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Úloha vzdelávania žien s nadmernou konzumáciou alkoholu a ich skutočný ozdravný proces v kontexte rozvoja ich sociálneho kapitálu

The Role of Education of Women with Excessive Alcohol Consumption and their Genuine Recovery Process in the Context of Developing their Social Capital

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Abstract

Huge numbers of women who are struggling with the excessive alcohol consumption have never looked for the professional help. The part of these women go through the natural process of recovery and they are able to abstain even without the professional help. One of the greatest challenges facing people in recovery from substance addiction is making and sustaining new friendships that are outside of the supportive recovery networks. Engaging with adult education can create opportunities to meet new people and establish new friendships. According to the authors, these personal attributes i.e. good education, sustained employment, and membership in a professional society along with the environmental and contextual conditions i.e. fear of disclosure and the capacity to build renewed structure in their lives, draw on non-using supportive networks and draw space between themselves and the 'drug world' constituted a set of formidable resources. According to Cloud and Granfield 'such attributes and conditions can be seen as resources, or forms of capital, that increase an individual's capacity to recover. We refer to the aggregate of such capital as ''recovery capital''. The aim of this research is to find out the important fields that are significant for the recovery process of the women overusing alcohol. The research has been realized in qualitative design. The case study has been chosen as a research strategy. To collect data, the method of semi-structured interview has been used and we initiated the interviews using the life curve technique. To compare the study sample, the measure of addiciton of individual participants has been detected retrospectively via the AUDIT testing. The narrative analysis has been used in the phase of data processing and assessment. There have been identified 5 thematic areas through the interview analysis that are related to the recovery process: support of the social environment, personal participaton in the recovery, the change of the state of health, professional treatment and the activity. Each thematic area contains another subthemes. The aim of the research has been fulfilled.

Keywords: Recovery process. Alcohol. Alcohol addiction. Social support. Self-management.

1 Introduction

According to Heller and Pecinovská (1996), the decisive factors in the dynamics of addiction development are two mechanisms that are changing typically in particular stage of development. There are an increasing tolerance to alcohol and the loss of control to assess the situations realistically from the point of view of the personal and social needs and obligations. The authors also state that the recovery alone is possible without elimination the basic disorder. The term alcoholism could be understood also as a socio-pathological phenomenon, socially undesirable habit of excessive alcohol consumption.

Topical terminology distinguishes the practice of psychoactive matter (one-shot matter, or also recurring use, which does not result to any significant damage of the user), then harmful using (the synonyms are abuse, dysfunctional use, risky, problem drinking, which results in physical, psychical, or interpersonal demage of the individual) and the dependence syndrome (Ježábek, 2015). Alcohol use according to the gravity of the risks:

- Low-risk alcohol use, moderate drinking, sensible consumption („low-risk drinking, moderate drinking“) – Determination of the measure at low-risk drinking is not unified. According to the Dietary Guidelines for Americans for the years 2015 – 2020, the sensible drinking is defined as one beverage on a daily basis for women and two drinks maximum in a day for men (of legal drinking age). In the USA one alcoholic drink equivalent is defined as containing 14 grams of pure alcohol. According to the WHO, low-risk drinking can be determined as daily consumption of alcohol in moderation by limiting intake to one standard alcoholic drink in a day for women (max. 20 g.) and two standard drinks (max 40 g.) for men and at least two days in week alcohol is not consumed at all.
- Risky alcohol drinking („risk drinking, hazardous use“) corresponds to more than 40 grams of pure alcohol in a day for men and more than 20 grams of pure alcohol on a daily basis for women.
- High-risk drinking of alcohol (called also „heavy drinking“) corresponds to consumption of pure alcohol in a measure more than 60 grams in a day for men and 40 grams for women. One drink corresponds to 20 grams of alcohol - 0,5 l of regular beer, 2 dcl of wine and 0,5 dcl of distilled spirits. Another aspect, according to the drinking is considered to be risky, is excessive alcohol consumption during the one consuming episode – that means drinking 5 and more alcohol drinks on one occasion (International guide for monitoring consumption and related harm, 2000).

- Binge drinking („binge drinking, bout drinking, spree drinking“) according to (NIAAA, 2004) means high intake of alcohol on one occasion. It is drinking when the blood alcohol content of a person is increasing to 0,08 grams or more. This phenomenon is typical if the men consume 5 or more alcohol drinks or if the women consume 4 or more alcohol drinks in about 2 hours. In the past, the term ,,binge drinking“ used to mean periodic fit of continual drinking, when the person addicted to alcohol consumed alcohol a few consecutive days until the moment when he or she was not able to drink more (2019).

Since we are considering the women who have overused (excessively used, riskily used) alcohol, but in the process of their recovery they have not been in professional care and so the dependence syndrome has never been diagnosed, we use the term excessive alcohol consumption. The term excessive alcohol consumption is understood as health-hazardous and high-risk drinking of above-average doses of alcohol as The World Health Organizations states (2000).

States an increase of the alcoholic (Alcohol Facts and Statistics, 2020) beverages consumption of over 2,4% when compared to the previous year. The alcohol consumption per one inhabitant was 98,7 l in 2018, which represents 8,5 l of consumed pure alcohol. The consumption structure of particular alcoholic beverages was comprised of: spirits 9,3 %, grape wine 12,9 %, beer 73,8 % and other alcoholic beverages 4,0 %. The alcohol consumption in Slovakia has not varied considerably, in the year 2017 it was 8,2 l of consumed pure alcohol per one inhabitant and in the year 2016 it was 8,4 l. From the year 2010 the alcohol consumption remains stable with the slight decreases or increases at an average of 8,5 l consumed alcohol per one inhabitant of the Slovak Republic (Vavrinčíková, 2010). The alcohol dependence is spoken to be a fatal illness. According to the National Health Information in 2018 a mental and behaviour disorder caused by alcohol consumption (dg. F10) accounted for the highest proportion (26,4 %) of the numbers of hospitalisation in institutional healthcare facilities (hospitals in general, specialized mental hospitals and drug rehabilitation centres, psychiatric hospitals, healthcare facilities of the Ministry of Justice SR. From the total number of the first examinations in the all psychiatric surgeries in SR the patients with the dependances accounted for 13,5 % and with the diagnosis alcohol dependence Dg. F10.2, it was 6,6 %. The proportion of men to women with Dg. F10.2 is worth menthioning, it was 3:1 in an out-patient and institutional care.

1.1 Selected Theoretical Models of Addiction and Forms of Helps

According to sociocultural theories see users of psychoactive substances as victims of the society and its prevailing adverse social conditions, as a result of which they reach for drugs. As possible interventions

there are social assistance and social services aiming to alleviate social conditions which lead to use of psychoactive substances by underprivileged individuals. Often times it is not the use of psychoactive substances that is the objective of an intervention, but it is the social conditions which need to be improved (such as poverty, racism). The objective is to help the individual integrate into the dominant social structure and the institutionalized system, and thus to adopt the standards of the mainstream society (Vavrinčíková, 2010).

According to Millerová, *the medical model* understands addiction as a progressive disease with a physiological basis (i.e., genetic predisposition, allergic reaction). A strong position among the theories on development of an addiction is currently held by the neurobiological model, which belongs under the medical theory. *The neurobiological model* perceives an addiction as a chronic recurrent condition of the brain. It is a sort of a reward system in which long-term changes occur in the brain system after taking the drug as a result of long-term preference of easy and effective strategies (blissful feeling achieved through the drug or, after certain amount of time, avoidance of unpleasant feelings during the absence of the drug, Dvořáček, 2008). In simple terms, as a result of long-term consumption of alcohol, the brain becomes spoilt, requesting a fast reward and right away, if possible. The compulsive model of "right now and fast" is a dominant pattern in further behaviour. An accompanying symptom of addiction is a craving – a compulsive desire to use a drug associated with compulsive use of psychoactive substances and the state of withdrawal. The modern understanding of addiction development relies on a large field of research, which agrees on the multiplicity of underlying conditions for development of addiction (Hajný, 2008). It does not confirm an assumption of any single specific areas and it builds on the fact that the risk factors may be found in bio-genetic, social, ethnic, anthropogenic as well as psychological areas. With a specific person or a group of people, the main reason may lie in one of those areas. There are many causes which can play an important role in development and continuation of an addiction; however, it is not possible to prove for all of them that they were the real cause and many times it is disputable whether they are causes or consequences. The fact that there is no single cause for development of an addiction and that an addiction is developed due to factors from different areas is well reflected in the *bio-psychosocial-spiritual model*, which is becoming more and more preferred by the experts in recent years.

- The biological dimension of this model includes genetic predispositions (in particular presence of addictions in biological father), effects on the foetus of an unborn baby, childbirth process, etc.
- The psychological dimension includes personality of the individual as well as the factors of personal responsibility of the individual. Harmonious development of the child, but also occurrence of different mental disorders.

- The social dimension includes in particular the environment in which the individual grows up and which influences formation of the individual's future attitudes. Other factors include cultural standards of the society, attitude to relationship with alcohol, etc.
- The spiritual dimension includes meaning of life, spiritual values (Kudrle, 2003). In addressing the addiction, the bio-psycho-social model combines bio-genetic features with psycho-social factors in order to provide an integrative, complex model. This perspective encourages individual assessment of the alcohol user in which different contribution is assigned to different causes.

With some alcohol users there might be, for example, a significant biological element, while the other two areas might not show many significant signs. As the author further states, promoting the model of a disease is based on believing that the problem of drinking is the primary problem which needs to be addressed. According to other opinions, a drinking problem does not meet the criteria of a disease, as we are not able to identify the cause, treat it directly, and we cannot even tell whether a disease has developed. Critics also bring attention to the fact that if all excessive behaviour is viewed from this perspective, it could devalue the definition of a disease.

The social capital can be seen as the sum of resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance recognition.

Engaging with adult education can improve social capital by opening up opportunities to develop new networks of friends that are outside the confines of the addiction recovery network.

2 Specificities of Alcohol Addiction in Women

In the case of addiction in women as opposed to men, the major role is played by life events and by psychological issues. Such life events can include (Nešpor, 2007) divorce, failed romance, loss or death of parents or a husband. The same is believed by (Kunda, 2014), who gravitates towards the opinion that from the biological perspective, the alcoholism in women is determined not as much by the genetic factors as by the constituent factors. In the case of women, drinking of alcohol is a response to relationship problems and to negative emotions, which can be caused by various stress factors, such as abuse in childhood, stages of the menstrual cycle or comorbidity with bulimia. In addition to that, women state that they use alcohol in order to increase sexual satisfaction and also in order to cope with various sexual situations (McCrady, Epstein, 2013). Problems associated with sexuality may thus be found as a cause, but also as a consequence of drinking.

The specificities of alcoholism in women also include secretive, solitary drinking. Nešpor (2007) sees the reason in the fact that women care more strongly about what they look like and how they are perceived by their surroundings.

According to Kunda (2014), addiction in the case of women has its specificities. The author talks about two types, with the possibility of transition from one to the other:

- In the case of women, drinking starts at an early age, often during the adolescence. Women start drinking in a group of friends, where criminal and promiscuous behaviour is not uncommon as well. Sometimes there is a combination of alcohol with other addictive substances. Most women in this category are women with psychopathological symptoms.
- Excessive use of alcohol occurs later and it is associated with psychogenic issues, experiencing emotional trauma, problems related to married life or partnership life, feelings of loneliness and abandonment. It occurs approximately at the age between 30 and 40. Solitary drinking as well as secretive drinking are most frequent. What is important for women are stimulating-doping effects of alcohol and tension numbing effects. Often times they combine alcohol with pharmaceuticals in order to cope with the negative symptoms caused by the consumption.

In their study, Wolt and Valachová (2019) looked into the specifics of alcohol use in women treated for alcohol addiction. They conducted a qualitative study with 10 female participants undergoing treatment for alcohol addiction at the ages from 24 to 70. The objective of the study was to describe and to bring to the light the specifics of alcohol use in the case of women: beginning of drinking, rituals which helped to develop the addiction, and how the drinking habits change over time. The results showed differences in drinking of younger women versus older women. Younger women prefer episodic drinking, while older women prefer to distribute alcohol over the course of the day to achieve a very low continuous level. The results of the study point to the fact that although the circumstances leading to the use of alcohol were different in the beginning, the motivation to drink was identical in the case of overuse. For women who participated in the study, alcohol served the function of self-treatment. To these women, alcohol served as self-treatment for anxiety, pressure and boredom, and as a way to release pressure and to relax. Another important finding was frequent occurrence of combination of alcohol with psychotropic drugs, the use of which delayed seeking of professional help for the problem of alcohol addiction. With all the women, there was a change in the way of drinking in the course of development of the addiction. A common attribute was transition into solitary drinking at the stage of overuse of alcohol.

2.1 Description of the Recovery Process

Lindenmeyer (2008) states that the idea of alcohol addiction as a disease with a consistent course, chronically progressing and finally leading to death and social decline has proved to be false. Based on various long-term studies, it is possible to identify different progress forms in individuals addicted to alcohol. Apart from progressive worsening of the condition, it is possible for the course of development of the addiction to fluctuate between heavy episodes of drinking and controlled alcohol consumption, possibly abstinence or spontaneous remission. With respect to spontaneous course, the author adds that the overview papers estimate the annual prevalence of the number of spontaneous remissions at 20 %. However, the number of permanently abstinent individuals is certainly significantly smaller.

Nepustil (2015) made conclusions based on his own study consisting of 19 narrative dialogues with people who used Pervitin and achieved recovery without professional help (respondents used Pervitin for over a year, with frequency more than twice a week, and at the time of the interview they had been off Pervitin for longer than five years, and the key condition was that they received no professional help as they were trying to quit regular use). The author talks about three key characteristic attributes of the process which the respondents went through, which the author thinks to be the common attributes of the recovery process regardless of whether professional help is present or not. Namely, these attributes are: uniqueness, boundlessness and forming relationships.

Uniqueness - a person in the process of recovery is not "getting rid of" the addiction in the sense of gradually cutting it off like a cancerous tumour. On the contrary, certain experience, knowledge and skills from the time of the addiction can be used by the recovering individual as one of the resources at their disposal, while the rest of them can be forgotten and allowed to "petrify". In this way, each story of recovery presents a necessarily unique and original picture.

Boundlessness - it was often clear from the narrative of the respondents that they were not able to identify a distinct "breaking point" which would represent the transition from addiction to recovery. Although they often identified the moment which was crucial for them or they at least remembered the last time they used Pervitin, these moments were not identical with the turning point from addiction to recovery. If we were to look at where the roots of their recovery were in more detail, we would often have to go as far back as the time before their addiction, when they were developing their self-reflection skills, a feeling of self-reliance or various strategies for coping with difficult situations. Similarly, during the time of their addiction they could often further develop skills which later helped them in their recovery - in some cases it was creativity, in other cases it was the ability to distinguish

between acceptable and unacceptable risks, or the ability to view their own life from different perspectives.

Forming relationships - (co-creation of relationship trajectories) - disruption of relationship flow, creation of relationship trajectories and forming of a new feeling of belonging are key elements in the process of recovery. What all of these elements have in common is that they require participation of others in order to allow the recovery process to continue. Based on all the available studies comparing treated and non-treated patients, Nepustil (2015) claims it is possible to formulate three main findings:

- Severity of problems with psychoactive substances is usually higher in the case of treated patients.
- The significant factors which played the main role in the process of recovery, and which often do not differ much from one another, include: social support, development of new activities, inclusion in new relationships.
- The individuals who did not undergo treatment continue in the controlled use of psychoactive substances a lot more often – the reason could be found in the lower severity of the problems or in the lack of discursus on the need of lifelong abstinence.

Studies clearly prove that most people addicted to alcohol go through recovery without professional help. Cloud and Granfield (2001) refer to the attributes and conditions that facilitated natural recovery from substance addiction among the 46 people they interviewed. They people were well educated; with most having attended college and several had obtained degrees. Most were employed, before, during and after their addiction experiences, some in professional occupations and others as self-employed business people. According to Granfield and Cloud the possession of educational credentials and employment histories among these people enabled them to manage their addiction within stable limits, retain important friendships and supports among professional colleagues and friends and retain some level of investment in their family life. In effect, despite their substance addiction, they remained embedded within a set of relationships and attachments to conventional life that accrued to them a level of social, physical, human and cultural capital.

3 Methodology

Initially, it could appear that alcohol addiction is a well addressed topic in the scientific literature, but only marginal attention is given to alcohol addiction in the case of women. The existing knowledge shows that women are an at-risk group with respect to starting and developing an addiction. For that reason, alcohol addiction in women and their process of recovery is considered to be an important topic for research. There are interesting

specificities with this group of clients. One of them is a wide spectrum of complications women experience as a consequence of alcohol addiction, another one is making progress in the recovery process once they have started the process. The information obtained from research can help us better understand recovery process of women who suffered from excessive use of alcohol, and thus also identify the mechanisms effective in fighting the addiction and transfer this knowledge into professional help for women addicted to alcohol.

That is why the objective we have set out for this study is to identify which key areas are significant in the recovery process of women who use alcohol excessively. Based on this main objective, we have also set out partial objectives, which are the following: Comparison of the areas affecting the recovery process of women with alcohol addiction who received professional help, and of the areas affecting the natural process of recovery of women who did not receive professional help, as well as identifying what is the experience of women with regard to professional treatment of alcohol addiction.

For our study, we have chosen the qualitative approach, which is characterized by the process of seeking and creating a new understanding, as stated by Smutek and Načeradský (2013), qualitative methods are widely used in social sciences, because they are able to "tell a story".

Qualitative approaches do not assume a transfer of the findings into the language of numbers and they stay at the level of verbal expression. They explain what happened, when, to whom and with what results. To ensure comparability of the participants who underwent a natural process of recovery and those for whom the recovery was initiated due to a therapeutic process, we retrospectively identified the level of addiction in all the participants using a screening tool - AUDIT questionnaire. This questionnaire is based on the addiction syndrome structure according to MKCH 10 (Babor, et al., 1989). The test contains 10 questions related to alcohol consumption, symptoms of alcohol addiction and problems related to alcohol. The AUDIT questionnaire was completed by the participants prior to our conversations. As our research strategy, we chose a case study.

To collect the data, we decided to use a semi-structured narrative interview according to McAdams (1988). Narration is initiated and controlled using a diagram prepared ahead of time, the process of narrating is not spontaneous (McAdams, 1993). The respondents are asked several questions which determine the focus of their narration and structure. Obviously, it is not possible to tell the whole story in detail, it is only possible to express its meaning or the main chapters of life. Then the dialogue focuses on specific areas, the key events. These events should point to the most important and critical experiences in life, turning points, memories (important memories from childhood, adolescence, adulthood and other significant memories, important persons with major influence on the life story, life plans and future projects). We also explore the stress factors and the problems which have not

yet been overcome, or the consequences of which have not yet been adequately processed. The researchers are also interested in personal believes. As stated by Miovský (2006), the role of the narrative interview is to encourage the respondent to narrate, rather than to have a typical conversational exchange. The strategy is to use suitable questions, additions, remarks, comments, etc., in order to encourage the respondent to talk to us about the phenomenon we are interested in. The objective is to obtain as much authentic material as possible. A downside to this interview is that the material obtained for processing is often incoherent, it differs based on the method of asking the questions and the content of the questions, their order, different communication patterns, different level of superficiality, different length and richness of the narrative.

We initiated the interviews using the life curve method. The technique was created by Jiří Tyl as a projective technique (Blatný, Vlčková, 2005). It is a graphic representation of formal aspects of autobiographical memory using the technique of a life curve drawing. The autobiographical memory is the memory of one's experience of their own self in the context of life-long development (Blatný, Vlčková, 2005). For implementation of the technique, we used "Handbook of Brno Research on Human Development" (Blatný et al., 2004) and we modified the instructions based on the focus of our study, see chapter 4.5. In the application, the technique was not used in the study in a projective manner, but as a basis for the interview about the course of the entire life, with focus on the process of recovery. It consists of graphic representation of formal aspects of autobiographical memory using the technique of a life curve drawing.

The structure of the interview was based on the significant points which were marked by the participants and partially structured using several additional questions inspired by McAdams. The questions were focused on the areas of: important events, turning points, development and change, important memories, important relationships and the view of the future. At the same time, supplementary questions were asked to clarify any confusion.

The objective of this procedure was to avoid departing from the key topics during the interview, but also to allow the participants to focus the interview on the areas which were most significant for them in the given moment. The length of the interviews was from 50 to 90 minutes. Prior to the beginning of the narrative interview itself, the participants were asked questions related to demographic data and use of alcohol, see chart no. 1. The interviews were recorded in the form of audio records and written notes. The data collected in this from were then transcribed word by word.

3.1 Description of the Study Sample

Overall, we analysed 7 participants. The study sample consisted of women only. The oldest participant was at the age of 67 and the youngest one was at the age of 22. The average age of the participants was 45.7, where 2 participants in the study were at the age of young adulthood (22-26 years old), one participant was at the age of middle adulthood (34 years old) and three were at the age of late adulthood (47-67 years old). 4 participants did not undergo professional treatment of the addiction and 3 participants did undergo treatment of the addiction, 2 of them in the form of a stay at specialized psychiatric departments and 1 of them in the out-patient form, two participants currently regularly attend abstinent groups**.** Three participants completed university education, two participants completed secondary education with a school-leaving certificate and one participant has elementary education. All women were either employed (5) or retired (2). All participants had stable living situation, most of the women (4) lived with a partner or a husband, or also with children (1), 2 women had their own place and lived alone, and one woman lived with her parents. The majority of the participants had children (4), most of them were married (3). 4 women were single and 1 was in a long-term relationship.

The AUDIT test score was over 20 points with all the participants (values in the sample from 22 to 36 points), which indicates alcohol addiction (Smutek, Načeradská, 2013). All women also had more than 1 point in questions no. 4, 5, 6, where the score of over 1 point in any of these questions indicates an ongoing or beginning addiction to alcohol (values in the sample 1-9), and all women had more than one point in questions no. 8, 9, 10, which indicates that damage to health in relation to alcohol use has already occurred, and it also indicates addiction to alcohol. In the sample, duration of the full non-interrupted abstinence from the last use of alcohol ranged from 1.5 to 15 years. The average duration of abstinence was 5.8 years.

3.2 Results

The narraative interview, initiated by the life curve, was the clear choice to collect data. This decision was unfolded due to the personal experience of the female researcher and a wide knowledge gained from the discussions that were held it this way at advisory work with the problem consumers (men and women) of alcohol. The more we immersed ouselves in discussions regarding with the narrative optics, the more we approached the idea of using the potential of the stories and processing the data by way of the narrative analysis.

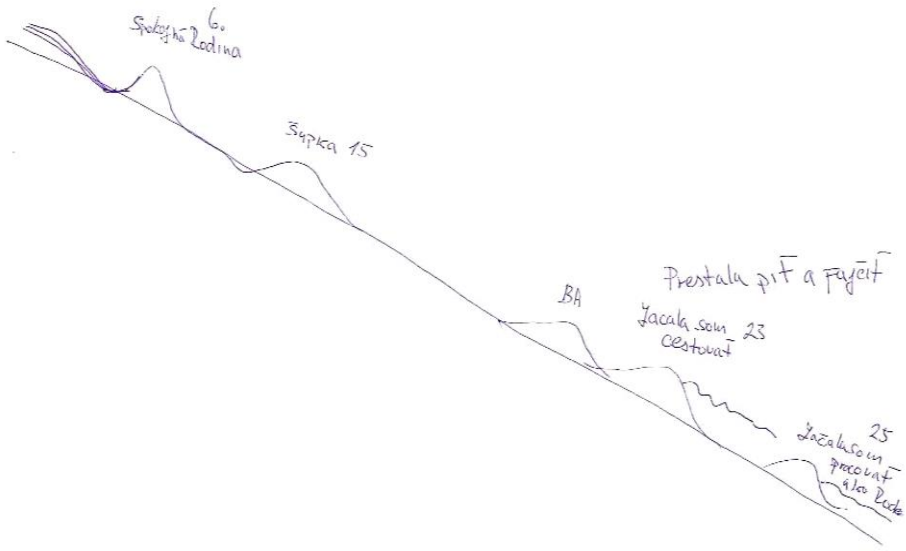

Fig. 1. The example of the female participant´s curve of life that has been used in pursuance of collecting the data in the research.

The analysis restores the particular stories of the female participants but it respects the stories which have been brought in the discussion by the female participants themselves. The particular thematic lines of each story are arranged in chronological and logical continuity. Five thematic areas have been emerged from the data analysis of the whole survey sample, which have been seemed as essential feature for the recovery process: support of the social environment, own participation in recuperation, the change of the state of health, professional treatment and the activity. Every thematic area includes other subthemes. The particular areas are mingled to a certain extent since they are related to the recovery process and it is typical with its change in time. In the discussion, the results are compared with the foundations that have been mentioned in the theoretical part. The main aim of the survey was to find out the important fields that are significant for the recovery process of the women overusing alcohol. There were three survey questions related to this aim.

Which of the theamtic areas predominate in the recounting of the women who have undergone the recovery process? It has emerged from the discussions with the female participants, who haven´t undergone the professional addiction treatment, that there are 6 important areas, while the largest area in the discussions has been filled by the area „support of the social environment“, which has been related to the subthemes: family, important people, the support of the wider social environment and the reaction of the surroundings and a new identity of the female abstainer. The next area was „own participation in recuperation“ which includes these two subthemes: the responsibility for

recovery and the risky situations. All the female participants in the survey have expressed themselves on these two subthemes. The third area is „the change of the state of health" which includes physical and mental level. This topic has appeared at particular female participants less frequently but it has greater importance for the recovery process. The important theme for the women who have undergone professional treatment naturally has been the field of the treatment including treatment and follow-up treatment. The last area is „activity" that is related to the work and interests. The areas that have been present in thematic lines at female participants in the survey are in agreement with Best et al. (2011) who has characterized the recovery process as a development process which includes the change of identity and values and it is supported and maintained by the changes of social networks and involving the family. Personal sources, social support and the involvment of the close relatives form the potential for recovery that is crucially put in the context of achievable sources.

Are there any differences between the natural recovery process and the recovery initiated by the therapeutic process? The analysis has proved that the natural recovery process and the recovery initiated by the therapeutic process differ little from each other. The differences have been found especially in aforementioned area of follow-up treatment, treatment, furthermore in the family area – in female participants, who have undergone the addiction treatment, the family members are more involved in the recovery process itself, they actively participate in commencement of the treatment or they confront the female participants with the negative side of the alcohol consumption. On the contrary, the important individuals in the form of partners have appeared more in thematic lines of female participants, who haven´t undergone the treatment, and these people played an important part in the recovery process to all female participants. The small differences have emerged in the field of risky situations. The women who have undergone the treatment clearly delimit themselves against the risky situations, they have the strictly given rules which are followed by them. These rules are not so strict at the women who have not undergone the treatment, but they do not feel that it could endanger their abstinence. The sigificant difference has not been detected in other fields. The last partial aim of the survey was to find out what is the women experience with the professional addiction treatment like.

What is the experience of women with the professional treatment of alcohol addiction? The female participants, who have experienced the hospital addiction treatment, have emphasized that the treatment have meant to them especially the creation of the space where they could detach themselves from the ordinary responsibilities and worries they have had in their lives and so they could concentrate on themselves. Then, it has provided valuable information they could not have figured it out on their own but they have received it in a package. Darina: „As if you are walking somewhere, to compare it, as if you are walking down some orchard and the knowledge about the addictions, and how to get out of it, is growing on these trees now. And you are walking along

and like on the internet, you will pick a cherry, then a pear and so on. And do you know what those doctors have done? They gave mi „fruit" from that tree, what I know about health, what organs it attacks, that what does it have... So, there was the whole box of those pears at the same time. There was the whole box of those cherries. And it has created great links to me. And I think, up to now, that it is possible that due to this I have started abstaining." The treatment formed some kind of boundary, strong point between the life „before" and „after". It was also a space where they could share their problems and devote to the women´s topics. Kalina (2015) has seen it in a similar way, according to him the process of the recovery in the treatment means mainly creating the space for speaking and listening, where the reconstruction of own story could be performed and finally as well as the narrative transformation – a human being recounts his/her story in more acceptable form. First of all, it is necessary to lend an ear to the clients and try to understand them. Two female clients were taking anticraving medications and psychopharmaceuticals, and both female participants were talking about unproblematic start of abstinence and they did not remember they had some worse period, that could be linked with their medication. One female participant underwent the follow-up treatment in outpatient form and two female participants have taken part in abstinent groups and it has been already perceived as a part of their life by them and they have attributed great importance to it in the field of relapse prevention. The interesting finding is that no woman, who has decided to abstain permanently, has not suffered any relapse. Furthermore, the experience with the relapses of alcohol addicted people is common phenomenon. It could have a relation to the fear of the stigmatisation and the pressure which is brought by neighbourhood but also by themselves.

4 Conclusions

It has emerged from the analysis that for the recovery process of the women who consume alcohol riskily, there are these significant areas: support of the social environment, own participation in recuperation, the change of the state of health, professional treatment and the activities. To start the recovery process, there was usually a mechanism when the female participant´s state of health had got worse either on physical or mental level and afterwords she started to participate acitvely in her own recuperation, or an important person entered her life and she, just as in foregoing case, mobilized her energy and assumed responsibility for the recovery process. After the initiation of natural recovery process in women who have not undergone professional treatment, the positive experience with the abstinence has played a significant role that could lead to the decision to abstain permanently. Among the most significant areas which support the sustaining of abstinence belong the support of the social environment, work, leisure activities and for the women who have undergone professional treatment also follow-up treatment. Granfield and Cloud (2001) describe the alternative activities that they 46 people engaged

with; they (re) developed a spiritual element in their lives by engaging with religion, some returned to education, most immersed themselves in their work and career and some did volunteer work in their community. According to the authors, these activities were the basis on which interviewees constructed new meaning in their lives and were instrumental in sustaining their cessation of substance use. Some comparisons can be drawn with the people accessed through Soilse and interviewed for this study, they too talked about developing a spiritual element in their lives and some used mutual-aid groups like A.A. and N.A., some had experience with employment and voluntary work most had returned to education. However, the contrast remains that the 20 people accessed through Soilse had developed these alternative pursuits through their engagement with formal treatment and self-help groups and the 46 people interviewed by Granfield and Cloud (2001) had immersed themselves in these activities without recourse to treatment or mutual-aid groups. The natural recovery process and the recovery initiated by therapeutic process did not differ significantly from each other. The differences between the natural recovery process and the process of recovery initiated by therapeutical process were in thematic lines of women present mainly in the areas of follow-up treatment, family, important individuals and risky situations. The experience of the women with the professional addiction treatment had a positive character. The women could see the significance of the treatment especially in gaining the information crucial for the recovery process, providing the space, where they could share their experiences with others and last but not least, the space that enabled them to detach themselves from their ordinary troubles, to concentrate on themselves and recover their strengths.

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