

One stated:

It happened soon after I finished my maternity leave. I came home after my night shift. I left home on a snowy day, wearing a pair of my husband’s sandals, to buy alcohol beverages in a vending machine in my neighbourhood, and I fell down and broke my arm. There were two kinds of vending machines; one for alcoholic beverages and the other for cans of pop and juice. When my husband and mother in-law asked me, “Where were you going?” I insisted I had gone to buy a can of juice. I needed to drink [alcoholic beverages] after my night shifts at that point.

Phase 2 - Turning points. After I inquired about the times they had been drinking, each was then asked: “What was the turning point for you?” Participants had a complexity of problems, but they did not have information or resources to help them. For instance, two women, who had partners employed in public service, stated that they hesitated to seek help as they were wives of public service employees. Their need was not as much a priority as their family’s need for secrecy about the issue.

One woman who was a medical professional stated: “I asked my family to look for a hospital that is located in other prefectures.” She continued, “I did not want my boss and co-workers at work to know that I have a drinking problem. I even told my family not to use my medical insurance. I said to them, ‘I pay the full amount from my savings’ in order to hide my problem.” It may explain how much stigma is attached to the problem and it resulted in their feelings of shame in living with it. They did not want others to know about their problems with alcohol in order to protect their social status and/or that of their husbands. Their need was not as much a priority as their families’ needs for secrecy about the issue.

In spite of such difficulties, these women also had other turning points prior to the process of recovery. They can be categorized into three areas: thoughts of death, connecting with resources, and being involved in a self-help group.

- *Theme 1: Thoughts of death*

All women in the study stated that they had had a variety of experiences by the time they needed to change their lifestyles. Before reaching a turning point, they were trying to stop drinking on their own. Despite their efforts, they had all failed to maintain abstinence on numerous occasions, and then faced further hardships because of alcohol-related problems. It was evident that they blamed themselves. For instance, some reported their feelings of worthlessness. All participants stated they had thought of death and dying due to their lack of control in their alcohol intake. In fact, a few attempted suicide. Although it was a very difficult time for them, there were also incidents that led to turning points. One woman stated, “I wanted to die,

but I did not want to die like this [with an alcohol problem].” Another woman stated:

I secluded myself in my room and drank a bottle of sake for hours. I was suffering so much [emotionally] and I wanted to die. So I tried to cut my wrist with a pair of scissors, but I couldn’t do it. Then I realized I should go to the hospital.

Despite thoughts and attempts of suicide, they reported that they did not want to die. Thoughts of death and dying seemed like a way to help themselves to get out of the situation they were in because they could not find any other way. This indicated that they were desperate, were in complete isolation, had no one to turn to, and no information on the subject during that time. Therefore, it seemed they reached the point that they thought they could only help themselves by dying. In retrospect, some women thought that ideas of death or attempting suicide were the turning point for their recovery. Eventually, all the women had been taken to hospital by their families.

- *Theme 2: Connecting with resources*

All the women in the study had experienced hospitalization. Prior to hospitalization, two women had attempted suicide. Another woman had told her family about her suicidal ideation. Immediately afterwards, her family had taken her to a psychiatric hospital. The women in this study had been hospitalized a minimum of three and a maximum of ten times. Some of the women had been diagnosed with alcohol use disorder during their first hospitalization; others were not. When diagnosed with alcohol use disorder, they had an opportunity to learn about the

addiction. Some women had been motivated to learn about alcohol dependency by attending programs and reading books. Others recalled feeling that this was helpful and needed. This experience prompted women to start the process of recovery. A woman stated:

My doctor said to me, “It is not your fault.” [Before this experience] I had been thinking that I would never be good enough; I wasn’t able to see a future for myself at that time and didn’t know whether I could go on living. It had seemed that there had been no hope for my future, and I didn’t know what was possible for the immediate future, but I decided to listen to my doctor because of what he said.

Furthermore, some women had met others in the self-help group who had problems with alcohol use and who were in the recovery process. The experience of someone feeling empathy for them helped them to start their own process of recovery. In hospital, five out of the six women had been connected to self-help groups prior to hospital discharge. The reasons for this were: (1) advice from a doctor; (2) information and encouragement from a social worker; and (3) hospital regulation that a patient must be connected to one of the self-help groups. As a result, the women’s hospitalization played a leading role in finding support for them. Another woman stated that she had found an article written about the *Danshukai* in a local newspaper. She had then contacted the main contact person to receive more information about it and later, she attended a group.

The participants expressed that support from significant others such as family

members, doctors, and other professionals had led to turning points as well. When a participant was diagnosed with alcohol addiction, she was told that it was not her fault, that she had a disease (addiction), and that this disease was curable like diabetes. Another woman stated that she was so shocked that she felt she had “become blind” when she was diagnosed with it. According to her, this experience became her turning point. She recalled that she could not connect to a self-help group without the diagnosis. One woman indicated that she had met over forty members when she attended the group in Tokyo. She had been astonished and stated that this might have been one of her turning points. In the self-help groups, women saw members who lived contentedly despite their problems with past addiction problems. Some of them also mentioned that the programs at hospitals, as well as reading material, were helpful to them in learning about alcohol dependency.

- *Theme 3: Being involved in a self-help group*

Women all stated that the self-help groups had been very supportive for their recovery from alcohol dependency. In fact, they continue to participate in their groups. One woman stated:

I wasn't so sure about AA. I had been going to an outpatient program at the hospital for a year, and had met people who were in recovery there. Some of them were also members of self-help groups and others were in a process of recovery on their own. At first, I didn't think that AA meetings worked for me. Yet, I eventually chose AA as my best support of all of my experiences in different programs. As days passed, I really felt that the AA approach worked

well for me, and I benefited from regular attendance and the support of AA members. Today I am certain that I should continue to participate in AA meetings.

It was evident that they had experienced empathy by attending the meetings. Clearly, the groups provided them with a safe place to share their experiences, a sense that they were not alone, and a place to learn by listening to others' experiences. Moreover, companionship in the group was a significant experience for participants. One woman stated, "I thought I might be judged by other women in the group because they were wives of alcohol dependent husbands. They might think, 'Why do you drink? You are a woman,' but they didn't. So I kept going there."

For another woman, it had taken some time for her to draw support from self-help group membership:

I don't remember at all where I lived at that time, how and what made me attempt suicide, or which building I jumped from. I don't remember things that happened when I had lived in [the name of the city]. I was hospitalized for either eating disorder or alcohol addiction. I submitted a request for a temporary leave from the hospital, saying I was going to a self-help group meeting. Well, I am sure about this because I have the piece of paper [to prove it]. In fact, I did not go to a meeting and I jumped off a building instead.

Despite the fact she was not able to benefit from the support groups immediately, this did happen overtime. Furthermore, relapse is expected even though

they are connected to resources and being involved with self-help groups.

In summary, women had not been able to find a healthy and alternative way to cope with their problems on their own. Once their drinking problems were out of control, the alcohol use had become a threat to their lives and they had felt the desperate need to do something. However, there had been no information available to help their recovery at that time, and no person(s) with whom they had felt enough safety to disclose their problems. Thus, the social stigma attached to alcoholism, the threat to one's family's social status, and lack of knowledge about the disease had been strong barriers to recovery which had led some women to consider dying as a way to solve the problem. Then all of the participants had become ill or injured and hospitalized due to their alcohol-related problems. In hospital, some of them had willingly received support, such as education programs and self-help group meetings. The others had found these supports helpful upon their release from the hospital. These turning points played a significant role for the women to begin the recovery process.

Phase 3 - The present: changes that occurred in the process of recovery. After experiencing turning points, the participants altered their feelings, actions, and daily routines in their recovery process. These are categorized into the following six themes:

- *Theme 4: From “naive” to “knowledgeable”*

The women stated that they did not have knowledge of the misuse of alcohol and the consequences of this misuse prior to starting the process of recovery. After

hospitalization, a majority of the women had started learning about alcohol misuse and the consequences to their physical and mental health. They became aware of the importance of having knowledge of addictions, such as the risks and consequences. One woman indicated that when she learned about addictions in the hospital and in the self-help groups, “everything made sense” for her. In the process of recovery, they continued to participate in the self-help groups. They gradually experienced how to deal with their problems as they learned about drinking alcoholic beverages, its misuse, and about themselves. In the self-help group meetings, they shared their stories related to issues around alcohol abuse and listened to others tell their stories. Throughout the sharing process, they had an opportunity to look back at their lives before problems with alcohol misuse arose. One participant said, “I think about what I want to say in the next group a couple of days before the meeting. It leads me to reflect on my past,” and another stated, “If I did not experience this addiction, I probably would have thought that I have experienced all these hardships because of my immaturity.”

A few women spoke about their self-esteem. One woman stated, “My self-esteem was a minus point when I was drinking. It is still pretty low, but now it increases to 1 or 2 out of five.” Another said, “My self-esteem was really low like I wanted to disappear from here. But now I have forgiven myself, and I feel it is okay to be myself. I said to myself, ‘Be yourself, accept who you are.’”

In summing up, these women realized that by thinking it over, re-evaluating themselves and their lives, and gradually accepting themselves throughout the

recovery process, they have transformed themselves from being naive to becoming more knowledgeable, as well as gaining confidence, and having new opportunities and experiences.

- *Theme 5: From “being alone” to “finding companionship and building new and better relationships”*

All six women in the study had been living with problems such as family issues and mental health issues. They indicated that they had had feelings of loneliness, hopelessness, anger, pain, and numbness. Some of them stated that they had felt isolated even though most of them were living with family. Some of them experienced physical, verbal, and emotional abuse by their family members in their childhood and/or adulthood. One woman began her interview by saying:

Well, it might be meaningless to talk about this, but my father, he does not have alcohol dependency, but he is a problematic alcohol drinker; I might say that he is not a problematic drinker—rather he is a problematic individual. He is a very quiet person, but he becomes physically aggressive or becomes verbally abusive towards my [past] mother. It was like his personality changed after drinking alcoholic beverages.

Some were not only victims of abuse but also experienced being abusers. Another woman stated:

I sometimes, but not often, hit my children on the head when I was stressed after drinking. I did this when my children did not act in a way that I wanted. I remember [these incidents] when I have an opportunity to talk about my

past. It remains in my mind as regret but I cannot do anything about it now. I leave it as it is. I remember and regret it. That is all I can do.

Some lost jobs due to their alcohol problems; others had run away from home due to family issues. One woman reported that she had shared daily occurrences comfortably with her husband; yet, she recalled she could not say one sentence to him: “I need your help.” After he found out about her problem with alcohol, he told her he did not know she was drinking although her mother-in-law had noticed her problems of drinking.

Additionally the women had a limited social network before recovery. One woman said, “I used to think I should be dead.” When she connected with the self-help group, she thought, “Well I have a place to go now.” Another woman noted, “My husband would go to work and leave me to deal with our son’s problematic behaviour.” She thought that he avoided the problem at home by working overtime. In the process of her recovery, her husband also supported her recovery by attending a self-help group meeting with her.

In summary, the women were not only isolated from society and community but also from family members, mostly due to their problems of alcohol use. After their turning points, they found a safe place to be, met other people who have the same experiences with addiction, and felt acceptance. Throughout this experience, they started building new relationships with other members of the self-help groups, and rebuilding better relationship with family members.

- *Theme 6: From “not caring” to “caring about well-being”*

At the time of the interviews, one woman was neatly dressed and wearing make-up. However, she had not cared about her appearance while drinking. She stated that she was shocked after her hospitalization when she saw herself in a mirror. “I was *boro-boro* [laughter]”: it means “worn out.” She recalled her nails were peeled, and her hair was messy. Then she stated, “All the women started to pay attention to their appearance and became beautiful after they began their recovery.” One woman stated that she used to cover her face with a mask at work to hide the smell of alcohol. Another shared her experience of struggling with both bulimia nervosa and alcohol misuse. At that time, she was excessively concerned about her weight and her trim figure; yet, she said, “I was not interested in caring for my body and health at all in those days.” After she began a process of recovery, she started caring for herself and wanted to be healthy. One woman asserted, “I pay attention to my body and health because I want to pass on a message to others who are hospitalized due to their addiction.”

In summary, it can be said that the priority in their lives was not their well-being, their appearance or health prior to the recovery process due to their preoccupation with alcoholic beverages. Today, they are more conscious about their health and have gained control back to care for their bodies and minds.

- *Theme 7: From “abandoning responsibility” to “taking responsibility”*

The women said that they changed from abandoning their responsibilities to taking them on. For instance, one woman stated: “I was hardly able to do housework. I did not care about the mess at home. Now I do housework.” Another commented, “I

used to run away from my life, but I am able to deal with these problems now.” One woman confessed, “I was pretty dependent when I was drinking, I always put blame on someone.” In the process of recovery, these women changed from blaming others for their problems to accepting responsibility. It does not mean that they were irresponsible, but they were not able to maintain control due to their alcohol dependency. When a woman could not manage her daily duties, it led her to drink more because of feelings of guilt. After experiencing their turning points, they changed by becoming more responsible and paying attention to their own feelings. They became aware of their feelings by looking back on their pasts, and facing themselves. Their feelings had changed in the process of recovery. One stated, “I am the one who drinks and I am the one who should stop drinking. It is nobody’s fault but mine.” Another said, “I used to feel sorry for myself, so I blamed it on someone else. Now I don’t blame others anymore.” And another reflected, “It is my life so I make decisions on my own.”

Women also experienced changes in their daily routines, behaviours, and beliefs. For example, one commented, “I am able to prepare breakfast and to see my husband off,” and “I used to think I can’t do anything. Now I can do it if I want.” It was felt that these experiences were transformations from being dependent to having autonomy. In other words, they now take the initiative whereas they waited for someone to change their lives prior to recovery. One woman stated, “I know how to deal with a problem.” Another said, “I can face reality now. I do not need to run away from my life anymore.”

- *Theme 8: From “losing control of one’s life” to “finding balance”*

One woman shared an interesting story. Her friend had said to her recently, “You might not be alive today if you had not been drinking at the time.” Alcohol consumption had become problematic after she had a baby: “I gave birth without marriage.” She also shared the difficulties of raising her child alone and, later, returning to the home of her parents, who had been against her decision to have a baby. She recalled, “Well my friend might be right.” She felt it was another way of looking at her life positively. Indeed, some of the participants stated that they had survived hardships in those days because they had been drinking alcoholic beverages. However, they had also lost control of their life because of it. After experiencing the turning points, they had found a way to regain control and to gradually find a way to live and enjoy life. “I think recovery is not about abstinence. Abstinence is just a start of the recovery process.”

A woman shared her experience of a family trip after she started her journey of recovery. She visited a popular sightseeing spot with her family. When she saw limestone caves, she felt, “How deep and beautiful the water is!” She said she was also moved by the beauty of flowers at that time, saying, “I am able to feel now.” She realized that she did not have these feelings for years, including the time she had problems with alcohol. How did other women express the experiences of recovery? One said, “I do not overdo things anymore” and “I feel easiness.” As a result of their recovery, all women interviewed used the word “樂”. It is pronounced *raku*, which means feeling easiness, relief, and joy. It is the opposite of feeling difficulty, hardship,

or pain. Each felt that her life had been changed positively in this process.

Phase 4 - The future and goals.

- *Theme 9: From “dying” to “having a future”*

All the women used the word “death” at some point in the interviews. One of them said, “I used to think, I want to end my life.” They indicated that they had thought of dying and some of them actually attempted suicide. Compared with life before the process of recovery, they now saw their life in a somewhat optimistic way. “I continue to live because it is my recovery.” The same woman who said she wanted to end her life said, “But now I want to live until I die naturally.”

One woman stated that she has been volunteering at the AA office on weekends. However, she has recently felt that she ought to enjoy her life more. She has done a lot of volunteer work for the group and said she needed to find time and space for herself. “I think I deserve to enjoy my life.” When I asked if she has any idea how she will spend her time, she replied, “I want to do baking. Recently I baked for the first time and it was good. So I am thinking about baking a cake for Christmas. I already have a recipe.” In the process, she has moved from internal work to taking action to expand her world by sharing her stories with others and by experiencing new challenges.

How do these women see recovery after they have experienced all of the above? I asked a question, “What is your goal or do you have things you want to do in the future?” There were three kinds of answers. One was to be involved with the self-help group and pass the message to others in need. At the time of the interviews,

a majority of the women were playing a leading role in their own self-help groups by providing sponsorship to other women and carrying this message to patients in hospitals. One stated that she believes in a higher power and wants to live in accordance to the ways of that higher power. My understanding was that she wants to live a faithful and spiritual life. Another said, "I want to see my grandchild grow."

The majority of women reported that they used to think they were worthless. Therefore, some of them indicated that they were not used to living, saying, "I used to think I should be dead." As I wrote in the section on bracketing, I considered the women who are in a process of recovery to be achievers who had overcome struggles. When I discussed recovery in the interviews, I chose words that had positive connotations, such as growth, overcoming, and happiness. One woman emphasized to me that she is still in the process of recovery and it is different from being recovered. Her journey still continues. The process of recovery is not stagnant: it continues to change.

Example of reduction

Process 1. In this first step, exact words of a participant are presented. When I asked one participant the question, "What is recovery for you?" she responded in the following way:

Participant 1: Recovery is when you look at yourself, you build, and you live again in a different way. I lived in a way that was not what I wanted, and then there was a gap between how I lived and what I believed. Then alcoholic beverages were around me, close to me. That is a reason why I became

alcohol dependent. If I could not drink, I could possibly become a *shopaholic* or something. Well, perhaps recovery is, recovery is, it is a time when you think of yourself for your own wellbeing.... I blamed my problem on someone else perhaps. I had blamed someone when I could not act as I wanted and I could not say what I believed. Now it is so good when I am able to say no. I like it. But I could not say that before. I was not able to say, 'This is not supposed to be this way' or 'I do not like this,' but now I am able to say this and it feels good. It is good and it does not give me any stress. [The reason why I could not say no was, that was] pride, pride, this is a way I supposed to be doing, yes, and I had pride. Maybe, well not maybe, it was pride. I wanted people to say, 'You are a great woman,' or 'You are a great wife.' So I put excessive effort on that. Because of that, it is normal for me to do well and I could not say, 'I can't do it.' And I have not changed much since because I am still not good at depending on someone, and I have excessive pride. Well, that is who I am but it is a big difference when you know yourself and when you don't know yourself. Well, this is who I am so that is why I think this way. So I can [now] manage by myself and know what steps I need to take when I face a problem. I'm learning.... In my life, for myself, well, things I am doing now are, the most important thing for me now is to say to myself that this is what I need to do. This is what I can manage. But I used to have too many things to do and I was thinking I have to do them all. I changed my thinking in what I can manage to do. So I feel relieved. I

have learned a way to not have too much stress. That is recovery. Well, it is not recovery. Is it a recovery? Recovery from alcohol dependency, is it a recovery when you think of yourself and you think in retrospect what you have done, is it? [pause] I misunderstood myself. I am who I am but I expected more from myself. So I think getting to know who you are is a part of recovery. Knowing who you are by not becoming a person that is not truly yourself.

Process 2. The first part of Process 2 involves the presentation of objective facts about the participant. Here I identify participants' facts such as their profile, information about psychosocial factors, and illness and disabilities that participants face. In this process, I used van Manen's selective or highlighting approach using "phrases that stand out" (2002, p. 94) to analyze the data. After selecting the text that is notable, I then analyzed the data by reducing the information to significant statements or quotes and combined the statement into themes."

The demographic facts about this woman are as follows:

Fact 1: This is a Japanese woman living in Tohoku region.

Fact 2: She married a *chonon* and integrated into her husband's family.

Fact 3: She was, therefore, expected to adopt his family's traditions and values and, in doing so, she minimized her own needs in order to fulfill all of her roles and responsibilities as dictated by these family traditions.

Fact 4: She had experienced alcohol dependency in a small community, where this is greatly stigmatized.

Fact 5: She is in a process of recovery and is an active member of a self-help group.

I have underlined and italicized phrases that “stand out” in the text under consideration as follows:

Participant 1: Recovery is when you look at yourself, you build, and you live again in a different way. I lived in a way that was not what I wanted, and then there was a gap between how I lived and what I believed. Then alcoholic beverages were around me, close to me. That is a reason why I became alcohol dependent. If I could not drink, I could possibly become a shopaholic or something. Well, perhaps recovery is, recovery is, it is a time when you think of yourself for your own wellbeing.... I blamed my problem on someone else perhaps. I had blamed someone when I could not act as I wanted and I could not say what I believed. Now it is so good when I am able to say no. I like it. But I could not say that before. I was not able to say, ‘This is not supposed to be this way’ or ‘I do not like this,’ but now I am able to say this and it feels good. It is good and it does not give me any stress. [The reason why I could not say no was, that was] pride, pride, this is a way I supposed to be doing, yes, and I had pride. Maybe, well not maybe, it was pride. I wanted people to say, ‘You are a great woman,’ or ‘You are a great wife.’ So I put excessive effort on that. Because of that, it is normal for me to do well and I could not say, ‘I can’t do it.’ And I have not changed much since because I am still not good at depending on someone, and I have excessive pride. Well, that is who I am but it is a big difference when you know yourself and when you

don't know yourself. Well, this is who I am so that is why I think this way. So *I can [now] manage by myself and know what steps I need to take when I face a problem. I'm learning....* In my life, for myself, well, things I am doing now are, *the most important thing for me now is to say to myself that this is what I need to do. This is what I can manage.* But I used to hold on too many things to do and I was thinking I have to do them all. I changed my thinking in what I can manage to do. So I feel relieved. I have learned a way to not have too much stress. That is recovery. Well, it is not recovery. Is it a recovery? Recovery from alcohol dependency, *is it a recovery when you think of yourself and you think in retrospect what you have done,* is it? [pause] I misunderstood myself. *I am who I am but I expected more from myself.* So I think *getting to know who you are is a part of recovery—knowing who you are by not becoming a person that is not truly yourself.*

On the basis of the demographic information and highlighted text in this passage, the following prominent themes are indicated:

- (1) self-reflection;
- (2) finding a way to resolve problems;
- (3) feeling *raku*;
- (4) recognizing own needs;
- (5) recognizing own feelings, actions, and their consequences.

Process 3. As mentioned earlier, it is at this stage that I rewrite pieces of text and merge them into a whole. It is not necessary that “it make sense at this point” (Ueda

& Yamamoto, 2009, p.51). In this study, the themes are organized in order to understand the women's experiences; moreover, these themes are considered as objective facts as well. Then the context is rewritten.

The exact words of the woman's experience were rewritten objectively as follows.

During recovery, it is possible to look back on how you lived your life, feelings that you had, and actions that you took. And then you rebuild your life by accepting yourself and your way of living. It is about changing your way of living. I had not been living in a way that reflected *who I am* because I struggled with pride and the expectations of others. In Japanese, to live as/be myself is *mi no take*, meaning that one knows one's own strengths and limitations. I was controlled by my image of the ideal woman as a good mother and good wife, which was shaped by Japanese cultural images of the ideal women. In order for me to achieve this image, I struggled and depended on drinking alcoholic beverages to fulfill the gap between *who I am* and my image of an ideal woman. I was not able to say the truth, my honest feelings before. It is because I wanted to be accepted by others, by my husband's family. I strove to reach that ideal. However, the more I tried, the more I failed to do so, and the more I was driven to alcohol. What is worse, I blamed my inability to be more assertive, and to be more true to my own self and personal needs, on others. If I could only have done this at that time, I may not have acquired an alcohol dependency. Today I am able to

express my feelings and opinions so I feel easiness and it won't give me any stress. My character has not changed much as compared to the time that I was drinking. I now know who I am and it makes a big difference in my life. There is still an expectation at home that I do everything. In the past, I wanted to be accepted and receive compliments and the gratitude of others for all that I did. However, I was not given such expressions of appreciation; yet, I had not been able to say, 'No,' to my family's expectations. It was taken for granted that these were my roles and duties. Now I know myself and I know what to do when I encounter a problem. I used to think I had to do everything perfectly, but now I prioritize things better and I don't have such a high expectation of myself.

Process 4. This is the process of reduction: the existential meanings are obtained from the context in *Process 3*. The existential meaning of this woman could be rewritten in a following way.

Recovery means reflecting on myself, accepting who I am, applying it to my life and taking actions to alter my life. I used to live for somebody else by trying to meet expectations of others. Yet, in going through the process of reflection and acceptance, I have learned to manage my wellbeing. Now I feel easiness and have confidence to deal with problems I encounter.

The conclusive reduction of the women is: Recovery is to accept who I am.

I followed the same steps to do reductions for the information shared by the

other five participants. The essential meanings that emerged are presented in this section. The conclusive reductions are as follows:

Participant 2:

Recovery means to be able to maintain an ordinary life.

Recovery is to getting used to live daily life.

Participant 3:

Recovery means that I learn common sense and social skills.

Recovery means to be mature and resourceful.

Recovery is to enjoy life.

Participant 4:

Recovery means that I am able to accept the values and beliefs of others.

Recovery is to believe that I am capable of new life challenges.

Participant 5:

Recovery is to live until I die naturally. Recovery is to live my life fully.

Participant 6:

Recovery is not an easy process; it could be another hardship at times.

Further reducing the meanings of all the participants, the meaning of recovery could be expressed as “Recovery is to live, to live fully.”

Process 5 - Phenomenological writing. Taking all the above existential meanings into consideration, I rewrite a “lived experience” story of women with alcohol dependency based on existential meanings of the women in this study. Although each participant attached different meanings to her experience of recovery, it was my

intention to combine all of these existential meanings into one story. Each woman's statements are inlaid into this story. The story I have written is not typical of, and cannot be generalized to, every Japanese woman, but it gives the western reader a taste of how Japanese context can contribute to the lived experience of women with alcohol dependency in a rural area of Japan. The story uses the ordinary language of a rural Japanese woman, as Masako represents any rural Japanese woman who is a member of a self-help group.

A Woman's Story

I am Masako. I am 57 years old, and live in Kitakami-city, Iwate prefecture. I have two children, who are all grown up. I have been going to a self-help group meeting regularly. I work on the family farm and have a part time job.

I was born and raised in the community. My whole life is spent here. I married my husband when I was in my early twenties. It was an arranged marriage. He works for a well known company in the community. He is a *chonon* in his family and owns a rice field, and four generations live in the same household. As you may know, this has historically been a common living arrangement for Japanese families. I was taught from my parents that becoming *yome*, the Japanese word for bride or wife, is not easy: "You will cry for three years and it gets better after five years of your marriage." I strove to be a good wife and wise mother so that I would be accepted in his family. I wanted to integrate well into my husband's family and wanted to be useful. Well, this is the life of a *yome*—what she is supposed to be doing.

I can talk for days about my drinking days. I started drinking heavily in my

mid-thirties. My husband is *chonon*, so we had family gatherings in our home quite often. A family gathering in Japan is similar to a family gathering for holidays in western culture. My mother-in-law believes women should not drink alcohol beverages so I never drank at these gatherings. I was too busy cooking and serving meals for guests, extended family members and neighbours anyway. I could usually sit down and eat only when the gathering was over, all meals had been served, and everyone seemed content with alcoholic beverages and food. On days when the gathering ended very late at night, I cleaned up in the morning. There was often left over sake on the tables so I drank it while cleaning up alone. In retrospect, that was the beginning of my problem with alcoholic beverages.

In those days, I took *osake* in a water bottle with me when I went to work in the rice field. I also drank while doing laundry, sometimes until I passed out. The machine was not automatic in those days, so water would keep running until I awoke. I drank in our bedroom before my husband came home. He found me drunk and I was beaten. Sometimes I woke up in our bedroom holding a bottle of sake. One day I was told at work that I smelled like sake. Soon I got fired because of it, but I was fine with that because that meant I could drink more.

One day I ran away from my family to stay with my friend for a while. My parents-in-law did not say anything, although they knew something was wrong with me. They are really good people. I could have been divorced and sent back home for my alcohol problem, but they didn't do that. It could have been more shameful for me if I had to return home. It is a small community you know.

I was worn out because of my preoccupation with *osake* and tried to cut my wrist with a knife. Of course I couldn't do it. Finally, I went to the mental health hospital outside of the community; the reason behind that is that I didn't want to affect my husband's job. You never know what people will think, say, or do if they find out that he has an alcoholic wife. I sought help for myself by calling a community mental health centre anonymously; I did everything by myself, except asking my husband to drive me because I wasn't able to even stand up. In the hospital, I was the model patient, so I left there after two months. I repeated this routine a few times, staying in the community and going back to hospital. When I went back home, my family thought that I was healed because I had been treated in the hospital. Nobody seemed to understand how hard it is to stay sober. They thought I was back to normal because I wasn't drinking. My effort to refrain from *osake* seemed underestimated. I used to promise my children that I would quit drinking this time. Then I failed. I would sometimes wake up in the morning and decide to drink only one glass of sake for the last time, but it only led to another.

I don't remember this, but I heard it from my son. After another one of my drinking binges, he had found me and called my husband to come home right away. My son told me later, "I was so close to beating you when I saw you passed out on the floor again." My daughter was different from my son. One time I called her from the hospital and she said, "You don't need to say anything, mom" in a comforting manner. If my daughter would have tried to convince me to quit drinking, or been angry or frustrated with me for drinking again, I would have defended myself. She

didn't, so all I could do was cry. My daughter always looked sad. This was my third and last time in hospital.

When I returned home, I just happened to open the newspaper. There was an article about a self-help group in my community. I had heard of the group and remembered I had participated in this group a few times at the hospital. At the time, I didn't remember very much about it because I still really wanted to drink. Anyway, there was a phone number to contact so I called. The contact person wasn't in so I called the next day. I see this incident as a miracle because I do not often read the newspaper and it is unusual for me that I did not give up after the first call.

Then I started going to a meeting. I was lucky because the meeting was held on the weekend. And because my children were all grown up, I had more time to do my own thing. I began to think about what I want to say at upcoming meetings—I think about this for a couple of days.

Here are some things I'd been thinking about when I started going to the meetings. As a new member of my husband's family, it would have been easier for me, if my husband had been more cooperative. But he is *chonon*, and had been treated as special in the family. He does not do anything at home; well, it is my duty as his wife to look after him though.

I also know that there is another way of living life as a woman. If I did not know about this alternative lifestyle, I would probably have had fewer struggles but...

If I were my husband, I would have been seeking help for my wife, called everywhere to find a place to help her.

If I had had the strength to say no, I would not have had to suffer this alcohol dependency.

If my family had acted upon my problem immediately, I may not have suffered this long.

There are many *ifs* I have thought about, but I also realize that what I have been living through was a result of my own choices. I don't blame anyone for this, but I do wish I would have known more about addictions, resources and, most of all, about myself.

I feel *raku* now compared with the days I had been drinking. I asked one woman in the group who had been sober for fifteen years, "What is recovery?" She paused a moment and said, "Recovery means to stay alive. I keep going whether I make a mistake, have a bad day, or whatever. I think that recovery is to live." Another member taught me to live with integrity. A woman needs integrity if she wants to recover.

These stories I had difficulty sharing in the group at the beginning. It has taken me a few years to say what I really want to say and to listen to others in the group meetings. Some of my stories I would not share in the group because I did not feel comfortable enough. After three years of attending the meetings, I was able to think better. I now feel *raku* so I live better. In the meeting, we talk about painful and shameful stories. I shared stories in the groups that I could not tell anyone before. The other group members had gone through similar hardships, so I feel empathy. They share their experiences that I can relate to and I learned to resolve the issues.

In recovery, I still have feeling of pain and sadness, but I have learned to resolve it. Recovery is, as someone in the group said to me, “an ongoing journey.” [end of story]

The phenomenological experience of alcohol dependency has changed the way this woman looks at life, and has altered her life as well. This story reflects the changes women in this study experienced regarding their past, their identity, relationships with others and their environment, and overall perspective of life. They continue to adopt changes into their lives, even after alcohol consumption has stopped. Then would these women never be free from being in recovery even after many years of adopting changes? How can women distinguish between *being in recovery* and *to live* when they are told that there is no *recovered* alcoholic? Where is the statement “There is no such thing of recovered alcoholic” coming from? I wonder if it really comes from the women who have the experience of alcohol dependency when “recovery” might be used interchangeably with “to live” from the perspective of these women?

CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

Introduction

The purpose of this study has been to understand the essential meanings of recovery for women with alcohol dependency so that I, as a social worker, can learn ways to work more effectively with Japanese women in Tohoku region affected by this phenomenon. First of all, I will discuss the findings of my research, as well as implications for social work practice, and potential action plans that can be developed. In conclusion, I will provide a summary of key outcomes of my research, and will present reflections that women who participated in this study would like to share with other women who experience alcohol dependency.

Discussion

My findings regarding women's experiences of alcohol dependency and recovery are similar to what has been expressed in the literature. For instance, it was evident in this study that alcohol dependency adversely impacted not only individuals but also family members (Kaneku, 2008). Alcohol dependency was often linked with low self-esteem (Forth-Finegan, 1991; Kawaguchi & Oosawa, 1984; Kamioka, Ooshima, 2009) and was sometimes related to shame about one's own immoral actions (Akahoshi, 2008). The experiences of alcohol dependency are linked with social isolation (Masui et al., 2006), dependency on men and obedience to fathers and/or husbands (Gotoh, 1994); prioritizing the needs of the family and not attending to one's own needs (Katamaru & Kageyama, 2008); and expectations that

women move beyond the traditional role (Kawaguchi and Oosawa, 1994). Another experience of women with alcohol dependency is that they are often not appropriately referred to services that will meet their needs (Karoll, 2002).

Kawaguchi and Oosawa (1984) state that women have shown some unwillingness to go to mental health hospitals because of the stigma attached to mental illness and alcoholism. On the contrary, the participants in this study utilized mental health hospitals when seeking support either voluntarily or involuntarily. Only one participant stated that she contacted a community mental health centre to retrieve information about finding a mental health hospital. This tendency for women to be hospitalized is perhaps due to the fact that there are few other options in this part of Japan, as compared to geographical areas where other research may have been done.

It was revealed from the data that women in this study were affected by their roles, such as the role of woman, mother, wife, employer/employee, and professional, when seeking help for their problems. The barriers for them to seek help were embarrassment; protecting their families' social status; their own professional status and pride; a lack of knowledge and information regarding alcohol dependency; and also the lack of knowledge as well as the myths about women in society.

Both informal and formal supports are needed for a woman when she attends a self-help group meeting. Support for child care and/or transportation may need to be arranged. One woman asserted that she is able to continue to attend the meetings because her children are grown up and the meeting is held in her neighbourhood.

Another woman, who resides three hours away from where the meeting is usually held, stated that she is able to attend meetings because she has financial support for transportation in that a friend gives her a ride. Indeed these women were quite resourceful since there is limited social support available in rural areas.

Three themes emerged as turning points in the recovery process of women with alcohol dependency. For some participants, coming face-to-face with the thought of death was that turning point. At that time, their own feelings of helplessness put them at risk of entering into a state of hopelessness regarding the possibility of change in their lives. This underlines how critical it is to provide appropriate information and services for individuals and/or family members in a timely and non-judgemental manner.

Two other themes were commonly experienced by all participants in this study—one being hospitalization and the other a connection with self-help networks. All women were hospitalized at some point due to physical and mental needs linked with their alcohol dependency. In hospital, they had received not only medical treatment but also information, education, hospitality, and encouragement that eventually led them to recovery. A few women reported that having a diagnosis of alcohol addiction had altered their lives. A majority of women made contact with a self-help group while in hospital.

Thus, it is critical for a woman to have been diagnosed properly while in hospital. It is also very important that medical professionals be knowledgeable about addictions, so that they can make an accurate diagnosis, as (1) women have difficulty

disclosing this issue and may not provide the information required because of previously mentioned barriers to such disclosure; and (2) a woman's first presentation in the system is often in a hospital setting. It may be helpful to develop questionnaires that capture the problems of alcohol dependency. It is also urgent that social service practitioners such as social workers have knowledge of addictions and available community resources so they can refer a woman to an appropriate service in a manner that she does not feel disrespected. In rural Japanese communities, addictions services are primarily offered within the context of hospitals, clinics, community mental health centres, and self-help networks.

With regard to the effectiveness of resources and supports, participants emphasized the significance of the self-help networks—indicating that either Alcoholic Anonymous or *Danshukai* had played a significant role in their recovery process. Self-help groups seemed to provide most of the conditions necessary to facilitate recovery. These conditions or aspects are: (1) being in a place where she is accepted; (2) experiencing a feeling of empathy; (3) having a feeling of “I am not alone”; and (4) having hope. With time, the women adjusted to life without drinking alcohol and then developed strategies to cope with their problems. It was felt that these women might still be struggling with alcohol dependency today if the self-help group had not been available in their communities. In rural areas it was found to be the only effective social support for these women and they seemed to acquire or develop their own individual and collective resourcefulness as few community resources other were available to them.

Since women were reluctant to disclose their problems in public, a social worker must ensure service will be confidential and that this is clearly pointed out on brochures or posters. Furthermore, and based on the findings, creating linkages between hospitals and self-help groups is necessary to support these women in rural settings, and the development of new resources would be an additional asset.

The women in the study made the following suggestions in terms of resources that would facilitate more effective support:

“I think we need [more] female professionals such as a medical doctor and a counsellor. Moreover, one who listens to what I say...”

“A medical professional needs to be more knowledgeable about addiction and have an awareness of it...”

“Supportive networks in the community are also needed. I know one community where there is an addiction treatment facility for drug dependents and a psychiatric hospital. The two facilities work together to support [clients]. We need more of those.”

One participant shared an interesting incident about a medical service discrepancy and inconsistency between communities. As a medical professional, she strongly asserted that attitudes of each medical professional make a difference in a patient's life. It can mean that some will be saved while others will not be saved, which is equal to death. She believed that a patient needs to receive praise and encouragement when she takes action for recovery, such as going to self-help group meetings. A medical professional may believe it is up to the client to alter her life;

however, it makes a huge difference for her recovery when professionals acknowledge and support her efforts to recover from alcoholism.

There is, indeed, a lack of knowledge, not only amongst medical professionals, but also in the community and society as whole, that can harm women with addictions. This lack of knowledge poses a risk to a woman's recovery and can impede the development of her motivation, courage, and the inner resources that are critical for her recovery process. It is important to dispel the many myths about alcohol dependency, for example, that alcohol dependency is caused by a woman's immorality; that women do not become alcoholics; and that women must be caregivers, but not care receivers.

In fact, I myself had no previous knowledge about alcohol dependency prior to entering into undergraduate social work studies. Also, I had no previous contact with Japanese women who had experienced an addiction. It can be said that someone known to me in the past may have been struggling with an addiction, and that I had been unaware due to my lack of knowledge. I acknowledge that I still hold the values and beliefs regarding what Japanese women are supposed to be. These are images, beliefs, and values that are deeply rooted from having grown up in a small city in Iwate prefecture—traditional Japanese values that my parents and relatives still have a strong attachment to. In such an environment, these women were not able to place their own needs in the centre. As a woman, one's life is easily defined by one's parent(s), husband, child(ren) and, particularly, husband's family; the family she marries into may very much define her identity. These women are caregivers, but

never receivers of care. It is not difficult to imagine their feelings of shame when they feel resentment towards those family members from whom they draw their public identity and whom they are obliged to respect and care for.

The meaning of recovery

The literature explains that recovery from alcohol dependence involves not only the absence of drinking alcoholic beverages but also contains the meanings of physical wellbeing, self-acceptance, social inclusion, personal growth, gaining back the control necessary to make healthy choices, and having hope. All of these elements of recovery were present or emerging in the personal experiences shared by participants in the present study. Interestingly, all the women used the Japanese word *raku* to describe their process of recovery as compared to the days of alcohol dependence. Women had gained greater self-awareness about the conditions that had contributed to their alcohol dependency, and were engaged in making positive changes and choices in their lives. Indeed positive changes are a feature of the process of recovery.

Nonetheless, it should be noted that there appears to be a tendency in the literature to emphasize recovery as positive progress. However, this study finds that the existential meaning of recovery for participants did not always include positivity. The experiences of the women revealed that one might still feel difficulties, pain, anger, sadness, and isolation even after the journey of recovery has begun.

Six significant transitions that can occur during the recovery process were presented in the findings. The themes were as follows:

- (1) from *naive* to *knowledgeable*;
- (2) from *being alone* to *finding companionship and building new and better relationships*;
- (3) from *not caring* to *caring about well-being*;
- (4) from *abandoning responsibility* to *taking responsibility*;
- (5) from *losing control of one's life* to *finding balance*; and
- (6) from *dying* to *having a future*.

These changes or transitions were common in women's experiences. When assessing a client in social work settings, awareness of the above transitional themes can be a useful assessment tool. When supporting a woman in the process of recovery, a social worker may identify these themes in women's lives to acknowledge and support them in accomplishing these transitions. Based on an awareness of these transitions, and the barriers to successfully making these transitions, a social worker can work alongside a woman with an addiction problem and support her in accessing the inner and outer resource to do so—and in developing a care plan. For instance, when a woman has limited knowledge of alcohol dependency and the area of self-care and she wants to gain the knowledge, the social worker provides information or makes a referral to a community nurse in order for her to be *knowledgeable* and *caring about well-being*. Additionally, the social worker may plan to organize a workshop for women. By doing so, a woman has the opportunity to gain knowledge about alcohol dependency and self-care skills; moreover, she may have the opportunity to relate to others—to be *finding*

companionship and building new and better relationships. These opportunities and new learned skills can aid her recovery and may empower her to carry on in her journey. When doing an evaluation with the client, the social worker and client may identify changes that the client has made during their time together and, on that basis, can assess whether the client requires more support or whether that support is no longer necessary and her file can be closed. From my social work experience in Canada and Japan, I have learned that gaining knowledge, experiencing life (whether in positive or negative ways), and expanding one's network adds more tools and strengths into a person's life. Thus, from a social work perspective, these transitional changes can be seen as objective signs of progress in the recovery process. To summarize, the knowledge of common transitions in recovery can be applied to assessment, planning, evaluation, and termination in social work.

While a majority of women had referred to recovery in a positive way, one woman indicated that recovery is far from easy. She stated that she sometimes needs confirmation from her doctor that she is "recovering." She feels relieved when the doctor acknowledges it by saying, "Yes, you are." She also stated that she asks herself, "What is recovery?" It was felt that maintaining abstinence for years doesn't automatically give the women confidence. Another woman said, "It was very hard for a few years. You simply go to the meetings. Then slowly, you are able to listen to others." She recalled that it had taken her three years to listen to other group members' stories.

The following comments also point to recovery as a less than positive

experience:

“I had experienced anger, irritation even after I stopped drinking ...”

“I still feel life is difficult...”

“I am still sad...”

One woman explained that, despite having stopped drinking, she still sometimes thinks of dying, although she was not actively thinking in terms of suicide.

While a majority of participants had expressed appreciation towards family members for their understanding and cooperation throughout the recovery process, one woman shared her complex feelings towards her family: “I stopped drinking because of my family. At the same time, I had become an alcoholic because of my family (pause).” Despite her struggle with resentment, this woman did not want to lay blame on her family for her problems. Not only this woman, but also the other women in this study, still had to strive to overcome all the issues they had prior to their abstinence and recovery process. Overall, when comparing the recovery process with the days of alcohol dependency, the women in this study became *raku*. On the other hand, they were not completely problem-free nor were they living happily ever after, as they had to deal with issues that they had previously avoided.

Indeed it is not hard to imagine their feelings of anger, sadness, and struggle, as the stressors in their living environment often remained the same. From a feminist perspective, a woman is expected to change *her problem* of being a person with alcohol dependency, and to change *her identity* by accepting a label, all the while being expected to retain her responsibility as traditional mother, grandmother, and/or

individual who can be financially efficient, to name a few. Is it all about changing these women so that they can better cope with their problems, feelings, and actions? This suggests that the problem lies primarily within the women, and ignores the responsibility of those in family, social, and community networks, where the stigmas that women face are deeply rooted, thus, limiting the development of more validating social resources for women. I wonder if these women would have gone through the same struggles if they had been able to voice their needs earlier, or they had been living in a community where they were respected and were expected to voice their opinions. Now I question, “Do people want to live in a community or society where their existence and voice is not valued and their needs are less important than others?” In addition to validating and empowering women in their recovery process, a complimentary social work practice approach would be to stimulate changes on a community level through innovative educational approaches, such as information and support services—in order to create a growing space where women can voice their opinions safely and comfortably. Although the use of feminist slogans in Japan would likely be polarizing and ineffective, an appeal to the core need of women to be valued and heard and for a more systemic perspective on issues such as addiction is more likely to carry some weight.

Based on my findings, it seems that there is more to recovering from alcohol dependency than is often expressed by professionals, researchers, and practitioners. Recovery appears to be not only a process but also a particular point in that process. Since the word *process* may also be applied to many aspects and points within the

overall course of recovery, how does one express the whole process in a few words?

In *Sonogo no fujiyuu* [Challenges of life after abstinence] (Kamioka & Ooshima, 2010), Kamioka describes recovery as “an ongoing process with no endpoint” (p. 216). She states that it is not about reaching a fixed point, like reaching a goal or a singular objective. Rather, it is an ongoing process that keeps adapting to life circumstances and helps to maintain stability in one’s ongoing life (Kamioka & Ooshima, 2010). These women regained their feelings in the process of recovery and those feelings were not always positive. However, as one participant indicated, “I used to think a problem was a big wave. Now I feel it is a small wave.” It can be said that they now have a place to go and have resources to deal with their problems, although they still have feelings of anger, irritation, and sadness. Even though they still face problems and feelings of depression, they now have the resources to deal with them. The authors write that it is all right to feel a bit of sadness because even people without the problem of addiction also live with sadness (Kamioka & Ooshima, 2010). This may be what life is like for all of us and feeling sadness may not be a negative thing as long as we experience acceptance from one or more human beings.

For one woman in this study, the essential meaning of recovery is succinctly expressed: “Recovery is to live.” Therefore, supporting women in recovery involves supporting them *to live*. It is important that women *want to live*, and that they recognize the potential *to live fully*. Thus, a social worker must work with women in ways that can empower them to live fully on their own terms.

For some women in this study, living fully meant having an ordinary life,

which included being able to cook meals, have a job, have fun, and/or have good relationships with family and friends. For one woman, it meant staying healthy so that she can live fully and do the things that are important to her in life.

Prior to this study, my focus was to help women stop drinking, and to help them find a healthy way to cope with stress and turmoil due to difficulties they face. Yet I found that it is more effective to support women *to live*, to live an ordinary life on their own terms. In order to do so, women need to be aware of the choices available to them; to be heard; to be accepted and to learn to accept themselves; to embrace the challenge of a new way of life; and to be allowed to make mistakes so that they can gradually learn to find the resources to deal with their problems.

Many researchers (Higa, 2000; Ishiguro, 2006; Kawaguchi & Oosawa, 1984; Masui et al., 2006; Takiguchi, 2007) assert a need for specialized treatment programs for women with alcohol use disorder. However, this need was not directly expressed by the participants of this study. One woman mentioned the need for facilities where people with addiction issues can seek a consultation. Everyone in this study had participated in, and emphasized the value of, self-help groups for women with alcohol dependency, and one reported a need for more female-only self-help groups in rural communities. Although only one woman said this, it may be that there is a need for more treatment and self-help programs catering to the specific needs of women. It was evident that the experiences and needs of women were unique. Therefore, special considerations are required when working with them to support their recovery process.

Implications for social work and my action plan

The incidence of female alcoholism is increasing (Higuchi et al., 2007). It can be easily predicted that alcohol consumption and the problem of alcohol dependency among women will continue to increase if no action is taken. In this section, the implications and recommendations, based on the findings and participants' suggestions, will be presented. Furthermore, I develop my own action plan to implement these recommendations. Participant input is incorporated into the recommendations.

As a result of conducting this study, I have learned what alcohol recovery means to women who are in a recovery process, and my view of the kind of supports women require throughout the recovery process has changed. Most importantly, I strongly believe that the following information: "Recovery from alcohol dependency is possible" and "There are supports available in your community," should become common knowledge in Japanese society. Otherwise women and their families will continue to struggle with these problems alone, thus hiding the problem within the family, which may ultimately lead to the woman's premature death.

Based on the findings, it seems advocacy is the most significant action that social workers need to take when working with women in rural areas. Furthermore, in order for Japanese communities and society at large to learn about alcohol dependency, education is a crucial part, and so, too, is collaboration with other professionals and people who have personally experienced addictions. These two actions will increase awareness of addiction and recovery in general. According to

London (2010), “Advocacy is the act of supporting an idea, need, person, or group” (p. 225). He describes advocacy as “critical for social changes” (London, 2010, p.224) and states that “it occurs within communities to improve quality of life and address social needs” (London, 2010, p. 224). The author further comments that “[e]arly outcomes of an advocacy effort may be to inform, educate, build awareness, change attitudes, elicit verbal expressions of support, or generate other forms of demonstrable commitment” (p.229).

Reaching out to individuals and family members. In the case of women with alcohol dependency in rural areas, special consideration is needed to work with the population and to develop support networks and programs. What was evidenced in this study was that it was hard for these women to seek information and support. Indeed, a majority of women who participated in the study, and their families, initially had limited or no information about alcohol dependency and resources. Therefore, the absence of adequate informational and outreach services will result in many women continuing to struggle with these problems alone. One woman recommended telephone support services, specifically for women with addictions, to ensure anonymity for women who fear inappropriate disclosure. It is important for a social worker to uphold the principle of confidentiality and provide this information to the caller to reassure her that her need for help due to alcohol dependency will not affect her, or her family’s, social status. The telephone numbers or mailing addresses of such services should be easily remembered. Additionally, women might be reluctant to seek help in their own communities due to stigma so it would be helpful

to provide information about resources in other communities.

The issue of alcohol dependency needs to be more visible in our everyday lives such as in the media, posted in the community, and in our daily conversations by talking about facts rather than myths about alcohol dependency. How could we make this happen? Here are three suggestions.

First, because addictions including alcohol dependency are such stigmatized issues, and because more and more people look for information online, information and educational materials related to alcohol dependency can be provided on special websites created to reach out to women in need. Such sites could also identify community resources that support recovery. They may also suggest how a woman can reach out about her addiction problem because she may not know how to talk about her problem to others (Kamioka & Ooshima, 2010).

Second, an information session for family members, for women who are interested in and /or for those who are struggling with alcohol dependency is beneficial. While I was writing this thesis, I found an article in nation-wide newspapers regarding a workshop for women (Sasaki, 2011, October 17, Sankei Newspaper, Increased incidence of female alcohol drinkers, retrieved October 19, 2011, from <http://sankei.jp.msn.com>). In the article, a community health worker, Kimiko Nomura, comments about the growing trend of alcohol consumption by Japanese women. At a seminar presentation she gave in Osaka, she stated that, according to research done by the Ministry of Health and Labour in 2008 regarding young adults aged 20 to 24 years, the number of women consuming alcohol is seven

percent higher than that of their male counterparts. She pointed out that workshops and seminars to learn about alcohol dependency are commonly open to both men and women. Therefore, women may be less comfortable and/or inclined to attend. For this reason, seminars are organized especially for women to gain knowledge without feeling awkwardness. Slowly but surely changes are taking place in some communities in Japan. Previously mentioned, one woman in the study, in fact, connected to self-help networks by reading an article in newspapers. She described this experience as a miracle.

Third, a brochure or leaflet containing facts about alcohol dependency and a message that recovery is possible should be placed in communities such as hospitals, clinics, community health centres, libraries, city or town halls, postsecondary institutions, and places where women are likely to go, such as grocery stores, pharmacies, and even restaurants and bars. Unless the information is visible, women are less likely to have this critical information when they need it. Additionally, the poster would include contact information that is easily remembered. Making this message visible may draw attention not only to the women and families in need but also to those who are not affected by the issue at the present time but may find this information useful in future.

When I came to Winnipeg, Manitoba, I noticed posters of social service agencies on city buses. For example, there are advertisements about community resources such as a telephone line for teens (e.g., “Teen talk”). There were non-judgemental, educational, and health-oriented messages to youth (e.g., “use

condoms”) and about “positive parenting” by the government of Manitoba. Those messages certainly grabbed my attention. So this approach may apply to our community in Japan as well.

Educating individuals, families and professionals. With regard to education, I suggest that workshops be offered to students and future practitioners in post-secondary institutions in collaboration with practicing social workers as well as women who are recovering from alcohol dependency. By attending the workshop, students have an opportunity to meet, listen, and direct questions to the person(s) who have the experience of alcohol dependency and who are in a process of recovery.

Seeing is believing. Providing and organizing such an opportunity for students can make a difference when they encounter a client or patient in their own practices. As one woman stated, information that is received in a timely way, and when it is critically needed, can save lives.

I would like to stress the importance of educating women. A majority of women in this study struggled because they were not able to express what they wanted. These women need to be able to say “No” to things that they are not able to manage, or say “I need” and “I want” by prioritizing their own needs and expressing it when it is necessary. It will be useful for them to understand a reason why they are expected to act, behave, and to live in a certain way as women in our society—a valid reason that supports the greatest good of all members of society, including them. It might be effective to organize a workshop for women to acquire assertiveness.

Most importantly, the general public should be educated to learn about

addiction and mental health because lack of knowledge, misunderstanding, and lack of support perpetuates the issue and the pain. It may be helpful to have a focus group with women, who are in a process of recovery, to make a plan for a campaign to inform and to educate others about alcohol dependency. I once participated in a march, in Tokyo, which was intended to create greater awareness regarding mental health and addiction. It is not merely up to these women to change. Rather, there is also an urgent need to change current systems that perpetuate the social issue of addiction so that women are not facing this challenge alone.

Other recommendations. What was evident in this study was the importance of assessment. Family inclusion to gather information about a client is also significant as denial is often a trait of living with alcohol dependency. Providing information and educating women and their families is another important action to support these women. Inclusion and building good relationships with family members played another important role in the recovery process of women in this study. Family interaction may be needed to help a woman to shift some of the housework to other family members so that she is able to focus on her recovery by attending a self-help meeting. One woman stated that her husband had learned about alcohol dependency as a result of hospital programs for family members. For this reason, she had no problem going to the meetings because her family understood the need for it. The husband of another woman supported his wife by driving her and attending the meetings with her. Her mother-in-law also showed understanding and support by saying, “You do whatever you need [in order to be sober].”

What if a woman has to stop attending a meeting due to a lack of resources? Since women in rural areas have limited resources, social workers should also actively support them in seeking additional ways to get to meetings, and this may involve supporting and empowering them to negotiate transportation strategies with family members and/or other members of the self-help group. Organizing a community network is invaluable in promoting and supporting a woman's recovery.

As stated earlier, networking is a significant action that can make these recommendations happen. One woman stated that, currently, information about Alcoholics Anonymous (AA) groups is transferred to hospital patients primarily through AA volunteers who visit hospitals. As AA volunteers are, themselves, in recovery from a previous addiction, and are often seen as having no credentials, the information they offer does not always carry enough weight with hospital patients who have an alcohol dependency. Thus, this woman would like to see medical and other professional hospital staff increase their awareness of addictions and reinforce the message of AA and/or other self-help groups. She added that it would be more helpful to be able to work with medical professionals, social workers and/or other addictions professionals more collaboratively. This collaborative network would include the women experiencing an alcohol dependency and could also include members of the community at large.

Developing effective and supportive treatment programs or groups for women can enhance the well-being of not only women but also that of their children and other family members. Undermining or neglecting the needs of women comes at a

cost to future generations, since women are often caregivers of children and the elderly in a patriarchal society. Using various community and educational systems to provide education to both men and women about healthy relationships and communication skills—including assertiveness and parenting skills—can be an effective approach to stimulating change and creating communities where women have the potential to live more fully. This would benefit not only women, but all community members, and impact all aspects of life—present and future.

Last of all, one woman indicated that she had hope for another woman even though she had experienced a relapse. Relapses have occurred for a majority of women in this study so it can be seen as part of the recovery process. As mentioned earlier, Kamioka advises practitioners working in the field of addictions to think of recovery as “an ongoing process”—that recovery is not a linear process that takes one to a fixed goal or a singular objective such as abstinence. Rather, the process keeps adapting to life circumstances and helps to maintain stability in one’s ongoing life (Kamioka & Ooshima, 2010, p.216). Kamioka also stated that it is impossible for one social worker or one agency to support the woman during her long journey of recovery. Therefore it is alright to *pass the baton* to others when a woman progresses to another phase of recovery and/or moves in variable directions on the road to recovery.

Merits of the study

This study allowed me to learn about the experiences of women with alcohol use problems by listening to their own voices. Specifically, a phenomenological

study allowed me to hear about women's needs from their own perspectives regarding their experiences and need for recovery. What is more, the results of this study are likely to help service providers to improve their understanding of the experiences and needs of women with alcohol dependency, because currently there is limited knowledge about women's needs and experiences from the viewpoint of their own existential meanings. Therefore, this phenomenological study added richness to our knowledge of the women who have experienced alcohol dependency and recovery. For women who participated in this research, having shared their stories in this way could result in empowering them to further help themselves and others who are currently struggling with alcohol use problems.

This study also aimed to challenge the current situation in Japan. Depending on what women think about the need for support throughout their experiences, I as the researcher and social worker, have the opportunity to advocate for these women by challenging policy makers, local governments and individual service providers in order to create more effective support networks and social resources for women with alcohol dependency in communities in Tohoku region.

Limitations of the study

Alcohol dependency is one of a number of addictions. This study may not be applicable to other types of addictions such as process addictions (e.g., shopping; gambling) and other substance addictions. This study focused only on alcohol dependency. However, there might be a possibility that cross addictions of these women could affect the findings of this study (Forth-Finegan, 1991).

Hirayama et al. (2007) noted that generalizing the findings of qualitative research has limitations. Therefore, the findings in this study may not be generalizable to all women with alcohol dependency. The findings may not be applied to men, women in other regions or in urban centres, and may not be applicable to Japanese immigrant women overseas. Due to the small sample in this study, it will be difficult to capture alcohol dependency experienced by Japanese women in general. In addition, all participants in this study were in middle age, so the findings may not reflect the experiences of younger or older women. Nowadays, it has become common for women to drink alcoholic beverages, both in public and in private. For this reason, women's experiences of alcohol dependency today may be different from addictions issues experienced by women years ago. Despite these limitations, *ideas and concepts* of this qualitative study can be generalized to other regions in Japan.

Another limitation is that the women who participated in this study can be regarded as the *successful* ones, in that they have expanded the capacity for their recoveries regardless of earlier struggles. Women who are in a recovery process but have not reached this level of success may have different experiences than those presented in this study.

Recommendations for future research

There is need for more research related to women experiencing alcohol dependency in Japan. The need for more gender specific treatment is supported by the literature and is also voiced by the women in this study. More research based on

evidenced based practice (EBP) is necessary to access funding and to verify the effect of existing programs in order to develop, to improve and/or sustain programs for women. It may be beneficial to study help-seeking behaviours of women in rural areas when they and their families have a stigmatized problem such as mental health issues, criminal activities, and/or child maltreatment. I am also interested in seeing how women in rural areas perceive the issue of addiction. Furthermore, how would their views and beliefs change after learning about alcohol and alcohol dependency? Both qualitative and quantitative research is necessary to capture the realities of women in rural areas, their needs, and the effective support necessary to improve women's lives in general. The experiences of women who do not utilize self-help networks could also help social workers to understand alternative ways of recovery and would expand our knowledge of recovery from alcohol dependency.

Conclusion

It still seems like a distant reality for women in rural Japan to raise their voices. However, the women in this study were once silent and they now do have a voice. When asked, all women had a message and/or advice to other women who are struggling with addiction. The following are some messages and words of encouragement they offered:

“You have to look for the answer for yourself. Please come to *Danshukai* and use the information that is available.”

“Everyone will recover if you are determined. If you try seriously, you will be raku. I really believe this because I have experienced it.”

“Join with a self-help group. It is a priority (for your recovery). And meet with others going through similar issues.”

I observed a number of strengths in participants. The following statement summarizes one woman’s experience very well:

My turning point [in my life] is having this disease [alcohol addiction]. Before having my addiction, I followed what my father or husband thought was right. I was obedient and depended on a man such as my father or my husband. Then after having experienced the disease, I learned that this is my life and I started making decisions on my own.

Women in this study had unique experiences with regard to having lived with alcohol dependency and recovery. Although there were barriers such as stigma, shame, and lack of social resources in communities when seeking and receiving support, they eventually began their process of recovery. It appears that these women have a capacity to change and to adopt new changes despite the difficulties in their lives.

It would seem that, if the women in this study were able to develop the strength, courage, and resources to change their lives despite the life challenges they have experienced, meaningful community change on a larger scale is possible as well. It is hoped that professionals who have had the privilege of witnessing their recovery process will be encouraged and inspired to listen to women’s voices and advocate for community awareness and professional supports that will truly respond to the needs of women with alcohol dependency.

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Appendix 1

Map of Tohoku region

Source from 帝国書院 © Discovering JAPAN A New Regional Geography (2011). p120.

Used with permission by *Teikoku-shoin*, December 19, 2011.



► ④ Temperature and precipitation of select cities <Chronological Scientific Table, 2007>

Appendix 2.1

To women who have experienced wanting to stop drinking alcoholic beverages

Call for Participants Flyer

I am looking for women who live in Iwate, and who have experienced alcohol-related problems, alcohol use disorder, or alcohol addiction and who have an experience of recovery from alcohol-related problems for a period of six months or longer. Would you like to share your experience in an interview with me?

As part of my studies for a Master's degree in Social Work, I am conducting research to learn: what it is like to experience alcohol use problems and recovery from it as a woman. Furthermore, I intend to explore the needs of these women in Iwate prefecture to learn what social resources are needed and what effective supports are when a woman is in a process of recovery.

I would like to hear from women, who meet the following criteria:

- Adult women aged 20 or more, who live in Iwate prefecture.
- Women who speak Japanese or/and English.
- Women who have experienced alcohol-related problems, alcohol use disorder, or alcohol dependence.

- Women who consider themselves in a process of recovery for a period of six months or longer and who have support for recovery (AA, *Danshukai*, counseling services, and/or others)
- Women who are willing to share their experiences

The length of the interview will be approximately two hours, but it could take longer than two hours. The interview will be done in person at a time and place convenient to you. Upon the completion of interview, you will receive 2000-yen as an honorarium.

If you are willing to participate in this research project, please phone me at your earliest convenience at XXX or email me at XXX. I will give you more information and answer any questions you may have. Information received from you will remain confidential. I appreciate your cooperation in this study.

Graduate social work student Junko Kameta

Appendix 2.2(Call for Participants Flyer in Japanese)

「お酒をやめたい」と思った経験のある女性のみなさんへ

調査参加のお願い

飲酒関連問題（アルコール依存、アルコール依存症）を経験し、さらにその問題からの回復の経験をお持ちの方で、この調査に参加して下さる成人女性を探しています。個人インタビューを通してあなたの経験を私に聞かせてくださいませんか。

カナダ国マニトバ大学の大学院ソーシャルワーク (www.umanitoba.ca) 修士課程のカリキュラムの一部として、岩手県の成人女性の飲酒に関する問題や、アルコール依存の経験、その回復過程における経験をお聞きし、女性としてアルコール依存の経験をするということはどういうことか、回復のためにどんなサポートが役立つのか、今後どんな社会資源が必要または有効かを知るための調査を行います。

以下のすべてに当てはまる方にお話を伺いたいと思っています。

- 岩手県にお住まいの20歳以上の成人女性
- 日本語、または英語で会話できるかた
- 飲酒に関連する問題、アルコール依存、アルコール依存症の経験をお持ちのかた
- ご自身で「回復に向かっている」「回復の過程にいる」と判断されるかたで、六か月以上断酒されている方、回復の助けとなる何らかのサポートを受けている方（AA、断酒会、カウンセリング等、しかしそれに限らず）
- その経験を調査者にお話して下さるかた

インタビューは一回のみ、長さはおおよそ二時間ほどを予定していますが、それ以上かかる場合もあります。場所、時間などはできる限りあなたのご都合にあわせています。インタビュー終了後、謝礼として2000円をお渡しいたします。この調査にご協力いただく意思がある方、または質問などある方はどうぞ遠慮なくご連絡ください。匿名でも結構です。連絡先は電話 XXXXXXXXXX（携帯電話）、メールアドレス XXXXXXXX です。詳しい内容をお話させていただきます。ご質問があればできる限りお答えいたします。秘密は厳守いたします。ご協力のほどよろしく申し上げます。

マニトバ大学大学院生

亀田順子

Appendix 3.1

Informed consent to a participant in the study of women who have experienced alcohol use problems, alcohol use disorder, or alcohol addiction, and who have an experience of recovery.

My name is Junko Kameta. As part of my studies for a Master's in Social Work degree, I am conducting research to examine the experiences of alcohol use disorder, recovery and the needs among adult women in Iwate prefecture. I would like to explore what it is like to have alcohol-related problems as a woman. Also, one of purposes for conducting this research is to learn from you about what would be needed to help women's recovery from alcohol-related problems.

Your Commitment

An in person interview with the researcher will last 2 hours or longer and will be done in person at a time and place convenient to you. The researcher will audiotape the interviews to improve accuracy.

Privacy/Anonymity and Confidentiality

Participation in this study is fully voluntary. You have a right to withdraw or refuse to answer questions at anytime without any penalty. In order to ensure your privacy, a number of steps will be taken. Interviewed tapes will

be stored in a locked secure box and will be only accessed by the researcher. I will use a computer memory device to store all transcribed data and these will be locked in the box. No one except the researcher will have access to interview data. The names of participants will be disguised and will be only identified by the researcher. I will change all personal information (names, ages, names of place etc) and descriptions that may identify you to others unless you are willing to identify yourself. The data will be shredded and destroyed safely upon the acceptance of my MSW.

You will receive 2,000 Japanese yen (approximately equivalent to 23 Canadian dollars as of June 13, 2009) when the interview is completed.

Your contribution to this research will add to knowledge about women who experience alcohol dependence. At the end, the final thesis will be provided to the University of Manitoba library.

Potential Risks

There is no known risk to you in participating in this study. However, you may experience some distressing emotions during or after interviews. You have the right to withdraw or refuse to answer questions at anytime without facing any consequences. The researcher will provide some resources such as information about self-help groups and counseling services in the event you need support. The researcher will ensure your right to discontinue and will encourage you to let the researcher know if this becomes necessary.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject.

In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities.

You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should free to ask for clarification or new information throughout your participation.

A copy of this consent form has been given to you to keep for your records and reference.

University of Manitoba

Junko Kameta, BA, BSW

Telephone/Fax XXX, Mobile phone XXX

E-mail: XXX

Supervisor: Dr. Tuula Heinonen

E-mail: heinonn@cc.umanitoba.ca

I have read this form, have had the opportunity to ask the researcher any questions I have about the research, understand what my participation in the study entails, and am willing to participate. My signature indicates my agreement and consent to be involved in this study.

This research has been approved by Research Ethics Board from the Office of Research Services. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Secretariat at 1 (204)474-7122, email margaret_bowman@umanitoba.ca. The University of Manitoba is located in Canada. The official languages are English and French. In order to ensure your rights and respect your opinions, you can locate a person who can translate your concerns and/or opinions from Japanese to English.

Participant's

Signature

Date

Researcher and/or Delegate's

Signature

Date

Appendix 3.2

インフォームド コンセント フォーム (Informed consent form in Japanese)

飲酒の問題, アルコール依存, アルコール依存症を抱えた経験があり、その問題から回復を 経験している成人女性に関する調査

私は亀田順子と申します。大学院修士課程のカリキュラムの一部として、岩手県の成人女性の飲酒の問題、アルコール依存の体験、依存からの回復体験の調査を行うことを計画しています。

この調査の目的は岩手県において飲酒の問題を抱えた経験のある成人女性の依存体験、そしてその回復体験を調査し、どのような社会支援が求められているかを調べることです。この調査結果は女性のアルコール依存に対する支援において、より効果的にサポートを提供するために役立てたいと考えています。

調査の主旨をご理解いただき、ご協力いただきますようお願い申し上げます。

参加者にやっていただくこと

インタビューに要する時間は2時間か場合によってはそれ以上の予定です。調査者は正確にインタビューを理解するためにテープに録音します。

プライバシーの保護について

この調査への参加はあくまで任意です。調査の質問の途中で参加を辞退したり、答えたくない質問に対して回答を拒否していただいても結構です。参加辞退、質問拒否によって何らかの支障が起こることはまったくありません。

個人的な情報の保護には、以下に示したように細心の注意を払います。

調査者以外がインタビュー内容を閲覧することはありません。インタビューのテープ、逐語録は、鍵のかかるキャビネットに厳重に保管し、調査者以外が閲覧することはありません。結果の公表に関しても、名前や個人を特定ができないように仮名を使用するなどの、細心の注意を払います。インタビューそのものの公表はしませんが、分析の結果を総合してカナダ国マニトバ大学ソーシャル学部で発表します。調査者は結果の分析が終了し大学院の卒業が確定次第、インタビューを記録したテープ、その他の関連資料は全て破棄いたします。

この調査に参加してくださった方へはインタビュー終了後、2,000円のお礼をお渡しいたします。そのほかにも、あなたの調査への参加は依存症の経験という既存の知識に新たな一ページを加えられることとなります。分析の結果の要約は各参加者にお知らせする予定です。他のアルコール依存を抱える女性にも要望があれば分析結果資料を提供する予定です。最終的には論文としてマニトバ大学の図書館に保管されます。

危害と利益について

この調査においてあなたが受ける危害はないと考えられます。しかしインタビューの途中、または終了後に様々な感情の起伏、問題が起こることも考慮されます。その際には調査者が近隣のカウンセリングサービスなどの情報も必要であれば提供いたします。

この研究に関する質問やご意見、苦情は以下までご連絡ください。

大学名： マニトバ大学（カナダ）University of Manitoba

氏名： 亀田 順子 BSW

携帯電話： XXX

電話・ファックス： XXX

イーメール：jkameta@hotmail.com

スーパーバイザー：ドクター ティユーラ ヘイノネン (Dr. Tuula Heinonen)

イーメール：heinonn@cc.umanitoba.ca

あなたがこの用紙にサインすることによって、この調査に参加する上での情報、注意事項を理解し、参加に同意したことになります。この用紙にサインすることによってあなたの法的な権利が奪われたり、調査者、関係者、関係機関の法的、専門職の責任が放棄されるというものではありません。あなたは調査のどの時点でも、調査への参加を辞退することができ、答えたくない質問にたいしては回避することができます。その際に不利益や損害を被ることはありません。調査参加に関しては、インフォームド コンセントに記されたことに基づいており、不明な点などはいつでも質問してください。インフォームド コンセント のコピーはあなた自身の記録、参考として保管していただくためお渡ししました。

上記の説明を読み、調査者にこの調査に関する質問をする機会がもうけられ、私が参加することによって起こりうることを理解した上で、この調査に参加することに同意します。

この調査はマニトバ大学のリサーチ倫理委員会(REB)によって承認されました。万が一、この調査に関して苦情がある場合、上記のいずれかの番号、またはリサーチ倫理委員会事務局 1 (204) 474-7122、またはイーメール margaret_bowman@umanitoba.ca まで連絡してください。マニトバ大学はカナダ国にありますので、公用語は英語とフランス語です。

しかしあなたの貴重な意見を尊重し、権利を守るため、日本語を英訳するための要請をしています。

参加者氏名

日付

調査者氏名

日付

Appendix 4.1

Interview guide:

Information about the interview (described to participate) will address;

- the purpose of this research and how it will be carried out
- meaning of consent forms and signing of the forms upon participant's agreement
- how the interview will proceed
- questions and/or concerns

Main questions

- **Have you had the experience of alcohol dependence?**
- **Please tell me about your experience of living with alcohol dependence.**

Example of probing questions (in bold letters) and other questions I may ask to clarify:

- **What is recovery in your view?**
- **Tell me your opinions about policies that could be altered to prevent, protect and help women from alcohol dependence.**
- **What are your personal goals?**
- **Is there anything you would like to add?**

- What was the turning point in your life from alcohol dependence to a process of recovery?
- Who or what is (was) helpful or important to you throughout the experience of recovery?
- Have you attended any treatment programs, or self-help groups? How did you experience it? If not, have you sought any support or help for your recovery?
- What do you think is (was) lacking in your environment in order to help you recover from alcohol dependence?
- Do you have any particular recommendations about policies in your community and Iwate?
- In retrospect, were the services or support helpful for you? (if applicable)
- What would your advice to other women be about what they will need to recover from alcohol dependence?
- What do you think would be helpful resources or supports for a woman in your community or Iwate who is currently struggling with alcohol-related problems?

Appendix 4.2

Interview guide in Japanese: Main questions

- あなたはアルコール依存の経験がありますか
- あなたのアルコール依存経験についてお話してください
- あなたにとって回復とはなんですか。
- 女性アルコール依存を予防し、アルコール依存から女性を守り、支援するために変えるべき政策についてあなたの意見を聞かせてください。
- あなたのゴール、目標はなんですか。
- なにか付け加えたいことはありますか。
- なにがアルコール依存から回復過程へのターニングポイントでしたか。
- 回復の経験を通して、誰がまたは何が重要でしたか。
- 治療プログラムやセルフヘルプグループ（自助グループ）に参加したことはありますか。その経験はどうでしたか。もし参加した経験がない場合は回復のためのサポートや助けを求めましたか。
- アルコール依存からの回復を手助けするためにあなたの環境の中で足りないものはなんですか？
- あなたはあなたの地元（岩手や東北地域）のアルコール依存の政策について意見や要望はありますか。
- 振り返ってみて、サービスやサポートはあなたにとって助けになりましたか。
- 他のアルコール依存をもつ女性にたいしてアドバイスするなら、アルコール依存からの回復に必要なものはなんですか。
- あなたの地元や岩手県において現在アルコール関連の問題で困っている女性にとって役にたつこと（もの）やサポートとはなんだと思いますか。

Appendix 5.1

Counseling Services in Iwate prefecture

Iwate Prefecture University (Social Services Centre).....019-606-1772

Iwate Prefecture University (Psychological Counseling Centre)....019-606-1772

Home page: <http://www.iwate-pu.ac.jp>

Women's Counseling Services (Morioka Women's Centre).....019-604-3303

From 9am to 9:30pm (Mon-Fri), 9am to 5pm (Sat- Sun and holidays)

Home page: <http://mjc.sankaku-npo.jp>

Iwate Prefecture Counseling Line.....019-622-6955

From 9am to 4:30pm (Mon-Fri)

Inochi no Denwa (Suicide Prevention Line)...019-654-7575

From Noon to 9pm (Mon-Sat), Noon to 6pm (Sun)

Home page: <http://www.iwate21.net/mit/menu02.html>

Alcohol Anonymous General Office.....03-3590-5377

Home page: <http://www.aajapan.org>

Danshukai in Iwate...0198-22-5730 (Hanamaki-city, Mr. Narishima)

...019-662-2204 (Morioka-city, Women's group)

Appendix 5.2

Counseling Services in Iwate prefecture (In Japanese) 岩手県内にあるカウンセリングサービス

岩手県立大学（ソーシャルサービスセンター）… 019-606-1772

岩手県立大学（心理カウンセリングセンター）… 019-606-1772

ホームページ: <http://www.iwate-pu.ac.jp>

もりおか女性センター … 019-604-3303

午前9時から夜9時半まで（月曜日から金曜日）

午前9時から午後5時まで（土、日、祝日）

ホームページ: <http://mjc.sankaku-npo.jp>

岩手県カウンセリングサービス … 019-622-6955

午前9時から午後4時半まで（月曜日から金曜日）

いのちの電話 … 019-654-7575

正午から午後9時まで（月曜日から土曜日）、

正午から午後6時まで（日曜日）

ホームページ: <http://www.iwate21.net/mit/menu02.html>

アルコールアノニマス ジェネラルオフィス（AA）… 03-3590-5377

ホームページ: <http://www.aa-japan.org>

断酒会 … 0198-22-5730（花巻市，成島氏）

019-662-2204（盛岡女性グループ）

Appendix 6: The letter of copyright permission

版 権 使 用 許 諾 書

平成23年12月19日

亀田順子 様

〒101-0051 東京都千代田区神田神保町3-29

株式会社帝国書院 開発部

部長 佐藤 清

平成23年12月13日付けで申請された、大学院修士論文「Women's Experiences of Alcohol dependency in Tohoku Region, Japan」への資料使用について下記の条件にて許可いたします。

記

転載元	帝国書院 「Discovering JAPAN A New Regional Geography」	
資料名	P.6①Location of Japan P.36,37 P.120	
掲 載 条 件	版權の表示	帝国書院
	出典の表示	帝国書院「Discovering JAPAN A New Regional Geography」
	版權使用料	なし
	完本見本の献本	不要
	その他	<ul style="list-style-type: none"> ◆刷り色2c ◆A4、約150頁 ◆発行部数 : 2部と電子書籍 ※平成24年発行