8-2001

Quality of Life Factors among Recovering Alcoholics

George Edwin Compton Jr.
Western Michigan University

Follow this and additional works at: http://scholarworks.wmich.edu/dissertations

Part of the Counseling Commons, Experimental Analysis of Behavior Commons, Other Mental and Social Health Commons, and the Substance Abuse and Addiction Commons

Recommended Citation

This Dissertation-Open Access is brought to you for free and open access by the Graduate College at ScholarWorks at WMU. It has been accepted for inclusion in Dissertations by an authorized administrator of ScholarWorks at WMU. For more information, please contact maira.bundza@wmich.edu.
QUALITY OF LIFE FACTORS AMONG RECOVERING ALCOHOLICS

by

George Edwin Compton, Jr.

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education
and Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
August 2001
QUALITY OF LIFE FACTORS AMONG RECOVERING ALCOHOLICS

George Edwin Compton, Jr., Ph.D.
Western Michigan University, 2001

The inspiration for undertaking the current research came from the Student Investigator's own experience of 19 years in recovery from alcoholism. During his early years in graduate school, the Student Investigator witnessed occasional misunderstandings among some academics and helping professionals regarding the nature of alcoholism, and, specifically, the tasks involved in sustaining enduring recovery from alcoholism. Thus, this dissertation research, which has sought to examine, through qualitative research methodology, the factors involved in achieving and sustaining quality of life in extended recovery from alcoholism was undertaken.

Several authors have noted the need for research which focuses on long-term recovery from alcoholism (Amodeo, Kurtz, & Kutter, 1992; Cary, 1999). A literature review revealed virtually no research which deals exclusively with quality of life in long-term recovery from alcoholism. A number of areas of existing alcoholism research were examined, however, which touch upon topics relevant to quality recovery; these included the “dry drunk syndrome” and relapse, spirituality, and the roles of therapy and Alcoholics Anonymous.

In the current research, phenomenologically-based qualitative methodology (Moustakas, 1994) was used. Eight participants were chosen from among male and female members of Alcoholics Anonymous. Each participant had at least 10 years of continuous sobriety. Each participant was interviewed twice; interviews were tape-recorded. A semi-structured interview format was employed.
INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

ProQuest Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
ACKNOWLEDGMENTS

I would like to extend my sincere appreciation to my doctoral committee, Dr. Mary Anderson, Dr. Dennis Simpson, and Dr. Edward Trembley, for their patience, guidance, and support during my writing of this dissertation. Each of them made a unique contribution to this project. In particular, I want to acknowledge how much of a privilege it has been to have my committee chaired by Dr. Trembley. His knowledge, experience, and willingness to be of help to me in accomplishing this goal have been indispensable.

My sincere thanks go to my fellow doctoral students who have shared with me their knowledge about qualitative research. In particular, I appreciate Robyn Geelhoed’s assistance in guiding me with the use of qualitative analysis software, and Nancy Rosenau’s willingness to share her vast knowledge of the qualitative methodology literature.

It would not have been possible to complete this dissertation, let alone graduate school, without the infinite patience, caring, and support of my wife Susie. In addition, I need to acknowledge the support and encouragement I have received from my family and friends throughout this process. Though my mother and my brother John could not see this process through to its completion, I trust that in spirit, they recognize this achievement.

The completion of this research would not have been possible without the participants who gave so generously of their time, experience, strength, and hope. It
Acknowledgments—Continued

was a great privilege for me to hear them describe in such thoughtful detail the path that each of them has followed to quality of life in sobriety, and I am in their debt.

Finally, I would be remiss if I did not acknowledge the influence of Midge S., from whom I learned some 19 years ago how effective one person’s counseling skill could be in helping another person to achieve sobriety. Without her, I would not have discovered a way of living which has made it possible to (as some of the research participants said) live “life on life’s terms.” It is to her that I dedicate this dissertation.

George Edwin Compton, Jr.
# TABLE OF CONTENTS

**ACKNOWLEDGMENTS** ......................................................... ii

**CHAPTER**

I. **INTRODUCTION** ............................................................. 1

  Statement of the Problem ..................................................... 5

  Abstinence Versus Sobriety ................................................... 5

  Dry Drunk Versus Surrender ................................................ 6

  Powerlessness and Unmanageability ...................................... 7

  The Essence of the A.A. Experience ...................................... 9

  Can Therapists Facilitate Acclimation to A.A.? ......................... 10

  Development of a Spiritual Life ........................................... 10

  Significance of the Problem ............................................. 11

  Definition of Terms ......................................................... 12

  Limitations of the Study .................................................. 16

  The Human Subjects Institutional Review Board ....................... 17

II. **REVIEW OF RELATED LITERATURE** .............................. 18

  Emotional State Changes Entering Recovery ......................... 18

  Surrender ........................................................................... 24

  The Dry Drunk Syndrome and Relapse .................................. 27

  The Roles of Therapy and Alcoholics Anonymous ................... 36

  Stages of Recovery .......................................................... 45

  Spirituality in Recovery ................................................... 53
Table of Contents—Continued

CHAPTER

Quality of Life in Alcoholism Recovery: Qualitative Research .......................... 62
Summary .............................................................................................................. 66
   Emotional State Changes Entering Recovery ............................................. 66
   Surrender ......................................................................................................... 68
   The Dry Drunk Syndrome and Relapse ........................................................ 69
   The Roles of Therapy and Alcoholics Anonymous ....................................... 70
   Stages of Recovery ........................................................................................ 71
   Spirituality in Recovery .................................................................................. 71
   Quality of Life in Alcoholism Recovery: Qualitative Research ...................... 72
   Conclusion ....................................................................................................... 73

III. METHODOLOGY .......................................................................................... 74
   Overview .......................................................................................................... 74
   Research Design ................................................................................................ 74
      The Empirical-Phenomenological Approach ............................................... 75
      The Researcher as Instrument ..................................................................... 77
   Selection of the Participants ........................................................................... 78
      Purposeful and Theoretical Sampling .......................................................... 78
   Pilot Study ......................................................................................................... 81
   Data Collection/Interviews ............................................................................... 81
   The Processing and Analysis of the Data ......................................................... 83
      The Rigor of the Data Analysis .................................................................... 86
Table of Contents—Continued

CHAPTER

Limitations .............................................................. 88

IV. RESULTS .......................................................... 90

Overview ............................................................... 90

John ................................................................. 91

  Quality of Life: General Observations .................. 92
  Continuity of Recovery .................................... 92
  Contributing Factors to Quality of Life ............... 94
  The Role of Surrender .................................... 95
  The Role of Spirituality .................................. 96
  The Role of Alcoholics Anonymous .................. 97
  The Importance of the Alcoholic Identity .......... 99

Priorities in Recovery ........................................... 100

General Observations and Reactions Noted in
Interview Number Two ............................................. 101

Dave ................................................................. 102

  Quality of Life: General Observations ............... 102
  Continuity of Recovery ................................... 103
  Contributing Factors to Quality of Life ............... 105
  The Role of Surrender .................................. 106
  The Role of Spirituality ................................ 107
  The Role of Alcoholics Anonymous ............... 108
  The Importance of the Alcoholic Identity ........ 110
# Table of Contents—Continued

## CHAPTER

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misunderstandings About Recovery</td>
<td>110</td>
</tr>
<tr>
<td>Priorities in Recovery</td>
<td>111</td>
</tr>
<tr>
<td>The Role of Therapy</td>
<td>112</td>
</tr>
<tr>
<td>General Observations and Reactions Noted in Interview Number Two</td>
<td>112</td>
</tr>
<tr>
<td>Jerry</td>
<td>114</td>
</tr>
<tr>
<td>Quality of Life: General Observations</td>
<td>115</td>
</tr>
<tr>
<td>Continuity of Recovery</td>
<td>115</td>
</tr>
<tr>
<td>Contributing Factors to Quality of Life</td>
<td>117</td>
</tr>
<tr>
<td>The Role of Surrender</td>
<td>118</td>
</tr>
<tr>
<td>The Role of Spirituality</td>
<td>119</td>
</tr>
<tr>
<td>The Role of Alcoholics Anonymous</td>
<td>120</td>
</tr>
<tr>
<td>The Importance of the Alcoholic Identity</td>
<td>121</td>
</tr>
<tr>
<td>Priorities in Recovery</td>
<td>123</td>
</tr>
<tr>
<td>General Observations and Reactions Noted in Interview Number Two</td>
<td>123</td>
</tr>
<tr>
<td>Susie</td>
<td>125</td>
</tr>
<tr>
<td>Quality of Life: General Observations</td>
<td>125</td>
</tr>
<tr>
<td>Continuity of Recovery</td>
<td>126</td>
</tr>
<tr>
<td>Contributing Factors to Quality of Life</td>
<td>128</td>
</tr>
<tr>
<td>The Role of Surrender</td>
<td>129</td>
</tr>
<tr>
<td>The Role of Spirituality</td>
<td>131</td>
</tr>
<tr>
<td>The Role of Alcoholics Anonymous</td>
<td>132</td>
</tr>
</tbody>
</table>
Table of Contents—Continued

CHAPTER

The Importance of the Alcoholic Identity ................................. 134
Misunderstandings About Recovery ....................................... 137
Priorities in Recovery ............................................................ 138
General Observations and Reactions Noted in
Interview Number Two .......................................................... 139
Marsha .................................................................................... 140
Quality of Life: General Observations ...................................... 141
Continuity of Recovery ............................................................ 141
Contributing Factors to Quality of Life ................................. 143
The Role of Surrender ............................................................ 144
The Role of Spirituality ............................................................ 146
The Role of Alcoholics Anonymous ........................................ 147
The Importance of the Alcoholic Identity ................................. 148
Misunderstandings About Recovery ....................................... 149
Priorities in Recovery ............................................................ 149
General Observations and Reactions Noted in
Interview Number Two .......................................................... 150
Betty .................................................................................. 151
Quality of Life: General Observations ...................................... 152
Continuity of Recovery ............................................................ 153
Contributing Factors to Quality of Life ................................. 154
The Role of Surrender ............................................................ 156
The Role of Spirituality ............................................................ 157
Table of Contents—Continued

CHAPTER

| The Role of Alcoholics Anonymous | 158 |
| The Importance of the Alcoholic Identity | 160 |
| Misunderstandings About Recovery | 160 |
| Priorities in Recovery | 161 |
| General Observations and Reactions Noted in Interview Number Two | 162 |

Kathy | 163 |

| Quality of Life: General Observations | 164 |
| Continuity of Recovery | 165 |
| Contributing Factors to Quality of Life | 168 |
| The Role of Surrender | 169 |
| The Role of Spirituality | 170 |
| The Role of Alcoholics Anonymous | 171 |
| The Importance of the Alcoholic Identity | 172 |
| Misunderstandings About Recovery | 173 |
| Priorities in Recovery | 174 |
| The Role of Therapy | 174 |
| General Observations and Reactions Noted in Interview Number Two | 175 |

Charles | 177 |

<p>| Quality of Life: General Observations | 178 |
| Continuity of Recovery | 179 |
| Contributing Factors to Quality of Life | 180 |</p>
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Role of Surrender</td>
<td>182</td>
</tr>
<tr>
<td>The Role of Spirituality</td>
<td>183</td>
</tr>
<tr>
<td>The Role of Alcoholics Anonymous</td>
<td>184</td>
</tr>
<tr>
<td>The Importance of the Alcoholic Identity</td>
<td>187</td>
</tr>
<tr>
<td>Misunderstandings About Recovery</td>
<td>188</td>
</tr>
<tr>
<td>Priorities in Recovery</td>
<td>188</td>
</tr>
<tr>
<td>The Role of Therapy</td>
<td>189</td>
</tr>
<tr>
<td>General Observations and Reactions Noted in Interview Number Two</td>
<td>191</td>
</tr>
<tr>
<td>Summary</td>
<td>194</td>
</tr>
<tr>
<td>V. CONCLUSIONS</td>
<td>196</td>
</tr>
<tr>
<td>Overview</td>
<td>196</td>
</tr>
<tr>
<td>General Observations</td>
<td>196</td>
</tr>
<tr>
<td>The Participants</td>
<td>196</td>
</tr>
<tr>
<td>Consistency of the Research Results</td>
<td>197</td>
</tr>
<tr>
<td>Continuity of Recovery</td>
<td>199</td>
</tr>
<tr>
<td>Composite Descriptions</td>
<td>203</td>
</tr>
<tr>
<td>Composite Description One: Spirituality</td>
<td>204</td>
</tr>
<tr>
<td>Composite Description Two: Membership in Alcoholics Anonymous</td>
<td>208</td>
</tr>
<tr>
<td>Composite Description Three: Service</td>
<td>212</td>
</tr>
<tr>
<td>Relational Meanings</td>
<td>213</td>
</tr>
<tr>
<td>Resentments and Anger</td>
<td>217</td>
</tr>
</tbody>
</table>
Table of Contents—Continued

CHAPTER

The Role of Therapy ................................................................. 219
Implications for Future Research ................................................. 226
Final Thoughts ............................................................................. 227

APPENDICES

A. Posted Announcement: Invitation to Participate in Dissertation Research ................................................. 229
B. Participant Phone Contact Script ............................................. 231
C. Anonymous Consent Document for Participation in the Dissertation Research Project ............................................. 234
D. Pre-Interview Guide: Demographic Information ....................... 237
E. The Interview Guide: Quality of Life Factors Among Recovering Alcoholics ........................................... 239
F. The Twelve Steps of Alcoholics Anonymous ......................... 243
G. The Promises of Alcoholics Anonymous ................................. 245
H. Human Subjects Institutional Review Board Letter of Approval .................................................. 247

BIBLIOGRAPHY ................................................................................. 249
CHAPTER I

INTRODUCTION

The purpose of the research herein is to examine the factors that contribute to the quality of life for recovering alcoholics. The inspiration for the undertaking of this research comes from my own experience as a recovering alcoholic. I became sober on June 11, 1981. I have been continuously sober since that time. In the early years of my recovery, I observed that there seemed to be a fair amount of misunderstanding among the general populace about alcoholism and what was involved in recovery. I found it frustrating that people who knew me either denied that I was alcoholic, or could not understand why I sought the support of other recovering alcoholics to aid in my own recovery. I have often speculated on the reasons why people would react this way; there are few who would dispute that there is still a stigma attached to acknowledging that one is alcoholic—this can be threatening not only to alcoholics, but to their significant others and friends (Levin, 1995). There is also a cultural taboo concerning admitting personal powerlessness and acknowledging the need for help (Kohn, 1984; Peteet, 1993). Some people that I have known have questioned why alcoholics cannot simply employ more personal strength in coping with their drinking problems. As frustrating as these aspects of my recovery have been, I accepted early on that for many people, at least, they held beliefs about alcoholism that I believed were either misinformed or inaccurate. I felt very strongly from those early years of recovery, however, that I would like to play a part in disseminating helpful and
accurate information about alcoholism in the future. Toward that goal, I returned to school, and went on to pursue graduate studies in counseling psychology.

There have been discouraging moments in my graduate counseling studies, however, as I have come to realize that there are those within academia and the counseling profession who, if they are willing to work with alcoholics, are uncomfortable with the concept of the disease of alcoholism (Brown, 1985). Some of these professionals do not view complete abstinence as a goal. While I respect their opinions, in my experience, "moderate drinking" is counter-productive to the recovery process of alcoholics (at least those with whom I am familiar). Suffice it to say that controversy still surrounds the disease concept (Vaillant, 1995), even though the American Medical Association classified alcoholism as a disease as long ago as 1956 (Lawton, 1985). I have also observed an occasional lack of understanding of the mechanisms and principles of Alcoholics Anonymous. A contributing factor to the antipathy which exists between A.A. and many therapists may also be the role of spirituality in recovery (Humphreys, 1993; Kurtz, 1985). I have long felt that much of the misunderstanding and occasional tensions that exist between those seeking recovery from alcoholism and therapists could be lessened through the advancement of accurate accounts of what alcoholism recovery has really meant to those who have been able to sustain a period of recovery (particularly, those who have accomplished this through participation in Alcoholics Anonymous and therapy).

There are several reasons for reviewing these experiences that I have had (and observations that I have made) in alcoholism recovery. I have had the privilege of sharing my own journey with hundreds of men and women who have given freely of their time to pass on to others the "tools" of recovery. It has been a remarkable process in which to be involved, and to observe. Many of these individuals have
sustained periods of recovery numbering not only in years, but in decades. By all accounts, their lives, while far from perfect, are full and rewarding. It has not escaped my attention that, when these individuals share with me anecdotally how they have gotten to such a positive point in their recoveries, they invariably refer to certain phases of growth which they feel have been "rites of passage" in their sobriety; additionally, they identify certain components of their recovery programs, which seem to receive frequent mention. A number of these components appear within the literature review, which follows in Chapter II (such as surrender, spirituality, etc.). Rarely, if ever, however, have I seen all of these facets of recovery gathered together comprehensively within individuals' personal portrayals of their contexts. For me, it is not a recent phenomenon to discover that these personal accounts of "quality recovery" could be both compelling and educational. Between recovering alcoholics, this sharing of meanings occurs frequently; it is central to sobriety.

Capturing the meanings of these experiences is the goal of phenomenologically-based qualitative research methods (Creswell, 1998). Hence, they provided an appropriate format for the qualitative research which was employed herein. One of the central premises of the phenomenological approach is that the researcher's personal experiences are "bracketed" at the outset of research. This represents the second reason why I have chosen to emphasize the role my own experience has played in providing inspiration for this research. McCracken (1988) has addressed this issue:

The investigator must use his or her experience and imagination to find (or fashion) a match for the patterns evidenced by the data. The diverse aspects of the self become a bundle of templates to be held up against the data until parallels emerge. The self-as-instrument process works most easily when it is used simply to search out a match in one's experience for ideas and actions that the respondent has described in the interview. (p. 19)
One of the distinguishing features of qualitative research is that the researcher does not purport to be without bias, values, experiences, or opinions (Taylor & Bogdan, 1998). Rather, those biases are acknowledged "up front," with the intention of minimizing the covert effect of coloring the ongoing research. This is one technique which contributes to the rigor of the research process. This aspect of qualitative research is referred to by Patton (1990), who has stated that:

_Epoché_ is a process that the researcher engages in to remove, or at least become aware of prejudices, viewpoints or assumptions regarding the phenomenon under investigation. _Epoché_ helps enable the researcher to investigate the phenomenon from a fresh and open viewpoint without prejudgment or imposing meaning too soon. This suspension of judgment is critical in phenomenological investigation and requires the setting aside of the researcher's personal viewpoint in order to see the experience for itself. (p. 407)

Over the course of some 19 years of interacting with other recovering alcoholics, I have observed common elements in our stories. Certain phenomena seem to appear with some regularity (i.e., surrender, making amends, etc.), though the process by which people arrive at these milestones are extremely varied (Cary, 1999). Hence, the richness becomes apparent in the lives of people who have sustained recovery. I would be remiss if I did not acknowledge my own experience at the outset of this research; nevertheless, it only served as a rough point of reference as data were gathered. I consider it a privilege to have undertaken research which illuminates the struggles and successes of the people who became its participants. I believe their stories can be of value to those seeking recovery, and to those professionals who provide treatment to such individuals.
The goal of this qualitative study is to investigate the meanings of quality of life in recovery from alcoholism. What are the factors that have contributed to contented long-term sobriety in the lives of men and women who no longer drink? This is but one aspect of alcoholism research which remains largely misunderstood. In the words of George Vaillant (1995), “Such a serious and widespread problem demands to be studied, yet our lack of knowledge is astonishing” (p. 1). One of the few authors who has dealt with the “journey” of long-term recovery is Sylvia Cary (1999). She believes that there are still so many people who are in need of recovery, that less emphasis is placed on exploring the factors that have sustained sobriety for the millions of people who have remained sober over time. Her thinking is that, for many helping professionals, it is understandably a priority to get people into treatment; less attention is given to follow-up on those who have completed treatment. Cary (1999) speculates that

Maybe that’s one of the reasons why so little is written about recovery over time. It’s simply not dealt with. Most of the existing literature only deals with the early stages of recovery—just the first few years—the assumption is that after that this phase, all recovery looks alike. But all recovery doesn’t look alike . . . different phases occur at fairly unpredictable times. (p. 2)

Cary’s views are shared by Amodeo, Kurtz, and Kutter (1992), who lament the lack of research on long-term sobriety: “Little is known about the extent to which reasons for not drinking change over time” (p. 708).

**Abstinence Versus Sobriety**

Perhaps one of the most widely misunderstood aspects of recovery is the distinction that is often made by recovering alcoholics between mere abstinence and a
contented life free of drink (Rosen, 1981; Zackon, 1989). Zackon (1989) maintains that what clinicians and researchers fail to recognize is that the initial attainment of abstinence is often marked by unhappiness, as a radically new lifestyle is undertaken. It is Zackon’s contention that therapists need to be especially active in the instillation of hope at this time: “The great thing that abstinence brings, of course, is not joy but the opportunity for recovery; and genuine recovery creates the conditions for new joy” (Zackon, 1989, p. 73). Rosen (1981) echoes these sentiments: “abstinence by itself for a significant group of patients is inadequate” (Rosen, 1981, p. 234). If abstinence alone is “inadequate,” how is it, then, that recovering women and men act upon “opportunities” for joy? That is a central question which the present research addresses.

**Dry Drunk Versus Surrender**

There are those who might maintain that if recovering alcoholics are unable to move beyond sheer abstinence to a point of greater peace and serenity, they are likely to remain “dry drunks,” who are inviting relapse into active drinking (Gorski, 1989b; Solberg, 1970). Solberg (1970) has defined the dry drunk syndrome as “the presence of actions and attitudes that characterized the alcoholic prior to recovery” (p. 2). It has been suggested by a number of authors that the key to moving beyond abstinence into a period of contented sobriety is the act of surrender (Brown, 1985; Lawton, 1985; May, 1988; Spahr, 1987, Tiebout, 1954). For alcoholics this entails the surrender of a destructive lifestyle, and the surrender of many long-held notions, including especially the belief that they are “self-sufficient” enough to navigate their recoveries alone. The preparation for the surrender process is one prominent example
of the potential that therapy holds to facilitate the alcoholic's progress toward this goal:

The counselor can work closely with the addicted client to identify the issues requiring attention. It can be assumed that for all it is necessary to address the feelings inherent in the human condition separating out powerlessness and responsibilities... It is difficult to determine the point at which surrender occurs but when it does, there is then the opportunity for contact with a higher power and the feeling of joy coming from a belief that basically all is well. The client has replaced his/her “ism” with a connection to a higher power and no longer feels alone. (Lawton, 1985, p. 63)

Capturing the experiences leading up to and surrounding surrender is one of the key goals of this research: if the phenomenon of surrender can be better understood, perhaps it can be better facilitated within treatment. While there is a fair amount of literature that deals with the topic of surrender (see Chapter II), most existing treatments have dealt with the topic conceptually; few have attempted to convey verbatim accounts of this process from recovering alcoholics (Bowden, 1998; Cary, 1999). The phenomenological qualitative methods of inquiry used in the present research have attempted to offer a faithful and personalized rendition of the surrender experience.

Powerlessness and Unmanageability

Associated with the experience of surrender are several attendant terms which may represent the recovery concepts that meet with the most resistance among both the general public and the therapeutic community. Among these would be “powerlessness” and “unmanageability.” These terms are both considered to be of such critical importance as to be highlighted in the First Step of Alcoholics Anonymous: “We admitted we were powerless over alcohol, that our lives had become unmanageable” (Alcoholics Anonymous, 1976, p. 59). This represents one of
the several paradoxes associated with recovery: in order to achieve “victory” over alcoholism, one must first admit “defeat” (essentially the defeat of the infallibility of one’s will). Prugh (1985) has stated that

> With the alcoholic, it’s a giant step to [admit that the drinking is out of control and then to] surrender his control over alcohol—admitting the powerlessness and unmanageability is an unbelievable act of surrender. They usually can’t do it in one sitting . . . It’s got to be done over and over again. (Prugh, 1985, p. 53)

In other words, admitting powerlessness and unmanageability is an ongoing process. The present research has sought to discover how it is that this process evolves over time. Does it get easier? What is the relationship between this ongoing admission of powerlessness and an improvement in the overall quality of one’s life?

Many alcoholics who have attempted to become sober have been unable to accept the concept of personal powerlessness; it remains an obstacle for many because of the cultural emphasis on individual strength:

> The admission of powerlessness and the surrender of self to a greater power which are in A.A.’s early steps have been misunderstood as an abnegation of responsibility. They represent, on the contrary, a breaching of the narcissistic defensive structure which maintained twin illusions: on the one hand the illusion that drinking could be controlled and on the other hand the illusion of self-autonomy or self-sufficiency. The admission of powerlessness over alcohol represents the first defeat of infantile egotism, a first step in the assumption of responsibility. At the same time, acknowledgment of a basic dependence upon others, and upon some power greater than oneself, begins the abandonment of a grandiose posture. (Mack, 1981, p. 145)

The preceding statement represents one of the most effective attempts to articulate the apparent paradox of powerlessness that I have encountered. How is it that others have resolved this issue in their own lives? What led up to this admission? How have recovering alcoholics responded to those who would advocate self-control?
The Essence of the A.A. Experience

As earlier noted, the admission of personal powerlessness is A.A.'s first suggested Step. As valuable as the self-reports of recovering alcoholics are regarding the admission of powerlessness, the present research recognizes particular value in capturing the essence of the A.A. experience for recovering individuals. Admitting powerlessness would appear to be the entrance into A.A., but why have people continued to attend into several decades of sobriety? Several authors have noted the effectiveness of A.A. (Brown, 1985; May, 1988; Vaillant, 1995). Sheeren (1987) believes that "Alcoholics Anonymous is a fellowship accepted worldwide as the primary and most successful therapy for the recovering alcoholic" (p. 104). A.A. is certainly not the only avenue by which individuals can achieve quality sobriety. For the purposes of this research, however, it represents the most expedient and uniform source of potential participants. The present research examines how it is that A.A. has played a significant role in the recoveries of its participants. Because of its tradition of anonymity, A.A. does not have the capability to maintain precise accountings of those who try A.A. and maintain attendance. Nevertheless, anecdotally, some A.A. observers have noted that a surprisingly small percentage of those who have begun initial attendance have remained in attendance on a long-term basis (Sheeren, 1987). The present research has sought to hear from recovering alcoholics themselves how it was that they began to feel a commitment to A.A., and whether this had a bearing on the deepening of their satisfaction with recovery.
Can Therapists Facilitate Acclimation to A.A.?

One of the questions that the present research raises is: Are there ways in which therapists can facilitate the process by which their alcoholic clients become acclimated to A.A.? If some of the participants in the present research have been well served by therapy, what can we learn from this? A.A. itself encourages the use of therapists for issues beyond the scope of their program (Alcoholics Anonymous, 1976). Khantzian and Mack (1994) have stated that:

It is our contention that an understanding of the individual and group psychology involved in a patient succumbing to and subsequently recovering from alcoholic and addictive disorders will help professionals to accept and recommend self-help modalities as an important or essential part of their patients’ treatment. The more clinicians understand about the A.A. model, the more skillfully they will be able to intervene therapeutically with patients who are substance dependent as well as with other patients with related conditions, who are in the process of recovery and self-repair. (p. 78)

Development of a Spiritual Life

Along with powerlessness and unmanageability, the other term associated with alcoholism recovery that continues to be controversial is spirituality (Kohn, 1984; Miller, 1990; Peteet, 1993). Though the acquisition of spirituality in recovery is not a concept exclusively associated with A.A. (Borman & Dixon, 1998), it is often associated with A.A., due to A.A.’s suggestion that the alcoholic should surrender her or his alcoholism to a higher power. What is not as frequently noted is that A.A. encourages recovering individuals to develop a personally formulated higher power, which for many people early in recovery, is often the group itself. The A.A. literature stresses that this higher power need not have any religious connotation (Alcoholics Anonymous, 1976). Nevertheless, “mental health professionals are often skeptical
about the relevance of the spiritual approach to treatment effectiveness” (Peteet, 1993, p. 263).

The present research hypothesizes that spirituality (along with its related concepts of surrender, powerlessness, and unmanageability) may, indeed, prove to be one of the most critical aspects of a quality life in recovery. Miller (1990) offers apropos thoughts on this element of recovery:

Psychological researchers and spiritual seekers are both on quests for understanding and change. Both infer unseen dimensions. Both realize that there are processes well beyond our present comprehension, and push forward in the hunger to know more. To me, it is a natural confluence, to bring together our rational faculties and our spiritual yearnings. . . . Perhaps, in the process, we will also discover important new pieces of the puzzle of addictive behaviors, and new tools to help those who look to us for healing. (p. 265)

Significance of the Problem

Any disease which claims 100,000 deaths a year could reasonably be termed a problem. It is discouraging to note that the same statistic was in use 10 years ago. Furthermore, of the 10% percent of alcoholics who attempt to quit each year, still only 1 in 10 of those succeed (Cary, 1999). Prevention of alcoholism and addictive disorders seems to be of limited effectiveness; many prevention approaches focus on providing factual information about the adverse consequences of substance abuse. However, “The existing evaluation literature shows rather conclusively that these are not effective prevention strategies when the standard of effectiveness concerns the ability to influence substance use behavior” (Lowinson, Ruiz, Millman, & Langrod, 1997). If the alternative to prevention is considered to be treatment, it is apparent that changes are occurring in the delivery of treatment services. As resources for longer-term inpatient treatment of alcoholism diminish (Lowinson et al., 1997), and
treatment shifts to an intensive out-patient modality, it becomes increasingly important that clinicians provide effective and efficient care. It is the hope of the Student Investigator that the qualitatively-analyzed reports of the experiences of those enjoying quality long-term recoveries that constitute the present research will offer the potential to be an extremely valuable treatment resource. Lawton (1985) has observed that “In comparison to the proliferation of information available on the addiction process, there is a limited amount of material relevant to the recovery process” (p. 55). When one considers the magnitude of the figures cited at the top of this paragraph, it is apparent that the urgency to augment the lack of recovery research has not diminished. The present research seeks to augment and expand the understanding of the phenomenon of quality recovery; the experiences of individuals who have attained rewarding sobriety are both rich, and informative. The “Big Book” of Alcoholics Anonymous offers a tantalizing hint of the rewards to be had in continuing recovery:

Life will take on new meaning. To watch people recover, to see them help others, to watch loneliness vanish, to see a fellowship grow up about you, to have a host of friends—this is an experience you must not miss. (Alcoholics Anonymous, 1976, p. 89)

Definition of Terms

*Alcoholic:* The recognition that one is an alcoholic may or may not involve the physical dimensions of alcoholism as an addiction (defined below), such as tolerance, withdrawal, etc. Within the context of the present research, however, the alcoholic can be characterized as a person for whom the use of alcohol consistently disrupts or prevents the conduct of activities and relationships which are necessary for the health and well-being of the alcoholic. The alcoholic is often the last person to
recognize that this has occurred, due to the phenomenon of denial. It has been said that an alcoholic is a person who keeps on doing the same thing expecting different results.

**Alcoholism:** One of the difficulties in attempting to define alcoholism is that it affects people in so many different ways, in such varying amounts, with varying frequency of use. The medical definition cited below of alcoholism as a disease notes its physical dimensions, such as progression. However, for the purposes of the present research, a definition offered by many recovering people reflects the aspect of self-diagnosis that is unique to alcoholism, and is deemed necessary by many of these same individuals for the process of recovery to begin. To paraphrase these recovering persons, it could be said that one knows one has alcoholism when one can no longer predict the consequences of one’s actions when drinking.

**Alcoholism as a Disease:** In defining the disease concept of alcoholism, Jokichi Takamine, M.D., has said:

I see chemical dependency as a disease like any other. It has a beginning, a middle, and an end. It has a diagnosis and a prognosis. It has symptoms; it can be replicated; it is chronic; it progresses over time; patients can relapse; there’s the withdrawal phenomenon; and if it is not treated, it ends in death. That’s a disease. (Cary, 1999, p. xviii)

The question of whether or not alcoholism is, in fact, a disease has been debated for many years (Vaillant, 1995). Jokichi Takamine’s definition (Cary, 1999) is attractive to the Student Investigator, however, because it succinctly states, in a convincing manner, what I (and many individuals that I have known in recovery) have observed to be the characteristics of the disease of alcoholism. Most notable, perhaps, is Takamine’s belief that alcoholism is a treatable disease. Obviously, abstinence would seem to be a major piece of that treatment. The description of what follows abstinence, however, is provided by the participants in the present research.
Alcohol Abuse: The *DSM-IV* has defined substance abuse (and, interchangeably, alcohol abuse) as “A maladaptive pattern of substance use leading to clinically significant impairment or distress . . .” (American Psychiatric Association, 1994, p. 182). While the Student Investigator concurs with this definition to the extent quoted, I would extend it to contend that abuse is a maladaptive pattern which can still be compartmentalized to the extent that the abuser retains the ability to maintain a reasonably functional degree of performance in critical aspects of living. The abuser still retains the ability to refrain from alcohol use by choice without the symptoms of withdrawal that characterize dependence (defined below). The vestiges of “manageability” that are present in alcohol abuse often contribute to the abuser’s rationalization and denial of their problem.

Alcohol Dependence: The *DSM-IV* has stated that substance dependence (in which they include alcohol dependence) is “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior” (American Psychiatric Association, 1994, p. 176). Hence, the primary distinction between alcohol abuse and alcohol dependence is physiological dependence, as manifested by tolerance and withdrawal.

Addiction: Within the context of the present research, addiction can be defined as a mental compulsion and preoccupation with drinking, coupled with physiological dependence on alcohol.

Abstinence: For the purposes of the present research, abstinence can be defined as the total cessation of alcohol consumption, on a 24-hours-a-day basis.
**Sobriety:** In contrast to the mere absence of alcohol consumption, which characterizes abstinence, sobriety involves the conscious pursuit and maintenance of a lifestyle which incorporates those elements which the recovering person has found to be facilitative of personal growth and a reasonable degree of contentment.

**Recovery in Sobriety:** “The alcoholism recovery process is one of construction and reconstruction of a person’s fundamental identity and resultant view of the world” (Brown, 1985, p. 55). “The focus is on daily growing by making free choices to evolve into the person we were meant to be” (Lawton, 1985, p. 57). These two quotes have been chosen for this definition because they effectively capture the idea of the *process* of recovery as one which allows an unobstructed view of a person’s true identity.

**The Dry Drunk Syndrome:** While abstinent, there is the presence of attitudes and actions that characterized the alcoholic prior to the cessation of drinking (Solberg, 1970). For many recovering alcoholics, periods of time occur in which an individual may exhibit irrational behavior and harbor thoughts which bear a resemblance to the behaviors and thoughts of that person before their commencement of recovery.

**Relapse:** A relapse occurs when an alcoholic returns to drinking after some period of abstinence.

**Surrender:** “Surrender is an emotional step in which the Ego, at least for the time being, acknowledges that it is no longer supreme. . . . For the alcoholic, surrender is marked by the admission of being powerless over alcohol” (Tiebout, 1954, p. 618). Tiebout’s quote captures well the essence of surrender for the recovering alcoholic: the acknowledgment that he or she not only is an alcoholic, but that his or her resources *alone* are insufficient to recover from alcoholism.
Spirituality: Spirituality is "that which enables the growth of positive and creative values in the human being" (Booth, 1984, p. 141). Particularly because spirituality is a rather broad concept, Booth's definition is effective at conveying the shift that occurs for many recovering alcoholics from an obsession with drinking-related troubles to a positive outlook which fosters personal growth, gratitude for recovery, and a willingness to be of service to others.

Quality of Life: Within the context of the present research, it could be said that the phenomenon of quality of life is individually defined by each of the participants. That, after all, is the goal of this research: for each participant to define what those factors are that have contributed to and constitute quality of life in recovery from alcoholism. For some recovering alcoholics, the very fact that they are now neither drinking nor consumed with the thought of drinking may constitute, in relative terms, what is to them a significant quality of life. It is the belief of the Student Investigator that the participants in the present research have emphasized those elements of their recoveries which have contributed to a cumulative process which Lawton termed "daily growing by making free choices to evolve into the person we were meant to be" (Lawton, 1985, p. 57).

Limitations of the Study

As is frequently the case with qualitative research designs, the findings of this research are based on a small sample of participants. As such, these findings are not generalizable to a larger population of alcoholics, in the manner associated with quantitative methods of research (Lincoln & Guba, 1985). In part, this is due to the changing nature of the participants' recoveries, which have occurred on a continuum. The view of Lincoln and Guba (1985) on this point is worth noting:
The naturalist is willing to concede what might be called "instrumental" unreliability... The naturalist sees reliability as part of a larger set of factors that are associated with observed changes. In order to demonstrate what may be taken as a substitute criterion for reliability—dependability—the naturalist seeks means for taking into account both factors of instability and factors of phenomenal... change. (p. 299)

The Human Subjects Institutional Review Board

The Student Investigator obtained the approval of the Human Subjects Institutional Review Board (HSIRB) in order to carry out the present research (see Appendix H). The confidentiality of the participants was ensured by the Student Investigator's use of anonymous identifying references.
CHAPTER II

REVIEW OF RELATED LITERATURE

Substantial literature exists which deals with the process an alcoholic goes through in getting sober. A much smaller body of literature concerns itself with what happens to alcoholics after they have achieved some sobriety; an even smaller portion of this writing has been devoted to what constitutes a quality recovery (Brown, 1985; Cary, 1999; Lawton, 1985). This literature review will focus on what the literature has to say about quality recovery from alcoholism. Specifically, what are the variables which have been cited as having an impact on the quality of recovery from alcoholism? I have arbitrarily divided this review into several broad categories, which examine these variables; they are arranged to reflect, in an approximate way, the process of change in which many alcoholics are engaged as recovery progresses. These categories include the emotional state changes entering recovery, surrender, the “dry drunk syndrome” and relapse, the roles of therapy and Alcoholics Anonymous, the stages of recovery, spirituality, as well as existing literature on quality of life in recovery. Roughly half of the literature reviewed herein is empirical. The remaining literature is conceptual in nature. I will note which pieces are empirical; where applicable, criticism will be offered.

Emotional State Changes Entering Recovery

Kellerman (1977) has described the emotional let-down that many newly recovering alcoholics feel as being part of the grief process. He makes a distinction
between grief and depression, however: “The person suffering grief is very much aware of the nature of grief as to its cause and origin. The depressed person is not aware of the cause” (Kellerman, 1977, p. 1). In his estimation, grief is a normal loss reaction, which is part of the path to recovery. Several alcoholic losses are cited by Kellerman, which include (a) the ability to drink normally, (b) memory (due to blackouts), (c) the ability to choose not to drink, and (d) the abilities to maintain socially responsible behavior and relationships. Steps involved in overcoming grief principally involve willingness to sacrifice time and energy toward recovery-oriented functions such as A.A. meetings and therapy, and the ability to “release in love” those aspects of drinking which may have been unrealistically “romanticized” in retrospect (Kellerman, 1977). Levin (1991) believes the depression in early sobriety is mostly neurochemical, and disappears as recovery evolves. He goes on to say that “transition is always painful and involves some mourning for the old, for what has been relinquished. Allow yourself to mourn. You have lost something” (Levin, 1991, p. 265). Lawton (1985) concurs with this view. She believes the newly-abstinent alcoholic’s grief conforms to the same principles enumerated by Kubler-Ross (1969) in her death work. If this process gets “stuck,” Lawton recommends therapy. She views transcending grief as one of the first tasks necessary to “achieve quality sobriety and the road to self actualization” (Lawton, 1985, p. 58).

Therapy, such as Lawton (1985) describes, should be supportive and nonconfrontational, in the view of O’Connor, Berry, Inaba, Weiss, and Morrison (1994), who found that the presence of depression, shame, and self-guilt was significantly higher for newly recovering women than men. O’Connor et al. (1994) conducted an empirical study, in which the subjects were 130 recovering chemically dependent individuals. There were 88 men and 42 women, ranging in age from 16 to
55. The mean abstinence time was 2.6 years. Ninety subjects were solicited from 12-Step meetings; 40 other subjects were solicited from a residential treatment center. Subjects were from a wide variety of ethnic groups (although the majority, 78%, were European-American), as well as radically different levels of education, which ranged from the incompletion of high school, to the completion of college. Instruments administered to the subjects included The Test of Self-Conscious Affect (TOSCA), which is a measure of cognitive, affective, and behavioral aspects of shame, guilt, externalization of blame, detachment/unconcern, and levels of pride in one’s self (generally), as well as in specific accomplishments. Items on the TOSCA were generated from both college and noncollege populations. The TOSCA consists of 10 negative and 5 positive scenarios, with response choices that reflect the dimensions listed above. Respondents are asked to rate each of several possible responses to each scenario, on a scale of 1 to 5. Additionally, the Beck Depression Inventory (BDI) was administered to the subjects. The BDI is a reliable and well-validated 21-item self-report inventory representing cognitive, affective, and vegetative symptoms of depression. Men and women were compared on the TOSCA and the BDI using unpaired t tests. Significant differences were found for shame, detachment, and depression. Results indicated that women scored significantly higher on shame and depression, and men scored significantly higher on detachment. All the tests which were reported were two-tailed. The authors believe that the results support anecdotal reports that women early in recovery tend to suffer from a greater sense of shame, self-blame, and depression than do men. Furthermore, O’Connor et al. (1994) feel that these results suggest that women would benefit more from nonconfrontational types of therapy. When the authors recommend further empirical research based on their results, it is appropriate. There would appear to be
confounding elements in the sampling of female subjects—it is impossible to
determine whether elevated shame, blame, and depression occurred more frequently
in those women in treatment, or in 12-Step groups. Given that the vast majority of
women were European-American in this research, what differences in shame, etc., fell
along racial lines, if any? Would different results have been obtained if the sample had
been of a more consistent length of recovery, racial/ethnic background, or level of
education? Because these elements cannot be teased out presently, the O’Connor
et al. (1994) results may not be generalizable.

Covner (1978) was particularly interested in the emotional state of alcoholics
immediately following treatment. In an empirical study, he administered the California
Psychological Inventory to 32 females and 83 males in alcoholism treatment; the test
was administered upon admission, and immediately following treatment. The CPI
contains 23 items, which reflect three aspects of emotional states—interpersonal
relations, emotional stability, and feeling of physical well being. The scale is easily
administered in 10 minutes, and uses simple language. Scores can be compared with
those of six alcoholic and two nonalcoholic populations on which Covner and his
associates had previously established percentile and standard score norms. These
norms show how a particular raw score compares with previous scores in the six
alcoholic and two nonalcoholic populations with which Covner previously worked.
Unlike O’Connor et al. (1994), Covner attempted to control for demographic
differences between subjects (age, education, income, etc.). t tests were run to
compare differences in pretest and posttest scores for both men and women. While
no significant differences were found in demographic and ability characteristics of the
subjects (with the exception of men, who were found to be stronger in arithmetic
ability), for both sexes in Covner’s (1978) research, significant posttest gains were
made in interpersonal relations, emotional stability, and feelings of physical well-being. While this is intriguing, it is typical of so much recovery research which lacks long-term follow-up (Pettinati, Sugarman, DiDonato, & Maurer, 1982). Covner acknowledges the need for follow-up research; additionally, he advocates further qualitative research to examine the individual contributory factors to emotional changes.

Hatsukami and Pickens (1982), by contrast, attempted to specifically look at depression among recovering alcoholics at 1, 6, and 12 months after treatment. In the empirical study which they conducted, 509 men and 202 women answered an alcohol use questionnaire, as well as the Zung Self-Rating Depression Scale. One third of the subjects completed these instruments at 1 month of sobriety, while each of the other two thirds completed them at 6 and 12 months, respectively. These instruments were mailed to all subjects. A one-tailed $t$ test was used to determine statistically significant differences in mean Zung scale scores and a chi-square analysis was used to test significant differences in rates of depressive symptoms. Among their results, Hatsukami and Pickens found that those subjects who had remained sober following treatment did not deviate from rates of depression found in the general population. This applied to both men and women in the study. However, subjects who had relapsed had significantly higher rates of depressive symptoms than abstinent subjects 12 months after treatment. The authors concluded that sustained abstinence appears to be important in combating depression in alcoholism recovery. This is probably a sound conclusion. It should be noted, however, that only 41% of those subjects who were mailed the instruments returned them. It would be intriguing to know how the nonresponding subjects rated themselves.
There are other authors, such as Ludwig (1985), who have focused on those who claim “spontaneous” recovery from alcoholism. Such individuals, in Ludwig’s view, do not progress through any stages of recovery. He conducted an empirical study, in which semistructured interviews were conducted with “spontaneous remitters” to explore their drinking and nondrinking behavior. It is not clear, however, to what degree the 29 subjects he interviewed achieved any measure of contentment in their recoveries. While he states that he chose subjects who had all been “sober” for 1 year, he goes on to say that six subjects were “relative abstainers” (Ludwig, 1985, p. 54). Most of his subjects “periodically had to struggle with the urge to drink, white-knuckling it or toughing-it-out, particularly over the first year of their recovery” (Ludwig, 1985, p. 57). What Ludwig was primarily interested in are the cognitive processes that these subjects employ to not drink: they had had no therapy, and no support-group participation. He concluded that willpower was the primary cognitive tool for his subjects. The relative effectiveness of Ludwig’s concept of willpower might be questioned, however, in that at least one of his subjects claimed to have consumed “an occasional beer” over several years of recovery. Since denial is a characteristic often associated with alcoholics, caution might be indicated in drawing conclusions from reports of still-drinking alcoholics who claim “occasional” drinking. Ludwig does not indicate that he is interested in the level of contentment in the recoveries of his subjects; he does, however, acknowledge their struggle to refrain from drinking. Ludwig also acknowledges the limitations of his research: “Because of the biased nature of the sampling procedure, generalization of results to all alcoholics would be imprudent” (Ludwig, 1985, p. 54).

The findings of Ludwig (1985) closely parallel the earlier results of Ludwig (1972), who used an interview methodology similar to that which he would later use
in 1985 to assess reasons for drinking and abstinence at several intervals (as far as 18 months out) in the recoveries of over 176 alcoholics who had been through inpatient treatment. In his sample, the “vast majority drank for varying periods of time” (Ludwig, 1972, p. 92). Those who did remain abstinent were afraid of the consequences of resumed drinking. Ludwig could not generate an overriding hypothesis about reasons for drinking or abstaining. He notes that he may have been limited by questioning the wrong “types” of alcoholics, who may not have been honest. Ludwig’s research exemplifies literature which views abstinence alone as a goal. Such a static recovery state begs the question of whether stages of recovery (and emotional change) are not, indeed, necessary for growth.

Surrender

In the views of several authors (Brown, 1985; May, 1988; Prugh, 1985), one of the primary stages in beginning recovery is surrender. These authors all cite Tiebout (1954), however, as the author of the seminal writings on that topic. In his landmark 1954 article, Tiebout viewed surrender as essential to alcoholism recovery (specifically, through A.A.). He distinguished between surrender and compliance, which acts as a barrier to that real acceptance which a surrender produces. Several components constitute the ego, in Tiebout’s estimation (as distinct from Freudian ego and superego concepts). They are persisting elements, in the adult psyche, of the original nature of the child. These would include a sense of omnipotence, a poor ability to tolerate frustration, and a tendency to do things in a hurry. These are people who have no time for growth, yet “always inwardly feel immature” (Tiebout, 1954, p. 616). This is reminiscent of the oft-quoted description of the alcoholic as an “egomaniac with an inferiority complex” (Wholey, 1984, p. 275). It is the ego which
must be surrendered (and, hence, the sense of power and control over alcohol use). Tiebout says that this is “a fact not sufficiently appreciated by many if not most therapists” (Tiebout, 1954, p. 617). In addition, the alcoholic surrenders omnipotence for a degree of humility, and impatience for the ability to accept staying in one position and being open-minded and receptive. These are all principles espoused within A.A. This view is shared by Denzin (1987), who believes that this process begins with the alcoholic’s surrender of his/her self-pride, bad faith, and imaginary ideals. For his 1987 book, The Recovering Alcoholic, Denzin conducted an empirical study (an ethnography) which examined the experience of surrender for those beginning alcoholism recovery in both treatment centers and Alcoholics Anonymous. The possibility of a return of the ego must be faced by every alcoholic, according to Tiebout. With its return, old feelings and attitudes return, which can contribute to an uncomfortable sobriety (and a “dry drunk,” discussed in the next section). Tiebout views group support as being critical to keeping the ego in check.

Of the numerous authors who deal with the surrender concept in the recovery process, Spahr (1987) has a particularly colorful interpretation:

In the simplest language, countless alcoholics have “hit bottom”. . . More than three quarters, if they stopped drinking, gained nothing but abstinence. Nothing happens! There is a second, better scenario. The person hits bottom, is “sick of being sick.” This person wills to be well even in . . . humility. God pulls the lever in the trash bin, and empties (the catharsis). . . . With that burden off the back, all the joys of life suppressed over the years of burdensome pain and guilt rush forward. (p. 240)

An attempt was made by Gerard and Saenger (1962) to quantify differences between recovering alcoholics who were merely abstinent and those who had a perceived increase in satisfaction with their lives due to not drinking. In this empirical study, 50 subjects who had completed inpatient treatment agreed to participate in follow-up research at least 1 year after treatment. A combination of Likert-type
scaled questionnaires and interviews were used to gauge patients' changes in health, living arrangements, social life, and employment. 54% of the subjects were still plagued by great tension, and were "medicating" themselves with compulsive work habits. A smaller percentage were "inconspicuously inadequate." They had "meager involvement" with their lives. A still smaller, but more contented group, the "A.A. successes," made a "spectacular shift" in their lives, having acquired a sense of purpose and value in life. Five subjects attained this same sense of life purpose as "independent successes." It is not always clear whether these descriptions emanate from the subjects or the authors. The authors' conclusion was that abstinence alone does not guarantee better functioning. For at least some of their subjects, surrender was instrumental (Gerard & Saenger, 1962). The authors acknowledge that there may be some question of the validity of statements made by their subjects regarding the length of their respective periods of abstinence. These were subjects who may have, by the authors' admission, been in denial about some aspects of their recoveries.

One problem inherent in much of the quantitative literature, which attempts to measure the maintenance of posttreatment alcoholics' sobriety (let alone issues of surrender and life-quality), is noted by Pettinatti et al. (1982), who are critical of research such as (and including) Gerard and Saenger's (1962) work. In their view,

The majority of these studies are fraught with methodological problems, making it difficult for results to be compared. Even when an adequate number of [follow-up period] patients are located, the validity of their self-reports may be questionable. Probably the most frequently occurring and yet rarely discussed issue is the problem of "window viewing" an individual's life at only one intervention . . . (Pettinatti et al., 1982, p. 201)

Pettinatti et al. conducted an empirical study which involved a 4-year follow up of 119 posttreatment alcoholics. Interviews with each alcoholic and with at least one
corroborative source were conducted at the end of the 4 years by a social worker experienced in interacting with alcoholics. Contacts were often made via phone during the time that elapsed between annual interviews, as well. One hundred percent of the original sample was contacted. The authors found that over half of their sample rarely maintained its first-year status consistently over the 4-year period. In other words, any of their subjects who were abstinent 1 year could be drinking by the next. Hence, "What gets reported depends on which year is 'window-viewed' in the follow-up study. This finding contradicts that of Gerard and Saenger, who assert that a 1-year follow-up provides an adequate evaluation of future drinking status" (Pettinati et al., 1982, p. 207).

The Dry Drunk Syndrome and Relapse

For those who have experienced an initial period of sobriety, there is often a psychological and emotional state that occurs that has been referred to as the "dry drunk syndrome" (Flaherty, McGuire, & Gatski, 1955; Solberg, 1970, 1980). Flaherty et al. (1955) have described the dry drunk syndrome as "emotional and physical tensions similar to those experienced during excessive, compulsive drinking" (p. 460). In an empirical study, Flaherty et al. had 33 men and 15 women with over 1 year's sobriety respond to a questionnaire which asked about length of sobriety, and the meaning of a dry drunk (and the feelings associated with it, in terms of its impact on home life, job life, spiritual life, etc). For those experiencing dry drunks (and the authors believe that most recovering alcoholics will), the authors wanted to know how that syndrome was combated. The respondents said the most frequently occurring idea relating to a dry drunk was indecision regarding whether or not to take a drink. Additionally, during dry drunks these subjects were plagued by
depression, self-pity, nervousness, irritability, and the craving for an emotional lift. These experiences could last from 1 day to 4 months, but they seemed to diminish with the passage of time. Several subjects reported having fleeting suicidal ideation. Among the methods subjects reported were effective in dealing with these emotional states were increases in attendance of A.A. meetings, talking with other recovering alcoholics, seeking help from psychologists, and prayer. Those least helpful were wives and friends not in recovery. While these dry drunk episodes occurred usually more than once, for most subjects, they were confined to the first year of sobriety. Principally, the episodes were related to the subject's own mood swings, and the subjective contentment in their "inner lives" (Flaherty et al., 1955).

Solberg (1970) describes the dry drunk syndrome as the presence of actions (excluding drinking) and attitudes that characterized the alcoholic prior to recovery. While Solberg shares many of the views espoused by Flaherty et al. (1955), he adds an interesting caveat. He emphasizes guarding against the euphoria that accompanies great accomplishments in early sobriety. In other words, emotional extremes of any nature are risky. The risk, according to Solberg (1980), is in taking on even more responsibilities and ignoring the need for self-renewal and contact with recovering people. Solberg comments that "Evidence suggests more alcoholics return to drinking because things are going too well than because the struggle is too great" (Solberg, 1980, p. 9). Other symptomatic attitudes for the dry drunk include grandiosity, dishonesty, false pride, depression, judgmentalism, and intolerance (Solberg, 1970). The best defense against the dry drunk (and in particular, the boredom that afflicts many recovering people who become complacent), in Solberg's estimation, is continual contact with other recovering people.
Dan F. (who chooses to remain anonymous), has compiled a book of personal stories from people who have become “stuck” in their recoveries and, hence, are “dry.” (Dan F., 1991). Several of these stories emphasize the difficulties recovering alcoholics can have in forming healthy, egalitarian relationships. Several instances are cited of people who have shifted their addictive behavior from alcohol to promiscuous sexual activity, in an attempt to stave off loneliness. In the case of one recovering individual, he found help with this behavior by working closely with his A.A. sponsor, and “inventorying” his excessive sexual behavior through A.A.’s Fourth and Fifth Steps. Briefly, those steps suggest that an alcoholic should take a “searching and fearless moral inventory,” and that that person should then share that inventory with a trusted confidante. The person which Dan F. was referring to in his example found that concurrent therapy with a sensitive therapist was also crucial to his ability to work past being “stuck.” This echoes the frequent recommendation in A.A.’s “Big Book” to seek therapy for problems beyond alcoholism (Alcoholics Anonymous, 1976). For the isolation and loneliness that plagued a number of Dan F.’s subjects, they reported that the act of sharing their stories with other people seeking recovery was helpful.

Solberg (1970) says that “Before any relapse, there is a dry drunk that goes untreated” (p. 11). There is much discussion in the literature about the behavior and thinking that precedes an alcoholic’s relapse, and what preventative steps might be taken (Crewe, 1974; Chiauzzi, 1991, Gorski, 1989b). Crewe (1974) has said:

Continued sobriety or recovery seems to depend on keeping the new attitudes strongly reinforced by a number of disciplines regularly practiced, in order to prevent reemergence of old attitudes. “Stinking thinking” is an A.A. expression describing the frame of mind of a member whose attitudes seem now to reflect the old personality more than the new. (p. 5)
In his estimation, relapse doesn’t occur on the spur of the moment; it comes after considerable irrational thinking. To the dry drunk symptoms already listed by Solberg, Crewe adds exhaustion, letting up on disciplines, the feeling of omnipotence, and a sense of invulnerability. Crewe states that 80% of the relapsed alcoholics he has treated that had previously attended A.A. had stopped attending meetings. Involvement with recovering people and having effective aftercare programs are cited as two effective methods for avoiding relapses.

For many who relapse, the phenomenon of craving is a significant factor. Mathew, Claghorn, and Largen (1979) investigated this by conducting an empirical study in which they administered the Profile of Mood States (POMS) to 46 alcoholics who had been sober 6 weeks. Additionally, a questionnaire was completed which was intended to gauge an individual’s level of craving. This resulted in the formation of four groups, which ranged from Noncravers to Severe Cravers. The POMS, which the members of all four groups completed, is a 65-question self-report inventory which measures several moods through the use of subscales, including tension, depression, anger, and fatigue, all of which were thought to be associated with relapse. The POMS subscale scores were converted into t scores, and group means and standard deviations were calculated for each of the craving groups. A series of one-way analyses of variance was used to compare the groups of cravers on each of the PMOS subscale measures. The authors found craving to be on a continuum, with severity decreasing with increased sobriety. Those with severe cravings did, indeed, show significantly elevated anger and depression. Environmental cues (such as liquor bottles) were elicitors of craving and stress, which was found to be relieved by “psychological means,” though this did not include therapy. Although the vast
majority of subjects found this relief through association with other recovering people, other helpful stress relievers included exercise and sex.

Mathew et al. (1979) cautioned against generalizing results beyond their subjects, who were in halfway houses. One might also question which, if any of the subjects, found “association” through A.A., or why it was, specifically, that therapy was not more helpful (Mathew et al., 1979). The difficulty in performing quantifiable, generalizable research regarding recovering alcoholics is pointed out by Vaillant (1995), who says “some individuals believe that all dimensions are meaningless and suggest that there are as many alcoholisms as there are drinkers” (Vaillant, 1995, p. 24).

Chiauzzi (1991) outlines strategies for the assessment of relapse potential, including what he terms “Biopsychosocial Risk Analysis.” He recommends systematic assessment of the following areas: (a) historical factors (such as family history and treatment history), (b) biological factors (such as level of dependence, and craving/cue reactivity), (c) psychological factors (such as coping skills and psychopathology), and (d) social factors (including stability of relationships and environments). As the result of such an assessment, the clinician can emphasize and build upon those coping skills already in place which could be used to avoid relapse (in a manner similar to the coping strategies of Marlatt & George, 1984). Conversely, negative drinking experiences may need to be emphasized to decrease the urge to drink. This is reminiscent of A.A. advice to “think through the drink” (Chiauzzi, 1991, p. 59). Chiauzzi places particular emphasis on the assessment of the alcoholic’s ability to communicate clearly within intimate relationships (an ability often impaired, as earlier noted in Dan F., 1991). This can be helpful in guiding treatment.
Marlatt and George (1984) proposed a relapse prevention program (RP), which is based upon self-control. Their aim is to teach individuals who are trying to change their behavior how to anticipate and cope with the problem of relapse. Their proposed program is psychoeducational in nature; it combines behavioral skill-training procedures with cognitive intervention techniques. Beyond simply preventing drinking, the authors hope that their program will teach individuals how to achieve a balanced lifestyle and to prevent the formation of unhealthy habit patterns. They object to the “all-or-none” outlook reflected in the traditional treatment outcome literature, which, they say, views a single “slip” as a total failure. It should be noted that this is not especially true for treatment facilities which adhere to the 12-Step philosophy; A.A. promotes “progress, not perfection” in recovery, and recognizes that obtaining abstinence is a process (Alcoholics Anonymous, 1976, p. 60). Marlatt and George propose a continuum of relapse-related behaviors from total abstinence to a complete return to pretreatment baseline levels of behavior. In their view, a relapse is looked upon as a transitional process, wherein the alcoholic who takes a single drink after some abstinence is someone who has made a “slight excursion” over the border between abstinence and relapse. Briefly, the RP program targets “high-risk” situations which “pose a threat to the individual’s sense of control and increase the risk of potential relapse” (Marlatt & George, 1984, p. 264). They divide these situations into three relatively frequent situations having the highest relapse rates. They are (a) negative emotional states, in which an individual experiences a negative emotion, or feeling (such as frustration or anger); (b) interpersonal conflict (which may be any recent conflict associated with an interpersonal relationship); and (c) social pressure, wherein the alcoholic may be pressured to drink. Reference is made to covert antecedents of relapse, which involve either winding up unexpectedly...
in a drinking situation, or deliberately placing oneself in a drinking situation without thinking through potential consequences. Marlatt and George (1984) caution against “Apparently Irrelevant Decisions” (p. 270), which could set the stage for relapse (such as keeping liquor in one’s home). Emphasis is placed on rehearsal and implementation of new cognitive and behavioral coping patterns to cope with relapse situations. While such strategies have already proven effective with many recovering alcoholics, there are questionable statements made by these authors, such as “Most traditional treatment programs for addictive behaviors tend to ignore the relapse issue altogether” (Marlatt & George, 1984, p. 267). This is not true, for example, for many programs which adhere to the Minnesota model (such as Hazelden and the Caron Foundation) which include relapse prevention as a standard treatment component. Additionally, the RP program prescribes contracting with the alcoholic to specifically limit the number of drinks that will occur in a relapse. Are there data to attest to the effectiveness of this strategy? Intuitively, it seems counter to the very unpredictability of alcoholic drinking behavior. What is, perhaps, most striking about the otherwise very worthwhile RP program proposed by Marlatt and George is that so much emphasis is placed on alcoholics coping with being in “toxic” situations, rather than emphasizing the ability to learn to recognize (and seek) healthy situations, which promote growth and abstinence.

One of the primary means by which recovering alcoholics attempt to avoid relapse is through participation in Alcoholics Anonymous. Rudy (1980) examined the functions of “slipping” and sobriety in A.A. Based on A.A.’s own membership data from 1976, Rudy asserts that slipping is common (and expected) in A.A. Rudy observed A.A. groups that met in a mideastern city for 16 months during 1973 and 1974. He emphasized to the A.A. group members that he observed during this time
that his role was that of a researcher concerned with learning about alcoholism. However, the line between “empirical research” and conceptual writing is blurred considerably in Rudy’s article. What he offers are a number of hypotheses about reasons for slipping in A.A. He bases these on “characteristic” statements made in the meetings which he attended, which he quotes to support his views. Slipping (an isolated drinking episode) would be distinguished from an extended relapse. In Rudy’s estimation, the positive effect of such slips is that other A.A. members learn from the mistakes of returning slippers; group boundaries and norms are actually strengthened by this. Rudy believes that sympathy and understanding extended to slippers by other A.A. members provides an experience which reaffirms adherence to A.A. principles; he goes on to say that “perhaps the normalcy of slipping and its dynamics help explain why the A.A. program has been successful in reintegrating many alcoholics into the community” (Rudy, 1980, p. 731). A.A. embraces the disease model; as such, Rudy would seem to be refuting Marlatt and George’s (1984) assertion that the disease model views slipping as “total failure.”

In an attempt to quantify the relationship between A.A. attendance and relapse, Sheeren (1987), conducted an empirical study, in which she administered a Likert-scaled questionnaire to 59 recovering A.A. members, which asked them to rate both their level of involvement in A.A., and whether or not they had relapsed during the course of that involvement. Subjects were divided into two groups (“relapse,” and “no relapse”). Analyses of variance were performed to compare differences between the two groups on mean scores which measured different components of A.A. participation. These components include such things as 12-Step work, meetings with a sponsor, attendance at meetings, etc. The level of involvement in A.A. was found to be related to whether relapse occurred. The most significant
area of involvement, where the greatest differences between subjects in each group were found, was in reaching out to other members of A.A. for help and in the use of a sponsor (Sheeren, 1987, p. 106).

The importance of A.A. in preventing relapse is further emphasized by Gorski (1989a), who has written frequently on the topic of relapse (Gorski, 1989a; Gorski & Miller, 1986). Gorski creates a definite link between the “maintenance” phase of long-term recovery (which he calls “enjoying the journey”) and relapse prevention. While acknowledging that there will be “stuck” times in sobriety, he suggests continuing to work the “maintenance” steps of A.A. (Steps 10, 11, and 12), and maintaining contact with A.A. members, in order to confront problems as they arise. Briefly, A.A.’s Steps 10 through 12 suggest that the alcoholic should continue to take a daily inventory of behavior that may have wronged others, and that that person should both continue to pursue spiritual growth and seek to offer help to other still-suffering alcoholics, when possible. Gorski’s relapse prevention model proposes a “RADAR” system, wherein the alcoholic (R) recognizes their “stuckness,” (A) accepts that it will occasionally happen, (D) detaches and “turns the problem over” to a higher power, (A) accepts help, and (R) responds with action (Gorski, 1989a). One form this action can take is the scheduling of annual “check-up” appointments with a relapse counselor. Gorski says that “When we stop growing, a dry drunk is just around the corner” (Gorski, 1989a, p. 191). In contrast to the emphasis of Marlatt and Gordon (1984) on simply coping with relapse potential as an end in itself, Gorski (1989a) is effectively saying that the opposite of a relapse is to be engaged in the active pursuit of growth and contentment in sobriety.

This theme of stressing growth in sobriety is adamantly emphasized by Zackon (1989). Zackon recommends a shift in emphasis from strictly relapse
prevention to seeking what constitutes a strong recovery, filled with pleasure and satisfaction (what he terms “rejoyment”). The author believes that most clinicians and researchers do not give simple satisfaction-seeking its due as a motive for relapse behaviors; Zackon clearly states that abstinence is not equated with joy—it is an opportunity. He emphasizes that pleasure is a learned experience, and that in recovery it must be relearned. This involves “lowering of the pleasure threshold” (Zackon, 1989, p. 75). The role that Zackon sees for therapy is to encourage participation in A.A. and in its many opportunities for fellowship—dances, conferences, dinners, etc., as well as renewal of contacts with nonalcoholic supports. Zackon clearly espouses the view that in order for a satisfied, enduring recovery to occur, much more is involved than cognitive exercises in saying “no”; this begins to hint at the idea of what might be involved in “quality recovery.” Zackon summarizes this viewpoint by saying that “in the moment of decision to use drugs or not, how vigorously and intentionally a person feels he or she is living will count as heavily as the techniques one was taught for saying ‘no’” (Zackon, 1989, p. 78).

The Roles of Therapy and Alcoholics Anonymous

In the relapse literature, the therapist clearly plays a pivotal role in guiding the recovering alcoholic in recovery. Rawson (1995) believes this is one of the most beneficial contributions therapy can make to an alcoholic’s well-being. Rawson notes that numerous therapists who have worked with alcoholics have seen positive movement in their clients, while “Conversely, many substance abuse patients can recount long, frustrating experiences in psychotherapy while their lives deteriorated as a result of unaddressed substance abuse problems. Both scenarios are accurate” (Rawson, 1995, p. 55). Rawson notes research conducted by Brown (1985), which
found that 77% percent of alcoholics had been in psychotherapy while drinking, and 30% felt that the therapy had not been helpful. Nevertheless, 45% of those recovering alcoholics also reported that they had been in therapy once abstinent, and only 3% felt that the therapy had not been helpful. Essentially, Rawson agrees with these findings: in his view, it is impossible to achieve any “meaningful program of therapy” until some detoxification has occurred. Even then, he states that “there are no data to support even modified insight-oriented therapy as a primary treatment for problem drinking disorders” (Rawson, 1995, p. 68). Rawson advocates a behaviorally-oriented approach to addiction therapy which seeks to help the client who is in early recovery to understand the meanings and benefits of several A.A.-oriented activities (such as sponsorship, service, etc.).

Barnes (1991) also chose to focus on how counseling might best serve the needs of clients in early recovery from alcohol dependence. Barnes takes the view that physical, emotional, and spiritual improvement are all characteristic of the linear progression of recovery, which occurs in stages. As such, this discussion of his research could well have been placed under the heading of “Stages of Recovery.” However, because of his emphasis on the application of therapy throughout these stages, it seemed more appropriate to include this discussion under the “therapy” heading of this review. In Stage One, physical withdrawal occurs. Social support increases in Stage Two (“euphoric promise”), which lasts until approximately forty-five days into sobriety. Stage Three is reality adjustment, in which addicts are becoming more aware of responsibilities. Barnes proposes State Directed Therapy to therapeutically address each of these stages. He advocates the use of large amounts of Rogerian warmth and empathy (and devalues the use of cognitive approaches) to offset the rawness of detoxification. In Stage Two, Barnes believes it is crucial to
support the addict in the establishment of an "alcoholic identity," which is analogous to taking A.A.'s Step One (acceptance of alcoholism). Finally, in Stage Three, the counseling goal is to establish coping mechanisms via the incorporation of a wellness lifestyle (which would include significant group support). In this stage, the therapist supports the client in recognizing ways in which they have moved from the recognition of simply being an alcoholic to being a "grateful alcoholic." The implication here is that the recognition of the new connections with other alcoholics on a common quest provides increased life-purpose and meaning. It is Barnes' contention that the stage-directed model facilitates the alcoholic's development of self-identity and a life-purpose. While Barnes advances an intriguing therapeutic model, which seems to be promoting a quality recovery, his article suffers from the lack of clinical examples of alcoholics' own perceptions of how therapy has been an effective adjunct in the attainment of such "life-purpose."

As a complete contrast to the view of Rawson (1995), and, to a lesser extent, Barnes (1991), Levin (1995) specifically advocates insight-oriented therapy. In particular, he recommends its use in later-stage recovery. The techniques he advocates are based on the self-psychology theory of Heinz Kohut; what is involved is weekly, intensive, psychodynamic psychotherapy that is informed by Kohut's beliefs about the aspects of narcissism. Alcoholic clients, in Levin's view, have an intense need for mirroring, or "approving confirmation," as well as a need to idealize the therapist. These are people who are vulnerable and narcissistically deficited. Consequently, the therapist needs to pay particular attention to the blows to the alcoholic's self-esteem, and the failure of the childhood environment to supply sufficient phase-appropriate mirroring and opportunities for idealization. According to Levin (1995),
Most recovering substance abusers have not developed realistic ambitions or livable ideals—these are characteristics of the mature self. The abuser’s depression can be understood in terms of the paucity of psychic structure, which was never built up through the normal process of transmuting internalization. (p. 283)

Levin does not believe that this emptiness always disappears with sobriety, which is why therapy may, in his view, be indicated. He is suggesting the use of Kohut’s approach in a modified form in which narcissistic transferences are allowed to unfold, the client’s need to have his or her own positive attributes “mirrored” is honored, and a gradual working-through integrates archaic-self components, which results in self-cohesion, stable-self esteem, and a strong recovery (Levin, 1995).

The objection might be raised by some observers, however, that many alcoholics have narcissistic problems and conflicts as a result of their drinking. Mack (1981) holds this view; he feels that such conflicts would not be viewed as “narcissistic personality disorders,” in Kohut’s sense, prior to the onset of drinking problems. Mack has said:

What seems to me useful in this theoretical approach is the emphasis it places upon the cohesive self and its vulnerabilities. We are concerned here with elements in the developing personality which might make the individual susceptible to alcohol addiction... If these formulations are correct, in alcoholism we are more concerned with poorly developed functions... i.e., specific susceptibilities to regression, than with a pervasive structural deficit in the development of a cohesive self... These susceptibilities could well be present in spite of a history of early accomplishments, ... and even a successful pre-alcoholic adult adjustment. (p. 151)

Mack (1981) feels that A.A. embodies all the elements—psychological, biological, social, and spiritual—which go into successful self-governance, not just for alcoholics, but for all human beings. What he correctly recognizes, I believe, is that many alcoholics will need a combination of group support and therapy to achieve a strong, contented recovery.
One of the most notable attempts to articulate a process through which therapy and A.A. can be jointly used to facilitate an alcoholic's recovery was that of Brown (1985). Brown admits sympathy for both the recovering and the using alcoholics who mistrust helping professionals (largely because these therapists may not be recovering alcoholics themselves). Nevertheless, she feels many alcoholics need therapy. It is her belief that many therapists do not understand the continuing need for A.A. attendance into recovery, and the focus on the alcoholic identity which underlies continued growth. She disagrees with the notion that therapy and A.A. must be at odds with one another; rather, she offers an integrated process model for recovery, and says that “there is no model for alcoholism which includes recovery” (Brown, 1985, p. xii). She is reiterating one of the first points raised in this inquiry: the therapeutic focus on the facilitation of ongoing recovery is a relatively recent occurrence. Brown is adamant in stressing a central point of her book: recovery involves acknowledgment of loss of control, and surrender. For therapists, however, Brown believes that there may also be a sense of a loss of control, in that, many cannot accept that they (alone) cannot make the alcoholic change.

Brown (1985) proposes a new long-term recovery model wherein the achievement of abstinence is the starting point. A primary goal is the emergence of self in relationship to others. She indicates that her prior research stressed the dual importance of continuing alcoholic identification, and a structure (A.A.) that can accommodate change. Ongoing sobriety may include re-evaluation of the meanings of work, the meanings of marriage/long term relationships, and the re-evaluation of one’s own identity (while holding constant the identification with the alcoholic identity). Brown believes that therapists working with newly sober alcoholics can be most effective by supporting A.A. attendance, and exploring resistance to concepts
such as sponsorship. One of the primary therapeutic goals at this stage is the provision of holding and support, as clients have one foot in denial, and one foot in the establishment of the new alcoholic identity. By facilitating A.A.’s “inventory” Steps, therapists can assist in the assessment of past behaviors. Brown suggests within her model of long-term recovery that the therapist and client need to be able to shift between three therapeutic orientations: behavioral, cognitive, and dynamic. In early recovery, the therapist would emphasize behavior changes (i.e., attend meetings, read recovery materials, associate with other recovering people, etc.). As recovery progresses, emphasis would shift to a cognitive mode, wherein the identification with the alcoholic identity is developed. Finally, when clients have begun to establish a firm base in recovery, Brown (1985) feels that they will be prepared to engage in a more dynamic mode of therapy, in which past behaviors and relationships are examined in greater depth. This is a juncture at which she feels that the self-psychological perspective, in particular, may be very useful: “Therapists can help with emotional problems considered to be ‘regular and psychological terrain’ and beyond the ability of the sponsor” (Brown, 1985, p. 205). Such an approach to therapy would be counter to those who decry “eclectic” theoretical treatment approaches, of course, but it speaks to the amount of consideration Brown has devoted to needs of those alcoholics who aspire to a sober life of expanding potential. As clients occasionally encounter temporary obstacles to growth in therapy and recovery, there may be momentary “contraction” to the reassurance of the alcoholic identity. Brown views this as a normal process, and, therefore, envisions her therapeutic model as a “spiral” of expansion and contraction of the alcoholic identity.

Rosen (1981) believes that therapy can be especially helpful to the alcoholic who still struggles with issues of separation-individuation, but he cautions that
For many alcoholics, the first step toward sobriety ought to be A.A. However, once patients achieve and maintain sobriety through membership in A.A., psychotherapy can help these individuals live more rewarding lives, free of some of the constrictions that are necessary during the time they are giving up drinking. (Rosen, 1981, p. 243)

In the estimation of Kurtz (1985), the lack of research concerning cooperation between therapy and A.A. is surprising because “since its founding in 1935, A.A. has tried to cooperate with professionals . . . In spite of close association between professionals and A.A. members, professional articles have identified ideological disagreements between them” (Kurtz, 1985, p. 104). In her empirical article, Kurtz’s 1985 research employed a Likert-scaled questionnaire (and interviews) which addressed the level of cooperation between three treatment centers and the A.A. members in the communities in which the treatment centers were located. She found that a majority of both organizations (85% of the treatment professionals; 61% of the A.A. members) perceived cooperation; a statistically significant correlation existed between level of interaction and perceived cooperation between the two groups. Such “interaction” could take the form of on-site A.A. meetings, employing recovering A.A. counselors, etc. There are limitations to this study. There was only a 51% response rate among A.A. members. Kurtz acknowledges that her sample populations were small (and limited to one southeastern state). Nevertheless, she believes that her research provides one indication that there may be positive results from further interactions between therapists and A.A. She specifically recommends further qualitative research in this area; in fact, the present research has implications for this area of study.

Humphreys (1993) shares the view that research concerning possible therapy/A.A. integration has been lacking. He laments that too many “polemic statements” have been made. From the A.A. perspective, he feels members may question paying a
fee (in therapy) for what could be obtained free in a 12-Step group. Eckhardt (1967) echoes this theme: a principal A.A. strength (in his view) is the provision of service without compensation. One of the things therapy can do best, claims Humphreys (1993), is to employ “helping strategies,” such as viewing alcoholism as the primary problem, followed in importance by other concerns. What therapy cannot do as well as 12-Step groups, in Humphreys’ view, is to facilitate the implementation of helping “values,” such as the development of a belief in a higher power. This has serious implications for a recovering alcoholic client’s quality of life: Humphreys says “twelve step members and psychotherapists have different conceptions of the ideal person” (Humphreys, 1993, p. 211).

Emerick (1989) acknowledges the diversity in recovery outcomes: “A posture of thoughtful consideration of individual differences regarding A.A. affiliation is the only sound one to take given our current state of scientific knowledge” (Emerick, 1989, p. 41). Emerick conducted a literature review to attempt to capture a consensus of opinion on how A.A. affects growth in recovery. His frustration with this process, however, was evident: “Efforts to isolate an ‘A.A. personality’ are apparently proving to be as unfruitful as were earlier attempts to define an ‘alcoholic personality’” (Emerick, 1989, p. 41). What this illustrates, however, are the limitations of trying to capture “quality of life” through quantitative measures.

In an empirical study, Hoffman, Harrison, and Belille (1983) concerned themselves simply with whether or not A.A. keeps people sober after treatment. They gathered follow-up data on 900 inpatients at 8 hospital-based treatment centers. Eighty-one percent of those contacted were interviewed via telephone; the remainder returned mailed questionnaires or responded in person. Participants were questioned regarding their longest period of total abstinence posttreatment, whether they
attended A.A., and if so, how often. Results of a contingency analysis between frequency of attendance at A.A. and the longest period of sobriety indicated that there was a high correlation between total abstinence 6 months after discharge and weekly attendance at A.A. during this period. Approximately 75% of the regular attendees remained abstinent, compared with approximately 33% of the nonattendees. While this led the authors to suggest that A.A. is a beneficial form of aftercare, they noted that sobriety dropped off when A.A. attendance fell to once a month or less (Hoffman et al., 1983). This is useful, if relatively sterile data, in and of itself. One wonders what the quality of sobriety was like for those in regular attendance versus those who had dropped their attendance to close to where subjects were found to relapse. Moreover, the authors cite conflicting research which either disputes or supports the validity and reliability of alcoholics' self-reports.

Kurtz (1982) has fashioned an extremely comprehensive examination of “Why A.A. works.” He believes that A.A. has “unique intellectual significance,” which it downplays due to its “inherent wariness of grandiose claims” (Kurtz, 1982, p. 38). Kurtz minces no words when he says that it is “unconscionable” for therapists to ignore it. One of the goals of the Kurtz article was to try to clarify several misunderstood aspects of A.A.. Chief among these would be powerlessness (earlier addressed by Brown, 1985, and Tiebout, 1954). Kurtz analogizes powerlessness to existentialist philosophy: the limitation imposed on the alcoholic (powerlessness over alcohol) represents the “ultimate freedom,” the ability to say “no.” This is hardly a passive process. Working the suggested 12 Steps of A.A. requires action, the goals of which are change and growth. Kurtz goes on to say that “the passage from ‘mere dryness’ to ‘true sobriety’ consists . . . in the change of perception . . . by which the
alcoholic moves from ... the prohibition, 'I cannot drink,' to understanding its
deep reality as the joyous affirmation, 'I cannot-drink' (Kurtz, 1982, p. 53).

There are occasional criticisms that A.A. attendance in itself is dependence.
Kurtz prefers to think in terms of mutuality (which he deems a more accurate term
than "self-help"); people learn not only that they need relationships with others who
are "essentially limited," but that it is meaningful to be needed (Kurtz, 1982). This
often paradoxical nature of A.A. is typified in Kurtz' statement that "A.A.'s very
existence, as well as its emphasis on attendance at its meetings, both continually
testify that progressive discovery of self—continuing honesty with self—requires
others with whom one can be honest" (Kurtz, 1982, p. 62). The present research
indicates that the phrase "progressive discovery of self" represents one element of
what the quest for growth in quality recovery entails.

Stages of Recovery

In the view of several authors, the "progressive discovery of the self" (Kurtz,
1982) occurs in relatively predictable stages. Melvin (1984) termed this the "lifecycle
of sobriety" (Melvin, 1984, p. 98). She chose to explore this concept through an
empirical study which employed qualitative research methods. Every one of her
subjects felt that sobriety involved an evolving process of growth and deepening
emotional experience. For her subjects, Melvin chose 4 men and 6 women, most of
whom had achieved sobriety ranging from 3 to 10 years. All had been active in A.A.;
al but one had been active in psychotherapy. She administered a semistructured
interview which had broad, open-ended questions. The questions were intended to
prompt reminiscences from the participants which would chronicle the progression of
feeling states, and overall emotional well-being, over the course of their recovery.
That progression was marked by predictable stages. In Stage One (Starting Over), addicts “awakened” from a time of arrested growth, which stopped at the beginning of chemical use. Feelings began to emerge at this time. In Stage Two (Growing Up), addicts begin to realize that abstinence will not be a cure-all for the problems of their lives. This stage was marked by increased self-acceptance, and a better perspective on others around them. Stage Three (Reaching Out and Sharing the Growth) is a time of greatly increased interpersonal risk, as well as the beginning of a process of becoming acquainted with long-deferred dreams and goals. By Melvin’s own admission, however, “This preliminary study invites the pursuit of further knowledge about how A.A. and psychotherapy may collaboratively support such growth, and about the re-adaptive problems posed by sobriety to the entire family of the recovering alcoholic” (Melvin, 1984, p. 113). There are several strong aspects of Melvin’s research design: she limited herself to subjects with at least 3 years of sobriety. These subjects were from diverse backgrounds. Most prominently, she limited the interviews to a specific group of topics related to level of functioning in sobriety. These are all elements which contribute to the strength of her data.

Larson (1985) devoted an entire text to what he terms Stage II Recovery: Life Beyond Addiction. For Larson, this stage involves “the rebuilding of the life that was saved in Stage I” (Larson, 1985, p. 15). He believes that learning to make relationships work is at the core of full recovery. Similar to Levin (1995) and Mack (1981), Larson is of the opinion that low-self esteem is a hallmark of recovering people. The problem, in his view, is not a fear of failure, but a fear of success; these are people with too little belief in what is possible for them. Larson (1985) believes that they have to “hit bottom” in Stage I, and realize that old habits (even sober ones) have become intolerable; i.e., recovering alcoholics cease to be caretakers, martyrs,
“people-pleasers,” etc. Larson suggests close affiliation with an A.A. sponsor to begin accomplishing these changes, particularly regarding A.A.’s Steps Six and Seven, which are concerned with the “turning over” of “character defects” (Larson, 1985).

Mooney, Eisenberg, and Eisenberg (1992) choose to refer to Phase II as the critical phase that “ensures maintenance.” They compare the comfortable sober alcoholic of 1 year to the diabetic who has learned to control her disease with insulin, yet questions whether she’s cured. Though the alcoholic may no longer drink, she is still suffering from an incurable (yet treatable disease). The risk is complacency. Transitioning to Phase II growth may involve a subtle shift in the way A.A. program time is structured. After a year, it may be possible to attend fewer meetings, yet devote more time to sponsorship and “giving back.” Deferred major decisions such as a job or relationship change may now be effectively enacted (Mooney et al., 1992). However, the authors caution the alcoholic to remember the importance of trying to locate himself/herself in positive and supportive work situations, for example; this recommendation is supported by research of Bromet and Moos (1977) and Ward, Bendel, and Lange (1982).

Bromet and Moos (1977), in an empirical study, assessed the posttreatment functioning of alcoholic patients in relation to (a) the presence or absence of resources within marriage or work; and (b) if present, the type of social environment in which the alcoholic patients lived. Four hundred twenty-nine subjects filled out the Family Environment Scale (FES), which contains 90 true-false items that evaluate the social climate of all types of families. Patients who were employed in nonsolitary occupations at the time of follow-up were asked to fill out a Work Environment Scale, which is a 90-item true-false questionnaire which assesses patients’
perceptions of the social climate of their work environments. The relationships between the availability of environmental resources at admission and posttreatment performance were analyzed using one-way analyses of variance. Of the 429 subjects, patients in stable marital and/or work situations at admission had significantly better outcomes (drinking, psychological, social) than patients without those resources (Bromet & Moos, 1977).

Ward et al. (1982), however, were critical of Bromet and Moos's (1977) methodology. They felt that Bromet and Moos did not control for the criterion variables at intake, and they did not assess the extent to which the social resource variables might interact with differing therapeutic modalities in determining improvement following the patient’s discharge from treatment. Ward et al. sought to overcome those drawbacks by randomly assigning 72 alcoholic inpatients to different therapy conditions and by statistically adjusting for prescore differences by the use of an ANCOVA. The results of their empirical research indicated that family and occupational satisfaction influenced improvement in some important areas of psychological and behavioral functioning and that this influence was independent of the type of therapy used (Ward et al., 1982).

In Kettelhack’s (1992) opinion, the changes that Larson (1985) and Mooney et al. (1992) describe take place in the third year of sobriety. Kettelhack has described the growth process of sobriety over three volumes (Kettelhack, 1990, 1991, 1992), but his comments on the third year are incisive:

You have data you didn’t have before. You learn that it’s possible to get through life without escaping through alcohol and drugs. You gain a new sense of what life might be about, a sense that’s quite different from the acquisitive goals (“Now that I’m sober I’ll have a great body, job, income, lover, house, car...”) you may have had before. (Kettelhack, 1992, p. 13)
The challenge inherent in realizing newly recognized sober potential is addressed by Weber (1991), who uses a metaphor to explain where surrender and powerlessness leave off, and will begins: “In the program, we say ‘Pray for potatoes, but first pick up a hoe’” (Weber, 1991, p. 87). In other words, one must now use a clear mind and physically healthy abilities to take coherent steps to affect change (for example, such as applying for a job). The results of one’s best efforts, however, can be “turned over,” rather than becoming the object of obsession, or self-debasing (Weber, 1991).

Small and Wolf (1978) are concerned that recovering alcoholics may simply “settle” for abstinence, without the help of a competent therapist to guide them. Like Larson (1985) and Mooney et al. (1992), Small and Wolf believe that recovery progresses in stages. In their conception of Stage Two, the most important insights and discoveries take place. The focus in Stage Two is still on the past; this is when clients often discover cause-and-effect relationships, themes, and patterns that have led to present difficulties. Stage Three, however, resembles Weber’s (1991) theorizing, in that it is “a time for experimentally venturing forward, transmuting . . . previous insights and emotional purging into risk-taking attempts at growth” (Small & Wolf, 1978, p. 34). The following processes are thought to occur: (a) fear is transmuted into courage, (b) hostility is transmuted into forgiveness, (c) self-pity is transmuted into personal responsibility, and (d) depression is transmuted into optimism. Therapists become much more confrontive at this time; additionally, they are supportive of the development of self-esteem (Small & Wolf, 1978).

Further support for the idea that personal growth occurs in long-term recovery is given by Kurtines, Ball, and Wood (1978), whose empirical research found that “long term recovering alcoholics . . . are relatively self-accepting, [and]
have a strong sense of well-being” (p. 976). Kurtines et al. employed three samples in their study: 60 newly recovering alcoholics, 62 long-term recovering alcoholics, and 61 nonalcoholic controls. All subjects were administered the California Psychological Inventory. A multivariate analysis of variance was used to test the significance of group differences on a host of personality variables, including self acceptance, sociability, and responsibility. The results of the analysis clearly showed the existence of different patterns of psychological adjustment at each stage of recovery. The overall personality profile of the long-term recovering alcoholics differed significantly from newly recovering alcoholics. Though the long-term subjects tended to be somewhat more socially inhibited than the controls, they were significantly elevated in comparison to the short-term recovering subjects in other areas of personality adjustment (Kurtines et al., 1978).

Clemens (1997) shares the view of Small and Wolf (1978) that getting “stuck” in sobriety is to be avoided: “The ultimate choice of long-term recovery . . . is whether addicts continue to expand themselves and their interpersonal field rather than attempting to maintain self and the interpersonal field as static” (Clemens, 1997, p. 83). In a manner similar to Small and Wolf, Clemens postulates that there are three essential recovery stages. While Clemens sees professional development as a part of Stage Three, he specifically notes that many alcoholics seem to be prepared to return to school to advance career goals at about 5 years of sobriety. Clemens views this as a phenomenon worthy of further research. It has been noted also in Cary (1999). Clemens also advocates vigorous therapeutic exploration of the ways in which sexual identities may be redefined in Stage Three. For many alcoholics, sexual behavior may have had addictive characteristics. This is one more arena of life in which some alcoholics struggle to achieve balance in recovery. Increasing work with other
recovering people is suggested at this time: "The ante is always raised, [as] new levels of change [are] necessary for an alcoholic to maintain growth and recovery" (Clemens, 1997 p. 99).

Yet another rendition of the three stage approach is offered by vanWormer (1987). VanWormer chooses to frame her version of these stages in terms of oppositional poles on a continuum: (a) denial (of alcoholism) versus alcoholic identity (at 1 to 6 months sobriety); (b) anger versus acceptance (at 6 months to 1 year of sobriety); and (c) isolation versus intimacy (the "ongoing" phase, which lasts from 1 to many years sober). VanWormer advocates the use of group therapy for the ongoing recovery stage, though she feels that success in group therapy is contingent upon continuous abstinence up until this stage. The research of Haberman (1966) supports this view. The ongoing recovery group’s tasks would be to help prepare members for increasing degrees of intimacy in their relationships. Relapse prevention exercises (similar to those of Marlatt & George, 1984) explore key emotional responses that trigger relapse. Affiliation is encouraged with A.A. for lifelong protection and support. A critical task of the group is "learning to have fun in sobriety!" VanWormer says that "Although this is the final period of treatment, it is one that essentially lasts for an indefinite period; alcoholism recovery always is, but never was" (vanWormer, 1987, p. 92).

Rather than describing recovery in terms of stages, Zackon (1987) believes there are two "tracks" to alcoholism recovery, which, overall, he views as "lifestyle rehabilitation." In the "primary" track, recovering alcoholics acquire psychological insight and healthy values, together with the generation of a healthy self-concept. A.A. attendance is encouraged in ongoing therapy. In the "secondary track," tasks include learning new sober pleasures, social integration (including not only A.A.
attendance, but increased community involvement), and the creation of new personal goals. Zackon concludes by strongly urging treatment facilities to work with their clients along the "secondary track." Unfortunately, in the present era most facilities will not have the time necessary to begin to go beyond what Zackon terms the "primary track," due to the restraints imposed by managed care.

While there seems to be a body of opinion that alcoholism recovery has the potential, at least, to proceed in relatively predictable stages, or phases, a note of caution is sounded by Cary (1999) and Vaillant (1995). Before a clinician would attempt to slot a recovering client in a "stage" of recovery, they urge consideration of the developmental history (and possible deficits) of the client. Vaillant (1995) has said:

Once abstinent, the alcoholic may resemble a child who, having missed years of school due to physical illness, now returns in adulthood to the classroom. Not only are there problems of self-esteem, but there are also tangible deficits in life experience that must be made up. Both clinicians and recovering alcoholics report that emotional growth may stop or even regress during the years spent abusing alcohol. Losses have gone ungrieved; social supports have gone untended; age appropriate advances in occupational proficiency have not taken place. (p. 276)

A convenient example of this phenomenon would be the author of this literature review: a 45-year-old recovering man still in graduate school! The sentiments of Vaillant (1995) are echoed by Cary (1999), who has written that during the first 10 years of a man's sobriety, his sobriety age is more important than his chronological age. If he started drinking young, he's got to learn how to grow up . . . However, . . . once they get clean and sober, they not only catch up, but start pulling ahead of their non-alcoholic contemporaries. (p. 3)

Cary's book represents one of the very few attempts to study extended recoveries from alcoholism. She observes a variety of changes in the personal growth of men she has interviewed who have been sober as long as 43 years. When these men remain
sober into their second and third decades, Cary observes that they exhibit increasing individuality, as they are continually refining the unique parameters of their identities. Cary has also noted an ever-deepening sense of spirituality among these men.

Spirituality in Recovery

The importance of spirituality in alcoholism recovery, which Cary (1999) noted, has been addressed on numerous occasions in the literature (Carroll, 1993; Johnsen, 1993; Miller, 1990). Prugh (1985) has stated that "For many alcoholics, the establishment of sobriety is only the first stone in the foundation required to build a meaningful life. Other stones must be laid through the continued pursuit of meaning and growth, especially in the spiritual dimension" (p. 29). Prugh contends that increasingly, helping professionals believe it is critical to raise spiritual issues in the counseling of alcoholic clients; this promotes continued growth and recovery. Miller (1990) believes that the initial spiritual aspect in recovery is, however, often "transformative," and does not proceed according to the "familiar successive approximations of learning theory" (Miller, 1990, p. 261). This factor may be off-putting to many therapists, Miller contends; nevertheless, he believes that therapists can no longer proceed in a "vacuum" free of values and beliefs. Indeed, Booth (1984) goes so far as to say:

All the human attributes make up the spiritual person. In this sense spirituality cannot ever be "a part of treatment," or "important to treatment"—it is essential to the treatment of this cunning and powerful disease. Indeed, spirituality is the treatment! (p. 139)

May (1988) firmly believes that there is a strong relationship between the quality of life in alcoholism recovery and spirituality. He describes the recovery process as a "journey home," which displays an increasing freedom from addictions,
while having as a central feature a firm commitment to the “mystical courtship” with a higher power. In May’s estimation this involves growth in five areas of one’s life: (1) honesty (acceptance of addiction), (2) dignity (acting “as if” one has the “goodness of a higher power” within him/her), (3) community (unbiased help is essential—a community of recovery), (4) responsibility (being willing to be of service to others seeking recovery), and (5) learning to remember to “keep it simple” in recovery (which builds on the A.A. slogan that it is a “simple program for complicated people”) (May, 1988). Kurtz and Ketchum (1992) are in agreement with May about the importance of a sense of community; specifically they maintain that it is the shared sense of being “flawed and imperfect” that creates what is truly a community.

The connection between quality of life in recovery and spirituality is a thematic thread that is woven throughout the work of several authors, including Corrington (1989), Green, Fullilove, and Fullilove (1998), and Spaulding and Metz (1997). As noted by Spaulding and Metz, research has neglected the role of spirituality as it relates to quality of life for those individuals recovering from alcoholism through the program of Alcoholics Anonymous. Nevertheless,

There is increasing evidence that A.A. helps patients succeed not only in arresting their uncontrolled drinking and drugging but also in transforming their lives physically, emotionally, and spiritually. For many, the transformation is dramatic . . . Can the medical and psychiatric professions afford to ignore the utility of such transformations and “cures” in a condition that so adversely affects so many patients? (Khantzian & Mack, 1994, p. 77)

This is ironic, in that the majority of American alcohol/drug abuse treatment programs do, in fact, adhere to a spiritually-based 12-Step approach to recovery (Miller & McGrady, 1993). Spaulding and Metz (1997) strongly embrace the connection between spirituality and the quality of life component: “Quality of life . . .
has relevance to the maintenance of successful sobriety. Those alcoholics who are happy and who embrace a positive self attitude would seem to be less susceptible to the relapse precipitants which have been implicated in previous research (Spaulding & Metz, 1997, p. 2).

Of the limited empirical research that does exist on the topic of spirituality and quality of life in recovery, Spaulding and Metz (1997) note that Carroll (1993) examined the relationship between the practice of A.A.’s Step 11 and perceived purpose in life. Step 11 states that “[we] sought through prayer and meditation to improve our conscious contact with God as we understood him . . .” (Alcoholics Anonymous, 1992, p. 96). Carroll employed 100 members of A.A. in her research as her subjects. They were asked to take the Purpose in Life Test, which was developed in 1964 to measure empirically the concept of meaning and purpose in life. Additionally, subjects completed a 38-item Step Questionnaire, which was designed to measure the extent to which A.A. members practice Step 11. This questionnaire was developed by Carroll. Step 11 behaviors included a variety of spiritual practices, such as meditation. Carroll constructed a frequency distribution table of responses to each item. Each answer was then assigned a score from 1 to 5 according to the frequency of participation. Step 11 affect included 13 Likert scale items, also scored from 1 to 5, asking the extent to which the individual felt that he or she had, for example, peace of mind or faith in a Higher Power. A stepwise multiple regression showed that Step 11 accounted for 32% of the variance in Purpose in Life Scores. The major finding of Carroll’s research was that the extent of practice of Step 11 was positively correlated with both purpose in life and length of sobriety. Carroll concludes by recommending that therapists should pay particular attention to spiritual issues for their recovering alcoholic clients. Specifically, discussions of clients’
practice of Step 11 is encouraged. Based on items that Carroll included in her Step Questionnaire, such as “gratitude,” and “connection to people,” it is apparent that she has a solid grasp on many of the components which alcoholics might associate with spiritual growth in recovery. The use of the Likert Scale format, however, remains limited by a certain sterility. What it does not capture is the depth and subtlety that a qualitative interview might have conveyed (Carroll, 1993).

Spaulding and Metz (1997) believe that some therapists simply do not grasp that traditional techniques are of little use in treating alcoholics unless those therapists are able to advocate and support their clients’ involvement with A.A. In Spaulding and Metz’s empirical research, a quantitative design was employed, which tested 80 A.A. members (40 were males, 40 were females), with a mean sobriety length of 64 months. Quality of life was measured by two instruments: The Satisfaction With Life Scale, which is a five-item scale which measures subjective well being and cognitive-judgmental levels of life satisfaction. The Index of Self Esteem (a second instrument) is designed to measure the degree, severity and magnitude to which a person has a problem with self esteem. A series of multiple regression analyses was carried out in order to explore the role of the independent variable (spirituality) in predicting the dependent variable, quality of life. When the entire subject population was examined, it was apparent that the Satisfaction With Life Scale (representing the independent variable) was the strongest measure of quality of life. This scale contained several subscales: spiritual coping style, length of time sober, and social support from friends. Results revealed that there was some indication that women had a higher quality of life than did males in general, but that positive social relationships with friends were strongly correlated with a better quality of life for all alcoholics in this study. A quantitative study such as this, however,
cannot get at the depth of some of these factors. For example, it is difficult to glean
from these results at what point in sobriety friendships began to provide quality of life
in recovery. There is no opportunity to follow-up with the female participants to
determine what elements of their recoveries could account for discrepancies with
male depictions of recovery quality. These are instances where a qualitative study
could potentially provide greater depth of information.

One empirical study that did use the qualitative approach to advantage was
that of Green et al. (1998), who explored the nature of spirituality in recovery
through stories of spiritual awakening told to them by 24 recovering African-
American women and men in two focus groups. In their analysis, the authors
examined the content of the stories told to them to delineate the manner in which the
subjects employed the Higher Power concept in enhancing their recoveries.
Participants in both of the focus groups identified the positive changes they
experienced in sobriety as being closely associated with a power greater than
themselves, which had the ability to do that which they had been unable to do alone
(stay contentedly sober). According to the authors, “The most important element was
that something [the higher power] be greater and more powerful than self” (Green
et al., 1998, p. 328). This harkens back to the original surrender concept of Teibout
(1954). While Green et al. (1998) are among the first researchers to look at
spirituality and recovery with qualitative methods, there are questions raised by the
limits of their exploration. For example, what were the subjects’ reasons for
developing such a strong reliance on a higher power? How does that reliance evolve
over recovery, and does it enhance perceived quality of recovery? Did any, or all of
the subjects hold a belief in a higher power prior to recovery? These are some of the
factors that could bear analysis in future research; they are examined in the present research.

Corrington's (1989) empirical research employed quantitative methods to examine the relationships between levels of spirituality, contentment with life, and stress, during recovery from alcoholism in A.A. As was the case with Green et al. (1998), however, Corrington effectively limits the concept of quality of life to spirituality components of recovery. His was a cross-sectional study, which was designed to explore the possibility of relationships between the following variables: (a) time in A.A., (b) level of spirituality, (c) level of contentment with life, and (d) level of stressors encountered in the previous year. There were 30 subjects in this study (10 women and 20 men; all were Caucasian). Length of sobriety ranged from 1 day to 28 years. Among instruments employed were the Spirituality Self-Assessment Scale (SSAS), the Generalized Contentment Scale (GCS), and the Life Events Scale. Regression analysis was used to explore the relationships between the independent variable of time in A.A. and two separate dependent variables: (1) scores on the SSAS, and (2) scores on the GCS. There was a direct linear relationship between scores on the SSAS and scores on the GCS. Corrington (1989) felt that this was the most significant finding of his study: it indicates a strong relationship between a subject’s level of spirituality and his or her level of contentment with life. The author states that "it appears that independent of the amount of time that a person has in A.A., the higher his level of spirituality, the higher his level of contentment with life will be" (Corrington, 1989, p. 156). Corrington's subjects who had been in A.A. at least 2 years also exhibited reduced levels of stress. Johnsen (1993) reached a similar conclusion, stating that "it does seem clear that the association between recovery and . . . spirituality, the use of prayer and meditation, is an important one" (p. 60).
Borman and Dixon (1998) noted that an emphasis on spirituality is a vital component of various treatment modalities. In their empirical study, they compared participants in 12-Step outpatient programs to patients in non-12-Step outpatient programs to assess the programs’ impact on spirituality. They administered the Spiritual Well-Being Scale (a Likert-scale type questionnaire designed to measure level of spirituality) to 12-Step and non-12-Step program participants. A univariate analysis of variance revealed no significant differences in levels of spirituality. Participants in both groups reported that after 4 weeks of attending these programs, there was an increase in their level of spirituality, which led the authors to suggest that an improvement in the recovering alcoholic’s spiritual life can be accomplished with or without A.A. participation. The problem of obtaining follow-up data is present in the Borman and Dixon research. They were unable to obtain follow-up data 4 months after their initial research because only one of the original patients was still attending the groups. Obviously, this would make it impossible to chart the relationship of spirituality and quality of life with the passage of time.

When describing the growth that accompanies a deepening spirituality in recovery, Peteet (1993) believes that 12-Step programs address individuals’ needs for identity, integrity, an enhanced inner life, and interdependence within a larger social and moral, or spiritual context. Peteet is sensitive to the apparent importance of spirituality; he notes that the Joint Commission on Health Care Organizations mandates that attention be given by substance abuse treatment facilities to the spiritual aspects of the patient with substance abuse problems. Nevertheless, he acknowledges that “mental health professionals are often skeptical about the relevance of the spiritual approach to treatment effectiveness” (Peteet, 1993, p. 263).
The uneasiness that many therapists have with spirituality is also of interest to Kohn (1984), who stated that

The issue of spirituality holds a special place in many modes of the treatment of alcoholism and other forms of substance abuse. This is true in spite of some built-in antipathy toward or misunderstanding of the concept of spirituality on the part of many medical and counseling professionals. (p. 250)

Kohn suggests that for many practitioners who have been indoctrinated into the medical model, the concept of spirituality may conjure up images of “faith healing.” Kohn struggles to fit spirituality into the medical paradigm, with which he appears most comfortable. Because spiritual experiences represent what he believes to be right-brain activity, they are “consistently difficult to describe in words” (Kohn, 1984, p. 252). Kohn proposes that alcoholics favor right-brain activity, and need to be trained to develop their “bimodal spirituality,” which, while it is vaguely defined, appears to involve an increase in rational approaches to drinking behaviors and relapse prevention (Kohn, 1984).

The struggle to achieve more empirically “valid” data on the spiritual aspects of recovery is captured well by Miller (1990), who believes that there has never been empirical verification that recovery in A.A., for example, (with its attendant spiritual emphasis) is dependent upon certain procedures outlined within the 12 Steps. Miller expresses frustration that there are “no established methods” for assessing character constructs such as honesty, patience, or unselfishness. As such, it is Miller’s contention that behavioral scientists are poorly-prepared to study spiritual processes. For those (including practitioners) who have, however, observed the facilitative role that spiritual emphasis can play in addiction recovery, the desire to see such “proof” may not be as urgent: “For believers, rather the opposite question emerges—why
bother to try to prove, through relatively weak and time-consuming methods, what
we already know to be true” (Miller, 1990, p. 264).

Part of the difference in perspective on spirituality of some therapists and
certain A.A. members may be accounted for by Kurtz and Ketchum’s (1992) analysis:
“Therapy’s goal is happiness, in the modern-day sense of ‘feeling good,’ while
spirituality suggests that valid feeling follows be-ing, and the more realistic goal is
therefore . . . ‘being good,’ of finding a real fit between self and reality outside of
self” (Kurtz & Ketchum, 1992, p. 27). These authors also maintain that for the
concept of spirituality to be effective, there must be surrender (as noted earlier by
Tiebout, 1954) of the “demand for certitude.” This notion, suggest Kurtz and
Ketchum, may be uncomfortable for some clinicians.

Carroll (1997) focused her empirical research on identifying approaches
which facilitate and encourage spiritual growth in recovery. She chose to employ a
qualitative approach to her research, wherein she interviewed 17 recovering
alcoholics (who also were Adult Children of Alcoholics) about potential mental
health and social resources, treatment methods, and specific characteristics of those
treatment methods which they found to be helpful in furthering spirituality in their
recovery. Carroll found that journaling and imagery (treatment methods) were
particularly helpful. Some of the primary themes which emerged from Carroll’s
interviews were self-trust (in one’s abilities and essence), along with the
interrelationship of spirituality and human behavior. It was also stressed that a sense
of interconnectedness which transcended individuality was considered to be crucial to
spiritual growth in recovery. Carroll concludes with a call to clinicians to affirm their
client’s spiritual resources; in her estimation, this can be achieved regardless of a
therapist’s specific theoretical orientation. Such an approach may not always be encouraged in the current political climate however; Carroll’s frustration is evident:

Spirituality and spiritual growth may seem meaningless in today’s managed care environment which emphasizes, almost exclusively, “medical necessity,” short term interventions, and treatment decisions by case managers who never see the client. However, increasing indications that body, mind, and spirit are interrelated support the need to identify which interventions are effective and under which conditions. (Carroll, 1997, p. 98)

When Miller (1990) says that “At present, behavioral scientists are ill-prepared to study the spiritual processes . . . ,” he is referring, I believe, to the shortcomings of traditional quantitative statistical methods in capturing the subjective elements of spirituality. Carroll’s (1997) qualitative research represents an alternative approach to establishing a body of research which demonstrates in depth which interventions have proved effective in promoting spiritual growth, albeit for a small group of subjects. By letting insights about the effectiveness of these interventions emerge in her subjects’ own words, Carroll has made a valuable contribution to the understanding of how treatment can be more effectively provided for those in recovery from alcoholism. In broader terms, the present qualitative research, the results of which appear in Chapter IV (“Results”) of this dissertation, has sought to expand on the vocabulary of essential components in alcoholism recovery.

Quality of Life in Alcoholism Recovery: Qualitative Research

Several pieces of literature cited thus far within this inquiry have employed qualitative research. Each of them, however, has imposed a relatively limited focus upon its research. Melvin (1984) examined the lifecycle of sobriety; Green et al. (1998) and Carroll (1997) concerned themselves with spirituality in recovery from alcoholism. While the latter two articles, in particular, touched upon elements of
quality of life in sobriety, their emphasis was on only one element of what many recovering people might feel is involved in the attainment of that quality.

This literature review has indicated that only a very small number of authors have attempted (through qualitative research methods) to capture a broader portrayal of quality of life in recovery from alcoholism. Young (1989), in the empirical research contained within her dissertation, assembled six case studies of recovering alcoholics, all of whom, in addition to being A.A. members, had also been in therapy. The length of recovery for her subjects ranged from 1 to 20 years. Her subjects essentially told their entire life stories, proceeding through the beginning of their drinking careers, and on to recovery and sobriety. While these individuals devoted many of their comments to what was involved in their obtaining sobriety, there was also a cross-section of ideas expressed regarding components of long-term sobriety. For several individuals, these included the personal, emotional, and spiritual growth they had experienced. These case studies, while they make interesting biographies, are so open-ended as to lack cohesion. It is difficult to determine what Young’s goals were. There is analysis of reasons why people drank, and ideas are offered about common characteristics of Adult Children of Alcoholics, among a host of other observations. What is lacking are clear conclusions which might have implications for future treatment of recovering alcoholics.

Within the context of the empirical research contained within her dissertation, Sommer (1992) conducted interviews with recovering alcoholics who had been sober from 4 to 7 years. All were members of Alcoholics Anonymous. Within the context of her interviews, Sommer asked her subjects to share the most important things they had learned in sobriety and how they solved problems in their lives today. Several essential themes emerged, including a change in self-perception, a change in
perception of the world, a sense of accomplishment, and how these individuals practiced their recovery programs in current times. One of Sommer's major findings was that her subjects believed there was still "much work to be done" related to recovery, and that there is a difference between the quality of early sobriety, and current sobriety. While Sommer's research strikes a much more equitable balance between the predetermined focus of, for example Carroll (1997), and the almost complete lack of structure in Young's (1989) research, the reason her subjects report that there is "much work to be done" may be due to the questionable "long-term recovery" inherent in even 7 years of sobriety. As earlier noted, Cary (1999) has observed considerable differences in the life structures of men in their second, third, and even fourth decades of sobriety.

Bowden (1998) chose to employ the heuristic research method, a qualitative phenomenological design, in the empirical study which she conducted to investigate the experience of recovery. She interviewed eight recovering alcoholics in depth. Each subject was interviewed at least three times. These individuals were encouraged to recall experiences, feelings, thoughts, and situations connected with recovery through writing, artwork, poetry, music, or other creative means of expression. They were asked to describe the subjective experiences to which they attribute recovery. In-depth self-searching and reflection were encouraged so that deeper awareness of the phenomenon could be reached. In the subjects' first interview, they told their story about becoming an alcoholic and how they were able to gain lasting sobriety. The second interview focused on changes in values, worldview, emotions, and purpose. During the final interview, the subjects discussed relationships and their experiences with spiritual growth. Bowden employed a unique perspective in analyzing her data: she analogized the process of recovery with a mythological
journey comprising a departure from the shadowland of drinking, initiation into the new world of sobriety, and knowledge gained along the way. The subjects conveyed that they acquired new adaptive strategies, including strengthening the will, training the mind, and exercising spiritual qualities in one's daily life. There were gains reported in self-acceptance, as well as an ongoing effort to increase a personal connection with a higher power.

Probably because she has chosen the phenomenological qualitative approach, Bowden's (1998) research seems the most satisfying of the qualitative literature cited herein. The phenomenological approach is very much concerned with the subject's personal experience of meaning-making. As Moustakas (1990) has put it, "Only the experiencing persons—by looking at their own experiences in perceptions, thoughts, feelings, and sense—can validly provide portrayals of their experience" (p. 26). A perspective such as this seems to fit the study of quality of life in recovery especially well, given the subjective nature of the topic, and the uniquely personal experience each person will have had. It is to Bowden's credit that she allowed her subjects enough freedom within her interview format to let their feelings emerge in depth, without the restrictions imposed by a topic of limited focus (such as, for example, spirituality). The use of other expressive media (art, music, etc.) beyond the spoken word is particularly intriguing. Like Young (1989), Bowden included subjects' perspectives on the process of getting sober, which seems to unnecessarily broaden the scope of their recollections. This is understandable, though, given that the sole focus here is not quality of life in advanced recovery, but the entire "spiritual journey" of recovery; this is a remarkably ambitious agenda for a single research article. It is also illustrative of the challenges inherent in qualitative research data reduction. Bowden's research serves as a guide to the sort of methodological
approach employed in the present research (which is described in Chapter III—Methodology of this dissertation), albeit with its sole focus on quality of life in recovery.

Summary

In summary, the preceding literature review has, in fact, indicated that several areas of focus are apparent in the literature which deals with quality of life in recovery from alcoholism. Although few authors dealt with this issue exclusively, the other articles cited within the divisions of this review do have relevant observations about what constitutes a contented recovery.

Emotional State Changes Entering Recovery

It would appear that a process of physiological and emotional transition is necessary for many individuals entering recovery. Levin (1991) believes this process is largely neurochemical, as the body adjusts to the absence of alcohol. Other authors, such as Kellerman (1977) and Lawton (1985), analogize this transition to the grief process involved in mourning a great personal loss. I believe this idea has considerable merit. I have known newly recovering people to describe this process as being similar to saying goodbye to a close and trusted friend. One rather grandiose individual likened his former relationship with alcohol to that of a lover who, after a period of rewarding intimacy, had betrayed him. Such is the nature of this process. This would appear to be another aspect of recovery that incorporates an element of acceptance: for many, at least, there is no short cut around the emotional and physical discomfort involved in this grief process.
It seems fitting that O’Connor et al. (1994) have suggested nonconfrontational therapy for female recovering alcoholics. Their research indicated higher levels of depression in women than men in early recovery. Nonconfrontational therapy would be indicated, in my opinion, since so many women (and men, more than likely) are in the tender stages of grief in early recovery. I might speculate that women in O’Connor et al.’s research exhibited this elevated shame, depression, etc., due to the stiffer societal stigma that has often been placed on the female alcoholic. As is the case with much of the research in this review, however, it is difficult to break down these findings to a much more detailed level. Further research examining demographically different groups of women would be intriguing.

In my estimation, additional clarity regarding the definition of “sober” would be welcome. For example, some of Ludwig’s 1985 subjects drank occasionally, yet were included in his “sober” data. Continuously sober alcoholics (who have come to value the importance of the “continuously” distinction) would likely be the first to object to inferring a great deal about the contentment present in the recoveries of those who still occasionally drink. One might ask, “How can I begin to grieve your loss [alcohol] if you never go away?”

A 41% return rate (such as Hatsukami & Pickens, 1982, had with their instrument) may be acceptable in some circles, but it is indicative of a shortcoming of quantitative methodology in the area of the study of quality of life in alcoholism recovery. The many and varied stories of recovery that are omitted in such return rates only heighten this researcher’s curiosity about how “the other half lives.”
Surrender

My impression is that surrender is a concept whose importance cannot be overstated in the quest for a satisfying recovery from alcoholism. It emerged as a significant factor in the recoveries of the participants in the present research. The surrender of one's sense of power and control over alcohol consumption is emphasized by several authors, including Tiebout (1954) and Denzin (1987). As earlier quoted, Tiebout believes that the significance of surrender is “not sufficiently appreciated by . . . most therapists” (p. 17). I believe he is right. Given the sweeping nature of Tiebout’s statement, I find it surprising that more research has not been devoted to the role of surrender in recovery, and how it’s implementation can be facilitated. The experience of the participants in the present research has indicated that surrender has not been (for them, at least) a one time event, either. Recovering alcoholics, in my experience, frequently revisit this concept, if not in direct regard to drinking, then in relationship to other aspects of sober living. This is why I believe that Pettinati et al.’s (1982) criticism of research which examines an alcoholic’s recovery at only one point in time is well-founded. This is one of the most notable criticisms that I would have of much of the literature cited within this review. One implication is that more quantitative research which attempts to chronicle recovery across a generous span of time would be welcome. The alternative approach would be to generate more qualitative research designs such as that employed in the present research, which allow the participants to determine where the critical junctures in the recovery process have occurred. Given what I perceive to be one of the problems in the existing research (an over-reliance on quantitative research methodology), I
believe that further research employing qualitative methodology would be appropriate.

**The Dry Drunk Syndrome and Relapse**

Given that Flaherty et al. (1955) asserted that most alcoholics will experience the dry drunk syndrome, why has there not been more research devoted to the methods which *alcoholics themselves* have found to be helpful in coping with this phenomenon? I remain intrigued with the reports of recovering individuals, such as Dan F. (1991) has cited, who have found help through therapy *combined* with A.A. attendance. Chiauzzi (1991) advocated assessment of the alcoholic’s ability to communicate within intimate relationships as a method of determining how well that person might be able to use this coping skill in dealing with a dry drunk. Might not those with experience in struggling with this issue be able to delineate how others helped them through these times? Might not these experiences have implications for the possible contribution of therapy in helping to treat the dry drunk?

While authors such as Marlatt and George (1984), with their research on their Relapse Prevention Program, and Gorski (1989a) with his conceptual writings on his RADAR program, have made valuable contributions to understanding ways in which dry drunks/relapses might be prevented, I am drawn toward the further exploration of Zackon’s (1989) view that the active pursuit of the pleasure to be found in fellowship with other recovering people may be as powerful a “prevention” technique for relapse as any others cited within this review.
The Roles of Therapy and Alcoholics Anonymous

Some disagreement about the value of therapy for alcohol-related issues is apparent from this literature review. Rawson (1995) and Barnes (1991) favor behavioral approaches (within the context of a stages-of-recovery framework), while Levin sees recovery as something more fluid, which can be successfully treated with insight-oriented therapy. While Brown (1985) noted considerable dissatisfaction with therapy among those who were still drinking, she found that a greater percentage of people in recovery found therapy helpful. I would echo her emphasis on this finding. In fact, I suspect that insight-oriented therapy is of limited value until clients have taken behavioral steps (such as seeking group support) in regard to their alcohol use. One of the participants in the present research had an experience with insight-oriented therapy after the attainment of a substantial length of sobriety. That participant’s experience in therapy (and other participants’ experiences with therapy) is discussed in Chapter IV—Results of this dissertation.

Of all the literature reviewed in this chapter, I was perhaps most impressed with Brown’s (1985) research, which proposed a developmental model of recovery. While Brown acknowledges factors that have contributed to the occasional tension between therapy and A.A., she makes a considerable contribution by proposing ways in which both can inform and facilitate recovery. Specifically, I am intrigued with her advocacy of “behavioral” approaches to early therapy (to support the adoption of A.A.’s suggested recovery methods), with a later shift to insight-oriented work, as clients become better equipped to sustain this approach.
Stages of Recovery

There is a strong body of literature which suggests that recovery does proceed through relatively predictable stages. The minority of these pieces of literature employ quantitative research methodology. Examples include Bromet and Moos (1977), Kurtines et al. (1978), and Ward et al. (1982). One of the strongest pieces of research within this review came from Melvin (1984), who employed qualitative methodology. Her research serves a model of an effective approach: she has limited not only the size of her sample (and its characteristics), but the range of her research question (what does the lifecycle of sobriety look like?). This research is elegant in its simplicity.

Of the other literature on this topic, I was struck by the power of the descriptions given by Cary’s (1999) subjects of their lives in long-term recovery. While Cary is quick to point out that she does not consider her collection of accounts of “heroic journeys” to be “science,” I believe she may be doing herself a disservice. She has devoted considerable effort to the analysis of the themes these individuals express. She makes a compelling case for the idea that after 10 years of sobriety, many individuals have constructed the template by which they will form the basic living patterns of the remainder of their lives. My own experience would suggest that this probably holds true for a great many people; hence, I have elected to employ the 10-year milestone in recovery as an inclusionary factor in the present research.

Spirituality in Recovery

Spirituality is another aspect of recovery which aroused some controversy among helping professionals. I have a sense that Prugh (1985), however, is probably
correct in his contention that helping professionals increasingly believe that it is critical to raise spiritual issues in the counseling of alcoholic clients. One of the stronger pieces of original research on the topic of spirituality in recovery was that of Carroll (1993), who found a correlation between the practice of A.A.'s Step 11 (see Appendix F) and both purpose in life and length of sobriety. It may be that Carroll’s focus on this singular aspect of A.A. contributed to the relative clarity of her findings.

My own reaction to Carroll, though, and other quantitatively-researched data dealing with spirituality in recovery, such as Spaulding and Metz (1997), is a nagging curiosity about the questions which their research raised, but was not equipped to answer. Why did Spaulding and Metz, for example, discover that recovering women in their study generally had a higher quality of life than did their male subjects?

Miller (1990) contends that researchers are ill-equipped to study the spiritual process. I share this view; I find that certain quantitatively-based studies which have restricted their research focus (such as Spaulding & Metz' 1997 results, cited in the paragraph above) yield informative, yet sterile data. By contrast, Carroll’s (1997) research, which employed qualitative methods, gave her subjects great latitude in conveying to her the mental health and social resources, and treatment methods which they found to be helpful in furthering the attainment of spirituality in their recoveries. From my perspective, these data provide a richness which seems to suit this area of inquiry.

Quality of Life in Alcoholism Recovery: Qualitative Research

This particular branch of the literature contained in this review is quite small. Hence, the need is apparent to expand this body of research. The research of Young (1989), for example, exemplifies one of the potential drawbacks to qualitative
research methodology. Her case studies, while interesting, have little structure. Her methodology seems somewhat lacking in focus, and, as a result, so are her findings. Bowden's (1998) research on the "spiritual journey" of recovery, while much more focused than Young, still has an agenda ambitious enough to render her conclusions somewhat diffuse.

The fact that there are few pieces of literature reviewed under the "Quality of Life" heading certainly amplifies my reasoning for undertaking the present research. The study of quality of life in extended alcoholism recovery is under-researched.

Conclusion

Lawton (1985) has stated that in alcoholism recovery "the challenge . . . lies in facing . . . major issues [necessary] to achieve quality sobriety and the road to self actualization" (p. 58). The challenge inherent in capturing through research an accurate portrayal of the factors involved in achieving quality alcoholism recovery seems no less daunting. Perhaps that is why, despite the array of literature cited herein which tangentially deals with this issue, its study remains largely neglected. In concluding this literature review, these comments of Amodeo et al. (1992) seem fitting:

The accumulating literature . . . suggests that criteria for assessing recovery cannot focus solely on abstinence or include only those more concrete areas of social adjustment, e.g., family, occupation, finances, and health. Abstract dynamics including purpose in life, a clear sense of life satisfaction, and positive reasons for not drinking must take their place as important measures of success and failure. Recovery needs to be seen as a long-term process, perhaps with periodic returns to treatment to work on these abstract and dynamically oriented issues. (p. 714)
CHAPTER III

METHODOLOGY

Overview

This chapter provides a description of the methodology employed in the present research. The chapter addresses the research design, participant selection, data collection, interview protocol, and data analysis. There is also a brief description of the pilot study which was conducted in this research.

Research Design

The principal objective of this research is to examine quality of life factors among recovering alcoholics. The literature previously reviewed indicated that the need exists to learn more about how it is that people have come to lead contented lives in their recoveries from alcoholism (Cary, 1999; Vaillant, 1995). According to Kinney (1991), little has been done to discover the qualities of those alcoholics who are committed to a life of sobriety. Moreover, Bowden (1998) contends that:

One's personal search for meaning, the ability to make moral choices, coming to know oneself, or acquiring the capacity to be creative are examples of internal phenomena, not applicable to objective observation. Alcoholism recovery has similar attributes: it is an internal phenomenon, a success story that can be told only from within. (p. 337)

The emphasis in the above statement of Lawton's, for the purposes of this research, is on the phrase “internal phenomenon.” The position of this research is that stories of recovery can only come from within. Hence, such personal and subjective
stories are particularly well-suited for being captured within the framework of the phenomenological qualitative research design. After all, "Only the experiencing persons—by looking at their own experiences in perceptions, thoughts, feelings, and sense—can validly provide portrayals of their experience" (Moustakas, 1990, p. 26).

It is the individual’s portrayal of the experienced meaning of quality of life in alcoholism recovery which is essential in the present research. Moustakas’ (1990) emphasis on experiences of feelings is particularly appropriate given that A.A. holds the belief that alcoholism is a disease of feelings (Alcoholics Anonymous, 1976).

Phenomenology, as a qualitative research discipline, distinguishes itself by maintaining “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” (Polkinghorne, 1989, p. 44).

The Empirical-Phenomenological Approach

Among the several different branches of phenomenological research, the empirical-phenomenological approach seems to be particularly appropriate to capturing the essences of experiences. For that reason, it is employed in this research. Polkinghorne (1989) believes that the adoption of this approach represents an effort to thematize, and to reflectively understand the phenomenon in question. Polkinghorne’s view is that “all experiences of a phenomenon of interest are potentially informative, regardless of who lives and describes them” (Polkinghorne, 1989, p. 128). What is being examined in this research is the personal significance of quality recovery to the alcoholic: how is that experienced internally, and how does it manifest itself in their behavior?
According to Moustakas (1994), the empirical phenomenological approach entails a return to internal experience for the purpose of obtaining comprehensive descriptions. These descriptions serve as the foundation of research data from which a reflective structural analysis is developed that illuminates the essences of the experience. The researcher determines the base structures of experiences by interpreting the initial descriptions which participants provide of their experiences.

Giorgi (1985) associates two descriptive levels with the empirical-phenomenological approach. In Level I, the initial data are composed of naive descriptions which the participants have provided to the researcher through open-ended questions and dialogue. In Level II, the structures of the experience are described by the researcher, based on his or her reflective analysis and interpretation of the participant's account. The goal in the present research is to arrive at an understanding of what the experience of quality of life in recovery means for the persons who have had it. A number of steps have been followed to ensure that the researcher's interpretations of these meanings are accurate (refer to the later section on Rigor of the Data Analysis).

The present research follows the three steps involved in empirical-phenomenological studies as outlined by von Eckartsberg (1986). The three research steps are as follows:

1. The researcher delineates a focus of investigation. The present research focuses on the quality of life experiences among recovering alcoholics.

2. In the second research step, which von Eckartsberg (1986) refers to as The Data Gathering Situation-The Protocol Life Text, the researcher gathers a descriptive narrative from the participants, with whom the researcher has engaged in dialogue, and has queried.
3. In the third step, called Data Analysis by von Eckartsberg (1986), the researcher explicates and interprets the narrative data. Once collected, the data are read, scrutinized, and interpreted by the researcher, so as to reveal their structure, meaning configuration, coherence, and the circumstances of their occurrence and clustering (von Eckartsberg, 1986).

The Researcher as Instrument

Within the framework of the present qualitative research, the Student Investigator himself serves as the "instrument." Lincoln and Guba (1985) have outlined several advantages to this situation. Those listed here seem particularly valuable:

1. Responsiveness: The researcher-as-instrument can sense and react to all personal and environmental cues that exist.

2. Adaptability: The researcher-as-instrument is virtually infinitely adaptable, and can collect information about multiple factors—and at multiple levels—simultaneously.

3. Holistic emphasis: The world of any phenomenon and its surrounding context are examined in a holistic manner by the researcher-as-instrument.

4. Opportunities for clarification and summarization: The human instrument has the "unique capability of summarizing data on the spot and feeding them back to a respondent for clarification, correction, and amplification" (Lincoln & Guba, 1985, p. 194).
Selection of the Participants

**Purposeful and Theoretical Sampling**

Lincoln and Guba (1985) believe that the terms *theoretical sampling* and *purposeful sampling* are virtually interchangeable. Both are worth noting, due to their relevance to the selection of participants for the present research. Patton (1990) believes that the power of purposeful sampling arises from the selection and in-depth study of information-rich cases identified as having the experiences and the issues of central importance to the research. Because of the richness in the stories of recovery that are offered by the purposefully sampled participants in this research, the actual sample size is relatively small. It is in regard to the matter of sample size, however, that Taylor and Bogdan (1998) make the following comment about theoretical sampling: “In theoretical sampling, the actual number of cases studied is relatively unimportant. What is important is the potential of each case to aid the researcher in developing theoretical insights into the area of social life being studied” (Taylor & Bogdan, 1988, p. 93). Participants for this research were purposefully chosen from the northern Indiana A.A. communities. The criteria were that they had achieved 10 years or more of continuous sobriety, and were considered by the Student Investigator to have achieved some measure of quality in their recoveries. A number of authors, including Cary (1999), and Vaillant (1995), have observed that those who stay sober to this length of time and beyond are often observed to be enjoying a higher quality of life than those who are just commencing their recoveries from alcoholism. In this respect, the purposeful aspect is apparent: an accumulation of information-rich narrative data might be anticipated from such participants. Indeed, the meanings that these people have constructed about the reasons for their own
levels of contentment in sobriety emerged from the participant data and the subsequent analysis of data. In conclusion, it is appropriate to describe the present qualitative research as employing both the purposeful and theoretical sampling strategies.

Following doctoral committee and Human Subjects Institutional Review Board approvals, this research proceeded as follows. Announcements of this research were posted in two Alano clubs in the northern Indiana area (see Appendix A). Alano clubs are privately owned facilities whose primary function is to provide a meeting place for Alcoholics Anonymous and other 12-Step programs. Additionally, recovering individuals gather and fellowship in these facilities at times when meetings are not being held. The posted announcements provided a brief and general description of this research, a brief reference to its potential benefits, and an invitation to interested persons to contact the Student Investigator at his telephone number, which was included. Those potential participants who were considered appropriate were male and female A.A. members with whom the Student Investigator had had no previous contact. Eight participants were eventually chosen.

During the initial phone contact, the Student Investigator explained this research in greater detail, as well as the details of the potential participants’ involvement with the research, specifically the interview process (see Appendix B). As earlier indicated, the essential requirement was that the participants had obtained at least 10 years of continuous sobriety. Additionally, the Student Investigator was looking for a prospective participant’s interest in the research, and his or her professed commitment to sobriety. These issues took precedence over specific demographic characteristics of the participants. The Student Investigator placed
particular emphasis on the assurance of the participants’ confidentiality and anonymity.

If the participants expressed an interest in participating in this research, the Student Investigator gathered from them the demographic information listed in Appendix D during the initial phone contact. This process also served as a screening interview to provide the Student Investigator with a preliminary impression of the participant’s quality of sobriety. Times, dates, and locations for the interviews were discussed at this time. Locations were ones which the participants found to be both suitable and convenient. The bulk of these interviews occurred within meeting rooms located in the Alano clubs where the participants attend meetings, although one interview took place at a restaurant where a participant often meets other recovering alcoholics for coffee. This site was used at the participant’s request.

At the beginning of the first scheduled interview, the participants were invited to read an informed consent document, which discussed matters of confidentiality, their commitment to the research, and permission to record the interviews (see Appendix C). After they had read this document and agreed to proceed, tape recording began. The consent document was then read aloud by the Student Investigator; at its conclusion, the participants were invited to offer their verbal signification that they had heard its contents, and that they consented to them. This “anonymous” consent process not only assured the confidentiality of the participant’s comments, but it also provided documentation of the participant’s consent to be interviewed.
Pilot Study

The first interview with the first participant served as a pilot study for this research. Glesne and Peshkin (1992) have stated that “Such . . . [an interview] if conducted in the right frame of mind—the deep commitment to revise—should suffice for pilot testing purposes” (p. 68). The greatest value in this pilot study was that it provided the Student Investigator with the ability to determine how effective the interview protocol was. Specifically, Marshall and Rossman (1995) place value on the concept of “informational adequacy,” which was judged, in part, on the basis of this pilot study. Not only did the pilot study provide an opportunity to assess how clear and appropriate the interview questions were, but it also provided the means to assess the “practical aspects” of the interview process: how facilitative was this format for the participants’ dissemination of information, and the researcher’s reception of it (Glesne & Peshkin, 1992).

Data Collection/Interviews

The following procedures were used to collect the research data. Each participant was interviewed individually on two occasions. Each interview lasted approximately 2 hours. The interviews were audio-taped on standard audio cassettes, which were later transcribed verbatim by a professional typist. For maximum fidelity and accuracy of reproduction, a Sony Professional Walkman recorder was used to tape these interviews.

The interviews were semistructured in that they followed the order of the questions on the interview protocol (see Appendix E). McCracken (1988) refers to
his list of questions as the “questionnaire.” His comments about the questionnaire are relevant:

Its first responsibility is to ensure that the investigator covers all the terrain in the same order for each respondent (preserving in a rough way the conversational context of each interview) . . . it allows the investigator to give all his or her attention to the informant’s testimony . . . It is important to emphasize that the use of the questionnaire does not preempt the “open-ended” nature of the qualitative interview. Within each of the questions, the opportunity for exploratory, unstructured responses remains. Indeed, this opportunity is essential. (p. 25)

Bearing in mind this opportunity for exploratory, unstructured responses, the two interviews with each participant did not have a rigidly imposed agenda. While it was desirable to cover as much material as possible, those questions which were not touched upon in the first interview were used in the second interview. The first interview was conducted with all 8 participants, before returning for a second round of interviews. During the intervening time, participants were invited to reflect upon their first interview, and to consider any significant thoughts which they might have failed to mention, so that they could be captured during the second interview. In keeping with the suggestions of Hill, Thompson, and Williams (1997), a copy of the typed transcript of their first interview was also mailed to each of the respective participants during the time between their first and second interviews. This provided the opportunity for each participant to check her or his transcript for accuracy; the Student Investigator was then able to check the level of accuracy of that first transcript at the start of the second interview. If all questions, or subject areas, were covered in the first interview, the second interview provided a more extensive opportunity for the participant to reflect upon the transcript of the first interview. During the second interview, the Student Investigator also offered for the participant’s consideration some preliminary interpretations of themes that he
perceived as having emerged from their first interview; the participant was then invited to indicate whether he or she found these themes to be accurate, or not. Additionally, the second interview provided an opportunity for the Student Investigator to share with each participant selected quotes from various other participant’s first interviews which seemed to support emerging themes. Again, the participant was invited to share his or her reactions, which were incorporated into the results of this research. The questionnaire which was used during these interviews can be referred to in Appendix E.

The Processing and Analysis of the Data

After completing the interviews with the participants, the audio tapes of each interview were professionally transcribed. According to McCracken (1988), “This transcript should be prepared by a professional typist, using a transcribing tape recorder. Investigators who transcribe their own interviews invite not only frustration but also a familiarity with the data that does not serve the later process of analysis” (p. 41).

Throughout the data collection process, the Student Investigator wrote analytic memos (Taylor & Bogdan, 1998), which allowed for the opportunity to reflect on the aspects of the participants’ contributions which most stimulated the researcher’s process of thinking and learning about their experiences. Additionally, such memos constituted the record of the formulation of tentative ideas about themes and meanings. These memos were vital as the Student Investigator began the process of coding and data reduction.

When speaking of the coding process, Taylor and Bogdan (1998) have commented that “In qualitative research, coding is a way of developing and refining
interpretations of the data. The coding process involves bringing together and analyzing all the data bearing on major themes, ideas, concepts, interpretations, and propositions" (Taylor & Bogdan, 1998, p. 150). The fourth revision of Qualitative Solutions and Research's Non-numerical Unstructured Data Indexing Searching and Theorizing (NUD*IST) computer software was used for the coding of the qualitative data which comprised this research.

According to Marshall and Rossman (1995), the first task in the analysis of the data obtained through this phenomenological qualitative method is for the researcher to set aside (or “bracket”) preconceived assumptions. This process, referred to as Epoche, was discussed within the context of the Student Investigator’s experience in Chapter I of this dissertation. Patton (1990) feels that Epoche is an ongoing analytical process throughout phenomenological qualitative research, rather than a single fixed event.

Moustakas (1994) offers a modification of the van Kaam (1966) method of analysis of phenomenological data, which served as the model of analysis for this research. In this method, the complete transcriptions of each participant’s interviews are analyzed in the following manner:

1. **Listing and Preliminary Grouping**: Every expression considered relevant to the experience of quality of life in alcoholism recovery is listed. This is referred to as “horizontalization.”

2. **Reduction and Elimination**: At this stage of analysis, each expression is tested to see if it meets two requirements: (1) Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it? and (2) Is it possible to abstract it and label it? Statements that meet these requirements are horizons of the experience. Those expressions which do not meet these
requirements are eliminated. van Kaam (1966) has indicated that further data reduction and elimination which occurs at this point results in the formation of what he terms "invariant constituents." When defining this term, van Kamm (as cited in Moustakas, 1994) states that "Overlapping, repetitive, and vague descriptions are . . . eliminated or presented in more exact descriptive terms. The horizons that remain are the invariant constituents of the experience" (p. 121).

3. Clustering and Thematizing the Invariant Constituents: The invariant constituents which are related are clustered into a thematic label. These become the core themes of the experience.

4. Final Identification of the Invariant Constituents and Themes by Application: Validation: The invariant constituents and their accompanying themes are checked to see if they are either expressed explicitly in the complete transcription, or are at least compatible.

5. Based on the final invariant constituents and themes, an Individual Textural Description of the experience is constructed for each participant. The Individual Textural Description is, essentially, a synthesis of the final invariant themes and constituents: this includes verbatim examples from the transcribed interview.

6. For each participant, an Individual Structural Description of the experience is constructed. This is based on the Individual Textural Description and Imaginative Variation. Moustakas defines Imaginative Variation as the seeking of "possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from different perspectives, positions, roles, or functions. The aim is to arrive at structural descriptions of an experience, the underlying and precipitating factors that account for what is being experienced . . ." (Moustakas, 1994, p. 98)
7. A **Textural-Structural Description** of the meanings and essences of the experience is constructed for each participant; it incorporates the invariant constituents and themes.

8. Based on the individual Textural-Structural descriptions, a **Composite Description** is developed of the meanings and essences of the experience which would apply to the group of participants in its entirety (Moustakas, 1994).

In the case of the present research, the Moustakas approach to data analysis provided an effective method by which to examine not only the individual participant’s experience of quality of life in alcoholism recovery, but to generate potential overarching themes which predominate for the group of 8 subjects, as a whole.

**The Rigor of the Data Analysis**

For both quantitative and qualitative researchers, the issue of trustworthiness of their data is critical. For quantitative researchers, four general concerns apply to the rigor, or trustworthiness of data: internal validity, external validity, reliability, and objectivity. Lincoln and Guba (1985) consider four qualitative research concepts to be reasonable analogs to those of the quantitative researcher. Credibility is an analog to internal validity, transferability is an analog to external validity, dependability is an analog to reliability, and confirmability is an analog to objectivity.

Within the present research, several methods were employed to meet the qualitative criteria for rigor outlined by Lincoln and Guba (1985). When defining what constitutes research **credibility**, Lincoln and Guba state that the researcher needs to be involved in “activities increasing the probability that credible findings will be produced” (p. 301). Within the present research, credibility was ensured by
“prolonged engagement,” which Lincoln and Guba refer to as “lengthy and intensive contact” (p. 301). Each participant was interviewed for as long as 4 hours.

Lincoln and Guba (1985) have defined what is necessary to ensure *transferability* in qualitative research:

The naturalist can only set out working hypotheses together with a description of the time and context in which they were found to hold. Whether they hold in some other context, or even in the same context at some other time, is an empirical issue, the resolution of which depends upon the degree of similarity between sending and receiving . . . contexts. Thus . . . [the researcher] can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility. (p. 316)

Moustakas (1994) describes thick description in the following manner: “*Rich, thick description* . . . describes in detail the participants or setting under study. With such detailed description, the researcher enables readers to transfer information to other settings and to determine whether the findings can be transferred because of shared characteristics” (p. 203). In the case of the present research, thick description was formed through the preliminary process of analysis of each participant’s first interviews (described in the preceding section on The Processing and Analysis of the Data). When the Student Investigator returned for a second interview with each participant, the Student Investigator had begun to form preliminary hypotheses about common themes that had been expressed by all or most of the participants in their first interview. Participants were invited to share their reactions to these preliminary hypotheses concerning shared participant themes. This process aided in the assessment of the potential transferability of the data which emerged from this research.

When speaking of *dependability and confirmability*, Lincoln and Guba (1985) have said that it is necessary to examine the transcripts “from the point of
view of their accuracy” (p. 318). Lincoln and Guba consider dependability and confirmability to be analogous to the concepts of reliability and objectivity; in this vein they have stated that dependability and confirmability are “held to be . . . synonymous with ‘stability, consistency, predictability [and] accuracy’” (p. 292). Dependability and confirmability were provided within the context of this research by member checks. Creswell (1998) offers the following statement as a definition of member checks:

In member checks, the researcher solicits informant’s views of the credibility of the findings and interpretations. This approach . . . involves taking data, analyses, interpretations, and conclusions back to the participants so that they can judge the accuracy and credibility of the account. (p. 203)

During the second interview with the participants, they had the opportunity to comment on how accurate they perceived the transcriptions of their first interviews to be. The participants were encouraged to note inaccuracies that they believed existed in either the verbatim interview transcriptions, or in the Student Investigator’s preliminary interpretations of the themes and meanings which had emerged from those transcripts.

Limitations

As noted in Chapter I, the present research cannot claim to be broadly applicable beyond the restrictions of its decidedly small group of participants: “Qualitative researchers usually work with small samples of people, nested in their context and studied in-depth . . . ” (Miles & Huberman, 1994, p. 27). Morse (1994) elaborates on this point with her comment that

Most qualitative researchers would argue against the notion of strict reproducibility as a standard for judging qualitative research because this notion contradicts their epistemological stance that the relationship between
the researcher and those being studied is interactive and unique and that all data are influenced by contextual time-bound factors. (p. 366)

Nevertheless, it is worth remembering that one major context within which the participants of this research are “nested” is Alcoholics Anonymous, an organization whose mechanisms for alcoholism recovery have been effective for a body of individuals now believed to number in the millions worldwide (Vaillant, 1995). As such, the themes and meanings of a quality life in alcoholism recovery for the participants in this research may hold meaning for other potential alcoholic clients.
CHAPTER IV

RESULTS

Overview

This chapter contains the results of the two interviews which were conducted with each of the 8 persons who participated in this research. Selected quotes from each of these interviews will be used to illustrate salient points that the participants have made; these quotes will also be used to support the Student Researcher’s analysis of the content of the interviews.

In the case of each participant, it proved feasible to ask them virtually all of the questions contained within the Interview Guide (see Appendix E) during the first interview. This made it possible to devote the bulk of each participant’s second interview both to verifying the accuracy of the transcript of the first interview, and also to offering some preliminary interpretations of their statements from that interview for the participants’ consideration. In addition, each of the participants was given the opportunity during the second interview to hear selected quotes from the other 7 participants, and to offer a reaction to those statements which they found to be of particular interest.

The process of coding the transcripts of these interviews revealed that the participants’ comments can be classified into a number of fairly broad response categories which pertain to quality of life in recovery from alcoholism. These categories include: (a) Quality of Life: General Observations, (b) Continuity of
Recovery, (c) Contributing Factors to Quality of Life, (d) The Role of Surrender, (e) The Role of Spirituality, (f) The Role of Alcoholics Anonymous, (g) The Importance of the Alcoholic Identity, (h) Priorities in Recovery, (i) The Role of Therapy (where applicable), and (j) General Observations and Reactions Noted in Interview Number Two.

John

John is a 70-year-old Caucasian male. He was divorced approximately 5 years ago; he is a father. He is employed part-time in a sales position. He says that in recent years he has eased back on the amount of hours that he works, and that this has allowed him more time to devote to working with other recovering alcoholics, which has enhanced the quality of his own recovery. John’s undergraduate college degree is in music. He has had some graduate education. John is an active member of the Methodist Church; in the course of these interviews, he devoted considerable thought to the distinctions between his religious beliefs and church involvement, and the spirituality which is a component of his recovery. John has been sober for 19 years. He went through a 28-day treatment program in Pennsylvania after he had been sober (or, as he might put it, “dry”) for approximately 18 months. This represents his only encounter with any professional counseling regarding his alcoholism; his only addiction is to alcohol.

As indicated in Chapter III of this dissertation, the first of these interviews, which was with John, served as the pilot study for this research. It was apparent from our first interview that it was, indeed, possible to address the questions on the Interview Guide (see Appendix E) within that meeting. During the second interview,
John confirmed the interviewer’s sense that most significant aspects of his quality of life in recovery had been addressed. He said:

Yes, it’s quite accurate. It’s amazingly comprehensive. I was somewhat surprised, and perhaps a little pleased with the extent . . . the scope of the questions was the thing that really took me by surprise. You asked me things that I had never been asked before and that was a little disarming. And probably good for me. And I don’t think there is anything that I want to change . . .

Quality of Life: General Observations

John describes himself as a pretty peaceful, serene person today with very few conflicts: “I enjoy my children. I enjoy my grandchildren. And I enjoy working part-time. And all that adds up to a pretty rewarding life. So I feel like I’m a very happy person.” Among other aspects of quality of life today, John notes that his recovery has given him the ability to live in the present, which he says has occurred only in the past decade. Additionally, he now enjoys pleasure reading. In recent years, he has stepped up the amount of contact that he has with newly sober people in A.A. meetings, and he believes that has increased his level of gratitude for the quality of life that he enjoys. He says that “what recovery means . . . to me [is to ] have fun.” When I asked John if the word “serenity” accurately captured his quality of life in recovery today, he replied, “Yes, you got it. I wouldn’t change it.”

Continuity of Recovery

As was the case with the other 7 participants in this research, John believes that recovery is a continuous process. In other words, not only does the quality of his life continue to improve, but that very quality is contingent upon his continuing to put
energy into his recovery. When I asked him if he couldn’t just say he was recovered now and ease up on his recovery activities, he replied:

'It never ends. I’ve recovered from my drinking but I’ve not recovered from my alcoholism. You don’t just get serene overnight. You never really stay still in this program. You just keep making progress. I guess the point I’m trying to make is it was a gradual process.'

Remarkably, John believes that he has made more progress in several areas of self-growth in the last 3 or 4 years than in all his prior years of recovery. The longer he has stayed sober, he has learned to “unclutter” his life, which has generally gotten simpler. I hypothesized that this is due to his increased ability to prioritize his needs; he said “I’m sure that’s true. That’s a good word.” He has been told by the woman he has been dating that he is a better listener than he was 4 years ago. It is apparent from speaking with John that he has a good sense of humor, but he notes that “just in the last 6 months” he has developed the ability to laugh at himself, rather than finding humor at the expense of others.

One of the most significant changes in recovery cited by John relates to the lessening of his need to be in control:

In early sobriety I still wanted to be all things to all people. Not unlike I behaved in my addiction. And hence the term one of my sponsors used, don’t try to be a chairman of the board of A.A. I wanted to run my business . . . and be on the Fair Board, and be on the Symphony Board, and be the Lieutenant Governor of Kiwanis. Gradually . . . I began whittling away . . . that took a few years . . . whatever change took place, I give that credit . . . to my sponsors.

The “need for control” is a factor that emerged in the lives of other participants, but it is particularly intriguing in the case of John, a man whose “over achievements” figured prominently into his drinking years, but did not suit his changing quality of life in recovery. I interpreted his interplay with others in recovery
as having revealed a mirror image of qualities that he now found less desirable. John said this is “True. [You] got it.”

It should be noted that the process of recovery for John has not been without its obstacles. At approximately 7 to 8 years into recovery, John hit a plateau. He attributes this to the death of his sponsor; he felt as though he was “like a ship out in the sea without a rudder. I was lost.” The quality of his life at this time is described as “perfunctory,” though he continued to do many familiar things (meetings, readings, etc.). What turned this around for John was obtaining a new sponsor and becoming more involved in volunteer activities related to recovery. John objected to my use of the word “plateau,” however, saying that in recovery “either you’re making progress or you’re slipping back . . .”

In concluding our discussion of this topic, John noted that “the way I treat people has changed dramatically . . . I’m a much kinder person than I ever was before. I do good things for people and I don’t want to take credit for it. And that was totally foreign to me.”

**Contributing Factors to Quality of Life**

In John’s estimation, there are a number of elements which contribute to his continuing quality of life in recovery. His day begins with prayer (specifically A.A.’s Third Step Prayer, in which one seeks to turn one’s will over to one’s chosen higher power); he reads from three “meditation” books with daily inspirational passages related to alcoholism recovery. He makes out a weekly calendar, in which he enters three to four A.A. meetings: “I don’t think I’ve ever gone to less than three meetings in the last 2 to 3 years. There are 63 meetings within an hour of where I’m sitting and if I can’t make a few of those there’s something wrong.” John considers meetings
critical; he has observed that many relapsed alcoholics report (upon regaining sobriety) that they had ceased attending meetings. Also, John makes a point to fellowship with others in recovery: he sponsors two people with whom he speaks every week. Regular contact is also maintained throughout the week with his own sponsor. This “interplay” with other recovering people is essential to quality of life in recovery, says John. Helping others with their own programs of recovery has enhanced John’s. As an example, he cites his efforts to help facilitate a prison work release program for recovering prisoners. Again, I noted that he sees a need to actively engage in recovery-oriented pursuits. He responded “Yes. Yes. And I think that has increased with each year that I’ve been sober.”

The Role of Surrender

The concept of surrender has been pivotal in John’s obtaining quality of life in recovery, although he acknowledges that he originally shared a common misconception of surrender in a recovery context: that it meant “giving up,” or a “battle-field” surrender (defeat). Now he interprets it, however, as “going with the flow . . . turning my will and my life over to the care of God as I understand it.” For one for whom control had been a critical concern, this is a powerful distinction. John offered these additional thoughts on surrender:

The bondage of self is what I was absorbed with. That’s why I couldn’t surrender. I was into me. Now that I’m not so important and the other person’s more important, this surrender thing comes pretty easy . . . Surrendering doesn’t mean you have to like what’s happening around you. You can only control your attitudes and actions. So if I get my attitude squared away, surrender comes pretty easy.

I asked of John, as I did of other participants, if this concept of surrender wasn’t contingent upon having “hit bottom.” In other words, is it possible to obtain
quality of life through surrender until one has reached a personal state of readiness?

He replied that

the key to working this program is you'd better damned well be done doing whatever it is you're doing before you even think about the First Step. [It's] the step you take before the First Step. It's another way of saying [hitting bottom]. Hitting bottom has an emotional connotation. And the "done doing what you're doing" [is] . . . more of an overt action . . .

Surrender for John first occurred while in treatment.

The Role of Spirituality

For John, surrender is one the central components of spirituality, the importance of which he cannot sufficiently stress in his own acquisition of quality of life in recovery. In his estimation, the "key element of staying sober is finding the spiritual part of the program [of recovery]." Like many recovering individuals (though not all, as some other participants' comments will indicate), John had long-standing religious beliefs. He believes his church involvement has been enhanced by his participation in A.A., although he hastens to add that his acquisition of spirituality has come more from recovery than from his religion:

There's more spirituality in an A.A. meeting with 20 people sitting around the table than there is in a committee meeting in my church on a Monday night. I've said that to my ministers so I don't mind saying it to you. Spirituality and religion get confused. Religion basically is designed for people that are afraid they're going to go to hell. And spirituality is for people that have already been there.

Sensing that spirituality was particularly meaningful to John's recovery, I asked him if he could prioritize its value to him. His reply was swift and direct:

The A.A. program and spirituality come ahead of anything else, church or anything, because the "Big Book" says we have a daily reprieve contingent upon our spiritual condition. Well, if we're living one day at a time and we just have a daily reprieve . . . , but then spirituality is the contingency, it's pretty darned important.
When I asked him if he could cite an example of spirituality in his life, he commented that he increasingly is moved by the shared experiences of those people in A.A. meetings who are new to recovery. In listening to their day-to-day trials and tribulations, he is reminded of where he was at one time. This gives him a deep sense of gratitude, which he finds is enhanced by trying to extend to them the same welcome that he once received.

I asked John, “Has your concept of that God or higher power, as the A.A. people refer to it, changed over the course of your recovery?” In response, he allowed that, “Yes. It got more personal. I talk to God like he’s just sitting on the other side of the room sometimes . . . It’s my awareness level [that] has increased, definitely.”

The Role of Alcoholics Anonymous

As is the case with the other participants in this research, John is a member of Alcoholics Anonymous. John has some definite opinions about how it is that A.A. has contributed to the quality of his life in alcoholism recovery. Perhaps the most critical point worth noting is that A.A.’s contribution has involved much more than the benefit he derives from being in meetings. A.A. is, in John’s estimation, teaching him how to live. When I asked him to specify what he meant by that, John offered these comments:

It’s taught me how to relate to other people in a less selfish manner . . . I’m much less self-centered than I was before. I was always thinking in terms of myself and what it would do for me, and what’s in it for me. And now I find myself reaching out to help other people. And then what I didn’t realize, that when I do that I somehow, I feel pretty good about myself, you know?

One of the hallmarks of life quality for John today is the ability to have fun in recovery. He incorporates this point into his story when he tells it at “open” A.A.
meetings: “You can have fun at A.A.” The ability to have fun leads to a consideration of the “Promises” of A.A. (see Appendix G). By almost any measure, these are states of existence that many would equate with quality of life. They include such things as: the knowledge of a “new freedom” and happiness, and the ability to know peace, etc.

For John, he began to notice the Promises coming true in his life after he had been sober for approximately 1 year. He continued to be aware of aspects of other Promises appearing in his life as he accumulated sobriety; for example, he says that the “fear of financial insecurity” left him after he had been sober about 5 years. I asked John, as I did all of the other participants, why he thinks A.A. chose to refer to these Promises after their first nine suggested Steps had been described in the “Big Book.” In response he said that:

There’s nothing automatic about the Promises. You have to earn them. If we don’t get those first nine [Steps], if we’re not painstaking with our progress at that point none of this is ever going to happen. Because yes, I think the Promises were strategically located in the “Big Book” as you pointed out in your question for a very, very good reason. You’re done with your amends. O.K. Now, this is what you can expect to happen to you as you work the program.

In other words, in order to begin to achieve the quality of life that A.A. indicates is possible in recovery, John is saying that it is necessary to proceed methodically through their first nine suggested Steps. In John’s estimation, it is the self-knowledge that comes through a written and verbally shared personal inventory of character defects, followed by concerted effort to correct those defects and the making of amends for wrongs done to others, that are critical to “earning” the freedoms possible in extended, quality sobriety.

As is the case with other aspects of his recovery, John does not work these Steps in isolation. He refers to the Steps as “a guideline or a highway map, if you
please, for living for me. When I work this [the Steps] with someone else, then I get the maximum benefit.”

In concluding his comments on the specific role of A.A. in his recovery, John emphasized the increased pleasure he has enjoyed in his recovery in recent years due to his deepened investment in service work in A.A. This involves (among other activities) his sponsorship of others, his participation in the organization of area conferences for A.A. members, and his facilitation of prison work-release programs for recovering prisoners. I asked John, “Do you think it’s possible to enjoy the quality of life you’re describing . . . without service? Or is that something that has come to you in more recent times?” He stated that

It’s come to me in more recent times, and the answer to your question is I could not have this quality of life without the service. I know that . . . I think you can stay sober and not do anything. But you can’t enjoy being sober and not do anything.

As is the case with the other participants in this research, John believes that alcoholism is a disease. Regarding meeting attendance, he says that it is the “medicine for my disease.” He believes that A.A. is uniquely suited to treating what he (and others) terms the three aspects of the disease—the mental, spiritual, and physical.

**The Importance of the Alcoholic Identity**

Many recovering alcoholics begin or end their days with times of prayer or meditation in which they remind themselves of the priority of remembering (for that 24-hour period) that they are in recovery, and that not drinking and attending to any other related activities to ensure their sobriety are priorities. To seek a better understanding of how this alcoholic identity relates to obtaining quality of life in recovery, I asked John (and the other participants) about its significance. He noted
that he enjoys attending A.A. meetings when traveling, not out of a fear of drinking, but because of the bond he feels: he’s “home.” The people he finds at these meetings, he says, know exactly who he is. It is one way that he is reminded of his identity, about which he says, “It is essential. It is at the heart of my existence. I have nothing if I’m not recovering. It is the foundation of my life, really.”

John seems acutely aware that his views regarding his identity as a person recovering from the disease of alcoholism are not always shared by people who aren’t alcoholic. Therefore, it may be difficult for such individuals to understand why he continues to invest so much energy in his quality of life in recovery:

I think it’s very difficult to explain . . . to someone who doesn’t understand what alcoholism is all about . . . And it’s hard for us to describe it to them because we’re talking about, well . . . [a] miracle . . . How do you explain that in 21st century jargon?

Priorities in Recovery

Based on all that he had said, I interpreted to John (in our second interview) that I heard him emphasize several factors that are instrumental in his maintaining quality of life in alcoholism recovery. Chief among these factors would be spirituality, followed by surrender (which he terms “a by-product of spirituality”). His third most important priority would be service to others in recovery. In response to my interpretation, he commented, “Yeah, I will agree with that because if you don’t get the first two, nothing else is going to happen. You’re going to be stuck, or you’re going to slip and you’re going to drink again.” To use Moustakas’ (1994) terminology, these factors comprise what for John are the Invariant Constituents of quality of life in alcoholism recovery. Contained within these factors are themes of an increasingly personal relationship with a personal higher power, a desire to relinquish
control over “unmanageable” aspects of his life (which he terms “people, places, and things”), and increasingly fulfilling relationship with other people in his life.

General Observations and Reactions Noted in Interview Number Two

When we met for our second interview, John indicated that he found the transcript of our first interview to be accurate. As noted in his introduction, he found it to be “amazingly comprehensive.” A significant portion of the second interview was devoted to checking the accuracy and meaning of some of the statements he had made. For example, I wanted to verify that he had specified (in order of importance) prayer, meetings, and fellowship with other alcoholics as daily contributors to quality recovery. In response, he said that was “Very accurate. Nothing’s changed in that department.” He agreed with my summation of his remarks about his A.A. participation—that he could not have achieved his present quality of life without it: “True. Got it.” Overall, John felt that I was accurately capturing the essence of his comments. Upon hearing some quotes from other participants, John was pleased to hear the consistency in their responses.

One of the most telling insights to John’s character arises out of recognizing the frequency with which he positively describes the decreasing need for control that he experiences in many areas of his life. He is a man who is justifiably proud of the many accomplishments of his life and the positions of leadership which he has sought, and in which he has excelled. Nevertheless, he currently derives at least as much satisfaction from his ability to work alongside and help others. Some of his most compelling remarks on this topic were centered on surrender. I suggested that one of the things he has surrendered is the need to be in charge. He replied, “I think so, yes. I think there’s a connection there, yes. I never thought of that until you just now
brought it up. I’m sure that’s part of the package.” John strongly agreed with my assessment that this surrender of the need to be in charge is a major theme of his recovery.

In closing, he enthusiastically recounted an encounter he had with a person who didn’t understand A.A. He was trying to explain why he continues to go to meetings, and what that might have to do with quality of life:

I said, “Do you ever drive by churches on Sunday morning?” He said, “What do you mean?” “See the cars in the parking lot? Why do they keep going back? Why don’t they just get right with God and show up every once in a while?” I said, “That’s why we go to A.A.” It’s really the same kind of thing. We go to be reinforced.

Dave

Dave is a 65-year-old Caucasian male. He has been divorced for a number of years. He is a father. He is now retired. Formerly, his occupation was sales. He has a high school education. Though he makes occasional references to having been raised in the Catholic Church, he describes himself today as unaffiliated and not practicing any religion. Dave has been sober for 18 years. Prior to becoming sober, he received some counseling in regard to his drinking. However, he achieved his sobriety through participation in Alcoholics Anonymous. He is addicted only to alcohol.

Quality of Life: General Observations

When describing what quality of life means to him today in recovery, Dave makes frequent comparisons with how things were before sobriety, and in his early days of recovery. Earlier in his life, he felt that he “never belonged,” that the world was divided into “them and me.” Today he perceives a “real world,” in which he belongs. Though he was “paralyzed” with fear in early sobriety, his fears have greatly
diminished today; his self-esteem is more consistent. It was important earlier in his life to always be right; He says, “Today if I’m wrong, it’s gee whiz . . . No big deal. So what.” When describing his approach to life today, he chose to use the very phrase used by John: he deals with “life on life’s terms. And that means there are real things in life and real problems and real stumbling blocks but that’s just life.” I wondered if this didn’t indicate that he recognized choices in his outlook on life today. He agreed, and offered the Serenity Prayer as an example of how he can “accept the things that I cannot change.” As I explored this idea further in our second meeting, Dave talked about how important willingness is in regards to the ability to accept: “I think it [willingness] is a part of quality of life . . . My willingness back there was out of desperation. My willingness today is out of a little bit of smarts . . . Life today is much easier and simpler . . . I’m not confined to the old ways of doing things . . . ”

Dave particularly values the “deeper, more meaningful relationships” that he has developed in long-term sobriety, most notably with his children. He says that “through the program [of A.A.] I’ve learned the meaning of love.” He succinctly summarized his concept of quality of life in recovery by saying that “I wouldn’t trade the best day of my drinking career for my worst day today.”

Continuity of Recovery

Dave shares the common view of the participants in this research that recovery is ongoing and an evolutionary process. He notes, for example, that what he thought was crystal clear 10 years ago is “foggy” compared to the clarity of mind that he has today. When I asked him if he was saying that things in recovery keep on changing, he replied:
Oh, absolutely. Yes. It evolves . . . And life does get easier the longer you are in recovery, and by recovery I mean the program of A.A. You pick up on things like the Promises as you’re living every day life. It’s easier to recognize a wrong if you have committed it. And it’s easier to make amends for those things. Life is not nearly as difficult as it used to be.

Dave analogizes the ongoing commitment to sobriety to an athlete’s need to maintain fitness through training; he believes that he needs to continue to exercise the principles he has learned in his program of recovery. He makes an interesting distinction in this regard: he says you need to “use them, not just work them, but use them in your every day life . . . I’ve heard it referred to as a spiritual set of tools.” I inquired about how it is that the nature of his spiritual “tools” has evolved. For Dave, this has involved a much more personalized relationship with his higher power (which echoes similar comments of John’s): he describes his God as being more of a friend today, who is located within Dave, rather than outside of him.

Among the criteria that Dave employs to gauge his increasing quality of life would be his ability to stay “on center” today. According to his description, the periods in which he feels “off center” and ill-at-ease are much shorter today. Seeking to expand on this idea, I asked him how it is that he might get back on center today. At those times, he says that he needs to “Pray. Go to meetings. Start my day over.” Generally speaking, he feels more centered when he can relinquish the need to be in control: “I don’t have to be in control anymore. Ain’t that nice? I used to like being in charge, but any more, I kind of avoid being in charge of anything.” The similarity of this quote to similar self-assessments made by John is striking.

One of the specific milestone events in recovery which indicated to Dave that he had, indeed, made progress in his ability to handle life on life’s terms was also a time of crisis in his life. He traveled to Atlanta, Georgia in 1993 to be with his son, who died a short time later. Though this is still obviously a painful event for him to
recall, his gratitude for his ability to cope with the demands of his son’s circumstances, and to be able to recognize and process his own emotions, is clearly evident:

While I was going through that it was extremely devastating. But what I realized, in retrospect, was that being in recovery I was able to be supportive, to do the things that needed to be done to assist him. To be able to do the things that needed to be done to maintain my own sanity. . . . I had a lot of meetings during that period. I prayed a lot. An awful lot.

Dave is willing to allow that recovery has at times proceeded very slowly. Though he doesn’t object to my suggestion of the word plateau he favors the term flat spot, when referring to such times. His observation is that as the quality of his life increases with the passage of time in recovery, . . . “with meetings and with sponsorships, there’s no reason to hit big flat spots or plateaus. The tools are there . . . So the pain doesn’t last as long and I can get out of it much more quickly and life goes on.”

**Contributing Factors to Quality of Life**

There are a number of factors which Dave cites which he feels contribute directly to the increasing quality of life that he enjoys today in recovery. On a daily basis, the most important thing that Dave says he does is to pray. In addition to specific prayers that he has formulated, he also reads from daily inspirational recovery-oriented books. Like some other recovering alcoholics who participated in this research, Dave concludes this morning routine with a time of meditation. He says that this sets the tone for his days; without it, he is inclined to “hit the floor running and . . . run . . . into a brick wall.” Close behind prayer in Dave’ citation of regular contributors to quality of life is A.A. meeting attendance. He has found that, like other areas of his life, he now has more flexibility and balance in this regard: “I can
slack off a little bit on meetings . . . I can probably reduce to one meeting a week and be very comfortable with that. However, when things are tough . . . you probably will see me in a meeting every day . . . ” He also values regular contact with his own sponsor (and those he sponsors): “This is not a professional. These are two people who are searching for the same kind of thing. They just want life to be more happily lived and live more simply and easier.” On an annual basis, Dave attends an A.A. retreat, which he terms “indispensable . . . this is the time . . . to recharge the batteries and get ready to face some new issues.” Here Dave is describing what appears to be one of the key components of the well-being these participants experience: a willingness to regularly take an “inventory” of themselves, and to assess how their growth can continue. In this respect, Dave several times stressed the importance of recognizing the three-fold nature of alcoholism. This led to my asking him: “Can I go so far as to say that quality of life in recovery would not be possible if you did not attend to all three of those [aspects of alcoholism: the physical, mental, and spiritual]?” He replied, “I don’t see how it could be. If you don’t concentrate on all three of those aspects, I don’t see how you can expect to obtain any kind of real quality of life.”

The Role of Surrender

In Dave’s acquisition and maintenance of quality recovery, surrender has been pivotal. In his estimation, “surrender, I think, is crucial. As crucial as spirituality is to recovery, I think surrender is to the recovery process.” Like John before him, Dave is linking the concepts of spirituality and surrender. The portrayal he offers of the conditions preceding initial surrender, however, is stark:
It’s amazing to me how anybody can come into recovery without almost total destruction. I don’t think recognition of addiction is a logical mental process... There reached a point where destruction was so devastating that I finally threw up my hands and said “I give up. I just can’t handle it.”

When he then began to attend A.A. meetings, that was the “springboard” for learning to surrender. Dave is reiterating the importance here of hitting bottom.

Emphasis in Dave’s comments on surrender is placed on its wide-reaching applicability:

I can’t change people, places, and things. I can change myself. And I even need a lot of help changing myself... And I had that experience in my previous marriage... I didn’t want that divorce. I tried every imaginable ploy to get that issue straightened out. I wasn’t able to... I surrendered that relationship... We wound up getting divorced. But, in retrospect, it was the best thing that could’ve happened to me. I just needed to get out of the way and let him [God] get the job done.

In concluding our discussion of surrender, I asked Dave, “What I’m hearing you say is... that you’ve applied this business of surrender not just to drinking, obviously, but to life situations,... and so you see that as important to you and the quality of your recovery?” Dave’s response evidenced considerable insight into a trait which characterizes several of the participants in this research: “Oh, absolutely. Yes... Yes, because by nature I am a perfectionist. I’m an obsessive.”

The Role of Spirituality

When discussing the importance of spirituality to his quality of life in recovery today, Dave was explicit about its role:

Spirituality is the essence... of recovery. Without spirituality I think I’m just spinning my wheels. The “Big Book” says we... have a daily reprieve based on our spiritual condition. I didn’t understand that when I first heard it, but I’ve come to realize that that’s specifically correct. If I’m in a poor place spiritually, I’m not going anywhere. In fact, I’m probably going backwards. If I can maintain a good spiritual posture... all the rest is much easier. The hills are smoothed out... It’s the foundation.
As was the case with John, I was struck by Dave’s emphasis on spirituality’s importance. Therefore, I sought to ascertain this impression by asking, “That really sounds like you’re putting it [spirituality] right up there . . . as the most important part of recovery today?” There was no equivocation in Dave’s reply: “You bet. You bet. Yes, I think so.”

Dave notes he probably cannot provide a description of his personal interpretation of spirituality. He does hasten to point out, however, what it is not: “It isn’t necessarily religion. Spirituality is that communal connection with a higher power . . . I don’t hear voices. I don’t see burning bushes. But I know this much, most of the time when I pray I see results.”

The Role of Alcoholics Anonymous

The comments that Dave made in our interviews regarding A.A.’s importance to his experience of quality of life in alcoholism recovery were uniformly positive. I wondered if he felt that he could have achieved his present level of satisfaction without A.A., or through some other approach to recovery. In his response, he indicated, “I know of no process, no program. I don’t know of any way, and I’ll include therapy. I’ll include religion. I’ll include you name it.” Dave derives great benefit from the “experience, strength, and hope” that he finds is shared at A.A. meetings. He finds it remarkable that very often meeting topics seem to address specific areas of living in which he is struggling.

The 12 Steps of A.A. figure prominently into Dave’s perception of how it is that he maintains quality of life today. He refers to them as “a method, a road map, a prescription for living if you will . . . And it covers almost any instance, experience, problem, what have you, in life.” A.A.’s Twelfth Step refers to “practicing these
principles” [contained in the previous 11 Steps] in all of one’s affairs. Of this point, Dave remarks that “if I’m practicing these principles in all my affairs, things are pretty good. I can deal with almost anything and deal with it pretty comfortably.”

The “principles” contained in the previous 11 Steps, however, require of alcoholics that they first complete the ego-deflating process of self-examination and amends that are contained in Steps One through Nine (see Appendix F). The “Promises” that A.A. believes occur after these Steps have, according to Dave, evidenced themselves over time in his life. He has, in particular, been aware of a diminishing fear of people: “I used to stand on my head if I thought that would make them like me. And today I want them to like me but it isn’t critical. That is their prerogative.” In my effort to understand why participants in this research believe these Promises, or quality of life factors, occur after Step Nine, I asked Dave’s opinion. He says that “we get outside ourselves and start trying to make amends for the messes that we made, the wreckage that we left in our wake . . .” These are powerful images, to be sure. Dave is suggesting that on the other side of these humbling efforts, however, is freedom: quality of life in recovery. Dave (and other participants) refers to Steps 10 through 12 as the “maintenance” Steps, wherein one promptly makes amends when wrong, and one incorporates other living principles embodied in the earlier Steps. He likens this to “the difference between major surgery and first aid . . .”

I raised the question, as I did with John, of why Dave finds it necessary after many years of recovery to continue attending A.A. He believes alcoholism is a progressive disease (even when one is abstinent), and that the potential physical danger of relapse increases with time (as distinct from the temptation to drink, which
he has not experienced for many years). He goes to A.A. today to “maintain” his quality of life:

The big thing is, again, the program of A.A. is not about not drinking, it’s about living, and if I want to continue to be happy and . . . enjoy a good healthy way of living, I have to continue with my program and my recovery in order to be happy.

The Importance of the Alcoholic Identity

When referring to the risks inherent in losing sight of his identity as a part of a network of recovering persons, Dave said:

We talk about alcoholism as being cunning, baffling, and powerful. And part of the baffling feature is that there is always that lurking notion that I did it. Things are going pretty good . . . you start taking credit for life being good and for things going smoothly. Danger sign.

Here Dave is referring to one of the character traits which has been consistent in the self-appraisals of this research’s participants: these individuals perceive a tendency within themselves to have an inflated sense of ego when contact is lacking with other recovering alcoholics, or when they are lax in “working their programs.” This can be observed in the struggle with control that both Dave and John have discussed. This trait would fall under the heading of what Dave describes as the “ism” in alcoholism:

I think we’re dealing with all three aspects of the psyche or the person and that is . . . those three areas [physical, mental, and spiritual] are affected by the “ism” and that’s what I refer to as the disease [of alcoholism].

Misunderstandings About Recovery

When I was asking Dave about aspects of quality of life in recovery from alcoholism that he feels may be misunderstood, he linked some of his preceding ideas about the “ism” of alcoholism with (what are to him) some important distinctions
between simply not drinking and retaining an awareness of his identity as a person recovering from the disease of alcoholism:

Whatever character defects that I have that encouraged me to blank out the . . . unacceptable, what have you, with the influence of alcohol, if those things would simply go away with the cessation of drinking, I wouldn’t need to go to meetings. I wouldn’t need to work any of the steps . . . But that’s not the case. All that the cessation of drinking does is to clear the air . . . to lift that first layer of the shroud from in front of one’s eyes in order to begin to even make any kind of move toward recovery. What sobriety is to me is living properly as I perceive that. It’s doing the next right thing . . . It’s facing life on life’s terms. Having some, not ego, but some self-esteem. It’s being able to surrender, accept and to exercise the options and choices that I have to make life easier, more palatable, happier. And without the program, without the spirituality, all I would be was a guy that just wasn’t drinking.

Priorities in Recovery

When I asked Dave if it would be possible to prioritize the elements of his recovery program that contribute to his quality of life, he explained that although he considers spirituality to be the “essence” of recovery, his spiritual life is contingent upon first surrendering his will to his personal higher power: “For me, surrender came first. Through the devastation and the surrender it gave me a little humbleness and a little open-mindedness. And the spirituality became a major issue.” Following these priorities would be a considerable degree of involvement in working with others in recovery, what Dave terms “action.” It was when discussing this topic that Dave employed one of the paradoxical phrases associated with recovery: “I cannot think my way into better living. I have to live my way to better thinking.” In other words, this process cannot be intellectualized. It must be learned. And it cannot, in Dave’s view, be accomplished alone. When further inquiring about this point, I specifically asked Dave to respond to an interpretation I offered of some of his statements about working with others through sponsorship: “I’m hearing you say that this is not
something that can be done in isolation. It requires this person reflecting back to you. It can’t be done in the intellect.” In response, he said, “No sir. No, it cannot be done . . . It couldn’t for me.”

It would then seem reasonable to suggest that the *Invariant Constituents* (Moustakas, 1994) of Dave’s concept of quality of life in recovery would be surrender, spirituality, and involvement in recovery-oriented activities. Though he has reversed the order of surrender and spirituality from the priorities that John cited, the similarity of the important themes for these two men are apparent.

**The Role of Therapy**

Dave is one of the few participants in this research who received some therapy which addressed his use of alcohol. He freely admits the obstacles he placed in his therapist’s path: he hedged about the subject of his drinking. Because Dave was not forthcoming about his problem, it didn’t become much of an issue in his treatment. While he doesn’t entirely blame this therapist for not being more aggressive about this issue, Dave does offer the following thoughts:

> A therapist who was knowledgeable in dealing with alcoholism . . . could be very beneficial and maybe accelerate a person’s recovery . . . Much as I think clergy can be beneficial and helpful. But I think for me the real grassroots way of dealing with my “ism” is through the program of A.A.

**General Observations and Reactions Noted in Interview Number Two**

Early in the second interview with Dave, his level of commitment to this research became apparent. He had written down extensive notes on a legal pad which contained thoughts that occurred to him between our interviews, and references to earlier statements which he wished to clarify. He had devoted considerable thought to
the reaction of the potential readers of these results; it was important to him to convey as accurate a rendition of quality of life in recovery as he could. Appreciation of his efforts was noted. A number of those comments have already been incorporated into the preceding sections. As for the transcript of the first interview itself, Dave found it to be accurate.

As I reviewed the priorities of quality recovery that I thought I heard Dave express in our first interview, I noted that surrender (his top priority) seemed to hinge on first establishing honest relationships with other recovering people: “Is it safe to say that establishing that kind of intimate relationship . . . where you’re able to be honest with someone in sponsorship . . . is one of the keys to beginning quality of life in recovery?” Dave answered: “Yes, definitely . . . I think in my case that probably preceded the development of a good relationship with a higher power. That was the first . . . bridge . . . to really look at myself in the world around me.”

Dave was concerned that he had not offered enough positive suggestions regarding ways that therapists could provide more effective treatment for alcoholism. He suggested that

Anyone who is considering working with alcoholics should read “The Doctor’s Opinion” [a chapter in the “Big Book”] . . . he was very succinct in his description of alcoholism and he even used the statement that . . . there was no solution to these people’s problem aside from divine help, the way he expressed it.

Dave is suggesting here that helping professionals should consider the role of an alcoholic’s spiritual life in the path to recovery.

As has been already noted, Dave and John (and later participants, as will be evident) have struggled with issues of control in their recovery, or perhaps more accurately the lack of control over “people, places, and things.” Their emphasis on this point suggests that a key element in their attainment of quality of recovery has
been attaining balance with this issue. When we revisited this issue in our second interview, I offered for Dave’s consideration my observation that the “obsessive” and “compulsive” features he noted within himself suggested the need for control, and that these were characteristics that seemed to be present in most of this research’s participants. This caused him to laugh knowingly, and to comment:

You bet. You bet. I’m going to get this done and I’m going to get it done perfectly. Then I can tie it up with a ribbon and put it away and I’ll never have to face it again. Well, life isn’t like that. Life is more a bathtub full of balloons. You push down over here and they pop up over here.

Jerry

Jerry is a 64-year-old Caucasian male. He is single and has never been married. In view of the fact that he is a Catholic priest, this is not surprising. Although Jerry is still active in the Church, he has not had a regular parish (in a professional sense) for a number of years. Instead, he has worked for some time in the field of substance abuse treatment. He is the only participant in this research employed in that field. Jerry had 8 years of college, culminating in a Master’s degree in Theology.

Jerry has now been continuously sober for a period of 16 years. The word “continuously” is emphasized here, because Jerry is one of a small number of participants in this research who relapsed after having obtained a considerable period of sobriety. Following his relapse, he once again began the process of recovery, which, for him, was obtained solely through participation in Alcoholics Anonymous. Jerry is addicted only to alcohol.
Quality of Life: General Observations

There is an unmistakable quality of peacefulness which pervades Jerry’s self-presentation—he appears to be very pleased with where he is in recovery today:

Yeah, what you see is what you get. Yep. Yep. We don’t have to impress anybody anymore and the self-esteem is coming from within. It’s nice to get compliments but you don’t need them anymore. We know who we are. So we don’t have to put the masks on.

These comments are quite similar to Dave’s thoughts about increases in self-esteem in sobriety. Not surprisingly, Jerry puts his own description of quality of life in alcoholism recovery in a spiritual context:

... it’s a relationship [between] myself, others, God, I think just the world around us. Well, I feed the birds ... and grow my flowers. I never gave a damn about flowers when I was drinking ... I never cared about birds before, because they used to wake me up in the morning and I had a hangover .... my whole life now revolves around recovery ... my whole spirituality is based on the 12 Steps ... bringing the message to others.

I asked Jerry if he could summarize his personal concept of quality of life in a sentence, and he replied, “Happy, joyous, and free. Yeah. That really kind of sums it up.”

Continuity of Recovery

It is significant to note the role that a period of relapse played not only in causing Jerry to be grateful for a second chance at recovery, but in motivating him to put more effort into that recovery. He had been sober 6 years when he drank again. After 3 years of on-again, off-again drinking, he once again became continuously sober. He believes that “the second round of sobriety was much better than the first. I did everything that I had to. I thought I did the first time, but looking back, it wasn’t good enough.” I asked Jerry, “Do you consider that experience [of relapse] necessary
and integral in your achieving the quality of recovery that you have today?"

Emphatically, he answered, “Oh definitely . . . I don’t regret that. I like who I am today. I wish there had been an easy way to get here. But this is the way it took and I’m happy where I am today.” In Jerry’s case, the “bottom,” the true point of surrender to a lifestyle of recovery, necessitated a relapse.

Things are different today for Jerry than in earlier recovery. He is able to spend 2-week retreats now in the Alaskan wilderness. These are spiritual milestones he feels would not have been possible in early sobriety. Within the last 2 or 3 years of recovery he has noticed that he is much better at dealing with people, and is better able to cope with authority. He experiences less anger and resentment.

Over the course of the years he has been in recovery, Jerry says that one of the most notable changes he sees in himself is that his “world view is a lot bigger now than just the Catholic world.” That world view has expanded from that in which he was raised. He told an illuminating story of a weekend which he spent with a Baptist, a Buddhist, and a Mormon:

We certainly had no problem talking spirituality. I mean, our religions were certainly different but spirituality was fine—you know, our quality of life and our feelings and relationship with a higher power. . . . I work with . . . atheists, agnostics . . . [who] have no religion at all . . . But they get into a very spiritual way of living.

Jerry’s views on the continuity of recovery are strongly held: he believes that physical withdrawal from alcohol alone takes an alcoholic at least a year. He credits Gorski with the theory that it takes 2 to 3 years to reach 75% of sobriety, and another 8 to 9 years to reach the other 25%, which Jerry terms “the maintenance level.” He believes this is a time when the true, stable, enduring personality emerges—one which permits an ongoing quality of life. This would suggest that the
criterion which was set for this research’s participants of at least 10 years of sobriety was prudent. Jerry notes that:

\[
\ldots \text{the longer we’re in sobriety, the better it gets} \ldots \text{part of the First Step says we’re powerless over alcohol. That was O.K. I never thought my life was unmanageable, though. The longer you get in sobriety and start looking back and you say, “Well, I guess it was.” And a lot of it is the experience of just coming from my own brokenness, my own woundedness} \ldots \text{It seems to me that we let God enter through the wound.}
\]

**Contributing Factors to Quality of Life**

As is the case with other participants, Jerry places great importance on the contribution which daily prayer makes to his quality of life in recovery. Though he says that part of his life “never went” when he was drinking, it has taken on increased depth and meaning in sobriety. He also has favorite A.A. meetings that he attends regularly. Fellowship with others, particularly in the form of service work, is the other vital contributor to Jerry’s quality of life. Specifically regarding sponsorship, Jerry says that

It kind of reminds me of things that I’m not doing when I’m telling them they’ve got to do it. Because it’s so easy to let things slip. When I tell other people that this is what I do, then I say, “Well, golly, I’ve got to get back to that myself.” So it reminds me of what I should be doing.

Jerry has daily contact with his own sponsor.

When I suggested to Jerry that he was portraying fellowship as essential to leading a satisfied life in recovery, he replied:

Oh yeah. Definitely. See, I wouldn’t have done this by myself \ldots \text{if you have a support group and no matter what you’re going through, you can just talk to someone about it. They’re not going to give you advice, really. They’re not going to say you must, you should, you ought. They’re going to say fine, you’re in the right place.}

In a manner reminiscent of Dave’s comments about the importance of working the “maintenance Steps” of A.A., Jerry also stressed that, after having
thoroughly worked the first nine Steps of A.A., Steps 10 through 12 (see Appendix F) provide a means to continue through steady progression of personal growth:

The last three [Steps] are just to carry the message to others, the prayer, meditation. It just becomes a part of life. And then . . . if you’re wrong, you promptly admit it. And it’s just a continuation, I think, of all of them . . . as I said, it’s [recovery is] my whole life.

The Role of Surrender

As indicated in Jerry’s comments about the continuity of his recovery, his relapse played a part in his finally hitting “bottom,” and reaching a point of personal surrender. When he realized that he had not been able to successfully stay sober by working the A.A. program according to his own isolated approach, it resulted in the “deflation” of his ego at “great depth.” He laughingly describes this as having “flunked A.A.” This is precisely the process which Tiebout (1954) believes precedes surrender. Amusingly, Jerry contends that the struggle with surrender so typifies alcoholics, that “My Way” should be “A.A.’s theme song.” When elaborating on this point, Jerry said:

I guess I just couldn’t do it my way . . . And the surrender comes when we just can’t do it our way anymore. Not only in drinking but in every other thing. You can’t control your boss, you can’t control your kids. Your wife or husband. We have to stop trying to control the world . . . and that’s where the serenity prayer comes in. Just to accept the things that I can’t change.

Jerry is quick to note that this process has taken time. As previously mentioned, he has been aware of personal growth in recent years in regard to his ability to cope with authority. Moreover, he stresses that he is increasingly finding balance in his use of surrender: “It doesn’t mean we become doormats. We can speak up . . . I’ve learned to do that. I can speak up when I’m angry at someone and let it go.” It is when speaking of the elusive concept of balance, that Jerry touches
upon one of the striking characteristics of all 8 of this research’s participants: the personal recognition of an increasing ability to find moderation in all of one’s activities.

The Role of Spirituality

It is plainly evident when speaking with Jerry that he considers spirituality to be crucial to his ongoing acquisition of quality of life in recovery from alcoholism. This led me to ask him if it was, in fact, accurate, to say that he considers spirituality to be the centerpiece of recovery. He replied that, “Yeah, well, I think the whole 12 Steps are about spirituality.” The choice of words which Jerry used to describe his own conception of spirituality was deliberate. There was a clear distinction that he was making between religion and spirituality:

I think my spirituality, my relationship with God is a personal... It’s not a head-trip anymore. It comes to be a relationship, it’s an experience with God rather than just a head-trip. See, one time I thought I knew all the answers and now that I’m getting older I’m just content with the questions. And that’s fine. I don’t need the answers anymore. To be content with the aura and the wonder of this higher power and the spirituality.

The description of the importance in quality recovery of an evolving concept of a “personal” relationship with a higher power is remarkably consistent with the terminology used by both John and Dave. As Jerry notes, focus tends to shift for the recovering person from the initial recognition of the novelty of simply not drinking to the recognition of the phenomenon of the ability to feel, recognize, and process emotions. In Jerry’s estimation, the gratitude that accompanies the recognition of that phenomenon promotes spiritual growth.

Given Jerry’s open-mindedness about the validity of different faiths (or atheism and agnosticism) it seemed appropriate to question whether he didn’t think
that it would be possible to have quality of life in recovery without some kind of higher power or spirituality. In reply, he said:

No . . . there has to be a higher power even if it’s the A.A. group. As long as it’s not me. There’s something outside of me. And the spirituality is just in our relationship . . . and our feelings and that type of thing. Now if there’s religion involved, and it’s healthy, that’s wonderful. But I would never force that on anybody. But there has to be this spirituality, in terms of relationships with others.

The Role of Alcoholics Anonymous

With a certainty that equaled the conviction of the other 7 participants in this research, Jerry stated that he believed he would not have been able to achieve the quality of life that he enjoys in his recovery from alcoholism without his participation in Alcoholics Anonymous.

In enumerating the qualities that initially attracted him to A.A., he stresses that he realized early on that he was genuinely understood in A.A. settings: “It’s safe. I can say any damned thing I want to these people and they’ll know exactly what I’m saying.” I interpreted this as indicating a sense of belonging (the importance of which was also earlier noted by Dave). This yearning to belong, prior to entering recovery, would seem to be a very revealing aspect of the characterological makeups of some of the participants in this research. It is as though that missing aspect “falls into place” in A.A.

When I asked Jerry to confirm my interpretation that he never had felt a sense of belonging prior to being in A.A., he replied: “I really didn’t. And, unfortunately, I didn’t find it in a church.” One of the benefits of continued A.A. attendance, to Jerry, is the reminder of his origins:

I think we tend to forget when things are going well. I get over-confident but to hear new people and everything they say is just . . . they’re in so much pain
and now I can say “I remember, been there, done that.” And I don’t want to go back there.

The 12 Steps are a vital element of Jerry’s recovery in A.A. He describes the 12 Steps in these terms: “The 12 Steps is a whole way of life. It’s a whole philosophy of life and I didn’t realize that when I got into A.A. I just wanted to quit drinking. I just wanted the problems to go away.” He strongly advocates that the Steps should be worked with a sponsor.

Regarding A.A.’s Promises, Jerry is in agreement with other participants that their realization depends upon first working Steps One through Nine. He notes that people that he has helped in recovery have often wanted to rush to make amends. He suggests to these persons that they should first forgive themselves by doing (particularly) Steps Four and Five, which entail writing a personal “moral inventory” and then sharing that aloud with a trusted confidante. As Jerry puts it:

We’ve forgiven ourselves and we’re making amends to other people because they should be done. But we can’t rush it . . . serenity won’t come until after we’ve done . . . the amends and then will we only begin to understand what it [serenity] means. And it will continue.

Jerry made perhaps the strongest statement of any of the participants in this research about the inclusive nature of A.A:

I was an equal rights commissioner at one time for the city of Anchorage. I dealt with discrimination . . . but I’ve never seen any organization where there’s no discrimination except A.A. I mean, no one cares whether they’re black, white, they speak English or not, gay, straight. Nobody cares. Everybody’s there for the same reason. Unfortunately, even in churches, I don’t see that type of acceptance.

The Importance of the Alcoholic Identity

Like other participants in this research, Jerry maintains a daily awareness of his identity as a recovering alcoholic. He chuckled when saying that he has no choice:
he's surrounded by alcoholism daily through his treatment of others seeking recovery.

Even when he is in other settings, however, he is ever mindful of the daily choice that he needs to make to not drink:

When I'm other places I don't mind telling people that I'm a recovering alcoholic. I'm with the Mexicans a lot and if I have a baptism or mass at their house then they'll ask me to eat, which I will. But if I have to sit around for an hour or two before the meal's ready, I don't wait. I'll leave. Because everyone else is drinking beer and I just don't feel comfortable. I'll say, "No, I'm an alcoholic." And I don't mind saying that. And I'm afraid. You know, I have that fear of going back again.

Jerry's "fear" might also be seen as the healthy respect for the devastation that he has personally learned can follow a relapse. As he puts it:

I got over confident. Got away from meetings. I think I tried to sober up too many people and forgot that my main job was keeping me sober. I forgot the program was for me and to keep working those steps at the meetings.

Jerry also commented on the misunderstandings that he observes surrounding his need to maintain an awareness of his alcoholic identity through continued participation in activities that support his recovery. Like John and Dave before him, Jerry expressed what would appear to be one of these participants' most succinct views on quality of life: "A.A. isn't so much about just not drinking; it's about a whole way of life." John might be surprised and/or amused to discover that Jerry would pose the same question to a doubter that he raised: "Why do you keep going to church every Sunday? Why don't you stop going?" He gets the impression that some individuals think that his continued attendance at A.A. meetings indicates he is "addicted" to A.A. Of those persons, he would ask, "Do you get addicted to growth?" As is the case with John and Dave, Jerry holds the view that alcoholism is a disease.

I asked Jerry if he could elaborate on what differences he perceived between not drinking and sobriety. He commented that "Well, just the not drinking, you can
still have all the resentments and anger and the blaming of others. So you’re just dry. Sober means you’re looking at every area of your life.” But why, I inquired, should it be necessary to look at every area of one’s life? After all, Jerry has successfully been not drinking for some time. After some consideration he commented that:

[It’s] because we’re one person. We can’t compartmentalize ourselves. Well, we go with the same person and we just can’t turn the honesty on and off. Since this program is rigorously honest, we can’t be honest one place and not in another place.

Priorities in Recovery

It was difficult for Jerry to prioritize the contributors to his quality of life today. As he noted earlier, he considers spirituality to be the centerpiece of recovery. For him, each of the 12 A.A. Steps represents an element of spirituality. Surrender is also “a spiritual issue,” as Jerry puts it. He goes on to say that it is important to have “openness and honesty with others. Trust. Trusting . . . a sponsor. To share stuff with . . .”

General Observations and Reactions Noted in Interview Number Two

When we met for the second time, Jerry confirmed that he found the transcript of our first interview to be accurate. I asked him if there were any aspects of his view of quality of life in recovery upon which we had not touched, and he responded, “I don’t think so. I think we covered it all pretty well.” I checked to see that I had heard and interpreted a number of Jerry’s earlier statements correctly. Specifically, I reiterated that I had heard several prominent themes expressed around the general idea of life quality. These included prayer, work with other recovering people on a regular basis, and meetings. In response, he offered that “Yeah. [It]
sounds good.” Surrender (in every area of his life) is also a prominent feature of Jerry’s recovery. When describing the all-encompassing nature of surrender, Jerry said that it means . . . “accepting life on life’s terms.” This made him the third of 3 participants to use this phrase in this context. All of these factors are embedded within spirituality for Jerry, however. Given his religious background, this would seem fitting. Spirituality, therefore, would be the Invariant Constituent (Moustakas, 1994) in Jerry’s quality of life schema.

After hearing selected quotes from other transcripts, Jerry did not seem particularly surprised by the consistency of many of the views held by the other participants in this research. He offered some insightful comments on a couple of points in particular. When it was noted that all 8 participants have alluded to the “physical, spiritual, and mental” aspects of alcoholism recovery, Jerry was quite convinced that this viewpoint had come about independently of whether or not people had been exposed to it in A.A: “It didn’t really hit me too much until I was in for a year . . . I began to understand what it really meant. So I think they’re saying it out of experience.”

I asked Jerry if it didn’t seem (based on what participants were saying) that times of personal crisis often seem to be times of great personal growth in recovery as well. He replied:

Yeah, I would go along with that definitely . . . I think the growth is always there, but it’s the crisis that makes us realize, “My God, there’s something different here. I’m reacting differently than I would have if I had been drinking.”

In other words, quality of life is on a continuum for Jerry. As he puts it, “It’s not an event.”
Susie is a 64-year-old Caucasian woman. She is a widow, in addition to being a mother. Her deceased husband was also a recovering alcoholic. She completed a high school education. She has been self-employed for a number of years as an upholsterer. Susie describes herself as a nonpracticing Catholic. She has been continuously sober for 24 years. She is the first of these participants to describe herself as a recovering “cross-addicted” alcoholic, as she also was addicted to tranquilizers. Our interviews focused exclusively on her alcoholism, however, which she considers to be her primary addiction. As was the case with each of the other participants in this research, Susie’s commitment to this research was apparent. In keeping with her spiritual outlook, she mentioned that, prior to our first interview, she had prayed for spiritual help with her ability to share those aspects of her quality of life in recovery which would be “pertinent.”

Quality of Life: General Observations

Among the different aspects of her quality of life in alcoholism recovery today that she is particularly aware of, Susie commented on her ability to appreciate “the moments.” She says that she has come to know a new freedom and a new happiness that she never knew existed prior to recovery. She goes on to say that, “I thought happy people were rich, good-looking, talented, and personable. I know today that that is not true. That happiness is an inside out job. That it starts on the inside.” In her view, she is more attuned to the people in her world in “a healthy way,” rather than thinking about what they can do for her. This does not mean that Susie looks at her world through rose-colored glasses. She says, “It doesn’t mean that I am always
happy or content... but I do not feel the hopelessness that I did before I became a part of this fellowship." It was at this point that I inquired of Susie, "Is it fair to say, then, that quality of life, to you, encompasses the ability to experience a wide range of feelings and emotions?" In affirmation of this, Susie said, "Yes. And not to be defeated by them or destroyed, which actually happened in my active addictions."

Of paramount significance in Susie’s appraisal of her quality of life, however, is the spirituality that she has discovered during her recovery:

The dependence upon His grace rather than depending upon my own resources to deal with life and life’s problems has enriched my life more than anything that I ever encountered before. It has enabled me to live by a different set of values... intangible things are more important than the tangible possessions that most people consider necessary for happiness. That being a faith, a self-respect, caring and friendships with other people and believing that everything that happens in life happens for a reason.

**Continuity of Recovery**

I asked of Susie, as I did this research’s other participants, if the acquisition of quality of life could be viewed as a ongoing, continuous process. Her opinion was that:

Yes, sobriety is definitely a continuous process. And I believe there aren’t any standing-still places... The absence of alcohol for the alcoholic is just the beginning. Drinking is only a symptom of this disease. The emotional growth and spiritual growth are absolutely necessary to maintain physical sobriety... To most people it appears that the process is reversed because they see us physically sober first. The spiritual growth was the last thing to become evident to myself as a recovering person.

Within these preceding statements, Susie has confirmed the unanimous belief expressed by participants that quality of life in recovery does improve with the passage of time. Moreover, she is referring, as well, to the physical, mental, and spiritual aspects of the disease that also are referenced frequently in these results. She is echoing a common theme: the recovering people who comprise this research’s
participants initially sought to simply end the pain of continued drinking. They were unprepared for the “bonuses” of growth that would occur in other arenas of their life. For example, Susie emphasizes the close relationships that she has been able to forge in later sobriety with her two daughters. She is grateful for the openness and the rapport they now enjoy, as well as the ability to find humor in Susie’s drinking history amidst its trauma.

Some of the most pivotal experiences which have contributed to Susie’s growth have occurred in the form of “tragedies of one kind or another.” She describes the pain involved when she and her recovering husband found out that he suffered from both diabetes and heart disease. The decline of his health and eventual death were events which challenged Susie’s faith, but ultimately strengthened it. Likewise, when Susie had been sober for approximately 15 years, one of her sons was imprisoned; she went through a period when she doubted the benevolence of her higher power, but continued to pray. Her faith returned, but her son eventually died an alcoholic death. Of this period, Susie observes: “I had no anger when he died. My faith was not questioned like it was when he was sent to prison. Through that process my faith deepened.” To hear Susie speak of her gratitude for sobriety both during these times, and after, presents a compelling depiction of the strength she has found through ongoing recovery. I asked her in our second interview how it was that she was able to move forward from these challenges which, to a less resilient person, could have been immobilizing. Her response was that, “When I’m able to get back to the simplicity and follow directions, then I find that enables me to move out of the problem and into the solution which is spiritual growth.”

Susie offered a unique description of the cyclical nature of continuous recovery. She describes an ongoing process of working A.A.’s 12 Steps (in order):
When we get down to Step 12 . . . then we start over again with Step One, [and] we’re different people than we were when we worked them before. And that process continues throughout a lifetime. That enables us to continue to grow emotionally and spiritually.

Arriving at a juncture in sobriety when she was aware that she was truly beginning to experience quality of life occurred for Susie when she realized that “her insides matched her outsides.” Susie had heard another recovering woman use this phrase earlier, but its meaning did not become apparent till she had achieved substantial recovery. Another colorful phrase was employed by Susie as she expressed gratitude for her current ability to face reality: “I think that living in day-tight compartments is a practice that enables me to live life on life’s terms.” I was struck by once again hearing a participant talk about daily living of “life on life’s terms.” Facing, perhaps even celebrating reality has been a hallmark of these participants’ portrayals of sobriety. In our second interview, I commented to Susie that, “It sounds as though this has been one of the really important parts of continuous growth, . . . this ability to live in the day.” Susie’s response was, “Yes, because I never before dealt with problems in a healthy way because I was always into the future or the past.”

**Contributing Factors to Quality of Life**

There are a number of activities in which Susie engages that she feels are instrumental in ensuring that her quality of life in alcoholism recovery continues to be enriched. Her description is a thorough one:

For me it’s beginning the day with a period of prayer. Meditation to the best of my ability . . . it’s quite short and part of it is reading two daily recovery books. To have a time at night for prayer and reflection. And that correlates with the Tenth Step of A.A. where we do a review of our day. The other necessity for me to maintain this quality of life is to interact with recovering people. Other recovering alcoholics. To continue to share my experience,
strength and hope so that I don’t forget where I came from and hopefully my experiences will benefit them on their road to recovery.

In her last few preceding phrases, Susie was referring to the fellowship that occurs for her both inside and outside of A.A. meetings. She does not offer an opinion on what would be a typical number of A.A. meetings for a person of her length of sobriety to attend:

Well, I believe that varies among alcoholics.... I do know that meetings alone will not keep an alcoholic sober.... it’s the effort that the individual puts into working this program that brings about the changes that are necessary for continuing reasonably happy sobriety.... I believe today.... that recovery for the alcoholic only happens through working the 12 Steps.

In a manner consistent with what the previous 3 participants have had to say about contributing factors to quality sobriety, Susie has emphasized that she continues to use these approaches in ongoing recovery. She values prayer and meditation, and the interaction with other people that comes through meeting attendance and other shared recovery activities. The importance of spending time with other recovering people is critical, according to Susie: “And I believe that that is the key that makes all of this work,.... that we take our worst problem and share that, interact with other people who also have.... the disease of alcoholism.”

The Role of Surrender

The concept of surrender plays an important role in Susie’s quality of life. I asked her about the on-going significance of surrender in sobriety. She believes that it is something which she must do

Over and over. The “Big Book” says that acceptance is our very first problem today. It also says that just as we surrendered to our inability to drink, we will have to return to that unflattering part of departure over and over again, concerning every other problem in our life.
The distinction is very clear for Susie that she cannot surrender until she has first accepted. I wanted to make sure, however, that I understood that, in her estimation, at least, surrender and acceptance go hand in hand. In response, Susie said:

Right. To me they go hand . . . It began with accepting that I couldn’t drink successfully. And accepting that I had this disease. Then the acceptance of reality as it exists today has been an on-going endeavor . . . It’s a daily exercise that makes it possible for me to have a quality of sobriety . . . If I’m fighting people, places and situations, than . . . I am on a dry drunk.

Recognizing the value of surrender did not come immediately for Susie; like other participants in this research, she had to come to understand the word’s usage in a recovery context: “It’s the beginning of any growth. It’s the point where I thought surrender meant the end of my life. I have found out it meant the beginning of a new life.” This is not a statement to be taken lightly. The “beginning of any growth” strongly suggests that attainment of a quality of life in recovery cannot occur prior to this process of surrender. In an attempt to further articulate her understanding of the term “surrender,” Susie said:

When we surrender, it means that O.K., absolutely my way didn’t work . . . In the beginning it was the people and the 12 Steps that they taught me how to use to live a different way. And that’s absolutely necessary. That surrender. Until you reach that point you can always maintain periods of dryness but sooner or later the alcoholic will always return to drinking.

There are a couple of striking points that Susie is making here:

1. Surrender of one’s will (and hitting a personal “bottom”) is critical to stable sobriety. Susie’s comments in this respect echo the previously cited participants.

2. Unless an alcoholic has surrendered, he or she will “always” return to drinking.

Susie’s 24 years of observing alcoholics enter and leave recovery has reinforced this strongly held view. Susie is quick to point out that surrender is not to
be confused with helplessness: it is still necessary to take action in her life to get things done. The results of those actions, however, she leaves to her higher power.

During our second interview, when I shared some other participants’ comments which seemed to consistently emphasize the essential prerequisite of surrender to obtaining quality recovery, Susie stated simply, “I think that’s the key to maintaining sobriety versus a state of dryness.”

The Role of Spirituality

In her earlier cited comments about how she struggled with and eventually strengthened her spiritual beliefs (particularly leading up to and following the losses of her son and her husband), it is evident that Susie’s spiritual life has followed an ongoing, evolutionary path. Her descriptions of her spiritual unrest in early recovery lend insight into alcoholic traits which seem to characterize most of the participants in this research:

I was constantly ill-at-ease in my own skin. In my own mind. As I began to grasp some spiritual concepts and attempted to live in day-tight compartments, I found that my mind slowed down and I became more comfortable in relation to the rest of society. The rest of my world.

From this description, it seems that the spiritual growth that occurred in ongoing recovery enabled Susie to experience a better internalized relational meaning with herself. With the further passage of time, spirituality not only enhanced her self-acceptance, but her view of her self in relationship to others. Within this passage, Susie joins with the voices of previously cited participants in describing the journey to a sense of belonging that has characterized quality of life in extended alcoholism recovery.
To Susie, the concept of spirituality in her recovery remains “intangible. I agree that it is an essence. It is a feeling.” While Susie, like other participants, struggles to articulate this perception, it is apparent that spirituality is an extremely personalized concept that transcends her early religious upbringing. Again, she hastens to note that spirituality supports her in facing the reality of life sober: “I’m not saying that I have a direct pipeline, and boy, you do this and life is a bowl of cherries. But I do have a strong belief that I don’t lead this thing called life alone.”

When, in the course of our second interview, Susie and I reviewed some of the comments that other participants in this research had made about the role of spirituality in their obtaining quality of life in recovery, the emerging emphasis on this point was apparent to both of us. I asked her reaction to this preliminary hypothesis: “It seems like . . . spirituality is turning out to be the . . . key element, perhaps, for quality of life in recovery.” Susie’s response offered confirmation: “I believe it to be the key element. That without a spiritual belief life becomes overwhelming and meaningless.”

The Role of Alcoholics Anonymous

Given her consistent emphasis upon the contribution of her Alcoholics Anonymous membership to her sobriety, I was not surprised to hear Susie’s ringing endorsement when I asked what A.A. meant to her quality of life: “A.A. gave me life in recovery. The 12 Steps are the guidelines I live by today. I had never encountered any information along this line . . . ” This statement provides one more description of the 12 Steps as a “guide” for living happily sober, rather than simply not drinking. Moreover, it is striking, I believe, that she had “never encountered” such a guide previously. One of the answers may lie in the fact that the 12 Steps’ effectiveness is
based on the recognition of unique conceptions of personal powerlessness over the
disease of alcoholism (coupled with acceptance of personal responsibility for actions
committed while drinking), surrender of self-will (or, as popular culture might put it,
self-sufficiency), and interdependence with a higher power and others in recovery. To
a culture steeped in self-sufficiency, such ideas might appear contrary to prevailing
behavioral norms.

The certainty with which Susie speaks of her commitment to A.A. has
resulted from her attempts to stop drinking without it:

No, I do not believe I could even have stopped drinking without A.A. I could
have stopped but previously in my life I could never stay stopped. Since I
came and became part of this fellowship, I have been able to stay stopped . . .
I cannot think myself into right-acting, I have to act myself into right-
thinking . . . this program is about changing my actions and as a result it will
change my thinking. That continues to be the key. Like don’t drink, go to
meetings. Don’t worry about your problems just don’t drink and go to
meetings. As you continue to go . . . you hear people say work the Steps . . .
if you take that action, then you begin to grow spiritually.

Just as Dave had earlier described “acting his way into right thinking,” Susie
uses identical language to describe how it is that she has embraced a lifestyle of
quality recovery (“right thinking”) through the ongoing process of simply continuing
to attend A.A. meetings and work its 12 Steps. “Right thinking” would be
impossible, in Susie’s estimation, without the 12 Steps, which she believes treat the
symptoms of alcoholism which extend beyond drinking. Without the 12 Steps, Susie
believes that: “I would be neurotic, I’m sure. Depressed. Probably suicidal. I would
be doomed to going back to drinking to kill the pain.”

As other participants have already stated, Susie believes that A.A.’s Promises
(see Appendix G) begin to occur after individuals have worked Steps One through
Nine:
I believe that recovery depends upon clearing up the wreckage of the past. That process happens in the first Nine Steps. Particularly Eight and Nine, where we . . . [make amends to] those people that we have harmed and make restitution . . . when possible . . . until that has been done the spiritual growth will be hampered.

Vivid examples of how A.A.’s Promises have come true are provided by Susie. They encapsulate much of what quality of life means to her today:

I do not any longer regret the past. Nor do I wish to shut the door on it. When I came, for many years, I avoided people, places, situations, family gatherings because of relationships, incidents in the past that I . . . was ashamed of or didn’t want to encounter certain people. I no longer have to do that today. I have reconciled with them . . . The fear of economic insecurity was very, very strong when I came to this program. My security was based on dollars and cents and possessions. And today I believe that my needs will be taken care of as long as I do the best that I can. A day at a time.

The other aspect of Susie’s A.A. participation that she sees as vital is service to others. She described several of the ways in which service has enhanced her quality of life, primarily through sponsorship:

For me, being a sponsor to new people or people with less sobriety has been enriching in that I grow from the experience . . . those opportunities are given to me as another means to always keep the door open a crack, so that I don’t forget where I came from . . . Some of us the service comes through giving open talks about ourselves . . . I do believe that service of some kind, even if it’s just attending meetings and speaking at that meeting, that is a necessary part of contented sobriety.

The Importance of the Alcoholic Identity

A great deal of emphasis was placed by Susie upon continually reminding herself of her self-identification as a recovering alcoholic. I asked her how this related to the quality of her sobriety. She answered:

First and foremost is to remember every day that I am an alcoholic. That there is no cure for my disease and that abstinence is absolutely necessary. Without it all of the emotional and spiritual growth that I have attained won’t mean anything. If I pick up a drink I will return to a state of active alcoholism almost immediately . . . I believe that if I forget where I came from that I am doomed to return to that place.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
It was during her discussion of her alcoholic identity that Susie touched upon one of the emotional states that is frequently cited in the A.A. literature as being dangerous to the alcoholic: living with resentments. Susie subscribes wholeheartedly to the contention contained within the "Big Book" that resentments are "the number one killer." From Susie's perspective, resentments "will take more alcoholics back to drinking than any other emotion." This is a strong claim. During our second interview, I sought to clarify just how vital the awareness of the alcoholic identity is to avoiding resentment. In response, Susie said, "That is imperative for me to remember because left to my own devices I will create resentments that will consume me." Sensing that we had touched upon a vital area of quality recovery, I further inquired of Susie, "So, concentrating on your identity, reminding yourself that you have this disease is one more defense against resentment. Is that a fair interpretation?" Without hesitation, Susie replied that, "Yes. My disease can take control again even though I haven't picked up the first drink." This statement that Susie has made may seem puzzling to those who are not familiar with the emphasis that the A.A. literature places upon the recovering alcoholic's need to avoid resentments. When Susie says that "My disease can take control again . . .," she is referring to what she considers the mental and spiritual aspects of the disease concept. It is A.A.'s contention that holding resentments leaves a recovering alcoholic (particularly one in early recovery) in an especially vulnerable state. Those who composed the A.A. literature observed that if such resentments are allowed to build and fester in the mind of the alcoholic, they can provide some of the most frequently cited reasons (albeit poor ones) for the alcoholic to rationalize taking a drink. In fact, in the section of A.A.'s "Big Book" (Alcoholics Anonymous, 1976) which offers suggestions on how to work the "inventory" Steps (numbers Four and
Five), the predominant emphasis is on listing (in Step Four) resentments which are held by the alcoholic, so that they may be verbally shared (in Step Five). What is key here is recognizing Susie's additional statement that "Left to my own devices, I will create resentments that will consume me." Susie, at this point in her recovery, does not leave herself to her "own devices." She indicates that she relies upon the feedback and support that she receives through her interaction with other recovering people, in order to keep those thinking processes which could potentially lead to resentments in check.

Obviously, holding resentments is not unique to recovering alcoholics. What Susie (and the other participants in this research) has discovered, though, is that resentful thoughts (and, moreover, any formerly destructive thought patterns) do represent for her one treatable "symptom" of alcoholism. The disease concept remains one of alcoholism's most controversial aspects. It is not the function or the intent of this research to move the debate over the disease concept any closer to resolution. What the results of this research do indicate however, is that for these research participants, the disease concept has come to hold personal meaning and validity Susie's thoughts on the topic of resentment (and how it is related to the alcoholic identity) provided another confirmation of the view held by these participants that because alcoholism is a progressive disease (even during abstinence), recovery, too, must be a continuous effort.

It would seem apparent from the preceding comments that Susie very definitely subscribes to the disease concept of alcoholism. She did not formulate this belief immediately upon achieving sobriety: "I didn't come here believing that . . . it took a long time." Through the process of recognizing her own patterns of behavior replicated in the lives of others in recovery, Susie came to believe that they shared a
common disease. The value of her identification with her own susceptibility to this
disease is viewed by Susie as necessary in recognizing old thought patterns. She relies
upon the feedback of other trusted recovering people to aid her in this process: “This
is a disease that tells me I don’t have a disease, but in other compulsive/obsessive
areas of my life I am the last to see the reality of what is happening, what I’m doing
to myself.” As earlier stated by Dave, these obsessive/compulsive traits invite (what is
for he and Susie, at least) the risky temptation to retreat into a solitary mode of
thought.

Like Jerry, Susie’s cautious view of slipping back into potentially dangerous
behaviors is informed by the experience of relapse. She originally had over 2 years of
continuous sobriety before beginning her current period of 24 years of recovery.
Although she attended A.A. meetings frequently and had “superficial” interactions
with other recovering people, by her description, Susie was only “dry,” and was
lacking in faith when she drank again. When she resumed abstinence, she then began
to attend Step meetings of A.A. for the first time. It is Susie’s belief that her ability to
start working the Steps, and, in particular, her ability to surrender to a personally
formulated higher power, permitted her to begin to grow in her recovery. Because of
experiences such as Susie’s relapse, the participants in this research base their belief
in the disease concept of alcoholism on personal knowledge; the disease concept, for
these individuals, has long since ceased to be an abstract concept. It has become a
personal reality.

Misunderstandings About Recovery

Susie, like other participants in this research, has had some frustrations in
trying to share her perception of quality of life in recovery from alcoholism with
people who are nonalcoholic. In fact, she has a fairly pessimistic view of the chances that her recovery can be understood in other settings:

And I have learned that my place is not to explain this disease and why I am the way I am, that other people aren't going to get it anyway. And they don't want to hear it. You know, I fall back on the theory that if you aren't an alcoholic you will never completely understand the disease of alcoholism . . . I think for the nonalcoholic person the belief that alcoholism is a spiritual disease is difficult for them to grasp because we are not a "religious" society. But the whole recovery depends upon spiritual principles . . . And they will never understand that the disease progresses within the alcoholic even though he is not drinking alcohol . . . Now I don't understand that but I believe it. I believe it because I have seen that experience happen with the alcoholics I've attended meetings with.

The preceding comments illustrate why Susie has some hesitation to broach the subject of alcoholism with nonrecovering people. Her experience is common among the participants in this research; the frequent misunderstanding they seem to be identifying may signify a cultural phenomenon that could potentially contribute to the relative lack of research into quality of life in extended recovery.

Priorities in Recovery

In an effort to summarize the most salient aspects of her quality of life in alcoholism recovery today, during our second interview I asked Susie to provide a statement of her personal priorities. She offered these comments:

My quality of life is dependent upon my belief in a higher power. My willingness to share my past with other recovering . . . people who have the same problem. Being active in the program so that I continue to work the 12 Steps. And asking for knowledge of His will for me and the power to carry that out each day.

Within these comments, Susie is stressing her emphasis in her personal program of recovery on spirituality, meeting attendance and interaction with/service to other alcoholics, and surrender.
General Observations and Reactions Noted in Interview Number Two

In keeping with the procedure followed throughout this research, I asked Susie during our second interview if she found the transcript of our first interview to be accurate. She responded that, “Yes. What I have read and shared with you here appeared to be very accurate as far as my views when I re-read it.”

Based on my interest in following up on the priorities that Susie designated in the previous section, I offered the following interpretation for her consideration: “I’m hearing that the focus on continuing spiritual emphasis and moving forward in recovery is important to having quality recovery.” In response, Susie concurred that, “I believe it is, and our ‘Big Book’ says that we grow spiritually through working with other recovering or suffering alcoholics.” The interaction with others in recovery is integral to Susie’s quality of life in recovery; I sought Susie’s appraisal of fellowship’s link with growth: “Again, I’m hearing that there’s a lot of importance being placed here on becoming more outer-focused. With the passage of time, you are able to be more and more outer-focused.” This interpretation resonated with Susie, as she responded, “Yes, because this disease alienates us from society as a whole. Eventually the alcoholic’s only focus is on where will he get his next drink.” This statement of Susie’s recalls a misconception that John earlier addressed—that A.A. members are set apart from society as a whole. In fact, John and Susie have sought to clarify that the goal of recovery is to be re-integrated into society. This point was explored in more depth when I offered the following interpretation to Susie: “So again, one of the maybe unexpected benefits of long-term recovery has been not just to be comfortable with other recovering people, but to have improved relationships with people outside of your recovery program.” Susie’s response
offered a succinct summary of her appraisal of A.A.’s role in her recovery: “Some people perceive A.A. to be a cult, if you will, that takes us out of society. But the main purpose is to put us back into society as productive, useful human beings.”

As much or more so than any of this research’s participants, Susie takes her role as a contributing, functional member of the world-at-large very seriously. The ability to handle the events of her life on a daily basis could, therefore, be interpreted as the Invariant Constituent (Moustakas, 1994) of her quality of life in recovery. She has endured painful personal losses during her recovery, and has used these events as opportunities for catharsis and growth—for a more profound degree of surrender to the spiritual program of recovery which she has previously described. She has provided a revealing example of how it is that these participants measure their quality of life through their ability to handle “life on life’s terms.”

Marsha

Marsha is a 72-year-old Caucasian female. She has remained single throughout her life. After many years of working for a university in Illinois, she now works part-time for a local church where she currently lives. Her education includes “some college.” Her religious affiliation is Roman Catholic. Marsha has been continuously sober for 27 years. She credits her recovery exclusively to A.A.; she has not received any other forms of treatment or therapy for her alcoholism. Her only addiction is to alcohol.

Marsha began her recovery in the Chicago area, where she lived for many years. Her involvement in Alcoholics Anonymous there was extensive. Her vast recovery experience in both a large metropolitan area and, in more recent years, in a
small midwestern town adds a unique perspective to the views of this research’s participants.

**Quality of Life: General Observations**

Marsha’s enthusiasm about her quality of life today in recovery from alcoholism is immediately apparent. When speaking of her quality of life, superlatives abound: “Excellent. Superior. Perfect, I guess . . . It can’t get any better, let’s put it that way.” I asked if she could specify some elements of her life that represent her well-being. She answered:

I think appreciation of family and friends. Spirituality. Before I had a religion but I didn’t have much spirituality in my life. Just being alive on a daily basis, and having my health . . . Enjoying every day as it comes. Being able to be responsible and being able to handle things without a drink, of course. And appreciating life like it is today . . . And the wonderful friends I’ve made in A.A.

It seems worth noting that Marsha represents yet another participant in this research who has had some prior formal religious beliefs, but who has found spirituality in recovery. While the ability to handle a day in a “responsible” way might not seem special to a nonalcoholic, to Marsha and other participants, it is a significant measure of quality of life.

**Continuity of Recovery**

Regarding the question of whether quality of life continues to improve as recovery evolves, Marsha is in clear agreement with the other 7 participants that, in fact, it does:

I think the first few years is just getting a handle on the fact that you’re no longer a drinking person. And a few years after that you begin to realize that a whole bunch of other things are opening up to you. That you can do things that you didn’t think you really could do . . . It [sobriety] gave me confidence.
And then I also realized that as time went on I was closer to people than I used to be. Not only females but males, too. Not in a sexual way but in a friendship way.

Over the course of recovery, Marsha asked of her sponsors if her current quality of life was "as good as it gets." She was amused to recall that she was told, "Oh, you’ve just begun." There were specific actions she took which facilitated this growth, however. After having taken A.A.'s Steps Four and Five (see Appendix F), which involve writing one's personal "moral inventory" and sharing that information verbally with a trusted individual, Marsha felt the weight of past guilt lifted off her shoulders. The Steps that follow this, Numbers Six and Seven, are concerned with removing the character "defects" that have been identified in the previous Steps. Some of the defects that Marsha has struggled with include anger, greed, envy, and jealousy. In Marsha's case, she has seen positive results in her life from effort applied to these Steps:

I'd say it probably took me 5 or 6 more years before I started recognizing that a certain defect was right there with the same severity . . . But what the program teaches you is to recognize that and then not let it get out of control. But I think you also have to recognize that you’re human . . . For me it’s learning . . . how to have a better life. If you do this and you stick with it, you keep going, it gets better.

One of the observations that Marsha made about the continuity of recovery was unique among this research's participants. She believes that there have been discernable phases to her growth, which have occurred at approximately 7-year intervals. These junctures have been notable for her due to a general sense of boredom that creeps into her life. She has discovered that at these times it is helpful to change her routine by going to A.A. meetings in different towns, and by increasing her level of participation in volunteer activities. Occasionally, she will visit old friends in Chicago.
As several of the preceding participants have already indicated, serious circumstances in their lives provided a point of reference for how much growth had already occurred during their recoveries; for others this meant the death of a family member or friend. For Marsha, this personal trauma took the form of illness:

I had cancer in 1989 and I just am sure that if I had not had my A.A. program before that illness I could never have dealt with it as well as I did. Because I had to learn then that you do everything one day at a time... I knew how I was going to handle it... Using my Steps and what I learned about living... that's what I applied then and that's what I apply today.

Marsha's lengthy time in recovery has allowed her to witness many people enter and leave recovery. And die. This has strengthened her commitment to the ongoing journey of recovery:

Recently I've been even more grateful because I've seen several people who are probably going to die because they have chosen not to keep going along this path... And they get sicker and sicker... And when I see those things happening... I think, "That could happen to me." So that makes me go to another meeting. It makes me call somebody on the phone.

**Contributing Factors to Quality of Life**

As we began to discuss the contributing elements to Marsha's quality of life, she first touched on the factor that she feels has been and continues to be vital not only to her quality of recovery, but to others she has known. This would be the ability to ask for help:

You can't do it alone... And I think that everybody that comes into this program has to learn to ask for help. And that is hard because I always thought I could handle anything myself. Anything. But obviously I wasn't handling it.

Marsha is reaffirming what Tiebout (1954) and the other participants have had to say about the necessity of deflating their own egos, and, in turn, surrendering to the need for help from outside of oneself.
On a daily basis, Marsha cites the importance of prayer/spirituality, the reading of recovery-related literature, and contact with other people. She usually attends four A.A. meetings a week (“I’ve never gone to less than three.”). For many years, she attended “Founder’s Day,” a celebration of the founding date of Alcoholics Anonymous, held in the city where it began, Akron, Ohio.

Marsha maintains that learning to recognize and cope with feelings is essential to her contented sobriety: “I call it a symptom of my disease . . . So the symptom of alcoholism is that you cannot let your anger or your defects, personality quirks, whatever, get out of control.” This means maintaining balance: “I like the quality of life. And when that balance gets off I think, O.K. What is it that’s making the quality of life less good for you today?”

The particular emphasis that Marsha places on regular contact with other recovering people led me to suggest that her ongoing level of involvement with a network of those in recovery contributed to her remaining happily sober, rather than dry. She responded:

That’s right. That’s exactly right. That’s what continues to keep people sober. Because the people that have long periods of sobriety are doing practically the same thing I’m doing. They go to meetings. They keep in touch with other people. They’re doing . . . And at first you think, “Oh my God, I’m going to have to do all these dumb things all my life.” Yeah. If you want to stay sober. But after a while they don’t become an obligation, they become a pleasure . . . That’s the quality of life. It’s a pleasure.

The Role of Surrender

There is agreement on Marsha’s part with the emerging consensus among these participants that the concept of surrender is crucial to ongoing contented sobriety. As, Marsha puts it, “That’s a big one.” In her case, Marsha claims that the surrender to the fact that she was alcoholic was not as difficult as her surrender to a
new way of life in recovery. In this respect, she cites A.A.’s Third Step (see Appendix F) as being the most difficult of the 12 Steps in *her* experience. It is suggested in this Step that the alcoholic should turn their will and their lives over to the care of “God as we understand him” (in other words, a higher power of one’s own personal formulation).

Once again, this illustrates the struggle inherent in these participant’s recoveries with the notion of surrendering personal *control*. Of that struggle, Marsha says, “That took time. Because I was the fixer and I was the doer and I was the one that would step in and fix everything when things got muddled.”

On an ongoing basis, however, I asked of Marsha how it is that surrender plays a part in her quality of life. She answered:

I guess mostly that it’s that I cannot run everybody’s life, not only my own, and that I cannot predict things . . . I just have to let things happen and mind my own business . . . And that does not mean that somebody comes down on a pink cloud that says, “My child, do this” . . . the reason it works is because I got out of the way. I’m getting receptive. I’m listening instead of talking. Now sometimes that comes from going to a meeting and hearing somebody say something. It sometimes comes as simply as a phone call . . . Now that doesn’t mean that you sit in a chair for the rest of your life and do absolutely nothing. But I have to say that I surrender my will and my life to something greater than I am. And since, for most of us, there was nothing greater than we were, it’s hard . . . that takes practice.

I could not fail to note the paradoxical nature of what Marsha was saying about surrender. Here she was suggesting that a recovering person needs to take action, and yet leave the results to a higher power. I asked of her if she did not think that this aspect of recovery *could* reasonably be misunderstood by nonalcoholics, who might initially perceive people such as herself (who are very active in their recoveries) as anything *but* powerless. She replied that, “It’s a great paradox, because once you let go of it all, you get it all back.”
The Role of Spirituality

Marsha makes it very clear that spirituality is the most important element of her quality of life in recovery today: “Spirituality is for me the most important thing . . . Something outside of myself. For me it’s almost 90% of recovery.” Marsha is the only one of these participants who assigned a percentage to spirituality. She goes on to say that, “I think it’s a closeness to something greater than you are. And then you can’t put your finger on it . . . I read somewhere recently it says there is a God and it’s not me.”

Marsha was first aware of her sense of spirituality (in a recovery context, as opposed to her formal religious upbringing) when she began attending A.A. She was impressed by the fact that people in these meetings genuinely seemed to be happy leading a life without drink. When describing those early encounters, she described meeting wonderful people that had what I call spirituality. I didn’t know that’s what it was. I just knew they didn’t drink and they were a heck of a nice group of people and they had a good time. They laughed a lot.

Marsha pointed out that a spiritual awakening is, in her view, inevitable if one works the 12 A.A. Steps in order: “It says in the Twelfth Step, ‘Having had a spiritual awakening [as the result of these steps . . . ].’ It doesn’t say ‘If’ you’ve have a spiritual awakening. It says ‘having had . . . ’” Like others among the previous participants, Marsha is adamant that spirituality is “not religion. It’s not running to church or reading the Bible a lot . . . If you want to do that and that’s your religion, that’s fine, but spirituality is something totally different.”
The Role of Alcoholics Anonymous

Each one of the participants in this research has said that they do not believe that they could have obtained the quality of life that they enjoy in recovery without their participation in Alcoholics Anonymous. Marsha is very grateful for what she believes her A.A. participation has given her:

A.A. gave me a life. It really gave me a life. And when I first came here I thought I won’t drink anymore and that will be it. But there’s so much more to it . . . I thought, “What I found here in this room [in her first A.A. meetings] I have been looking for all my life . . . and I never found it” . . . I felt like it was . . . like a ship coming into a harbor and this was the port and this was where I belonged.

There are remarkable similarities, once again, between the language Marsha uses and the other participants use to describe their A.A. experiences. There are references to having been given a life, and of feeling a sense of belonging; it is this sense of belonging that appears to be emerging as one of the most meaningful parts of these participants’ A.A. membership.

The early recovery benefits of A.A. seem clear for Marsha. How was it, though, I wondered, that continued A.A. attendance contributed to her quality of life? Why does she keep going to meetings? She believes it is because I’m sober 27 years. I wouldn’t be sober 27 years if I hadn’t gone to meetings, I’m sure of that. Because I’ve seen too many people say I don’t need them anymore and 6 months later they’re back in rehab . . . I go to meetings to find out what happens to people who don’t go to meetings. My medication is my meetings . . . A.A. is the medicine for my disease . . .

In other words, Marsha benefits from the contact with still-suffering alcoholics who are just beginning to get sober (and who remind her of where she could be if she drank again). This is reminiscent of Susie needing to be reminded that she has “a disease that tells me I don’t have a disease.”
The so-called “Promises” of A.A. (see Appendix G) are viewed by Marsha as a good indicator of quality of life in recovery; like other participants, however, she believes their appearance in A.A.’s “Big Book” after Step Nine is strategic: “They’re . . . there because you have to do some of your amends and clear out some of the garbage before you can expect things to be . . . , an amend means that you’ve changed in some way, that things are going to change.”

Though Marsha is pleased to see the increased attention to alcohol treatment that has occurred over the time she has been sober, she became wistful when speaking of the days when she first got sober in Chicago before the proliferation of treatment centers for alcoholism. She remains grateful for her first A.A. contacts who went out of their way to give her transportation to meetings and who kept her busy with A.A.-related activities in her first days of sobriety. Because people tend to enter A.A. today after hitting a “higher bottom,” she feels the sense of urgency and commitment to getting new A.A. members involved may not be what it once was.

The Importance of the Alcoholic Identity

Marsha has a unique approach to remaining cognizant of her identity as a recovering alcoholic. This is expressed in her behavior at A.A. meetings:

At meetings I say, “My name is Marsha. I’m powerless over alcohol.” I don’t say I’m an alcoholic . . . Because I know that I’m an alcoholic but I also may not realize that I’m still powerless over alcohol. I think those are two different kinds of things.

I asked of Marsha if the contact with newly sober people in A.A. meetings wasn’t one of the factors that helped her to keep this distinction clear and fresh in her mind.

She answered:

That’s right, you can get complacent and you think, I’ve got it made. I’ll never have it made . . . It’s the first drink that’s going to kill me. It’s not just
going to get me a hangover, it's going to kill me eventually . . . Because for us with our disease, . . . you just cannot stop.

It is apparent from her preceding comments that Marsha considers her alcoholism to be a disease. This is consistent with all 8 participants in this research. And, like the other 7 participants, Marsha makes reference to the three aspects of the disease (though the words “emotional” and “mental” appear to be used interchangeably by different persons): “You take the drink and the first thing that goes is your spirituality, then your emotions and then your physical well-being . . . when you quit, you get well the other way. You get well physically, emotionally, and then spiritually.”

Misunderstandings About Recovery

The relationship between quality of life in recovery and an ongoing commitment to sobriety is cited by Marsha as one of the most misunderstood aspects of alcoholism:

It’s a lifestyle. It’s an elective lifestyle . . . For me it’s learning . . . how to have a better life. If you do this and you stick with it, you keep going, it gets better. You can’t just get to a certain point and say “I’m done.” I’m O.K. I’m fine. I’m not drinking I’m fine. There’s always something you can work on. And of course, nobody wants to say, “Gee . . . you mean I’ve still got faults?” For God’s sake. You keep doing it until you die.

Priorities in Recovery

When I asked Marsha if it would be possible to prioritize those elements of her recovery which ensure quality of life for her today, she reiterated that spirituality remains most significant, followed by A.A. meeting attendance and fellowship with other recovering people (often in the form of sponsorship). She describes the way A.A. meetings help her in keeping things prioritized in the following terms:
You have to realize that because you have that ability to build something up and make it a gigantic thing where it isn’t and sometimes when I go to a meeting I think what’s important? What’s really important. The quality of life. Not the guy that gave you the finger that went around you on the way here. Or some silly little thing that set you off.

General Observations and Reactions Noted in Interview Number Two

When I began Interview Number Two with Marsha, I asked, “Now that you’ve had a chance to look at the transcript [of Interview Number One], does it appear to be accurate?” She replied:

Yes. I would say it’s quite accurate. I didn’t realize I said that much. Well, when I read it back, it seemed to be precisely what I had in mind, I wanted to say, for the most part . . . As a matter of fact, I read it over . . . and I thought huh, that’s interesting. That’s very interesting.

Marsha and I reviewed certain statements of hers made in Interview Number One so that I could verify the accuracy of some of my interpretations of them. She made several references in our first interview to how important sponsorship of others has been to her, and, in a more general sense, service to others in recovery. I noted to her that sponsorship and service had emerged as vital elements of all the participants’ quality of life. This did not surprise her. Regarding how critical service is to all of these 8 people, Marsha said, “I think it is. Service work, whatever you want to call it, to continue to give back what has been given to you.”

I shared with Marsha that all of the participants had stressed the importance of surrender to their recoveries. I recalled that she had, when discussing surrender, spoken of the necessity of trusting in her higher power. I wondered if that didn’t imply that . . . “this business of surrender is very much tied into spirituality.” Marsha’s response was, “Very much so . . . I don’t find that you can separate the two.” It also was important, I felt, to clarify that the guidance of her higher power
finds expression in day-to-day interactions with people in recovery. In reference to this point, Marsha said:

I find the answers I need from other people and from the program, yeah. And I know that’s a simplistic way of looking at it but it’s worked for me for a long time, so I don’t distrust it, in other words.

Marsha was pleased by the “real consistency” that she heard in the comments of other participants that I shared with her.

With 27 years of continuous recovery, Marsha is tied with Betty (whose interview results follow) for having the longest recovery of these participants. In view of her belief that spirituality is “90% of recovery,” it could safely be said that after such a lengthy time sober, spirituality is the Invariant Constituent (Moustakas, 1994) of Marsha’s quality of life in recovery. As is the case with all 8 of these participants, however, her spirituality, like every other aspect of her recovery, is anything but passive. As Marsha puts it, “I live in the now. It’s not eat, drink and be merry for tomorrow . . . It’s not that. It’s that you’ve got to take care of business today so that tomorrow’s O.K. too.”

Betty

Betty is a 64-year-old Caucasian female. She is married, and has two grown children. Betty is now retired, but prior to retirement she worked for a period of 12 years as a hearing officer for the Bureau of Motor Vehicles in the state where she resides. After leaving that position, she worked as a retail sales manager for several years. Her education extends through the completion of high school. Although she describes her present religious faith as being Protestant, she (like other participants) emphasizes that her belief in a personally formulated concept of a higher power has emerged during the time that she has been in recovery. Betty is unique among these
participants, in fact, in stating that prior to her entering recovery, she was an atheist.

Her time in recovery is extensive; like Marsha, she has been continuously sober for 27 years. Betty’s only addiction is to alcohol. Her recovery has occurred solely through her participation in Alcoholics Anonymous. She received no therapy or other forms of treatment for her alcoholism.

**Quality of Life: General Observations**

Simply stated, life today for Betty in alcoholism recovery “is . . . and has been from the beginning, an adventure.” She goes on to say that:

> I look forward to the challenges today that might be presented to me . . . The new beginning of each day, I was taught early on in my sobriety, that all avenues are open if I don’t pick up a drink . . . How do I go on about the gratitude that I have for the things that I’ve been given? One of the greatest things and one of the greatest freedoms that I’ve been given is the freedom from fear . . . And I think among the many, many blessings of sobriety are the choices that I have. If I don’t pick up a drink. The choices would be made for me. I can give you lots of things that I’m grateful for . . . [like] the birds. I used to be terrorized by the birds because they were too loud for my head in the morning.

It is amusing to note that Jerry had earlier expressed an identical change in his appreciation of birds! Both he and Betty are now grateful that they can appreciate nature.

As was the case with several other participants, Betty cited her ability to be responsible as one of the most meaningful measures of quality recovery today:

> If I say I’m going to do something you can bet I’ll do it. If given a time frame to be on time, I’ll be on time. These are all things that were new to me. Being responsible. And I had heavy responsibilities that went with my occupation . . . to the point where I came very close to leaving the position which I could see today would’ve been a terrible thing. By giving into fear.

It is the freedom from fear that figures more prominently in Betty’s description of what characterizes quality of life than in any of the other participants’
You know, if you don’t have freedom in sobriety, what the hell do you have? It’s one thing to get free of alcohol but it’s another to get free of all this baggage that was part of me.” In the context of this previous statement, Betty has found yet another way to express that ending the act of drinking was only a part of the process involved in obtaining quality of life in recovery.

**Continuity of Recovery**

Betty shares the view held by the other 7 participants in this research that the quality of life continues to improve with the passage of time in recovery. What has been distinct about each of these participants, however, are the transitional, or pivotal times in sobriety which they have recognized as signifying their greatest growth. Betty’s story is unique, in that she did not move beyond the first three Steps of A.A. (see Appendix F) for the initial 3 years of her sobriety. In other words, while she had admitted her alcoholism, she had stopped short of taking a comprehensive “moral inventory” (as suggested in A.A.’s Fourth Step), and then sharing the results verbally with another trusted person (as suggested in A.A.’s Fifth Step). The self-awareness of her “character defects” that resulted from taking those Steps was a “revelation” for Betty, but she remained hesitant to apply effort to eradicating these flaws until she later hit what she describes as the “emotional bottom” that came with taking A.A.’s Sixth and Seventh Steps (which suggest seeking the support of one’s higher power in diminishing undesirable character traits):

Well, I again reiterate that [in] the Sixth and Seventh Steps the surrender became very necessary, just as much as the surrender of the alcohol. Surrendering sometimes not just one time; it’s the thing that I have to be willing to give up in order to keep . . . the quality of life that I have today. It’s very precious and I’ll do anything to keep that at any cost.
Betty indicates that she is referring here to giving up character traits which no longer benefitted her in sobriety, such as her need for control. To anyone who might mistakenly interpret that this process mystically occurs in an instant, Betty is quick to add, "I didn’t just go over night from a strong-willed rebellious person to becoming open to the will of a higher power." Betty stresses her belief in the connection between her personal growth and quality of life in sobriety and her willingness to continue to work A.A.’s Twelve Steps: "I call the 12 Steps a circle because you don’t ever end . . . I don’t ever end with one where it doesn’t revert back to another." This belief that the 12 Steps are cyclical and on-going is a unifying characteristic of the participants in this research.

Although Betty would appear to be the very personification of serenity and peace of mind today, she shares another notable characteristic with this research’s other participants; she does not take her quality of life for granted:

How easy it would be especially as old age sets in, to sit back and rest on my laurels . . . I’ve been around long enough to see what happens to people that have done exactly what there were thoughts that I could do. And I have to say, even though I still talk to some people that say they never go to meetings, I can’t believe they have any quality sobriety. I’m a firm believer that my old traits and character would come back in a heartbeat if I didn’t stay level with A.A . . . As I said, it’s a journey. It goes on and on.

Contributing Factors to Quality of Life

First and foremost among the contributors to Betty’s quality of life is prayer. Though she says that she has gotten out of the habit of reading daily meditation books, she still has a time of meditation which she describes as her “morning ritual.” These are daily activities for her. On a weekly basis, she attends an A.A. meeting which focuses on the 12 Steps. She attributes the fact that she is not attending more
meetings to her unwillingness to drive at night. Nevertheless, meetings serve as a renewing force in her recovery:

When I see . . . new people . . . that come in, I can see the desperation in their eyes and then see them open up like flowers. It just reaffirms my belief in a higher power, number one, and number two, that this is a people program . . . it's always been a “we” on all the Steps that we take.

She is referring to the inclusive language of A.A.'s Steps; all of them either begin with the word “we,” or are written in a plural form. One of the keys pieces of the interactive aspect of Betty’s recovery is sponsorship. She notes:

It means an awful lot. Certainly in the beginning of having someone who cares. Not about unimportant things, about whether I get in and stay in recovery. And that continues to be what I do when I sponsor gals.

It seems that Betty has developed a keen awareness of when she could benefit from attending an A.A. meeting. When I offered this observation for her consideration, she responded:

Exactly. Just like if you need some kind of medication for some kind of physical condition. It’s like I know when to take my medicine. And I don’t fail to do that. I’ll force myself to do that to get out of any negativity that I may have experienced for more than one-half hour.

Betty has been in recovery long enough to speak freely of the many pleasures of enduring sobriety. She enjoys walking for a half-hour each day (and listening to the birds!). Due to being retired, she now has time to have lunch and fellowship with her recovering and nonalcoholic friends. She speaks of the joys of working jigsaw puzzles and reading books. Time spent with her grandchildren is a particular source of pleasure. I suggested that it sounds like one of the benefits of consistently putting effort into the practices which have sustained quality recovery for Betty is the degree of balance she has found in most areas of life. Betty reacted to this hypothesis by saying, "Exactly . . . Comes the time when I’m starting to think poorly, I will go to a meeting."
The Role of Surrender

As indicated in the preceding “Continuity of Recovery” section, Betty had a profound experience of surrendering her will (or, as she puts it, the idea that “my way is better”) when she began to apply A.A.’s Sixth and Seventh Steps in her recovery. It was then that she began to see the need for her to surrender much more than simply her drinking (i.e., her character “defects”), if she was to enjoy a reasonable quality of life as a sober person. She echoes the belief which other participants have previously expressed that surrender is an ongoing process; in fact, she says, “It has to be.” When asked if she could cite some typical daily situation that might require surrender, Betty replied, “When somebody reacts . . . or acts in a way that I don’t like, I have to realize that I’m not the boss, and I have to surrender the idea that my way is better than somebody else’s.” She most regularly struggles with the issue of surrender when it involves “trying to know all the answers in one relationship or perhaps maybe two. And expressing opinions when none are asked for.”

One of Betty’s most significant moments of heightened awareness as to the importance of surrender came when she realized that in order for her to move forward into contented sobriety, it was going to be necessary for her to be open to learning all that she could from others about sustaining recovery. It struck me that this must have seemed like a tall order for a self-described “rebellious” person. Nodding her head in agreement, she allowed that

I believe it is. It’s surrendering to a new way of life. You couldn’t have told me that in early sobriety . . . And it continues to be absolutely primarily the thing that is one of the keys to this program. And you couldn’t tell a former fighter that surrender was going to do anything for my life, but the paradox again is that you have to surrender to win.
These precise words were also employed by Susie in regard to surrender; with notable consistency, other participants have used similar language when describing the importance of this paradox.

**The Role of Spirituality**

Perhaps more so for Betty than for any of the other participants in this research, the journey to spirituality began from a point of nonbelief:

I was never taught about one [a higher power] and I was an atheist before I hit my bottom. What transpired was through the people I became dependent on a power greater than myself. And I think through being able to see that people have feet of clay and that as I had sponsors move away or what have you, my dependency started to transfer from people, slowly into knowing I'm not walking alone.

Betty clarified for me that, although she does not need to be with other people today to feel the presence of her higher power, she still experiences a great sense of spirituality when in an A.A. meeting: “How can you not believe when you . . . walk into a room and you see all these happy faces and you know that a power is certainly working, not only in my life, but theirs as well.”

In a manner reminiscent of Susie’s earlier observation that, for her, “pain is the touchstone of spiritual growth,” Betty commented:

I believe with everything that’s in me that I have learned more about my higher power through the painful experiences than I have through any of the good times. If nothing else, I’ve learned that, number one, I’m not the boss.

A pattern is beginning to emerge from such descriptions: the first stirring of spirituality in the recoveries of these participants occurs with personal devastation (the “bottom”), followed by a willingness to entertain alternate points of view (particularly regarding how to not drink), and the willingness to implement suggestions gleaned from interactions with other successfully sober persons. The
successful results of those actions for these participants seem to generate a sense of belonging and identification with early recovery mentors.

For all the certainty that Betty brings to her estimation of spirituality's continuing importance to the enhancement of her quality of life in alcoholism recovery, she finds that adequate words elude her when trying to describe spirituality more concretely:

As I said, this is a continuous thing. It's a necessary thing and certainly has everything, at least for me, to do with any kind of recovery. But to put words as to who I believe, how I believe, and where and when I believe, I couldn't begin to put words to that. It just happens. It's internalized. I know it is.

The Role of Alcoholics Anonymous

From the earlier references that she made to her A.A. participation, it is apparent that Betty values her A.A. experience highly. She does not believe that she could have achieved the quality of life that she enjoys in sobriety without it. Both Betty and Marsha have been members of A.A. long enough to see some changes in the way A.A. conducts itself in their localities. In Marsha's case, she noted that new members seemed, in her early sobriety, to be the recipients of more focused attention than she sees given to newcomers today. Betty thinks part of the reason she stayed on the first three Steps of A.A. for her first 3 years of sobriety was due to the fact that there were no "Step meetings" in her area. These are A.A. groups which devote entire meetings to discussions of one of the Steps exclusively. These meetings tend to run in 12-week cycles, working their way through the 12 A.A. Steps, and then beginning the cycle again. When she discovered Step meetings, this helped her to gain an in depth understanding of the benefits she might accrue through work on particular Steps. A Step meeting remains a part of her weekly routine to this day.
When speaking of the healing process of the 12 Steps, Betty says, "It's a great paradox of the A.A. program of getting into self. And then getting out of self." When I questioned the meaning of this, she explained that it is first necessary for the alcoholic to go through a great deal of admission, self-examination, and inventorying of not only one's addiction and its consequences, but the character traits that one possesses (both positive and negative). It is from the self-awareness gained through this process (comprising essentially Steps One through Seven), that one is prepared to become accountable to other people for harm done to them when one was drinking. This signifies the shift from being "into self" to getting "out of self." It is in the remaining Steps that recovering alcoholics start to shift the focus of their attention to helping other individuals seeking recovery. As Betty points out, the ability to effectively sponsor people is a natural outgrowth of this endeavor. In Betty's estimation, working Steps Four through Seven prevented her from returning to drinking. Instead, she embraced an opportunity for growth which has sustained and enriched her till this day. I wondered, in fact, if her decision to move forward with the Fourth Step after 3 years of sobriety didn't represent a personal bottom, of sorts. She answered:

Oh, exactly. Exactly. And probably more painful than the physical bottom of the beginning of my recovery . . . After I rested on the Fifth Step, I had a feeling of relief. Just complete relief, because I found out in the Fourth Step certainly, who I really was. It's like finding an identity that I never had had before. Something that was meaningful to me as far as, my God, this is what I've always been. And it was like taking a mirror inside and looking at these things. Now to any normal person out there I suppose this wouldn't be a big deal.

Betty is a believer that the "Promises" of A.A. (see Appendix G) are a fitting preview of what quality of life in recovery holds. She is insistent, however, that their realization depends upon one's prior efforts: "I had to be free of all those things
[undesirable presobriety behaviors] in order for the Promises to happen in my life.
And I’m firmly convinced that they won’t happen until the first nine Steps are taken.”

Would it be possible, I inquired, to specify one of those Promises that she has seen transpire in her own experience? She answered, “I think [it was] intuitively knowing how to handle situations that used to baffle me . . . I began to recognize that every problem has a solution. Even though it may mean doing nothing . . . And that’s when that started to happen.”

The Importance of the Alcoholic Identity

Betty is of the opinion that in order for her to continue to enrich the quality of life that she enjoys in recovery, she needs to continue to foster her awareness of her identity as a recovering alcoholic. She has been in recovery long enough to see people who have been sober many years become complacent and eventually get drunk. Of this phenomenon, she comments,

It reaffirms my belief that I need to go to meetings to continue to have the quality of life that I have and to be responsible if anyone anywhere needs to be helped . . . Just not drinking certainly doesn’t give me any hope about dealing with the things that really caused my disease. . . . I couldn’t even visualize just not drinking. That emptiness and that hole had to be and continues to need to be filled with all the positive aspects of the program of A.A . . . But I’ve been disciplined . . . to use my medicine, as I’ve spoken about before. Of using the tools of recovery.

Misunderstandings About Recovery

Strong opinions are held by Betty regarding the factors that are involved in some alcoholics (but not all) achieving satisfying recoveries. It is in regard to these matters that she feels misunderstanding (among nonalcoholics) exists:

There used to be a saying around the program that never deprive a person the right to suffer. Consequently, I don’t believe in interventions and I’ve tried to
interrupt a lot of drunks and failed miserably. And you just have to let go and let them suffer. And some make it and some don’t.

I questioned if this view of Betty’s was not gained through her own frustrations with trying to help people who weren’t ready to receive it. She commented that she arrived at this opinion only through experience. Nothing I’ve read in a book. It’s having witnessed life and seeing and believing with everything that’s in me that this is the way it is . . . I’ve seen people die of this disease. I’ve seen wet brains. I’ve seen many, many things that make me know that I do have a disease, . . . but until someone learns from their own experiences, this way of life would be meaningless.

Priorities in Recovery

As we neared the end of our first interview, I gave Betty (as I did all other participants) an opportunity to prioritize what has led (and continues to lead) to her acquisition of quality of life in recovery today. She offered the following thoughts:

I was taught that this is a mental, spiritual, and physical disease. And I think putting priority on any one of those three for me would be the spiritual. That’s the slowest process of them all. The physical gets better fairly soon. The mental, it takes awhile because it takes working through those Steps to get that readjusted somewhat. The real insane stuff pretty well stopped when I stopped drinking, but the thought processes continued on, just not acted out. But I would say above all the spirituality.

Betty does not consider herself to be engaging in old “thought processes” today, for the most part. She believes, however, as do others cited earlier in this research, that if she did not continue her commitment to recovery activities, she could, at some point, be inviting their return. Her declaration that alcoholism is a disease with three components continues the unanimity that previous participants have expressed on this point.
General Observations and Reactions Noted in Interview Number Two

When Betty and I met for our second interview, I asked her, after she had reviewed the transcript of our first interview, if she found it to be accurate. In response, she said, "Yes it is." Additionally, I wondered if there were any areas pertaining to her quality of life in alcoholism recovery which she felt that she had omitted or slighted in her earlier remarks. She answered:

I think not. As I reviewed it, I covered . . . just about everything that I would ever have dreamed of covering actually, on my own. What I maybe didn't stress enough is the value of sobriety, number one. None of this, absolutely none of this would have been possible . . . without sobriety one day at a time.

Although I had perceived her to be articulating this point quite well, I was happy to note her observation.

As could be ascertained from Betty's comments in the "Priorities in Recovery" section, she considers her concept of spirituality to be of the utmost importance to her quality of life. Hence, it would be the Invariant Constituent (Moustakas, 1994) of her recovery process. Her view of spirituality, as is the case with other participants, however, encompasses other horizons of the experience (Moustakas, 1994) of quality recovery. To clarify my perception of this point, I noted that, "You went on to say that spirituality followed by surrender of the will to the higher power are key to recovery." Betty affirmed this with a soft-spoken "Yes." So it is that surrender is integral to Betty's experience of spirituality.

Betty's reliance on spirituality and surrender today are all the more remarkable in view of her former atheism. By her own admission, the struggle to give up control in daily struggles has not always been easy. Betty was especially candid about the difficulty she faces in maintaining an appropriate distance from the affairs of her alcoholic son's family:
I was weary with what I ran into recently with the family situation and so I didn’t intuitively know how to handle that situation for several “24 hours.” More pain than I have experienced in a long time before I’m in prayer and meditation, and came to understand that there is not a solution to all problems. Or, if you will, to choose the solution to do nothing.

I was struck by the degree of self-knowledge Betty was acknowledging, and was intrigued by the process she followed. To follow up on this, I asked, “I’m interpreting here. So even though it might not have seemed as though you had an answer at hand, you knew of something to do that would help you walk through this situation? To cope with it?” Betty responded: “Yes. Yes . . . That’s one of the many gifts this program offers us. To be able to do that. To know again, maybe intuitively, that these are the solutions. Now, I must be willing to use them.”

Kathy

Kathy is a 36-year-old Caucasian woman. She is married, with children. Although she is not employed at this time, she works in her home attending to her family. She holds a Master’s degree. She identifies her own religious denomination as Episcopalian, although she indicated that she enjoys attending the Catholic Church along with her husband and children, who are Catholic. Kathy has been continuously sober for 16 years. Her entrance into recovery occurred through a treatment center for chemical dependency. Since being treated, she has attended Alcoholics Anonymous on a regular basis. She describes herself as cross-addicted, although she focuses her recovery efforts on her alcoholism, which she considers her primary addiction. The focus of these interviews with her centered on her alcoholism, as well.

By a considerable margin, Kathy is the youngest of the participants in this research. She became sober at the age of 19. Among the participants in this research,
she is not the person with the shortest period of sobriety. That would be Charles, whose results follow; he has been sober 14 years.

Quality of Life: General Observations

Kathy displayed an unmistakable enthusiasm for the quality of her life today in recovery from alcoholism. As was the case with the other participants in this research, she credits her recovery with having made possible the many things for which she readily expressed her gratitude. As she commented on these things, I was aware of hearing a somewhat younger person (than the other participants in this research) savoring the opportunity that she has been given to lead the sort of a healthy lifestyle that one might expect with a person of her age:

I would say the quality of life that I have today is excellent. Everything that I have in my life is a result of my sobriety and that would include being able to finish my education, being able to enter into a quality relationship and get married and have children, as a sober person. And, most importantly, providing a happy, healthy home for my family. Just basically being what I consider to be a stable and positive role model for my kids and my husband and generally being able to contribute to society.

While Kathy spoke in detail about the things she continues to do to stay sober, it is noteworthy that she emphasized under this general heading her pleasure at being able to be integrated into the world. Due to the strength and quality of her recovery, she is able to go where liquor is served today (when the occasion calls for it) and feel comfortable. Her comments throughout these interviews evidenced her pleasure at feeling personally “settled” in her own identity:

I have a lot more self-confidence. I’m more emotionally stable, and I’d say my maturity level is greater. Just my reaction to daily events and people in situations has become calm and peaceful. And that’s the best way I can describe it.
Continuity of Recovery

There is no doubt in Kathy’s mind that the quality of her life has improved as she has remained sober through the years:

It’s definitely a continuous process. Over the period of years, I’d say the first year was definitely the most difficult and that really pretty much set the tone for the years following . . . After the second year then, . . . my actual sobriety wasn’t difficult, I’d say learning how to deal with life became a learning process.

Yet again, a participant is noting the journey toward dealing with life “on life’s terms,” and the critical link which that holds to experiencing one’s life as being one of quality.

A number of milestones occurred for Kathy around her fifth year of sobriety. She completed her Master’s degree and got married. She moved away from her A.A. home group where she had gotten sober; when she and her husband moved she got a job. This was a critical juncture; as Kathy puts it, “that pretty much started what I consider to be my adult life.” A year later she had her first child. In her first 2 years of sobriety, she attended two or three A.A. meetings per day. After completing school (when she had achieved about 5 years of sobriety), she lowered her attendance to three to five meetings per week; today she attends one or two meetings per week, and is not comfortable falling below this quota.

In many ways, the template for the “true” personality Kathy discovered began to be in place around 5 years in her recovery. Of this period, she recalls:

I think by the time I had reached that point, I had definitely had a profound psychological change, as it describes it in the A.A. literature. And after that . . . in small increments I probably became more emotionally stable and able to handle life as . . . just problems.
In a manner similar to previous participants in this research, Kathy describes the process of first becoming aware of, and then acting upon the negative personality traits which characterized her drinking years:

I would say dishonesty probably [was] . . . the most obvious characteristic; not only did I become aware of those characteristics, but they began to change in that when I participated in those behaviors, I was uncomfortable; . . . today those things don’t even enter my mind. They’re not an option. But I would say that the way I look at the world completely changed . . . as a drinker and in early sobriety, I was an extremely self-centered and selfish person. And I have heard that described in many meetings, that self-centeredness is the root of our problems . . . that has changed dramatically. That I think about people around me.

Kathy is reiterating what has been a consistently expressed self-description of these participants; they have been transformed from being self-centered individuals to having a focus on others.

One of the most important passages in Kathy’s attainment of quality of life in sobriety occurred approximately 4 years ago, when she had been sober for 12 years. Two members of her family, her father and her grandfather, both of whom to which she was very close, passed away within a year of each other. Kathy’s description of these events is poignant:

So I had 12 years of sobriety to develop and mend the relationship with these two individuals. And they saw my progression from the state I was in when I was drinking, and basically they considered me unsalvageable as a person, to someone who was able to get through school and succeed in life in a way that they considered important . . .

As she offered these observations, Kathy called to mind comments on the meaning of personal loss made earlier by Dave and Susie. Kathy has provided yet another example within these results of a recovering person who has found that within the cathartic experience of the deaths of those close to her was a meaningful gauge of her gratitude for the quality of life that sobriety has permitted.
Kathy has generally felt that her quality of life in recovery has continued to improve through the years with consistency. There was, however, one period she recalls during which she felt stuck. This occurred, by her estimation, at about 8 years into her recovery. She began to experience anxiety attacks again, which had plagued her prior to and during her early recovery. She felt an "emotional crisis" building, but she could not figure out why; in an effort to understand what was happening to her, she met with her sponsor. As she told her sponsor, she was going to A.A. meetings. She thought she was working the 12 A.A. Steps. What her sponsor suggested to her, though, was that Kathy needed to begin to employ the "maintenance" Steps (Numbers Ten through Twelve) on a daily basis. The explanation Kathy offers of this process is insightful:

I daily take an inventory and instead of as in early sobriety, and going through my Fourth and Fifth Steps, where I had to do this inventory which was pages long and years of crap, I needed to keep up with my house cleaning on a daily basis [through Step Ten]. And make amends and take care of things as they happened. Not let things build up . . . And then the Twelfth Step, which is to carry the message to other alcoholics and practice these principles in all my affairs, which is kind of a neat and tidy way of saying I need to help other alcoholics. I need to give away what I've been given. And I basically need to work the program in everything I do. All that kind of puts things in perspective for me.

The point that Kathy is making here has been expressed previously by other participants, but it is critical and bears repeating. These so-called maintenance A.A. Steps have provided the on-going mechanism by which the participants in this research have consolidated and enriched the quality of their recoveries. These Steps, when worked by these individuals with consistency, allow these recovering persons to benefit from the hard-earned self-awareness and personal work inherent in the earlier Steps; not only do these people benefit from this knowledge, however, but their work with newly recovering people allows them to share their wisdom. This is
exactly the process that Betty earlier referred to when she spoke of initially “getting into self,” in order to be able to later “get out of self.”

**Contributing Factors to Quality of Life**

In a general sense, I interpreted that Kathy’s daily focus on Steps Ten through Twelve motivates her to “practice these principles” in all her affairs. Therefore, each day, for her, involves the application of principles gained through A.A.’s Steps to all areas of her life. When I sought her response to this view, she commented:

Oh, definitely. And that’s one of the concepts in A.A. . . . that I will practice these principles in all my affairs . . . And so alcohol today isn’t a problem for me. So today the quality of my life is dependent on the A.A. program.

Could it be said, I wondered, that quality sobriety, for Kathy, means daily putting active energy into recovery? “Yes, very much so,” she replied.

Specifically, Kathy rates her spiritual life as the most vital daily contributor to her quality of life:

I’m very disciplined about my prayer life in the fact that I feel I have a pretty good relationship with my higher power which I consider to be God. And I’m diligent every day to thank him for my sobriety and to pray for my sobriety for the following day.

In descending priority, Kathy describes A.A. meeting attendance as the next most important contributor to her quality of life. She attends at least one meeting regularly each week:

And I’m more comfortable if I attend more than one meeting a week. And that’s kind of a conscious decision that I’ve made and probably have continued with over the last several years. Just because of my family’s schedule. But that’s without fail.

Tied in with her A.A. meeting attendance is Kathy’s commitment to service:

Service work is a big thing in A.A. and one of my foundational . . . one of the things that I promised myself that I would try to live, in especially my early
sobriety, but has continued on, is that when asked to do something in A.A., some type of service work, if I possibly could do it, I wouldn't say no.

The Role of Surrender

If there is one personality trait that the participants in this research have used to characterize themselves with resounding consistency, it would be the need for control. These individuals have clung to the notion that, first of all, they could control their drinking; this took some individuals nearly to the point of death. Upon achieving sobriety, they have discovered that this need for control was pervasive in their lives, and yet, an obstacle to satisfying sobriety. The far-reaching implications for the concept of surrender in quality of life in alcoholism recovery then begin to become all the more apparent. Of this phenomenon, Kathy observes:

My understanding and my personality, I think, fits the model to a T. That I always wanted to be in control. And I don’t want anybody else to be in control, I don’t want God to be in control, I want to plan my life and I want it to go the way I want it to go. And I have found that the way I want things to be is not necessarily the way they should be and... typically they don’t work well that way. So I have had to learn to surrender. I’ve had to surrender my will and I’ve had to surrender my control. And usually what that means is that I have to pray about it... and actively and emotionally let go of things. And in that process believe and have faith that when I let go it’s going to be O.K. And it always has been...

The question arose, once again, if it would be possible for an alcoholic to reach this point of being ready to make a gut-level surrender until that person had hit, what was for them, the “bottom.” Kathy believes that this is not possible. She has also observed that people’s bottoms have involved both greater or lesser degrees of personal loss and devastation than she herself has endured:

... and this gets tricky because as a member of A.A., I’m not really supposed to judge other people or their sobriety, but... you kind of get an idea of who’s having a good time and who’s not. And those people who don’t seem to have really hit a bottom are not having a good time.
The Role of Spirituality

As imperative as Kathy considers spirituality to be in her acquisition of quality of life, today, it is worth noting that, although she grew up attending a church, she, like other participants, did not develop a personally meaningful sense of spirituality until she began her recovery from alcoholism. Regarding her spiritual development, she said the following:

As I grew up I went to church. I never really got it... I never really had what I would consider spirituality or an understanding of God, until I came into A.A. My spiritual life consists of prayer and what I consider to be a conscious contact with God. Basically acknowledging to myself and anyone who asks me that God has given me everything that I have, including my sobriety, and all the credit goes to him... when I came into A.A. I think I kind of had a rebellion against God. I had to choose a higher power and... it wasn’t going to be God. I wasn’t going to have anything to do with God.

Kathy’s eventual designation of a higher power was an unusual choice. She picked her grandparents. Her reasoning for this decision was clear, however. Despite having strained relationships with others during her drinking, Kathy’s grandparents housed her and took care of her physical needs in her first year of sobriety. As she puts it, “They were there for me emotionally, they were very strong, very giving people.” This is a apt illustration of the many creative ways in which people have chosen to formulate a personal higher power. In time, Kathy was able to define a personal concept of God with which she was comfortable:

I think that is definitely a relationship. It’s not all just me expecting and believing and taking. I have to give credit. I feel that I have to give back in any way that I’m asked to give back. And I’m definitely more spiritually fit than I’ve ever been... It’s definitely a living, growing kind of thing that progresses over time.
The Role of Alcoholics Anonymous

Based on her previous comments, it would be easy to discern that Kathy places great importance upon her membership in Alcoholics Anonymous. She is in agreement with all of the other participants in this research that she could not have achieved her present quality of life without it. Moreover, she is sure that she simply would not be sober. She indicates that meeting attendance is something she expects to do the rest of her life if she plans to remain sober. Obviously, there is a continuing benefit for her in remaining a part of the A.A. fellowship. In reference to this commitment, Kathy comments:

I think the longer I go, the more leery I am of the warning signs that people over the years have told me . . . everybody I’ve heard in A.A. meetings, and I’ve gone to hundreds of A.A. meetings, that if they stop going to meetings they eventually go out and drink. And that scares me. The longer I’m sober I think the more aware of that I am.

Kathy feels that A.A.’s 12 Steps represent, to her, a “way of life.” She is convinced that she could not have continued to live her life as she had prior to recovery and remain sober. Simply not drinking would not have sufficed for Kathy: “I had to change everything about how I behaved and thought about things.”

Kathy is in agreement with the previously cited participants who feel that A.A.’s “Promises” have come true in her life. They have gradually unfolded, in her case. One of A.A.’s Promises states that “Self-seeking will slip away.” This is a process that Kathy has observed occurring for her most noticeably within the past 5 years of her sobriety: “I’m thinking about other people first. And that wasn’t always the case.” Her thoughts on why A.A. has positioned them after Steps One through Nine are intriguing:

When you get into the later Steps, there’s . . . action . . . that leads to what I referred to earlier as a profound psychological change. If I go through the
Steps where I take account of my personality and my behavior and how that . . . has affected my own life, and if I admit that those things are wrong and that I try to make them right and I try to basically clean my side of the street, then I can move on . . . If I’m going to be a happy, healthy, productive member of society, I can’t act like this [meaning, the behaviors inventoried in earlier Steps]. And I’ve known a lot of people who’ve gotten to that point and aren’t willing to do that for whatever reason. It’s painful. And those people, some of them have gone back out to drink and some of them have died. And that is a very . . . good lesson for me . . . basically, if you don’t go through that process and then come out the other side, the Promises are not going to come true.

Kathy’s degree of conviction on this point prompted me, in our second interview, to observe: “I am beginning to hear a theme running not only through your responses . . . but those of others, that this process of these first nine Steps seems to be essential to getting quality of life.” Kathy stated simply, “Yes. I would say so.”

Continuing on, she said, “Without A.A., it’s either not possible or not a positive thing. Not a good life. So I’m happy where I am.”

The Importance of the Alcoholic Identity

Each of the participants in this research has expressed conviction that remaining cognizant of their identities as recovering alcoholics is vital to their continuing acquisition of quality recovery. Kathy, who shares this view, is an example of a recovering alcoholic who feels that she has sufficient data from her own experience to prove to her satisfaction that she has the disease of alcoholism, and that she will need to continue to treat it for the rest of her life. She shared the following thoughts relative to this point:

I totally buy into the disease concept of alcoholism and believe it’s a spiritual, mental, and physical disease that I have all the symptoms of and that I’m not going to recover. The way I drank proved it to me. How difficult it was to not drink proved that to me. The way I can still think about alcohol on a daily basis proves that to me. And so . . . I have to go through the motions like a diabetic would have to go through giving insulin shots every day, and will never recover . . . my experience has been that there are some definite musts.
And one of them is to go to A.A. meetings. And so that I consider to be something that I will have to do for the rest of my life if I plan to stay sober.

I have sought to follow up with these participants about their consistent references to alcoholism as a disease with physical, mental, and spiritual aspects. How is it that this concept has come to hold such prominence for Kathy and the other participants? Kathy offered these thoughts:

I think that over time you come to believe it. I mean, it’s not something that you can just go to therapy and have your emotional and psychological problems treated like a lot of other problems. So that’s probably where you get the phrase.

In an effort to further clarify this point, I asked of her, “So it’s something [the belief in the three-part disease] that you’re introduced to in A.A., but it’s something that acquires personal meaning for you?” “Right,” replied Kathy.

**Misunderstandings About Recovery**

When Kathy was speaking about what she perceives to be people’s misunderstandings about quality of life in extended alcoholism recovery, I had the sense, as I had with prior participants, that she relished this opportunity to expound on some of these views in a “scientific” forum which is separate from recovery-oriented settings. Her personal experience with medical misunderstanding of alcoholism is revealing:

People outside the program don’t get it at all . . . I have yet to run into someone who’s not alcoholic who understands what sobriety means and what it means to be an alcoholic. You just can’t tell someone that. My grandfather was a physician, and he was probably the smartest person I’ve ever known . . . very interested in understanding anything he could. And I remember him telling me I have a long genetic history of alcoholism . . . on my mother’s side . . . I lived with my grandparents for 4 years after I got sober. He had read several books about it and he said, “Well, when are you going to stop going to these meetings?” I mean, this is a doctor who’s read what he can about alcoholism, who knows my family history . . . And I said, “Well, I hope I never stop going to these meetings.” And he was perplexed.
He just didn’t get it. And that was really the most striking example to me of what the misconceptions are. People don’t get it.

It could be said that, in spite of this fairly discouraging view that Kathy takes of the nonalcoholic’s potential for understanding her beliefs, she retains enough optimism to be willing to participate in this research, which, after all, will be read by nonalcoholics.

Priorities in Recovery

As we began our second interview, I shared with Kathy what I had interpreted as her priorities in recovery. As I had earlier perceived her to be saying, she stated that for her ongoing recovery she most values her relationship with her higher power, and the sense of spirituality that provides. A.A. meeting attendance and service work to others in recovery are the activities which would be just below spirituality in importance to her. In order to verify the accuracy of these interpretations, I asked, “Those are my initial thoughts on the themes you are expressing. Any reactions to what I’ve said?” “No,” said Kathy. “I think that’s very accurate . . .”

The Role of Therapy

Kathy is one of the participants in this research (along with Dave and Charles) who received some therapy which dealt with her alcoholism. Unlike Dave and Charles, Kathy had already been sober for some time. She did not seek therapy specifically for her alcoholism. I asked her how it was that the topic of alcoholism arose in her therapy:

When I was in about the second year of my sobriety, I really was having trouble with anxiety and depression. And I saw a psychiatrist probably for
about 6 months and that was part of my case history to explain where I was. . . . he tried to put me on anti-depressants and I just said, “You know, I just think I’d rather not.”

I asked Kathy if she thought this doctor had been supportive of her alcoholism recovery, and she replied, “Yes, I mean, he was like great, good for you! Going to A.A. meetings, that’s important.” Having her doctor promote her meeting attendance made a positive impression on Kathy. In contrast to the rather pessimistic view Kathy earlier expressed (under “Misunderstandings About Recovery”) about the medical profession’s ability to grasp the meaning of alcoholism, she believes that her particular doctor did understand the process of recovery. Moreover, she does not believe that there was anything he could have done differently or more effectively that would have been a further support for her recovery.

This is an encouraging example of a mental health professional’s ability to provide effective treatment for a client which is conducive to that client’s ongoing alcoholism recovery. Her alcoholism, of course, was not the primary reason why Kathy sought treatment. Nevertheless, her example is typical of many alcoholics who struggle with a host of issues (of both short and longer-term duration) which can be effectively treated by a mental health professional concurrent with on-going recovery. The fact that Kathy was already in her second year of recovery seems noteworthy. Her treatment would seem to exemplify the view of Brown (1985), that individuals with some accumulated recovery time possess sufficient insight to be capable of productive work as clients in therapy.

General Observations and Reactions Noted in Interview Number Two

The beginning of Interview Number Two with Kathy provided the opportunity to ask if, after reviewing the transcript of her first interview, she found it
to be accurate. She assessed it as being “very” accurate. At this time, I also inquired
if there were things in retrospect that she would have wished to add or clarify. Kathy
responded:

No, I really felt like it was very thorough. It seemed to really cover a wide
range of issues involved with sobriety . . . and quality of life. And I couldn’t
really think of anything to add. It just seemed like a lot of detail that I
probably wouldn’t have thought of without the right questions. So it’s very
thorough.

Kathy offered some further personal reactions to her first interview transcript:

It was kind of . . . well, I wouldn’t say startling, but it was profound to me to
read sort of the progression, you know? When you’re talking to people about
your sobriety and most of the time that’s with people in A.A. that you’re
getting to know. But you kind of have little snippets of time periods and it
was very interesting to me to have such a wide scope of the information that I
had never really thought about in quite that large terms. So it was very
interesting. I appreciated it.

While most of her second interview involved my checking the accuracy of
what I perceived to be critical points that Kathy was making (all of which are
conveyed in the preceding sections), we did revisit the topic of spirituality. As she has
emphatically stressed its preeminent importance in her sobriety, it should be
considered the Invariant Constituent (Moustakas, 1994) of Kathy’s quality of life.
Kathy’s journey to a personal concept of a higher power is not unlike that of Betty,
who built a sense of spirituality from the ground up after achieving recovery. I shared
with Kathy some of the comments other participants in this research had made about
the importance of spirituality, and her reactions are worth noting:

It [spirituality] wasn’t emphasized at the beginning and it wasn’t something
that came right away. In fact, I think that people tend to be nervous about the
concept of God when they come into the program. I know I certainly was.
And it’s not hammered and you just kind of get it along the way. For people
who have been sober for a while, to say that’s 90% of it or that’s the most
important thing is interesting to me.
Kathy's lengthy sobriety enabled her to contribute to this research a degree of experience and wisdom that is largely in accordance with the views expressed by other participants. However, when one considers that she commenced this period of sobriety when she was barely out of her teenage years, it is remarkable achievement. It speaks to the wide-ranging applicability of the principles of recovery which she has employed which have afforded her quality of life. She clearly is a woman who, with so much of her life yet ahead of her, exudes gratitude for her opportunity to further embrace the principles of recovery which, thus far, have served her so well.

Charles

Charles is a 55-year-old Caucasian male. He is a divorced father. Charles is employed in the publications division of a university. At an earlier point in his life, he taught English. Charles’ education extends through a Master’s degree. He is a practicing member of the Catholic Church. Charles has been continuously sober for 14 years, which is the briefest period of recovery among any of the participants in this research. His only addiction is to alcohol. Charles’ recovery has occurred through his participation in Alcoholics Anonymous, although, prior to his beginning recovery from alcoholism, he did receive some counseling through his place of employment which was related to his drinking problem.

Although Charles is the last of the 8 participants in this research to be discussed in these results, he has provided one of the most powerful examples of triumph over challenging circumstances in his life. This refers to events he has faced while sober. Like Marsha, Charles is a cancer survivor. Additionally, he has had a heart transplant in recent years of his recovery. When he speaks of the quality of his
life today in sobriety, there is no mistaking his enthusiasm for his alcoholism recovery.

**Quality of Life: General Observations**

Charles describes the general quality of life that he has in sobriety today as being "nothing short of fantastic." In his description, life before he became sober was "horror." He says that word means a lot to him, because it reminds him of the stark contrast between his former existence and his present circumstances. He believes that he would not have "anything" if he weren't sober. His relationships with his family and friends are a particularly satisfying measure of quality of life for Charles; he has "restored" his relationship with his former wife and children (who live in his town). Additionally, he believes he has "the best friends in the world. The most incredible people in the world, the most compassionate people, the most understanding, the most forgiving people are the people I go to meetings with. And do some socializing with." Charles provides a unique description of what he expects from life today:

There’s nothing that I need. There are things I want; I understand that I can’t have everything that I want. That’s a big new thing for me. That’s just because I’ve grown up here. I came in at age 41, I’m 55. But I haven’t had a drink in 14 years and the quality of my life is terrific. I’ve sustained a couple of serious health problems: bladder cancer and a heart transplant. I came through them both with the help of this program, the people in the program, my faith in a higher power. So for me to say that the quality of my life is great, somebody will say, “But you’ve been so sick,” or this or that. I don’t have any problems today.

As the preceding statement indicates, Charles (and other participants in this research) measure their quality of life, in part, by their consistent abilities to meet their basic needs, to be responsible, and to be able to develop and sustain meaningful relationships. Charles’ reference to having “grown up” in recovery recalls Melvin’s (1984) description of what she terms Stage Two in recovery. Like Kathy before him,
Charles has realized deferred developmental milestones (in, for example, career and relational areas of his life). The developmental progress of Charles (and other participants) in sobriety seems to exemplify Vaillant's (1995) description of the alcoholic in recovery as picking up from a point at which emotional growth became impeded by alcoholism.

**Continuity of Recovery**

Charles supports the view which has been expressed by the other 7 participants in this research that the acquisition of quality of life has been a process that has become enhanced through continued recovery. He comments that, "Yes, I think it's a process. Absolutely. I think it's an ongoing process and I think it's going to continue for the rest of my life."

One of the parts of this process that Charles recalls was his gradual realization that he was regaining the ability to recognize the feelings he was having. When he had been sober for approximately 2½ years, Charles expressed to some recovering friends of his that he was concerned about a confrontation that had recently occurred between him and his boss. They pointed out to him that he was experiencing fear. As Charles describes it:

They had to identify for me an emotion. I didn't even know it. I didn't have emotions... I would have loved to have felt the real great ones [emotions], but whatever I got was good because it meant I was alive. And I've been alive ever since.

According to Charles, learning to grasp the tools of recovery, particularly through A.A.'s 12 Steps, was not a seamless transition from drinking; it took time:

No, when I started it was like a class; like a test; like the desperate thing that I had to do to stay sober. Today it's just my life. It's just a very smooth part of my life. But at the beginning it was—I did it because I had to do it. I had to do it to be sober. And it worked. So... it's very different from the beginning.
to now. And it's just a natural, seamless part of my life. The most important part of my life.

There have been some pivotal events in the course of Charles' recovery that have enabled him to recognize how his relationships have become deeply enriched. In his words:

About 2½ years into sobriety I was diagnosed with bladder cancer. Got tremendous support from my groups. And then about 10 years into sobriety, I needed a new heart. They did a heart transplant. And one of the things they investigated was did I have a support group? I'm a single person. And what happened was, they saw, 140 miles away [in the hospital], a whole bunch of people, strange people, coming into my room. Visiting all the time. And I didn't give away their anonymity, but it was pretty clear to these doctors, nurses . . . , that these were fellow alcoholics. And they came, and the family, my former wife, and our children were all there too . . . Because I had worked at restoring the relationship with my family and I'd built up these incredible friendships—lifelong, with members of the program.

As Charles was concluding his remarks on the topic of the continuity of recovery, he noted some ways in which his values have changed with lengthening sobriety:

Well, my values today . . . I just want to do the next right thing. I want to be kind, I want to be decent. Because I wasn't those things and frankly, it's the easier, softer way to be good . . . My purpose in life is to help other alcoholics achieve sobriety. My purpose in life is to be decent, to be a very good man. It's very simple. My life has become much more simple.

**Contributing Factors to Quality of Life**

While the factors that Charles lists as being vital contributors to his ongoing quality recovery are familiar from the comments that other participants have made on this topic, Charles chooses to place his attendance at A.A. meetings at the top of the list:

The most important thing is going to meetings. And the meetings I go to are two or three a week. One Step meeting, one discussion meeting at my home group and maybe once every other week a Saturday night open meeting. Second most important thing is probably my daily prayer. And my prayers are
mainly a list of things I’m grateful for. Starting with thank you for the gift of sobriety. Thank you for the gift of faith. Thank you for the gift of hope... Just thank you for everything.

Charles is unique among the participants in this research in that he has placed A.A. meetings as being ahead of spirituality for him in the regular contributors to his quality of life. Charles’ view on this is that, “I treat the disease by going to meetings. I treat the disease by talking to other alcoholics.” For Charles, in other words, the contact with other recovering alcoholics is paramount in his recovery. Our second interview confirmed, however, that, as is the case with the other participants in this research, these factors are very interdependent. To illustrate this point, Charles hastened to add that service work to alcoholics, which he would rate just below the importance of meetings and spirituality, cannot be viewed as distinct from his overall commitment to recovery in A.A.:

I treat the disease by giving everything I’ve got in this program away... I’ll get more in return, and it’s absolutely the truth. I’ve gotten 10, 100, or 1000 times back anything that I’ve ever given. Anything. And so... that service thing is very important. It’s very important... for two reasons. One, to keep the fellowship going. Two... If I can keep myself focused on somebody else, I’m much better off than focusing on myself.

With the goal of clarifying the role of service work in his quality of life, I offered to Charles the following interpretation: “It sounds as though if you can keep your thinking oriented toward the service, the business of being sober, that keeps you in the frame of mind that you desire.” In response, Charles said, “Yes... I really believe that my higher power puts me number one so I can put every other person who He puts in my life number one and not worry about myself.” One way Charles maintains a commitment to service is through his role as a sponsor. He tries to sponsor one or two people “all the time.” He meets with his own sponsor every 2 weeks.
The Role of Surrender

Surrender is an act in which Charles say he engages on a daily basis: “Every
day I have surrender to my higher power and ask Him to remove from me any
obstacles that are in the way of my service to others.” The concept of surrender was
something that became comfortable for Charles relatively early in his recovery,
perhaps earlier than some of the other participants in this research. Charles indicates
that he came to believe very quickly in his sobriety that his personal concept of a
higher power was essential to sobriety. In view of this, he was able to “gladly”
surrender, knowing it would keep him sober.

Charles offered a unique example of how it is that he has found surrender to
be applicable to negotiating daily situations in a way that can contribute to his quality
of life in sobriety:

I surrender every day to the fact that it doesn’t matter what I think about so
many things. I formulated a thing with a guy that I sponsored, where he and
I—because of his anger problem and just because of other things—we
decided that on 24 out of 25 occasions he and then I also, as it turned out,
would not offer our opinion unless asked. And then we discovered that if we
didn’t do that on the 25th occasion also, things would be even more peaceful.
If we would just shut up and not get into something with our spouse, not get
into something with a friend, not get into something with a co-worker, just let
it roll off, . . . we would be much more peaceful and so would you . . . So
that’s surrendering to the idea that I’m not important.

What Charles is hinting at here, as well, is that he recognizes in these
situations that his ego does not need to be dominant. Charles has provided yet
another example of Tiebout’s (1954) views on the relationship between the
diminishment of the alcoholic ego and the act of surrender.

When we conducted our second interview, Charles and I revisited the topic of
surrender. I offered an observation from the first round of interviews with all the
participants: “As I’m hearing it, surrender, and some people wanted to clarify this for
me... surrender seems to be a big part of spirituality.” In response, Charles commented, “I would say that it is. And surrender is something people outside of this program have difficulty understanding... But I’ve had to learn to accept a lot. More than the average bear.”

The Role of Spirituality

Spirituality plays a crucial part in the maintenance and enhancement of Charles’ quality of life in recovery. He wanted to emphasize that the concept of spirituality which his A.A. participation has helped him to develop is “not religion.” Interestingly, he refers to it as the “most important” thing he has. In this context, he is referring, I believe, to the overriding aspect of spirituality which informs all of his recovery. Unlike the specific regular practices he uses to stay sober (meetings, prayer, fellowship), he is speaking of spirituality in more general terms.

After some consideration, Charles attempted to put words to this concept of spirituality, a task which has proved elusive to some other participants:

Spirituality is maybe peacefulness to me. Spirituality is living right, doing the next right thing, and I’ll repeat myself again, being a decent man. Spirituality means I’m not in charge. That there is a higher power. That higher power is not me, that higher power is no longer alcohol. That higher power is no longer an enemy of mine. That higher power is something that today I call God. And I respect everybody in A.A. who calls the higher power anything else. But it worked for me because it was part of me going back to when I was a kid, you know; I finally picked up what I was supposed to get.

The words Charles has chosen to describe his spiritual growth bear a remarkable similarity to other participants, most notably Kathy, who spoke of going to church as a child, but not being able to “get it.” In Charles’ case, he was able to adapt a pre-existing higher power concept (originating in his Catholic upbringing) to his new life in sobriety. He believes very strongly that the establishment of a
personalized higher power is central to surrender, spirituality, and quality of life in recovery:

When alcohol was ruling me, things were horrible. And so I have to just, as all of us do, ... find a power greater than alcohol or myself. I happened to have found it in God. Other people find it as a force, as nature, as anything. It does not matter. A.A. is not religious; it’s tricky, but it’s spiritual.

I suggested to Charles that he and the other participants seemed to be saying that spirituality has emerged as a major concept which characterizes quality of life in recovery; it is under this general idea that so many other aspects of recovery fall. His reaction to that interpretation was as follows:

It may be, but I don’t think anybody went looking for that. I think we all just wanted to quit drinking and leave hell. What happened has been so much better that, yes, spirituality has happened, but all A.A. says we’ll do for you is help you stop drinking one day at a time. The rest are great big bonuses.

This response further prompted me to inquire of Charles, “So this discovery of spirituality, again, is not due to A.A. pushing something on people, but a personal discovery?” To this question, Charles answered, “Yeah, I think it’s individual. Very individual. Yeah. I bet if you did another 8 people or another 80 people you’d get the same thing.”

The certainty with which Charles makes this last prediction is understandable. After all, spirituality does loom large in the experiences of quality of life in recovery for the 8 people who have participated in this research; whether spirituality retains this importance in the lives of people who have recovered from alcoholism through approaches other than A.A. is an open question.

The Role of Alcoholics Anonymous

In Charles’ view, as in the case of the other 7 participants in this research, he could not have achieved the quality of life that he enjoys in his alcoholism recovery
without his participation in Alcoholics Anonymous. Like many alcoholics, Charles tried for a long time to stop drinking unassisted. He says that he tried “100 times” to quit drinking on his own, although he acknowledges that this is an exaggeration. His point is well taken, however; from the perspective of Charles and the other participants in this research, every attempt was made to stop drinking through these persons’ own willpower. It was not until all of these attempts had proved futile and great pain had been endured, however, that these persons “hit bottom.” The time for surrender had arrived. Charles offers these comments on that process:

I couldn’t stop. I could quit but I couldn’t stay stopped. And so I needed the structure of A.A. I needed the groups. I needed the power of the Steps. I needed the principles of the program. A.A. gives me everything... I couldn’t have my life, perhaps, let alone the quality of my life, without A.A. When I was recovering from bladder cancer, I was living by myself. I had to wake up every two hours and do some physical things. Now, had I been drinking, I would’ve passed out, or whatever... I don’t know that I would’ve survived. I don’t know that I would’ve been considered a candidate for a heart transplant, which would mean I would have died...

Several participants have previously referred to their A.A. participation as having given them life; in Charles’ case, this claim assumes a particularly moving resonance.

The 12 Steps of A.A. (see Appendix F) are one of the primary mechanisms by which Charles devotes daily effort to his recovery. I made the observation to Charles, at one point, that he seemed to be implying that his use of the Steps is an ongoing, repetitive process. He confirmed this. For Charles, there is, in other words, no point of termination, or “graduation” in his working of the 12 Steps. I asked Charles if he could elaborate on this thought, and he made these comments:

I have to recognize every day of my life that I’m probably doing some of these Steps. Like probably working the Third Step when I ask my higher power to help me not take a drink today. Working the Third and Eleventh Step when I thank my higher power for helping me to not take a drink at the end of the day. Just generally asking God to take away whatever is in the way
of my service to others. I think that’s the Seventh Step . . . I worked the
Steps with my sponsor as a study kind of a thing, as I first came into the
program. I just work them now, every day. Just as part of my life . . . It
wasn’t until I started working the Steps of A.A. that I achieved some
semblance of peace . . . not drinking without A.A., which I did, was really
nenervous. It was fraught with peril. How’s that for a cliché? You can quote me
on that.

The working of these 12 Steps has, for Charles, gone from being an
unnatural, intellectual exercise, to an intuitive process which has integrated itself into
the rhythms of his daily life. It was impressed upon Charles that the 12 Steps are
most beneficial when one proceeds through them in order; their effects tend to be
cumulative. This is the central reason, Charles states, as to why the “Promises” which
are listed in A.A.’s “Big Book” (see Appendix G) are listed after the Ninth Step has
been completed. He offered the following thoughts on this point:

Yes, the Promises have come true for me. I think that they follow the Ninth
Step in the “Big Book” because you’re clueless until you get there. The Steps
have to be worked in order, I believe . . . I found it to be true with myself and
anybody else I’ve worked the Steps with. You have to get to a certain point
to even understand the Promises.

The results of this research have shown that each participant has had her or
his own unique experience of recognizing the attainment of some or all of these
Promises in their recoveries. How was it, I wondered, that Charles became aware of
the benefits of these Promises in his own recovery? In response, he commented:

I just knew that as I looked at what was going on in my life, things were
happening. I wasn’t afraid. I still had economic problems, but I wasn’t afraid
of them. I knew that I wasn’t afraid of the past. In fact, I wished to keep a
door open on it, as it says in one of the Promises . . .

The “medicinal” effects of attending A.A. meetings have already been referred
to be virtually all the participants in this research. Charles offers a particularly vivid
portrayal of what this feels like for him:

When I walk into the rooms of an A.A. meeting, no matter what has
happened in my day, what has happened in my drive across town to the
meeting place, I walk in the meeting room and I’m at peace. It’s a wonderful feeling.

The Importance of the Alcoholic Identity

Becoming convinced of his identity of a recovering alcoholic has been essential to Charles’ achievement of stable and lasting sobriety. Retaining his awareness of that identity has been essential in his continuing enrichment of quality of life:

Even 14 years later, it’s very, very good for me to be on the First Step at a meeting and talk about the horror of my life. And the things that I did, knowing that I don’t do them today. But knowing that I could in a moment go back to it.

Charles is able, as the other participants have been, to readily offer an example of the “horror” of his life:

I had not drank for a month. I went to celebrate it and tried to pick up this girl. That didn’t work. But I just got drunk. My friends took me, dropped me off at my apartment complex. I was wandering around there with my keys in my hand. The police came; I had no idea where I lived. I’m sure if I had been able to point out my apartment they would’ve opened the door and thrown me in. But they had to take me to jail. I couldn’t tell them where I lived . . . People have, over the years told me that I had a problem. I never heard it. I don’t think an alcoholic is ready until that bottom is reached. My bottom was waking up in jail.

It is evident as Charles recalls these events that they remain vivid in his memory; rather than causing his pain, however, the awareness of his “bottom” experience keeps him cognizant of his identity. It provides a stark contrast with the quality of life which he enjoys today in sobriety. It is also a reminder of the risk inherent for him in becoming complacent in his recovery. As he puts it, “I cannot tell you the number of times I’ve heard it said, and I so believe it, that people who don’t go to meetings don’t find out what happens to people who don’t go to meetings.”
Misunderstandings About Recovery

Charles expresses some frustration, as have all of the participants, with misconceptions that he feels exist about the quality of life that is possible in long-term recovery from alcoholism. He notes that for him, at least, the realization that alcoholism was a treatable disease was a positive discovery:

I tell other people, I was so happy to hear that alcoholism was an AMA approved disease and that I wasn’t a moral, just total reprobate. I did bad things but I wasn’t a horrible person and I don’t do those if I don’t drink. So, yes, I was very, very delighted to hear that this was a disease rather than a moral failing. And I’m not proud of what I did, but I did it, I’m responsible. I don’t do it anymore.

There has been a common belief expressed among the participants in this research that nonalcoholic individuals very often have difficulty grasping the recovering alcoholic’s point of view. Charles’ comments on this issue contain now-familiar sentiments:

I wish every person could have the opportunity to know the peacefulness I feel. I don’t know that any person that’s not an alcoholic could come to meetings of A.A. and understand it. And so I don’t know if what I get can be transmitted to somebody that’s not an alcoholic. I don’t know that at all. I wish that everybody could get the results of what I’ve gotten.

The frustration that Charles conveys at trying to express in words what quality of life looks like in recovery may, in fact, touch upon one of the most useful functions of this research. Through sharing their experiences, these participants have, indeed, effectively articulated what the concept of quality recovery means to them, personally.

Priorities in Recovery

When the end of our second interview was drawing near, I asked Charles if he wished to add any observations regarding what he saw as the uppermost priorities in
the attainment of quality of life in recovery. He felt very strongly about the aspects to which he had earlier referred: "I would say meetings, prayer, service." He did stipulate, however, that the effort required of him in daily living in order to achieve quality of life in recovery extends to virtually all areas of his life:

Recovery for me is the way I treat my co-workers, my boss, the way I live my life, the way I try to be a good son, good father, good worker. If I drank, I would get drunk, I would behave badly, and I don't want to behave badly . . .

The Role of Therapy

Along with Dave and Kathy, Charles is the only other individual among these research participants who received any counseling in reference to his drinking. Prior to his beginning recovery, Charles’ employer sent him to an employee assistance program, where Charles received some counseling which dealt with his use of alcohol. Charles saw this therapist for a period of about 1 month, during which time Charles says he did nothing but lie to him. As the result of his lying, says Charles, he was dismissed from the program. For a month, Charles managed to not drink. At the conclusion of this time, he drank again. It was after Charles had begun drinking again that he eventually wound up in jail, an incident which he previously referred to as his bottom. Charles recalled that his therapist had warned him of the risks of continued drinking:

Yeah, he had told me at some point in the month that we talked that what would happen to me if I was an alcoholic was that I would really do something bad at work and really screw myself up. And then this thing happened where I tried to go to this [business] meeting and I couldn’t get out of my apartment because I was so drunk.

I observed to Charles that, "It sounds like what the therapist had to say to you about kind of previewing or predicting that there would be these negative things happening . . . made an impression on you.” Charles replied, “Oh yes. It made an
impression because it came true. And those things had happened before but nobody had ever made the connection.”

According to Charles, after he had the experience of being drunk again (his “bottoming out” experience) after the month of not drinking, he immediately returned to the therapist whom he had earlier seen, and asked what kind of help would be available for his drinking problem. Charles went on to describe what he was told:

There was some program that was available, some classes about alcoholism, but it wouldn’t start until February. I said what do you have right now? He says, well, there’s A.A. So he . . . told me about some meetings. And for the first time it was revealed to me that he was an alcoholic. And he said why don’t you go to a meeting some time within the next week and talk to me about it on Monday. So I waited until the next Sunday night, 7 days later. I went to my first meeting.

It was striking to me that Charles’ therapist had only revealed his alcoholism to Charles after Charles had returned to him for help. When I commented on this, Charles said, “Right. And he only revealed that by saying . . . A.A. is available. I said O.K., tell me some more. He said, well, these are some particularly good meetings that I attend.” Regarding the predictions of negative consequences from his continued drinking that Charles’ therapist originally made to him, Charles commented, “Now, I don’t think he could have told me that if he was a counselor who was not an alcoholic . . . I don’t know whether counselors who are not alcoholics know what happens in an alcoholic’s mind.” In Charles’ estimation, the single most effective thing that his therapist did to facilitate his entrance into recovery was that he “just pointed me to a meeting.”

While Charles believes the treatment he received was uniquely effective because his therapist was himself a recovering alcoholic, he also wished to note the risk he believes is present for such recovering professionals:
I don’t understand how people who are alcoholics can be counselors and try to deal with alcoholism in their 8-hour work day and then try to work on their own alcoholism after work. And I’ve seen too many counselors screw up. They think that they’ve done their meetings and their A.A. work during their workday and they haven’t. All they’ve done is their job. It’s like the most valuable counselor for an alcoholic could be an alcoholic, but maybe to his own peril.

Charles shows considerable insight into the issues of self-care and boundary-setting with which recovering helping professionals struggle. Nevertheless, it seems that he did, at least by his own account, benefit greatly from his treatment at the hands of his recovering therapist. That particular professional apparently demonstrated an intuitive grasp of how far Charles’ drinking had progressed. The word “progressed” is critical in this context, because it indicates that Charles’ therapist may well have recognized that Charles was initially in denial (evidenced by his lying), and that he probably was not yet ready to quit drinking, or perhaps, to “surrender.” Charles’ therapist did, however, effectively communicate the potential consequences that could result if that progression were allowed to continue. This information was remembered by Charles; it helped to prepare him to enter recovery. It is an illuminating example of how an informed therapist (whether in recovery or not) can bring knowledge and awareness of alcoholism and its symptoms to bear upon a client’s treatment.

General Observations and Reactions Noted in Interview Number Two

After he had the opportunity to review the transcript of our interview, Charles declared, during the beginning of our second interview, that he found the transcript to be accurate. He went on to say:

I really enjoyed reading the transcript and seeing how much we had covered. I wouldn’t need to add anything . . . I was very pleased that what I thought I’d
heard myself say over the years, I said again. So, apparently, I’m telling the truth . . .

The early part of our second interview provided an opportunity for me to seek Charles’ feedback on the accuracy of some of the themes that I perceived as emerging from our first interview. I reiterated that he seems to judge his general quality of life in recovery by the fact that his needs (as distinct from his wants) are all met today. His reaction was, “I just have to say that I mean by that that I have everything that I need. I have shelter. I have a wonderful job. I have a family that loves me . . .”

I then focused on what I perceived as the other big themes of Charles’ recovery. Specifically, A.A. meetings, prayer, and service to others are the daily contributors to quality of life in recovery. He believes it is a process that will go on for the rest of his life, one day at a time. This process of recovery has happened because he is sober, and it is the most important thing in his life. Without it, he could not have handled the great health challenges he has faced (such as his cancer and heart transplant). Was I capturing the essence of these themes, I wondered? Charles answered, “Oh sure. Those would not have happened without me being in recovery, without me being sober.”

Among the changes that have occurred for Charles as his quality of life has become enriched with ongoing recovery is his transition from someone who (in early sobriety) was scared and confused to someone who appreciates letting people see his recovery. Generally, life has become more simple. Again I inquired if these significant themes that I was attempting to capture were being accurately rendered. Charles offered this response:

Yeah, it seems even more significant when you say it, life has become more simple . . . it was like I was a student studying. Just trying to get it right at
first. And now I’m just living it. And sometimes we say that we shouldn’t seek the easier softer way; that’s the way out. But for me, sobriety is the easier, softer way. It’s easier and softer to be sober and go through my life than to be drunk. It’s one of, to me, A.A.’s wonderful contradictions. I love the contradictions.

Given Charles’ consistent emphasis on the importance of the program of recovery that he has found in A.A., it seems that this would be the Invariant Constituent (Moustakas, 1994) of his experience of quality of life in sobriety. It is under this broad concept that the other horizons of the experience (Moustakas, 1994), such as spirituality, service, etc., can be found.

Near the end of our second interview, I shared with Charles (as I had with the previous 7 participants) selected quotes from the previous participants’ transcripts which were clustered around the by-now familiar themes which have emerged from them. In particular, Charles was fascinated that all 8 participants have cited prayer/spirituality, meetings, and service as the primary daily contributors to quality of life in recovery (although, in Charles case, the order of prayer/spirituality and meetings was reversed). Charles reacted to this information by stating, “Isn’t that wonderful? That’s powerful to have 8 people, 8 very different people in your study come to that conclusion.”

Charles’ story of alcoholism recovery and his view on what constitutes, for him, quality of life today are illustrative of the difficulty that arose in trying to provide a working definition of “quality of life” at the outset of this research. Charles’ recovery provides one of the most profound examples among these research participants of how one’s life experiences both prior to, and after the onset of sobriety, render the term quality of life extremely subjective. For example, having his needs met today is profoundly satisfying to Charles. That view may not be shared by many nonalcoholics. It may not be shared even by some other people in recovery.
from alcoholism. But then, that has been a primary goal of this research: to accurately portray this phenomenon of quality of life in long-term sobriety as it has acquired personal meaning for these 8 alcoholics.

Summary

As Charles was the last of these research participants to be interviewed, his thoughts upon hearing the similarity in some of the previous participants' selected quotes provide an appropriate observation for this summary:

I'm thrilled with the consistency . . . It's thrilling to hear the consistency in the person who talked about 7-year cycles. I've only got two of those. Two times seven, so I don't know about that but we each of us believe similarly and we're different people in many ways. Yet we were all hopeless drunks and today we're not. For you to have found so much consistency in the 8 of us is very remarkable to me.

That consistency is remarkable to this Student Investigator, as well. Given that all 8 of these participants are long-standing members of Alcoholics Anonymous, perhaps that should not be considered quite as remarkable, however. It might be expected that they would share a common vocabulary. It does seem noteworthy however, that these persons have assembled their personal approaches to recovery with considerable similarity. Some possible explanations for these similarities follow in Chapter V of this dissertation.

I am indebted to each of these individuals for the time and thought that they gave to these interviews. Each of these participants expressed satisfaction in their being able to be integrated into the mainstream of life, in which they interact effectively both with nonalcoholic people and others in recovery. At some point, they all also alluded to the occasional frustrations they have felt with misunderstandings about what it means for them to be recovering people. The level of consideration...
inherent in their interview responses speaks to the opportunity I believe these persons recognized to provide an accurate accounting of quality of life in recovery (in a neutral, non-A.A. forum). It is the hope of this Student Investigator that these results and their analysis can, in fact, contribute to the understanding of the experience of quality of life in alcoholism recovery.
CHAPTER V

CONCLUSIONS

Overview

This chapter contains general observations that the Student Investigator has made regarding the interview process and the results of this research. These observations will be followed by Composite Descriptions (Moustakas, 1994) of the research participants' results, Relational Meanings, Resentments and Anger, The Role of Therapy, Implications For Future Research, and Final Thoughts.

General Observations

The Participants

For reasons of practicality and expediency in choosing participants, this research purposively sampled from among members of Alcoholics Anonymous. This factor alone could, reasonably, be expected to introduce some degree of homogeneity in the results of this research. Undoubtedly, it is necessary to bear this factor in mind when considering the possible meanings of these results. This research was not designed to intentionally introduce diversity among its participants. Nevertheless, it does seem worth noting that there are some distinct differences among these participants. They represent several different chronological ages, different levels of education, and a variety of careers. Among these participants are people who are, or were, married, divorced, or never married. Some of these participants entered their
recoveries with little or no religious faith; others had existing religious beliefs. Great differences still exist between the levels of religious faith these people have. All, however, are deeply committed to a personal sense of spirituality. In spite of these apparent differences between the participants in this research, they were remarkably consistent in describing the factors that contribute to their perceived quality of life today in long-term recovery from alcoholism. Though the events of their lives which led them to recovery differed, they all wound up following paths to quality of life in recovery which have proved to be quite similar.

Consistency of the Research Results

All of the participants in this research indicated that they found the transcripts of their first interviews to be accurate. Additionally, when the participants were invited to react to the preliminary themes which the Student Investigator perceived to be emerging from those interviews, they uniformly judged them to be accurate.

Perhaps the most positive result of the interviews with the participants, however, was the consensus that emerged that the interview process had, indeed, been successful in capturing an accurate portrayal of their quality of life in long-term recovery from alcoholism. At the conclusion of the interviews, none of the participants felt that any vital aspects of quality recovery had been omitted. John, in particular, commented:

The scope of the questions was the thing that really took me by surprise. You asked me things that I had never been asked before and that was a little disarming. And probably good for me. And I don’t think there is anything that I want to change . . .

Kathy noted:

I couldn’t really think of anything to add. It just seemed like a lot of detail that I probably wouldn’t have thought of without the right questions. So it’s
very thorough . . . it was profound to me to read sort of the progression, you know?

The amount of detail to which Kathy refers is present not only in her transcripts, but in those of all 8 of the participants. The detail was so extensive, in fact, that only a fraction of it could reasonably be presented within the results of this research. The scope of the responses offered by these participants was vast; it is greatly appreciated, and it certainly contributes enormously to the value and meaning of this research.

A general definition of quality of life was offered in Chapter I of this dissertation. The difficulty in attempting to provide one definition of this term is illustrated by the General Observations these participants made about quality of life in recovery. All of these participants are enthusiastic about quality of life in recovery, and they gave thoughtful consideration to trying to offer their perceptions of what it means. Personal experiences of quality of life in recovery include, for example, the ability to listen to the birds and appreciate nature (for Jerry and Betty), the ability to finish school and raise a family (for Kathy), and the awareness of having one’s needs, rather than one’s wants met (for Charles). Several participants commented on how much it means to them to be responsible, to have health, to have choices, to have caring relationships with others, to have built a personalized relationship with a higher power, and to have a solid sense of self-esteem. John commented that recovery enables him “to have fun” in his life today. As one reviews participants’ statements about quality of life, it might be tempting to view comments such as Marsha’s that life is “Excellent. Superior. Perfect, I guess . . . ” as hyperbole. They are anything but that. After sitting with these participants as they reviewed the intimate details of their journeys in recovery, this Student Investigator experienced
descriptions such as Marsha’s as being profoundly heartfelt and sincere. Marsha’s comments exemplify the transformative effect upon the lives of these participants which has resulted from the cathartic experience of coming back from the brink of advanced alcoholism. Perhaps the ultimate measure of quality of life in recovery for these participants is that they enjoying being in the mainstream of life, interacting among people who are not alcoholic, as well as those who are in recovery. They are living (as several participants put it) “life on life’s terms.” Kathy, for example, noted her pleasure at being integrated into the world. Susie’s comments are particularly apt: “The main purpose [of recovery] is to put us back into society as productive, useful human beings.”

Continuity of Recovery

If there is one overarching theme that characterizes all of these research participants in their approach to obtaining and maintaining quality of life in recovery, it would be that they all, after many years in recovery, continue to actively pursue the same recovery-oriented activities in which they have engaged from virtually the beginnings of their terms of sobriety. These individuals are all still attending A.A. meetings, and are working A.A.’s 12 Steps. They continue to sponsor others, and they are still working with their own sponsors. They are still attending conferences and retreats. In other words, none of these people made a decision at some point in their recoveries that they were recovered (in the past tense), or that they were sufficiently satisfied with their sobriety that they found it no longer necessary to devote time to recovery-oriented activities. It should be noted that for years, none of these participants has had the desire to drink. They are not living an existence which shields them from the presence of alcohol. John’s observation about the ongoing
nature of involvement in recovery is applicable here: "I think you can stay sober and not do anything. But you can't enjoy being sober and not do anything." That these participants have found it necessary to continue to work on their recoveries is one of the points that they have expressed as occasionally being misunderstood by people who are not alcoholics. As Jerry has commented, in his perception recovery is not "an event." I believe that these participants have articulated this point well, however, in terms of the personal value that a continuing effort toward recovery has had toward their increasingly enhanced quality of life. The idea of continuing effort toward recovery is probably the single most significant finding of this research.

There was a consensus among these participants that they have learned the value of continuing to invest effort in recovery through experience. Marsha, for example, has been sober long enough to observe many people enter recovery, stop attending meetings after long periods of sobriety, and eventually relapse. Some of those people made it back to meetings, according to Marsha, and some have died. Her observation is not unique among these participants.

It could be said that these participants have done their own research regarding the differences between dryness and sobriety. Jerry and Susie, for example, both relapsed after a considerable period of not drinking. They discovered that they could not achieve stable, satisfying recoveries until they had truly surrendered to the fact that they were alcoholics, and were then able to benefit from the support and guidance of other recovering people. Betty spoke of being "stuck" on A.A.'s first three Steps until she reached a point of willingness to continue on with the other suggested Steps. It was through experiences such as these that these participants came to accept the disease concept of alcoholism; they discovered the risk inherent (for them) in continuing to engage in old behaviors and thought patterns which were
counter-productive to the acquisition of a contented recovery. Each one of these participants has said that it has been through their own similar experiences with "dryness" in recovery that they came to believe that alcoholism does, indeed, have mental, and spiritual components, in addition to its physical component. When Susie spoke of the importance for her of avoiding resentments, she was echoing the sentiments of other participants who have pointed out the risk for them in allowing excessive amounts of resentment and anger to occupy their thought processes. The roles of these emotions in recovery are examined in greater detail in the later "Resentments and Anger" section of these Conclusions. Harborinextreme amounts of such emotions as anger and resentment are what Susie terms "symptoms of the disease" of alcoholism. As various participants went on to observe, the "medicine" for their disease is their involvement with the program of recovery that they work through Alcoholics Anonymous; specifically, it is the interaction with other trusted recovering people that assists them in gaining perspective on their own behavior. It is also noteworthy that most of the participants have cited A.A.'s so-called "maintenance Steps" (numbers Ten through Twelve) as one of the valuable tools that they have employed in ongoing recovery. These Steps involve an ongoing daily personal "inventory" of behaviors, an emphasis on an enhanced relationship with one's personalized higher power, and a continued effort to extend help to those who are seeking to recover from alcoholism. Practicing these Steps has been one of the most frequently-cited contributors to quality of life in long-term recovery. They are essential to providing the balance which all these participants have come to value in their lives.

The experiences of these participants in long-term recovery have indicated that for each one of them the quality of life has continued to improve with time. John,
for example, believes that within the last 3 years, he has become a much better
listener, and he can more readily laugh at his own foibles; he says that life is less
cluttered today. Similarly, Dave says that life has gotten simpler. Jerry believes that
he (and other people that have attained 9 or 10 years of sobriety) has entered into a
more stabilized, "maintenance" phase of recovery. He notices that, in recent times, he
is better able to deal with authority. Susie and Betty have both spoken of the process
of working A.A.'s 12 Steps as a continuous cycle; at each round of completion of
working the Steps, a new level of self-awareness emerges. Charles has said that it is
easier to be a decent man; life is also easier today, for him. Additionally, he observed
that he has "grown up" during recovery. This developmental theme is shared by
Kathy, who has credited recovery with enabling her to return to school. Recoveries
such as Charles' and Kathy's exemplify the growth that can occur during recovery.
Kathy, in particular, would seem to embody Melvin's (1984) Stage Three of
recovery, in which she has shown the ability to realize deferred developmental goals.
Kathy also indicated that in recent recovery, she has thought more of the needs of
others, and less of her own. This speaks to the continuum of change that seems to
occur in the relational meanings of these participants; additional discussion of this
topic can be found in the later section of this chapter entitled "Relational Meanings."

Each of the participants has acknowledged that some of their views on the
ongoing nature of quality recovery, and specifically, the disease concept of
alcoholism, may not always be fully understood or accepted by people who are not
alcoholic. John, for one, has commented on the difficulty of trying to explain a
"miracle" in "twenty-first century jargon." Susie, for example, recognizes that though
these may be tough concepts for some nonalcoholics to grasp, even she does not
need to fully understand them. She simply has observed the aspects of what she
considers to be this “progressive” disease often enough in her own life, and in those of many other alcoholics, to find this to be a concept which is, for her, personally congruent. She exemplifies the general view of other participants, who, while they may have had the occasional frustrations with misunderstandings about the ongoing nature of quality recovery, are not especially concerned about them. What they have been eager to convey through their comments, I believe, is that the need to continue to treat their alcoholism on an ongoing basis is a personal reality of their lives. Moreover, as the result of that effort, they experience quality of life in recovery.

Composite Descriptions

Moustakas (1994) has used the term Composite Descriptions to refer to the meanings and essences of an experience which would apply to a group of participants in its entirety. While these Composite Descriptions incorporate the individual participants’ Invariant Constituents (Moustakas, 1994), they are not limited to them. In the preceding Chapter IV (“Results”), I have designated the Invariant Constituents which seemed to characterize an overriding theme for each of this research’s 8 participants. Only in the case of Susie, did I deem it appropriate to combine several of her ideas about the meaning of daily sober living under the Invariant Constituent “the ability to live life on life’s terms.” This idea seemed to have had particular importance for Susie. All the Invariant Constituents for the other participants, however, have been based upon the daily contributing factors to quality of life for those individuals. For those participants (and, in fact, for Susie), those daily contributors have been spirituality, A.A. membership, and service. Only Charles chose to place A.A. meetings ahead of spirituality in terms of its importance on a daily basis as a contributor to his quality of life. Nevertheless, it is worth noting that
all 8 participants have cited the same three factors as being critical daily contributors to their quality of life. Even the slight differences in priorities that seem to exist appear to be attributable to semantic distinctions. Charles, for example, went on to state that spirituality is “most important” in recovery. Susie noted that spirituality is the “key element” of quality of life in recovery. Therefore, it seems reasonable to conclude that for these 8 participants, their Composite Descriptions comprise those factors involved in their quality of life in alcoholism recovery which they have deemed most essential: spirituality, A.A. membership, and service. A discussion of the role of each factor follows.

Composite Description One: Spirituality

Spirituality has emerged as the most important contributor to quality of life in recovery for these participants. As they offered their thoughts on this topic, it became apparent that spirituality encompasses many different aspects of recovery, such as surrender, acceptance, and a relationship with a higher power of each person’s own individual formulation. Within the context of the interviews with these participants, spirituality has been termed the “essence” of recovery, “90% of recovery,” the “key element” of sobriety, and “the most important thing.” It was said that quality of life in recovery “depends on it.” The comments of these participants about the role of spirituality in their recoveries would seem to support Carroll’s view that there are “increasing indications that body, mind, and spirit are interrelated” (Carroll, 1997, p. 98). Corrington (1989) believed that with higher levels of spirituality, a greater quality of life in recovery would be experienced. That belief is strongly supported by the views of these research participants.
These research participants arrived at their individual experiences of spirituality from a variety of vantage points. At least one person (Betty) entered recovery as an atheist. For many years she experienced her higher power as being expressed through the words and actions of her fellow recovering alcoholics. Other participants (such as Charles and Kathy) were raised in a religion which provided minimal personal meaning until they had first established a sense of spirituality in recovery. For Kathy, this meant establishing her grandparents as her initial higher power. It has been particularly striking to hear Jerry, who has devoted his professional life to his chosen faith, to echo the view that spirituality has been more meaningful and present for him in his recovery experience. As he puts it, it has gone from being a “head trip” to a personalized relationship with a higher power. All of these participants have been adamant that spirituality is not to be confused with religion. As John observed, “Religion . . . is designed for people that are afraid they’re going to go to hell. And spirituality is for people that have already been there.”

The genesis of spiritual growth for these alcoholics began when they realized that it was going to take a power greater than themselves to stop drinking, and to remain sober. As noted in the discussion of Betty’s comments on the role of spirituality, a discernable pattern is present in these participants’ spiritual journeys. All of these participants believe strongly that, for them, it was absolutely necessary that they hit bottom with their drinking. It was at this point that each of these individuals realized that they were unable to quit drinking through their own resources. At this point, each of these participants had their initial experience with the concept of surrender, which, in their view, is subsumed under the heading of “spirituality.” What was originally surrendered was the belief that they alone could
control their own drinking; they reached a state of *acceptance* of the personal unmanageability of their alcoholism. By virtue of their willingness to accept the suggestions of other recovering people about how to stay sober, some of the first experiences of the “higher power” concept occurred for these individuals. Several of these participants indicated that they had their first experiences of feeling as though they “belonged” in early A.A. meetings; of this sensation, Marsha said “I felt like it was . . . like a ship coming into a harbor and this was the port and this was where I belonged.” As Betty and Marsha articulated particularly well, the strength of the people with whom they were interacting in recovery became a power greater than themselves. Betty, for example, has gone on to expand this concept to a higher power which now can transcend even other recovering people. She has become comfortable with a God of her understanding. This is very similar to the experience that each of these participants relates. Each of them has remained steadfast in the conviction, however, that their continued growth in recovery requires (what John termed) “a daily reprieve, contingent upon our spiritual condition.” In other words, the continued surrender of their alcoholism to a power greater than themselves is paramount in their recoveries.

Prugh’s (1985) contention that surrender is an ongoing process for the recovering alcoholic is confirmed by the comments of these participants. Virtually all of them have stated that they have struggled with issues of control in their recoveries. The need for control has emerged as the psychological dynamic which these participants most consistently have recognized as being a difficult obstacle to the attainment of serenity and peace in sobriety. Once they discovered that they alone could not control their drinking, they had experiences with recognizing their lack of control in other arenas of their lives. Control over these aspects of their lives was one
more thing to be surrendered in recovery. John, for example, recognized that his need
to be “chairman of the board” had ceased to be conducive to his spiritual growth.
Beyond the consideration of control in their professional lives, each of these
participants has struggled mightily to surrender their need to control those close to
them, including spouses and children. John says today, however, that he does not find
it necessary to “push the river.” Dave relates that “Today, if I’m wrong, gee, so
what?” The achievement of such attitudes has been one of the most significant tasks
which these participants have undertaken. It is all the more intriguing, considering the
rather paradoxical nature of these persons; by their descriptions they would match
Dave’s assessment of an alcoholic (earlier attributed also to Wholey, 1984) as an
“egomaniac with an inferiority complex.” Beneath the bravado associated with an
insistence on control has been what Charles termed his two primary “character
defects”: pride and fear. Just as these individuals clung to the last vestiges of control
with their drinking, they have had to achieve considerable growth in recovery to
admit that their efforts to control some other aspects of their lives were futile. The
comments that these participants have made in regard to their struggles to surrender
control echo the view of Mack that “acknowledgment of a basic dependence upon
others, and upon some power greater than oneself, begins the abandonment of a
grandiose posture” (Mack, 1981, p. 145). Experience in advanced recovery has
taught these persons, however, that surrender is one of the greatest of the numerous
paradoxes associated with their recoveries. As Betty and Susie noted, they have had
to “surrender to win.”

Several participants stressed that the concept of surrender does not imply
inactivity. As Jerry noted, “It doesn’t mean we’re doormats.” He chooses to accept
what he feels he can’t change: “people, places, and things.” In Susie’s estimation,
surrender “is not to be confused with helplessness.” In other words, she attends to those things in life which require her actions; it is the results of those actions that she leaves in the hands of her higher power. Of this paradoxical notion of surrender, Marsha has said, “You don’t sit in a chair . . . [I have to] surrender to something greater than I am . . . Once you let go of it all, you get it all back.”

The emphasis on spirituality’s importance to these participants is clear. It has provided them with a sense of belonging and an identification with a power greater than themselves. For these individuals, that was where the seeds of recovery were sown. As they have discovered, it has come to mean much more than an approach to the cessation of drinking. It has provided a means by which they could learn to “surrender” counter-productive modes of thought and action (most conspicuously, the need for control) which had often prevented them from building an existence which captured those elements which they have each described as representing “quality of life.”

Composite Description Two: Membership in Alcoholics Anonymous

The participants in this research are unanimous in their view that they could not have achieved the quality of life that they enjoy in recovery without Alcoholics Anonymous. All of these research participants have continued to attend A.A. meetings throughout recovery. Marsha, for example, after 27 years of recovery, says that she never attends less than three meetings a week. John is relishing the opportunity that semi-retirement is providing him to attend more meetings. Kathy and Betty each are content attending between one or two meetings a week. The frequency of these participants’ attendance at meetings seems contingent on the degree of self-awareness that they have developed. They have experienced what it is
like to feel “the need” to be in a meeting. As Betty puts it, “Comes the time when I’m starting to think poorly, I will go to a meeting.” All of these individuals have had the opportunity to observe what has happened to alcoholics who have ceased attending meetings after a period of sobriety. Marsha’s observation is relevant to this point:

I wouldn’t be sober 27 years if I hadn’t gone to meetings, I’m sure of that. Because I’ve seen too many people say I don’t need them anymore and 6 months later they’re back in rehab . . . I go to meetings to find out what happens to people who don’t go to meetings . . . A.A. is the medicine for my disease.

Several participants have similarly expressed that they view their meetings as being medicinal. John expresses a common sentiment as well: that his identity as a recovering alcoholic is reinforced when he continues to be around newly recovering people in A.A. meetings. It reminds of where he came from, of where he could be if he chose to drink again, and of the need he sees to guard against complacency in his recovery. His thoughts reiterate the prominent theme of these research results that quality of life in recovery is something which these participants have continued to actively pursue.

As earlier noted, the desire to drink has long since left each of these research participants. One of the reasons that they remain so committed to their programs of recovery is that they have each made the personal discovery that, for them, their working of the A.A. Steps and their attendance at meetings has come to represent a new way of life. As Dave put it,

The big thing is, again, the program of A.A. is not about not drinking, it’s about living, and if I want to continue to be happy and . . . enjoy a good healthy way of living, I have to continue with my program and my recovery in order to be happy.

Regarding the role of A.A. and its 12 Steps, various participants have said, “It’s a way of life”; [the Steps are] “a road map for living”; “It taught me how to live”; “It
gave me life.” These are strong statements, to be sure. They are infused with gratitude for the discovery of a “way of life” which seemed to elude all of these individuals earlier in their lives.

One clue to understanding why this “way of life” has been so transformative for these participants may lie in the oft-stated appraisals they have made of themselves as having been self-centered, or as having had to be in control of situations and other people. The “Big Book” of Alcoholics Anonymous has made this related observation: “Selfishness—self-centeredness! That, we think, is the root of our troubles. Driven by a hundred forms of fear, self-delusion, self-seeking, and self-pity, we step on the toes of our fellows and they retaliate” (Alcoholics Anonymous, 1976, p. 62). The process of working the 12 Steps has resulted in a significant change in how these participants view themselves in relationship to others (additional comments on this topic can be found in the later “Relational Meanings” section of these Conclusions). As John commented, “[A.A. has] . . . taught me how to relate to people in a less selfish manner.” In part, the diminishment of the alcoholic ego, to which Tiebout (1954) referred, results through the rather humbling process of advancing through the 12 Steps. The Fourth and Fifth Steps, in particular, which suggest the taking of a personal “moral inventory” of behaviors and attitudes, and the subsequent verbal sharing of that inventory with another trusted individual, are difficult passages in the working of the A.A. program. As Kathy observed:

I’ve known a lot of people who’ve gotten to that point and aren’t willing to do that for whatever reason. It’s painful. And those people, some of them have gone back out to drink and some of them have died.

Equally, or perhaps even more daunting to these participants, was the act of making amends for wrongs committed to others while drinking; this is suggested in Step Nine. Participants have variously referred to the working of Step Nine as “cleaning
house," "cleaning up the wreckage of the past," and "cleaning up my side of the street." What has been discovered at the conclusion of this process, though, is the freedom that has resulted from the removal of this emotional and mental burden. This has been a challenging process for all of these participants. As Kathy's statement makes clear, it is not for everyone. However, in the view of each of these 8 participants, completion of (in particular) the first nine Steps of A.A. has been absolutely essential to their attainment of quality of life in recovery.

As earlier noted in each of the participants' results, they have, to a person, each felt that A.A.'s "Promises" (see Appendix G) have become a personal reality as the result of working the first nine A.A. Steps. It is worth noting the statements that A.A.'s "Big Book" makes when introducing the Promises, and after listing them: "If we are painstaking about this phase of our development, we will be amazed before we are halfway through . . . Are these extravagant promises? We think not. They are being fulfilled among us—sometimes quickly, sometimes slowly. They will always materialize if we work for them" (Alcoholics Anonymous, 1976, p. 83). Each of these participants has, indeed, worked diligently and consistently on the Steps of A.A. (not only the first nine). The participants are unanimous in their belief that they are experiencing the Promises in their lives; some of the specific Promises which have been cited include the following:

We will not regret the past nor wish to shut the door on it. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Fear of people and economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. (Alcoholics Anonymous, 1976, p. 84)

John was eager to emphasize how often his sponsor would point out to him that the phrase which introduces the Promises in the "Big Book" begins with "If we
are painstaking . . .” In other words, it was made clear to him that significant effort would be involved if he wished to attain these desirable goals. John remains convinced that these Promises, which to him (and to the other participants in this research) capture much of the concept of “quality of life,” are accessible to those who are willing to be painstaking about the suggested Steps that precede them. He commented that “This is what you can expect to happen if you work the program.”

**Composite Description Three: Service**

Service to other people seeking recovery from alcoholism has been cited by the participants in this research as being the third most important contributing factor to their ongoing quality of life in recovery. Service to other people takes many forms; Susie’s views on service speak to these different approaches:

I believe that each of us have our own niche; that we find as we maintain sobriety in this program. Some of us it’s working with others. Some of us it’s being involved in, if you will, the organization. We have a central service office for information concerning related groups in the area and social events. Some of us the service comes through giving open talks about ourselves. Relating how it was, what happened and how it is today. And giving rides to people, etc. There are a lot of areas where I believe we will each find our own area to be of service as we stay sober. I do believe that service of some kind, even if it’s just attending meetings and speaking at that meeting, that is a necessary part of contented sobriety.

As earlier noted, John has been especially pleased to be semi-retired, because it has allowed him to attend more meetings, where he can share his experience; additionally, he can provide other forms of service now, such as his efforts to organize a prison work-release program for alcoholic prisoners. John spoke of a rewarding and instructive relationship with his own A.A. sponsor. Each of these participants, like John, has retained a clear memory of how vital the help of other recovering alcoholics was to them in their early days of recovery. It is through
sponsorship that these participants received guidance and support in working the 12 A.A. Steps, in addition to general mentoring in the process of how one lives life with a reasonable measure of contentedness in sobriety. This is now something that these people feel it is incumbent upon them to pass on to others.

The goal of A.A.’s Twelfth Step, in fact, is to “carry this message to other alcoholics.” Here again, the architects of the A.A. program may have recognized that it continues to benefit the recovering alcoholic if they can take the focus off themselves. Kathy has made the following observation in this regard:

It definitely takes the focus off myself and I feel like I’m giving what I know to another person who needs it and I have empathy for that person. I know what they’re going through. They know that they can depend on me and I know I’m responsible to be dependable.

Charles’ comments provide a fitting summation of the importance of service to the quality of life that these research participants experience in recovery:

I think it’s so important. It just puts me number two to whomever I’m serving and reminds me again that I’m number one in the eyes and love of my higher power. So that’s a bonus. And service keeps the whole thing moving. If somebody doesn’t open the room, make the coffee, lead the meeting, the meeting doesn’t happen. Somebody doesn’t get sober. That somebody might be me. That’s pretty scary for this guy.

Relational Meanings

During the time that the participants in this research have been in recovery, they have each, by their own accounts, experienced significant changes in the relational meanings that their lives hold. These meanings include the relationship with oneself (and one’s personal higher power), as well as self in relationship to others. These relational meetings are among a number of concepts critical to the quality of life of these research participants which are subsumed within their Composite Descriptions (spirituality, A.A. membership, and service). While relational meanings
may not represent concepts as overarching and inclusive as the Composite
Descriptions, they are, nevertheless, deserving of particular consideration within
these Conclusions.

At several points in these results, it has already been noted that virtually all of
these participants indicated that prior to their beginning their recoveries from
alcoholism they had a sense of not belonging, or not fitting in with society as a whole.
Susie’s comments in this regard seem especially applicable:

I was constantly ill-at-ease in my own skin. As I began to grasp some spiritual
concepts . . . I found that my mind slowed down and I became more
comfortable in relation to the rest of society. The rest of my world.

One of the cliches of 12-Step programs is that recovering alcoholics believed they
were “terminally unique.” That phrase seems very applicable to the experiences of
these participants. It is as though these people feel as that they missed out on the
“instructions” on how to relate to other people in a positive manner. On several
occasions, participants have spoken words to this effect during their interviews. Each
of these persons has also indicated that the 12 Steps of Alcoholics Anonymous
provided the “guidelines” (or any number of other terms, such as a “road map,” or a
“way of life”) for learning these relational skills.

Susie’s comment about being ill-at-ease in her own skin points out that the
meanings that these individuals held in relationship to themselves were, first and
foremost, uncomfortable ones. At some point in their interviews, virtually every
participant has made reference to their formerly low self-esteem. These people were
their own worst critics. It has been said that an alcoholic is particularly adept at
“snatching defeat from the jaws of victory.” For people such as these participants
who had little belief in their own abilities, and for whom self-pity was a frequently
cited “character defect,” “snatching defeat” may not be not be such an exaggerated
behavioral assessment. The alternate attitude which a number of these participants have held has been one in which their judgment was (in their opinion) infallible. This has evidenced itself in the frequently-cited “need for control” to which the participants have referred. The combination of these behaviors and attitudes served to distance these people from others with whom they would have wished to relate effectively. It virtually guaranteed that the self-relational meanings these individuals held would remain negative, as well; their behaviors reinforced their isolation. The origins of these traits are beyond the scope of inquiry of this research; they would be an appropriate focus for further retrospective research with alcoholics, however.

A.A.’s Twelve Steps and Twelve Traditions, when speaking of Step Five (in which it is suggested that the alcoholic should admit their shortcomings to another trusted person) articulates the alcoholic’s self and other-relational dilemma in an articulate manner:

...we shall get rid of that terrible sense of isolation we’ve always had. Almost without exception, alcoholics are tortured by loneliness. Even before our drinking got bad and people began to cut us off, nearly all of us suffered the feeling that we didn’t quite belong. Either we were shy, and dared not draw near others, or we were apt to be noisy good persons craving attention and companionship, but never getting it—at least to our way of thinking. There was always that mysterious barrier we could neither surmount nor understand... When we reached A.A., and for the first time in our lives stood among people who seemed to understand, the sense of belonging was tremendously exciting. (Alcoholics Anonymous, 1992, p. 57)

The redefining of relational meanings to oneself seems to have occurred on a gradual basis for these participants. Initially, participants spoke of developing a relationship with a higher power. For some, this was a group of recovering alcoholics. For others, the higher power took a nonmaterial form. The relationship with a higher power has evolved as well. Of this process, John, for example, has said, “It got more personal. I talk to God like he’s just sitting on the other side of the room
sometimes.” Dave has said that his higher power is now “in here” (inside of him), not “out there.” For Jerry, this relationship is no longer a “head trip” (intellectualized); it has become personal. This increasingly personal relationship with a higher power has proved beneficial for these individuals: It has provided the basis for a redefined relationship with the self. With the sense that they were acceptable in their higher power’s estimation, several of the participants have indicated that they then could begin to forgive themselves for their past actions, and to find self acceptance. As Jerry has noted, “We don’t have to impress anybody anymore and the self-esteem is coming from within.” For Dave, this process represents fulfillment of one of the A.A. Promises, a diminishing fear of other people:

[Sobriety is] having some, not ego, but some self-esteem . . . I used to stand on my head if I thought that would make them like me. And today I want them to like me but it isn’t critical. That is their prerogative.

As each of these participants has redefined their self-relational meanings in a more positive manner, they have become aware of the rewarding relational meanings with others that result from service work with alcoholics (which was described in some detail in the earlier “Service” section of this chapter). Service provides the means to achieve an enhanced relationship with one’s higher power, as well, according to Susie: “Our ‘Big Book’ says that we grow spiritually be working with other people.” This process was described by Betty as “a great paradox of the A.A. program of getting into self. And then getting out of self.” Betty is referring to the work on early A.A. Steps which entails considerable self-examination, and, ultimately, self-forgiveness. This process seems to build a bridge to working with others. As one of the A.A. Promises describes it, “Self-seeking will slip away.” John’s comments on this idea are worth repeating:
It's taught me how to relate to people in a less selfish manner . . . I'm much less self-centered than I was before. I was always thinking in terms of myself and what it would do for me, and what's in it for me. And now I find myself reaching out to other people. And then what I didn't realize, that when I do that somehow, I feel pretty good about myself, you know?

The long-term recovery model proposed by Brown (1985) has as one of its primary goals the emergence of self in relationship to others. The participants in this research represent an example of the attainment of this goal.

Resentments and Anger

Another of the concepts which has figured prominently in these research participants' discussions of quality of life is resentment (and its related concept anger), or more specifically, the importance of avoiding resentments in recovery. As was the case with the preceding Relational Meanings section, the idea of avoiding resentment and anger is woven throughout the Composite Descriptions of these research participants (spirituality, A.A. membership, and service). While not as all-encompassing as the Composite Descriptions, resentment and anger warrant additional consideration within these Conclusions.

When Susie referred to resentments as the “number one killer” in alcoholism recovery, she was emphasizing the inherent risk she recognizes in holding resentments. It is Susie’s belief (as well as that of most of the other participants) that resentments and anger place the recovering alcoholic in a particularly vulnerable state which, if left unattended, could precipitate a relapse.

A.A.’s “Big Book” devotes particular emphasis to how seriously it views resentments when it describes the construction of a “moral inventory” in its suggested Step Four:
It [resentment] destroys more alcoholics than anything else. From it stem all forms of spiritual disease, for we have been not only mentally and physically ill, we have been spiritually sick. When the spiritual malady is overcome, we straighten out mentally and physically. In dealing with resentments, we set them on paper. We listed people, institutions or principles with whom we were angry. We asked ourselves why we were angry. In most cases, it was found that our self-esteem, our pocketbooks, our ambitions, our personal relationships (including sex) were hurt or threatened. So we were sore. We were “burned up.” (Alcoholics Anonymous, 1976, p. 64)

The process of sharing these resentments with another trusted individual (who could be, for example, a sponsor, a priest, or a therapist) in A.A.’s suggested Step Five often proves to be a liberating experience for the alcoholic. It is from here that many recovering alcoholics begin to feel the lifting of the mental burden that these resentments have represented.

From a psychologist’s perspective, such as that of this Student Investigator, it seems apparent that resentments and anger increasingly are recognized as detrimental to the link between mental and physical well-being; resentment and anger are contributors to stress. As such, the accumulation of states of anger, resentment, and stress have been suggested as possible contributors to physical illnesses, such as high blood pressure, and even cancer. The ill effects of stress, anger, and resentment are, in other words, not exclusively felt by alcoholics. The participants in the present research have indicated, however, that they have learned to recognize and act on anger and resentment promptly. Jerry related a story which is particularly illustrative of how he has learned to respond to anger and resentment:

I can look back on when I’ve done things that I wouldn’t have done a few years before. While I was at an A.A. meeting one night, in this Spanish group . . . someone came in and said could you go to the hospital . . . to translate? . . . And I did . . . And the nurses were just completely rude and unprofessional. And I was angry. And I left and on the way home I said, “Wait a minute. I’m not going to take this to bed with me.” So I called them up and told them in a very nice way, “I was just there to translate.” I said, “. . . I come here whenever you want me. I just want you to know I was a little upset that you were very rude, very unprofessional. And I really didn’t
appreciate that.” I said, “I’m telling you this because it’s your problem—it’s not mine, and I’m not going to hold on to it.” And they were very apologetic. And I said, . . . “I’m not looking for an apology. I just want to get it off my chest. Otherwise it would turn into a resentment.” So they knew how I felt. And I can do that now. I can speak up to people . . .

It is especially noteworthy, I believe, that in the preceding statement of Jerry’s, he stressed the phrase “it’s not mine, and I’m not going to hold on to it.” Experience has taught Jerry to “let go” of anger and resentment quickly. This has been a function of A.A.’s suggested Step 10 for Jerry, wherein he continues to take a daily “inventory” of behavior. What distinguishes Jerry, by his report (and the other long-term recovering alcoholics who make up this research’s participants) is that the ability to take such a personal inventory has become extremely acute. As such, this ability to process anger and resentment promptly cannot be minimized as a contributor to the quality of life of Jerry and the other participants in this research.

The Role of Therapy

Three of the participants in this research, Dave, Kathy, and Charles, received some counseling in regard to their abuse of alcohol. As Dave indicated, he felt that the relative ineffectiveness of his counseling in respect to his alcohol abuse was due largely to Dave’s lack of full disclosure about the extent of his drinking. Nevertheless, he went on to say that he believes that “A therapist who was knowledgeable in dealing with alcoholism . . . could be very beneficial and helpful.” Dave’s experience is illustrative of one of the biggest problems that confronts a therapist treating an alcoholic client: clients may deny or fail to disclose their alcoholism. Certainly being “knowledgeable” of alcoholism, as Dave puts it, would be beneficial in allowing a therapist to penetrate the elaborate defense systems which alcoholics can often construct.
Kathy and Charles had much more positive experiences in therapy. Kathy saw her therapist when she had already been sober for 2 years. She sought therapy in regard to issues other than her alcoholism. While Kathy did not elaborate on the details of the treatment which her therapist employed, she indicated that her therapist was supportive of her membership in Alcoholics Anonymous. Kathy was appreciative of her therapist’s attempt to affirm the importance of her ongoing participation in her chosen alcoholism recovery program while continuing her work on other issues in therapy. Kathy’s experience illustrates A.A.’s position (expressed in its “Big Book”) that the use of therapy is strongly recommended for problems which extend beyond alcoholism.

Charles’ therapist made the decision to disclose his own membership in Alcoholics Anonymous. What is of particular note, however, is that his therapist did not break his anonymity until Charles returned to him in a fairly desperate emotional state about the deterioration of his life due to his drinking. It may be that Charles’ therapist judged that Charles was at a point of sufficient readiness, or, in fact, surrender, to act on the therapeutic suggestion which he was about to offer: to begin attending A.A. meetings. By Charles’ own admission, his “bottom” had immediately preceded this juncture in therapy. It may be (though this would only be speculation) that Charles’ therapist was sufficiently knowledgeable (as Dave described) about the progressive nature of alcoholism to recognize that, earlier in their work, Charles may not have been prepared to hear and act upon a similar therapeutic intervention. His therapist’s “warnings” to Charles (in their initial sessions) of the potential harmful consequences of continued drinking indicate that his therapist may, in fact, have been cognizant of the progression phenomenon. This point of readiness at which Charles
had arrived recalls an earlier opinion that John voiced about the necessity of hitting one’s personal bottom:

The key to working this program is you’d better damned well be done doing whatever it is you’re doing before you even think about the First Step. [It’s] the step you take before the First Step. It’s another way of saying [hitting bottom].

A pivotal phrase in John’s preceding statement is “the key to working this program . . .”, which refers, of course, to A.A. This brings into relief one of the chief limitations of this research: all of its participants are members of Alcoholics Anonymous. It would seem logical that the results of their interviews and, hence, the findings of this research, would be of particular meaning and value to those therapists who are open to accommodating the principles of the A.A. program within the therapeutic frame of reference that they bring to bear when working with clients who are alcoholics.

As earlier indicated in Chapter II, objections by therapists to aspects of the A.A. program have been raised in the literature. Miller (1990) believes that spirituality remains one of the largest obstacles that therapists see to accepting A.A. principles. One reason may be that terms such as “higher power” may not lend themselves easily to empirical validation. In fact, Miller believes that there has never been empirical validation that recovery in A.A. is dependent upon certain procedures outlined within the 12 Steps. Kohn (1984) suggests that for many practitioners who have been indoctrinated into the medical model, the concept of spirituality may conjure up “faith healing.” To those with such reservations about the spiritual aspect of recovery described in this research’s results, the “leap of faith” necessary to accommodate such a concept may prove insurmountable. Nevertheless, for the participants in this research, spirituality is the most vital Invariant Constituent of the
quality of life of their respective recoveries which has uniformly emerged from their data.

One particularly insightful analysis as to why spirituality and, by extension, the idea of surrender to a higher power, may be not be a comfortable concept for some therapists is offered by Suzanne Kirschner. She has written about the “influence of Anglo-American culture on this ‘reshaping [of] the psychoanalytic domain’ (to borrow Judith Hughes’ phrase)” (Kirschner, 1990, p. 824). She goes on to say that:

... the intensified emphasis on and elaboration of “self and object-relations”... issues and motifs evince a comingling of Anglo-American concerns and anxieties about the self’s autonomy and individuality... those psychoanalytic theories which have achieved hegemony in America and Britain have done so because they emphasized and expanded elements in psychoanalysis which are congruent with certain unstated but pervasive Anglo-American cultural values and ideals... the ascendance, in the United States and Great Britain, of those psychoanalytic theories—"later" ego psychology, object relations theory, and self psychology... highlight the development of the ego and/or self. (Kirschner, 1990, p. 824)

Kirschner specifically cites the values of self-reliance and self-direction as being prominent ideals of Western psychoanalytic therapy. These values, of course, proved to be of little value to the participants in this research in their efforts to achieve sobriety. It was not until they were able to surrender to a power greater than themselves (which was, in several cases, the combined strength of groups of recovering people) that they were able to achieve sobriety. In fact, in the estimation of all of the participants, their ongoing sense of spirituality and surrender has proved to be the most critical component of their quality of life. The by-now familiar paradox of this phenomenon is that, to all appearances, these participants would, at this point in their extended recoveries, seem to embody values of individual accomplishment and growth. What they have been careful to clarify, however, is that these individual achievements have occurred within the context of a continuing network of group
support and spirituality. Kirschner holds that therapeutic efforts to promote strict self-reliance are not entirely overt, however. She notes "a cultural assumption which many psychotherapists in this country seem to share unwittingly that they can help the patient only insofar as he helps himself" (Kirschner, 1990, p. 842).

For those therapists who do find the idea of supporting their clients' A.A. attendance to be personally congenial, there are a number of authors who have suggested how therapy can prove to be a valuable adjunct to alcoholism recovery in Alcoholics Anonymous. Rawson (1995) advocates a behaviorally-oriented approach to addictions therapy, which seeks to help the client who is in early recovery to understand the meaning and benefits of several A.A.-related activities, such as sponsorship, and meeting attendance. As Dave has suggested, a "knowledgeable" therapist who understands the content of A.A.'s 12 Steps can provide an additional source of support as clients grapple with the "ego-deflating" tasks inherent in the early Steps. An example of one of those tasks would be surrender. Lawton (1985) suggested that

> the counselor can work closely with the addicted client to identify the issues requiring attention . . . It is difficult to determine the point at which surrender occurs but when it does, there is then the opportunity for contact with a higher power and the feeling of joy coming from a belief that all is well. (Lawton, 1985, p. 63)

By contrast to Kirschner's relatively negative view of the contribution of psychoanalytic therapy to patients' ability to achieve a healthy integrated relationship with others in their culture, Levin (1995) is a strong advocate of insight-oriented therapy, specifically from the orientation of self-psychology. In particular, he advocates its use in later-stage recovery. Levin's adaptation of Kohut's self-psychological theory to the needs of recovery seems especially well-suited to alcoholics whose characterological profiles are similar to the participants in this
research. Levin believes that alcoholic clients have an intense need for mirroring, or “approving confirmation,” as well as a need to idealize the therapist. These are people who, in Levin’s (1995) view, are vulnerable and narcissistically deficited. They possess low self-esteem. Levin’s description of such clients echos the self-descriptions of the participants in this research (particularly in their early phases of recovery). Levin also addresses an ongoing need for such clients to maintain A.A. contact: “You have a very real need for companionship, human contact and relationship” (Levin, 1995, p. 30).

The word “relationship,” as used by Levin at the end of the previous quote speaks to what is ultimately the end goal of the 12 Steps of recovery which the participants in the present research have worked: a healthy sense of self in relationship to others. Brown (1985), as indicated in the earlier “Relational Meanings” section, feels strongly that the quality of relational life to others characterizes mature recovery. In the view of this Student Investigator, her long-term recovery model of therapy (as noted in the literature review of Chapter II of this dissertation) seems especially viable given the portrayal that the participants in this research have offered of their journey of “self and other discovery” during their time in extended recovery from alcoholism, and the critical importance this has had for their current experience of quality of life. Brown’s model advocates therapeutic support (from a relatively behavioral posture) in early recovery of the assimilation of behaviors (such as meeting attendance, association with other recovering people, etc.) which are conducive to the building of a strong base in recovery. As earlier indicated, this passage in recovery (and therapy) could provide an opportunity for the therapist to help the client to explore the meaning and value of such concepts as the 12 Steps, surrender (and its many applications, to which this research’s participants
have referred), and sponsorship. As clients progress in their recoveries, Brown (1985) feels that they will be prepared to engage in a more dynamic mode of therapy, in which past behaviors and relationships are examined in greater depth. It is at this time in therapy that Brown feels that the self-psychological perspective, as espoused by Levin (1995), may be especially useful.

Needless to say, the degree of flexibility that Brown (1985) is advocating in the orientation from which the therapist works may not be fitting for some therapists. Again, that reflects the limitations of this research, in that its participants are all A.A. members, and their experiences may not reflect the experiences nor the therapeutic needs of many potential clients who are alcoholic. The case of Kathy, however, indicates that at least one of the participants in the present research has benefitted from therapy which both affirmed and supported her A.A. participation, while simultaneously meeting her where she was in recovery. Her therapist correctly recognized that she possessed the capacity to engage in productive insight-oriented therapy which complemented her ongoing recovery.

As earlier noted in the results of this research, the accounts of quality of life in recovery that its participants have offered represent only their unique experiences as recovering alcoholics. It is an obvious limitation of the qualitative design employed in this research that its results can not be generalized beyond the limited scope of this specific group of participants. At the very least, however, this research has provided a thorough and remarkably consistent portrayal of the factors which have contributed to the experience of quality of life which these participants have so emphatically indicated that they enjoy in long-term alcoholism recovery. As such, this research represents, at the very least, a collection of data upon which helping professionals can draw in gaining an increased understanding of how quality recovery feels to certain
alcoholics. The thoughts of Khantzian and Mack (1994), in reference to the value of research such as this, bear repeating:

It is our contention that an understanding of the individual and group psychology involved in a patient succumbing to and subsequently recovering from alcoholic and addictive disorders will help professionals to accept and recommend self-help modalities as an important or essential part of their patients’ treatment. The more clinicians understand about the A.A. model, the more skillfully they will be able to intervene therapeutically with patients who are substance dependent as well as with other patients with related conditions, who are in the process of recovery and self-repair. (Khantzian & Mack, 1994, p. 78)

Implications for Future Research

Given the fact that the present research limited itself to studying a group of participants who were all members of Alcoholics Anonymous, it would seem logical for future research dealing with quality of life in alcoholism recovery to examine the recoveries of individuals who have achieved sobriety by methods other than A.A. One approach could potentially involve comparing the experiences of both A.A. and non-A.A. participants within one study.

The experiences of “not belonging” which have been conveyed by the participants in the present research are sufficiently intriguing to make one question how that experience is affected by being a member of any number of minority populations. In particular, given that gay, lesbian, and bi-sexual individuals have historically found social opportunities in (among many other places, obviously) establishments where alcohol is served, this would be but one segment of the alcoholic population which would be deserving of further research. What has the achievement of quality of life in recovery entailed for those who represent minority segments of the overall population experiencing sobriety?
With any combination of the diversity of potential participants suggested above, any one of the factors of quality of life in recovery which the present research has already examined could certainly bear further, exclusive scrutiny. For example, what has been the role of specific therapeutic interventions in promoting the growth of spirituality among recovering alcoholic clients?

In view of the fact that virtually every one of the participants in the present research has alluded to long-standing feelings that they had somehow missed out on the "guide to living" which they have since discovered through A.A.'s 12 Steps, would it not be appropriate to design retrospective research of a qualitative design which examines how it is that such persons came to feel so developmentally deficited?

These suggestions represent but a handful of potential research opportunities with a population that remains under-researched, and misunderstood. As the results of this research bear out, I believe, the application of qualitative methodology to the study of long-term recovery from alcoholism holds considerable potential. This is a population with a wealth of life experience, which is deserving of the depth and detail that such a research methodology affords.

Final Thoughts

To reiterate an earlier observation (made at the conclusion of the "Results" section of this research), it has been a privilege to have the opportunity to interview the participants who were a part of this research; I hope they share my belief that their honest and articulate conveyance of this data, which represents for each of them a journey of profound proportions, has made but a small contribution to the literature which seeks to illuminate the factors involved in the attainment and maintenance of
quality of life in recovery from alcoholism. The thoughts of Clemens (1997) provide a fitting summary: “The ultimate choice of long-term recovery . . . is whether addicts continue to expand themselves and their interpersonal field rather than attempting to maintain self and the interpersonal field as static” (Clemens, 1997, p. 83). The participants in this research represent the very personification of that “ultimate choice,” and the very real benefits that they perceive to have resulted from it.
Appendix A

Posted Announcement: Invitation to Participate in Dissertation Research
Posted Announcement: Invitation to Participate in Dissertation Research

Research Participants Sought

My name is George C. I am a long-time member of A.A. in the Michiana area. I am pursuing my doctorate in Counseling Psychology at Western Michigan University, in Kalamazoo, Michigan. At the present time, I am conducting research for my dissertation, which is titled Quality of Life Factors Among Recovering Alcoholics. I would like to interview some individual A.A. members on two occasions about their experiences which they feel have contributed to their quality of life in recovery.

I'm looking for some persons for my interviews who have been sober continuously for at least 10 years, and who would be interested in talking to me about their recoveries. I believe that what these people have to say could make a real contribution to the increased understanding of how to lead a contented, productive life, without drinking.

Naturally, no one's names will be used at any time during this research, so that anonymity will be protected. If you are interested in participating, please call me at the number below, and we can discuss this research in more detail. If I'm not in, please leave a message, and I'll get back to you.

Thank you.

George C.
(616) 651-6949
Appendix B

Participant Phone Contact Script
Participant Phone Contact Script

Thanks for calling me. I gather you read my announcement and are interested in possibly participating in my research for my dissertation, which is called Quality of life factors among recovering alcoholics. If it's O.K. with you, I'd like to give you more details about the project, respond to any questions you might have, and then talk about whether you are still interested in participating. My name is George Compton, and I'm a doctoral student in Counseling Psychology at Western Michigan University, in Kalamazoo, Michigan. The purpose of my research is to explore in-depth the experience of quality of life in recovery from alcoholism. My research has shown that while there is a lot of research about people in early recovery, there is very little known about how it is that people live contented lives in long-term recovery.

As you probably read, I'm interested in interviewing some recovering alcoholics who have at least 10 years of continuous sobriety about how it is that they experience quality of life in recovery. I'd like to conduct audiotaped interviews with each person on two occasions, each of which would last about two hours. During the second interview, I'd like to take some time to let the participants read a transcript of their first interview, and to tell me if it is accurate. Also, I'd like to share some of my thoughts about the meaning of what they said, and invite them to respond to those thoughts.

All the participants' anonymity will be strictly protected. I will not record anyone's real name at any time. Instead, I'll use pseudonyms to identify the participants. I will read a consent statement at the start of the first interview. If the participants then say that they have heard and understood what I have said in that consent statement, that will document their consent to participate. Participants can withdraw from this research at any time.

Toward the conclusion of this phone contact, if you say that you wish to participate in my research, I will then ask you some demographic questions, such as your age, occupation, marital status, years of sobriety, etc. Following these questions, you and I will decide together on places that you find suitable and convenient for the interviews. Possible locations would include Alano club meeting rooms, church rooms which are used for A.A. meetings, or study rooms in local libraries.

I'd just like to express my appreciation again for your willingness to inquire about this research. I'm very enthused about the potential contribution this research can make to the understanding of how people remain happily sober over an extended period. I believe, too, that participants can benefit by having their own recoveries strengthened from sharing their experiences with others.

I hope I've explained this research clearly in this brief explanation. If you have any questions, I'd be happy to answer them at this time [a pause occurs, while questions are answered]. If not, I would like to invite you to tell me if you have understood my description of this research, and if you are interested in participating.
[Assuming that the potential participant has expressed their interest in participating, I would then say the following]: Thank you. At this time, I'd like to invite you to answer my demographic questions.
Appendix C

Anonymous Consent Document for Participation in the Dissertation Research Project
Anonymous Consent Document for Participation in the Dissertation Research Project

Western Michigan University
Department of Counselor Education and Counseling Psychology
Quality of Life Factors Among Recovering Alcoholics
Dr. Edward L. Trembley: Principal Investigator
George Compton: Student Investigator

You are invited to participate in a dissertation research project entitled "Quality of life factors among recovering alcoholics." My name is George Compton. I am the Student Investigator. The chairman of my doctoral committee, Edward L. Trembley, Ed.D., is the Principal Investigator. This research intends to explore in-depth the experience of quality of life in recovery from alcoholism. The only condition of participation is that you have achieved at least ten years of sobriety. This research is conducted as a partial fulfillment of the requirements for the student investigator's doctoral degree in Counseling Psychology at the Department of Counselor Education and Counseling Psychology, Western Michigan University.

Should you choose to participate, you will be interviewed between February, 2000 and April, 2000. There will be two separate interviews, each running for about 2 hours. During the course of these interviews, you will be invited to share your experiences of how it is that you have had quality of life in recovery from alcoholism. During the second interview, you will be invited to review both a transcription of your first interview and the results of its analysis in order to provide necessary feedback. All interviews will be audiotaped. We will decide together the date, time, and location for the interviews.

All of the information collected from you will be confidential. A pseudonym will be used to protect your identity. Your real name will not be recorded at any time, in order to provide complete anonymity. All audiotapes, transcriptions of interviews and analyzed data, will be stored in a secure, locked file. At the conclusion of this time, the tapes will be erased and destroyed; other raw data (such as memos and field notes) and transcripts will be stored in a secure, locked file by the Student Investigator in his home office in Sturgis, Michigan for a period of five years following publication of all or portions of this dissertation, in accordance with American Psychological Associations practices. Following this time, such remaining data will be destroyed.

You may benefit from this research project by becoming more aware of the factors involved in quality of life in alcoholism recovery. By sharing your experience, you may help to
disseminate knowledge and raise awareness with regard to the importance of quality of life in recovery from alcoholism. This research does not involve any procedures which would present any foreseeable inconvenience or discomfort for you.

As in all research, there may be unforeseen risks to the participants. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to you except as otherwise stated in this consent form. If any problems or discomforts should arise during the course of participating in this research, particularly due to the content of the interviews, the student investigator can refer you to Western Michigan University's University Substance Abuse Clinic (USAC), where services can be provided at no cost to you. Referrals can also be made to other appropriate counseling agencies. In these latter instances, you will be responsible for the cost of counseling if you choose to seek it.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right hand corner of both pages. You should not participate in this project if the corner does not have a stamped date and signature.

Since participation is voluntary, you may withdraw from this research at any time without penalty. If you have any questions or concerns about this study, you may contact either George Compton (the Student Investigator) at (616) 651-6949 or Dr. Edward L. Trembley (the Principal Investigator) at (616) 387-5115. You may also contact the chair of the Human Subjects Institutional Review Board at (616) 387-8293 or the Vice President for Research at (616) 387-8298 with any concerns that you have.

By providing your verbal consent at the conclusion of the reading of this form, you are indicating that the student investigator has explained to you the purpose and conditions of participation in this study and that you agree to participate.
Appendix D
Pre-Interview Guide: Demographic Information
Pre-Interview Guide: Demographic Information

1. Pseudonym:
2. Gender:
3. Age:
4. Marital Status:
5. Race/Ethnicity:
6. Occupation:
7. Education:
8. Religion:
9. Number of Years of Continuous Sobriety:
10. Method of Attaining Sobriety (i.e., Therapy, Treatment Program, Alcoholics Anonymous, Other):
11. Addiction only to Alcohol, or Cross-addicted:
Appendix E

The Interview Guide: Quality of Life Factors
Among Recovering Alcoholics

239
The Interview Guide: Quality of Life Factors Among Recovering Alcoholics

Questions

1. How would you describe the quality of life you have today in sobriety?
2. Is it fair to say that recovery is a continuous process, as some have described it? How would you describe the process you have gone through and the milestones you have experienced?
3. How is life different today than when you were in early sobriety?
4. What are the elements that contribute most significantly to your quality of life in recovery today? Which factors are important on a daily, weekly, or monthly/yearly basis?
5. How has Alcoholics Anonymous contributed to your quality of life in recovery?
6. Could you have achieved this quality of life in recovery without Alcoholics Anonymous? If your answer is “yes,” “no,” or even if you are not sure, could you please explain how you feel about this?
7. In the “Big Book” of Alcoholics Anonymous, the “promises” of recovery (see Appendix F) occur conspicuously after the first nine suggested steps. Why do you think this is so? Have they come true for you? How would you describe this process?
8. Did you ever feel “stuck,” or at a plateau in recovery? What did those experiences feel like?
9. If you were stuck, what were the most important things you did to move yourself beyond that point?
10. At this point in your recovery, how has sobriety influenced your values, worldview, and purpose in life?

11. What impact has continuing sobriety had upon the quality of your relationships?

12. What has been the role of spirituality in your recovery, and in the acquisition of quality of life?

13. What is the meaning for you of your identity as a recovering alcoholic, and its relationship to your quality of sobriety?

14. What has been the significance of surrender in your obtaining quality of life in recovery?

15. How do you feel that powerlessness and unmanageability may be related to surrender?

16. How would you describe the difference between simply not drinking and being sober? What does this have to do with having quality of life in recovery?

17. Are there things about quality recovery that you wish people (in and out of A.A.) understood better? If so, what are they, and how would you wish to express them to others?

18. If you have ever sought therapy in regards to your alcoholism recovery, can you describe for me what that experience was like, and whether or not it facilitated your recovery?

19. What were the most effective aspects of the way therapy was used to treat your alcoholism recovery?
20. If there were aspects of the therapeutic treatment of your alcoholism which you feel could have been addressed more effectively, how do you feel that could have occurred?

21. If you were to try to describe in one sentence what quality of life in alcoholism recovery means to you today, how would you express it?
Appendix F

The Twelve Steps of Alcoholics Anonymous
The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of his will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs (Alcoholics Anonymous, 1976, pp. 59–60).
Appendix G

The Promises of Alcoholics Anonymous
The Promises of Alcoholics Anonymous

We are going to know a new freedom and a new happiness. We will not regret the past nor wish to shut the door on it.

We will comprehend the word “serenity” and we will know peace.

No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear.

We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic security will leave us. We will intuitively know how to handle situations which used to baffle us.

We will suddenly realize that God is doing for us what we could not do for ourselves.

(Alcoholics Anonymous, 1976, pp. 83–84)
Appendix H

Human Subjects Institutional Review Board
Letter of Approval
Date: 8 February 2000

To: Edward Trembly, Principal Investigator
   George Compton, Student Investigator for dissertation

From: Sylvia Culp, Chair

Re: HSIRB Project Number

This letter will serve as confirmation that your research project entitled "Quality of Life Factors Among Recovering Alcoholics" has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 8 February 2001
BIBLIOGRAPHY


Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.


