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THE STORIED EXPERIENCES OF COUPLES DURING THE FIRST SIX MONTHS OF RECOVERY FROM ALCOHOL: A PHENOMENOLOGICAL INQUIRY

DISSERTATION

Presented in Partial Fulfillment of the Requirements for

the Degree of Doctor of Philosophy in

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in the Adrian Dominican School of Education of

Barry University

By

Jose R. Marmolejo, M.S.

Barry University

2007

Area of Specialization:

Marriage and Family Counseling/Therapy

THE STORIED EXPERIENCES OF COUPLES DURING THE FIRST SIX MONTHS OF RECOVERY FROM ALCOHOL: A PHENOMENOLOGICAL INQUIRY

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To all these people, a loving thank you.

DEDICATION

This work is dedicated to my mother, Maria Miller, and my sister, Rose Kleeman, without whose sacrifice and love in my life I would not have been able to complete my academic journey.

ABSTRACT

THE STORIED EXPERIENCES OF COUPLES

DURING THE FIRST SIX MONTHS OF RECOVERY FROM ALCOHOL

A PHENOMENOLOGICAL INQUIRY

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Barry University, 2007

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Purpose

Although numerous models claim to conceptualize addiction and recovery from a family perspective, many of these approaches nevertheless locate the problem in the individual and organize treatment accordingly. A review of the literature indicates that there is a paucity of research in the area of outcome studies in the field of recovery. Further, an increasing number of strength-based models of counseling and psychotherapy have emerged in the last quarter century, including narrative therapy, solution-focused therapy, and the social-psychological model. An inquiry into the storied experiences of couples during the first six months of recovery from alcohol and a description of the human experience is helpful in increasing an understanding of the essence and central underlying meaning of their lived experiences for this population. The researcher uses narrative therapy (White & Epston, 1990) as a theoretical framework from which to conduct a phenomenological inquiry for a qualitative research design.

Method

The data consists of researcher transcribed, semi-structured interviews conducted with six couples ages from 18 years to 60 years. Relevant statements from the transcriptions were divided into groups. This process is known as extracting significant statements (Colaizzi, 1978). Meanings were then formulated for each significant statement, and these meanings were grouped into themes (Colaizzi, 1978). The researcher's biases and preconceived ideas were bracketed so as not to combine with the participants' voices (Colaizzi, 1978). The themes were put together to form an exhaustive description of the phenomenon of the inquiry (Colaizzi, 1978).

Findings

Participants experienced that life's hardships, legal issues and having an alcohol problem led them to seek recovery. However, the support from their significant others and/or family members was necessary for the transition for recovery to occur.

Most of the couples expected that while they were in recovery their relationships would improve. Also, couples expressed the need for more self-control and the desire to be able to handle stressful situations more effectively. The discovery of some universal themes were derived from the storied experiences of couples, where one in each couple had an alcohol problem and is in the early stages of recovery, as defined in this study for a period of no less than six months.

However, some of these same universal themes continue to appear, as in Bruning's study (1985). As such, a change of paradigm from the traditional medical models for the treatment of alcohol problems is recommended to strength–based models

of counseling, three of which are narrative therapy (White, 2000), solution focused brief therapy (de Shazer, 1985), and solution-focused counseling (Guterman, 2006).

The findings contribute to an understanding that may increase the literature base on the recovery process from alcohol and may also be capitalized by all professionals in related fields as well as the public at large. Also, the recognition and attention to the ways in which alcohol problems are embedded in couple's relationships while in recovery is vital for effective treatment.

The current study has been instrumental by offering an interpretive phenomenology of couples' alcohol problems during the first six months of recovery. It has highlighted couples' storied experiences about the use of alcohol, their relationships, and recovery that could not have been detected with available questionnaires.

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CHAPTER ONE

THE PROBLEM

Introduction

There are countless people standing up right now at Alcoholics Anonymous (AA) meetings throughout the world and saying the words, "Hello. My name is . . . and I am an alcoholic."

For millions of people experiencing alcohol problems, this was the story of recovery. It was the traditional story, and for many it was the only story that they have come to know. And there are other stories in our culture about alcohol and substance problems that have become traditional and pervasive. Among these were stories that described the problem as a medical disorder, a family dysfunction, and a sign of moral weakness. Recently, however, increasing attention has been given to the role of sociocultural factors in conceptualizing alcohol and substance abuse.

Historically, persons experiencing alcohol problems have been viewed as the locus of such problems. Also, their family members have been viewed as a cause or maintainer of such problems or an obstacle to their solution. In this dissertation, a new area of inquiry was explored in hopes of focusing on the client's unique experience during the recovery process. In keeping with the postmodern zeitgeist and its emphasis on language-based epistemology, the researcher sought to understand the stories as they relate to the recovery process of couples during the first six months of recovery from alcohol. In particular, narrative therapy was used as a theoretical framework (White & Epston, 1990).

Nature and Scope of the Problem

Addiction is a complex clinical syndrome that affects 18.5 million Americans each year (Lewis, 1994). The prevalence of current alcohol use in 2001 rose with the increasing age of youths, from 2.6 percent at age 12 to a peak of 6.75 percent for persons 21 years old (SAMSHA, 2002). Approximately 14 million Americans meet the diagnostic criteria for alcohol abuse or alcoholism (NIAAA, 2002). Also, more than one half of American adults have a close family member who is an alcoholic, and approximately one in four children younger than 18 years old in the United States is exposed to alcohol abuse or alcohol dependence in the family (NIAAA, 2002).

Studies suggest that the period of continued abstinence from drugs or alcohol, often referred to as recovery, brings new, complex behaviors, emotions, and patterns of interaction for individuals and relationships (Cohen & Krause, 1971; Estes & Hanson, 1976; Kogan & Jackson, 1965). Addiction has been characterized as a family disease since the mid-20th century. Although numerous models claim to conceptualize addiction and recovery from a family perspective, many of these approaches nevertheless locate the problem in the individual and organize treatment accordingly (White, 2005). For example, many rehabilitation programs and clinicians consider alcohol problems to be a family disease, yet assess, treat, and provide support services to individuals in isolation from their spouses or significant others (White, 2005). If such treatment is to be considered family oriented, then it should be delivered with couples and significant others (White, 2005).

A review of the literature suggests that little attention has been given to couples during the recovery process for alcohol problems. In addition, a common assumption is that early in the recovery process, sobriety will bring peace and happiness for couples

(White, 2005). While those participating either personally or professionally in the area of addiction know that sobriety is a prerequisite for any hope of recovery. Also entering sobriety is only the beginning of a long and arduous struggle to regain or create a productive, meaningful existence for the person with an alcohol addiction and for those emotionally close to them. Although no figures are available at this time, it is believed by many in Alcoholics Anonymous (AA), in Al-Anon, and in alcohol treatment programs that a majority of couples entering sobriety will separate and/or divorce in the early stages of the recovery process (Peele, 1984).

Traditionally, treatment approaches for couples in recovery have been organized by the disease models (Peele, 1984). One of the most important reasons for adopting a disease model for addiction by AA was that psychiatrists had commonly assumed that alcoholism was secondary to another disorder, such as anxiety or depression, and they often treated the presumed underlying disorder while they encouraged the drinker to try to stop drinking (Ray & Keir, 2002). Gorski (1989), a proponent of the disease model, stated that it is necessary to recognize this, and that an alcoholic can never safely use alcohol. Also, the alcoholic must practice a daily recovery program in order to keep addictive thinking from returning (Gorski, 1989).

Fitzpatrick (2003), another proponent of the disease model, holds that addiction is a chronic, lifelong, relapse-prone disease that carries with it episodic needs. He goes on to say that relapse rates are hard to pin down, but what numbers there are, along with anecdotal evidence, clearly depict relapse as a robust component of the addiction and treatment reality. However, the disease model is largely individually oriented. In contrast, an increasing number of strength-based models of counseling and psychotherapy have emerged in the last quarter century, including solution-focused therapy (de Shazer, 1985),

narrative therapy (White & Epston, 1990), and language systems therapy (Anderson, 1996) that in turn hold promise as alternatives to the disease-, pathologizing-, and individually oriented approaches that have dominated addiction and recovery. In this dissertation, the position is taken that there is value in looking at the experiences of couples during the recovery process and, in particular, identifying the strengths and weaknesses that correspond to couples' experiences during the recovery process. The researcher's interest in the experience of people with alcohol problems and their spouses or significant other goes back to the 1970s, when his aunt's husband, his favorite political uncle, died at age 45 of cirrhosis of the liver, and in the late 1990s, his son's oldest first cousin also died of the same condition. Little did the researcher know that coming into the 21st century he would have already been counseling clients with drug and alcohol problems for approximately six years in alternative school settings, community mental health centers, and residential programs.

When the researcher first started counseling drug and alcohol clients, he was under the assumption that, after a six-month residential program, the drug or alcohol use would stop for several reasons, if other than a true desire for recovery. One reason was that the client would know that if he or she had been in jail prior to treatment for any alcohol-related offense and would break the law again, he or she would be breaking probation and be sent back to jail. Another reason was that the return home to the spouse or significant other would assist in the recovery process, and in the long run he or she would be a successfully recovered addict. However, alcohol is not an illegal drug, and this makes it all the harder for the person in recovery. It took the researcher's aunt and her family many years to recover from her husband's early death. All questioned why he continued to drink after stopping for some time. Aside from his significant period of

sobriety, he was living with his wife, who is a non-alcoholic. Her support and sober influence should have helped in his recovery.

An inquiry into the storied experiences of couples during the first six months of recovery from alcohol has become the researcher's topic of interest and the subject of his phenomenological inquiry in this dissertation. He also wants a description, an illumination of this human experience (Hoshmand, 1989), and an identification of the essence of behavior that is based on meditative thought (Field & Moorse, 1985). As the investigator of this inquiry, he also wishes to further his understanding of people with alcohol problems and the lived experiences of their non-using spouses or significant others after their being in treatment for a period of six months, as the general length of time given for residential treatment by the Florida Department of Corrections and Children and Family Services in fact is for a minimum of six months.

Justification for the Study

A proliferation of research has assessed outcome effectiveness related to traditional models of addiction (e.g., disease models), including both quantitative and qualitative studies (e. g., Tims, Fletcher, & Hubbard, 1991). In prevailing approaches to addiction treatment, the addict tends to be viewed as caught up in an inescapable cycle of behavior (Peele, 2004). No matter how many years ago a person had his or her last drink; he or she is still considered an alcoholic. Moreover, the very term *alcoholic* can have the untoward effect of allowing for no other possibilities (Peele, 2004).

Due to an increasingly complex society, it is unlikely that any one theoretical orientation will suffice to address the problem of alcohol (Lernet, 1991). An increasing social-scientific research has conflicted with disease theories of alcohol, yet non-disease conceptions are not well represented in the public consciousness, treatment problems, or

in policies affecting nationwide drinking practices (Peele, 1984). Also, conflicting ideas and approaches toward the treatment of alcoholism have intensified in the last decade (Peele, 1984). Peele also states that there continues to be a need for mental health professionals to present alternative models of alcoholism. A review of the literature, however, indicates that there is a paucity of research in the area of outcome studies in the area of recovery. Moreover, there is a lack of outcome studies related to the strength-based models in addiction, including narrative therapy, solution-focused therapy, and language systems therapy. The research that has been found consists of case-based, anecdotal research.

An increasing number of empirical studies have addressed narrative therapy applications to alcohol problems (e.g., Lyness, 2002; Madigan & Law, 1998; Smith & Winslade, 1997; White & Epston, 1990). Using the narrative approach, Madigan and Law (1998) described a case of a 23-year-old male dealing with alcohol abuse. In this case, these authors illustrated the narrative technique of mapping the influences of the problem of alcohol abuse and identifying unique outcomes. In another case Madigan and Law (1998), described a young Native American man dealing with alcohol and family problems. In this case, the narrative technique of restorying was illustrated.

An increasing number of empirical studies have addressed solution-focused therapy applications to alcohol problems (Berg & Miller, 1992; de Shazer & Isebaert, 2003; Guterman, 2006; Juhnke & Coker, 1997; Polk, 1996). Berg and Miller (1992) provided a solution-focused therapy application to alcohol problems. The authors described a case involving a 36-year-old husband with alcohol abuse and his wife. The case was organized around helping the couple identify exceptions to the problem (i.e., what was different when the husband did not drink). Guterman (2006) described a

solution-focused case for substance abuse involving a 27-year-old African-American man who was mandated to counseling by his supervisor when marijuana was detected in his urine. Although the client was initially resistant to the mandated treatment, Guterman eventually shifted to a collaborative working relationship by working on the client's chosen goals. In an ensuing session, the client acknowledged that he had been abusing marijuana and chose to abstain. After the sixth session, the client's urges to use were minimized to the point of not needing counseling any longer.

Another strength-based approach was Peele and Brodsky's (1975) social-psychological model. This model involved making sense out of people's experiences and the addict's low self-esteem. Peele and Brodsky have found that addiction affects a genuine involvement with life. They have stated that motivation is the antithesis of addiction. Peele (2004) gives six principles as a key for change. Sanchez-Craig, Annis, Bernet, and MacDonald (1984), using the social-psychological technique and following Peele's (2004) six principles, told one group they should abstain from drinking, and they told the other group about controlled drinking. Sanchez-Craig, et al. found a significant reduction in drinking but not in abstinence between the groups. The most important factor contributing to change was found to be individual motivation. Guterman (2006) has suggested that "future research assess outcome effectiveness related to solution-focused applications to substance problems" (p. 93). Along similar lines, in this dissertation the position is taken that more research is needed in the area of the applications of strength-based models to addiction and recovery.

Research Questions

The proposed research questions studied the meanings that couples ascribe to the recovery process. A phenomenological research design was used. The main purpose of

this inquiry was to determine the experiential nature of the recovery process during the first six months for people with alcohol problems and their non-using spouses or significant others who are living together and where one is in the recovery process. Given the current available information pertaining to the area of recovery (sobriety) and the complexity of the subject matter, the first concern of this researcher was that of the methodological approach. While information was available from previous studies, formalized, conceptualized, and workable theories and hypotheses were not in evidence. Furthermore, no information was systematically derived which covered the topic of inquiry, namely, the experiences of people with alcohol problems and their non-using spouses or significant others during the first six months of the recovery process. With a desire to provide an empirically sound base to further research in this area and for a clinical understanding of the subject, a qualitative phenomenological method was chosen as the most suitable approach in this investigation. Guidelines for conducting proper qualitative research were presented by Colaizzi (1978). A detailed description and procedural steps of the qualitative phenomenological approach conducted in this inquiry is provided in Chapter III.

A narrative theoretical framework is used in this dissertation (Caetano & Cunradi, 2002; Caetano, Schafer & Cunradi, 2005; Cohen & Krause, 1971; Kogan & Jackson, 1965; Miller & Hester, 1986; Miller, Wilsnack & Cunradi, 2000; White, 2005). Following the principles of narrative therapy (White & Epston, 1990), the researcher proposed a narrative approach, a process-oriented model informed by postmodernism from which to conduct the phenomenological inquiry using a qualitative research design. From this perspective, problems are conceptualized in terms of narratives that are influenced by one's culture (Guterman & Rudes, 2005). White and Epston (1990) have

referred to these narratives as dominant stories. According to White (1995), a dominant story is reinforced by one's culture and thereby internalized, becoming a habitual pattern of construing situations or issues. Postmodernism expresses that human experience is language-based and socially constructed (Derrida, 1989; Gergen, 1985; Lyotard, 1984). For purposes of this inquiry, the researcher investigated the stories that participants construct about their lives, and particularly in relation to the alcohol recovery process. In addition, the researcher inquired about their strengths, also referred to as unique outcomes in narrative therapy, and about the recovery process. This narrative approach took the position that people's views of so-called reality are intersubjective and language-based (Gergen, 1985) and increased the opportunities for identifying unique experiences in a person's life.

The research questions in this study were as follows:

1. What stories do couples construct about recovery with regard to both the problem and strengths (i.e., unique outcomes) in relation to recovery?

2. What themes can be derived from these stories, which, in turn, might inform the theory and practice of recovery from alcohol and substance abuse?

This inquiry is intended for clinicians, mental health professionals, therapists, and marriage and family counselors who serve clients with drug and alcohol addictions; also to provide useful information to couples and family members experiencing the recovery process, and to promote the acknowledgment of the recovery process as a legitimate area of concern and for study in the field of drug and alcohol rehabilitation. The research is, in general, for the public at large as well as all professionals in related fields.

Overview

In summary, Chapter I the researcher described the nature and scope of the problem, the justification for the study and the research questions. The remainder of this dissertation is organized as follows. Chapter II consists of a review of the literature of empirical studies pertaining to the application of narrative therapy and other strength-based models of the recovery process from alcohol. Chapter III presents the method to be applied in detail. It includes a thorough description of the research design, the recruitment of participants, general procedural steps, and it addresses how this design fits this particular inquiry. Chapter IV explains the findings resulting from the data collection. Lastly, Chapter V gives an exhaustive description of the experiences of the couples, a discussion of the findings and recommendations.

CHAPTER TWO

REVIEW OF THE LITERATURE

Overview

This chapter consists of a literature review of empirical studies pertaining to the application of narrative therapy and other strength-based models of the recovery process from alcohol. Three models—narrative therapy, solution-focused, and the social-psychological model—are described in terms of its theory and practice. Following the description of each model, a review of empirical studies related to substance abuse problems is provided.

Narrative Therapy

Theory and Practice

In narrative therapy, problems are conceptualized in terms of narratives, which are influenced by one's culture (White, 1995, 2000; White & Epston, 1990). White and Epston (1990) refer to these narratives as dominant stories. Various postmodernist theories as well as social constructionist positions regard narrative therapy as people's views of so-called reality, which are intersubjective and language-based (Gergen, 1985). Hoffman (1990) describes narrative therapy as creating notions of truth and knowledge through conversations that people have with one another. Foucault (1987) has provided epistemological analysis of knowledge and power, which, in turn, has been adapted within narrative therapy. Also expressed by Foucault, was that oppressive ideas develop in political, cultural, and social contexts and in turn impact individuals (Guterman & Rudes, 2005).

In narrative therapy, problems are understood as largely the result of restraining narratives that are influenced by one's culture (Guterman & Rudes, 2005; White &

Epston, 1990). These restraining narratives are referred to as dominant stories (White & Epston, 1990). The change process involves helping the client identify and amplify unique outcomes in relation to the restraining narratives or dominant story (Monk, Winslade, Crocket, & Epston, 1997). The therapist in the reconstruction of life events engages the client. The narrative therapist helps the client rediscover the remnants of favored experiences in his or her life. Hence, these favored experiences will open up avenues by which the clients can bypass the problems that have stalled them on their journey through life (Monk, et al., 1997).

One of the main goals in regard to the change process in narrative therapy is to help the client create a more preferred story about his or her life (Guterman & Rudes, 2005). The following four phases are usually followed in narrative therapy: (a) mapping the influence of the problem, (b) identifying unique outcomes, (c) restorying, and (d) formulating tasks (Guterman & Rudes, 2005; White & Epston, 1990).

Mapping the influence of the problem involves helping the client understand how the problem might have influenced his or her life (Guterman & Rudes, 2005; White & Epston, 2005). This process can serve to increase opportunities for identifying unique outcomes and externalize the problem. In such instances, clients are able to view themselves as separate from their problems (White & Epston, 1990). When mapping the influence of the problem, counselors help clients to identify unique outcomes. *Unique outcomes* in narrative therapy refer to behaviors, thoughts, and feelings that contradict the dominant story (White & Epston, 1990). The phase of identifying unique outcomes is designed to encourage clients to acknowledge exceptions to their problems that might otherwise have been considered insignificant (Guterman & Rudes, 2005). An example of such questioning include, “When has there been a time when you did not experience this

problem?" or "When have you been able to overcome the problem?" (Guterman & Rudes, 2005).

Following the phase of identifying unique outcomes, the counselor asks questions and makes comments aimed at amplifying and ascribing meaning to the outcomes (White & Epston, 1990). This phase is referred to as restorying and is designed to empower clients with a sense of self-efficacy (Guterman & Rudes, 2005). *Restorying* questions include, "What do the unique outcomes say about your ability to deal with the problem?" (Guterman & Rudes, 2005; Monk et al., 1997; White & Epston, 1990). The fourth and final phase is *formulating tasks* and often involves behavioral goals, including writing exercises to help clients work toward the goals of treatment (White & Epston, 1990).

Empirical Studies

An increasing number of empirical studies have addressed narrative therapy applications to alcohol problems (e.g., Lyness, 2002; Madigan & Law, 1998; Smith & Winslade, 1997; White & Epston, 1990).

Smith and Winslade (1997) provided a case example of Patrick, age 23, whose older brother died after he was released from jail because his older brother had lost control of the car he was driving while drunk. Patrick struggled to contain his emotions, and he tallied up the toll alcohol had taken from him and his family. Patrick gave a lengthy and substantial account of the personal costs to him of living under the domination of alcohol. Over the following months, the counselor mapped the influence of alcohol in Patrick's life. He began to identify in the assessment process unique outcomes, not only in his drunken behavior and its consequences, but also as significantly limiting the options to him in other areas of his life. As Patrick weighed up a fresh start, such a move was difficult for him to even contemplate; however, alcohol had not yet succeeded

in completely blinding him to the possibility that life could be different. The counselor then assisted Patrick in restoring his confidence, which had been lost to low self-esteem, due to the many consequences from his alcohol problem. This was done by empowering him with information about alcohol that assisted him to negotiate his escape and gradually free himself to discover alternative ways to grieve for his brother and relate to his family and others in ways that were not available to him in alcohol's domain. In the last phase of the narrative therapy, the counselor enhanced the restorying process by encouraging externalization of alcohol as a problem. Patrick was then able, over time, to identify alcohol as both promoting disrespect and supporting him in not facing up to the consequences of disrespect in his relationship with his girlfriend, his mother, and his sister. He was also able to identify other instances of irresponsibility, and he also understood how this behavior influenced the way people saw him. The counselor was able to assist the client to not permit alcohol or his brother's death to overpower him, and Patrick resolved to be more active in his nephew's life. During the conversations with Patrick, the counselor was able to assist the client to go against his dominant story, which almost capitalized on his life.

In a case presented by Madigan and Law (1998), a young Native American man was living at Peak House, a coed residential program for young people and families struggling against the negative effects of alcohol problems within their lives. The community of origin in which Laurie lived with his mother, brother, and other extended family, was impoverished, and many of the families suffered from longstanding difficulties with alcohol. During the first session, the counselor was able; through questioning, to understand how Laurie's poverty-stricken life had influenced him in his alcohol problem. Laurie was able to externalize the problem with the assistance of the

counselor, and the theme throughout the conversations centered on living with the real effects of poverty. The counselor was able to identify what had affected the client, and the fact that social problems such as alcohol misuse often occur within the matrix of a sociocultural context from which a person's experience cannot be divorced. Laurie believed that his impoverished, indigenous community were themselves responsible for their anguish and pain in the Indian reservation. The dominant story was that his ancestors and family members had always been living with the effects of Colonialist practices and that he lived within a social context in which generations of family members had suffered through alcohol misuse and oppressive practices. However, the counselor was able, through conversation, to restory Laurie's life by amplifying and ascribing meaning to his life and inspire positive outcomes. The client, designed the final phase of formulating a goal with the assistance of the counselor, to get off the reservation and make a commitment to live a different life, staying away from certain places and people. In his therapeutic conversation, the client was able to see how sociocultural influences shaped the specific dilemmas in his life and how they affected his family relations. Hence, the goal of the counselor was to assist the client in externalizing the problem and making a commitment, and empowering him was attained.

Solution-Focused Brief Therapy

Theory and Practice

According to de Shazer (1991), the idea of "problem" necessarily suggests the other side of the distinction, that is, "non-problem." De Shazer, (1991) says there are always times when the problem does not occur:

> The whole concept of *problem/complaint* can be read to imply another concept, *nonproblem/noncompliant* (i.e., exceptions, times when the complaint/problem

> does not happen even though the client has reason to expect it happen) and, of course, the space between problem and nonproblem or the areas of life where the problem/nonproblem is not an issue and is not of concern to the client. This space between problem/nonproblem is also available to the client and therapist for use in constructing a solution. (de Shazer, 1991, p. 83)

The change process in solution-focused brief therapy involves helping the client to identify and amplify exceptions (de Shazer, 1991; Guterman, 2006). If exceptions are identified and amplified, then problem resolution can be brought about in an efficient and effective manner. In solution-focused brief therapy, the therapist and client collaborate to define a problem and a goal. The problem definition is subsumed by the problem/exception distinction (Guterman, 2006). For example, if a client defines the problem as ineffective coping skills for alcohol abuse, then the problem would be conceptualized as ineffective coping skills for alcohol abuse/effective coping skills for alcohol abuse. The process of change would be organized around helping the client identify and amplify exceptions; that is, times when he or she is able to cope effectively with alcohol abuse.

Solution-focused brief therapy usually includes the following stages: (a) co constructing a problem and goal, (b) identifying and amplifying exceptions, (c) co constructing tasks, (d) evaluating the effectiveness of tasks, and (e) reevaluating the problem and goal (de Shazer, 1994; de Shazer, et al., 1986; Guterman, 2006; Molnar & de Shazer, 1987). Because each client and family is unique, these stages serve as a guide that will at times require detours by counselors and therapists (Guterman, 2006; Molnar & de Shazer, 1987; O’Hanlon & Weiner-Davis, 1989).

The first stage, *constructing a problem and goal*, involves clients and therapists negotiating a solvable problem and attainable goal (de Shazer, 1994; de Shazer, et al., 1986; Guterman, 2006; Molnar & de Shazer, 1987). During this stage it is important to formulate a problem definition and goal that fits with clients' unique worldviews (Guterman, 2006). When constructing a problem and goal, it is particularly important for the therapist to look to clients for direction in selecting a problem definition (Guterman, 2006). Clients tend to attribute their problem to various causes. Hence, it is crucial for therapists to gain an understanding of clients' worldview when coconstructing a problem and goal.

The second stage involves *identifying and amplifying exceptions.* This is done through prepositional questioning aimed at creating expectancy for change (O'Hanlon & Weiner-Davis, 1989). For example, it is important to ask, "*When* has there been a time when you coped better with the problem?" rather than, "*Has there* been a time when you coped better with the problem?" (Guterman, 2006). The latter is a yes-or-no question that provides an opportunity for the client to respond negatively. The former carries with it a sense of expectancy that indeed there have been times when the client has coped better with the problem (Guterman, 2006). If exceptions are identified, clients are helped to amplify exceptions. A main purpose of amplifying exceptions is to help clients identify differences between those times when they have the problem and when they do not (O'Hanlon & Weiner-Davis, 1989).

If clients are unable to identify exceptions, therapists may encourage clients to consider small differences (Walter & Peller, 1993). If clients state that there have been no exceptions even after being asked to consider small differences, therapists can aim to identify potential exceptions (Guterman, 2006). Questions aimed at identifying potential

exceptions include; what will it be like when you are coping better with the problem? This type of questioning evolved from de Shazer's (1978) crystal ball technique, which involves asking clients to see themselves in a future situation in which they are functioning better. Molnar and de Shazer (1987) have noted that the "Crystal Ball Technique" came to be regarded as a precursor of a solution focus, in that it was an early attempt to systematically focus the client on solutions rather than on problems (p. 350). Like the crystal ball technique the "Miracle Question" has become one of the most widely practiced solution-focused techniques:

> Suppose that one night there is a miracle and while you are sleeping the problem that brought you into therapy is solved, how would you know? What would be different? (de Shazer, 1988, p. 5)

The miracle question can serve to identify potential exceptions. When clients consider the miracle question, they are then sometimes able to identify real exceptions. In some cases, however, clients might not identify exceptions or potential exceptions. In such cases it might be necessary to clarify the problem and goal further.

The third stage, *assigning tasks,* is aimed at building on the problem, goal, and exceptions. For instance, if a client identifies and amplifies exceptions, then he or she might be given the following task:

> Between now and the next time, I would like you to continue to do more of the exceptions.

If a client is able to identify only potential exceptions, but is not able to identify exceptions, then he or she might be given a task along the following lines:

> Between now and the next time, I would like you to observe those times when it (exceptions) happens in your life.

The fourth stage is *evaluating the effectiveness of the* tasks and involves identifying and amplifying exceptions derived from tasks that were given in the previous session (de Shazer, 1994; Guterman, 2006; Molnar & de Shazer, 1987; Walter & Peller, 1993). The fifth stage, *reevaluating the problem and goal,* involves clients and therapists assessing the degree to which the exceptions derived from tasks amount to goal attainment.

Empirical Studies

An increasing number of empirical studies have addressed solution-focused therapy applications to alcohol problems (e.g., Berg & Miller, 1992; de Shazer & Isebaert, 2003; Guterman 2006; Juhnke & Coker, 1997; Polk, 1996). Berg and Miller (1992) provided a case example involving a 36-year-old alcoholic husband and his wife. The husband promised his wife that he would stop drinking, although he really did not think he had a drinking problem. However, each time he relapsed into drinking, he developed feelings of guilt. After the counselor listened to the client's brief descriptions of the complaint, he began to explore with the client the times when he did not drink and the differences in his behavior during those times. The client agreed that there were times when drinking was not a problem and that he and his family benefited from such times.

The counselor utilized those healthy periods when drinking was not a problem and helped the client to recognize what was already in existence but unrecognized by the couple due to the problem. Therefore, the counselor was able to redirect the focus away from pathology and towards health. Capitalizing on such periods as healthy patterns should lead to solutions. The very basis of a solution-focused approach was focusing on the fact that healthy patterns lead to the belief that clients, rather than counselors, have

the answers to their problems. In solution-focused therapy, the simplest and most straightforward means to an end was preferred (Berg & Miller, 1992).

The case described above exemplifies a solution-focus because the therapist was able to capitalize on the client's healthy periods in their lives as opposed to their problems. The discrepancies in the client's life produced the answers to his problems because he was able to recognize what was already in existence, but due to their problems, solutions were unrecognizable. These exceptions led to the client's awareness and to the production of a solution to their problems.

Guterman (2006) using the solution-focused counseling model reported a similar case involving work with a client recovering from substance abuse. The case involved an African-American married male who was ordered by his supervisor to get counseling when a random urine test returned positive for marijuana. During the first session he denied having a problem with marijuana or any other drugs. He reported that he went to work, gave a urine sample which came back positive for marijuana, and was sent to seek treatment. However, he stated that he smokes weed only occasionally, approximately once a week or even less. During the second session, however, the client acknowledged that he had minimized his marijuana use during the first session. He admitted that he had a problem with marijuana use. He stated that he had been smoking weed daily ever since age 26, but did not want to tell the counselor. He considered this was all right since he had actually already spent one week without using. In his attempt to help the client, Guterman (2006) recounts how he shifted his strategy to a working relationship with the client.

> In hopes of maintaining a cooperative relationship, I accepted the client's having been dishonest with me during the first session and reinforced his leveling with me during the second session. I created a context where it is acceptable to lie and then to tell the truth about having lied. I forgave him. By shifting to a discussion about the task that was given at the end of the first session, I attempted to show the client that we could move forward. (p. 91)

The ensuing treatment was organized around identifying and amplifying exceptions to the problem, including times when the client was able to resist using marijuana and times when he was able to espouse more constructive behaviors that were incompatible with addictive behavior. By the fourth session the client reported that he understood how marijuana had been a significant problem in his life and, moreover, that he was better off without it. He stated that although it was difficult to keep his mind off his urges to use marijuana, it was becoming easier. After the sixth session, Guterman (2006) informed the client that he was no longer required to continue counseling as he had made sufficient progress and the treatment was no longer mandated. Guterman (2006) noted, however, that the client stated that he wanted to continue treatment to insure that he maintained his gains and to work on other issues in his life.

This case exemplifies a strength-based approach because Guterman (2006), acting on the principles of the solution-focused approach, was able to join with the client and thereby establish rapport. Also, through therapeutic conversation, Guterman (2006) identified and amplified exceptions to when the client's problem was not influential in his life. By internalizing positive qualities, a unique redescription of himself and a new direction was made possible for the client.

Social-Psychological Model

Theory and Practice

The social-psychological model of addiction emphasizes a person's emotional state and his or her relationship to his or her surroundings (Peele & Brodsky, 1975). In the social-psychological approach, Peele & Brodsky try to make sense out of people's experience by asking what people are like, what in their thinking and feeling underlies their behavior, how they come to be as they are, and what pressures from the environment they currently face.

The problem is conceptualized when an addiction exists and a person's attachment to a sensation is such as to lessen his appreciation of and ability to deal with other things in his environment, or in him, so that he has become increasingly dependent on that experience as his only source of gratification. A person will be predisposed to addiction to alcohol to the extent that he cannot establish a meaningful relationship to his environment as a whole and thus cannot develop a fully elaborate life. An individual's susceptibility grows with each new exposure to the addictive object, in this case alcohol.

Peele and Brodsky (1975) go on to say that their analysis of addiction starts with the addict's low opinion of himself and his lack of genuine involvement in life, and they examine how this malaise progresses into the deepening spiral which is at the center of the psychology of addiction. Addiction is marked by an intensity of a sensation and primarily its intoxicating effects.

From this perspective, the change process, or the antithesis of addiction to alcohol and recovery, is that of achievement motivation. The motivation to achieve refers to a

person's positive desire to pursue a task, the satisfaction he gets from successfully completing it, and a desire to change.

Using a social-psychological approach, a counselor would try to make sense out of people's experience by asking them questions about what they are like, what in their thinking and feeling underlies their behavior, how they have come to be as they are, and what pressures from the environment they currently face (Peele & Brodsky, 1975). Peele (2004) gives six principles to use: (a) the belief that you can change is the key to change, (b) the type of treatment or technique is less critical than the individual's motivation to change, (c) brief treatment or techniques can change longstanding habits, (d) life skills can be the key to licking addiction, (e) repeated efforts are critical for change, and (f) improvement, without abstinence counts, and all improvement should be accepted and rewarded.

Empirical Study

Sanchez-Craig, Annis, Bernet and MacDonald (1984) conducted a study aimed at evaluating the social-psychological model. One group was told to abstain from drinking while a second group was asked to attempt to control their drinking. The controlled drinking group was administered the social-psychological techniques (Peele & Brodsky, 1975) along with Peele's (2004) six principles. The results of this study, at six months, 12 months, 18 months, and 24 months, were that although there was a significant reduction in drinking between both groups, there was not a significant difference in abstinence between the groups. What was seen were people in action working through in their minds what was going to work for them and what was going to be the best benefit to them. The findings suggest that the key ingredient to making recovery work was the person's motivation to really wanting to do something to change. Sanchez-Craig, et al., (1984)

asserted that we need to know more about what people are feeling and experiencing with regard to recovery from alcoholism.

Gerard and Saenger (1966) state that in most cases recovery from alcoholism results from a change in the alcoholic's attitude, which takes place outside of any clinical interactions. Peele (2006) states that it takes no secret potions or mechanisms aside from rearranging whole areas of one's life and parts of all aspects of that life for the curing of addiction. Therefore, anything, which enhances life, can serve to combat addiction. Other activities or life skills must be found to replace the old focus on alcohol and on the recovery process. Hence, empowerment and reinforcement, as opposed to humiliation or coercion, will help in the process of recovery (Peele, 2006). If counselors want success for their clients, they must place the responsibility of recovery squarely on the clients, and it is possible that positive events may jumpstart change (Peele, 2004), as did happen in the case of Sanchez-Craig et al. (1984).

Summary

While the previously cited research literature on the alcoholic with marriage and family problems has provided some insight into the circumstances which take place or may take place prior to or during the recovery process, they are limited if one wants to determine the nature of sobriety as a separate entity and as experienced by both the alcoholic and the spouse or significant other. Most of the previous studies suggest the need to look further into the recovery process as experienced by the marital couple or people that are cohabitating (e.g., Berg & Miller, 1992; Guterman, 2006; & Sanchez-Craig et al., 1984). It is important to consider that the most important significant others in a person's life may not be the most obvious ones; it may not be the spouse, but rather a person of the same sex or an adult's parent or grandparent, child, or best friend. Not only

do these people have important contributions to offer in the recovery process, but creating an accurate picture of the individual's relational functioning and involving them is often an important aspect of the overall process as well (Walden & Slesnick, 1998). The studies and cases presented in this chapter exemplify strength-based approaches to alcohol and addiction treatment. These models hold promise for the field of addiction and recovery, which is presently organized by a host of pathologizing models.

Chapter III is a thorough presentation of the methodology to be used in this phenomenological inquiry of the storied experiences of couples during the first six months of recovery from alcohol.

CHAPTER THREE

METHODOLOGY

Overview

This chapter provides the methodology used in this study. A qualitative phenomenological inquiry sought to describe the essence or central underlying meaning of the experiences of people with alcohol problems and their non-using spouses or significant others during the first six months of the recovery process. The forms of data that were collected in this inquiry will encompass written and recorded interviews, using audiotape equipment and verbatim transcripts of conversations with the participants.

Cresswell (1998) recommended that all collected material be read in order "to obtain a sense of the overall data" (p. 140). The raw data was transcribed verbatim for each participant. These transcriptions were subjected to phenomenological analysis using the methodology developed by Colaizzi (1978). The procedural steps included all the participants' descriptions, significant statements, and meanings that were formulated (Colaizzi, 1978). Clusters of themes were organized from the aggregate formulated meanings; these themes were examined, and exhaustive descriptions of the phenomenon (Colaizzi, 1978) were produced by the integration of the results of the analysis (Colaizzi, 1978). The chapter also reviewed the phenomenological research design, the paradigm, and method of inquiry along with the questions asked of the participants. The description of Colaizzi's (1978) procedural steps was provided in detail along with the method and selection of participant samples. Data generation and treatment were discussed as well as rigor and trustworthiness of the study. Ethical considerations were presented. Munhall (1988) noted that qualitative research has a moral as well as a knowledge-generating

activity. The method of journaling was discussed in order to show how the researcher could separate his beliefs and assumptions from the inquiry (Colaizzi, 1978).

Phenomenological Research Design

Streubert and Carpenter (1995) asserted that the tradition of using qualitative methods to study human phenomena is grounded in the social sciences and grew out of a need to understand that parts of the human system were not amenable to study through quantitative measurements. Qualitative research calls for a recognition of patterns in phenomena rather than the explication of facts that will be controlled and generalized.

The information provided through a qualitative methodological research design gave a solid empirical ground for the discovery and creation of themes and the generation of a theory or hypothesis, which would in turn; serve as a basis for further research. The phenomenological method will provide the guidelines, which would minimize the use of prestudy expectations, hypotheses, and theoretical assumptions, and it will maximize the ability of the researcher to gain access to the human experiences under investigation.

The narrative theoretical approach used (White, 1995, 2000; White & Epston, 1990), was a useful framework for describing the lived experiences through the client as a "storyteller." In turn, the researcher can describe these experiences and is able to analyze and conceptualize them into workable, describable themes, theories, and hypotheses. This postmodern model emphasizes the importance of language and a collaborative approach to working with clients (Anderson & Goolishian, 1988; de Shazer, 1991; White & Epston, 1990).

Munhall and Oiler (1986) postulate that there are key concepts in the languages of phenomenological philosophy that heightens a comprehension of the qualitative style of studying the world. Phenomenological themes of consciousness (man's or woman's

presence in the world) and modes of awareness (man's or woman's expression of consciousness) assist in the understanding of the paradigm and ways of knowing. Lived experience of the world of everyday life is the central focus of phenomenological inquiry, and the goal of phenomenology is to describe this experience.

As Merleau-Ponty (1962) explains, the lived experience is reality, and this experience is the focus of attention in phenomenology rather than the process of experiencing. Because the purpose of phenomenological inquiry is to describe and illuminate the meanings of human experience (Hoshmand, 1989), and identification of the essence of behavior that is based on meditative thought (Field & Moorse, 1985), this theoretical framework is applicable to the specific topic of study as outlined in this study. The objective of this phenomenological inquiry is to describe the experiences of people with alcohol problems and their non-using spouses or significant others during the first six months of the recovery process, and also to provide an understanding of the experiences.

The intention of the researcher is to inform clinicians, mental health professionals, therapists, and marriage and family counselors who treat people with alcohol problems, and also to promote the acknowledgment of the recovery process as a legitimate area of concern and study in the field of drug and alcohol rehabilitation. In general, the research is for the public at large as well as for all professionals in related fields.

To investigate human experience objectively implies that the method for the objective investigation of human experience cannot be the experimental method. It must be a method, which neither denies experience nor denigrates it or transforms it into operationally defined behavior; it must be, in short, a method that remains with human experiences as they are experienced and which tries to sustain contact with experiences as

it is given. This can be achieved only by the phenomenological method of description as it has been articulated by the germinal phenomenologist Martin Heidegger (1962): "to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (p. 58).

Reality and Experience

According to Hoshmand (1989), paradigms are regarded as having as much perspective as descriptive power. They may be defined as systems of inquiry with their particular epistemological and ideological foundations, conceptual assumptions, and methodological standards and procedures. Valle and Halling (1989) state that research methods are plans used in the pursuit of knowledge. They are outlines of investigative journeys, laying out previously developed paths, which, if followed by researchers, are supposed to lead to valid knowledge. They go on to say that experience, as it is directly given, occurs at the meaning of person and world. Experience is a reality that results from the openness of human awareness to the world, and it cannot be reduced to either the sphere of the mental or the sphere of the physical. Spiegelberg (1965) remarked that phenomenological method investigates subjective phenomena in the belief that essential truths about reality are grounded in the lived experience. What is important is the experience as it is presented, not what anyone thinks or says about it. Shutz (1970) described the world of everyday life as the "total sphere of experiences of an individual which is circumscribed by the objects, people, and events encountered in the pursuit of the pragmatic objectives of living" (p.320). In other words, it is the lived experience that presents to the individual as what is true or real in his or her life. Further, it is this lived experience that gives meaning to each individual's perception of a particular phenomenon and is influenced by everything internal and external to the individual

(Streubert & Carpenter, 1995). Cresswell (1998) states that qualitative research studies things in their natural setting, attempting to make sense of or interpret phenomena in terms of meanings people bring to them. He continues to say that qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem.

The narrative approach is a postmodern theory that emphasizes the problem-saturated stories of people's lives. This model, which is being used in the interviewing process of the research, suggests that experiences are mapped into stories that constitute reality, and these stories are constructed through language and are influenced by unique life situations. Lou Holtz (as cited in Hoyt, 1994) stated that he never learns anything by talking but only by asking questions. Knowledge is arrived at through an inductive process, leading from specific observations to the identification of general patterns (Patton, 1990). Cresswell (1998) emphasizes a "complex, holistic picture," a reference to a complex narrative that takes the reader into the multiple dimensions of a problem or issue and displays it in all of its complexity (p. 15). As per Merriam (2002), a central characteristic of qualitative research is that individuals construct reality in interactions with their social worlds; therefore, constructionism underlies the basic qualitative inquiry. Also, a phenomenological study seeks understanding about the essence and underlying structure of the phenomenon.

Qualitative research is interested in how meaning is constructed, how people make sense of their lives and their worlds. The primary goal of a basic qualitative inquiry is to uncover and interpret these meanings. The inquiry aims to interpret the phenomena through the lens of narrative theory, which uses the stories people tell to understand the meaning of the experiences as revealed by the storyteller (Merriam, 2002). Heidegger

(1962) states: "The question of existence never gets straightened out except through existing itself" (p. 33). According to Colaizzi (1978), experience is objectively real, not an internal state, but a mode of presence to the world, a mode of world presence that is existentially significant and is a legitimate and necessary content for understanding human behavior.

May (1994) suggests that knowledge is not completely shaped or defined by the process that created it. Based on her ideas about knowing, she gave credibility to what she called magic, which is similar to the intuitive connections discussed in Benner's (1984) work on expert clinical judgment. Based on her conversations with and observations of qualitative research, May (1994) stated that, at a certain point, pattern recognition creates the insight into the phenomenon under study. She believed that the ability to see knowledge is a result of intellectual rigor and readiness (magic). She provided a validation for knowing other than in the empirical sense. Knowledge is generated from either an inductive or deductive posture. Inductive reasoning is a process that starts with the details of the experience and moves to a more general picture of the phenomenon of interest (Liehr & Smith, 2002). Therefore, qualitative research is inductive.

Exhaustive Descriptions

In a study by Riemen (1986), he formulates meaning statements from significant statements, presents them in tables, and advances the exhaustive descriptions for the essence of the experience. Denzin (1989) talks about the importance of using "thick description" in writing qualitative quantitative research. By this, he means that the narrative "presents detail, context, emotion, and the webs of social relationships, and evokes emotionality and self-feelings . . . the voices, feelings, actions, and meanings of

interacting individuals are heard" (p. 83). Wolcott (1994) states that the quotes in the narratives provide a vivid picture, and these pictures in turn produce thick descriptions of the details given in the process of the interviewing of each of the participants. Reinharz (1983) refers to an exhaustive description as an intent to synthesize and capture the meaning of the experience into written form without distortion or loss of richness of the data. In other words, the exhaustive description of quality of life would reveal the richness of the experience identified from the very beginning of the investigation as perceived by the individual. Patton (2002) pointed out that qualitative data are observations that yield detailed, thick description, inquiry in depth, interviews that capture direct quotations about people's personal perspectives and experiences.

Experimental versus Experience

Wilhelm Wundt gave birth to scientific psychology and baptized it with the experimental method (Colaizzi, 1978). Since then, scientific psychology has proceeded with perfect assurance that it, like any other science, which is to be deemed legitimate, is named experimental (Colaizzi, 1978). Colaizzi (1978) asserts that human experience was eliminated from psychological methodology since the very inception of scientific psychology. He goes on to state that the experimental psychologist forcefully achieves this elimination of human experience, both in the penchant for operational definitions and conception of objectivity. Empirical scientists believe that the study of any phenomena must be devoid of subjectivity (Namenwirth, 1986). Also, they contend that objectivity is essential in guiding the way to truth. However, the problem with this position is that no human activity can be performed without subjectivity. Since empirical science is a human quest for knowledge, it is logical to presume that human activity will be necessary to seek this knowledge.

Phillips (1987) believes that objectivity is impossible. Based on his reading and interpretation of Hanson, he stated, “The theory, hypothesis, framework, or background knowledge held by an investigator can strongly influence what he sees” (p. 9). Kerlinger (1979) said, “ the procedures of science are objective and not the scientists. Scientists, like all men and women, are opinionated, dogmatic, and ideological” (p. 264). Therefore, the idea of objectivity loses its meaning.

Laine (1967) asserts that our experience is not inside us, but instead our experience is always of how we behave toward the world and act toward others. Colaizzi (1978) states that experience is always already out in the world. Therefore, to believe that one’s experience does not count amounts to believing that one’s existence does not count. However, as long as one is alive, existence counts. Streubert and Carpenter (1995) note that human scientists value the subjective component of the quest for knowledge. They embrace the idea of subjectivity in the recognition that human beings are incapable of total objectivity because they have been situated in a reality, which is constructed by subjective experiences. Meaning, and therefore the search for truth, is possible only through social interaction. Constructivist human scientists believe that “knowledge is the result of a dialogical process between the self-understanding person and that which is encountered, whether a text, a work of art, or the meaningful expression of another person” (Smith, 1990, p. 177). This leaves the researcher in the unenviable position of spelling out the characteristics of qualitative research method and procedures, hoping that it will form into a general understanding of the phenomenological methodology.

Characteristics of Qualitative Research

Denzin and Lincoln (1998) define qualitative research as being multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials: personal experience, introspective, life story, interview, observational, interactional, and visual texts that describe routine and problematic moments and meanings in individuals' lives. Cresswell (1998) relies less on sources of information, but he conveys similar ideas: Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting.

Streubert and Carpenter (1995) emphasize six significant characteristics in qualitative research: (a) belief in multiple realities, (b) a commitment to identifying an approach to understanding that will support the phenomenon studied, (c) commitment to the participant's point of view, (d) conduct of inquiry in a way that does not disturb the natural context of the phenomena of interest, (e) acknowledged participation of the researcher in the research, and (f) conveyance of the understanding of the phenomena by reporting in a literary style rich with participants' commentary.

Finally, it is essential that all the participants experience the phenomenon being studied. Miles and Huberman (1994) describe this process as *theory based*, which means that the investigator examines the individuals who can contribute to the evolving theory, and then selects and studies a heterogeneous sample.

Bracketing

According to Speziale and Carpenter (2003), phenomenological researchers must first identify any preconceived notions or ideas about the phenomenon under investigation. Having identified these ideas, the researcher must bracket or separate out of consciousness what they know or believe about the topic under investigation. This is known as bracketing, and it requires researchers to remain neutral with respect to belief or disbelief in the existence of the phenomenon.

According to Stewart and Mickunas (1990), researchers have to set aside all prejudgments by bracketing their experiences and relying on intuition, imagination, and universal structures to obtain a picture of the experience. They also stated that phenomenology's approach is to suspend all judgments about what is real—the "natural attitude"—until they are founded on a more certain basis. Stewart and Mickunas (1990) state that Husserl termed this suspension *epoch.* According to Streubert and Carpenter (1995), once the thoughts, feelings, and perceptions about the phenomena are revealed, it is recommended that they be bracketed. Streubert and Carpenter (1995) go on to say that bracketing is the cognitive process of putting aside one's own beliefs, not making judgments about what is observed or heard, and remaining open to data as they are revealed. Also, in qualitative studies, this activity is usually carried out before the beginning of the study and is repeated throughout data collection and analysis. By doing this, researchers are able to keep their personal thoughts and feelings in check and remain cognizant of when data collection and analysis reflect their own personal beliefs rather than the informant's beliefs. As per Speziale and Carpenter (2003), bracketing requires researchers to remain neutral with respect to belief or disbelief in the existence of the phenomena. Also, bracketing begins the deductive process and, like that process, must

continue throughout the investigation. Further, bracketing must be constant and ongoing if descriptions are to achieve their purest form. However, Haggman-Laitila (1999) holds the position that researchers cannot detach from their own views and offers practical aspects to help in overcoming the researcher's views during data gathering and analysis.

Having a second researcher review the data and verify categories can also serve as a validity check. According to Ramos (1989), the investigator, even with the validation of inferences afforded by the relationship with the respondent, imposes his or her logic and values onto the communicated reality of the respondent. He or she imposes his or her subjective reality upon the interpretation of meaning data from the respondent. The researcher cannot extract correct meanings unilaterally. Without the validation afforded by member checking, a leap in logic could occur, and a serious misinterpretation of sensitive information can occur.

Haggman-Laitila (1999) expands on the discussion of authenticity of data and overcoming the researcher's personal views. Haggman-Laitila (1999) bases a discussion of data collection and analysis on the assumption that the researcher cannot detach from his or her own view in phenomenological research. He goes on to state that the researcher is able to understand the experiences of an individual only through the researchers own view. The research process, he states, is a "balanced cooperative relationship between the subjects and the researcher" (Haggmen-Laitila, 1999, p. 13). Haggman-Laitila (1999) suggests that researchers keep a diary to facilitate recognition of the researcher's own views during the data analysis process, plan key interview questions in advance, keep interviews open and discussion-like, verify interpretations by asking more questions and allowing additions and corrections. Also, avoid rhetorical or leading questions, write down questions that emerge during the reading of the data, compare researcher and

participant views, reexamine all experiences, and be sure that the presentation of findings is based on the views expressed by the participants.

Qualitative Research

The key to understanding qualitative research according to Merriam (2002) lies with the idea that individuals in interaction with their world socially construct meaning. The world, or reality, is not a fixed, single, agreed-upon, or measurable phenomenon. There are multiple constructions and interpretations of reality that are in flux and that change over time. Qualitative researchers are interested in understanding what those interpretations are at a particular point in time and in a particular context. Merriam (2002) further states that learning how individuals experience and interact with their social world, and the meaning it has for them is considered an interpretive qualitative approach. On the other hand, according to the postmodern stance, researchers question all aspects of the construction of reality, what it is and what it is not, how it is organized, and so on (Merriam, 2002).

The first characteristic in qualitative research is that researchers strive to understand the meaning people have constructed about their world and experiences; that is, how do people make sense of their experience? As Patton (1985, p.1) explains qualitative research:

> is an effort to understand situations in their uniqueness as part of a particular context and the interactions there. This understanding is an end in itself so that it is not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting--what it means for participants to be in that setting, what their lives are like, what is going on for them, what their meanings

are, what the world looks like in that particular setting . . . the analysis strives for depth of understanding.

A second characteristic of all forms of qualitative research is that the researcher is the primary instrument for data collection and data analysis. Since understanding is the goal of this research, the human instrument, which is able to be immediately responsive and adaptive, would seem to be the ideal means of collecting and analyzing data. Other advantages are that the researcher can expand his or her understanding through nonverbal as well as verbal communication, process information (data) immediately, clarify and summarize material, check with respondents for accuracy of interpretation, and explore unusual or unanticipated responses (Merriam, 2002).

Husserl (1931) held that knowledge of the structures of consciousness was not a matter of induction or generalization from a sample but was the result of a direct grasp of eidetic seeing. He states that it takes only one instance (even an imaginary one) to grasp or see (not in the sense of visual sighting but of apprehending) the principle and inner necessities of a structure. In practice, the process lending to grasping the essential pattern of a structure usually requires a careful working through and imaginative resting of various descriptions of an essence, until the essential elements and their relationship are differentiated from the unessential and particular.

In qualitative study, the literature review is conducted after the research has been completed and data analyzed. The purpose of reviewing the literature in a qualitative study is to place the findings in the context of what is already known. The key of qualitative research is not prediction and control but rather description and understanding (Streubert & Carpenter, 1995). Interviews, observations, and documents are the three traditional sources of data in a qualitative research study (Merriam, 2002). Merriam states

that even though there is no standard form for reporting qualitative research, what does need to be considered is the audience for the report and to adequately and convincingly present the study's findings.

Writing of the Lived Experience

Phenomenological research is descriptive (Ihde & Silverman, 1985) and qualitative (Bogdan & Taylor, 1975; Schwartz & Jacobs, 1979), but it has, in addition, a special realm of inquiry–the structures that produce meaning in consciousness. Simple identification of phenomenological research with descriptive or qualitative research overlooks the important differences between phenomenology and the other sciences that use descriptions and natural language data.

Although phenomenological research is sometimes identified with other descriptive and qualitative approaches, it differs from them because its focus is on the subject's experienced meaning instead of on descriptions of their overt actions or behavior (Valle & Halling, 1989). Phenomenology maintains the critical distinction between what presents itself as part of a person's awareness and what might exist as a reality outside of our experience (Valle & Halling, 1989). From the qualitative perspective, the richness and profundity of human reality is seen as closely related to the structures and meanings of natural language; therefore, qualitative is identified with a commitment to the logic of natural language as the preferred form of understanding human affairs (Valle & Halling, 1989). Qualitative research uses natural language descriptions (for example, unstructured interviews) for its data and usually presents the written results in natural language (Valle & Halling, 1989).

One of the most difficult aspects of the data-analysis process to explain is the transformation of a meaning unit, which is given in a subject's everyday language, into a

statement using psychological terms to describe the phenomenon being investigated (Valle & Halling, 1989). The phenomenological psychologists generally use the language of common sense enlightened by a phenomenological perspective for their redescriptions (Valle & Halling, 1989). An adequate transformation should not be simply an idiosyncratic process in which the results are unique to the particular researcher producing the redescription. They must be publicly verifiable so that other researchers will agree that the transformed expression does describe a psychological process that is, in fact, contained in the original expression (Valle & Halling, 1989). Giorgi (1985) reports that when different individuals and the results carry out the transformation on the same protocol is compared, the degree of "intersubjective agreement is surprisingly high" (p. 73).

Synthesis involves tying together and integrating the list of transformed meaning units into a consistent and systematic general description of the psychological structure of the experience under investigation (Valle & Halling, 1989). Most phenomenological researchers have been interested in investigating the presence of meaning in experience. In experience, events appear as meaningful, both the appearance of worldly objects and happenings and our own thoughts and feelings. Although experience is meaningfully ordered, the structure and order of meaning are difficult to describe. The purpose of phenomenological research is to produce clear, precise, and systematic descriptions of the meaning that constitute the activity of consciousness (Valle & Halling, 1989).

The descriptions provide specific instances from which the researcher can tease out the structure of consciousness that constitutes the experience. Phenomenologists need reports of the experience as it actually appears in a person's consciousness (Valle & Halling, 1989). These reports are different from common sense descriptions that are

aimed at depicting things or happenings, as they exist independently of a person's experience of them; therefore, the production of phenomenological protocols requires that subjects' awareness be redirected toward their own experiencing (Valle & Halling, 1989).

The way the researcher frames questions can help subjects to report their experiences rather than to give wordy depictions. Therefore, as the researcher interviews the participants about their experiences of the phenomenon of the experiences of people with alcohol problems and their non-using spouses or significant others during the first six months of the recovery process, he or she will remain close to the experience as the participants lived it in a concrete way (Van Manen, 1990). The researcher will ask participants to think of specific events or situations associated with the phenomenon and will explore these experiences to their fullest (Van Manen, 1990). Some of the basic interview questions (Appendix E) this researcher asked the participants are as follows:

1. What have been some of the effects of recovery on your relationship?
2. What major obstacles that prohibited from what you want make recovery difficult?
3. What are some of the ways you have been effectively dealing with recovery?
4. What contributed to your being in recovery?
5. What actions have you taken in order to reclaim the effects alcohol has had in your relationship and life at home?
6. What events have led to or stopped you from relapse?
7. How have your expectations of recovery and your relationship being home been met?

8. What are some of the specific situations or contexts in your life at home and in your relationship where alcohol could take advantage of you?
9. What is it you now know about recovery that can help you stand up to alcohol's influence and improve your relationship and life at home?
10. What would you like your experience to be like from now on continuing in recovery?

The participants were advised that they have the right to refuse any question or questions, stated above, they see fit. According to Patton (2002), the foundation of questioning in phenomenology is: What are the meaning, structure, and essence of the lived experience of this phenomenon by an individual or individuals? He suggests that the researcher has to gain access to the individual's life-worlds, which is his/her world of experience. Patton (2002) goes on to state that conducting in-depth interviews is a common method of gaining access to the individuals' life-worlds.

Method

This section will provide a concise and comprehensive review of the methodology for conducting this study. The selection and criteria for the recruitment and selection of participants will be described. The forms of data collection in this study will be identified and how this data will be recorded will be explained. Procedures, strategies, organization and management of the data for analysis will also be explained.

Selection of Participants

Qualitative researchers generally do not call the individuals who inform their inquiry subjects (Streubert & Carpenter, 1995). The use of the terms *participants* or *informants* illustrates the position that qualitative researchers subscribe to, which is that the individuals who take part in the research are not acted upon but rather are part of the

study (Streubert & Carpenter, 1995). They are active participants in the inquiry and help to inform with the purpose of helping the researcher to better understand their lives and social interactions (Streubert & Carpenter, 1995).

While it is usually not necessary to have a large sample size in phenomenological research, it is believed by this researcher that a condition where valid themes and concepts would be obtained could be met only when the sample size was greater than five participants. For a phenomenological study, the process of collecting information involves primarily in-depth interviews with as many as ten individuals (Cresswell, 1998). Dukes (1984) recommends studying three to ten individuals, as was investigated in Riemen's (1986) study which included ten individuals. The important point is to describe the meaning of a small number of individuals who have experienced the phenomenon (Cresswell, 1998). Cresswell states that ten individuals in a study represent a reasonable size.

In order to address the gender issue, the researcher decided that six couples (or a total of twelve participants), of which three are female recovering alcohol users and three are male recovering alcohol users, who have all experienced no less than six months in the recovery process and neither of whom have been specifically treated in individual or group counseling sessions by the researcher, would be used for this inquiry. The participants' ages ranged from 18 years to 60 years (male or female) who have experienced the phenomenon of being a person with alcohol problems and is living with a non-using spouse or significant other for at least six months of the recovery process. The participants should be able to converse in English, as Colaizzi (1978) stated that anyone who has had the experience with the phenomenon being researched and is able to communicate that experience qualifies for the selection as a participant.

To obtain participants for this study, the researcher placed flyers (Appendix F) advertising the study at AA and Al-Anon meeting centers of the Greater Miami area of Florida. The flyers included all relevant study information as well as the necessary requirements to be able to participate. Also, the flyers indicated to the potential participants that involvement in the study is voluntary and can end at any time or for any reason they may have. There was a contact number on the flyer for those interested in volunteering for the inquiry. Upon phone contact (Appendix A), an appointment was made to respond to provide the participants with questions they may have regarding the study. No information was withheld. If the volunteers agree to participate in the inquiry, an interview was scheduled to begin shortly thereafter, and consent forms (Appendix B) were signed.

The personal nature of this research results in several ethical considerations for the researcher. Issues of privacy must be considered, and the researcher must consider how to present the data accurately without revealing the identity of the participants in the study. The informed consent requires that the researcher explain to the participant all of the potential risks and benefits of his or her participation, and to obtain his or her voluntary consent to participate. According to McCracken (1988), the use of the long interview as a method allows the researcher into the lived world of the informant “to see the content and pattern of daily experiences” (p. 9). Therefore, the opportunity is given to bring to language the human experience. The researcher had a collaborative relationship with the participants, communicating the objectives of the research study, and exploring any potential risks or fears in order to ensure a total understanding of the project.

Coding

For the purpose of data analysis, the researcher grouped the statements, and each was given a code for ease of identification in the study (Streubert & Carpenter, 1995). As Bernard (1994) points out, codes can be used as an encryption, indexing, or measurement device; however, this researcher focused on using index codes to the text for retrieval and the identification of large segments of text on a specific topic. These segments then formed the basis for an in-depth analysis of the topic of inquiry. The use of linguistic cues assisted the verification readers (Ms. Elizabeth Vicens-Ortiz, M.S., and Father Jude Nwabugwu, M.S.) to correctly apply the codes. This will reduce the potential for misinterpretation and omission of relevant information (Bernard, 1994).

In order to facilitate the qualitative analysis of the open-ended responses, the number of codes to be used will be limited. This will be done by collapsing code categories together through data transformations performed on the matrix. The final code categories were built into the coding process through the use of hierarchical codes and code families (Bernard, 1994). When the coding was complete, the two verification readers were given the task of independently coding the same sample of text. The results will be compared for consistency of text segmentation and code application. After this, the coding continues with periodic checks for continued inter-verification reader agreement (Bernard, 1994).

Data Collection

The forms of data collected in this inquiry encompassed written and recorded interviews, utilizing audiotape equipment, and verbatim transcripts of conversations. Exclusively the researcher conducted all interviews. The option to meet with the recovering person and his or her spouse or significant other in separate sessions was

provided to all the participants; however, all of the interviews may have been conducted with both participants present. All interviews were tape recorded, and the questions were be open-ended in order to explore the meaning of people recovering from alcohol and the experiences of their non-using spouses or significant others, and also to elicit a description of their lived experiences. The researcher submitted to Barry University's Institutional Review Board a copy of the consent form authorized by the Barry University Human Participants Protocol form (Appendix G).

Handwritten field notes were used during direct observation in the session. These notes reflected the experiences of the person with alcohol problems and his or her non-using spouse or significant other during the first six months of the recovery process and the researcher's reflections during the research process. The researcher utilized the audio recording equipment during all of the interview sessions in their entirety. The researcher utilized a personal field diary, recording aspects of the process during the entire project. The handwritten field notes reflect observed behavior and the researcher's own reflections during the research process. Field notes are summarized and verbatim transcripts of conversations were completed. Cresswell (1998) recommends that all collected material be read in order "to obtain a sense of the overall data" (p. 140).

The interviews were approximately 90 minutes in length for each participant, and a 60-minute follow-up interview (within six weeks) for transcript verification. Patton (2002) stated that thick descriptions might be obtained from in-depth interviews that capture direct quotations about people's personal perspectives and experiences. The researcher-conducted interviews with twelve participants, and a narrative format was used, augmented by tables and figures of statements and meanings units to reflect

findings and conclusions. No information in the transcriptions identified any of the participants or link the data to their names.

The transcribed interviews were nonlinked. This means that there is no information identifying the participants linking them to the data or to the names in any way. The individuals' interviews were conducted at a location convenient and comfortable for them. This researcher completed the Barry University Human Participants Protocol form, and submitted to the Barry University Institutional Review Board (IRB) copies of the consent form and questions designed were used for the interviews. This was done in order for the IRB to be certain that the rights of human participants were safeguarded.

Data Management and Analysis

A methodology as developed by Paul F. Colaizzi's (1978, p. 59) specific procedural steps was used as follows:

1. All the subject's descriptions were read in order to acquire a feeling for them, and a sense of the person's experience (Colaizzi, 1978, p. 59). The researcher then recorded any thoughts, feelings, or ideas he had as part of the bracketing and reflective process (Thorne, 2000).
2. Significant statements were then extracted from each of the descriptions, phrases, and sentences that directly pertain to the investigated phenomenon (Colaizzi, 1978). A listing of the highlighted statements, which was provided from the transcripts and statements, which contain the same, or nearly the same statements, were eliminated. Themes were identified early on from the data, and ongoing reflective process will continue to be recorded in the journal.

3. Meaning was formulated by researcher reflection and interpretation of each significant statement (Colaizzi, 1978). In this step, the researcher arrived at a meaning for each significant statement, and the meanings arrived at must not sever the connection with the original description (Colaizzi, 1978). The researcher's formulations must discover and bring out those meanings hidden in the various contexts of the phenomenon that are present in the original descriptions (Colaizzi, 1978). The researcher documented the meanings and themes concerning the experiences as to their revelations. Also, the researcher's thoughts and feelings were entered in the journal.
4. These meanings and themes were the organized into clusters of themes from the aggregate formulated meanings. This allowed for the emergence of themes common to all of the participants' descriptions (Colaizzi, 1978). These clusters of themes were referred back to the original descriptions in order to validate them. This is done to see if there is anything in the original description that was not accounted for in the cluster of themes, and whether the cluster proposed anything, which was not in the original description. If either of the above is true, a reexamination is necessary (Colaizzi, 1978). At this time, discrepancies may be noted among and/or between the various clusters; some themes may flatly contradict other ones or may appear to be totally unrelated to other ones. This researcher then proceeded with the solid conviction that what was logically inexplicable might be existentially real and valid (Colaizzi, 1978).
5. As a result, an exhaustive description of all the themes and ideas of the phenomenon were integrated into a narrative account of the lived experience

from the perspective of the participants. Sanders (2003) stated that the exhaustive description can be achieved by "incorporating the formulated meanings and theme clusters into the descriptions to create an overall structure" (p. 299). Cresswell (1998) also said that the narrative produced will have a textual component of what the descriptions of the experience were and a structural component of how it was experienced.

6. After the lengthy narrative, an exhaustive description of the phenomenon resulted from the statement of the essential structure of the phenomenon as possible (Colaizzi, 1978, p. 61).
7. The descriptions of the experiences were validated, as this researcher reinterviewed each of the participants. Each of the participants was asked to compare the descriptive results with their experiences and if anything was left out of the description (Colaizzi, 1978). New data that comes from these interviews will be incorporated into the narrative (Colaizzi, 1978). Cresswell (1998) states that the end results of the study should provide a better understanding of essence of the experience of people with alcohol problems and their non-using spouses or significant others during the first six months of the recovery process. Participants' problems exist in and are mediated through the language used to frame their experiences (Lax, 1992).

Rights of the Participants

The personal nature of this research results in several ethical considerations for the researcher. Issues of privacy and confidentiality were considered, and the researcher has presented the data accurately without revealing the identity of the participants in the research. The informed consent forms, codebook, and audiotapes are placed in a locked

file cabinet at the researcher's office. Descriptions of any potential risks and/or benefits of participating were discussed with the participants. Streubert and Carpenter (1995) explained the concept of "process consent" (p. 309) originally recommended by Munhall and Oiler (1986) that allows the researcher to renegotiate the consent as unforeseen events or consequences arise. This is very attractive to this researcher, as the opportunity to renegotiate consent and be a part of the decision-making process affords participants the chance to withdraw or modify their initial agreement, and at the same time allows the researcher more freedom in dealing with situations that are unplanned. The informed consent and permission to use recording devices were obtained on the first interview. Audiotapes were destroyed immediately after transcribing is complete. Consent forms, notes and transcripts will be retained for a period of five years. In order that verification of results based on the data may take place, original data will be allowed to be reviewed through nonlinked transcribed interviews. The researcher explained thoroughly how confidentiality will be maintained, and the researcher informed the participants how they may contact him after the research is completed. The researcher will have a collaborative relationship with the participants and communicate the objectives of the research and explore any potential fears in order to ensure a total understanding of the research.

Validity, Rigor, and Trustworthiness

Concerning validity in the research process of the phenomenological paradigm, Hoshmand (1989) contends that the use of "imaginative variations as an analytic procedure allows the researcher to test the presence and tenacity of emergent findings in the forms of figures against shifting grounds" (p. 29). The use of multipersonal observations further supports the meaningfulness of the findings.

Mishler (1986) concludes that the narrative research relies on procedural details to evoke acceptance of their trustworthiness. Streubert and Carpenter (1995) suggest that the researcher questions the participants as to whether the exhaustive description accurately reflects their experiences and incorporates additions or deletions into a revised description. This also ensures the trustworthiness of the data analyzed.

Lincoln and Guba (1985) stated that the phenomenological researcher will lay an "audit trail" (p. 39) to allow for evaluation of methodology and replication of findings. To lay an audit trail, the researcher kept accurate records of all the raw data generated, methods of generation of data, and the research process. The researcher was willing to explain methods of interpretation and presentation of actual samples of original descriptive data for review, as this further allows for the evaluation of methodology and ensures authenticity (Hoshmand, 1989).

In order to ensure and protect trustworthiness and authenticity of the research, the researcher utilized standard qualitative checks and balances of quality criteria as outlined in constructivism (Denzin & Lincoln, 1998). The researcher presents the findings and interpretations, and questions the participants to see if they are true representations of their experiences. Also, the researcher employed Ms. Elizabeth Vicens-Ortiz, M.S., and Father Jude Nwabugwu, M.S., as reviewers and verification readers of the study, as they have experienced research and provide invaluable assistance in keeping the pattern of the research together logically (Cresswell, 1998). Both signed third party confidentiality agreements (Appendix C).

The method of peer debriefing and review was also employed. Because of the personal interest in the topic, the researcher used the concept of bracketing to consciously identify the researcher's own biases and in this way remove them in order to protect the

validity of the inquiry (Thorne, 2000). Rigor in qualitative research is demonstrated through the researcher's attention to and confirmation of information discovery (Streubert & Carpenter, 1995).

The goal of the researcher was to accurately represent what those who have been studied experience. Guba (1981) offers the following four terms to describe operational techniques, which were used in this study to support the rigor of this work: *credibility*, *dependability*, *confirmability*, and *transferability*. *Credibility* was established through prolonged engagement with the subject matter and "member checks" (p. 314). The purpose of this exercise is to have those who have lived the described experience validate that the reported findings are true (Lincoln & Guba, 1985). *Dependability* is a criterion, which will be met through obtaining credibility of the findings, as there can be no dependability without credibility (Lincoln & Guba, 1985). According to Guba (1981), dependability is related to the consistency of the findings.

Confirmability is a process criterion, which was established by the audit trail, which will illustrate the evidence, and thought processes which led to the findings (Lincoln & Guba, 1985). *Transferability* refers to the probability that the findings of this study have meaning to others in similar situations. Transferability has also been labeled fittingness. The expectation for determining whether the findings fit or are transferable rests with the potential user of the findings and not with the researcher (Greene, 1990; Lincoln & Guba, 1985; Sandelowski, 1986). As suggested by Lincoln and Guba (1985), this researcher followed these four criteria in order to allow others to judge the rigor and credibility of the findings. Ultimately, the knowledge of the experiences of the participants in the study will lead to new ways of viewing people with alcohol problems

and their non-using spouses or significant others during the first six months of the recovery process.

Limitations of the Inquiry

The limitations of this inquiry as related to generalizability and the specific literature review are due to the uniqueness of the inquiry and the number of participants in the study. The generalizability of the results may be limited by several factors evident in that the information obtained can be applicable only to people with alcohol problems and their non-using spouses or significant others during the first six months of the recovery process. However, the findings of this inquiry may not be generalizable to all populations in recovery. Also, in the desire to maintain simplicity and stay within the qualitative research design, the researcher used 12 participants and a 90-minute interview time.

While the phenomenological method considers all information obtained to be a valid representation or indication of the subjective lived world of the participants, in this inquiry the interactional process of the participants to establish a mutual relationship may be perhaps limited, due to a lack of time in getting to know each other more and limit the participants' ability to divulge more information to the researcher.

Ethical Issues

The purpose of the study was explained to all the participants who volunteered, and written consent was obtained prior to interview. Ethics approval will be obtained from the University's IRB Committee prior to data collection. Due to the sensitive nature of the research topic, careful steps were taken to protect confidentiality, especially when recruiting people with alcohol problems and their spouses or significant others from AA or Al-Anon centers in Miami. According to Richards and Schwartz (2002), information

about lifestyle and family may provide clues to participant's identity. In order to protect the participants' identities, this researcher numbered all written transcriptions, and consent forms are kept separate from all other written data. Also, the researcher informed the participants of the purpose, boundaries of the study, the method of data collection that will be used, and how the data will be stored and destroyed (Merriam, 2002). The participants were also instructed on how the findings will be used and the methods used to conceal their identities.

Punch (1994) points out "acute moral and ethical dilemmas often have to be resolved situationally, even spontaneously"(p. 84). All possibilities cannot be anticipated, nor can one's reaction. Examining the assumptions one carries into the research process, assumptions about the context, participants, data, and the dissemination of knowledge gained through the study is at least a starting point for conducting an ethical study (Merriam, 2002).

Summary

The purpose of this chapter was to present the methodology used to obtain meaningful, analyzable information reflecting human experiences of people with alcohol problems and their non-using spouses or significant others during the first six months of the recovery process. After presenting the design of the inquiry, the chapter provided a justification and description of the selection of participants. The interviewing process was defined, and the role of the researcher, including concepts and methods, was outlined. Validity, ethical considerations, data collection and data management, and analysis were also exposed, along with the limitations of the study. The quality and rigor of the inquiry were discussed, and at the end of the chapter, issues on steps that can be taken to protect the rights of the participants were addressed.

CHAPTER FOUR

FINDINGS

Overview

In this chapter, the findings resulting from the data collection and analysis are presented. The findings that resulted from the data collection are organized according to the Colaizzi (1978) method. These findings describe the storied experiences of couples during the first six months of recovery from alcohol.

The data were collected from recorded interviews utilizing audiotape equipment and verbatim transcripts of the conversations. Participants were recruited using flyers (Appendix F) advertising the study at AA and Al-Anon meeting centers of the Greater Miami area of Florida. Dukes (1984) recommend studying three to ten individuals. This researcher decided that for this study he would use six couples where one in each of the couples is in recovery from alcohol and who have all experienced no less than six months in the recovery process. Also, their significant other is a non-alcohol user. The participants' ages ranged from 18 years to 60 years. Colaizzi (1978) stated that anyone who has had experience with the phenomenon being researched and is able to communicate that experience qualifies as a participant. No demographic information was given (as was requested by the couples), in order to provide full confidentiality. Couples were assigned a number from one to six, and their gender was identified either male or female. The aim of this chapter is to provide information of the first six months of recovery, which will define the lived experiences of the couples, where one is in recovery and the other is a non-alcohol user. After pulling out the significant statements from the transcribed interviews, meanings were formulated for each of the statements described in detail in the Methods section in Chapter 3 by this researcher.

Full listings of both the significant statements and their attached meanings are provided in Appendix D (Colaizzi, 1978). The formulated meanings were organized into themes. These themes were then integrated into an exhaustive description of the phenomenon (Colaizzi, 1978). This description given is a narrative account of the lived experiences from the perspective of the couples interviewed (Cresswell, 1998). What do the couples experience and how it is experienced is integrated in their narrative account (Moustakas, 1994). This narrative account is made up of textual and structural components. Therefore, these components together make up the essential structure of the inquiry by preparing a synthesis of their experiences (Moustakas, 1994). The narrative was then reduced to a basic "statement of identification of the fundamental structure of the phenomenon" (Colaizzi, 1978, p. 61).

This researcher increased the study's trustworthiness by using member checking (Cresswell, 1998). This is a strategy, which was used to evaluate the quality of analysis by using the twelve participants of this study to comment on the analysis made of the transcripts. These comments helped in the evaluation of the assumptions of the phenomenon in question. Reader verification (Cresswell, 1998) also took place via this researcher's doctoral dissertation committee by their reviewing of the data, manner in which it was analyzed, and also data interpretations in order to verify that the descriptions of the experiences made sense. This researcher also used two Barry University colleagues Ms. Elizabeth Vicens-Ortiz, M.S., and Father Jude Nwabugwu, M.S., from the counseling Ph.D. program, who were doctoral candidates at the time, to serve as reviewers and verification readers of the study (Cresswell, 1998), as they have experienced research and provide invaluable assistance in keeping the pattern of the research together logically (Cresswell, 1998). The reviewers were considering whether

the patterns of interpretation fit together logically, and whether or not entirely different interpretations could have been made using the same data (Cresswell, 1998). The purpose of the reviews was to verify the process of collection, analysis, and the interpretation of the data. The reviewers were able to identify alternate ways in which the significant statements of some participants could be interpreted, and they also gave ideas in which some of the themes could be grouped. This process did promote a deeper reflection on these issues by the researcher. Some appropriate interpretations of the participants' significant statements were made, and the grouping of the themes in order to provide the most accurate description of their experiences. Both reviewers signed third party confidentiality agreements (Appendix C).

Reflexivity was used by this researcher, as recommended by Guba (1981) during the collection of this data. Reflexivity was used as a process to facilitate preconceived ideas and biases of the researcher and how those notions may affect the manner in which the data were being collected, analyzed, and interpreted. The method of peer debriefing and review was also employed in the research process (Lincoln & Guba, 1985), as discussed in detail in the method section of Chapter 3 (Guba, 1981). Peer debriefing provides an external check of the research process, much in the same way as interrater reliability in quantitative research. This debriefing keeps the researcher honest with the task that is at hand by asking hard questions about the methods used in the research, meaning, and interpretation (Lincoln & Guba 1985). The researcher used journal entries to document these notions. The researcher wrote down his biases to facilitate appropriate reflection in order to decrease the chance of a biased interpretation of the analysis of the data.

In order to ensure and protect trustworthiness and authenticity, the researcher utilized standards of qualitative checks and balances of quality criteria as outlined in Denzin and Lincoln (1998). The journal entries are included in this chapter and are bracketed in order to identify the researcher's own biases and in this way remove them in order to protect the validity of the inquiry (Thorne, 2000).

Themes

The main themes derived from the transcribed interviews are listed below.

Theme 1: Recovery helps relationship function better.

Theme 2: Some old friends can be a negative influence during recovery.

Theme 3: Support groups can be effective ways of coping during recovery.

Theme 4: Family support contributes to recovery.

Theme 5: Counseling can contribute to recovery.

Theme 6: Family cohesion contributes to the prevention of relapse.

Theme 7: Having an improved relationship with one's significant other will contribute to positive outcomes in recovery.

Theme 8: Stress or personal loss are triggers for relapse.

Theme 9: Recovery works.

Theme 10: Staying in recovery contributes to a satisfactory family relationship.

Exhaustive Description of Experiences of Couples During the First Six Months in Recovery from Alcohol

The researcher, from the transcribed experiences of the interviews, formulated meanings of the participant's significant statements. The formulated meanings were then organized into ten themes, which are described separately. These themes are features of participant's narratives characterizing particular experiences that the researcher saw as

relevant to the research question. The researcher identified the dominant meaning of each unit of the lived experiences of the six couples that participated in the study. This researcher sifted through each meaning unit and eliminated the non-essential ones. This researcher also classified a cluster of themes which were then put into ten core themes of the lived experiences of the couples.

The texts in brackets, which are italicized, facilitate the preconceived ideas and biases of the researcher in order to decrease the chance of a biased interpretation of the analysis of the data. Also, this is done to remove these biases and protect the validity of the study as recommended by Guba (1981). Each of the following themes will be organized with an exhaustive description.

In addition, verbatim statements from the participants as well as subjective observations and interpretations of the researcher are provided for insight and a substantiation of the themes.

Theme 1: *Recovery helps relationship function better*

The literature linking alcohol abuse and couples problems are well defined. However, couples stated that recovery helps relationships function better. This represents the participant's perceived effects of recovery on their relationship. Female, couple #1, described that an effect of recovery on their relationship as a couple is the ability to be able to be more tolerant with each other and acquire more insight into the problem with alcohol. She stated, "I have more tolerance and knowledge of the problem with alcohol." Male, couple #1, stated, "We are able to have conversations." [*I find myself reflecting upon most of the participants I interviewed and how they wanted so much for their significant others to understand the purpose of their being in recovery. Because of my own experience with family members in recovery, I will set aside this bias and listen to*

and consider more the experiences of the participant's themselves.] Murphy (2007) states that many people experiencing drug and alcohol problems often become isolated and develop negative views of themselves and others. This researcher's observation of the experiences of recovery on the couple's relationship was an increase in tolerance and communication. Prior to recovery the problems experienced by couples appeared to be a reflection of dysfunction. Familial functioning is so essential that a clinical diagnosis of alcohol abuse can be assigned to an individual who consumes enough alcohol to disrupt major role obligations in the home (American Psychological Association, 1994).

Common problems identified by couples that abuse alcohol include reports of greater dyadic disagreement and disputes (Epstein & McCrady, 2002; O'Farrell, Murphy, Neavins & Van Hutton, 2000). McCrady and Epstein (1995) state that there is greater avoidance of effective communication strategies and less effort toward working cooperatively than those strategies evidenced by non-alcohol abusing couples.

Marital relationships can be a catalyst in retaining or disrupting commitments to abstinence. Among alcohol abusing populations, marital problems have been cited as a leading cause of relapse (Epstein & McCrady, 2002). Conversely, marital and familial problems, accompanied with treatment, have also been reported to increase the alcoholic couple's chances of resuming abstinence following relapse (Maisto, Mckay, & O'Farrell, 1995). These findings together highlight the importance of considering the intimate relationship in the treatment of alcohol problems in order to facilitate long-term abstinence (recovery) (Ripley, Cunion, & Noble, 2006). This emphasizes the importance of addressing marriage and family issues in alcohol abuse treatment prior to a client's return to his or her significant other.

Theme 2: *Some old friends can be a negative influence during recovery*

Most of the participants expressed that socializing with some of their old friends would be a major obstacle to their recovery efforts, as negative influences plays a large factor in relapse. Female, couple #4, reported that "socialization with some old friends after attending the support groups was a major obstacle." [*Due to my own experiences, I find myself thinking about the times when old friends did influence me in my youth. Viewing this from my personal perspective, I realized that I did hold the assumption that old friends do influence one's behavior through the passage of time, especially the behaviors that society brands as unacceptable, such as alcohol problems. With this realization, I will be careful to reflect only in the context, which is presented by the participants and not on my own experiences.*] The learning framework emphasizes the role of social influences on behavior. Social learning theory (Bandura, 1969, 1977), for instance, attends to the role of social influences and rewards on performance. Alcohol drinking is understood as a socially learned behavior that results from an interaction of personal and social-environmental factors. Male, couple #6, said "being with people and neighborhoods that can influence me to drink are obstacles for me." Mejta, Naylor, & Maslar (1994) commented that consistent with the social ecology perspective, increased attention is being devoted to environmental contributions to substance abuse (this includes alcohol) such as neighborhood and peer influences.

Also, embedding programs within family and community is respectful of cultural and contextual considerations while allowing for existing social support to be harnessed naturally. However, by contrast, removing individuals from their local settings to participate in a structured program offered elsewhere ignores the protective empowering features of family, neighborhood, and community. Risk factors for relapse can be traced

to social environment, perceived environment, and behavior (Mejta, et. al., 1994). Evidence also suggests that the greater the number of risk factors present, the greater the risk of relapse (Bry, McKeon & Pandina, 1982). Examples of such risk factors include social influences encouraging substance abuse (Mejta, et. al., 1994). These risk factors include environmental factors (availability of drugs, norms favorable to use, and community disorganization) and family factors (family conflicts and family history of alcoholism) (Catalano, Haggerty, Gainey, Hoppe, & Brewer, 1998). Also, these factors are conceptualized as interdependent parts, serving to influence behavior regarding alcohol use (Mejta, et. al., 1994). Recovery can be jeopardized by risk factors, including social factors such as peer group pressures (Mejta, et. al., 1994). The focus of treatment should be on the addictive behavior itself, but lasting changes require an emphasis on the context within which these behaviors occur (Mejta, et. al., 1994).

Theme 3: Support groups can be effective ways of coping during recovery

When participants were asked about some of the effective ways they were dealing with recovery, participants expressed that having someone hear them express their feelings when they most needed it, attending support groups, and their church of choice was very helpful in keeping them in recovery. This also contributed to a better family relationship. With reference to support groups, male, couple #1, stated, “ I have someone that I can trust when I need to talk.” When attending support groups, female, couple #1, adds, “I am able to express my feelings with him, instead of holding them in me.” Also, male, couple #5, stated, “I have had a lot of support from my church, and the new friends that I have made there.” [*During the interview and while rereading the transcriptions, I felt emotional about how church and getting closer to God reunifies the family and is effective in recovery; however, I am aware that while I am listening, I must*

maintain my own awareness that I must listen to the participants' interpretations while setting aside my own fluctuating emotions and assumptions that may come to mind which are based purely on these emotions, not on the participants' voices.] Groups emphasize dealing with current problems (here and now) rather than searching for past causes and explanations or reconstructing possibly traumatic early experiences (Goldenberg & Goldenberg, 1996). Also, groups make an effort to provide interpersonal feedback information to the participants so that they can gain a better understanding of their particular issue (Goldenberg & Goldenberg, 1996).

There is also a growing body of research in the addiction treatment field supporting the practical wisdom and personal experience of recovering people and addiction counselors, which confirms that spirituality is an essential part of the recovery process (O'Connell, 1999). More recently, there has been a growing body of literature focusing on efforts to integrate a spirituality sensitive focus into counseling (Richards & Bergin, 1997). Spiritual experiences may be profound and life changing, but they may also be simple moments of clarity or a felt sense of wonder, elation, peace, or fulfillment (Burk, 2005). According to McGovern and Brent (2006), a general assumption in the field of substance abuse treatment has been that attendance at church serves as a primary buffer against alcohol use (McGovern, & Brent, 2006). Also, Collins (2006) states that treatment recovery groups specified religion as important to resolution from alcohol dependency and maintenance in recovery.

Theme 4: *Family support contributes to recovery*

The encouragement from the participants' significant other and family members contributed to their entering into recovery. Male, couple #6, expressed that "I got tired of living the way I was, and I had encouragement from my wife to enter into recovery."

Also, female, couple #6, stated that "accompanying him to support groups and showing him support" got her husband into recovery. [*I became aware, while listening to the participants' experiences, that from my own experiences, I developed the belief that in most families there was support, and that in my own there was none. I see that I was molding my own view of the lack of family support in my life versus family support, which was given to the participants when they needed it. I am aware that this bias was to be put aside, and that any assumption, which would come to mind, should be removed from thought, as only the participants' experiences will be maintained.*] Alcohol problems have pervasive effects on family functioning, with negative effects on the marriage relationship. On the other hand, family members and family relationships have a powerful positive or negative effect on the family (Ripley, Cunion, & Noble, 2006). Marital relationships can be a catalyst towards retaining or disrupting commitments to abstinence, thus creating a feedback loop from couples dysfunction to alcohol abuse. Among alcohol abusing populations, marital problems have been cited as a leading cause of relapse (Epstein & McCrady, 2002). These findings together highlight the importance of facilitating long-term gains towards recovery (Epstein & McCrady, 2002).

The substance abuse field has long recognized the need to have the family and other support persons involved in an individual's recovery effort. Unfortunately most facilities still lack family education services of any type for a variety of reasons (Marshall, Kimball, Shumway, Miller, Jeffries, & Arredondo, 2005). Edwards and Steinglass (1995) concluded that there is compelling support showing the value of having family members involved in the treatment process.

Although many treatment programs have some protocol for including family members in the treatment process (Perkinson, 1997), relatively few programs strongly

emphasize family therapy or provide their clients and family members with the opportunity to participate in multi-family groups (Marshall, et. al., 2005). Many researchers and clinicians are coming to the conclusion that family members may not be so much part of the problem when dealing with alcohol problems, but can be part of the solution and offer important support in the recovery process (Marshall, et. al., 2005).

Theme 5: *Counseling can contribute to recovery*

Couples experienced that certain actions helped them to reclaim the negative effects alcohol had on their relationship. Male, couple #2, stated, "we went to individual and couples therapy," also, male, couple #4, said "we take preventive measures by going to marriage counseling." [*As I perceived patterns of participants expressing feelings that were missing from their lives when they were not in recovery with their significant others, I started forming pictures in my mind of personal situations and how I would have responded to them had I been in recovery with my significant other. I am aware that I am making assumptions based on general notions and ideas. I will maintain awareness that these notions and ideas are not based on participants' descriptions but rather on my own assumptions about behavior and couples dynamics regardless of context. I will place these notions and ideas aside and be certain to consider only the participants' context of their experiences, listening only to their voices instead of interjecting my own biases*.]

Treatment interventions for alcohol-abusing couples have been conceptualized from multiple view points, with the most pertinent clinical debate focusing on the dichotomous benefits of individual treatment for an alcoholic mate versus couples in family treatment with the entire family (Epstein & McCrady, 2002). This debate is complex, with some experimental designs documenting the superiority of family therapy in achieving sobriety (Edward & Steinglass, 1995). Systemic theorists typically support

the use of couple and family interventions as the first approach to treatment with alcoholic populations (Ripley, et. al., 2006).

The earliest research in treatment outcome for alcoholism compared treatment with and without spouse involvement. Researchers have found strong evidence for involving at least a spouse and other family members in the treatment process (Lewis, 1994b). Berger (1981) found that the number of family members involved affected the outcome in a positive direction. Spouse involvement may mean conjoint therapy on education for the spouse (Mejta, et. al., 1994). Evidence is accumulating, however, that marital and family therapy stabilizes relationships in alcoholic drinking during the 6-month period following treatment entry for alcoholism (Mejta, et. al., 1994).

Heavy drinkers, when counseled, have shown to cut down in their drinking. Several studies have shown that this type of intervention is effective. In one report, two brief counseling sessions resulted in an average 37 percent reduction in average number of drinks in men and 47 percent reduction in women 12 months after counseling sessions. (Oakley & Ksir, 2002).

Theme 6: Family cohesion contributes to the prevention of relapse

Another factor that contributed to recovery was family cohesion. Male, couple #2, expressed that “we have each other to help remind us to stay in recovery.” Male, couple #3, also stated “the recall of my past negative experiences with alcohol and the fact that I am now close to my family has helped me stop from relapse.” Also, male couple #6 stated “getting closer to my family is what helped me from relapse.” [*As I hear the participants describing their families’ concern and support for their recovery, I get strong emotional reactions, as I come from a single-parent family and could relate to these experiences. However, I am aware that these ideas are based on my own emotions*

and not on the descriptions of the experiences from the participants. I will place these emotions and ideas to one side and consider only the accounts of the participants.]

Majta, et. al., (1994) stated that protective factors, such as a cohesive family, can moderate the risk factors serving to inhibit or prevent undesirable life style or outcomes. Reverend Vern Johnson (cited in White & Savage, 2005) felt that there had to be a better way to intervene in alcoholism than to sit and wait for the alcoholic to hit bottom. He developed a technology of family intervention through which the bottom could be raised to meet the alcoholic. He pioneered the use of a loving confrontation between the alcoholic and those who cared for the alcoholic to precipitate a crisis that most often resulted in the alcoholic's entry into alcoholism treatment (White & Savage, 2005).

Family recovery begins with what are, in essence, individual recoveries of its members. Without the environment to sustain these individual recoveries until couple and family relationships can be reconstructed, the risk of collapse and disintegration of the family is quite high (White & Savage, 2005). Each family must be its own model. Intervention with families must be characterized by gentleness and humility rather than by clinical arrogance born of knowing the truth about the impact of addiction and recovery on the family (White & Savage, 2005). Families telling their stories of survival, forgiveness, and reconciliation are powerful antidotes to the hopelessness that so often pervades the perception of addiction in this culture. It is time to define the family as the basic unit in the design of addiction treatment and sustained recovery support services (White & Savage, 2005).

Theme 7: *Having an improved relationship with one's significant other will contribute to positive outcomes in recovery*

Participants in recovery come to believe that over a period of time the relationship with their significant other would lead to positive outcomes. Female, couple #4, said, "The expectations I have about recovery and my relationship have been better than what I had ever imagined." Male, couple #5, stated, "My expectations are being met by having a better relationship with my wife, family and parents." Also, male, couple #6, added, "My needs are being met by getting closer to my wife and knowing her more." [*I found myself relating this to past personal experiences and I developed a perspective of this issue. I am aware that I am forming my own assumptions based on this perspective. I will maintain awareness that these ideas are not that of participant's descriptions, but are based on my own perspectives about couples dynamics. I will place these perspectives to the side to consider the context of the couple's experiences and listen only to their voices and block my own ideas*.]

Johnson (1986) indicated that the human species seems to have a relationship imperative. The human species desires and seeks out relationships with others, and we have personal needs that can be satisfied only through interacting with other humans. Johnson (1986) extended the point by suggesting that the basis for personal well being is effective interpersonal skills. In his view, human development follows a pattern of expansion of interdependence with others, individual identity is built out of our relationships with other people, and psychological health depends almost entirely on the quality of relationships with others. Johnson (1986) also contended that each of us needs to be confirmed as a person by other people.

By providing relationships that are characterized by caring, trust, empathic understanding, and the like, counselors model the types of behaviors their clients need to learn to interact effectively with others and enhance the probability that they will be

successful in their activities (Locke, Myers & Herr, 2001). In a meta-analysis of family approaches to alcohol abuse treatment, the following three factors mediated the successful effects of treatment in maintaining abstinent gains: gender (with female alcoholics reporting greater couple/family interventions), investment in the relationship, and perceived support from one's spouse (Edwards & Steinglass, 1995).

Theme 8: *Stress or personal loss are triggers for relapse*

Couples expressed that situations such as a significant loss or financial difficulties would set off negative emotional feelings, such as, anger and frustration. In turn, this becomes a precedent where alcohol would take advantage and relapse would occur. When male, couple #1, was asked about specific situations that would lead him to a relapse, he stated, "probably a death." Female, couple #6, said that "anger and being frustrated, when things are not going our way, is what sets us up for failure in our relationship." Also, male, couple # 4, stated, "Financial difficulties and disagreements may allow alcohol to take advantage of us." Male, couple #5, stated, "Stressful situations will always lead me to consider drinking. [*During the interviews and while reading the transcriptions as well as listening to the tapes, I could not help but think of the stress and loss in my own personal life and what I had to go through to get as far as I have. However, I am aware that while I am listening to the participants, these sudden thoughts may come to mind that they are not based on the emotions or experiences of the participants. I must listen to the participants' interpretation of their own experiences and leave aside my own fluctuating emotions.*]

Stress management plays an important role in recovery from alcohol problems (Mejta, et. al., 1994). People with alcohol problems may never have learned alternate methods for dealing with the stressors of every day life, let alone for handling major

upheavals. When a stressful situation arises, even the most highly motivated client may be put at risk. As Washton (1989) points out, the buildup or onset of stress often serves as the first link in the relapse chain (p.118).

A recent analysis of data from the U.S. general population sample reported that both acute stress, measured as a count of negative past-year like events, and specific types of stressors (e.g., interpersonal, job-related) were positively associated with volume of alcohol intake, frequency of heavy drinking, and usual and longest quantities of drinks consumed per drinking day (Dawson, Grant, & Ruan, 2005).

On the basis of data from four waves of the Health and Retirement study, Perreira and Sloane (2001) reported that retirement and divorce were associated with increased usual daily consumption of alcohol, and that widowhood was positively associated with increased consumption.

Theme 9: *Recovery works*

When couples were asked about what they knew now about recovery that they did not know before, most answered that recovery works. Male, couple #3, stated that "being in recovery works." Also, female, couple #5, added "recovery has made us a stronger couple, able to accomplish what we set out to do." Male, couple #4, expressed that "being in recovery can allow me to really enjoy life, as I never did before, to the fullest." Female couple #1, with respect to recovery, stated, "I understand what I am feeling and I know myself better." [*As I hear the participants describing such a delicate issue, I again form my own assumptions about recovery and what it means to me. I am aware that these ideas are my own biases and not the participant's experience. I will place these ideas to one side and listen more to the participant's context and personal accounts of this issue.*]

There are some commonly recognized and, at least within treatment communities, commonly agreed-upon goals of drug abuse treatment. The primary goal of drug abuse (including alcohol abuse) treatment is to eliminate or reduce the client's illicit and licit drug use (Mejta, et. al., 1994). Also, some of the secondary goals of drug abuse treatment often include developing social and communication skills, and achieving stable familial relationships (Mejta, et. al., 1994).

How effective are our current drug abuse treatment programs in accomplishing these goals? In a review of treatment outcomes studies, Tims, Fletcher, and Hubbard (1991) stated, "The available evidence from treatment outcomes studies shows that drug abuse treatment works for a significant number of clients who enter treatment" (p.93). Two major national longitudinal treatment outcome studies conducted within the past two decades support this contention. The first study, the Drug Abuse Reporting Program (DARP), was conducted between the year 1969 and 1974, and the second study, the Treatment Outcome Prospective Study (TOPS), was conducted between 1979 and 1981. The results of the DARP and TOPS studies clearly demonstrated that positive behavioral changes are associated with drug abuse treatment. These changes included reduced use of licit and illicit drugs during and after treatment (Craddock, Bray, & Hubbard, 1985; Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginsburg, 1989; Simpson & Sells, 1982). However, Hubbard, et.al., (1989) stated that there is no question that treatment and recovery work, but much more needs to be known about how and why treatment and recovery works (p.43).

Theme 10: *Staying in recovery contributes to a satisfactory family relationship*

When the couples were asked how they would like their experience in recovery to continue, most reported that they wanted to improve their quality of life and family

relationship. Female, couple #1, expressed “to continue having an honest relationship.” Male, couple #3, reported, “I would like my family life to continue to get better,” and female, couple #5, said ,“I would like to live as a happy couple with a good family life, and not worry about the past experiences when I had a problem with alcohol.” Female, couple #6, stated, “My expectations (with reference to staying in recovery) are staying focused and together (with her significant other) and continue to give each other support, knowing also that there are resources when we need them; also to continue to make our family life a better experience and not be so selfish.” [*As I perceived patterns of participants expressing feelings that were missing from their lives when they were not in recovery with their significant others, I started forming pictures in my mind of situations and how I would have responded to them had I been in the recovery process as a couple. I am aware that I am making assumptions based on general notions and ideas. I will maintain awareness that these notions and ideas are not based on participants' descriptions but rather on my own assumptions about behavior and couples dynamics regardless of context. I will place these notions and ideas aside and be certain to consider only the participants' context of their experiences, listening only to their voices instead of interjecting my own biases*.] Families encourage healthy patterns during times when the person with the alcohol problem is doing well and is committed to recovery. Families should also respond warmly and supportively, and help each other to achieve their goals (Mejta, et. al.,). Family cohesion has a major impact on long-term recovery from alcohol problems (Moos, Finney, & Cronkite, 1990). This is not surprising, given the reciprocal effects of family systems and alcohol use. An individual’s alcohol use affects the functioning of his or her family system (Mejta, et. al.,1994).

McCrady, Noel, Abrams, Stout and Nelson (1986) compared three treatments as part of their program for alcoholic couples treatment study. Couples were assigned at random to one of three treatments: (a) minimal spouse involvement, (b) alcohol-focused spouse involvement, and (c) alcohol behavior marital therapy. In all of the treatments, decreases in alcohol were cited, but the behavioral family therapy led to more stability and satisfaction in the couple's marriage and family relationships.

Statement of the Fundamental Structure of the Experiences of Couples

Some of the effects of recovery on the relationships of couples, as expressed by the participants' experiences, are that they can be more tolerant of each other while one of them is in the recovery process. Also, the issue of trust comes into focus as the relationship continues while in recovery. Being in recovery helps couples cope with each other and function better as their communications are improved and respect is shown towards each other. Some of the participants, nevertheless, had feared intimacy with each other and worried that the relationship would not be able to work. Couples in recovery expressed that the relationship would not have been able to function had they not been in recovery. Also, another positive effect of recovery, experienced by participants, was the role that spirituality plays in their lives as couples. Couples expressed that not being able to handle small but difficult situations becomes a major obstacle, which leads to relapse. When this occurs, emotional control is lost and may trigger negative behaviors, such as seeking out some old friends who have a negative influence on their recovery. Most of the participants described that socializing with some old friends who are not in recovery is a major obstacle in their recovery efforts. Consequently, some of their old neighborhoods are also a cause to meet up with the wrong people who may trigger relapse, and this makes recovery difficult.

According to the participants, the experience of having someone to listen to them, when in need or in a relapse mode, is very effective in dealing with recovery. Also, going to their local church and associating themselves with new friends helps to unify them as a couple, and also strengthen their family relationships. However, the most significant and effective way of dealing with recovery for couples, as expressed by most of the participants, is attending the support groups. When the significant other and family members of participants with alcohol problems gave them support, this contributed towards their entering into recovery. Participants described that not having a place to call home, hardships in their lives, and becoming uncontrollable also contributed to having to make the decision to enter into recovery. They also expressed that anger, legal, and financial problems greatly contributed to making the decision towards recovery.

Participants stated that doing significant things, as couples and adjusting to a new life without alcohol were positive actions, which can be taken, in order to reclaim what alcohol had done to their relationships. Most of the participants had become aware that attending marriage and family counseling were a proactive move towards staying in recovery. Also, learning to trust each other and having open communication while in recovery was very important to all the couples. According to the couples, although at first recovery appeared to be difficult, the need to give the person in recovery attention and care many times prevented relapse. Also, talking to people who have been in recovery for a period of time helps in the prevention of relapse. Participants experienced that stressful situations and not being able to handle them, or having too much time and doing nothing with it (boredom), are also causes for relapse. Couples, however, expressed a belief that their relationship and family life would eventually go back to being normal while in recovery.

The participants also described some expectations that were being met while in recovery that helped their relationships. These included staying sober, having a closer relationship with their significant other, and moving forward to a more stable family life. The most specific situation that was expressed by most of the participants was if they had allowed alcohol take advantage of them while in recovery, it would have been due to the suffering of a loss, such as a death in the family or something else equally as serious. It was also expressed that when losses occur, this may lead to poor decision-making, losing focus, and a situation in which triggers may emerge. This may also allow difficult situations to take over and set the stage for a relapse.

Most of the participants expressed that they came to the realization that “recovery does work.” They learned that drinking does not need to be part of their lives, and that it is possible to attain self-control. Also, they learned that facing up to difficult situations and becoming stronger as a couple was possible. For most of the participants, an enjoyable, harmonious lifestyle could be maintained while in recovery if the focus on recovery was not lost, and the recovery process was not rushed. Participants often related how they were able to start knowing themselves better as a couple in recovery, and in turn this improved their relationships. Most couples expressed that while continuing in recovery, they would like to improve their quality of life along with their significant other and family. The participants’ future desires were to attain abilities to better resolve difficult situations and live happy and trustworthy relationships with their significant others.

Summary

While couples experience in recovery what helps them to cope and function better, there are still obstacles such as some friends and neighborhoods that may still have an

influence on them, and as such may be a cause for relapse. Participants in recovery expressed that they were led into treatment by life's hardships, legal issues, and having an alcohol problem. Participants also expressed that going into recovery always occurs when there was support from their significant other and/or family members, and that one of the most effective ways to stay in recovery as a couple is through mutual and family support and attending support groups.

A proactive stance taken by some of the couples was to attend individual and couples counseling. Doing this, they experienced being able to have a closer relationship with their significant other and the fact that it was a measure to take for relapse prevention. Most couples' expectations were to have a better relationship with their significant others and improve their family lives. For most of the couples, the onset of anger and frustration came from not having outcomes they wanted, of events that were not really under their control, as well as legal and financial difficulties. However, most stated that recovery works for couples and that one could enjoy and accomplish goals while in recovery. In the recovery process, couples experienced the need for more self-control and the desire to handle difficult situations more effectively. Also, most wanted their experiences as couples to continue improving while in recovery, along with better family relationships.

CHAPTER FIVE

RECOMMENDATIONS

Introduction

The purpose of this study was to describe the storied experiences of couples during the first six months of recovery from alcohol. Chapter IV presented an exhaustive description of the experiences of couples where one is in recovery by presenting their experiences instead of the more frequently used self-reports used in previous studies. In this present study, the data collection was done in such a way as to allow positive, negative, and neutral experiences to be exposed. This researcher entered into the study with a sense of curiosity; however, there were assumptions and personal perspectives, which were identified and separated by bracketing (Speziale & Carpenter, 2003). By suspending these preconceived notions, the researcher felt that the study would not be affected or predisposed to positive or negative effects of the lived experiences as narrated by the couples.

This study contributes to the existing knowledge about the phenomenon not only by presenting the experiences based directly on couples' stories but also by considering the recovery process, particularly as it relates to the marital relationship (may it be as a married couple or living with a significant other). The exhaustive description itself paints a picture of the couples' experiences during the first six months of recovery from alcohol. Within this context, the narrative represents how couples experience recovery when one of them does not have an alcohol problem and what factors the couples experience as contributing to positive or negative effects on the recovery process and their relationship. The results deriving from the research also adds to the existing knowledge the experiences of couples with alcohol problems in early sobriety, defined here as a period

of no less than six months and the effects of these experiences on the marital relationship. The discovery of universal meanings can be derived from the description of the experiences by providing readers with a deeper understanding of the phenomenological inquiry of the storied experiences of couples during the first six months of recovery from alcohol. As mentioned in Chapter III, according to Merleau-Ponty (1962), the lived experience is reality, and this experience is the focus of attention in phenomenology rather than the process of experiencing. Hoshmand (1989) asserts that the purpose of phenomenological inquiry is to describe and illuminate the meanings of human experience and identify the essence of behavior. Both human experience and the essence of behavior can be found within the exhaustive description of the couples' lived experiences during the first six months of recovery from alcohol. These findings will be discussed in detail below.

Discussion of the Findings

In this inquiry, the experiential reality of couples during the first six months of recovery from alcohol was described and provided. As a result, a heuristic and motivating body of knowledge for other researchers who wish to explore this phenomenon was established. In addition, the results provide a salient picture of the experiences of couples where there is an alcohol problem and assist clinicians who work with clients who have an alcohol problem. The results of the study also serve to inform families and family members in the community about the recovery process.

This study also provides a basis to build and create additional research and theories about couples in the recovery process. For most of the couples, the most effective way to stay in recovery, as a couple or with a significant other, is through mutual and family support, and attending support groups. Also, the findings suggest

complex and problematic issues within couples themselves and their relationships. Further research is needed in the study of couples with greater than six months of recovery in order to see if the same themes are still apparent during later periods. Children were not given consideration in this study. Future studies should focus on the children of persons recovering from alcohol problems. This type of study would facilitate the expansion of the knowledge of recovery and the effects it has on children. Findings indicate that couples in the relationship are in significant emotional distress, and consequently the partner in recovery is at great risk of relapse and also that going into recovery would always occur when there is support from their significant other and/or family member. One of the most effective ways to stay in recovery, as a couple or with a significant other, is through mutual and family support, and attending support groups.

A study done by Bruning (1985) indicates some similarities in the findings of this researcher's study, with respect to couples with alcohol problems during the first six months of recovery. Consequently, traditional models treating alcohol problem appear to continue to be used at this present time. As such, some of the treatment programs that provide services to clients with alcohol problems are still administering treatment in isolation from their spouses or significant other.

Limitation of the Study

The limitations of this study are due to the uniqueness of the inquiry and the number of participants in the study. Also, the fact that several variables were not included, such as family members and children; thereby, limiting the generalizeability and literature review. The results of the study are limited by two evident factors: first, that the information obtained can only be applicable to people with alcohol problems and their non-using spouses or significant others during the first six months of the recovery

process, and second, that the findings of this inquiry cannot be generalized to all populations that are in recovery.

Finally, in order to maintain simplicity and stay within the qualitative research design, only six couples (12 participants) were interviewed for 90 minutes each. In this inquiry, the interactional process with the participants may have been short due to the amount of time spent in the recruitment process and the short time spent on getting to know each of the couples better. The participants' rapport with the researcher was good; however, their ability to divulge more information may have been limited because of the lengthy recruitment process and the short time spent to know each of the couples.

Recommendations

A scientific paradigm is a set of beliefs and values based on past scientific achievements in that a particular scientific community acknowledges for a time as supplying the foundation for its further practice (Kuhn, 1970). It defines the appropriate questions to be pursued, the ideal and acceptable methods for pursuing them, the criteria for evaluating the results of those methods, and the legitimate theories in the light of which those results will be interpreted (Pinsof, 1992). A scientific paradigm is particular to a specific historical period. There is no ultimate paradigm. A paradigm emerges and endures for a time, to be replaced by another paradigm that incorporates its predecessor and opens new scientific vistas (Pinsof, 1992).

Science is defined as a systematic effort to solve certain problems and a set of rules that minimize the likelihood of lying to each other about the results of those efforts (Pinsof, 1992). A good paradigm lays certain problems or issues to rest, thereby creating an assumptive foundation that can be taken for granted, and opens new vistas or problems to be solved, such as: What makes a good marriage? What are the essential components

of couple satisfaction? What is a road map to couples in recovery? Answers to such questions increase our understanding of how couples and families work in order to ultimately help design programs and counseling interventions that will improve the quality of family life (Pinsof, 1992).

At present, scientists, psychologists, psychiatrists, researchers, clinicians and people in related fields, practices and research are guided by the dominant paradigm of the time (Pinsof, 1992). Family and individual therapy no longer represent different therapeutic modalities, but rather different intervention contexts and strategies dealing with particular patient systems and presenting problems. However, the relevant question is no longer which is better, but which context (individual, couple or family) is best for dealing with particular types of patient systems with particular types of problems. With certain populations (e.g., Hispanic families with substance abuse problems), it may be better to work directly with only one system member. On the other hand, with other populations (e.g., married women), it may be best to work with the family or the couple (Pinsof, 1992).

Human knowledge is always partial and limited; therefore, we never really know exactly with what we are dealing. We can know something more or less about a couple after questioning them, but we never have a complete exhaustive or definitive understanding of that couple. Much of the time our knowledge is good enough to get us through. Frequently, it is not. When we fail, we must look again at our environment and ourselves and reconstruct new and more accurate understandings of the reality with which we are dealing with at that moment (Pinsof, 1992). A paradigm is a construction that works for a group for a time in a particular context. As the group, time, and context changes, paradigms fail and must be replaced (Pinsof, 1992). The task of replacing a

particular paradigm at this time in the field of substance abuse, namely alcohol problems, is advantageous for several reasons. First, it would help to formulate what may constitute strength-based treatment modalities for couples with alcohol problems and methods of counseling. Second, it forces us to delineate criteria and rules that can be used to guide, evaluate, and improve the quality of work in the field of drug and alcohol rehabilitation. Lastly, it can help us make more informed and intelligent decisions about our future as a science and professionals.

This idea is offered to spur dialogue about the nature of couples with alcohol problems and to facilitate the development of alternative treatments for people with alcohol problems. A closer analysis of alcohol treatment questioned the efficacy of traditional methods (Pinsof, 1992). Miller and Hester (2003) reported Alcoholic Anonymous, and other 12-step groups finished 37th and 38th out of 48 treatment modalities in treatment outcome research. Yet, the traditional methods remain dominant in alcoholism treatment centers despite the fact that other treatment approaches have been found to be more effective. Finney and Moos (1992) and Vaillant and Milofsky (1982) found treatment experiences received as much as 10 years earlier did not predict later drinking behaviors. Rather than insisting that a client accept the addict label, we should respond to the client's needs as they are presented.

The emergence of new theories is generally preceded by a period of pronounced professional insecurity. As one might expect, that insecurity is generated by the persistent failure of the puzzle of normal science to come out, as they should. Failure of existing rules is the prelude to search for new ones (Kuhn, 1970). With this said, the study suggests that the couples bring with them unique stories about their recovery experiences that can be used in their interviews with this researcher. Gergen (1985) states that

people's views of so-called reality are intersubjective and language-based. Because identities are intrinsically linked to story telling, the strength-based models of treatment and, in particular, narrative therapy, and solution-focused models are particularly fitting for clients in recovery and are a vehicle for re-storying their lives.

While support groups are available to couples in recovery, it is suggested that the solution-focused models would be potentially effective treatment approaches as both partners, as couples, experience similar if not identical emotional issues in the early recovery stage. According to Guterman (2006), in solution-focused counseling, instead of emphasizing the problem as in the traditional models of treatment, the main goal is to help clients identify and amplify exceptions to the problem. Further, in treating couples, exceptions can be amplified by the couples because both can identify and amplify exceptions in relation to the problem.

Due to lack of outcome studies related to strength-based models in addiction, this researcher recommends two of the solution-focused models, one of which is solution-focused counseling. Being that it is a strength-based model of counseling, it can be employed for the counseling of alcohol problem. Substance abuse, as per Guterman (2006, p. 83), is like any other clinical problem insofar as the focus is on the clients' existing strengths, resources, and problem-solving skills. In solution-focused counseling, clinicians use what is already working that is positive, and they encourage a positive interpretation of events in order to bring awareness of the strengths and resources that they already possess (de Shazer, 1985).

Even though the healing of old wounds, made during the active drinking period, would be slow and may take time to occur, Guterman (2006) asserts that clients' problems are frequently viewed as always happening. Therefore, instances when the

problem is not occurring are often dismissed by the client, and those instances are not perceived to make a difference to the client. Working on small changes is often all that is needed to start the ball rolling in the direction of change. The first step is that each client and the therapist must agree that there exists a presenting problem (Guterman, 2006). Solution-focused counseling shows clients that within the problem is the solution. The solution lies in the exceptions to the problem. Even though the magnitude of alcohol problems in couples is evident, Guterman (2006) explains that interventions in solution-focused counseling are aimed at assisting clients to identify and amplify what was working and help them work with those resources and strengths, instead of focusing on what has to be done and what will be done by the client.

Being that solution-focused counseling is language-determined, a positive proactive language is used to identify those past behaviors that represent positive substitutions for drinking, and these represent potential exceptions. It is suggested that future research explore outcome effectiveness of couples with alcohol problems using solution-focused counseling. Accordingly, relapse prevention's purpose is to help clients identify stressful situations and to develop skills to help them deal with difficult situations that people with alcohol problems have. Thus, the solution-focused counseling approach, using the positive proactive language strategy, can also be applied to the treatment of couples with alcohol problems. As Guterman (2006) suggested, "Just as the creation and maintenance of a clinical problem is contingent on social interchange, so is its resolution." As such, solution-focused counseling, which is a strength-based model of treatment, is recommended as a potentially effective approach for treating couples with alcohol problems. It is a creative and innovative approach to help couples focus on what

they were doing right in the past that worked for them, as opposed to working on their problems or weaknesses.

Another solution-focused model is solution-focused brief therapy. This model was devised by Steve deShazer in the 1970s. It is a collaborative approach that encourages people to talk about preferred futures rather than the pathology of the problem (Murphy, 2007). When working with couples, it allows for them to be heard and introduces possibilities rather that focusing on limitations. By using the respectful and collaborative language of the approach, clients are encouraged to assess what works for them and what works for change (Murphy, 2007). With respect to problems with alcohol, clients are encouraged to utilize their strengths and resources in the journey towards achieving change (Murphy, 2007). Through his early writings, it can be seen that Steve de Shazer found Wittgenstein's writing about the role of language and meaning compatible with Bateson's ideas (Andrews & Clark, 2007). The resulting method that he initiated was solution-focused brief therapy (Andrews & Clark, 2007). He changed the focus of therapy talk from rehashing the past to paying attention to what people want in the future. This is done conversationally by asking questions about what people want (Andrews & Clark, 2007). Generally, solution-focused brief therapy sees people as having greater potential for creating the lives that they would prefer to live (Andrews & Clark, 2007).

This model uses a systematic approach in which the agenda for counseling is determined by the client rather than the therapist (Sklare, 2007). This enables the solution-focused brief therapy approach to be used for a wide variety of issues and clients. Clients are not always experiencing failure, such as when they say, "Hello my name is . . . and I am an alcoholic." Focusing on even slight exceptions to problems that occur suggests solutions which become empowering for clients as they begin to recognize

previously unnoticed successes that can be expanded and repeated (Sklare, 2007). Therefore, clients are uplifted with their strengths rather than emphasizing their deficits in counseling. This provides incentives to further clients' successful efforts. A system according to Von Berthlanffy (1968) is comprised of many elements interacting together as part of a whole structure. Solution-focused brief therapy also has some if its roots in this thinking. Systems theory during its initial development, like the communication projects work, must have been seen at least as being very alternative with its direct challenges to the well substantiated medical model (Rodway, 1986).

Lastly, another strength-based model that is recommended by the researcher is narrative therapy. Narrative therapy is a form of psychotherapy using narrative with an approach to helping people that was developed during (and has evolved since) the 1970s and 1980s in good part by Australian Michael White (of the Dulwich Centre) and his friend and colleague, David Epston, of New Zealand. Narrative therapy finds ways of developing insight into the stories of the client's life. Therapists using a narrative approach are interested in the stories the clients bring to the counseling session. They are searching for an in-depth account of the problems that are affecting the client's life. Narrative therapy is sometimes identified as having the client re-author or re-story their experiences with a positive proactive language. These descriptions emphasize that the stories of people's lives are pivotal to an understanding of the individual (Morgan, 2000).

The word *narrative* refers to the importance that is placed upon the stories of people's lives and the differences that can be made through specific telling and retelling of these stories. These stories are examined like literary criticism in which the story line is deconstructed, and the plot, characters, and timeline are individually inspected for importance (Cooper & Lesser, 2005). In narrative therapy, people are the experts of their

own lives. When people examine themselves, they view their problems as separate from themselves. People place their problems outside of themselves and in the environment. Within narrative therapy, people's beliefs, skills, principles, and knowledge will assist them in reducing the severity of the problems in their lives. The clients can readily identify the antagonist of their story, and with some time, they are able to identify the successes they have achieved to combat their problem (White, 2005). In narrative therapy, clients are encouraged to see that the person is not the problem, and that the problem is the problem. Problems, therefore, are externalized, allowing strengths or positive attributes to be internalized, and allow people to engage in the construction and performance of preferred identities (White, 2005). People make sense of and give meaning to their lives, including the people and events in it through their narratives, the stories they tell others and themselves, and the stories they are told. That is, narratives or stories about others and self shape experiences, and thus lives. People's narratives are their realities (Anderson, 2007).

Future research in the areas of substance abuse and alcohol problems should include more phenomenological qualitative research using the storied experiences approach of narrative therapy, the Solution-focused models, and other language-based approaches. The emerging recovery research agenda should also focus attention on difference in pathways and styles of recovery across the developmental life cycle. Ongoing qualitative research should continue into the important phenomenon of spirituality and recovery. In this way, the field of alcoholism studies and treatment may come, over time, to a deeper understanding of spirituality and long-term recovery. Also, longitudinal studies should be conducted in the relation between the interaction patterns that emerge during alcohol consumption and subsequent functioning, both with regard to

the marriage as well as with regard to alcohol problems. This would clarify the importance of family processes in the different outcomes of alcoholism. Finally, no research on same-sex couples with alcohol problems has been reported, and research on the functioning of these couples is also needed (McCrady & Epstein, 1995).

Additional comparative studies are also needed. Such studies might incorporate subjects with smaller differences in sobriety. Research using recovering females only with alcohol problems as participants would also further the sobriety process, as undocumented opinion holds that in the general population, females with alcohol problems may comprise at least 50 percent of the alcoholic population and a similar number in the recovery process (Brunning, 1985). Also, children were not given consideration in this study; however, future studies should focus on the offspring of the recovering person with alcohol problems. This type of research would help in the expansion of the knowledge on sobriety. Future studies should employ more process based research and experimental/quasi-experimental design (i.e., pre-, post-, and follow-up testing), in order to examine the effectiveness of interventions for clients and their family members/significant other.

Programmatic recommendations can include treatment approaches that combine behavioral cue exposure with craving specific coping skills, which could reduce cue elicited craving and provide the individual with skills to manage cravings when they arise (Hoerter, Stasiewicz, & Bradizza, 2004). Also, research has shown that counseling and treatment programs can be successful if attention is paid to motivating the clients for treatment; involving the family and other members in the treatment and long-term recovery process; using developmentally appropriate, individualized, and formalized treatment techniques; treating any related physical, psychological, and social problems;

and providing for aftercare for the client and the family (Fagan, 2006). On the other hand, participants who have higher levels of severity of substance use at intake, treatment in in-patient/residential treatment settings is associated with better outcomes than outpatient treatment. More research needs to be conducted for residential settings before clients are further reduced as part of the substance use disorders continuum of managed care (Tiet, Llegen, Byrnes, Harris, & Finney, 2007).

This study speaks to the call for qualitative research such as Gergen and Gergen's (1988), Mishler's (1995), McAdams' (1993), and Reissman's (1993) that examines life stories or narratives to understand how an individual makes sense of himself or herself in the world. Narrative methods span a range of approaches, from analysis of thematic content to a focus on linguistic form or structure (Lieblich, Tuval-Mashiach, & Zilber, 1998). Researchers have used these methods to examine the turning point in a drinking career, the choice of self-help method, the process of recovery from alcohol abuse, and personal narratives presented in alcoholics anonymous (Brown, 1985; Kaskutas, 1996; Steffen, 1997).

On the basis of the results of this study and the call for further research, it is suggested that future studies and treatment should use story telling among families within the traditional AA and medical models, as this will help provide a better understanding of the impact that addiction has on individuals, couples and families, and help give permission for all individuals, couples and families to speak about their issues. Also, being that AA is a support group, families would help to make it more acceptable for other families to seek help for addicted family members.

Conclusions

The purpose of this study was to investigate the experiential realities of couples with alcohol problems during the first six months of recovery. Through the incorporation of a qualitative-phenomenological approach, information about these experiences was obtained from couples' interviews. These interviews were analyzed through Colaizzi's (1978) method of research and then presented in a descriptive form to the reader.

The literature and research in alcoholism has focused on the nature, etiology, maintenance, and treatment of this phenomenon. With few exceptions, the study of couples in recovery from alcohol problems is scarce, as a review of the literature indicates that there is a paucity of research in the area of outcome studies in the field of recovery. This study was based on thick descriptions of couples' experiences during the first six months of recovery from alcohol. Even though couples described stressful and negative emotions during recovery, they also identify strengths and strategies they had used in the past that worked and have to be redeveloped in order for their relationships to continue. During the investigation of their lived experiences, it became evident that all of the couples were going through the recovery process together. As such, the aim of this inquiry was to provide information to professionals, clinicians in the field of counseling, families and the community, about the experiences of couples with alcohol problems in the early stage of recovery.

A decision between alternative ways of practicing science is called for, and no matter the circumstances, that decision must be based less on past achievement than on future promise. Traditionally, treatment approaches for couples in recovery have been organized by the disease model (Peele, 1984). However, the disease model is largely individually oriented. Investigators who embrace new paradigms at an early stage must

do so in defiance of the evidence provided. They must have faith that the new paradigms will succeed with the many large problems that will confront them, knowing only that the older paradigms have been failing (Kuhn, 1970). Also, existing institutions have ceased adequately to meet the problems posed by continuing to use paradigms that do not meet their expectations. Furthermore, some existing paradigms have ceased to function adequately in the exploration of an aspect of nature to which these paradigms had previously led the way (Kuhn, 1970). The narrative approach, in this inquiry, takes the position that people's views of so-called reality are intersubjective and language-based (Gergen, 1985) and increases the opportunities for the participant's identities to be intrinsically linked to their story telling.

The findings indicate that the most effective way to stay in recovery and continue in a relationship, as a couple, with your significant other and family member, is by mutual and family support, and by attending support groups. This description contributes to the existing knowledge about the phenomenon not only by presenting the experiences based directly on couples' reports on their lived experiences, but also by considering the recovery process, particularly how it relates to couples and their family members. Also, the strength-based approaches for the treatment of alcohol problems, such as the solution-focused models and narrative therapy, were recommended in this study. These strength-based models hold promise for the field of addiction and recovery from alcohol, which is presently organized by a host of pathologizing models. Finally, if counselors want success for their clients, they must place the responsibility of recovery squarely on the clients, and it is possible that positive events may jump start change (Peele, 2004). Hence, empowerment and reinforcement, as opposed to humiliation or coercion, will help in the process of recovery (Peele, 2004).

According to Gergen (1985), human experience is language-based and socially constructed. The word *abstinence* is usually synonymous with *sobriety* (Fletcher, 2001). Abstinence is an act of refraining from the use of alcohol. According to Webster's dictionary, sobriety is defined as sparing from the use of drink (alcohol) (Fletcher, 2001). With this said, in this study the effects the word *recovery* had on the participant's lived experiences was that of going through a process. Finally, it is suggested that future research focus on abstinence, rather than recovery, as an organizing metaphor pertaining to the first six months when alcohol is discontinued. Whereas the current study was organized by a language of recovery and the multitude of cultural and social influences that this dominant story sets forth, using the term *abstinence* would likely invite researchers and participants to create and recreate much different stories than those that derived in the current study as a result of the use of the term recovery as an organizing metaphor.

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APPENDIX A

PHONE CONTACT

As the principal researcher of the study (The Storied Experiences of Couples during the First Six Months of Recovery from Alcohol: A Phenomenological Inquiry), and upon initial phone contact with a potential participant, the following is the phone presentation, which will be followed when conversing with potential participants:

Hello, my name is Jose Marmolejo. I am a Doctoral candidate at Barry University and I am conducting a voluntary research study of the storied experiences of couples during the first six months of the recovery from alcohol. First, to participate in this voluntary research study you must read, review, and sign an informed consent form, which will be fully explained to you and your spouse or significant other by me at the initial interview. You must be at least 18 years of age to 60 years of age, and be able to speak English. Also, you must be in recovery from alcohol for a minimum of six months and living with your non-using spouse or significant other.

There are no direct benefits to you in this study; however, it is possible that the interviews may be helpful to you and your spouse or significant other. Also, the study may help our understanding of the storied experiences of couple during the first six months of the recovery process from alcohol. Aside from this, the increased understanding may in turn help clinicians, mental health professionals, therapist and marriage and family counselors who serve clients with alcohol problems. On the other hand, this may provide useful information to couples and family members experiencing the recovery process.

The informed consent forms will be signed and interviews and data collection will be conducted at my office located at 22790 SW 112 Avenue, Miami, Fl. 33170. Participants will be allowed to see the written research questions they will be asked during the initial interview. The participant has the right to refuse to answer any question or questions as they se fit. There will be one initial interview of 90 minutes for the collection of data, which will be tape recorded and transcribed by me. Also, there will be a follow-up interview (within six weeks) of 60 minutes to verify the accuracy of the transcripts. As a research participant, names will not be used and each participant will be assigned a number that will be recorded on each tape recording. Also, any information about participants is completely confidential. All forms and data, which have no names or identifiers, will be kept in a locked file. As a standard of the Barry University Institutional Review Board, the consent forms, any notes and transcripts will be destroyed after a period of five years. Audiotapes will be destroyed immediately after transcribing is complete. The anticipated number of participants will be 6 couples. The risk of involvement in this study may include a possibility of anxiety during the interviews or unpleasant memories; however, if intervention is needed referrals to a local center here in Miami or one nearest to were you live, with a full range of health services and a sliding scale fee, will be available. Also if you choose you may be referred to your current health insurance plan or preferred provider.

If you are interested in participating in this study, we will make an appointment to meet when possible and at your convenience at my office located at 22790 SW 112 Avenue, Miami, Fl. 33170. I will also provide you with any further clarifications or questions that you may have regarding this study. If you are not interested in this research, I would like to take this time to thank you for taking your time to inquire about this study.

APPENDIX B

Barry University
Informed Consent Form

You are being asked to take part in a research project. The title of the study is The Storied Experiences of Couples During the First Six Months of Recovery From Alcohol: A Phenomenological Inquiry.

The research is being conducted by Jose R. Marmolejo, M.S., L.M.H.C., a Doctoral Candidate in the Counseling program with a specialization in marriage and family counseling/therapy housed in the Adrian Dominican School of Education at Barry University. The purpose of this study is to further understand the experiential nature of the recovery process during the first six months for people with alcohol problems and their non-using spouses or significant others and, also, to examine the essence and central underlying meanings of the lived experiences of this population.

In accordance with this aim, the following procedures will be used. This researcher will conduct a maximum of two interviews with recovering alcohol users who have all experienced no less than six months in the recovery process and their non-using spouse or significant others. When possible and comfortable for the participants, this researcher will conduct interviews of 90 minutes for the initial session. The initial session will be tape-recorded and will be transcribed. When possible and comfortable for the participants, this researcher will conduct a follow-up session of 60 minutes for the purpose of verifying the transcripts for accuracy. The researcher will personally record and transcribe the interviews. The anticipated number of participants is to be 12 adults.

The interviews will be conducted at the researcher's office located at 22790 SW 112 Avenue, Miami, FL 33170. In order to obtain the fullest descriptions possible, the researcher will allow the participants to see the questions in written form as follows:

1. What have been some of the effects of recovery, on your relationship?

2. What major obstacles, that prohibited you from what you want, make recovery difficult?

3. What are some of the ways, that you have been effectively dealing with recovery?

4. What contributed to you being in recovery?

5. What actions have you taken in order to reclaim the effects alcohol has had in your relationship and life at home?

6. What events have led to or stopped you from relapse?

7. How have your expectations, of recovery and your relationship, being home been met?

8. What are some of the specific situations or contexts in your life, at home, and your relationship that alcohol may likely take advantage of?

9. What is it you know now about recovery that can help you stand up to alcohol's influence and improve your relationship and life at home?

10. What would you like your experience to be like, from now on, continuing in recovery?

The participants will be informed that they have the right to refuse to answer any question or questions they se fit. Also, participants will be asked to make themselves available for the first interview, which will be 90 minutes, and a follow-up interview (within six weeks) of 60 minutes. The follow-up interview is for the purpose of verifying the transcripts for accuracy. Your consent to be a part of this research is voluntary. Should you wish to withdraw or remove yourself from the study, there will be no adverse effects on you or your spouse or your significant other.

The risks of involvement in this study may include the possibility of experiencing an emotional reaction during the interviews. It is also possible that the interviews may be helpful to you or that you may have a neutral reaction to the interviews. The following procedures will be used to minimize the risks. If it is determined at any time during any interview that you need a referral for mental health or substance abuse intervention, the interview will immediately be stopped. This researcher is a licensed mental health counselor (L.M.H.C.) and a certified addiction professional (C.A.P.). You will then be referred to New Horizon Community Mental Health Center (N.H.C.M.H.C.), 1313 NW 36th St, Miami, Fl. 33142 (305) 635 0366, a Community Mental Health Center (C.M.H.C.) which provides a full range of mental health and substance abuse services either free of charge or on a sliding scale fee. Also, the researcher will refer you to your current health insurance plan or preferred provider as an alternative option.

Although there are no direct benefits to you, your participation in this study may help our understanding of the storied experiences of couples during the first six months of recovery from alcohol. This increased understanding may help clinicians, mental health professionals, therapists and marriage and family counselors who serve clients with alcohol problems and, also, to provide useful information to couples and family members experiencing the recovery process.

As a research participant, any information you provide will be held in confidence to the extent permitted by law. Names will not be used and each participant will be assigned a number that will be recorded on each tape recording. All data will be kept separate from the consent form and audiotapes. Data will be kept in a locked file cabinet in the researcher's office located at 22790 SW 112 Avenue, Miami, FL 33170. The audiotapes will be destroyed immediately after transcribing is completed. Consent forms, notes and transcripts will be destroyed after 5 years. Any published results of the research will protect the anonymity of all participants, and no names will be used. You may come to

the researcher's office and obtain a copy of the results of the study if you choose. Please contact the research at (305) 496-0179. The results will be available in approximately 6 months.

If you have any questions or concerns regarding the study, you may contact me, Jose R. Marmolejo, M.S., L.M.H.C., at (305) 496-0179, my supervisor and faculty sponsor Jeffrey T. Guterman, Ph.D. at (305) 899-3862 or the Institutional Review Board point of contact, Nildy Polanco, at (305) 899-3020.

Voluntary Consent - I acknowledge that I have read this consent form and have been informed of the nature and purposes of this research study by Jose R. Marmolejo, M.S., L.M.H.C. Also, all questions I have regarding this study have thus far been answered by Jose R. Marmolejo, M.S., L.M.H.C. and I have read and understand the information presented above. I have also received a copy of this form. If in the future I have further questions, I will contact the researcher Jose R. Marmolejo, M.S., L.M.H.C. or his supervisor and faculty sponsor Jeffrey T. Guterman, Ph.D. I hereby give my voluntary consent to participate in this research study.

______________________________ __________
Signature of Participant *Date*

______________________________ __________
Researcher *Date*

APPENDIX C

CONFIDENTIALITY AGREEMENT

As a member of the research team investigating, The Storied Experiences of Couples During the First Six Months of Recovery from Alcohol: A Phenomenological Inquiry, I understand that I will have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my obligation to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to applicable protocol or court order, or public health or clinical need.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I understand that a breach of confidentiality will result in termination from the study.
- I agree to notify the principal researcher, Jose R. Marmolejo, M.S., immediately should I become aware of an actual breach of confidentiality or situation, which could potentially result in a breach, whether this be on my part or on the part of another person.

______________________________ __________ ____________________________
Signature Date Printed Name

______________________________ __________ ____________________________
Signature Date Printed Name

APPENDIX D

<u>*Bold print</u>: direct participant statements

<u>*Regular print</u>: meanings attached by the researcher

We are able to talk about things.

We are able to have conversations.

It's just the small triggers that come.

It's the small situations that I can't handle which are obstacles for me.

When I need to talk, I have somebody to talk to.

I have someone that I can trust when I need to talk.

When I got in trouble before and went in the county jail.

When I was in trouble and went to jail, I realized that I had to make a decision.

We're going to ensure that it doesn't happen again, so we deal with it.

We can now adjust difficult situations so they will not recur.

(Researcher question: What events have led to or stopped you from relapse?) **When everything is going too good, I don't have any struggles.**

When there is nothing to do, I lose focus and I don't worry about anything.

I’m going home and I’m expecting everybody to love me and everything is going to be all right.

All I want is to have a normal lifestyle at home.

(Researcher question: What are some of the specific situations that alcohol may likely take advantage of?) **Probably a death.**

Uncertainty and a loss.

I know it’s a minute by minute, hour by hour, day by day fight.

Recovery is an ongoing process.

I don’t like a rigorous schedule.

I don’t want my life to be monotonous from now on.

I’ve gained a lot more patience and understanding.

I have more tolerance and knowledge of the problem with alcohol.

Anger.

I loose control of my emotions.

I talk out my feelings.

I am able to express my feelings with him instead of holding them in me.

Anger and legal issues.

Being angry and having legal issues.

Asking him to help me because I was at the point where I needed somebody.

Communicating with him when I needed help.

Having too much time on my hands and nothing to do with it.

Getting bored because I did not have anything to do.

To have someone that can be honest with me.

Having someone honest whom I can depend on.

Going out with various friends that are drinkers.

Going to places with old friends that I know have alcohol problems.

Being more aware of my feelings and where they may be coming from.

Understanding what I am feeling and am knowing myself better.

I'd just like honesty, and that's it.

To continue to have an honest relationship.

My self image was poor.

I thought very poorly about my self image.

I think my ego at the time was the hardest problem.

My major obstacle was that I had an inflated ego.

We travel a lot and we find meetings to go to along the way.

Traveling and going to support groups helps us.

I just reached a low point, and I was right on the edge.

Being at the lowest point in my life and being on the edge.

We did individual and couples therapy.

We went to individual and couples therapy.

I guess we have each other to stay in recovery.

We have each other to help remind us to stay in recovery.

To be able to not drink, keep my job and my family.

I would like to stay in recovery, be employed, and have a good family relationship.

If I had a reoccurrence of cancer, or if something happened to my job, I would have to drink again.

If something drastic happened to me where I could not handle the situation, I think I would relapse.

I've got a life at home, and I'm not alone.

I have a family who gives me support.

I would like to get a better grip on those type of defects that I know I have, that I have not quite resolved yet.

I would like to handle difficult situations better and overcome my weaknesses.

Opening channels of discussion and conversation.

Being able to have conversations with one another.

Sometimes I am influenced by the fact that I don't make the effort that I should for my own self.

I am easily influenced and I do not make an effort to make my own decisions.

We have couples, friends that are in recovery, and we go to support groups.

We attend support groups with couples and friends who are in recovery.

It wasn't just Bob's problem, but it was my problem.

Recovery was not just my husband's problem, but it was also my problem.

I involve Bob in things that I think are important to our relationship.

Doing significant things together in order to strengthen our relationship.

A sponsor has played a very large role in stopping me from relapsing and meetings.

Someone I can talk to and attending support group meetings has played a major role in my not relapsing.

I expect him not to drink.

My expectations are that he remain in sobriety.

I often talk myself into going to the bar to watch a game.

I often make poor decisions in my self-talk.

To take one day at a time and attend a spiritual program.

Not to rush into life and take care of my spiritual well-being.

I just want to be open to growth and mature.

I would like to be more open and continue to learn and mature.

I was afraid of being intimate with another person.

I was afraid of intimacy with my partner.

Making the changes that I had to make, learning how to live clean.

Having to make the necessary changes in order to stay in recovery.

Being humble and being grateful, and also by following the rules that I have learned.

By being humble and grateful, and having structure in my life.

A lot of years of suffering, being on the streets, and in jail.

Time spent on suffering, no place to call home, and incarceration.

I don't go out with people that drink.

I am not associating with people who have alcohol problems.

The memories of the misery that I had as a homeless in Miami, I stay close to my family and am very grateful that God gave me an opportunity.

The recall of past negative experiences with alcohol and the fact that I am now close to my family, has helped me stop from relapse.

I'm fortunate to have a great wife, a very understanding lady that's always by my side.

I have a great relationship with my wife, who is very understanding and is always there for me.

I had a problem with my anger. I used to be very violent when I drank.

I get very violent because I have an anger management issue that gets triggered if I drink.

That recovery works.

Being in recovery works.

To continue my life with my family.

I would like my family life to continue to get better.

There was a lot of fear and an inability to cope with the relationship.

I was very fearful and could not cope with the relationship.

His family used to scare me talking about the negative things that he used to do when he was in recovery.

Fear about the negative stories relating to my husband's recovery that his family would talk to me about.

Uniting the family and gaining sincerity in the relationship.

Having a closer relationship with the family in a sincere way.

He decided to get into recovery because of the many changes in his life.

A sincere decision because of the changes in his life.

Keep him away from people with alcohol problems.

Helping him stay away from old friends who have alcohol problems.

I have shown him a lot of affection, love, companionship, and positive advice.

Giving him the attention he needs in order to overcome any obstacle in his recovery.

Having a family and to maintain unity.

To have a united family and a good relationship.

I have learned that it brings problems, loneliness, and death into your life.

The negative byproducts such as loneliness and death help you stand up to alcohol's influence.

Anything to do with the breakup of tranquility would upset the relationship.

The disruption of harmony within the relationship would take advantage of us.

For him to continue clean and sober and also to continue trusting himself in recovery.

To continue in sobriety and trust the process of recovery.

If we are not in recovery, that can lead to a lot of tension, and there's a lot of anxiety.

The relationship will not function if we are not in the recovery process because it would lead to tension and anxiety.

We have to devote a lot of time to support groups and the recovery process itself.

Everyday devotion to the recovery process is difficult in itself.

We have started a little group and do our own meetings.

Doing support group meetings with others on our own has been effective for our recovery.

We have been going to marriage therapy and counseling.

We take preventive measures by going to marriage counseling.

They say that relapse happens long before the first drink is taken and going to a lot of meetings is the best prevention.

Understanding that one may always be in a relapse mode prevents relapse along with going to support groups often.

There are a lot of ups and downs when you are not drinking, but over a period of time it begins to level out more.

Even though life brings its own problems, when you are sober for a period of time, things start to go back to a normal pace.

Financial. Alcohol can rally take advantage of you financially and also when you have disagreements.

Financial difficulties and disagreements may allow alcohol to take advantage of you.

I know that I can enjoy my life and have really great moments with real joy and happiness and also live life to the fullest.

Being in recovery can allow me to fully enjoy life, as I never did before, to the fullest.

I would want to continue to improve every area of my life, financially and socially.

From now on I would like to improve my quality of life, including my finances and social life.

Positive effects is that it has brought respect.

Recovery has brought respect back into our relationship.

An obstacle has been socialization outside of the support groups. That's the major one.

Socializing with some old friends after attending the support groups, was a major obstacle.

Meetings and talking about it with my family and people. I think that it helps me.

By going to support groups and talking to others about recovery, I believe that this helps me.

Life. I was in bad, and it was to the point of death.

The hardships of life were so unbearable that I was at the brink of death.

Going to support groups and helping others have definitely helped.

Attending support groups and helping others in recovery have helped me in turn.

Thinking about the last three relapses and what I could lose.

Thinking about the past mistakes that led to relapse and all that I could lose as a result of relapse.

It's even better than I ever imagined.

The expectations I have about recovery and my relationship have been better than what I had ever imagined.

Death. The loss of someone important to me would be a big struggle.

I would have a big problem if someone close to me would die.

That I didn't have to drink and that life can be so wonderful.

Drinking does not have to be a part of my life because life without it can be wonderful.

I would like my experiences to continue to be better and good.

While in recovery I would like my experiences to continue to be better and more positive.

You have to get rid of some of your old friends. It's like starting over again.

It's like starting a new life all over again, getting rid of your old drinking acquaintances and choosing your new friends carefully.

Not being able to be my old self with old friends or old acquaintances.

Restriction to a life without doing the negative things I used to do and not spending any time with old friends from my past.

I have had a lot of support from church and my new friends at church.

I have had a lot of support from my church, and the new friends that I have made there.

Problems at work, in my marriage and with my extended family, contributed to being in recovery.

Difficulties at work and with my marriage and extended family contributed to my being in recovery.

Stress from problems always make me want to grab the bottle.

Stressful situations will always lead me to consider drinking.

A better relationship with my wife, family and parents.

My expectations are being met by having a better relationship with my wife, family and parents.

Parties, family reunions, the holidays. It's always a time where people want to celebrate.

Stressful situations will always lead me to consider drinking.

That as long as I don't touch the alcohol, I'm in control, that I have power.

As long as I am able to not ingest alcohol I have self control.

I would like to continue to be strong and surround myself with positive friends, which in turn make my relationship stronger.

If I continue to be strong and have friends who do not use alcohol, my relationship becomes stronger.

It's making our relationship much better and stronger.

Recovery is making our relationship much better and stronger.

A lot of it is old friends.

The major obstacle is the old friends that I had.

Trying to be a little more understanding and more patient.

I have been trying to be more understanding and more patient.

Well, the support of our friends and members from church.

Support from our friends and church members has contributed to my being in recovery.

You become accustomed to things in a certain way and you have to find a way to change it.

You have to be able to accept change and get accustomed to it.

I would reach out to one of my friends to talk and work it out and remove myself from the situation.

I talk to a friend I trust to help me remove myself from a relapse situation.

I am looking forward to the future, get back on track, and be happy.

I am looking forward to a stable and happy future.

I have to say influence of other people and getting together at other people's houses where they tend to drink.

The influence of old friends and people who invite us to their homes where drinking takes place.

I now know that we are stronger than I thought we were. Now together we can be anything.

Recovery has made us a stronger couple, able to accomplish what we set out to do.

Well, just want to live our lives and be happy and grow old together. I would like to raise our kids and not have to worry about the effect alcohol had on our lives.

I would like to live as a happy couple with a good family life and not worry about past experiences when I had a problem with alcohol.

Trusting in God to make my recovery and my relationship work.

One of recovery's effects on me is my ability to trust in God to make recovery and my relationship successful.

Some obstacles are hanging with the wrong set of people and in the wrong neighborhoods.

Being with people and in neighborhoods that can influence me to drink are obstacle for me.

By staying away from negative people, areas, and getting closer to God and my family are effective ways I have been dealing with recovery.

Some of the ways where I have been effectively dealing with recovery are by staying away from old friends and getting closer to my family and God.

I was sick and tired of living the way I was living, and also from the encouragement of my wife.

I got tired of living the way I was, and I had encouragement from my wife to enter into recovery.

I stayed focused on support groups and trying to do things with my wife and kids.

I focused on attending support groups and participating in more interaction with my family.

I got closer to my family and God. Also attending support groups and keeping positive.

Getting closer to my family and God and participating in support groups as well as having a positive attitude is what helped me from relapse.

Getting closer to my wife and getting to know her better – that's how my needs are being met.

My needs are being met by getting closer to my wife and knowing her better.

When I don't stay focused on reality and staying focused on the right things.

I relapse when I lose focus on reality instead of being in reality.

I learned how to deal with life instead of running from situations.

While in recovery I learned how to face difficult situations instead of running away from them.

I would like to stay positive and keep my wife, God, and my job. Also, staying focused.

I would like my present experiences to continue by staying positive, continuing to have a strong relationship with my wife, keeping close to God, and staying focused and employed.

Trust is, to sum it up all in one; the biggest effect recovery has done for me and my relationship.

Trusting one another has been recovery's biggest effect on our relationship.

I think the major obstacle is relying on a person that is in recovery.

Having to rely on a person who is in recovery is my major obstacle.

Basically having hopes that it's going to work and that he's going to stay focused, and continue to attend the support groups.

Continuing to hope that recovery will work and that he won't lose focus, and also for him to continue attending the support groups.

Going along with him to the support groups and giving him a lot of support.

Accompanying him to support groups and showing him encouragement.

Beginning to learn to trust again and having a lot of hope and support.

Learning how to trust and show support are some of the actions I have taken to reclaim our relationship.

The children and family life has helped stop him from relapse.

Being together with my family has prevented relapse.

Just knowing that he's on the right track, trying to make the right steps and move forward, are my expectations.

My future expectations are to know that he is focused on his recovery and moving forward in the right direction.

When we get frustrated and angry because things are not going right are situations that can take advantage of us.

Anger and being frustrated when things are not going our way is what sets us up for failure in our relationship.

We can sit down and talk to each other or seek support from other support groups that there are alternatives.

While in recovery we have learned that we can talk to each other or even get support from other people at support groups, and there are alternatives as well.

Most of all, just continuing the togetherness, giving support to each other, and knowing there's always going to be resources available so we can go to them when we need to; also, staying focused and not be so selfish.

My expectations are staying focused and together and continuing to give each other support, knowing also that there are resources when we need them. Also, to continuing to make our family life a better experience and not be so selfish.

APPENDIX E

The interview questions the researcher asked the participants are as follows:

1. What have been some of the effects of recovery on your relationship?
2. What major obstacles that prohibited from what you want make recovery difficult?
3. What are some of the ways you have been effectively dealing with recovery?
4. What contributed to your being in recovery?
5. What actions have you taken in order to reclaim the effects alcohol has had in your relationship and life at home?
6. What events have led to or stopped you from relapse?
7. How have your expectations of recovery and your relationship being home been met?
8. What are some of the specific situations or contexts in your life at home and in your relationship where alcohol could take advantage of you?
9. What is it you now know about recovery that can help you stand up to alcohol’s influence and improve your relationship and life at home?
10. What would you like your experience to be like from now on by continuing in recovery?

APPENDIX F

Couples Research Study

Seeking English speaking adult couples between the ages of 18 and 60 with at least one partner in recovery from alcohol for a minimum of six months.

Participate in a study to investigate the experiences of couples during the first six months of the recovery from alcohol. The participants will be asked to be available for two interviews between November 2006 and May 2007. The first interview will be 90 minutes. The follow-up interview will be 60 minutes. The interviews will be held in Miami-Dade County.

Participation is strictly voluntary and confidential. You may choose to withdraw from the study at any time with no consequences of any kind.

The researcher is Jose Marmolejo, L.M.H.C., and doctoral candidate at Barry University, Department of Counseling. If you are interested in participating in this research study, please contact the researcher directly at (305) 498-0179. The Barry University faculty sponsor is Jeffrey T. Guterman, Ph.D. is at 305-899-3862.

APPENDIX G

Barry University

Research with Human Participants

Protocol Form

PROJECT INFORMATION

1. **Title of Project**

THE STORIED EXPERIENCES OF COUPLES DURING THE
FIRST SIX MONTHS OF RECOVERY FROM ALCOHOL:
A PHENOMENOLOGICAL INQUIRY

2. **Principal Investigator**

Jose R. Marmolejo
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(305) 899-3862
jguterman@mail.barry.edu

Faculty Sponsor Signature: ________________________________ Date: _____________

4. **Research Sponsor**

Counseling Department, Barry University

5. **Proposed Project Dates**

Start 11/29/2006

End 05/28/2007

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A. Project activity STATUS is:

xx **NEW PROJECT**

— **PERIODIC REVIEW ON CONTINUING PROJECT**

— **PROCEDURAL REVISION TO PREVIOUSLY APPROVED PROJECT**

B. This project involves the use of an **INVESTIGATIONAL NEW DRUG (IND) OR** AN **APPROVED DRUG FOR AN UNAPPROVED USE** in or on human participants.

__ YES xx NO

C. This project involves the use of an **INVESTIGATIONAL MEDICAL DEVICE (IMD)** or an **APPROVED MEDICAL DEVICE FOR AN UNAPPROVED USE.**

__ YES xx NO

D. This project involves the use of **RADIATION or RADJOISOTOPES** in or on human participants.

__ YES xx NO

E. This project involves the use of Barry University students as participants. (If any students are minors, please indicate this as well.)

— YES Barry Students will be participants (Will minors be included? YES — NO)

xx NO Barry Students will participate

F. **HUMAN PARTICIPANTS** from the following population(s) would be involved in this study:

— Minors (under age 18)

— Fetuses

— Abortuses

— Pregnant Women

— Prisoners

— Mentally Retarded

— Mentally Disabled

— Other institutionalized persons (specify)

xx Other (specify) _ Six couples ages from 18 years to 60 years, of which three are female recovering alcohol users and three are male recovering alcohol users, who have all experienced no less than six months in the recovery process, and are living together.

G. Total Number of Participants to be studied: 12

Description of Project

1. Abstract

This study is to investigate the nature of the recovery process and essence of lived experiences during the first six months for people with alcohol problems and their non-using spouse or significant other. Research questions are: What stories do couples construct about recovery with regard to both the problem and strengths in relation to recovery? What themes can be derived from these stories, which in turn, might inform the theory and practice of recovery of alcohol, and substances abuse? Social-scientific research conflicts with disease theories of alcohol, yet non-disease conceptions are not well represented (Lernet, 1991). A phenomenological research design and qualitative method, using a narrative theoretical framework, will be used.

Flyers to AA and AL-Non centers (Greater Miami Area) will be distributed, and include study information and requirements for participation. Six couples ages 18-60 will be selected; English speaking, with one partner in recovery from alcohol (minimum six months). Participation is voluntary and confidential. Informed consent and descriptions of risks will be explained to participants. Researcher will separate personal beliefs about the topic (Bracketing) (Steward & Mickunas, 1990). Two recorded interviews (90 minutes and follow up 60 minutes) will be transcribed (Cresswell, 1998). Relevant interview data will be grouped, and coded (Streubert & Carpenter, 1995). The result section will provide a better understanding of the experience of interest (Cresswell, 1998).

2. Recruitment Procedures

Participants will be solicited for this study through flyers, which will be placed at AA and AL-Anon centers of the Greater Miami Area of Florida. Also, the flyers will indicate to the potential participants that involvement in the study is voluntary and can end at any time or for any reason they may have. There will be a contact number on the flyer for those interested in volunteering for the study. Upon phone contact (Appendix–A), an appointment will be made to provide the participants with questions they may have regarding the study. No information will be withheld. If the volunteers agree to participate in the inquiry, an interview will be scheduled to begin shortly thereafter, and consent forms will be signed. Six couples (or a total of 12 participants) ages from 18

years to 60 years, of which three are female recovering alcohol users and three are male recovering alcohol users, who have all experienced no less than six months in the recovery process, are living together, neither of whom have been specifically treated in individual or group counseling sessions by the researcher and are not Barry University students, will be recruited. The participants should be able to converse in English, as Colaizzi (1978) stated that anyone who has had the experience with the phenomenon being researched and is able to communicate the experience qualifies for the selection as a participant.

3. **Methods**

After the participants have read, reviewed, and signed the informed consent form (Appendix-B) the researcher will explain the interview agenda and then respond to any of their questions or concerns. Before beginning the interview process, this researcher will focus on building rapport with the participants. After this, the researcher will conduct open ended interviews with recovering alcohol users who have all experienced no less than six months in the recovery process, and their non-using spouse or significant others. Initial interviews of 90 minutes and a follow up interview of 60 minutes (for the accuracy of the participant's transcripts), both of which will be taped recorded and transcribed, will be conducted. The researcher will conduct all interviews. The researcher will transcribe the audiotapes. The transcribed interviews will be non-linked. There will be no information identifying the participants linking them to the data or to codes (identifiers) in any way. The anticipated number of participants is to be 12 adults. The interviews and data collection will be conducted at the researcher's office located at 22790 SW 112 Avenue Miami, FL 33170. Also, the audiotapes and transcripts will be stored in the researcher's office in a locked file. They will be maintained for 5 years and then they will be destroyed. In order to obtain the fullest description the researcher will allow the participants to see the open ended questions in written form as follows:

1. What have been some of the effects of recovery, on your relationship?
2. What major obstacles, that prohibited you from what you want, make recovery difficult?
3. What are some of the ways, that you have been effectively dealing with recovery?

4. What contributed to you being in recovery?
5. What actions have you taken in order to reclaim the effects alcohol has had in your relationship and life at home?
6. What events have led to or stopped you from relapse?
7. How have your expectations, of recovery and your relationship, being home been met?
8. What are some of the specific situations or contexts in your life, at home, and your relationship that alcohol may likely take advantage of?
9. What is it you know now about recovery that can help you stand up to alcohol's influence and improve your relationship and life at home?
10. What would you like your experience to be like, from now on, continuing in recovery?

Participants will be advised that participating in the research study is voluntary and they may discontinue at any time without consequence. Potential risks will be discussed and the informed consent will fully explain these potential risks. The researcher will also explain in detail how confidentiality will be maintained. In order to ensure that the interview data has been interpreted accurately, the researcher will use the technique known as member checking (in the follow-up interview). This technique involves having the participants verify the interpretations of the data (Lincoln & Guba, 1985). The participants will review the final report to ensure their voices are heard accurately and the meanings of their stories are correctly interpreted. Two disinterested peers, who are not familiar with the study, will review the study (Cresswell, 1998), and sign third party informed consent forms (Appendix-C). Also, they will ensure the quality, the readability, and the data analysis of the study (Patton, 2002).

Accuracy and transferability of the study will also be enhanced through the peer debriefing technique. This involves a review by a peer who will ask questions about the study in order to ensure the study will resonate with readers (Cresswell, 1998). The peer debriefer will not have access to any raw data or any indicator that may connect the peer debriefer to the participant. The result section will provide a better understanding of the experience of interest (Cresswell, 1998).

4. Alternative Procedures

Flyers and consent forms will include all relevant study information and will advise participants that involvement in the study is voluntary. The risks of involvement in this study may include a possibility of anxiety during the interview or unpleasant memories. After each interview the researcher will advise the participants that he is available throughout the research process if any issues or concerns arise. If it is determined at any time during interviews that a participant needs mental health or substance abuse intervention, the interview will immediately be stopped. The participants will then be referred to New Horizon Community Mental Health Center at 1313 NW 36th St. Miami, Fl. 33142 (305) 635-0366), a community mental health center which provides a full range of mental health and substance abuse services. If the participants need to be referred to a facility that is closer to their residence, the researcher will have a referral list for mental health and substance abuse centers in their areas. Participants may withdraw at any time and for any reason, and there will be no adverse consequence of any kind for ending their participation in the study. Also, participants will be advised that if they wish to withdraw from the study, there will be no adverse consequences, on them, their spouse, their significant other, or the study.

5. Benefits

Participants will be advised that there will not be any direct benefits to them. Although there will not be any direct benefits for the participants in this study, the study may help our understanding of the storied experiences of couples during the first six months of recovery from alcohol. This increased understanding may in turn help clinicians, mental health professionals, therapists and marriage and family counselors who serve clients with alcohol problems and also to provide useful information to couples and family members experiencing the recovery process. The study may promote the recovery process as a legitimate area of concern and for study in the field of Drug and Alcohol Rehabilitation.

6. Risks

Some of the possible risks in any qualitative study may provoke anxiety and distress (Richard & Schwartz, 2002). The risks of involvement in this study may include a possibility of anxiety during the interview or unpleasant memories (Patton, 2002). The

following procedures will be used to reduce the risk of harm. Participants will be provided the research questions, a clear understanding of participation boundaries, and sources of follow up care. This researcher will also provide the following: a) The purpose, scope and boundaries of the study, b) The methods of data collection to be used in the study, c) How the data will be stored and destroyed, d) How the results will be used, and e) How identity of the participants will be concealed (Richard & Schwartz, 2002). If it is determined at any time during interviews that a participant needs mental health or substance abuse intervention, the interview will immediately be stopped. This researcher is an L.M.H.C. and a C.A.P. The participants will then be referred to New Horizon Community Mental Health Center at 1313 NW 36th St. Miami, Fl. 33142 (305) 635-0366), a community mental health center which provides a full range of mental health and substance abuse services either free of charge or on a sliding scale fee. Also, if applicable, the researcher will refer the participant to their current health insurance plan or preferred provider. After each interview the researcher will advise the participants that he is available throughout the research process if any issues or concerns arise. The informed consent form fully explains the above-mentioned possibility of risk.

7. Anonymity/Confidentiality

In order to protect the confidentiality of participants, data will be coded so that no names will be used. No other identifiers will be collected from the participants. Flyers announcing the study will not have the location of where the study will be conducted. Consent forms, codes, and audio tapes will be kept in a locked file cabinet located at the researcher's office at 22790 S.W. 112th Avenue Miami, Florida, 33170 and these identifiers (codes) will not be stored in the same file cabinet as data collected. The researcher will be aware that audiotapes contain numbers throughout the course of the interview process. The researcher will transcribe the interviews. Consent forms, audiotape and transcripts will be retained for a period of five years. In accordance with the Barry University's Institutional review board standards, the consent forms, audiotapes, notes and transcripts will be shredded and destroyed after a period of five years.

8. Consent

Please see attached Consent Form. A copy of these forms will be offered to all participants.

9. **Certification**

I certify that the protocol and method of obtaining informed consent as approved by the Institutional Review Board (IRB) will be followed during the period covered by this research project. Any future changes will be submitted to IRB review and approval prior to implementation. I will prepare a summary of the project results annually, to include identification of adverse effects occurring to human participants in this study. I have consulted with the department or program faculty/administrators and the Dean of the school, which is to be the subject of research and have received prior approval to conduct the research and/or to disseminate the results of the study. A copy of that approval has been included with this protocol.

______________________________ __________________

Principal Investigator *Date*