EXPERIENCES OF INDIVIDUALS WHO MAINTAIN ABSTINENCE FROM MOOD ALTERING SUBSTANCES USING SELF-DIRECTED, COGNITIVE-BASED RECOVERY SUPPORT GROUPS

by

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ABSTRACT

ROBERT HENRY KITZINGER, JR. Experiences of individuals who maintain abstinence from mood altering substances using self-directed, cognitive-based recovery support groups. (Under the direction of DR. PAMELA S. LASSITER)

The purpose of this study was to examine how individuals who utilize self-directed recovery support groups perceive the recovery process and how the described experiences of participants compare to 12-step recovery as reported in existing academic literature. Six individuals who have maintained sobriety for a minimum of one year participated in this qualitative study. The individuals also participated in SMART Recovery, Secular Organizations for Sobriety or Women for Sobriety within the past year, and did not participate in 12-step support groups for at least one year prior to the study's approval date. Data collection included a demographic form and one 60-90 minute, audio-recorded interview, during which participants were asked primarily open questions about their respective experiences in sobriety.

Data analysis consisted of a phenomenological procedure adapted from Moustakas (1994). The procedure revealed that participants perceive the recovery process as beginning with freedom and individual choice, continuing into a sense of community and belonging, proceeding with a journey of self-discovery, and culminating in the development of recovery maintenance tools. Participant experiences relate to 12-step recovery in terms of community and fellowship within recovery support groups. Participant experiences diverge from 12-step recovery in terms of spirituality and adherence to sequential steps or perceived programmatic rigidity. Participants maintain

that sobriety is a “separate issue” and not necessarily related to spiritual/religious issues or to the attendance of recovery support group meetings.

The findings suggest that individuals who use support groups such as SMART Recovery, Secular Organizations for Sobriety, and Women for Sobriety maintain abstinence through face-to-face or online support group meetings and by utilizing a variety of self-directed relapse prevention methods. Counselors are recommended to consider self-directed recovery support groups as a viable referral option for clients dealing with substance use issues. Further research is needed to gain more insight into how individuals use self-directed support groups and online recovery resources to maintain abstinence from mood altering substances.

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DEDICATION

This research is dedicated to the memory of Dave O'Neill. In my imagination, you would have approved. This research is also dedicated to The City of Philadelphia, PA and all past, present, and future residents of The Greater Philadelphia Region: One Love.

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CHAPTER ONE: INTRODUCTION

According to the National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration; SAMHSA, 2011), over 22 million individuals, or approximately 8% of the United States (U.S.) population aged 12 or older would meet criteria for a substance use disorder in the year 2010. The survey also reported that in 2010, over 4 million individuals, or approximately 1.6 percent of all adults in the U.S. received treatment for substance abuse or dependence. It is estimated that only 10-12% of individuals who meet criteria for substance use disorders receive treatment (National Institute on Drug Abuse; NIDA, 2011). According to the SAMHSA (2011) survey, individuals who abused or were dependent on alcohol accounted for a majority of treatment episodes (2.5 million), and over half (2.3 million) of the individuals who received substance abuse treatment in 2010 participated in mutual recovery support groups such as the 12-step programs of Alcoholics Anonymous or Narcotics Anonymous.

Over 90% of substance abuse treatment programs in the United States are 12-step oriented (Rogers & Cobia, 2008), meaning that the framework of 12-step philosophy is integrated into counseling and discharge planning. Substance abuse counseling often includes direction to attend 12-step meetings during or at the termination of treatment (Miller & Bogenschutz, 2007). The 12-step suggestion that a spiritual awakening, found through working through the steps of Alcoholics Anonymous, is a necessary prerequisite to successful recovery from mood-altering substances (Alcoholics Anonymous, 2001;

Warfield & Goldstein, 1996) is often integrated with the psychological components of substance abuse counseling (Bristow-Braitman, 1995).

According to Culbreth and Borders (1999), the substance abuse counseling field is comprised of both recovering and nonrecovering clinicians and also clinicians with and without graduate-level training in counseling. In their survey of substance abuse counseling supervisor perceptions of supervisory style, Reeves, Culbreth, and Greene (1997) concluded that both younger supervisors and supervisors with more graduate education communicate more flexibility in supervisory style than older supervisors and supervisors with less formal education. The authors posited that graduate training exposes counselor trainees to different theoretical approaches, which may translate into "the perception that there are numerous ways for a client to become more healthy" (p. 83).

Regarding the issue of how individuals become healthy in recovery, most providers of substance abuse treatment integrate a spiritual model based on 12-step philosophy (Rogers & Cobia, 2008). A vast majority of practicing substance abuse counselors continue to direct clients toward attendance of 12-step meetings (Miller & Bogenschutz, 2007) despite calls for a wider range of referral options (Kelly, Kahler, & Humphreys, 2010; Vick, 2000) and the possibility that components of 12-step philosophy conflict with overarching theories of professional counseling regarding self-direction and self-responsibility (Le, Ingvarson, & Page, 1995).

This dissertation study described the lived experiences of an underutilized source in professional counseling literature: Individuals successfully maintaining abstinence using support groups outside of traditional, spiritually-based 12-step programs. Chapter One of the proposal is organized as follows: (a) statement of the problem, (b) purpose and

significance of the study, (c) research questions, (d) research design, (e) definition of terms, (f) assumptions, (g) limitations, (h) delimitations, (i) summary, and (j) organization of the proposal.

Statement of the Problem

The field of substance abuse counseling features a range of diversity regarding counselor theoretical orientation (Thombs & Osborn, 2001), educational level (Reeves et al., 1997), and recovery status (Culbreth & Cooper, 2008). Despite this diversity, a majority of substance abuse counseling interventions are delivered from a traditional, 12-step orientation (Rogers & Cobia, 2008; Winters, Stinchfield, Opland, Weller, & Latimer, 2000). Also, counselors are more likely to refer clients to AA than any other mutual support program (Fenster, 2005).

As therapeutic approaches, Cognitive Behavioral Therapy and Motivational Enhancement Therapy have shown recovery outcomes comparable to Twelve Step Facilitation Therapy (Project MATCH Research Group, 1998), and authors of conceptual, peer reviewed journal articles have proposed using existential approaches (Rogers & Cobia, 2008) or art therapy techniques (Horay, 2006) as alternatives to 12-step oriented treatment. In their comparison of Alcoholics Anonymous and professional counseling philosophies, Le et al. (1995) claimed that “counseling theory and AA principles have become enmeshed and roles have become confused” (p. 607), meaning that counselors operate within two overarching frameworks that contain divergent viewpoints on who (the self) or what (a higher power or the 12 steps) is responsible for an individual client’s progress. The authors advocate for a wider variety of support group referral options in substance abuse counseling.

Several options exist in the realm of recovery support groups. For example, Women for Sobriety (WFS) is a female-specific recovery support program based on changed thinking patterns and behavior modification (Kaskutas, 1996; Manhal-Baugus, 1998). In addition, WFS challenges 12-step assertions that sobriety comes from outside the self (Manhal-Baugus, 1998). Secular Organizations for Sobriety (SOS) is a self-directed sobriety support group that also challenges the notion that dependence on a higher power is a necessary determinant of successful recovery (Connors & Derman, 1996). SOS advocates a reasonable, secular approach to recovery and encourages healthy skepticism and application of the scientific method in attempting to understand recovery ("Secular Organizations for Sobriety," 2012). Self-Management and Recovery Training (SMART) utilizes the framework of Rational Emotive Behavioral Therapy (REBT; Ellis, 1962), a cognitive system based on the theory that thoughts and perceptions inform feelings and behaviors. It is difficult to determine the efficacy of these programs through the lens of existing published research due to the lack of attention toward 12-step alternatives.

Purpose and Significance of the Study

The study adds to professional literature by giving voice to individuals who maintain abstinence with the assistance of a self-directed, cognitive-based support program. The study also sought to validate the experiences of individuals who rely on means other than traditional, explicitly spiritual programs. A thorough review of existing literature, the results of which appear in Chapter Two of this proposal, reveals few qualitative studies regarding subjective experiences of individuals in addiction and

recovery. The review of literature also suggests a perceived disconnection between researchers of substance abuse counseling and treatment providers.

Academic researchers and treatment providers may share a mutual disdain regarding appropriate delivery of substance abuse counseling (Bristow-Braitman, 1995), which is a possible explanation for overall tension within the field (Bell, Montoya, Richard, & Dayton, 1998). This perceived tension might stem from a disagreement between academic researchers' emphasis on evidence-based practices and treatment providers' reliance on anecdotal, hands-on experience in substance abuse counseling. Another possible explanation of tension within the field is the opinion that substance abuse counseling "has virtually no empirical evidence to support its purpose and direction" (Reeves et al., 1997, p. 76). Historically, substance abuse treatment programs have "selected practices based on personal recovery experiences rather than on criteria based on data" (Thombs & Osborn, 2001, p. 450). One apparent point of contention within the field is the integration of spiritual, 12-step principles with professional counseling. Conceptual articles in professional counseling journals support the integration of AA's spiritual tenets in substance abuse counseling (Bristow-Braitman, 1995; Warfield & Goldstein, 1996). However, other researchers advocate for clear boundaries between counseling and AA (Le et al., 1995) and articulate the need for a wider variety of support group referral options (Kelly et al., 2010; Vick, 2000).

The purpose of the study is to describe the subjective experiences of individuals who successfully maintain abstinence from mood-altering substances using self-directed, cognitive support groups. The researcher believes that the study informs two significant areas of research that remain relatively unexplored in professional counseling literature:

(1) description of how individuals who use self-directed, cognitive based support groups perceive the recovery/sobriety process, and (2) description of subjective experiences in recovery.

Research Questions

The study will examine the following research questions: (1) How do individuals who maintain abstinence through self-directed, cognitive-based recovery support groups perceive the process of recovery/sobriety, and (2) How do participant experiences compare to 12-step recovery as reported in existing academic literature?

Research Design

Qualitative research is a methodology that permits researchers to "record and understand people in their own terms" (Patton, 2002, p.22). As a methodology, it refers to research that examines spoken words and observable behavior (Taylor & Bogdan, 1998). Qualitative research is appropriate for research questions that explore how people make meaning in their lives (Creswell, 1998). Humans make meaning through describing and interpreting lived experiences (Moustakas, 1994).

The study used a qualitative, phenomenological methodology. As a philosophy, phenomenology addresses conscious experience without the imposition of preconceptions or presuppositions (Spiegelberg, 1975). As a research methodology, phenomenology explores lived experiences (Creswell, 1998) and seeks to understand individual perceptions of reality and meaning (Patton, 2002; Taylor and Bogdan, 1998). To the phenomenological researcher, "the important reality is what people imagine it to be" (Taylor & Bogdan, 1998, p. 3). The phenomenon in question is the experience of

individuals who remain abstinent from mood-altering substances using self-directed mutual support groups.

After receiving approval from the Institutional Review Board for Human Subjects in Research of The University of North Carolina Charlotte (IRB), the researcher approached the primary contact person for the recovery support programs Secular Organizations for Sobriety, SMART Recovery, and Women for Sobriety via email or telephone. The researcher recruited participants by posting a recruitment letter (Appendix B) on the recovery support programs' website forums or email distribution lists and selected a total of six individuals for participation in the study. Participant inclusion criteria were a minimum 12 consecutive months of abstinence prior to the study's approval date and participation in one of the three recovery support programs selected for recruitment. Exclusion criteria were participation in Alcoholics Anonymous or Narcotics Anonymous programs or the use of mood-altering substances within the 12 month period prior to the study's IRB approval date.

After screening participants for eligibility, the researcher distributed an informed consent document (Appendix C) outlining the purpose of the study, participant inclusion criteria, data collection and analysis procedures, informed consent, confidentiality, risks and benefits of the research, and compensation for participation in the study. Participation will included one audio-recorded 60-90 minute interview. The researcher conducted interviews via telephone following receipt of signed consent documents. Further detail regarding participation appears in Chapter Three of the proposal.

Data collection included recorded interviews and a researcher reflexive journal. The reflexive journal is a form of data triangulation that strengthened the study through

using more than one of data source (Patton, 2002). The reflexive journal also allowed the researcher to bracket personal bias (Wertz, 2005). Prior to data collection, the researcher assured participants that access to identifying information is limited to the researcher. Also, interview recordings, transcripts, and data analysis materials were stored in a secure location in compliance with the IRB protocol and destroyed following completion of the study.

Data analysis included steps consistent with phenomenological methodology as outlined by Moustakas (1994). The researcher clustered data into themes, constructed individual textural and structural descriptions of participants, and created composite textural-structural descriptions across all participants. An independent analyst assisted with the analysis process as a form of investigator triangulation, which strengthens a study through the use of more than one researcher (Patton, 2002). The researcher ensured dependability and confirmability of the study through the use of auditing (Lincoln & Guba, 1985) by dissertation committee members. Chapter Three of this proposal contains a detailed explanation of the research design.

Definition of Terms

The following list of terms was compiled from a variety of sources, including recovery support group literature and academic journals in the disciplines of counseling, medicine, nursing, and psychology. Other sources include academic publications on addiction and mental health.

12-step groups are defined as recovery support groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) based on the original 12 Steps of Alcoholics Anonymous. Because the overall 12-step philosophy originated in the

original AA text (Alcoholics Anonymous, 2001) and AA is the most widely used 12-step support group, *12-step programs* and *Alcoholics Anonymous* are sometimes used interchangeably throughout this proposal. Regarding references, this dissertation distinguishes between the terms 12-step program, AA, and recovery support group depending on the language used in cited literature.

Abstinence is operationally defined as refraining from the use of mood-altering substances such as alcohol, cannabis, cocaine, opioids, or sedatives. Participants in this study reported a minimum of 12 consecutive months of abstinence from substance use prior to the date of IRB approval of the study.

Alcoholics Anonymous is a recovery support group based on admission of powerless over addiction, belief that a power greater than oneself can restore one to sanity, and turning one's life over to the care of God (Alcoholics Anonymous, 2001).

Minnesota Model refers to a treatment approach developed in the state of Minnesota during the 1940s that integrated 12-step principles into substance abuse treatment (Cook, 1998).

Mood-altering substances are operationally defined in this proposal as any substance listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) chapter labeled *Substance-Related Disorders* (American Psychiatric Association, 2000) with the exceptions of caffeine and nicotine. While these two substances appear in the manual, the researcher did not include participant use of caffeine or nicotine as exclusion criteria in this study.

Participants are individuals who have maintained a minimum of 12 consecutive months of abstinence prior to the study with the use of a self-directed, cognitive based recovery support group and without the use of 12-step support groups.

Recovery refers to the state of abstinence from mood-altering substances and a process of "recovering" from the effects of substance use. The parameters of recovery vary between recovery support programs. However, recovery is operationally defined in this study as the state of abstinence or sobriety. Recovery and sobriety are often used interchangeably throughout this proposal. However, the researcher made every effort to include the language used in primary sources regarding the terms "recovery" and "sobriety."

Recovery support group is operationally defined as a mutual aid support group designed to assist individuals in recovery/sobriety efforts.

Self-directed, cognitive based recovery support groups are organizations such as Secular Organizations for Sobriety, SMART Recovery, and Women for Sobriety.

Sobriety refers to the state of abstinence from mood-altering substances. It is often used interchangeably with the term "recovery." See the operational definition for *recovery.*

Traditional substance abuse treatment or *12-step oriented treatment* is operationally defined as substance abuse counseling that facilitates participation in 12-step programs, includes participation in 12-step programs during and after treatment, or provides treatment based on the Minnesota Model.

Assumptions

The researcher assumed that participants honestly answered interview questions and accurately recalled experiences in addiction and recovery. The researcher also assumed that themes would emerge regarding participant experiences in recovery.

Limitations

Differences might exist between participants of this study and other individuals who use self-directed support groups. Also, differences might exist between participants and individuals who achieve abstinence through spontaneous remission (Walters, 2000), without the aid of counseling or support groups. The small sample size also limited the researcher's ability to obtain a culturally diverse sample of participants.

Delimitations

The researcher purposely recruited individuals that participate in self-directed, cognitive based recovery support groups and reported a minimum of 12 months continuous abstinence from mood-altering substances.

Summary

Chapter One provided an introduction regarding the importance of exploring the lived experiences of individuals who use self-directed, cognitive based mutual support groups as recovery aids. More than half of individuals who receive treatment for substance use disorders in the U.S. participate in recovery support groups (SAMHSA, 2011). Most treatment providers integrate the principles of one recovery support group, Alcoholics Anonymous (Rogers & Cobia, 2008), and counselors often direct individuals to attend 12-step groups during treatment or following discharge from treatment (Miller & Bogenschutz, 2007).

Recovery support group options exist. Women for Sobriety (WFS) is a female-specific recovery support program based on changed thinking patterns and behavior modification (Kaskutas, 1996) that also challenges 12-step assertions that sobriety comes from outside the self (Manhal-Baugus, 1998). Secular Organizations for Sobriety (SOS) is a self-directed sobriety support group that also challenges the notion that dependence on a higher power is a necessary determinant of successful recovery (Connors & Derman, 1996). SOS advocates a reasonable, secular approach to recovery and encourages skepticism and application of the scientific method in attempting to understand recovery ("Secular Organizations for Sobriety," 2012). Self-Management and Recovery Training (SMART) uses the framework of Rational Emotive Behavioral Therapy (REBT; Ellis, 1962), a cognitive system based on the theory that thoughts and perceptions inform feelings and behaviors. Due to the lack of attention toward 12-step alternatives in published research, it is difficult to determine the efficacy of these programs.

This study used a qualitative methodology to explore the experiences of individuals who utilize self-directed, cognitive based support groups to remain abstinent from mood-altering substances. The study included one audio-recorded 60-90 minute interview with each of six participants recruited through Secular Organizations for Sobriety, SMART Recovery, and Women for Sobriety. The research provides much needed insight into subjective experiences of sobriety. Also, the research contributes to professional counseling literature through examining the use of 12-step support group alternatives, a topic that has received little attention in academic journals to date.

CHAPTER TWO: REVIEW OF LITERATURE

The review of literature examines the theoretical base and the historical use of support groups within professional counseling and the treatment of substance use disorders. The section begins with an overview of substance abuse and dependence issues in the United States (US) and the parameters of recovery according to 12-step philosophy and existing professional mental health counseling literature. Overviews of traditional, 12-step based substance abuse counseling philosophy and relapse prevention models are included, along with an examination of the historical integration of 12-step philosophy and chemical dependency counseling. A review of non-traditional treatment philosophies, which include existential and cognitive approaches, is also included. The chapter describes self-directed, cognitive based recovery support groups and contains an overview of existing outcome studies regarding the treatment of substance use disorders and relapse prevention models. The concluding sections include a summary of the chapter and reflections on the current state of professional substance abuse counseling literature.

Substance Abuse and Dependence Disorders

According to the National Survey on Drug Use and Health (SAMHSA, 2011), over 22 million individuals, or approximately 8% of the US population aged 12 or older were dependent on mood-altering substances in the year 2010. The survey also reported that in 2010, over 4 million individuals, or approximately 1.6 percent of adults in the US

received treatment for substance abuse or dependence. Individuals who abused or were dependent on alcohol accounted for a majority of treatment episodes (2.5 million), and over half (2.3 million) of the individuals who received substance abuse treatment in 2010 participated in self-help groups such as AA or NA.

A majority of substance abuse treatment programs in the United States integrate the framework of 12-step philosophy into treatment (Le et al., 1995; Rogers & Cobia, 2008). Substance abuse counseling often includes direction to attend 12-step meetings during or at the termination of treatment (Miller & Bogenschutz, 2007). The 12-step suggestion that a spiritual awakening, found through working through the steps of Alcoholics Anonymous, is a necessary prerequisite to successful recovery from mood-altering substances (Alcoholics Anonymous, 2001; Warfield & Goldstein, 1996) has influenced professional counselors to integrate the psychological components of recovery with the spiritual tenets of 12-step programs (Bristow-Braitman, 1995). The philosophy of 12-step programs originated in Alcoholics Anonymous, which began with the first meeting between eventual founders Bill Wilson and Dr. Robert Smith in 1935 (White, 1998), held with the goal of assisting alcoholics in the quest to achieve abstinence (Alcoholics Anonymous, 2001). This philosophy has informed the practice of chemical dependency treatment since the development of what is widely known as the Minnesota Model.

Traditional Theories and Methods of Substance Abuse Treatment

The Minnesota Model

The Minnesota Model (MM) of substance abuse treatment developed in the 1940s and 1950s as Alcoholics Anonymous spread to the state of Minnesota and eventually to treatment centers (Cook, 1988). In the late 1940s, Pioneer House was one of the first

centers to develop inpatient treatment primarily focused on the philosophy of AA. The Hazelden Foundation, formed in 1949, opened with the goals of treating professionals and using AA as the core of treatment (White, 1998). The 12-step based, MM-inspired approach remains the most widely used treatment intervention strategy in the U.S. (Winters et al., 2000). According to Cook (2008) MM is defined by four overarching themes: (1) belief in the possibility of change for alcoholics and addicts, (2) the treatment goals of abstinence from mood-altering substances and improved lifestyle, (3) the concept that alcoholism is a disease, and (4) 12-step/AA principles.

Belief in the possibility of change is relevant to prior research findings that suggest individuals with alcohol abuse issues report significantly higher feelings of hopelessness than non-alcoholic individuals (Krampen, 1980). Completion of MM treatment has also correlated positively with increased feelings of control over recovery (Morojele & Stephenson, 1992). Belief in the possibility of change and instillation of hope is also consistent with the theories behind Motivational Interviewing techniques (MI; Miller, 1983) and general counseling theories (Rogers, 1961; Yalom, 1985).

The abstinence tenet of MM treatment is endorsed by a majority of treatment providers (Rogers & Cobia, 2008; Nowinski, Baker, & Carrol, 1992). Abstinence is also relevant to the diagnosis of substance use disorders. Many professional counselors are trained in graduate programs accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP), which are not explicitly aligned with 12-step programs. However, the Council's standards for addictions counseling (CACREP, 2009) include direction for counselors in training to demonstrate competence in using the current edition of the *Diagnostic and statistical manual of mental disorders* (DSM) as a

diagnostic tool. The most current edition (DSM-IV-TR; American Psychiatric Association, 2000) refers to substance use disorders as either substance abuse or substance dependence as opposed to the terms alcoholism or addiction. The introduction to the manual contains a tentative definition of mental disorders: “The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction (p. xxx.).” Despite the apparent uncertainty present in that statement, some counseling professionals have criticized the DSM as part of a static, reductionist medical model that fails to view individuals holistically (Eriksen & Kress, 2006), is based on social conformity (Laungani, 2002), and lacks efficacy in diagnosing and treating individuals from underrepresented or marginalized groups (Kress, Erikson, Rayle, & Ford, 2005).

Regarding periods of abstinence following diagnoses of substance use disorders, the DSM-IV-TR uses the word remission rather than recovery. Remission specifiers in the DSM-IV-TR begin after one month of an individual meeting no criteria for dependence or abuse following a diagnosis of Substance Dependence or Substance Abuse. As a manual of mental disorders, the DSM-IV-TR is integral to the current disease model understanding of substance use disorders in that sustained full remission is marked only by the absence of all substance abuse or dependence criteria for a period of twelve months or longer.

The disease model understanding of addiction, the third tenet of MM treatment, posits that addiction has a genetic component (Morojele & Stephenson, 1992) along with psychological, social, and spiritual dimensions. The disease model conceptualization of

addiction from the Minnesota Model perspective apparently contrasts the moral model understanding of addiction (White, 1998). Prior to explanation of the disease model, it is important to provide an overview of the moral model.

The Moral Model

In moral model conceptualizations of alcohol and drug addiction, individuals alone are held responsible for the etiology of addiction (weak character) and the solution to the problem, which is perceived as willpower to overcome the sinful behavior of excessive substance use (Marlatt, 1980; White, 1998). In this model, addicted individuals are considered in control of behavior, and continued addiction or relapse is evidence that evil remains within an individual (Thombs, 2006). In an examination of the historical connection between morality and alcoholism, May (1997) asserted that interest in the "moral ecology" (p. 170) of alcoholism is rooted in mid-19th century arguments regarding the etiology of addiction and that fundamental questions about the relative truths of moral and disease models remain unanswered. The basic AA text refers to alcoholism as an illness and a disease (Alcoholics Anonymous, 2001). Although disease model concepts often coexist with 12-step philosophy in treatment environments, the original steps of AA include mention of moral inventory, defects of character, and shortcomings.

The Disease Model

The disease model understanding of chemical dependency remains a commonly held belief among substance abuse professionals (Osborn, 1997). According to Gori (1996), assumptions regarding the portrayal of addiction often range between moral and disease models. Thombs (2006) claimed that the emergence of mixed disease-moral

models sustains “incongruous assumptions” (p. 4) that move between the perceptions of whether addicted individuals should receive treatment or face punishment.

Research suggests that mixed disease-moral conceptualizations are common among substance abuse counselors. Thombs and Osborn (2001) used a cluster analysis to examine chemical dependency counselors’ (n=406) clinical orientations. After administering the Treatment Processes Rating Questionnaire and Understanding of Addiction Scale, the authors used the results to group participants into three distinct groups: Counselors who favored a moral-disease (uniform) model, counselors who favored an “incongruent moral-disease-psychosocial model,” (p. 450), and client-centered counselors. Client-directed counselors were the smallest group (15%) and differed from the other groups in reporting that insistence on clients using the AA model was not a central tenet of their respective counseling orientations. The authors concluded that that the largest group (56%), counselors favoring a uniform moral-disease model, showed the least interest in psychosocial interventions. The authors also posited that uniform counselors may demonstrate less willingness to consider or implement new practices or techniques.

Preference for 12-step oriented treatment models also appears relevant to supervision of substance abuse counselors. Culbreth and Borders (1999) found that counselors rated supervisors higher when the recovery status (recovering or non-recovering) of the counselor and supervisor matched. Many established clinicians in the substance abuse field earned supervisory positions through work experience as opposed to formal training (West, Mustaine, & Wyrick, 2002). Graduate level supervisors are more likely than non-graduate level supervisors to support supervisee conceptualization

of client issues that differed from the supervisor's point of view (Reeves et al., 1997). The authors concluded that graduate level supervisors may operate with more flexibility regarding theoretical approaches. Regarding age differences in the study, the authors also posited that younger supervisors may exhibit less rigidity in personal supervision styles than older supervisors.

Relevant to the training of future clinicians, CACREP (2009) has adopted standards for the education of substance abuse counselors in accredited programs. Coupled with the movement to require Master's-level education for licensed substance abuse counselors in many states, adoption of the new CACREP standards places substance abuse counseling at the forefront of issues relevant to current and future counselor educators and supervisors (Hagedorn, 2007). Spirituality is a core tenet of traditional 12-step treatment models (Le et al., 1995; Rogers & Cobia, 2008), and with more non-uniform and client-directed counselors (Thombs & Osborn, 2001) entering the workforce, it seems reasonable to conclude that more person-centered, non-spiritual approaches may emerge as legitimate alternatives to the notion of spiritual centrality in recovery. The spiritual roots of substance abuse counseling approaches are derived from the 12 steps of Alcoholics Anonymous.

Alcoholics Anonymous and its Origins

Bill Wilson and Dr. Robert Smith, referred to as Bill W. and Dr. Bob in AA literature, are credited as founders of Alcoholics Anonymous and creators of the original 12 steps (Alcoholics Anonymous, 2001). AA was also influenced by Oxford Groups, originally called The First Century Christian Fellowship, founded by Lutheran minister Frank Buchman in 1908 (Kurtz, 1979). The groups centered on the suggestion that

spiritual change is the central tenet of personal healing. Oxford Groups focused on the spiritual principles of confidence, confession, conviction, conversion, and continuance (White, 1998). Regarding the problematic use of alcohol, Oxford Group methods included recognition of defeat by alcohol, service to others, and submission of self to the help of a higher power (Finlay, 2000). Oxford Group philosophy apparently influenced the original Twelve Steps of Alcoholics Anonymous. In the original AA text (Alcoholics Anonymous, 2001), the first three steps read:

> 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.* (p. 59).

Regarding the religious roots of AA, Bill W. also cited *The Varieties of Human Experience* (James, 1911) as a major influence on his personal understanding of spirituality's transformational power (Finlay, 2000) and the value of surrender after periods of chaos and suffering (White, 1998). Regarding religious conversion, James (1911) states:

> It makes a great difference to a man whether one set of his ideas, or another, be the centre of his energy; and it makes a great difference, as regards any set of ideas which he may possess, whether they become central or remain peripheral to him. To say that a man is 'converted' means, in these terms, that religious ideas, previously peripheral in his consciousness, now take a central place, and that religious aims form the habitual centre of his energy. (p. 196).

It seems reasonable to conclude that the writings of James directly influenced AA philosophy. While James (1911) wrote of religious conversion, the original AA text states in Step Twelve that a spiritual awakening is necessary to the successful recovery of alcoholism according to AA (Alcoholics Anonymous, 2001).

The Spiritual Awakening in AA

AA literature claims that the program relies on spiritual principles but does not require any specific religious beliefs (Alcoholics Anonymous, 1952). However, regarding the legality of forcing individuals to attend AA meetings, state and federal courts have ruled that, based on a reading of the 12 steps, AA is religious in nature (Magura, 2007). After admission of powerlessness over alcohol and life unmanageability, the steps progress through the second step, an attainment of the belief that a Power greater than oneself can restore sanity, and the third step, which includes turning over one's will to God as understood by the individual. The 12 steps also include making a fearless moral inventory, admitting the nature of wrongs, and offering a humble petition for God to remove one's shortcomings. The last four steps of AA involve making amends, ongoing personal inventory and admission of wrongdoing, the seeking of improved conscious contact with God, and, following a spiritual awakening, attempting to carry the message to other alcoholics and practice AA principles in all affairs (Alcoholics Anonymous, 2001).

In the quest for spiritual awakening, the other major component of recovery from the AA model is fellowship, which consists of sponsorship and attendance of 12-step group meetings. Within the framework of AA, recovery includes working the steps, attending meetings, working with a sponsor, and prayer/meditation. Professional counseling literature has called for the merging of AA's spiritual principles with cognitive-behavioral psychology (Bristow-Braitman, 1995). The suggestion that recovery from mood-altering substances includes cognitive, behavioral, and spiritual components has also received support in academic journals (Warfield & Goldstein, 1996).

Spirituality and Addiction

Regarding traditional, 12-step philosophy of treating substance use disorders, the ultimate expression of positive spirituality has been described as a relationship with God (Warfield & Goldstein, 1996). Step Three of AA involves turning one's will and life over to God (Alcoholics Anonymous, 1952). Research suggests that treating substance use disorders using spiritual approaches helps many clients. Johnsen (1993) surveyed a sample from a Minnesota Model substance abuse treatment program (n=174) and found that prayer and meditation was important to the spiritual recovery of the participants. He tentatively concluded that spirituality was a strength that recovering individuals use in sobriety. The mean age of his study was 36.8 years.

Other research suggests that 12-step, spiritual models are not the best approach for treating adolescents. In their study of spiritual orientation of adolescents in substance abuse treatment, Sohlkhah et al. (2009) found that participants (n=181) reported significantly lower spirituality scores than adults in a similar treatment setting on a measure developed to gauge response to 12-step philosophy and spirituality. The authors concluded that adolescents are not "little adults" (p. 69) and that traditional substance abuse treatment methods may prove less effective in treating adolescents. Wong et al. (2009) examined the treatment histories of participants ages 14-26 in the At Risk Youth Study and found that 50.8 % of the authors' analysis sample (n=478) reported at least one prior substance abuse treatment episode. In a survey of perceptions of and experiences with AA/NA, the most common reason cited by adolescents for dropping out of 12-step groups were boredom and lack of fit (Kelly, Myers, & Rodolico, 2008).

According to Hohman and LeCroy (1996), adolescent post-treatment attendance of AA meetings positively correlated with higher rates of abstinence (77%) at the time of the study than adolescents who did not attend meetings in a survey based study with a small sample (n=70). However, almost half (49%) of the non-affiliated with AA sample also remained abstinent. The authors found that the non-AA affiliated group were more hopeful and had higher levels of parental involvement in treatment than the AA affiliated group. If adolescents are regularly integrated into adult populations in substance abuse treatment that feature 12-step orientation, they are apparently exposed to high levels of the spiritual components of AA and NA early and often, regardless of individual characteristics or spiritual orientation.

Prior research supports the assertion that prayer and spirituality are positive contributors to sobriety for some individuals. In a quantitative, interview-based pilot study on spirituality and cravings, Mason, Deane, Kelly, and Crowe (2009) found that 75% of male participants age 19-74 (n=77) believed spirituality and religion were important parts of substance abuse treatment. Spirituality and self-efficacy regarding sobriety were positively related in the study. However, the generalizability of the study is questionable due to exclusive sampling within a faith-based program. Participants were drawn from a program that featured regular attendance of AA or NA meetings and chapel services. As the authors noted, the study is limited by the lack of control group, the contribution of factors other than spirituality to self-efficacy, and the absence of results in a secular program. During their review of literature on spirituality and addiction, Miller and Bogenschutz (2007) stated that few well-controlled trials exist regarding the scientific study of spiritual interventions. While prior studies suggest that spirituality is a

positive influence (Johnsen, 1993; Mason et al., 2009), it is also possible that spirituality is detrimental to some individuals in recovery.

Cashwell, Clarke, and Graves (2009) suggested that *spiritual bypass* "is a way to enlist religion or spirituality to avoid the work of healing one's development" (p. 39). The authors claimed that spiritual bypass occurs when an individual uses spirituality in an unhealthy way to avoid emotional distress. While the authors suggested that some individuals in recovery may use religion to avoid psychological or emotional issues, other recovering individuals might not practice religion. Regarding nonspirituality, Tonigan, Miller, and Schermer (2002) found that individuals who identify as non-religious drop out and avoid 12-step meetings at a higher rate than individuals who self-label as spiritual or religious.

Religious/Spiritual Orientation

A review of existing professional literature in the substance abuse counseling field reveals that few studies exist regarding the efficacy of secular programs or individual recovery experiences of individuals who identify as atheistic, agnostic, or non-spiritual. Few articles appeared in a broader search for articles referencing atheism, agnosticism, or non-spirituality in any professional counseling journal. In one of the few articles, the authors (D'Andrea & Sprenger, 2007) advocated for the consideration of self-described atheists and agnostics as a distinct cultural group. The authors stated that professional literature regarding belief systems and spirituality often omits discussion of individuals without religious or spiritual beliefs as a diversity issue.

Research studies often exclude non-Christian religious identities or specific subsets of non-spirituality as demographic characteristics, either through design or lack of

a sample population. For example, in a survey instrument-based study of spiritual transcendence as a predictor of psychosocial outcomes (n=73) in an outpatient substance abuse treatment program, Piedmont (2004) concluded that spiritual transcendence, as defined by higher scores on his Spiritual Transcendence Scale (STS), among participants associated with more favorable outcomes on the study's symptom and coping indices over the course of an 8-week program. Concerning religious affiliation, 44% were Baptist, 21% were Roman Catholic, 8% were Methodist, 3% were Episcopalian, 9% were "other Christian," 6% were Muslim, and 9% indicated "other." It appears that 85% of his sample identified as Christian, and a majority of his sample was male (57 men and 16 women), ages 19 to 66 ($M = 41$). The sample was primarily African-American (85%) but adhered to the historical tendency for substance abuse research to sample primarily Christian, male alcohol users in studies.

Other studies have shown that individuals who report higher levels of religious orientation are less likely to have substance abuse or dependence disorders (Connor, Anglin, Annon, & Longshore, 2009; Miller & Bogenschutz, 2007). Individuals who self-report high levels of religious involvement also report low levels of substance abuse or dependence. A thorough review of the literature regarding spirituality and addiction reveals the theme that spirituality often acts as a protective measure against substance abuse or dependence (Miller & Bogenschutz, 2007). What remains unclear is whether the spiritual awakening as described by AA (Alcoholics Anonymous, 2001) and proponents of 12-step oriented substance abuse treatment (Warfield & Goldstein, 1996) are necessary determinants of recovery or the best referral fit for all individuals.

The introductory pamphlet *Frequently Asked Questions About AA* (Alcoholics Anonymous, 1952), explains: "A.A. suggests that to achieve and maintain sobriety, alcoholics need to accept and depend upon another Power recognized as greater than themselves" (p. 19). The existing body of professional literature offers no clear answer regarding the question of how counseling professionals might treat individuals who communicate or demonstrate an inability or refusal to accept the aforementioned prerequisite need for the achievement of sobriety. The suggestion that it is possible for individuals to arrest substance dependence issues through self-will seems antithetical to AA Step Two (Alcoholics Anonymous, 2001) "Came to believe that a Power greater than ourselves could restore us to sanity," (p. 13) and Step Three, "Made a decision to turn our will and our lives over to the care of God as we understood Him." (p. 13).

From the AA perspective, recovery maintenance is a lifelong process that involves continued participation in 12-step groups, sponsorship, and working through the steps. Addiction is arrested but not overcome. Non-spiritual methods of substance abuse treatment and theories endorsed by professional counselors often focus on personal responsibility (Le et al., 1995), as opposed to the 12-step focus on higher power, adherence to program instructions, and addressing of character defects.

Non-Traditional Theories and Methods of Substance Abuse Treatment

Motivational Interviewing

Motivational Interviewing (MI) was first used with substance abusing populations and later used with other behavioral issues (Miller, 1983). Brown and Miller (1993) found that MI positively impacted treatment engagement and drug use outcomes with a sample of psychiatric hospital admissions. According to Miller and Rose (2009), MI was

developed to utilize the principles of using accurate empathy in counseling (Rogers, 1961). Miller and Rose (2009) suggested that a coherent theory of MI is emerging and that MI is complementary to other treatment methods. Therefore, clinicians might utilize MI as an alternative to 12-step orientations or as a means to facilitate client engagement in 12-step programs.

The MI philosophy is comprised of four basic principles. The first principle is *expressing empathy.* Miller and Rollnick (2002) define this practice as accepting and attempting to understand clients without endorsing or criticizing behaviors. Regarding substance abuse issues, clinicians might express empathy within the realms of environmental relapse trigger concerns, interpersonal issues, client behavioral patterns, attitudes toward addiction or recovery, ambivalence toward counseling or treatment, and individual attitudes toward 12-step orientation.

The second principle of MI is *developing discrepancy.* Clinicians assist clients by amplifying perceived discrepancies between current behavior or attitudes and client goals. It is important to note that the authors omit mention of counselor goals or program goals. As stated earlier, clients are often directed to attend AA or NA meetings as part of counseling or substance abuse treatment (Miller & Bogenschutz, 2007). MI appears to address a current deficiency in developed research and theory regarding what to do with clients who refuse to engage in 12-step programs. Clinicians are often advised to move client attitudes and behaviors toward acceptance of 12-step theory (Nowinksi, Baker, & Carroll, 1992), but it remains unclear whether clients resistant to the 12 steps would benefit more from individualized treatment and relapse prevention planning. In a case

study of mediators of treatment effectiveness, Karno (2007) found that clinician confrontation in substance abuse treatment had a negative impact on session attendance.

Rolling with resistance is the third principle of MI, which encourages clinicians to respect the individual while using MI strategies. Miller and Rollnick (2002) suggested that perceived client resistance is a signal that the counselor should alter personal behavior or approach rather than confronting the client's perceived resistance. The idea of rolling with resistance seems to mark a core difference between the philosophies of MI and 12-step oriented treatments.

Despite the widespread, nearly exclusive use of 12-step models to address substance abuse and dependence in treatment, individuals often cease using mood-altering substances with no formal intervention. Walters (2000) used the term *spontaneous remission* to describe the phenomenon of achieving abstinence without the help of substance abuse treatment, counseling, 12-step programs, or any other formal intervention. In the author's review of existing professional literature, he found that individuals who decided to cease using mood-altering substances independent of outside intervention cited health concerns, feelings of disgust, and "will to stop" (p. 455) as motivating or determining factors. In a theoretical debate article regarding the principles of free will versus determinism, Howard (1993) defined *determinism* as the theory that certain events are produced or caused by other events.

If most substance abuse treatment offered in the United States features a 12-step orientation (Rogers & Cobia, 2008) and the deterministic quality of the 12 steps includes turning one's will over to a higher power, it seems that spontaneous remission and other non 12-step recovery phenomena remain relatively unexplored. Professional counselors

would benefit from a variety of support group referral options (Kelly et al., 2010; Le et al., 1995; Vick, 2000). Regarding self-described eclectic therapists, Prochaska (1979) stated that eclecticism includes relativistic thinking patterns. Relativistic perspectives are contextual and contain more than one valid system or theory (Prochaska & DiClemente, 1982), which seems incongruent with the traditional model of substance abuse treatment.

The fourth and final principle of MI is *supporting self-efficacy.* This tenet of MI suggests that belief in the possibility of change is important for both the clinician and counselor in developing client self-efficacy regarding recovery. Prior studies have shown a positive relationship between spirituality and self-efficacy in recovery (Johnsen, 1993; Mason et al., 2009). However, the current body of research offers little insight into other contributing factors to positive self-efficacy in recovery or the suggestion that individuals free themselves from substance dependence progressively, over time (Yeh, Che, & Wu, 2009).

Prochaska and DiClemente (1992) outlined the process of client behavioral change within five stages. The authors suggested that clients do not move through the stages in a linear fashion but instead in a spiral pattern marked by circling back through prior stages in a gradual movement toward behavioral change. The stages are (1) *precontemplation,* (2) *contemplation,* (3) *preparation,* (4) *action,* and (5) *maintenance.* The authors also suggest that individuals move through a process of change independent of formal counseling, treatment, or support group intervention. The stages of change approach informs the *biopsychosocial model,* which assumes that addiction is determined by multiple etiologies and develops through stages (Marlatt & Gordon, 1985). In an earlier version of their model, Prochaska and DiClemente (1982) suggested that "human

action is freely chosen and to say anything else determines our choice is to show bad faith in ourselves as free beings" (p. 279).

Existential Approaches

Freedom is a central tenet of existential psychotherapy. Individuals are responsible for choices and actions, and humans are charged with creating meaning in a world that has no inherent meaning (Yalom, 1980). The importance of meaning making in psychology was introduced by May (1953) in *Man's Search for Himself* and Frankl (1962) in *Man's Search for Meaning,* which presented the framework for his development of *logotherapy,* or therapy by meaning. Frankl (1962) described his experience in a World War II concentration camp, during which he was separated from his family and lived under the constant threat of death while almost daily witnessing murders of other incarcerated individuals. He lived through his experience and survived to develop a seminal piece of psychological theory, and more specifically, the theory of existential psychotherapy. Frankl (1969) described individuals' will to meaning and posited that all humans are disposed to searching for meaning in their respective lives.

Philosopher, novelist, and playwright Jean-Paul Sartre (1969) also contributed to the formation of existential psychoanalysis through his charge that human beings should strive for freedom, personal responsibility, and authenticity. In his landmark work *Existential Psychotherapy,* Yalom (1980) described the perceived need for professionals to practice psychology with immediacy and to view individuals as fellow travelers rather than afflicted patients or clients. The basic tenets of his philosophy of human existence were the individual struggle with (a) death, (b) existential anxiety, (c) existential guilt, and (d) isolation. In existential approaches, guilt arises when people do not act in

accordance with their respective authentic selves and instead transfer personal power to an external individual or force.

In an examination of substance abuse counseling and 12-step program orientations, Rogers and Cobia (2008) proposed the use of existential approaches in treating client substance abuse issues. The authors posited that existential approaches focus less on the specific substance abuse issue and more on using an empathetic approach that encourages clients to accept personal responsibility. The authors concluded that existential approaches are appropriate for counseling individuals through struggles with personal freedom, alienation from others, development of personal values, and the search for meaning in life.

Some non-traditional approaches differ in technique but share the same goal as traditional forms of substance abuse treatment: Moving clients toward adherence to the 12-step model. In a survey of existing literature in using art therapy with substance abusing or dependent populations, Horay (2006) found that a majority of art therapy interventions were designed to confront perceived client resistance, elicit the admission of client powerlessness over addiction, and foster the creation of recovery as a positive experience. Horay (2006) suggested using art therapy in tandem with the tenets of MI (Miller, 1983) and Stages of Change (Prochaska & DiClemente, 1992) in order to encourage client self-efficacy and explore rather than confront client ambivalence toward recovery. Along with different counseling theories and change models, specific frameworks and support groups for confronting substance abuse and dependence issues have emerged as alternatives to the traditional, 12-step approach.

The 16 Steps and Women for Sobriety

In her critique of the 12-step model and presentation of an alternative 16-step model, Kasl (1992) opined that 12-step philosophy often fails to address the recovery needs of women and minorities, partially due to the White, upper middle class roots of Alcoholics Anonymous and drug and alcohol treatment. The author's criticisms of the AA model included the assertion that AA sends a mixed message in that AA literature clearly states that it is not a religious program. Despite the claim, she perceived the opening paragraph of the *How It Works* chapter in the basic AA text (Alcoholics Anonymous, 2001) as an echo of Christian righteousness. The paragraph begins:

> Rarely have we seen a person fail who has not thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault; they seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty (p. 58).

Kasl (1992) explained that 12-step models are a poor fit for women due to the promotion of what she perceives as a patriarchal, hierarchical structure that relies on external authority. The author also states that critical feedback of the 12-step model is not welcome in AA /NA meetings and mentions that the original twelve steps were based primarily on the experiences of White males.

Other theorists have suggested that treatment for female substance abuse issues should build on relationships and connections with others (Manhal-Baugus, 1998), and a prior study on post-treatment affiliation with AA in a sample (n=162) drawn from a Swedish treatment center found that women were more likely than men to call an AA member for help (Bodin, 2006). Regarding the issue of women in recovery, Prendergast,

Messina, Hall, and Warda (2011) found that attendees of women-only outpatient treatment (n=135) reported significantly lower incidents of post-treatment substance use compared to a participants of mixed-gender outpatient treatment programs (n=124), which supported the authors' argument that treatment needs of women are different that those of men. However, Kaskutas, Zhang, French, and Whitbrodt (2005) found that substance-dependent women (n=122) exhibited no significant difference in abstinence rates between members of a community women's program and members of mixed gender community and hospital programs.

Regarding the point of traditional male dominance in AA and substance abuse research, McCreary, Newcomb, and Sandava (1999) examined the impact of (a) stereotypical male gender roles, (b) attitudes toward traditional male roles, and (c) the impact of masculine gender role stress with a sample of males (n=106) and females (n=181) on alcohol consumption and alcohol-related problems. All participants were graduating seniors from a Canadian university who volunteered for a longitudinal study with follow up periods of six months, one year, and four years. The researchers retained 73% of the original sample at the four-year follow up. The authors found that men who held traditional male gender role values correlated with more alcohol consumption and that women who possessed stronger beliefs regarding traditional male roles experienced higher rates of alcohol-related problems. The authors' findings apparently support the suggestion that internalization of traditional male values in treatment may inhibit the recovery processes of women (Kasl, 1992).

Kaskutas (1996) stated that Women for Sobriety (WFS), a self-help organization separate from traditional 12-step groups, developed due to the perception that women

seeking sobriety should focus on changing thought patterns as opposed to relying on an external higher power. WFS promotes an abstinence-based model, and other stated goals are emotional/spiritual growth and improved feelings of self-esteem. WFS does not direct women to attend AA meetings, but some members participate in both WFS and 12-step recovery groups.

In her 1991 survey of WFS members (n=600), Kaskutas (1996) found that length of sobriety rates among respondents who attended WFS meetings alone were comparable to rates of members who reported attending both WFS and AA meetings. The author also noted that the more members referred themselves to WFS (40%) than through any other referral method, and 13% of referrals to WFS came from treatment centers. While WFS is comprised of 100% female membership, a survey of more than 8,000 members of AA in the US and Canada revealed that AA participants were 67% and 33% female. Over 85% of survey respondents were White. The survey states that the average age of AA membership survey respondents was 47 years, and the most common member occupation is retired, followed by self-employed/other, manager/administrator, and professional/technical. Approximately 39% of respondents reported that a healthcare referral brought them to AA (Alcoholics Anonymous, 2008), three times higher than the referral rate to WFS cited in Kaskutas (1996).

SMART Recovery and Rational Recovery

Rational Recovery (RR; Trimpey, 1988) was developed as a non-spiritual, cognitive-based method of confronting alcohol abuse and dependence issues. In an examination of RR membership, Galanter, Egelko, and Edwards (1993) found that 47% of RR meeting attendees surveyed (n=429) “believe in God or a Universal Spirit,” (p.

505) and 13% identified religion as very important in their lives. In an examination of God beliefs and AA attendance (n=1,526), Tonigan et al. (2002) used a sample of Project MATCH outpatient and aftercare participants and found that self-described atheists and agnostics attended significantly fewer AA meetings than their religious and spiritual counterparts at follow up interviews. In their conclusion, the authors stated that AA may not be an appropriate referral for atheist and agnostic individuals, which could explain the high levels of individuals (87%) in surveyed RR groups who report that religion is not important in their lives.

Self-Management and Recovery Training (SMART) program provides a cognitive behavioral framework for individuals to confront substance abuse and dependence issues. The program is not centered on spirituality but instead the basic tenets of self-motivation, coping, management of self-defeating behaviors, and a balanced lifestyle (Horvath & Velten, 2000). SMART Recovery is based on Rational Emotive Behavior Therapy (REBT; Ellis, 1962) techniques for disputing irrational thoughts and combating negative self-talk. Ellis (2000) called REBT an internal control psychology that teaches people to improve relations with other people through self-change.

Clinicians are more likely to refer patients to AA than any other mutual self-help program such as SMART Recovery (Fenster, 2005). In their inquiry into why individuals refuse participation in or drop out of 12-step groups, Kelly et al., (2010) found that participants rated social anxiety, low motivation to attend, and no perceived need for attendance as the most common factors. The authors also concluded that participant perceptions regarding discouragement of discussing psychiatric issues or medication in 12-step fellowships and discomfort with spirituality during meetings may contribute to

initial refusal to attend or discontinuance of meeting attendance. The authors recommended that clinicians explore the possibility of referring clients to non 12-step groups such as SMART Recovery when clients refuse to attend 12-step meetings. Vick (2000) suggested that the cognitive approach of RR is also an appropriate referral for college students as an alternative to the AA approach that teaches powerlessness.

Secular Organizations for Sobriety

According to Connors and Derman (1996), Secular Organizations for Sobriety (also known as Save Our Selves) was founded in 1986 as a support group alternative to the religious and spiritual messages of AA. SOS argued for the viability of secular self-help groups that would promote individual "sobriety priority" as opposed to dependence on a higher power. SOS groups are "free and autonomous" and seek to provide peer support, a forum for the expression of thoughts and feelings regarding sobriety, and a "nonreligious atmosphere" (p. 283). The existing body of academic counseling literature contains almost no mention of SOS as a recovery support group referral option.

Harm Reduction

Controversy remains within the field of substance abuse counseling regarding abstinence and harm reduction (Grant 2009). 12-step oriented treatments traditionally practice from abstinence models, meaning that recovery entails the absolute cessation of substance use, whereas harm reduction strategies, which include methadone treatment, needle exchange programs, and reduction of risk-taking behaviors during or as a result of substance use (Hayes, Curry, Freeman, & Kuch, 2010). While there is little discussion of harm reduction in US professional counseling journals, McCambridge and Strang (2004) tracked the progress of individuals age 16-20 (n=105) in London, U.K. who received

motivational interviewing and found that the sample reduced overall levels of cigarette, alcohol, and cannabis use. However, the treatment produced low levels of post-treatment abstinence. The authors concluded that the interventions benefit moderate use as opposed to abstinence or "quitting altogether" (p. 99).

Based on interviews regarding staff (n=18) and participant (n=32) experiences of harm reduction programs, Lee and Zerai (2010) recommended the demarginalization of individuals with substance abuse issues. The authors stated that any positive change regarding substance use should suggest a positive outcome. The authors also noted that perceptions of positive outcomes according to the US substance abuse treatment standard are dualistic in that perceived success is related only to long-term sobriety and perceived failures include non-abstinence and non-completion of treatment. Much of the published research regarding substance abuse counseling focuses on outcome studies regarding abstinence and treatment completion rates.

Outcome Studies

Project MATCH (Project MATCH Research Group, 1998) studied the interactions of matching clients (n=1,726) to three treatment approaches: Twelve Step Facilitation Therapy, Motivational Enhancement Therapy, and Cognitive Behavioral Therapy based on hypothesized best fit according to 20 client attributes. The research group concluded that all three treatment approaches contributed to positive outcomes for outpatient clients that maintained at follow up periods from 3, 6, 9, 15, and up to 39 months. During treatment, Motivational Enhancement Therapy (MET) was the least effective in "limiting drinking and drinking related consequences" (p. 593). However, the research group found little difference in the post-treatment outcomes of the three

approaches despite the clear differences in philosophy and technique. The authors reported that more members of the Twelve Step Facilitation Therapy group were able to maintain abstinence than members of the other groups. The authors also suggested that relapses of Twelve Step Facilitation Therapy (TSF) participants may last longer than the recipients of either Motivational Enhancement Therapy or Cognitive Behavioral Therapy.

Regarding Motivational Enhancement Therapy, Project MATCH (1998) confirmed its hypothesis that the non-confrontational style of MET would benefit outpatient clients with higher scores on pre-treatment anger scales, which seems consistent with prior findings that Motivational Interviewing techniques are also effective with individuals in inpatient levels of care (Miller, 1983). Cognitive Behavioral Therapy (CBT) was most effective with participants on the lower end of substance dependence scales, while TSF had the best outcomes with individuals who scored on the higher end of the dependence spectrum. TSF also had the highest level positive outcomes among aftercare patients in the study. In the discussion section, the research team concluded that individuals who seek treatment generally experience positive outcomes.

Outcome studies regarding the use of 12-step programs in the treatment of substance abuse and dependence have focused on different aspects of the 12-step model. Some research studies focus on the efficacy of Alcoholics Anonymous participation on abstinence from mood-altering substances. Research suggests that AA/NA participation correlates with higher rates of abstinence (Magura, 2007). Other studies have asserted that AA participation causes decreases in alcohol consumption and related problems (McKellar, Stewart, & Humphreys, 2003).

In a study of directive approaches and motivational enhancement on facilitation to participate in AA, Walitzer, Derman, and Barrick (2002) found that directive approaches led to more AA involvement and that such involvement contributed to more participant days of abstinence than a control group that did not receive directive treatment. Motivational Enhancement techniques had no significant effect on post-treatment AA attendance. The authors also noted that motivational enhancement approaches are more client-centered, thereby less likely to overtly direct clients to AA. Motivational interviewing approaches also show significantly better outcomes than no treatment (Lundahl & Burke, 2009) and comparable outcomes to 12-step based therapy (Lundahl & Burke, 2009; Project MATCH Research Group, 1998). In addition to the counseling approaches, techniques, and support group philosophies outlined above, treatment for substance use also employs relapse prevention strategies.

Relapse Prevention Models

Several models of relapse prevention exist to assist individuals in maintaining recovery and reducing alcohol and drug use when relapse occurs. Relapse prevention involves habit change and social learning (Marlatt & Gordon, 1985). The theory that cognitive and behavioral events are the catalysts for relapse contrasts the philosophy of 12-step based treatment (Rawson, Obert, McCann, & Marinelli-Casey, 1993). Bandura (1977) related social learning to self-efficacy, and the relapse prevention movement is built on a cognitive-behavioral framework (Rawson et al., 1993).

Substance abuse treatment and relapse prevention also includes cognitive-behavioral techniques. Project MATCH (1998) found that Cognitive-Behavioral Therapy (CBT) had comparable success rates to both Motivational Enhancement Techniques and

Twelve Step Facilitation Therapy. In an examination of Project MATCH participant satisfaction scores, Donovan, Kadden, DiClemente, and Carroll (2002) found that outpatient participants of the CBT group indicated higher levels of satisfaction that members of the Motivational Enhancement and Twelve Step Facilitation participant groups. According to Rawson et al. (1993), the work of Marlatt and Gordon (1985) was a major influence on the further development of relapse prevention models.

The Center for Applied Sciences (CENAPS) relapse prevention model (Gorski, 1989) also includes a cognitive behavioral focus and outlines processes for individuals to assume personal responsibility in recovery efforts and combat negative self-talk. The techniques of confronting negative self-talk and decreasing irrational thoughts are based on Rational Emotive Behavior Therapy (Ellis, 1962). The CENAPS model (Gorski, 1989) also includes self-directed cognitive and written assignments designed to self-monitor recovery maintenance.

Relapse prevention models have contributed to positive abstinence outcomes with different psychoactive drugs. Stephens, Roffman, and Simpson (1994) found that recipients of relapse prevention interventions based on the Marlatt and Gordon (1985) model reported lower levels of post-treatment marijuana use at 3-month follow up interviews than recipients of a social support group approach. Recovery Training and Self-Help (RTSH), a psychosocial relapse prevention approach, significantly decreased relapse rates of outpatient opiate abusers (McAuliffe & Chien, 1986).

In a study of post-treatment relapse prevention outcomes, Moser and Annis (1996) found that the number of different relapse prevention coping strategies used positively correlated with non-drinking outcomes following a self-described crisis

situation. The authors found that participants who reported no use of coping strategies had less than a 10% chance of achieving non-drinking outcomes in crisis situations. Empirical findings on the use of relapse prevention models in treating substance use disorders appear consistent with the suggestion that relapse prevention methods allow individuals to engage in positive, meaningful behaviors in response to high-risk situations in recovery (Rawson et al., 1993). However, few published studies focus on individual experiences utilizing the cognitive theories and techniques of relapse prevention or individual perceptions and experiences of the recovery process.

Subjective Experiences of Recovery

In the existing professional counseling literature, little attention is given to individual experiences of recovery or what individuals believe recovery entails. In one of the few existing qualitative studies on individual recovery processes (n=57), Mohatt et al., (2007) used a heuristic model in concluding that Alaska Native participants moved through what the authors called Stage One sobriety, characterized by cravings and the desire to drink, and Stage Two sobriety, during which participants were concerned less with coping and more with "living life as it was meant to be lived" (p. 205). Prior to the sobriety stages, participant narratives included experiences of (a) thinking over drinking versus sobriety, (b) experimenting with sobriety, and (c) a self-described turning point. Participants cited reflection, self-questioning, losing a loved one to suicide, and self-healing as perceived turning points. Some participants explicitly stated that they did not need AA; one participant mentioned AA as part of his sober support but clearly stated that he got sober on his own. Spirituality was perceived by one participant as an experience of regaining control in his life. Findings of this study seem contrary to the

alleged error of self-reliance claimed in the 12-step model. The AA basic text (Alcoholics Anonymous, 2001) states:

> …the actual or potential alcoholic, with hardly an exception, will be *absolutely unable to stop drinking on the basis of self-knowledge.* We wish to emphasize and re-emphasize, to smash home upon our alcoholic readers as it has been revealed to us out of bitter experience (p. 39).

This dissertation study sought to describe the experiences of individuals who utilize support groups that promote the values of self-knowledge and self-efficacy in recovery. A rich history of tradition, theory, and research has informed the existing body of knowledge regarding the treatment of substance use disorders. However, it appears that the substance abuse counseling field might benefit from turning to the expertise of an underutilized resource: The perceptions and experiences of individuals who maintain abstinence using self-directed strategies and support groups.

Summary and Conclusion

This review of literature examined the historical use of 12-step support groups and theoretical base in professional counseling and treatment of substance use disorders. The chapter began with an overview of substance abuse and dependence issues in the United States (US) and recovery according to 12-step philosophy and existing professional mental health counseling literature. The chapter also included reviews of traditional and non-traditional substance abuse counseling philosophies and relapse prevention models. The chapter concluded with an examination of existing outcome studies regarding substance abuse treatment and relapse prevention strategies.

The overall strengths of the existing professional literature on substance abuse include a coherent argument for the efficacy of 12-step oriented treatment (Magura et al., 2007; McKellar, Stewart, & Humphreys, 2003; Project MATCH Research Group, 1998),

an explanation of the positive relationship between spirituality and recovery (Connor et al., 2009; Miller & Bogenschutz, 2007; Piedmont, 2004) and the development of theory and techniques within a 12-step oriented treatment framework (Bristow-Braitman, 1995). Clearly, 12-step oriented treatment and support groups have assisted many individuals in recovery. Although outcome studies on non-traditional models are scarce, the literature base includes theoretical proposals for using Motivational Interviewing (Miller, 1983), art therapy (Horay, 2006), and existential approaches (Rogers & Cobia, 2008). Also, the existing literature base provides adequate information on relapse prevention frameworks (Gorski, 1989; Marlatt & Gordon, 1985) and non-12 step recovery such as Women for Sobriety and SMART Recovery.

The overall weaknesses of the existing literature are a relative lack of consideration for 12-step treatment models from a multicultural perspective, the dearth of research studies on the efficacy of alternative programs, and the almost complete omission of subjective individual experiences of abstinence or the process of becoming abstinent. Also, there is little discussion in the existing literature base regarding how individuals achieve abstinence through means other than 12-step support groups or 12-step oriented treatment. Due to the preponderance of 12-step orientation among providers, it appears that spirituality remains a central component of most formal substance abuse treatment interventions.

A thorough review of available literature in substance abuse counseling reveals two apparently contradictory themes: (1) During treatment, substance abuse counselors often utilize structured relapse prevention models, which are primarily based on self-efficacy (Bandura, 1977) and are cognitive in nature (Gorski, 1989; Marlatt & Gordon,

1985), and (2) the majority of substance abuse treatment is provided within the 12-step framework (Miller & Bogenschutz, 2007; Rogers & Cobia, 2008), which proposes that a spiritual awakening is necessary for successful recovery and suggests that individuals rely on a higher power as opposed to self-will in recovery (Alcoholics Anonymous, 2001). The outcomes of Project MATCH (1998) suggest that cognitive-behavioral and motivational enhancement techniques produce outcomes comparable to twelve step facilitation therapy. Also, Donovan et al. (2002) found that participants in the cognitive behavioral group during Project MATCH (1998) reported higher patient satisfaction scores than the other two groups.

The substance abuse counseling field apparently remains committed to traditional 12-step oriented treatment and referrals despite theoretical (Kasl, 1992; Le et al., 1995; Rogers & Cobia, 2008) and empirical (Kelly et al., 2010) challenges regarding the appropriateness of the uniform application of the AA model to all treatment-seeking or mandated clients. Tension between the “mystical, imprecise” (p. 553) nature of AA and the attitudes of academic researchers might explain the apparent disconnection between published research findings and application of those findings by clinicians (Bell et al., 1998). Bristow-Braitman (1995) opined that a possibly unrivaled mutual disdain exists between substance abuse researchers and treatment providers. This dissertation seeks to deemphasize this perceived tension while embracing the respective worldviews of individuals who successfully maintain abstinence using an approach that has received little attention from professional counseling literature to date.

Several non-traditional options are available for clinicians to use if clients exhibit aversion to 12-step oriented treatment or if a different theoretical model/support group

seems a more appropriate fit for individual clients. Because the current literature base offers no clear, uniform answer regarding the most effective approach, it seems that individual clinicians remain free to choose which theories or techniques are most appropriate with clients, and individuals remain free to choose support groups that best reflect their respective worldviews. Through qualitative inquiry, this study examined and explored the perceptions and lived experiences of individuals who choose self-directed, cognitive-based methods to support their respective recovery efforts.

CHAPTER THREE: METHODOLOGY

Introduction

Chapter Three includes description of the research purpose and research questions, a brief overview of qualitative research as it pertains to the study, explanation of phenomenology and rationale for the use of phenomenological research methods, and a detailed outline of the research design and procedures. The research procedures section includes explanation of recruitment, data collection, data analysis, measures to ensure confidentiality, and risks and benefits of the research. The study explored the perceptions of individuals who utilize self-directed recovery support groups in their respective recovery efforts. The primary research question was: “How do individuals who maintain abstinence through self-directed, cognitive-based recovery support groups perceive the process of recovery/sobriety?” The second research question was: “How do participant experiences compare to 12-step recovery as reported in existing academic literature?” Qualitative research is appropriate for this study considering the lack of available published literature regarding recovery support groups other than 12-step programs. A qualitative methodology allowed the researcher to access detailed descriptions of lived experiences in recovery.

Qualitative Research

Taylor and Bogdan (1998) state that *qualitative methodology* refers “in the broadest sense to research that produces descriptive data—people’s own written or

spoken words and observable behavior" (p.7). Qualitative methodology is appropriate for research questions that explore how people make meaning in their lives (Creswell, 1998; Taylor & Bogdan, 1998). Qualitative measures permit researchers to "record and understand people in their own terms" (Patton, 2002, p. 22). This study operated within a constructivist research paradigm, during which the researcher explored socially constructed realities. A qualitative, constructivist approach provided a lens for the consideration of individualistic worldviews (Ponterotto, 2002). The qualitative approach was appropriate for the exploratory nature of this research, which sought to illuminate and validate the experiences of individuals who utilized non-traditional methods to maintain sobriety. Within the qualitative approach, the researcher used a phenomenological method, which seeks descriptions as opposed to explanations. Descriptions "keep a phenomenon alive, illuminate its presence, accentuate its underlying meanings, enable the phenomenon to linger, retain its spirit, as near to its actual nature as possible" (Moustakas, 1994, p. 59).

Phenomenology

Phenomenology is a philosophical movement concerned with the conscious experience of phenomena "as free as possible from unexamined preconceptions and presuppositions" (Spiegelberg, 1975, p. 3). Though they are not the first documented discussions of phenomenological concepts, the writings of German philosopher and mathematician Edmund Husserl (1859-1938) are most readily associated with the phenomenological movement as a science and philosophy (Creswell, 1998; Spiegelberg, 1975). Other philosophers and psychologists describe the phenomenological perspective as the study of a thing in itself (Sartre, 1969; Yalom, 1980). The Husserlian suggestions

that humans collect evidence through sensory experience and that self-acquired knowledge is necessary for philosophical beginnings were influenced by the writings of Descartes (1641/2008), who claimed that in order to reject false opinions, one must "straight away attack the very principles that form the basis of all [his] former beliefs" (p. 17).

As a research method, phenomenology applies the aforementioned philosophical tenets to exploring lived experiences (Creswell, 1998) and understanding individual perceptions of reality and meaning (Patton, 2002; Taylor & Bogdan, 1998). For the phenomenological researcher, "the important reality is what people imagine it to be" (Taylor & Bogdan, 1998, p. 3). Phenomenology rejects subject-object dichotomy, meaning that the reality of objects are perceived within a subject's experience (Creswell, 1998). As stated earlier, no published research to date explores the recovery experiences of individuals who utilize cognitive-based, self-directed support groups. However, researchers have used phenomenological methods to explore the use of specific substance treatment techniques and the perceived role of others in recovery.

Monakes, Garza, Wiesner, and Watts (2011) used a phenomenological methodology to examine the perceptions of four adult male substance abusers regarding Adlerian sand tray therapy. The sand tray activities were integrated within an overall cognitive-based treatment program for substance abuse. Using open questions in a long interview format, the researchers developed themes from participant responses and concluded that, following an initial period of discomfort, the participants discovered personal insights and enjoyed a positive, collective experience during the sand tray activities. Participants agreed that the sand tray therapy uncovered deep insights and

motivated them to pursue positive goals. In the concluding section, the authors noted that, although the study did not measure specific goals or changes, "of central importance was that the participants viewed themselves as having improved their self-efficacy to move forward and establish positive life goals" (p. 104). This study sought to utilize a similar methodological approach by focusing on the subjective experiences of individuals in recovery.

Palmer and Daniluk (2007) also used a phenomenological approach to explore the perceptions of six recovering individuals regarding the role of other people in their respective recovery efforts. Using unstructured interviews, the researchers developed descriptions of participants' perceived facilitating and impeding interactions with others across the themes of loss, understanding, support, belonging, meaning, helpfulness, and hope within the context of personal recovery experiences. In the discussion section, the authors assigned significance to participant perceptions regarding both positive and negative interactions leading to positive change. The researchers concluded that a counselor would benefit from "assuming the perspective of the client as expert in terms of their addiction" (p. 210) and maintaining a role as supporter of the client's healing process. Phenomenology is appropriate for this qualitative inquiry due to the nature of the research questions and the overall aim of the study, which is to explore the lived experiences of recovering individuals.

Because wisdom is acquired through individual experience from a phenomenological perspective (Husserl, 1950/1970; Keller, 1999), the researcher's experience of another person also affects an observed experience. Bracketing or *epochés* (Husserl, 1939/1954) are strategies that allow the researcher to preserve unbiased

description of an observed experience. These strategies are further discussed in the following section outlining the role of the researcher and again in the explanation of procedures to establish trustworthiness.

Research Design

Role of Researcher

In qualitative inquiry, the researcher is the instrument (Rossman & Rallis, 2003). From a phenomenological perspective, the researcher creates "social constructions of social constructions" (Taylor & Bogdan, 1998, p. 19). Phenomenology requires *reflexivity*, which involves (1) the unexamined reflexes in both researcher and participant and (2) reflectivity and introspection from the researcher's perspective (Rossman & Rallis, 2003). The researcher assumed responsibility for the participant selection and data collection. The researcher also used a reflexive journal to bracket his experience and "reflectively describe the meanings and psychological performances of lived-through situations" (Wertz, 2005, p. 168). The journal served as a form of *analytic memo*, which is designed to facilitate researcher reflection (Maxwell, 2005).

Bracketing or *epochés* (Husserl, 1939/1954) are strategies that allow the researcher to preserve unbiased description of an observed experience. The *epoché of the natural sciences* requires the researcher to bracket "natural scientific theories, explanations, hypotheses, and conceptualizations of the subject matter" (Wertz, 2005, p. 168). The researcher sets aside presuppositions based on prior scientific knowledge and approaches individual study of lived phenomena within the context of consciousness (Polkinghorne, 1989), returning to what Wertz (2005) called a "natural attitude," which is "the unreflective apprehension of the world as it is lived, precisely as it is encountered in

everyday affairs" (p. 168). The method also marks a return to the traditional philosophical quest for wisdom through means other than pure empirical science (Creswell, 1998; Stewart & Mickunas, 1990).

The *epoché of the natural attitude* involves bracketing belief in existence of the "validity of human situations," which allows the researcher to reflect on "how the life-world presents itself" (Wertz, 2005, p. 168). The epochés provide space for *eidetic reduction,* the method of studying themes through free imaginative variation (Husserl 1913/1962). The emerging themes are connected with universals (e.g., temporality or relation to self and others) and meanings within everyday experiences. Through the epoché and reduction processes, the researcher blends the present with "what is imagined as present from the vantage point of possible meanings; thus a unity of the real and the ideal" (Moustakas, 1994, p. 27). The use of phenomenological epochés in this study provided the researcher with opportunities to address personal biases developed throughout the researcher's lived experiences and to remain focused on the collection and analysis of interview data.

Researcher Subjectivity

In 2007, I received a Master of Arts (M.A.) degree in Community Counseling and a graduate certificate in substance abuse counseling. My education included 12 credits in graduate level chemical dependency courses. The foundation for my current beliefs and biases regarding the art and science of counseling was built during my Master's program. Through my studies, I embraced a biological, psychological, and social understanding of substance use disorders. I also learned that counselors in training possess diverse attitudes toward working with addicted individuals. I encountered students who sought

understanding of addiction from a compassionate perspective. I also studied with individuals who apparently embraced moral model perceptions of addiction and upheld notions of social stigma regarding substance dependence.

I believe that counselors are entitled to their respective opinions on addiction or any other issue. I also believe that, within the context of counseling relationships, it is the ethical duty of counselors to respect all clients, including individuals who struggle with substance use. I believe that the existence of over 22 million Americans with addiction issues (SAMHSA, 2011) is a strong basis for an argument that all counseling professionals must acquaint themselves with basic knowledge of addiction and recovery processes. I chose my dissertation topic in part to assist counselors in understanding experiences of individuals who struggle with substance abuse and dependence.

In five years of clinical experience in a substance abuse treatment center and a county jail, I have provided group and individual counseling to male and female individuals aged 16-73 in both inpatient and outpatient settings. During that time, I developed personally meaningful relationships with hundreds of individuals who struggle with substance use issues. Many of these individuals embraced 12-step philosophy and considered AA/NA a necessary component of successful recovery, while others struggled within the 12-step construct or rejected the model completely. As a counselor, I often felt frustrated by the perceived lack of options or support available for individuals seeking strategies outside of the dominant 12-step model.

In addition to my academic and professional experiences, personal experiences also influence my perceptions. I have attended AA/NA meetings in the past and decided that the philosophy and format was a poor fit for me. More specifically, I experienced

aversion to what I perceived as the religious overtones and rigidity of the culture. As a person with a history of substance-related issues, I was interested in how AA/NA might help me. I perceived that the emphases on finding a higher power and surrendering self-will outweighed the potential positive benefits. From my perspective, the 12 steps outline too much external control and too little self-reliance.

I possess strong personal beliefs, opinions, and biases regarding addiction, treatment, and recovery. I believe that individuals with substance use issues encompass such a wide range of physical, emotional, cognitive, interpersonal, cultural, and spiritual diversity that it is difficult to present a typical case. I believe that subjective experiences of addiction and recovery are unique and that people utilize a variety of methods to maintain sobriety. As a counselor, I believe in providing treatment and relapse prevention options as opposed to counseling all individuals from the perspective of a single treatment philosophy. I am biased toward a person-centered approach and away from program-centered approaches to substance abuse counseling.

While my personal and professional experiences are potential disadvantages to the research, I believe that my counseling/rapport building skills and familiarity with addiction and recovery processes also augmented the data collection and analysis. Regarding the data analysis, I have completed five doctoral level research courses, including two courses that exclusively focused on qualitative methodology. I also completed a qualitative prospectus design project and two qualitative data analysis projects that featured topics related to this proposal. In order to protect the integrity of the research, I paid close attention to reflexivity and bracketing during the data collection and analysis processes.

Data Collection

Participant Interviews

Participant interviews occurred after the researcher completed the steps outlined for recruitment in the *Procedures* section of this proposal. Recruitment letters (Appendix B) included explanations for the purpose of the study, participant inclusion criteria, data collection and analysis procedures, informed consent, confidentiality, risks and benefits of the research, and compensation for participation. The letter explained that participation included two interviews: one audio-recorded 60 minute face-to-face or telephone interview and, if necessary, a second, 20-30 minute follow up interview to further elucidate participant answers and utilize member checking. The letter also stated that participants would receive a choice of a $25.00 prepaid Shell gas card or an Apple iTunes gift card after completion of the second interview and that they would maintain the right to withdraw from the research at any time with no penalty.

Data collection included the demographic form (Appendix D) and participant interviews. The interview protocol (Appendix A) contains primarily open-ended questions (Creswell, 1998; Patton, 2002). The guide implemented the feedback of the dissertation committee, which includes individuals familiar with qualitative methodology and substance abuse counseling practice and research. The interview guide ensured that the researcher explored the same topics with all participants (Taylor & Bogdan, 1998). The open interview questions examined participants’ lived experiences in addiction and recovery. Semi-structured interviews allowed the researcher to further explore specific questions as appropriate within the context of each respective interview (Patton, 2002).

The questions remained consistent with the central concepts or phenomena (Creswell, 1998) of addiction and recovery processes.

The research explored participant experiences in recovery during the interviews. The researcher inquired about participants' emotional, cognitive, behavioral, spiritual, and interpersonal experiences in recovery. Questions also focused on participants' self-perception and self-relation in recovery, perceptions of addiction and recovery processes, and perceived turning points regarding the decision to seek abstinence. The questions focused on participant perceptions regarding the nature of addiction, effective relapse prevention strategies, threats to continued sobriety, internal and external influences in recovery, and the participants' respective decisions to seek sobriety. Appendix A contains the complete guide.

The researcher anticipated variation regarding client preferences of addiction-related language. For example, some participants apparently preferred the term sobriety to recovery or self-referred as either a sober person or an alcoholic. The researcher remained attentive to participant language and adjusted the wording of questions accordingly.

Reflexive Journal

The reflexive journal provided the researcher with opportunities to bracket researcher bias (Patton, 2002). The journaling process occurred outside of the interview process. The researcher made entries before and after each participant interview.

Data Analysis

During the data analysis process, the researcher began with what Wertz (2005) described as a required “attitude of wonder that is highly empathic” (p. 172). Through reflexive journaling, participation in interviews, and immersion in collected data, the researcher remained in the epoché process. The data analysis followed the steps of phenomenological research proposed by Giorgi (1997): (a) collection of verbal data, (b) reading the data, (c) breaking the data into parts, (d) organization and “expression of the data from a disciplinary perspective” (p. 242), and (e) synthesis or summary of the data. More specifically, the data analysis included a modification of the Stevick-Colaizzi-Keen method presented by Moustakas (1994). With the modified Stevick-Colaizzi-Keen method as a general guide, the researcher analyzed the data using the following steps:

1. *Full description of the researcher’s own experience of the phenomenon.* In the *Researcher Subjectivity* section of this dissertation, the researcher provided an overview of his perceptions regarding the phenomena of addiction and recovery within the contexts of his personal, educational, and professional experiences. The researcher also described his personal experience within the context of participant interviews through the use of a reflexive journal. Full description of the researcher’s experience provided space for the epoché process and ensured that the researcher perceived and described participant experience “in its totality, in a fresh and open way” (Moustakas, 1994, p. 34).

2. *Immersion in collected data and recording of relevant statements.* The researcher listened to each recorded interview in its entirety prior to transcription. The researcher also read and reflected upon reflexive journal entries throughout

the data analysis process. Immersion in collected data is consistent with the process of bracketing researcher bias (Wertz, 2005).

3. *Listing significant statements and excluding overlapping and repetitive statements.* The researcher and independent analyst separately followed the modified Stevick-Colaizzi-Keen method (Moustakas, 1994) of (a) considering each participant statement in a single interview, (b) recording all significant statements, and (c) excluding repetitive and overlapping statements. After the completion of the interview transcription and member checking processes, the researcher and independent analyst separately recorded significant statements and produced independent lists for each participant interview transcript.

4. *Clustering horizons into themes.* After following the aforementioned three steps, each of the two researchers produced a list of meaning units or horizons (Moustakas, 1994) regarding participant experiences. The researcher and independent analyst collaboratively examined the separate lists of horizons for the first of transcript and produced a final list of horizons for the first transcript (Tim). Each significant statement from the lists were examined separately and included on the final list if the analysts agreed (a) that the statement was significant and (b) that the statement was not repetitive or overlapping. The process was repeated for each individual transcript. After the process produced a final list of horizons, each analyst independently clustered the individual meaning units into themes and then collaborated to develop a final list of themes or “clusters of meanings” (Creswell, 1998, p. 55). The analysts agreed on a list of themes for the first transcript (Tim) and then used a form of *constant comparative*

(Creswell, 1998) theme development to compare the transcript one themes to transcript two, adding new categories of themes or altering the overall category name as needed. The analysts applied this process to each separate transcript until a final list of meaning clusters was constructed.

5. *Constructing textural descriptions for each participant and a composite textural description.* The researcher then consulted the final list of categorized themes and produced a narrative description for each participant. After constructing textural descriptions for each participant, the researcher created a composite textural description across all participant experiences.

6. *Constructing structural descriptions for each participant and a composite structural description.* Through the process of free imaginative variation, the researcher consulted the individual textural description of each participant and sought to describe participant perceptions in order to "distinguish essential features from those that are accidental or incidental" (Wertz, 2005, p. 168). Imaginative variation aims to arrive at underlying factors of an experience and asks, "How did the experience of the phenomenon come to be what it is?" (Moustakas, 1994, p. 98). After constructing individual structural descriptions, the researcher created a composite structural description across all participant experiences.

7. *Constructing a composite textural-structural description.* The researcher consulted the textural, structural, and composite descriptions and constructed a composite integration of meanings. The composite textural-structural description

represented “a universal description of the experience representing the group as a whole” (Moustakas, 1994, p. 122).

Procedures

Participants

Purposive sampling allowed the researcher to recruit individuals who would enrich understanding through description of a phenomenon (Polkinghorne, 2005). In this study, the phenomenon is maintenance of abstinence for at least 12 consecutive months from the study’s approval date using a self-directed, cognitive based support group. The researcher recruited two participants from each of the recovery support group programs Secular Organization for Sobriety, SMART Recovery, and Women for Sobriety for a total of six participants.

The researcher attempted to recruit a sample that reflected a diversity of culture regarding age, gender, race, ethnicity, occupation, sexual orientation, and socio-economic status. Participants varied in age from 33 to 65. Five of the participants identified as White/Caucasian, and one participant identified as Hispanic. Regarding sexual orientation, five of the participants identified as heterosexual, and one participant identified as bisexual. The sample reflected a range of geographic diversity. Four participants reside in large metropolitan areas, and two participants live in either rural or smaller town environments. Three participants reside in the U.S. Southwest or “West,” one resides in the U.S. Northwest, one resides in the U.S. Midwest, and one lives in the U.S. Northeast. Gender representation was equal with three female and three male participants. Participant self-described socioeconomic status ranged from “poor” and “I

don't have much money," to "middle." Occupation/employment status included "currently unemployed," "disabled," "self-employed," and "management."

The researcher selected six individuals who met the following inclusion criteria: (a) abstinence from mood altering substances for a minimum of 12 consecutive months from the study's approval date, and (b) participation in a self-directed, cognitive based recovery support group during the 12 month period prior to the study's approval date. Exclusion criteria included (a) participation in 12-step recovery support groups such as Alcoholics Anonymous and Narcotics Anonymous during the 12 month period prior to the study's approval date, and (b) substance use during the 12 month period prior to the study's approval date. All participants verified that they met inclusion criteria prior to the beginning of data collection.

The rationale for excluding participants of 12-step programs was that the study sought understanding of recovery processes for individuals who do not use AA or related support groups. The rationale for excluding individuals who used substances during the past 12 months was that the study focused on the phenomenon of sustained abstinence within the context of self-directed, cognitive based support groups. As discussed in the review of literature, the existing body of professional literature offers little insight into self-directed, cognitive based support groups, especially from a qualitative perspective. Therefore, this exploratory, phenomenological research sought to gain new insights into the recovery experiences of individuals who utilize such groups.

Participant Recruitment

After receiving approval from the Institutional Review Board for Human Subjects in Research of The University of North Carolina Charlotte (IRB) to proceed with the

study, the researcher approached the primary contact for each of the three selected support group organizations via email or telephone. After receiving permission from the executive director and research directors of SMART Recovery, the researcher posted a recruitment letter on the SMART Recovery support group message forum. After receiving permission from the founder of SOS and the director of WFS, the researcher requested that members of SOS and WFS receive the recruitment letter via email. Participants initially contacted the research via email or telephone. During the initial contact, the researcher screened potential participants using the inclusion and exclusion criteria listed in the previous section of this proposal. During the screening process, the researcher obtained only information necessary to determine eligibility for participation and sample diversity. The researcher mailed informed consent documents (Appendix C) to selected participants and provided postage-paid envelopes for the return of signed informed consent documents. The consent form repeated information from the recruitment letter and included contact information for the researcher, the university's research compliance office, and the dissertation committee chair.

Risks and Benefits of the Research

The researcher anticipated minimal potential risk to participants. Due to the sensitive nature of the explored phenomena, the researcher anticipated that participants might express concern about anonymity. Prior to the conduction of the first interview, the researcher reviewed the purpose of the research, data collection and analysis procedures, confidentiality, and all other details of the informed consent document with each participant. The researcher informed participants that only the research team would have

access to data, which included demographic information, interview recordings, and transcriptions.

The researcher assured participants that access to identifying information was limited to the researcher and that audio recordings, transcripts, and data analysis materials would remain stored in a secure location in compliance with the IRB protocol and destroyed following completion of the research process. The researcher deleted all interview audio recordings after completion of the data analysis and destroyed all paper documents using the UNCC Counseling Department shredding machine following conclusion of the research study. Interviews did not proceed until the researcher provided the opportunity for participants to ask questions regarding the research study and measures to ensure confidentiality.

The researcher anticipated that participants might not often discuss aspects of addiction and recovery experiences. The researcher also anticipated that the process of explaining substance use history and associated thoughts and feelings might lead to emotional discomfort. Individuals who meet criteria for substance use disorders or receive treatment for such disorders often perceive external stigma or experience self-stigmatization (Luoma et al., 2006). However, research also suggests that individuals gain improved self-acceptance through recovery from substance abuse (Payne, 2010). All selected participants are currently maintaining abstinence.

While participant stories of addiction and recovery might provoke uncomfortable feelings or unpleasant memories, the goal of the research was to explore the phenomenon of recovery as it is lived by individual participants. The researcher used open questions, rapport building, and appropriate use of silence to facilitate a comfortable interview

environment. Open questions allowed participants to answer individual questions according to their respective comfort levels. The researcher believed that potential benefits of the study outweighed the aforementioned potential risks.

The researcher anticipated that participants would benefit from the opportunity to describe the successful maintenance of abstinence. Participants may benefit from the knowledge that publication of the research could raise student, counselor, and researcher awareness of recovery experiences. Also, it is possible that participants discovered new insights into their respective lived experiences in addiction and recovery through descriptive explanation. Descriptions of experiences may "provide data that transcend even what the participants themselves think or know about the topic" (Wertz, 2005, p. 171).

Procedures to Establish Trustworthiness

Standards of quality and verification procedures ensure the trustworthiness of qualitative research. Creswell (1998) describes standards as criteria imposed by researchers and others regarding the conduction of research and verification as a process that occurs throughout the conduction of research. This study addressed emerging standards in qualitative research (Lincoln, 2002) through adherence to publication guidelines, giving voice to participant experiences, and engaging in the "heightened self-awareness" (p. 196) of critical subjectivity.

The researcher ensured c*redibility* (Lincoln & Guba, 1985) through *member checking* (Denzin & Lincoln, 2007), which provided opportunities for participants to check transcripts for accuracy. The use of an independent researcher for theme development provided researcher triangulation. The researcher ensured *dependability* and

confirmability (Lincoln & Guba, 1985) through the use of auditing by dissertation committee members who have extensive experience in substance abuse counseling practice and qualitative research methods. Consultation with the independent analyst and qualitative methodologist during the data analysis and with the dissertation committee members throughout the dissertation research process also addressed the issue of dependability.

The researcher addressed potential limitations regarding the aforementioned researcher life experiences and biases through the use of several techniques, such as reflexive journaling and bracketing. Reflexive journaling is a method of bracketing researcher bias (Patton, 2002). Also, the independent analyst provided researcher triangulation (Patton, 2002), which further mediated researcher bias. The data collection and analysis sections of this chapter outlined the strategies in detail. Also, two members of the dissertation committee have extensive experience in substance abuse counseling and will examine the audit trail for potential researcher bias.

Summary

Chapter Three began with a description of the research purpose and research questions, a brief overview of qualitative research as it pertains to the study, explanation of phenomenology and rationale for the use of phenomenological research methods, and a detailed outline of the research design and procedures. The research procedures section included explanations of the recruitment process, data collection, data analysis, methods to ensure confidentiality, and risks and benefits of the research. Qualitative methodology with a phenomenological approach is appropriate for this study due to the lack of available published research on self-directed, cognitive based recovery support groups

and the nature of the primary research question, which is, “How do individuals who maintain abstinence through self-directed, cognitive-based recovery support programs perceive the process of recovery/sobriety?”

Following the sections regarding the use qualitative methodology and the rationale for using phenomenology, the chapter detailed the research design and procedures. The research design section included explanation of the role of the researcher in qualitative, phenomenological research, and a statement of researcher subjectivity. The chapter also included an explanation of data collection and analysis steps. Data collection included the processes of interviewing and reflexive journal entries. The data analysis section included the phenomenological analysis steps. The procedures section included participant selection, recruitment procedures, measures to ensure confidentiality, risks and benefits of the research, and procedures to establish trustworthiness. Chapter Three concluded with a summary of the chapter organization.

CHAPTER FOUR: FINDINGS AND INTERPRETATIONS

Introduction

Chapter Four includes a detailed description of the data collection and analysis steps that led to the findings and interpretations. The categories of participant perceptions of the recovery process included openness/individualized choice/freedom, community/sense of belonging, journey to self-discovery, and recovery maintenance tools. This chapter begins with a textural description of each individual participant's experience across the aforementioned themes. The textural descriptions also contain background information for each participant to provide detail and cultural context regarding individual experiences. Following the individual textural descriptions, the chapter includes a composite textural description that synthesizes the textural descriptions across all participant experiences.

Following the individual and composite textural descriptions, the chapter includes the construction of structural descriptions of each individual experience. The next section describes a composite structural synthesis across all participants including emergent themes and a textural structural synthesis. Chapter Four concludes with a summary of the chapter organization.

Textural Description: Tim

Background information

Tim is a Caucasian, heterosexual male in his 40s. Tim is currently self-employed, resides in the U.S. Southwest and has earned a Bachelor's degree. Regarding his current socioeconomic status, Tim states, "I would say that I am middle class." He learned about this study through a fellow SOS member and through the SOS website. Tim initially contacted the researcher via email and indicated that he was interested and met all inclusion criteria. On what made him decide to participate in the study, Tim states:

> I'm a big supporter of SOS and I was hoping that in some way it helps the organization and the movement to just have you know…someone who's had a very positive experience and good things to say about it…and, that's my motivation.

Tim's current length of sobriety is 23 years. He began involvement with SOS approximately 6 months into his period of sobriety, "22 and a half years ago." He attended AA meetings for "three or four months" in early sobriety. When asked about his last attendance of an AA meeting, Tim responded, "The last time I attended was 1988." He has participated in SOS since he became sober 23 years ago.

Openness/individualized choice/freedom

Tim perceives that his process of recovery began after "sort of an accumulation of being sick and tired of my life." Regarding the experience that led him to seek help in recovery support groups, Tim states:

> …well there was no sort of immediate lightning bolt or anything but you know I would say that life in general was…rather bleak and sick all the time and I found myself continuing to drink and drink and drink and at some level I knew at a rational level this is crazy this has got to stop if I want to have any hope of recovering some semblance of good things in life…I sort of knew intellectually that I had to stop and I was down but, I guess I never tried that seriously on my own…

Once Tim made the decision to pursue sobriety, he became interested in the "self-help, nonprofessional" aspect of recovery support groups because "there was no sort of authority telling you what to do, it was a self-help peer group." Initially, Tim found such support in AA meetings. However, Tim "had trouble" with the AA reliance on "the concept of a god or higher power or sort of, you know, religious or spiritual traditions or practices," so he explored SOS after reading about meetings that occurred on the U.S. West Coast.

Two aspects of SOS immediately struck Tim as particularly helpful: (1) His perception that, in SOS, "sobriety was treated as a completely separate issue from everything else in life," which was what he expected from a recovery support group rather than "beliefs and practices that did not work" for him, and (2) His perception that SOS required or encouraged no fostering "of dependence on the group." Beyond the environment of recovery group dynamics, these aspects of SOS appeal to Tim's sense of independence and insistence that his sobriety is independent of recovery support group participation. Although he continues association with SOS, Tim states "I don't feel like now…that I have to go to SOS meetings or I will drink, that's nonsense, that's got nothing to do with it…"

Tim's chosen association with SOS reminds him of where he "came from" and why he enjoys life in sobriety today. While he feels supported by the "community of like-minded people who've had a similar experience," he maintains that "whether somebody gets it in AA or SOS" is entirely up to the individual. On how he would respond to individuals who are considering participation in a recovery support group, Tim states, "I

guess I would talk to them and find out—I would make all the options available, I would tell them everything I know about the different groups."

Tim believes that the process of recovery involves self-reliance and self-direction. Regarding what he relies on most in recovery, Tim states:

> …you have to face the challenges as they come and draw on whatever resources you have to face them, I guess in general not being a religious person I can't give a kind of neat answer that you know I rely on god to fix everything because I don't, and I certainly appreciate the support and help of friends and colleagues and, I try to get whatever I need from them when I can and I give back also, but there's no guarantees…

Tim reduces all recovery-related issues to a single statement, which is that "the fundamental bottom line is do not drink or use no matter what." When he faces adversity, Tim reminds himself that "drinking is not going to make it any better" and that "there are no magical guarantees," but he prefers to deal with situations "in a reasonable way."

Tim also feels free from the influence of alcohol. He has "almost no reaction to it." Tim does not intentionally seek out the presence of alcohol, but when he encounters alcohol in a store or at a family function, he states that it "doesn't apply to me, you know, you don't even really see it, it's like I know it's there, I know there's bars on the corner, and I know it's all out there but it…it's not any sort of obsession or something that I particularly notice…"

Community/relation to others/sense of belonging

Tim believes that community and relation to others are part of his recovery but not a "determinant" of the recovery process. He perceives that his "relationships with others have a genuine and honest quality" that was not present when he was drinking. Tim felt encouraged by early interactions with other sober people in AA and SOS. On his early meeting experiences, Tim recalls:

> …at first feeling sort of exhilarated because I saw these sober people who were actually getting on with life and, and, seemingly happy and that was just exciting because it seemed to, you know, show that this was possible, since some of the stories were not unlike mine, so initially encouraging…

Regarding AA meetings in terms of relationships, Tim's initial feelings of encouragement gradually changed to discomfort. Tim's discomfort stemmed from his perception that other AA members were initially "content" to let Tim sit and listen but "by three or four months" there was "more pressure to get a sponsor" and "do the steps."

After transitioning into SOS, Tim continued to feel encouraged by stories of other people in recovery. Regarding his perceptions of sobriety in an SOS meeting during his first year of sobriety, Tim states:

> It just seemed like such an impossibility, almost beyond my ability to comprehend, and another fellow was celebrating his first year of sobriety…and I listened to him describe what his drinking had been like and what the year since had been like and it really, it really relieved some pressure and I think because… it seemed feasible, it didn't seem, you know, the idea didn't seem so…to hear, did not seem so impossible or daunting.

As stated earlier, Tim believes that meeting attendance is not a necessary determinant of sobriety. Regarding SOS meetings, Tim states, "I certainly get something out of it and certainly I think that it's a sobriety-enhancing experience, but I don't feel that it's a matter of, you know, a necessary part of sobriety, it's a separate issue…" However, he feels a sense of belonging in SOS meetings. Of his SOS friends, Tim states that they "have sort of been through similar experiences we have similar reactions and, it's very helpful to know that there are people with same basic feelings and reactions, people who are like-minded and similarly inclined…" The community of SOS also provides Tim with less "positive" but personally helpful reminders of Tim's commitment to sobriety. Tim

describes his experience with an individual who attended SOS meetings for a short time, and then the individual

> …disappeared and one could presume that he didn't stay sober, and that's just very sad and, but in a way, it reinforces my sobriety, too. I mean I wish he had made it, I'd wish that on anyone, and I tried to offer whatever help I could, but, the reminders of people who don't, they're sort of negative reinforcers too…

Journey to self-discovery/self-awareness/self-knowledge

Tim perceives that his recovery process involved a shift in thinking toward the idea that abstinence from alcohol use was the way for Tim to transform himself into "a functional human being." He believes that that abstinence applies not only to his personal journey, but also to the respective journeys of any individual struggling with a substance use issue. On the issue of moderation versus abstinence, Tim states, "…abstinence from alcohol and other mind-altering drugs and that's I think the sensible approach for the overwhelming majority of people who are going to be seeking help for that sort of thing."

The transition from "the religious and spiritual aspects" of AA meetings into the "feisty and independent-minded" nature of SOS meetings was also part of Tim's journey. He believes that he is "an alcoholic." However, he conceptualizes alcoholism in specific terms:

> … I'm comfortable with the word alcoholic, it doesn't bother me. I don't want to get into semantic controversies with people who are troubled by it, I mean…It works just fine for me…all I mean by it is someone who can't drink, and sometimes…it's the problem with drinking, I don't take the word to mean I have some spiritual disease or, you know, any sort of moral judgment…

Tim's journey from substance use to sobriety includes his current self-definition and self-perception within the context of SOS participation. Regarding his experience of SOS meetings, Tim states, "…it helps to remind me, you know, I'm not a bad person, there are lots of very good, decent people who have this sort of issue…"

Recovery maintenance

Tim perceives that recovery maintenance relies heavily on a simple phrase: "Don't drink or use no matter what." As stated earlier, Tim considers SOS participation an important part of his recovery but not a determining factor. Tim states that "SOS is helpful, and I'm glad it's there, but if it would go away, I'm going to stick to my number one priority which is to not drink."

Another part of Tim's recovery maintenance is advocacy for the group that helped him get sober. He insists that SOS is separate from programs, commenting, "…I've heard talk about moderation and harm reduction and things other than total abstinence, and I want to emphasize that SOS is based on total abstinence." He aligns his personal philosophy of recovery maintenance with the guiding principle of SOS. Tim describes SOS as

> …neutral about theories of alcoholism, whether it's a disease or it's not, and you know, it's wonderful for academics to debate, and I'm sure they will, but that's not our concern, our concern is don't drink or use no matter what.

Textural Description: Abigail

Background information

Abigail is a White, heterosexual female in her 50s who lives in the U.S. Southwest. She is currently self-employed, and she her current length of sobriety is over 3 years. She classifies her socioeconomic status as middle class. She maintained sobriety for almost 2 years in the past using AA. She has participated in SMART Recovery during her current period of sobriety. She learned about this study through the researcher's recruitment for a prior research project. Abigail did not participate in the prior study but granted the researcher permission to contact her for future studies. During the recruitment

phase for this study, the researcher resumed contact with Abigail, and Abigail stated that she was interested and met all inclusion criteria for the study. When asked what made her willing to participate in the study, Abigail replied:

> I'm a real science-based person, and I think the more that we study how people recover or how anything happens, in science the more we study that stuff and figure it out, the better it is for the people coming after me.

Openness/individualized choice/freedom

Abigail perceives that the recovery process is a quest for freedom. Abigail contrasts her perceived freedom in sobriety with a perceived lack of freedom during her drinking years. On her overall experience recovery, Abigail comments that "relative to being alcoholic for twenty years," she feels more energetic, is "enjoying life," and feels "willing to extend" herself in new directions because she is not worried "about when and where is the next drink." She further elaborates on the concept of freedom in recovery:

> …I think when you gradually become an alcoholic or get into that lifestyle, it's not something you see, that you're losing all of this freedom, you don't see it go away but when you get it back uh it's a real eye-opener to real life, that your life doesn't revolve around any particular need like that, I mean beyond food and breathing and a little bit of sleep occasionally, life is good…

Abigail also describes her freedom in terms of choice. She states, "I can do whatever I want to now…anything that I have the urge to do I can pursue I can, I face it I can explore it I can determine whether or not I'm truly interested in it…"

Regarding the decision to pursue sobriety or continue drinking, Abigail chooses to remain abstinent. However, she also believes that "you can choose to drink, that's valid, too…that's not an invalid choice to make. Is it best for you? You've got to decide that." She believes that individuals need to "find their own path," depending on "where they are in the process." Abigail perceives SMART Recovery as an outlet for individuals to make

such a choice. In Abigail's opinion, SMART Recovery is a welcoming place for "people who are looking for a solution but they're not necessarily convinced." Regarding the decision to quit drinking within the context of the SMART Recovery program, Abigail states:

> You can explore that for yourself, you don't have to listen to somebody tell you, you know, not the judicial system or your mother or anybody else to tell you that you must stop drinking, you can put it all down on paper and look at it and decide for yourself, and once they've got the motivation, the tools, the, initially spending a great deal of time on that site can help.

Abigail places emphasis on self-responsibility in recovery and does not rely on "submission to a higher power." She wonders if her aversion is that she "is just too based in science." During her explanation of what she relies on most in recovery, Abigail once again places emphasis on choice:

> …just because you don't believe in gravity doesn't mean gravity doesn't believe in you. And the same thing can be said of a deity or gods or whatever, just 'cause you don't believe in them doesn't mean they're not real, it just means you don't believe it…so I don't thumb my nose at people that have particular, any kind of particular religious beliefs…

Abigail also considers herself free from the influence of alcohol, regardless of her proximity to the substance. She goes dancing at a local casino where "there's drinking and smoking and gambling." When she goes dancing, she feels "no adverse drives or urges in any of those regards. Abigail states that drinking is "not an issue, it's not a question, it's not a problem, it's kind of like I became a regular person in that regard, that you know you take it or leave it, and I've chosen to leave it…"

Community/relation to others/sense of belonging

Abigail credits a realization that "it was finally time to grow up and become a more responsible member of society and the community" as a contributor to her decision

to seek sobriety. She also states that got “turned on to SMART Recovery” by her counselor. She “got lucky” because, based on what she reads on the SMART website, “therapists recommending SMART Recovery are pretty far and few between.” The SMART Recovery website is the place where Abigail feels the strongest sense of belonging. In describing the way the SMART message board works, Abigail states, “once you become familiar with how it works, you can always see how many people have read your post, even if nobody’s answering you, you get the feeling that you’re being heard, or you know, somebody is listening…” She further describes the sense of community she feels on the SMART message boards by stating her knowledge of what her friends are doing in other parts of the world: “…internationally, the guy in Thailand is 14 hours ahead of me right now, so he’s looking at 11, 12…4 in the morning Monday morning and he’s not in the website yet but he will be within about the next two hours starting his day…”

Abigail sometimes experiences interpersonal difficulty with individuals who continue to use alcohol. She believes that people are “not a lot of fun to be around” when she is sober and they are “drunk.” Conversely, she also believes that she might not seem “fun to be around” to people who are drinking. She does not insist that others “choose to quit,” but she realizes that her sobriety might “cost” her relationships with individuals who continue to use alcohol. She also retains some “real fond memories” of watching thunderstorms with her father and his “glass of whiskey and his unfiltered Camel cigarette.”

She relates her enthusiasm for recovery research with her science-based personality: “I think the more that we study how people recovery or how anything

happens, in science the more we study that stuff and figure it out, the better it is for the people coming after me…" While Abigail believes that "tools" are important in recovery, she states that "sometimes people just want you to listen" rather than hear about what specific "recovery tool" a person should utilize to handle a specific situation. She has befriended farmers and fellow scuba-diving enthusiasts in SMART Recovery, and she believes in the value of discussing every day concerns on the online forums. She elaborates:

> …sometimes they just want you to listen. And people do get tired of the tool-pushers that every time you turn around they're pushing another tool on you or, it's like they've lost their human edge, their human touch, and to bring these conversations about scuba diving and pig farming and cattle farming, whatever's going on in your life, that you get to know these people, I mean I'm actually closer to some of these people on this website that I am in people in real life in 3-D.

Journey to self-discovery/self-awareness/self-knowledge

Abigail's journey to self-awareness and self-knowledge culminated with her "conviction" that she "does not drink anymore." Rather than ruminating on the question, "What do you mean I can never have another beer?" Abigail finds "a sense of peace" in her decision that she does not drink. Drinking is no longer on Abigail's "list of things to do." She elaborates on her statement that to drink or not to drink is no longer an issue:

> …it's not a question, and, but I think that just having made that decision and being comfortable with it, and have decided, I'll say, decided firmly and once and for all, is um, there's peace in that, there's contentment, there's, I can spend my energy on other things now.

Abigail also states that her involvement with SMART Recovery and cognitive-behavioral tools "actually shortened" her therapy by helping her realize that a relationship existed "between drinking and depression." In the past, Abigail felt certain that there was "absolutely no connection between these two things."

Abigail's journey to self-discovery involved "breaking connections." She experiences "place/time memories" in specific situations that lead to her thinking, "when you do this, you usually drink and smoke." She states that "they are not terribly strong urges," but she remains "surprised that "they still happen." She also broke a connection with AA, a program in which she remained sober for almost two years in the past. Abigail considers her experience with AA "a white-knuckle experience" because she had not replaced her drinking with "anything other than AA." All of the energy she "spent on beer" was "spent on when is my next meeting."

Abigail turned the "daunting" prospect of never having another beer into a personal choice. On the subject of deciding whether to quit drinking, Abigail states:

> …once you realize that, you know, that really is a pretty sound decision for you as a person, as the individual who's facing that decision in what alcohol has done for you in the past 20 years, which is squat, to decide to never drink again, or at least for today, to never drink again, when you see it on paper it's a sound decision, and if you get to revisit that every day and make that choice as many days in a row as you need to, every day, if you have to face that question every day then you face it every day.

She also believes that "recovery is not just about quitting, it's about picking up the other pieces of your life and going on, and making it better." She states that "anybody can be a dry drunk," but "you've gotta have something in your life that is better and more exciting than sitting around drinking." She concludes, "..If you're still sitting in the same four walls watching the same boring TV, sooner or later you're probably going to pick up a beer again…"

Recovery maintenance

Abigail perceives the process of recovery maintenance as involving specific cognitive-behavioral techniques learned from SMART Recovery such as "cost-benefit

analysis" and "the ABC exercise" as recovery maintenance tools. She values the opportunity "to be able to understand why you're making the choices you're making" and "putting it all down on paper." Abigail considers SMART Recovery tools as applicable to more than simply recovery: "If I had my druthers I'd be teaching those to third-graders, that these are tools for life." She appreciates that SMART Recovery provides recovery tools "in layman's terms" available to "the common man." Regarding tools for recovery on the SMART website, she states, "All you gotta do is go there and get it. It's right there." She elaborates on the utility of the SMART Recovery tools:

> …if I recognize that I need change in my life, I have tools to examine ok so what is the problem? Is it that you're breathing at all or that you're breathing too much? And to be able to write that stuff down and look at it in what seems to me to be a very logical and organized manner no matter what the question is, and to be able to sort it out for myself and arrive and what feels like a comfortable decision logically.

Abigail also uses the SMART Recovery website itself for recovery maintenance. She uses both the specific tools and conversations with others on the site to "scratch things off her list" regarding "situations to be weary or aware of." Regarding the constant availability of the SMART website and her description of its utility, Abigail states:

> Like I said before the one thing I like better about SMART is that there is the web presence, I got a meeting 24 hours a day, when do you want to be in a meeting go, you know, not that they're doing organized chat meetings or anything like that but I can go on and read, you know peruse the message boards and see what other people are having issues with and spend some time responding to, to help other people, to give back to that community…

Textural Description: Anna

Anna is a White, bisexual female in her 30s who lives in the U.S. Northwest. She is currently a college student. When asked to describe her socioeconomic status, Anna replied, "I'm poor. I'm a student. I don't have much money." She has been sober for

approximately two years and six months. She has been involved with WFS for approximately three years and six months. Anna "tried AA" for approximately one year in her early sobriety, and she "has not participated in AA" for approximately one and a half years.

Anna learned about the study from the WFS central office. She read the recruitment letter and emailed the researcher, stating her interest and verifying that she met the inclusion criteria. When asked what made her want to participate in the study, Anna replied, "I think that WFS is kind of underrepresented in the rehabilitation field, and I wanted to contribute to making it more widely known."

Openness/individualized choice/freedom

Anna perceives the recovery process as a choice to practice openness and an opportunity to experience personal freedom. Anna contrasts her openness to new experiences in recovery with events from her period of substance use, which she describes as her "old life." During Anna's "old life," she often felt "depressed and anxious," had "false experiences," and felt "generally unreliable." While describing perceived changes in herself during sobriety, Anna states, "… when I say I'm going to do something, people know I'm actually going to do it, and that's really big, I'm not as reactive with people and I'm a lot more open and willing."

She experiences her decision to pursue sobriety as "empowering." While describing her ongoing choice to remain sober, Anna states, "It fills me with pride." She "wasn't really on board" with abstinence when she began attending WFS meetings because she "had not quite accepted" her "addiction yet." During her WFS meeting experiences, Anna maintained a belief that she "could maybe manage" her drinking. At

"some point it just shifted," and Anna decided that she "really wanted to be sober" and "to really use the program." She elaborates on her feeling of self-responsibility:

> …being able to take responsibility for myself and for my actions, and for my thoughts and for my life, you know, I get to decide what I do with my life, and I can decide to drink again but not really a choice that I could make, it's not a choice that I want to make anymore (laughing), you know, but I do get to decide ultimately, and my life is in my control now and not under my addiction's control, and I think that's the most powerful aspect of the program for me…

Regarding recovery support group options, Anna believes that different programs work for different people. When describing what advice she might provide to someone approaching recovery for the first time, Anna states, "I guess I would suggest that they explore the different options that are out there…there's a lot of different paths to recovery…and find the one that works for them." She also states that some people "do marvelously in AA." She elaborates on her advice to newcomers:

> I'd encourage someone new to look at other programs like SMART or Rational Recovery or WFS or just you know a medical model treatment like an inpatient or an outpatient program, and just kind of see which one speaks to them and works best for them because I think recovery is an incredibly personal journey, and you know, you need to find the right thing for you to get better.

Community/relation to others/sense of belonging

Anna perceives community and relation to others as major components of her recovery process. Regarding her sense of community and belonging, Anna states that "helping other people through their journeys of healing and growth is really important to me." Helping others makes her "feel good," and she "finds it inspiring" to witness women who are new to recovery. She believes that "it takes just incredible courage to even start a sobriety journey, and it takes a lot of hard work and intention." She enjoys watching others "develop in positive ways." Witnessing success stories of other women in recovery gives her "strength and energy" and keeps her going.

Anna perceives that her sobriety also improves her relationships with people outside of the WFS community. On the question of how her relationship with her father has improved in recovery, Anna states,

> I'm a lot more willing to let things that I disagree with that he says, I can just let them go now, better than trying to argue with him and bring him around to my viewpoint, I can now accept that different people have different viewpoints, and that's ok…

Anna turned to sober support during difficult periods in her early sobriety. When she experienced a major education-related disappointment, she "kept in touch with sober support, and other supportive family members, and somehow I made it through." She overcame several obstacles within a short period of time, including the death of her grandfather, and she "is still kind of in awe to this day" that she "survived all of those things without drinking."

Anna also feels comforted by the presence of 24-hour availability within the WFS "worldwide forum" online. She knows that she can find support "in the middle of night." Anna perceives the people around her as an indispensable tool in recovery. Regarding the positive influence of others in sobriety, Anna states:

> I think having positive people around me, that's really important…you know, I don't live in a fancy house, I don't have a fancy job, I don't have a car, I live in the city, so I take the bus everywhere, I don't have nice clothes and none of that matters because I have…I have myself, I have my sobriety, I have wonderful men and women around me who are also walking the same path and engaged in self-exploration and self-growth, which is really inspiring to be around…

Journey to self-discovery/self-awareness/self-knowledge

Anna perceives that her recovery process involved a journey to self-discovery. Anna describes her journey to accept that she "really had to quit and learn a new way of life" as "really difficult at first." In contrasting her sober life with her "old life," Anna

states, “I really like my new life better than I liked my old life.” Her self-discovery culminates in her belief that she “can be disappointed without being devastated now,” whereas before she would “get really overwhelmed by problems” and “just sort of shut down and self-destruct.” Today she accepts that “sometimes we don’t get what we want, and that’s just part of life.” Anna states that when problems arose in the past, she “just dwelled on it, drank on it, used over it, you know, been angry and disgruntled, for who knows how long.” Today she perceives problems as “little puzzles to solve.” Anna claims that today she is “much better letting things go” and not letting problems “take up space” in her brain.

Anna credits changing the way she thinks as the “biggest part of her recovery” internally. She finds it difficult to explain everything about her recovery “in a nutshell.” However, on describing the details of her recovery journey, she also states, “it reminds me of how far I’ve come and how much I’ve learned.” Anna also expands on her belief that changed thinking patterns are the “biggest part” of her recovery:

> …just changing the way I see the world and the way I see myself and the way I see what happens around me, and the way that I think about it, you know, trimming bad habits, thinking well that person did that to hurt me, or I can say that person is speaking from their own pain, and what I say to myself about the situation really changes the way I feel about it and the way I react to it, which is just really key for me…

Recovery maintenance

Anna perceives that changed thinking patterns and specific WFS statements serve as recovery maintenance tools. Although she jokes that she is “not a Zen Buddha master”, she believes that she efficiently “counteracts negative thoughts” when they occur through the use of the WFS statement “negative thoughts destroy only myself.” Anna uses a

"thought-action" technique to the WFS statement, "I am what I think." Anna further details her thought-action for the statement:

> …the thought action for that is I am a capable, competent, compassionate, caring woman, and, you know, the idea that I create who I am with my thoughts and that I get to define myself, and nobody else can define me and, that I am capable of things, and it's my choice what I do, that's really huge to me, and I used to just repeat I am what I think over and over in my head…

Anna credits her changed thinking patterns about herself, other people, and "the world" with shifting her identity from "party girl" to "sober person." Part of her identity as a sober person is her ability "to handle things" now because, due to her old thinking patterns, Anna "used to be a very depressed person, a very anxious person."

The WFS statement "the past is gone forever" contributes to Anna's ability to "let things go." Reminding herself that the past is gone counteracts Anna's past tendency toward "guilt and shame" regarding things she "did and did not do," and things that she perceives were "taken away" by her "addiction." Part of Anna's recovery maintenance is telling herself "that's over" and that she "can't go back and change" the past. Instead, she "learns a lesson or two" from the past and "moves on." Anna summarizes, "Now my focus is on the present and on the future and that's really comforting for me, because my past is not a very happy place."

Anna often shares recovery maintenance tips with others in support group settings. She suggests that people "find something else to fill their time" because "you have a lot of extra time when you first get sober because certainly your primary activity is gone." She advises people to "get a new hobby" or "find something" else to fill that time. Anna believes that the "number one contributor" to relapses is the mindset, "I can't drink anymore, I want to drink, I can't do this, I can't get sober, I can't live without alcohol."

Anna suggests a message to confront that type of thinking: "…tell yourself I can be sober, I can be happy, I deserve it, I'm worthy of a good life…that leads you down a better path I believe, from what I've witnessed in others…"

Textural Description: Louis

Background information

Louis is a heterosexual male in his 60s who resides in the U.S. "West." Louis currently works in "management." When asked to describe his current socioeconomic status, Louis responded, "lower-middle at this point." Louis has been sober for 24 years, and he has maintained involvement with SOS throughout the 24-year period. Louis states that he spent "one month in AA" at the beginning of his sobriety, and he has "rarely" attended AA meetings since that time.

Louis heard about this study from Jim Christopher, the founder of SOS. Louis contacted the researcher via email, stated his interest, and verified that the met the inclusion criteria for the study. When asked what made him agree to participate in the study, Louis replied, "I always like people to know that there are alternative means of getting sober and staying that way."

Openness/individualized choice/freedom

Louis perceives that the recovery process involves an individual choice and the pursuit of a freer lifestyle. Louis describes his sobriety as "…totally freeing, it's like being free once again, and I'm just very happy." He is "having a good" time and "every day" feels "rewarding" now that he has "come back" from his drinking life, a place and time he describes as, "the gates of darkness, so to speak, darkness being lights out." Louis attributes this freedom to his decision to seek sobriety. He decided to get sober "many,

many, many times in the past," but his last decision was "life or death." Louis calls it "a deep decision, I'd call it spinal deep, not cerebral." He told himself that he wanted "to live" and that he "wasn't going down without a fight." Louis maintains that "there are more ways to get sober than you know." He perceives different recovery support groups like AA and SOS as "a series of safety nets." Louis believes that the more information and options people have regarding support groups, "the safer they're going to be."

Louis also insists that he "and most people" he knows require a choice. He states that he is "listening" when people relate recovery options that they "have found helpful," but Louis is "not listening" if someone tells him that he "has to do something." Louis believes that "there's a safety" in "not having an authority" tell him what he "must do to get sober." He states that the only "must" is the question of "whether you want to live." He concludes, "You must do something if you want to stop being an addict, but nobody tells you how to do that or what to do." For Louis, "it all depends on what you're willing to bring to the party." The important question in sobriety is "How much do you want it?" He also considers himself "example of someone who can do it, someone who shouldn't have made it." It is important for Louis "to express that" to others.

Louis attended AA meetings for a short period of time in his early sobriety and discontinued attendance of those meetings once he found SOS. Louis states that SOS offers "a dynamic kind of sobriety" wherein he can react in a "spontaneous" or "knee-jerk" manner. He prefers a "gut-level" sobriety, and he perceives that AA commentary such as, "you need to re-work your Step Three there, partner" does not work for his "kind of head." Louis is "able to speak freely in SOS" without worrying about how he should "couch things in AA terminology so no one gets offended." He believes that is important

to keep his expressions during SOS meetings "in the realm of sobriety," but he "feels free" to let his "mind do whatever the heck it's got to do."

Louis also describes freedom from fear in recovery. He sees "life's issues are exactly in proportion to what they ought to be," as opposed to "being skewed by alcohol." He elaborates on the proportionality of problems in recovery:

> Nothing is terrifying to me, you know, I'm not putting a spotlight on a one-inch tall thing and creating a giant shadow of fear on the wall, and fearing the shadow. I can see the one-inch thing and go, it's nothing.

Louis also appreciates a wider range of emotions in recovery. When describing early recovery, Louis recalls "certainly the heartbreaks and challenges," but also "the joys started coming in" and "they were terrific." Louis concludes, "Have you ever heard the Ode to Joy, the Ninth Symphony of Beethoven, oh my god, you know, I can't listen to it without bursting into tears every time I hear it, that's the kind of thing I wanted."

Community/relation to others/sense of belonging

Louis perceives community and a sense of belonging as parts of his recovery process. Louis describes community and relation to others in terms of hope. He states, "I think hope is very important to people who have no hope." Louis jokes that if he "can get sober, anybody can get sober." On a more serious note, he states, "I'm still standing." Louis describes himself as "a low-bottom drunk," and he believes that "by all accounts, I'm not supposed to be here." In early recovery, Louis "felt a unity with other people who were suffering from this disorder" in meetings. What Louis calls "the commonality of experience" was useful to him because he knew that he "wasn't alone." He wanted to "hear the stories of people who wanted a better life" because it made him "feel good…to hear that there's a chance."

Interacting with others in meetings helped Louis realize that “empathy is a wonderful thing.” He believes that he “maybe had no empathy at all” when he was drinking. He elaborates on empathy: “I really do care about other people and it breaks my heart when people can’t get sober, or when they’re fighting like crazy to get it…” During his initial experience with AA meetings, Louis felt like he “actually belonged somewhere.” The presence of other “like-minded” people at SOS meetings helps Louis feel “plugged in” to himself and “free” to speak honestly.

Louis comments that he “did not lose anyone” during his “drunken state.” He registers surprise, stating that he has a child whom he thought that he “would never have” and a family whom he thought that he would “certainly lose.” He states that sobriety is “more than just one or two things.” He describes recovery as “a totality,” “being with people,” and “really appreciating life.”

Louis also describes community across different recovery support groups. He believes that “it is important for us to get along with…other people who are in the same situation.” Louis feels “free to go to any AA meeting anywhere” without worry. However, he states that “an AA person coming into an SOS meeting” appears “very tense.” Louis desires cooperation among individuals in recovery. He states, “Come on, we’re all in the same boat here.” He also believes in the importance of presenting support group options other than AA:

> …a lot of the people who staff clinics are AA people, people who are in the court system are AA people, so subconsciously or consciously there’s a drive for AA to be the only kid on the block, and people are going to their death or whatever because they can’t find a way to get sober through AA, it’s just not for them, but they’re told it’s the only way there is, so raising the consciousness level of the people who are the gatekeepers so to speak is so important…

Journey to self-discovery/self-awareness/self-knowledge

Louis perceives that his recovery process involved a journey to self-discovery. Louis's self-discovery and self-knowledge culminated in his transition from AA to SOS. During his initial experience with AA, Louis wondered how he "would maintain going to these meetings" knowing that he "entered as an agnostic" and thought that he "might become an atheist" amidst individuals saying "The Lord's Prayer" in AA meetings. Louis thought that "honesty was the way to go." However, he asked himself how he could "talk sobriety from the podium without saying thanks to my higher power." While "feeling alone" during one of the regular "blue-collar" AA meetings, Louis shared with the group: "I don't think I'm getting this…I might become an atheist," and the group response was "general laughter, ho-ho it's great, we all come to believe, we all come in like that, don't worry about that stuff." Louis continued to worry that he would "always be lying" to either members of AA groups or to himself.

After Louis attended his first SOS meeting, he "thought about it" for four days and suddenly "felt light of body…like a rock had been lifted from my shoulders." Louis concluded that in SOS, he could "do it off the rack" without "having to alter" himself. He elaborates on his thought process at the time:

> I can get sober and stay sober without having to deal with spiritual issues as my sobriety, as part of my sobriety, I can check it out later if I want to, if I want to worship a dancing elephant or a tree trunk, that's fine, or worship nothing, but I don't have to deal with that in sobriety, sobriety is a separate issue, I got it, I can do this.

As his sobriety progressed, Louis decided that "challenging" himself to overcome "situations that were perilous" was important for developing self-confidence. He explains, "…every time you accomplish something it gives you self-confidence, it grows

your inner strength." Louis intentionally went to "places where there is alcohol" while he continued "being very aware that he was "an alcoholic" and that he "can't drink or use no matter what." Each time Louis "encounters an obstacle," he "deals with it without drinking." He believes that overcoming obstacles improves his chances of "being able to take care of whatever" comes his way in the future. Louis "has no interest in alcohol." On the presence of alcohol, Louis states, "…this is not a thing that I look at anymore, so I'm free from it." When he sees alcohol on television or "in a market," Louis feels free to go about his business because "it's not me." He remains unsure if he will ever consider himself "a normal person," but in sobriety Louis feels more like himself.

Sobriety is sometimes "hard," but it is "much easier" than Louis anticipated. Some parts are "just simple," and "the easy parts" surprise him. When he first got sober, Louis anticipated that the experience "would be the tortures of the damned as pictured in Dante." He believed that his motivation to "get very, very serious" about sobriety was bolstered by what he heard from others, specifically that "only a very small club of people" remained sober. Louis states, "Sobriety is not a casual thing for addicted people, you know, it's very tricky, it's very complex, convoluted."

Recovery maintenance

Louis believes that challenging himself and maintaining sobriety as a priority in his life are parts of his recovery maintenance process. Louis believes that his "forms of behavior modification" were effective. In the past, he "personified" alcohol and convinced himself that "alcohol was a dark and ugly thing" that was "lurking behind you and waiting to tap you on the shoulder." Louis believes that remnants of "26 years of behavior" patterns remain, so he seeks to create different patterns.

He credits "curiosity" as a contributor to his "rewiring." In early recovery, Louis watched movies, read books, even "went to plays that had alcoholism involved in them." He read journals and attended lectures to learn more "about alcoholism." On one of the most important things he learned about alcoholism, Louis states, "…you're always chasing that high you once got that you can never get again." On the only rule that he follows today, Louis states, "The only thing that seems to be true is don't swallow the stuff, even if it's in your mouth, spit it out, don't swallow it." Louis would not "change a thing" about his recovery because "it worked like a charm." In summarizing his recovery, Louis states, "I had the hope, I had the idea, I think I just, I'd say, keep on truckin' don't give up no matter what…"

Textural Description: Rose

Background information

Rose is a White, heterosexual female in her 40s who resides in the U.S. Midwest. She is currently disabled. When asked to describe her socioeconomic status, Rose replied, "I don't have very much money." Rose has remained sober for the past 13 years. She participates in WFS, and she has "been involved with them for 12 years." She attended AA meetings for approximately one year at the beginning of her sobriety, and she "ended" her association with AA in the year 2000.

Rose learned about this study from Becky Fenner, the Director of WFS. Rose received the recruitment letter via email. She then contacted the researcher via email, indicated her interest, and verified that she met the inclusion criteria for the study. When asked what made her agree to participate in the study, Rose replied, "Because if…this

helps get the knowledge out there regarding substance abuse and that there is help available, I'm more than willing to do that."

Openness/individualized choice/freedom

Rose perceives that her recovery process involves independence and freedom of choice. Before she sought sobriety, Rose's mother often implored that she stay sober. Rose uses her mother's words as a simple message, "Just…stay…sober…three words." She describes her behavior throughout the day as a series of choices. She utilizes WFS statements as part of her daily recovery. For example, Rose states:

> …if you love something, if you put forth the effort, you will get it back in return, so as I go through the day, if someone irritates me or cuts me off driving, I just have to think of the statement and remember no you don't have to act like that, that's them that's not you…

Rose also chooses to stay away from the presence of alcohol. Alcohol is prohibited in her home. She states, "I don't allow alcohol on my property…anywhere near it. I look at it this way, I deal with my addiction each and every day, I don't have to open my refrigerator door and stare at it…" When Rose goes to "someone else's house," she makes certain that she "parks on the street" rather than park in the driveway "and drag someone to their car and ask could you move your car and let me out?" She prefers not to draw attention to herself, and she wishes to leave when she has "her fill." Rose offers further detail on her strategy for dealing with the presence of alcohol:

> I felt more comfortable just getting up and quietly going out the door…and, and learning tricks like that, to do deal with being around alcohol, you know, and knowing that it's still legal and people do drink, and just little things that…that helps…

Rose describes self-reliance and self-worth as what helps her most internally in sobriety. She tells herself, "I am worthy," and reminds herself of what she has

accomplished on her own, including the purchase of a home. She also states that she went through the "process of disability" on her own. Rose states, "It was me who did that…and not relying on someone else or a husband to do that…and to be able to take action and not depend upon others…"

Community/relation to others/sense of belonging

Rose perceives that community and relation to others is an integral part of her recovery process. Rose describes community and relation to others in terms of family relationships. Overall, she considers her relationships with other people "very good relationships now because I can be honest…and just knowing I don't have to hide my feelings or drink them away is the best thing that I've learned in 13 years…" Specifically, Rose perceives the most positive change in her relationships with her two children. Rose states,

> I like…the idea of being a mom to not just the oldest one, but being given a second chance to being a mom for my second one…it's just, that's priceless…I feel I screwed up so badly with my oldest one that I was given a blessing, and I take that seriously…

Rose credits her mother with helping her see that sobriety was the right decision. Rose states, "I should have listened to my mother…well before I did." When Rose was attending meetings in early sobriety, she recalls that her mother would say, "go to your meetings," because "even she [mom] could see what it was doing."

In sobriety Rose has also experienced tension in her relationship with her sister. Rose claims that her sister remains "very active in her addiction." Although it "still hurts" Rose, she "cut off all contact" with her sister. Regarding her decision to cease communication with her sister, Rose claims that "otherwise she would take me with her."

Rose "knows what is good" for her recovery, even in "very, very difficult" circumstances.

Rose recognizes "when to put the boundary down" in order to protect herself. She also believes that she is "a very compassionate person, especially when it comes to people in recovery." Regarding her willingness to participate in this study, Rose states, "…if this helps get the knowledge out there regarding substance abuse and that there is help available, I'm more than willing to do that." She remains motivated to share her story with other WFS members because "after 13 years, it's just…being able to give back and if it helps that person, that's what I want to do because living in addiction...there's a better life." Rose also relates to women who are no longer part of the WFS community, and she reflects on how her life might have turned out if she continued drinking: "I'm filled with pride…I'm grateful…for being given all the opportunities that I have in 13 years…'cause I could have easily ended up one of them dead girls…

Journey to self-discovery/self-awareness/self-knowledge

Rose perceives that her recovery process included a journey to self-awareness and self-discovery. Part of Rose's journey of self-awareness included reflections upon her mortality and her perception that sobriety was a serious issue. Rose believes that the death of other women due to drugs and alcohol use had the "biggest impact" on her recovery. She elaborates:

> I have unfortunately seen several women who have died because of addiction and that just, that just hits home to me that you must stay sober, Rose, you have to stick to your program, you have to stay with what's true to you…

Rose describes her entire process of recovery as a journey. In summarizing her experience as a sober person, Rose defines recovery as "…a growing experience…I'm

really…with every year, and every stumbling block, or whatever's put in my path, I grow from it…and I learn from it…so it is a journey…"

Rose also describes her "journey" in terms of self-definition. She recalls the "difficulty" of changing her self-perception in several areas of her life. She cites "being around alcohol" as an obstacle in early recovery. She used self-affirming statements in WFS to help herself through obstacles. WFS gave her "something to work on, something constructive to do."

Rose contrasts her past relation to drinking with her current relation to self:

> I feel I'm very compassionate, I'm honest, now I'm trustworthy…and all of those things, I was not all of those things when I was drinking…I couldn't be because I was too busy trying to figure out where my next drink was coming from…where here, today, with the program…I can be, and I am…a member of society…and it, it's been great…best thing I ever did…

Rose also learned how to "get over" her old sense of self and "stand up" for herself despite messages she received from others during her period of alcohol use. Rose states, "I had always had everyone tell me well you're just a drunk, you're a drunk, it's your own fault…who, Rose? Oh, Rose, she's just a drunk…"

Rose's journey to self-discovery culminated with a re-definition of self. On what helps her most internally, Rose states, "Self-esteem and self-confidence. I have that now and I never had it before…" She also claims that she is "not afraid to speak about" her experience. Rose summarizes her recovery by stating, "I like who I am today…and I'm not ashamed of it…where, had I been drinking, I was ashamed of that…of that behavior and everything that went with it…but I am proud of myself today…"

Recovery maintenance

Rose perceives that self-esteem, self-confidence, and reliance on WFS statements are part of her recovery maintenance process. Rose maintains her recovery with consistent internal messages about her identity as a recovering person. Rose claims that one of the keys to her successful recovery is “standing up” for what she believes in and listening to her “gut instinct.” Rose maintains a high level of awareness regarding her past tendencies and recovery tools that keep her rooted in a present-focus. In early recovery she was “unfamiliar with” the process of standing up for herself. However, she claims that “being assertive” is “very easy today.”

Rose credits WFS with helping her to learn “self-esteem and self-confidence.” She remains engaged in WFS due to her perception that, in those meetings, “we actually work on things” such as the WFS statements. Rose believes that she receives “information she can use” in WFS meetings rather than “just hearing one story after another,” which was how she experienced AA meetings. Every day Rose “picks a statement and works on it all day.” On how she is different as sober person, Rose states, “I feel my feelings more, I don’t bury them, I don’t run from them, I’ve learned to deal with them as they come up…” She maintains consistency by reminding herself (and other WFS members) that “if you stayed sober yesterday, don’t worry about anything else…” Rose believes that “if you stayed sober yesterday…duplicate it.” Rose’s favorite recovery maintenance tool comes in the form of a daily reminder to herself: “…the past is gone forever…no longer will I be victimized by my past, I am a new person…and I am…”

Textural Description: Jeff

Background information

Jeff is a heterosexual, Hispanic male in his 30s who resides in the U.S. Northeast. Jeff has completed "professional school" and "some graduate school." He is currently unemployed and describes his socioeconomic status as "lower currently." Jeff has been sober for approximately four years. He has participated in SMART Recovery since 2008. Jeff attended AA meetings for a short time in his early sobriety. He has not attended an AA meeting since "the end of 2008." Jeff describes his AA meeting attendance as "three or four times total over the course of a couple months."

Jeff learned about the study through an email sent to SMART Recovery facilitators, and he noticed that the study "went through SMART Recovery's proper channels," so he decided to participate. Jeff emailed the researcher, indicated his interest, and verified that he met inclusion criteria for the study. When asked what motivated him to participate in the study, Jeff stated that he has "a penchant for volunteering" for scientific studies and that he has something to say about his "somewhat unique experience." Also, Jeff believes that it is "a good idea for people to get some information about non-AA groups out there."

Openness/individualized choice/freedom

Jeff perceives his process of recovery as beginning with an individualized path. He states, "…there are a billion, there are many paths to recovery." Jeff believes that "everybody has their own strengths and weaknesses and preferences" and that "experimentation in recovery is important as to what will work for you, it's not a one-size-fits-all path." Jeff describes himself as an atheist. He does not "believe in anything supernatural." He tried AA meetings for a short time in early sobriety, but he switched to

SMART Recovery within a few months. Jeff perceives AA as a poor fit for him but possibly the right fit for others: "…I was really, really frustrated in AA, and so that was definitely not for me, but I think that just because it wasn't for me, doesn't mean that it's not for everybody, but SMART to me was a much better fit…."

Jeff also experiences the process of recovery in terms of freedom and openness to new experiences. He believes that he possesses both "an austere streak" and "a strongly hedonistic streak" that allows him to "go out to great parties, and just not do any of the drugs." When he talks to new members of SMART Recovery in meetings, he tells them that "there's definitely life during sobriety." He further describes his perception of life in sobriety: "it's great, because now I can party all night on Friday, get some sleep, and then go and party on Saturday, instead of nursing a hangover, so I can do that, I can party better sober…"

Jeff perceives that he relies on himself more than anything else in recovery. When asked what he relies on to overcome obstacles in sobriety, Jeff states:

> I don't think that anything besides my own mental faculties allow me to do it, I mean it's a constant struggle to be able to turn my own mental faculties against themselves in order to analyze the situation properly, and I need, definitely external tools like SMART Recovery those tools are essential and the material support my family has provided is also very, very helpful. However, I think that I, if I wasn't motivated to do it, and if I didn't have the skill set, and the inclinations I do, then my path of recovery would have not been as successful as it is.

Although Jeff states that he relies heavily on his mental faculties in recovery, he finds "the limits of our knowledge" as "mentally freeing." He maintains that he cannot know what would have happened if he "had never started drinking in the first place" or if he "never got married." He resists the question of what he would say if he could go back and give himself a piece of advice because "it goes against the grain" of how he has "trained

himself" in recovery. His recovery process is present-focused. Jeff repeats that asking him to predict futures or contingencies is "a somewhat freeing, but also difficult question" due to the limits of his "epistemic abilities."

Community/relation to others/sense of belonging

Jeff perceives community and relation to others as part of his recovery process. Jeff's process of recovery involves volunteerism, social circles, and SMART Recovery meeting facilitation. Jeff states that one of the reasons his "recovery has been successful" is his "ability to become more altruistic is some ways as opposed to being self-involved and self-pitying." He credits his experience in SMART Recovery as "an outlet" for that altruism. As stated earlier, he sometimes volunteers for scientific studies because he likes "contributing in some small way." Volunteering for SMART gave Jeff the "altruism bug," which he found rewarding and also led to "improved feelings" about himself. Volunteering for SMART also provided Jeff with "a lot of extra value that people who don't volunteer wouldn't necessarily perceive." Jeff does "tons and tons" of volunteer work in his community, so he feels like a "productive member of society."

Jeff perceives his recovery process as outside the realm of his family. He appreciates the practical support that he receives from his family. However, he perceives that his family does not "understand the dynamics of addiction" or "mental health issues." Jeff believes that he cannot do anything "to make this relationship any more desirable or more healthy," so he is content with the "equilibrium" that he has reached with his immediate family members.

Outside of his SMART Recovery meeting facilitation, Jeff "doesn't really socialize too much with people who are being sober people." He states, "…I've just gone

on and done normal things at life at this point…" For Jeff, the process of a normal life includes a variety of activities in "expanded social circles," including dancing and meditation groups. He decided to "restart a social circle" after moving back to the U.S. Northeast after attending professional school in another state. Jeff is "very selective about" whom he considers a friend. He confides in "two or three people" and the rest are acquaintances, which is "very good" for him.

Journey to self-discovery/self-awareness/self-knowledge

The early part of Jeff's recovery process involved moving back to the U.S. Northeast after "some rough times," during which he experienced "a very big culture shock." Jeff "dropped out of graduate school" after "becoming disillusioned." Due to "a lot of factors," Jeff believed that he "couldn't cope with life without drinking, that it was the only way to deal with things…" After relocating back to the Northeast, he continued drinking and eventually received "a referral" to counseling after a brief hospitalization. He "immediately started drinking again" because "staying at a hospital does not convince one to change one's lifestyle." After following through on the referral, Jeff attended counseling sessions at an outpatient center, and at that point in his life, Jeff states, "…I was at least convinced to give sober living a trial, if nothing else, and my, that appeals to my scientific, intellectual curious mind, and I thought ok well I can give it a go, and see how it works…"

During his self-described "trial" period of sobriety, Jeff attended AA meetings on the advice of his counselor. Jeff states that the program and the counselors "were very AA-centered." At that point, Jeff had "zero experience with AA" and "had no idea it was

a spiritual organization." He describes his transition from AA meeting attendance to search for alternatives:

> My counselor told me to try going to AA meetings, and she gave me the whole you can take what you want and leave the rest behind speech, which didn't really turn out to be true, at least from what I could tell, and I went there and got frustrated with it, and uh so we started searching for alternatives.

Jeff's recovery process eventually turned to a journey of self-knowledge and self-discovery. At around the same time in Jeff's life, he developed an interest in "meditation and mindfulness." Mindfulness is one of Jeff's primary recovery maintenance tools and part of his journey to self-awareness and self-knowledge.

Recovery maintenance

Jeff perceives the process of his recovery maintenance as using a blend of self-knowledge, self-education, philosophical principles, and cognitive-behavioral techniques. Jeff's recovery maintenance is primarily based on "internal" motivators. However, Jeff also credits SMART Recovery as a contributor to his successful sobriety. Jeff attempts to "keep a clear mind by not ingesting substances that cloud the mind." SMART Recovery facilitation is an "external factor" that positively influences Jeff's desire to remain sober. Jeff states that, as a SMART facilitator, he must remain sober. If he relapsed, SMART Recovery might want him to "take a break from his responsibilities" and "work on himself."

The process of facilitation helped Jeff to "learn the tools" on his own "in a more thorough manner." Jeff describes his process of self-education in terms of "reading all of the psychological literature behind" SMART Recovery and Cognitive-Behavioral Therapy:

> I feel that I'm quite well-versed in what's behind SMART Recovery in terms of Albert Ellis and REBT, how he combined some of Beck's CT stuff later on into it and how he did so, how it's an eclectic therapy, how SMART Recovery has also combined Motivational Interviewing and Alan Marlatt, mindfulness-based relapse prevention, I know where all of these things have come from, and I feel that I know different ways of presenting them and using them.

SMART Recovery techniques are "useful" because they are based in Cognitive-Behavioral Therapy, which "appeals to the evidence-based side" of Jeff. Specifically, the "SMART tools" allow Jeff to "really disconnect any anxiety or depression triggers from using." The "cost-benefit analysis" tool that he used in early recovery assisted Jeff with "systematically" looking for other ways "to gain the benefits" that he "got from drinking." Through the use of these tools, Jeff states that he has "eliminated almost all of the causes that made me drink in the first place, and so it really almost never comes to mind, it's not a temptation…"

Jeff also believes that "willpower" is useful as "kind of a booster rocket" in sobriety. However, he cautions against exclusive reliance on willpower: "you can use willpower in bursts in order to change your thinking and change your habit, but white-knuckling it through sobriety is probably going to end up in failure." Instead, Jeff recommends "changing your thinking in moments of temptation" and taking a look "at the reasons, what you get out of the addictive behavior." In Jeff's opinion, individuals in sobriety might avoid having "to white-knuckle" by changing patterns "into realistic from unrealistic thinking." Through this process, Jeff believes that "you'll find out that honestly and deep down inside you'll know that you're not doing yourself any good by giving in to the addictive behavior."

Jeff states that therapists were "somewhat helpful" but did not "scientifically" teach him "the proper tools." When describing basic recovery maintenance tools, Jeff

states that “Cognitive Behavioral Therapy” tools help. Also, Jeff states (with laughter), “Know yourself, as the Delphi Oracle would say.” Jeff perceives that his primary recovery maintenance tool is his mind. Using SMART Recovery techniques, Jeff describes his process of analyzing his “thoughts and worries” in further detail:

> …I think that actually analyzing my own thoughts often just simply dissolves problems, problems become non-problems, because I find that by thinking and worrying about them, and certain issues are based on fallacious understanding of things, reification and a whole bunch of other fallacies that, upon inspection, kind of dissolve the problem for me.

Jeff’s recovery maintenance has extended into “other areas of his life.” He has “gotten down a road” to where he uses “the principles” that led him to sobriety to examine other behaviors. He asks himself, “Why am I doing this in the first place,” and “Is it causing harm or benefit?” If a behavior is “causing too much harm,” Jeff states that he will “try and reduce it, and then eventually eliminate it.” He summarizes how giving up alcohol has impacted his life overall:

> …giving up alcohol was one of the first things which made me realize like however painful things are to give up at the time that actually you get really used to not having them really quickly, and I consider it being the first step in a whole series of things that I’ve attempted to give up to simplify my life and get toxic elements out of it…

Textural Description Composite

Participant experiences of the recovery process differ slightly according to recovery support group. Two participants use WFS, two use SOS, and two use SMART Recovery as recovery support groups. Participant experiences also differ in terms of recovery support groups are utilized in recovery. The overarching contextual similarity of participant experiences is that that they all switched from AA to a self-directed recovery

support group and now perceive the process of sobriety as an experience rooted in self-knowledge.

Participants describe the process of recovery as beginning with a conscious choice and a desire to achieve freedom from the negative effects of substance use. All participants indicated a positive attitude toward existence of recovery support group options. Participants perceive the recovery process as a gradual shift toward self-reliance and changed thinking patterns. Participant experiences differ from 12-step recovery in that participants describe self-knowledge and self-reliance as major components of their respective recovery programs, while AA (2001) philosophy apparently eschews attempts at self-knowledge in favor of turning one's will over to "God" as the individual understands "Him." Participant experiences also differ from 12-step recovery in that Step One of AA (2001) includes admission of powerlessness over addiction, while participants describe perceptions that their respective recovery process are rooted in self-empowerment and self-responsibility.

All participants tried 12-step recovery support groups and decided that AA was a poor fit due to the spiritual/religious content, the process of sponsorship, the structure of 12-step support group meetings, or the idea of reliance on a higher power to achieve successful sobriety. Participants maintain that AA and other 12-step programs are valid alternatives for individuals seeking recovery. However, participant experiences differ from 12-step recovery in that participants reject the notions that recovery is necessarily a spiritually-based process and that successful sobriety includes reliance on an external higher power. Four participants specifically cite the religious/spiritual nature of AA meetings as primary reasons for seeking support group alternatives.

Five participants describe aversion to the sponsorship and meeting structures of 12-step groups, and the other participant simply states that AA did not work for her. Participants describe a preference for recovery support group meeting environments that allow for freedom of thought and topical exploration. All participants cite specific cognitive-behavioral or "behavior modification" recovery maintenance tools as integral to successful sobriety.

Participants also note that professional counselors and substance abuse treatment programs almost exclusively refer clients to 12-step groups and that counselor referrals to SMART Recovery, WFS, and SOS are rare. Three participants were initially referred to AA by counselors before finding SMART Recovery or WFS. One participant found SMART Recovery through web-based research. One participant read about SOS in a newspaper and another one discovered SOS through an anonymous note passed at an AA meeting.

Participants describe improved relation to others in sobriety. All participants credit shifts in thinking patterns or perceptions of their respective relations to other people and the world as significant contributors to improved relationships. Participants are active in their recovery groups and/or community and engage in volunteerism in a variety of ways, including facilitation of newcomer participation, face-to-face or online meeting facilitation, participation in recovery support group meetings, and active posting in web-based recovery support group forums. Participants also indicate that sobriety is not contingent upon recovery support group meeting attendance. Three of the participants mention the use of web-based support group meetings. Support group participation varies

from regular engagement in face-to-face meetings, daily use of web-based support group forums, and facilitation of online or face-to-face meetings.

The overarching composite textural theme is self-responsibility and self-direction in recovery. Participants report slightly different paths to similar ends: The participants determine the direction of their respective recovery processes, and sobriety is either considered a separate issue from everything else in life or the participants' number one priority. All participants describe detailed, individualized recovery maintenance programs and strong motivation to remain sober.

Structural Description: Tim

The primary structure of Tim's experience is *relation to self* as demonstrated through his emphasis on self-reliance, self-determination, and independence of mind. Although Tim relies on members of SOS for support, his primary mode of being in sobriety is as an individual. His story features turning points during substance use and recovery during which he made a decision or came to a realization. For example, a major turning point in his early recovery occurred during SOS meetings when he finally "made a decision to really do it." Tim perceives his decision to seriously pursue sobriety as an accumulation of experiences rather than a single moment of clarity. Prior to making that decision, Tim "knew at a rational level" that pursuing sobriety was probably the right path, but he had not acted on that knowledge. During the early months of his recovery, Tim felt both relief at finding like-minded people in recovery and apprehension regarding a life without drinking. After 23 years of sobriety, he feels no such apprehension.

He speaks of his experience and decision-making processes from an internal perspective. Tim is the key to his recovery. All other relations proceed from Tim's

foundation of self. He insists that sobriety is independent of all other forces in his life, including SOS. It appears that Tim refuses to accept that his sobriety depends on external factors such as meetings or steps. For Tim, sobriety is a completely separate issue that is the fundamental basis of his life, and remaining sober hinges only on his ability and willingness to keep sobriety the number one priority in his life. He is "feisty," intellectual, and convinced that no one true path to recovery exists. It appears that he is willing to show his "feisty" side in SOS meetings because he perceives that he is welcome to share more of himself in those meetings.

Relation to others in recovery: Tim appreciates the familiarity and comfort that he experiences with "like-minded people" in SOS. During early experiences in AA groups, he experienced hope through hearing the stories of other sober people but eventually experienced aversion to the spiritual and religious content of AA group discussions, which led him to experiment with SOS meetings. While he maintains that his sobriety is not dependent on SOS meetings or its membership, Tim experiences a sense of belonging in SOS groups. He perceives other "feisty, intellectual" types as like-minded, and receives inspiration from attending the anniversary celebrations, or "birthdays" of friends in recovery. Throughout his 23 years of participation in SOS, Tim's relation to others in group gradually shifted from newcomer to "old-timer." Although he rejects the idea that people in recovery should develop dependence on a support group, he feels some obligation to "pay back" and provide newcomers and struggling group members with support. It is interesting that Tim states his belief that meeting attendance is not necessary or required but also describes a self-imposed "obligation" to support newcomers. It seems that the difference lies in the originator of the rule. Tim apparently possesses the

willingness to impose and follow rules in recovery. However, if those rules are imposed by someone or something other than himself, he is unwilling to obey.

Stories of individuals who return to drinking provoke empathy and sadness, but Tim also perceives such stories as a reinforcement of his sobriety priority. Outside the realm of recovery support groups, Tim sometimes encounters individuals who suggest that one drink will not kill him. He perceives such interactions as nonthreatening to his sobriety because they remind him of past thinking patterns. He believes that one drink is dangerous because one drink would mark the end of abstinence. It seems that self-definition as someone who cannot drink under any circumstances is a rule that Tim follows in order to protect his sobriety.

Finally, in terms of relation to others, he relates to the larger culture through advocating for SOS as a valid alternative to traditional, 12-step oriented recovery support groups. He defends his organization against rumors or disinformation regarding SOS and moderation. Tim serves as an ambassador for the program through explaining that SOS is an abstinence-based program and a viable option for seeking sober support. Tim seems comfortable representing SOS as an independent-minded representative.

Relation to space: Tim's relation to space was integral in his selection of a recovery support group. While he reveals no negative feelings toward individuals who use AA, he perceived early in his period of sobriety that the large, "town-hall" AA meetings were less helpful than the smaller, more intimate SOS groups. He relates more comfortably to an "intellectually engaged" recovery support group meeting space, as opposed to meeting spaces that feature regular discussions of spiritual issues or "traditional religion" within the context of alcoholism. Because Tim believes that his

sobriety is predicated on an independent choice, he requires a group environment that supports his right to that choice.

Regarding Tim's relation to space outside of meetings, he appears undisturbed by the presence of alcohol around him. He asserts that his proximity to alcohol or the presence of drinking in the culture at large is unproblematic for him, which seems conjunct to his overall perception that "sobriety is a separate issue." While Tim appears generally attuned to his surroundings, he protects himself against external influences through the rigorous application of his priorities. It seems that Tim's self-determined, self-reliant manner of being informs his personal space, regardless of what is happening outside of that personal space. Tim seems to exert more influence on his environment than the environment exerts on him.

Relation to time: Tim provides little detail about his experiences with drinking. He usually describes it as a "bleak" and "isolated" period of his life. It is unclear how the past affects him, but it is possible that Tim primarily experiences the past as a source of information for the present. One apparent difference between Tim's relation to past and present is consistency and reliability. During his pre-sobriety days, Tim often failed to follow through on promises to himself, made unsuccessful attempts at moderate drinking, and experienced career difficulties related to alcohol use. His relation to the past does not dominate his thoughts, but the past serves as a reminder of where he was versus where he is today. After 23 years of sobriety, he feels like "a functional human being."

Tim has a stronger relation to the present. The present is when and where he knows himself as a reliable, dependable person who remains committed to sobriety through thought and action in a world where "there are no guarantees." He welcomes the

present as it continues to arrive. Based on his descriptions, it seems easy to imagine that 12-step processes of moral inventories and asking for the removal of character defects are unnecessary or even counterproductive for Tim in recovery.

Structural Description: Abigail

The primary structure of Abigail's experience is *relation to space* as demonstrated through her strong association between physical space and either past substance use or current sobriety. Regarding past substance use, Abigail describes a constant state of checking her proximity to the next available alcoholic drink or place of purchasing drinks for later. Many of her "situational urges" for alcohol involve specific spatial relations. For example, she associates being outside during a summer storm with drinking and smoking due to a childhood memory of witnessing storms and recalling her father's drinking as part of that ritual. Whenever Abigail experiences a situational urge, she seeks to disrupt the association with substance use and transform the space. Her situational awareness allows her to confront automatic thoughts such as "when you barbeque, you drink," or, "when you get in the car, you light a cigarette." She is initially surprised by an experience of relating substance use to space, but she is rarely surprised when a specific situational urge resurfaces. It seems that Abigail understands her relation to space so well that she consciously seeks to change her relation when she realizes her past association between substance use and a specific space or place.

In her sobriety, she utilizes space to distance herself from past spatial relationships. She maintains awareness of the space she wishes to create for her grandson. Awareness of that space was one her motivators to seek sobriety. She plans vacations and discusses her plans with others. Her relationship with the world around her has changed

in sobriety, as she is willing to extend herself in new directions. Rather than worrying about how she will remain in close proximity to the next drink, she imagines where she will experience her next sober adventure. She is fond of scuba diving, and recently went on a trip to celebrate her birthday. Abigail often discusses travel plans on the SMART Recovery message board, which is where she apparently experiences her strongest relation to space.

While Abigail physically experiences the SMART Recovery message board through a computer screen, she relates to the board as an expansive, ever-changing recovery support group meeting that never ends and spans the entire planet. Within that space, she feels secure that support is always present, that people are "listening," that she has built friendships through mutual support in the forums, and that she knows what time of day her friend in Thailand is likely to wake up and begin using the forums. For Abigail, her participation in the SMART Recovery online message boards seems to mean that recovery is everywhere, and her collective support network never sleeps or ends a meeting.

Abigail's relation to space is also expressed through her use of metaphor. She uses a metaphor drawn from an episode of an old television show to describe her freedom of choice regarding sobriety. In the television episode, which occurs in a military setting, a character is under "house arrest" in a tent. A second character jumps in and out of the tent, in a mocking demonstration that he can go in or out as he chooses, while the first character remains relegated to the tent and unable to choose due to arrest. Abigail draws the metaphor out to parallel her spatial relation in sobriety. She states that, as a sober person, she can go in or out. She is permitted to experience whatever she chooses. Prior

to sobriety, she was under house arrest, stuck in the small space of the “tent,” which represented her limited options, whereas today she feels free to choose.

Relation to self: Abigail’s relation to self is expressed through the emphasis she places on personal responsibility and individual choice. Similar to her spatial relationships, Abigail relates to herself through a sense of freedom. An early “eye-opener” for Abigail was her realization that alcohol use was costing her freedom. She equates sobriety with “growing up” and experiencing positive changes in other areas of her life.

Much of Abigail’s past substance use was done alone, and most of her recovery work and support group meetings are also experienced alone (from a physical perspective). However, Abigail relates to herself differently as a sober person and within the SMART Recovery online community. She utilizes time alone to engage in her scientific, analytical nature, which is an integral tool in her personal recovery program. Writing exercises drawn from SMART Recovery that are “available to the common man” help Abigail to focus “in a logical and organized manner.”

Although Abigail’s relation to self is rooted in freedom of choice, she has exercised that freedom to remove one choice from her life. She places alcohol use on a list of things that are “not an issue” because she has no interest in drinking. A turning point in her sobriety was when she decided firmly, “once and for all,” that she would remain sober. Since making that decision, she has felt “peace and contentment.” Her decision contains an element of finality—the decision is made, and drinking is no longer entertained as a viable option. However, she respects the individual right to choose substance use or sobriety. She states that individuals choose, and that choosing to drink is

also a valid choice. According to Abigail, it is up to the individual. From Abigail's perspective a "regular person" can take alcohol or leave it. Through choosing to "leave" alcohol, she relates to herself as a regular person, someone who does "what a reasonable person would do."

Relation to others in recovery: Abigail's relation to others is primarily expressed through her interactions with other members of the online SMART Recovery community. She refers to people in her "3-D" life as acquaintances, while other users of the SMART Recovery website are her friends. Abigail relates to others through humor and shared interests. In the SMART Recovery forums, she facilitates discussion of travel and fun sober activities. She empathizes with people who remain in a struggle with substance use. However, she respects the right to choose or not choose sobriety.

Abigail relates to her family as a stable, reliable mother and grandmother. The desire to provide support for her daughter and care for her grandson in difficult times contributed to Abigail's "final" decision to seek sobriety. Overall, she relates to others as a participating member of society and a "more responsible member of the community," both online and offline. The only apparent barriers to relating freely with others for Abigail are the presence of alcohol or others' attempts to control or direct her. In her opinion, being around others who drink is "not a lot of fun." Regarding perceived control, the sponsorship component of AA was one of Abigail's major criticisms of the program. "Checking in" with a sponsor or "wasting time" driving to and from AA meetings that featured predetermined speakers or topics were part of Abigail's "white-knuckle" experience with AA. Abigail relates to other recovering individuals as an adjunct to her recovery, not the source. It appears that Abigail's attitude toward support group meetings

is that if she is going to attend a meeting, the meeting should feature something that she perceives as useful to her sobriety.

Relation to time: Abigail relates to time in a scientific manner. Memories and associations with substance use are transformed into learning experiences and opportunities to mold the present. She experiences the past as a deterrent against giving away her present sense of freedom. She relates to the present as a limitless possibility, and she strives for full engagement with living here and now. Her present is unbound by time zones or the start/stop times of traditional, face-to-face support group meetings. She knows that her friend in Thailand is "14 hours ahead," but he exists in her present. She experiences him in real time when he logs into the SMART Recovery forum. The forums are "a meeting 24 hours a day." The present is also her launching pad for future endeavors. Prior to sobriety, her relation to time was a countdown to the next drink. In early sobriety, all conversation "focused strictly on recovery." Presently, Abigail is looking into the future and "moving on with life." Her next trip is on the way; her future is now.

Abigail seems to use her relation to the present as a buffer against guilt, shame, or other negative influences from the past. She states that drinking is no longer on her "list of things to do" along with sky-diving, which she jokingly refers to as "jumping out of a perfectly good airplane." Considering Abigail's penchant for metaphor and wit in recovery, it seems appropriate to suggest that, metaphorically speaking, jumping out of planes is unnecessary because she already maintains a curious and adventurous outlook toward the present and the future. It seems that she experiences something akin to the thrill of skydiving every day that she wakes up as a sober person.

Structural Description: Anna

The primary structure of Anna's experience is *relation to self* as demonstrated through her emphasis on self-knowledge, self-confidence, self-empowerment, and self-affirmation. The turning point in Anna's path to sobriety was changing the way she perceives herself and the world around her. Anna's relations to others, space, and time all extend from her changed thinking patterns. Her favorite WFS statement is "that negative thoughts destroy only myself." When describing her identity as a sober person, Anna refers to how changed perceptions have positively affected her experience of herself. The most valuable aspects of her experience in WFS is "the self-empowerment and being able to take responsibility" for herself. She has overcome the past tendency to see only one side of an issue (hers), and she now experiences problems as puzzles rather than terrible situations. Anna knows that she will not always get what she wants, but she maintains positivity and relies on her training and practice to experience "disappointment without devastation" in situations that in the past would have led her to substance use or insistence that the "other person" needed to change.

In sobriety, Anna feels confident that she is back in control of her life. She is no longer controlled by her addiction. Ultimately, she makes the choice to either use substances or abstain from them. Messages of self-affirmation such as "I am what I think" and "I am a capable, competent, compassionate, caring woman" bolster her daily recovery efforts. Belief that other people cannot define her is congruent with her sense of personal responsibility and self-direction. She describes her past identity as a "party girl" as "false" and "not genuine." Her sober identity appears tied to her work as a WFS meeting facilitator. During those meetings, she strives to assist women who need support

or encouragement. She is a beacon of hope to other women in recovery. Anna relates to herself as the primary support person in her recovery program and her life in general. She is honest, genuine, and determined. She also punctuates many of her sentences with laughter, which seems consistent with Anna's self-described sober identity. It seems reasonable to conclude that Anna experiences her sober identity as more fun than her past self-described existence as a "party girl."

Relation to others in recovery: Anna's relation to others is a direct extension of her shift in self-perception. Regarding a family member with whom she historically does not "always see eye-to-eye," Anna believes that the relationship is improved due to her ability to step back and consider that individual's perspective, as opposed to insisting that the other person see things her way. Self-absorption has disintegrated in favor of cooperation and community. While past relationships were often revolved around substance use, she now associates with others through shared interests such as listening to the same music or "having things to talk about."

In describing her recovery experience, Anna often uses the word "help" within the context of relation to others. The help she provides other WFS members also helps her through reminders of tools that she could use or aspects of her life on which she needs work. Other women in recovery inspire her. It is unclear whether Anna is aware of the positive impact she has on other women in recovery, but she seems motivated by a genuine drive to help rather than any desire for attention. She appears uninterested in accolades or credit for the successes of others.

Anna spends so much time speaking about the positive aspects of WFS that she offers little detail regarding criticism of 12-step support groups. It appears that Anna sees

all paths to recovery, including AA, WFS, "SMART or Rational Recovery or a medical model treatment," as valid depending on what "speaks to" the individual. She maintains that recovery is an "incredibly personal journey" and an individual choice. Anna is willing to offer suggestions based on her personal experience but maintains that the key to successful recovery is to "change the way you think about alcohol and drugs." From Anna's perspective, the number one contributor to relapses is the mindset "I can't get sober, I can't live without alcohol," and the antidote to such thinking is found in self-affirmations such as "I can be sober, I can be happy, I deserve it, I'm worthy of a good life."

Relation to space: Anna's relation to self also affects her relation to space. In the past, her space was crowded with inauthentic relating and a constant desire for substance. Perceived problems constricted her movement and limited her options. Her balanced approach to self and others in sobriety expands her space and provides her with room to work through problems, which she now refers to as "puzzles." For Anna, more space means more options, which contribute to her sense of freedom. Anna utilizes recovery tools in order to "let things go" and prevent problems from "taking up space" in her mind. Anna uses space to invent herself. She believes that she both creates and defines herself with her thoughts. Anna is the architect and builder of her personal recovery space.

Relation to time: Anna's relation to time is "focused on the present and the future." Anna experiences the present as a constant self-improvement opportunity. She insists that her past does not define her. In the past, she felt guilt and shame about actions related to substance use. However, Anna finds comfort in the WFS statement and daily

personal reminder, "The past is gone forever." Anna punctuates this statement with conviction. The past maintains value for Anna. She draws lessons from past experiences and integrates those lessons into present living. Over time, Anna's feelings of guilt, shame, anxiety, and depression subsided in the face of determination, compassion, competence, and capability. Although the past is "gone forever," Anna would not change her past. When asked what sort of advice she might give herself if she could travel back to the past, she would say, "don't give up." Outside of that message and a general assurance that someday she would feel happiness, Anna would offer herself no advice. The past is gone forever but also a permanent aspect of, in Anna's words, "who I am today, and I don't know that I would tell myself to do anything differently…"

Structural Description: Louis

The primary structure of Louis's experience is *relation to self*, as demonstrated by his emphasis on self-confidence, spontaneity, honesty and self-determination in sobriety. For Louis, self-confidence builds through accomplishment; every time he accomplishes something in sobriety, his "inner strength" grows. Louis immersed himself in initially uncomfortable situations as recovery training exercises. He wished to shed old thinking patterns and eliminate "red flags" that represented old patterns in his consciousness. He engaged in "behavior modification." Some of the immersion experiences involved attending artistic and cultural activities that seemed uninteresting in his past, and some experiences served as personal challenges for Louis to integrate himself into social situations. In early sobriety, he guarded his sobriety "like a crazy man." However, he also realized that he needed an internal push to "consciously challenge" himself and to broaden his life experience. Louis's sobriety is predicated on an individual choice; he

does not use drugs or alcohol “no matter what” happens. He perceives his final decision to pursue sobriety as a life-or-death decision, a decision he experienced as “a deep decision, spinal deep…not cerebral.”

Louis’s relation to self also involves spontaneity and what he defines as a “gut-level” or “knee-jerk” recovery. He views sobriety as “a separate issue” from everything else in his life and, for him, outside the purview of spiritual recovery programs or set guidelines to maintaining sobriety. He is happy, having a “good time,” and insistent that “sobriety has to be worthwhile…otherwise, why bother?” Based on his apparent relation to self and manner of relating to the world around him, it appears that Louis challenged himself to make living worthwhile. It seems that he succeeded because he likens recovery to the sensation of “being strapped to a comet.”

Relation to others in recovery: Louis’s preference for spontaneous, honest interactions extends directly to his relation to others. His past substance use was internally tumultuous but had little lasting impact on personal relationships. Louis “lost no one” in terms of family and intimate relationships as a result of his drinking. Louis possesses an apparent craving for authentic interaction with others in recovery. In sobriety, he found his empathy, “which is a wonderful thing.” Regarding the recovery community, he feels a natural affinity for and “unity with other people suffering with this disorder.”

While he maintains that 12-step recovery support groups are a poor fit for his style of relating in recovery, he feels an affinity and camaraderie with all recovering individuals. He feels free to attend an AA meeting if he so chooses. However, he sometimes senses apprehension from individuals who use AA as a primary support and

occasionally attend SOS meetings. While he remains unsure whether his “dream” is possible, he wishes for all individuals in different recovery groups to get along and realize “that we’re all in the same boat.” Other individuals in recovery contribute to his feeling of self-efficacy. Louis is comforted by the company of others who are attempting “to have a better life,” and he finds listening to how others effectively “deal with problems” extremely helpful to his own sobriety.

Outside of recovery support groups, Louis relates to others as part of a full, “worthwhile” sober existence. Increasing general social interactions and exposure to “situations that are normal” and sometimes feature alcohol such as art exhibits and jazz clubs were parts of Louis’s plan to re-integrate passion into his life. Louis describes himself as a “low bottom” drinker, so “up was an unpleasant place” in early recovery. Going out and experiencing a full social life takes time. Louis claims, “You don’t force that…it has to come organically.” It seems that Louis needed other people to reach his goals of feeling passion, appreciating life, and feeling more like a “normal person” in recovery. Louis states that his interaction during his period of substance abuse was often low, drugged, and monosyllabic. He jokes that in early recovery, he could barely connect crossword puzzle clues to simple words. His determination to pull himself out of that self-described low state included a conscious plan to multiply his use of syllables through increased interaction with other people inside and outside of recovery support groups.

Relation to space: Louis’s relation to self also influences his relation to space. Louis’s self-awareness informs his need for free, open space in recovery. He often refers to his need for spontaneous, “gut-level” sobriety. He seems to feel more alive within a space that encourages free expression and topical flexibility. SOS meetings provide Louis

with the space to "speak honestly" about whatever is on his mind. Initially, he felt surprised by the SOS meeting space because he came into SOS "inculcated with AA terminology."

Although he states that some aspects of AA meetings are useful, such as "just people talking about sobriety issues," his perception of what usually happened within AA meeting spaces is what eventually led him out of AA and into SOS. Louis experienced an apparent conundrum when faced with the almost simultaneous realizations that (1) honest relating was the key to his successful recovery, and (2) he would need to stifle himself, relate dishonestly, or "couch" his comments "in AA terminology" during 12-step meetings. He prefers a support group space where "sobriety is treated as a separate issue." Throughout his life, Louis explored various religions and types of spirituality, but "no religion made sense" to him. He remains an explorer of ideas and possibilities, so he requires a space that allows him to constantly examine his sobriety without "having to deal with spiritual issues" as part of his sobriety. For Louis, the most valuable aspect of SOS is "that it doesn't tell anybody what to do." As a self-determined individual working within free and open "dynamic" space, Louis apparently figures out ways to tell himself what to do in recovery.

Louis experiences a strong emotional reaction whenever he hears Beethoven's Ninth Symphony. The piece may represent Louis's perception that his relation to space remains full of limitless possibility. The thread of music that runs through Louis's story evokes imagery of the apparent contrasts between his drinking life and his sober life. Louis's drinking years evoke images of a man playing a single instrument, sometimes only a single note. In sobriety, he seems more like part of a full orchestra. He moves from

chair to chair and instrument to instrument as he sees fit. Whether he is writing the music, conducting the orchestra, playing an instrument, or experiencing the music as a listener, he welcomes collaborators to step in and participate. It seems that Louis is interested in experiencing nothing less than the full sound of humanity's symphony.

Relation to time: Louis's relation to time is present-focused and future-oriented. He spends little time discussing the past except as a contrast for the present. During the interview, Louis's only mention of the word "past" involved a description of his many past decisions to "get sober" prior to his final decision, which was the life-or-death, "spinal deep" decision to seek sobriety 24 years ago. The period of drinking in his life led him to "the gates of darkness," a time that he experienced as "sad, grey, monotone, and depressing." Much of Louis's practice in early sobriety included searching for old patterns in his thinking, patterns that he wished to restructure through changing his thinking, behavior, and approach to life. In SOS meetings, Louis sometimes experiences a meditative state, during which he feels "a sort of different brain-wave pattern." He attributes this state to the absence of "lectures" about religious belief and the perception that he enjoys true "freedom of thought" in SOS meetings.

Louis's relation to time also apparently influenced his decision to discontinue attendance of AA meetings in favor of SOS meetings. As he continued to struggle with the religious/spiritual content of AA meetings, he thought, "I'll always be lying to them or myself if I continue going to these [AA] meetings." His anticipation of dishonest relating in a topically limited recovery group dynamic was apparently at odds with his desire for an amplified experience of self, space, and time. Louis describes the pattern of his mind as a drinker as like embers. Regarding time in recovery, Louis states, "I wanted

the embers in my mind to become flame-like." Similar to Louis's relation to self, others, and space, his relation to time is one of limitless possibilities for growth and reexamination. He would not change anything about his experience in sobriety because "it worked like a charm." For Louis, it seems that time is the flame that lights the darkness.

Structural description: Rose

The primary structure of Rose's experience is *relation to time* as exemplified in her assertion that "the past is gone forever." Regarding her relationship with her sons, Rose states that she has "the best relationship with them now," better than she "could have possibly imagined." Rose describes her self-identity in terms of then versus now. She seems to perceive time as a self-improvement resource and a reminder of her present-focused preference.

She enjoys attending WFS meetings because they give her "something constructive to do" with her time. Rose also relates to time through contemplating her mortality. She feels gratitude for her life trajectory and apparently perceives the past 13 years as an ongoing series of opportunities. At the same time, she feels sadness about women who relapse and die in addiction. While reflecting upon her time in sobriety, Rose states that she "could have easily ended up one of them dead girls." She remembers the temporal costs of addiction, the times during which she consistently spent time calculating when and where she would find her "next drink."

Rose's present is also future-oriented, as she plans ahead and looks for ways to protect her sobriety. When she anticipates company, she insists that her visitors keep alcohol away from her home. When she anticipates the presence of alcohol outside her

home, she always leaves herself an escape route. While describing why she feels no fear or apprehension about sobriety-related interviews, Rose stated, “I like who I am today…and I’m not ashamed of it.” Rose apparently experiences the present as a reflection of her journey toward self-reflection and self-acceptance.

Regarding her relation to time, it seems that Rose wishes to clarify that she no longer identifies with her past roles or past tendencies. She often uses the word “now” during descriptions of her recovery experiences. Rose discusses “boundaries” within the context of relationships. However, boundaries also seem relevant to Rose’s temporal relation. Rose identifies herself as who she is today. Who she “was” seems less relevant to her. Rose insists that “the past is gone forever” and that she “will no longer be victimized” by the past.

Relation to self: Rose’s relation to self is an apparent extension of her refusal to allow the past to harm her. Rose perceives herself as “compassionate,” “trustworthy,” and “honest.” While it seems clear that Rose cares for others, she protects her sobriety at all costs. She is most proud of her independent accomplishments, of which she reminds herself, “…that was me who did that…not relying on someone else…”

Rose recalls others telling her, “You’re a drunk, you’re just a drunk…it’s your own fault.” She admits that she initially experienced difficulty breaking from that identity. Rose apparently reached a turning point at which she transitioned into self-definition. The process of learning how to, as Rose says, “stand up for myself” seems like a crucial component of her recovery maintenance. She also relates to herself as determined, consistent, and dedicated to recovery. She “wakes up every morning, picks a statement, and works on it.”

Rose makes several references to “standing up” for herself as a sober individual. She also describes feelings of pride and self-responsibility. Rose’s description of self-relation evokes images of Rose as a person who no longer bends to the will of others. She is compassionate and fair. However, it also appears that Rose considers herself equally important as she considers others in recovery. She “stands up” for herself against her old self-identity. The “new” Rose prevails on a daily basis.

Relation to others in recovery: Rose’s relation to others seems like a clear extension from her relation to self. Rose seems to place a high value on self-respect. To respect Rose means to respect her sobriety. She reminds others that they are not permitted to bring alcohol into her home. She also seems to have low tolerance for “drama” or the problematic substance use of family or close friends. Rose seems caring and generous. However, she refuses to sacrifice the integrity of her sobriety for anyone else. Others are surprised when she “puts down a boundary” because she is usually calm and agreeable.

She seems happiest about “being a mom to” her two sons, a role that she “takes seriously.” Rose also feels inspired by other women in recovery. She is especially “amazed” by her best friend, who went back to school in recovery. She seems to take pride in helping other WFS members. Rose’s mother was an early proponent of Rose getting sober. Rose states that she “should have listened” to her mom sooner. Rose appreciates her mother’s positive influence, and it seems possible that her mother’s support also drives Rose’s desire to provide strong support for her two children.

Relation to space: Rose relates strongly to the space of her home as her “own environment,” an “intimate” refuge from alcohol. Rose appears to prefer spaces that are free from the presence of alcohol. Her sober space is so important that she is willing to

end contact with people she perceives as dangerous to her recovery. Regarding support group meeting space, Rose discontinued attendance at AA meetings after she was introduced to WFS by her counselor. Rose experienced WFS meeting spaces as more practical. While describing her preference for WFS, Rose stated, "I like it more because it's not just one person's story after another." In WFS, Rose receives "tools" and information."

Rose's relation to space is apparently similar to how she relates to self, others, and time. When Rose perceives that something is not supporting her recovery, she seeks change. She told her counselor, "AA is not working for me," and then she found WFS. She was tired of hiding her feelings, so she found ways to express how she felt. She prefers living without alcohol, so she made her home alcohol-free. Rose seems to possess a quiet confidence. She apparently works best in small, controlled spaces where she is able to protect her family and her recovery. Rose seems unselfish and asks for little from others, but she worked hard to create her recovery space, and she guards that space against any outside threats.

Structural Description: Jeff

The primary structure of Jeff's experience is relation to self, as expressed through the importance he places on self-knowledge, self-evaluation, and self-education. Jeff relies mostly on his "mental faculties" to maintain sobriety. He possesses a self-described "scientific, intellectual, curious mind" that he trained for successful sobriety "through behavioral exposure" and internal motivation. Jeff considers philosophy and empirically-based psychology as contributors to a happy life. Jeff finds that practicing cognitive-behavioral techniques works to inform the apparent primary tool of his recovery

maintenance: Analysis of his own thoughts. Jeff states that analyzing his thoughts "often just simply dissolves problems, problems become non-problems."

He strongly believes that without his motivation, skill set, and inclination toward sobriety, "then my path to recovery would not have been as successful as it is." He also believes that willpower is useful in bursts, "like a booster rocket," but he suggests that willpower alone is insufficient. He believes that in order for willpower to work, it is also necessary for an individual to alter unrealistic thinking patterns. Jeff initially tried sober living on a trial basis and seemed to value experimentation and hypothesis-testing in early sobriety. After much practice and consideration, Jeff has assembled a personalized approach to living based on self-education, tenets of philosophy, and cognitive-behavioral exercises. His pragmatic problem-solving approach extends beyond the realm of recovery. Jeff states, "I've gotten down a road to where I've tried to apply the principles that led me to sobriety and actually apply them to other areas of life."

It seems that Jeff's scientific nature lends insight into his methods of recovery maintenance. When Jeff practices self-reliance, it seems that he maintains the ability to control for more variables in his life. He seems to run experiments and integrate his findings into his daily living. However, Jeff is more than simply a scientist. He states that he has both "austere" and "hedonistic" sides. He enjoys dancing and believes that as a sober person, without substances that "cloud the mind," Jeff is able to "party better."

Relation to others: Jeff relates to others through facilitation of SMART Recovery groups and through volunteerism and various social outlets. Outside of SMART Recovery meeting facilitation, Jeff spends little time around "sober people being sober

people" socially and more time focusing on "normal life things." It appears that Jeff's efforts to sustain abstinence do not interfere with his social activities.

He describes his past interactions at AA meetings as "frustrating," mostly due to the "magical language" used in meetings. He appreciates the community and ritual aspects of religion, but he finds no use for "supernatural beliefs." In AA, Jeff perceived that the common saying, "Take what you want and leave the rest" was not actually true, so he explored alternative support groups. He chose SMART Recovery because of the cognitive-behavioral focus and absence of the "magical lingo" he perceived in AA. Jeff finds the community experience of SMART Recovery valuable because volunteering helped Jeff "catch the altruism bug" and improve his feelings about himself.

Jeff experiences some tension in his relationships with immediate family members. However, through periodic renegotiation and readjustment, Jeff feels "fine about the equilibrium" that he perceives in his family relationships. Although Jeff seems thoroughly self-educated and self-reliant, he apparently flourishes in social situations. Regarding hedonism, Jeff states that people "can definitely party and be sober." In addition to the various methods Jeff uses for recovery maintenance, it seems that Jeff also remains sober because the party did not end when he ceased the use of mood-altering substances. As Jeff says, he "can party better sober."

Relation to space: Jeff's relation to space is an extension of his self-education. The meeting space of SMART Recovery helped Jeff catch "the altruism bug," and it also provided Jeff with cognitive tools for altering his personal space. Jeff values self-improvement and self-evaluation. While studying psychology or engaging in debate, Jeff

operates within spaces that hone his “mental faculties,” which, as stated earlier, are his primary recovery maintenance tools.

Jeff’s “hedonistic side” apparently works in tandem with his “austere” side. They are not in opposition. He celebrates and contemplates life. Jeff seems to experience space as a quest to maintain internal and external balance. His personal recovery program is comprehensive and almost entirely self-directed. Jeff appears flexible and able to operate in any space due to the internal mental space he creates and carries with him everywhere.

Relation to time: Jeff’s relation to time is almost exclusively present-focused. His actions are also oriented toward the future, and he maintains a high level of awareness regarding the past, but he remains temporally anchored in his present existence. Jeff remains undisturbed by the presence of alcohol or the onset of “problems,” as he possesses a variety of methods for dealing with such issues. Jeff is so immersed in a present focus that he prefers not to entertain questions about how his life might have turned out differently. Jeff finds freedom “in the limits of our knowledge.” He is comfortable in the present, noting that his “epistemic abilities are limited in predicting futures and predicting contingencies.”

Structural Description: Composite

Participants operate in recovery spaces that are similarly self-directed and contingent upon internal forces. All participants adamantly oppose any suggestion that their respective recovery experiences are predicated on anything outside of self-responsibility, self-talk, self-awareness, self-empowerment, and self-education. Several participants of the study verbalized aversion to outside control or others telling them “what to do.”

Participants also describe a process of creating personal recovery space. Some participants choose to stay away from alcohol and other mood-altering substances and others choose to proceed with a "normal life" and continue engaging in activities or attending events that feature alcohol or other mood-altering substances as part of the experience. The participants determine the boundaries of these recovery spaces. One participant focuses descriptions of her recovery support group experience almost exclusively on her current support group. However, the other five participants clearly state how personal experiences within 12-step meeting group spaces were either detrimental or unhelpful to their respective recovery processes. All participants describe what they appreciate about their current support group. Descriptions of SOS meeting spaces include freedom of thought, intellectual curiosity, topical flexibility, and the absence of steps or rules to individual recovery processes. Participants describe WFS as compassionate, collaborative, present-oriented, cognitive-focused, and empowering. Participants describe SMART Recovery as focused on tools, topically flexible, always available, individualized, and applicable to other areas of life outside of recovery.

Similar to the composite textural themes, the overarching structural theme is freedom and self-knowledge as central to recovery processes. Participants describe determination, openness to new experiences in recovery, and willingness to maintain sobriety as a life philosophy and primary priority as parts of the recovery process. Participants describe a desire for choices in recovery, for others as well as themselves. All participants state that individuals seeking sobriety should enjoy the benefit of recovery support group options. One participant describes support groups as "a series of

safety nets," and another participant suggests that if one program is a poor fit for an individual, other groups are available.

Experimentation as part of the recovery process emerged as a theme of participant stories. Some participants experienced a period sobriety in the past, and all participants attempted recovery in a 12-step program. Some participants attended only a few AA meetings, while others maintained association with 12-step groups for several months in early recovery. The theme of experimentation is reflected in participant experiences of seeking out support group alternatives. The two participants who use SOS knew early on that AA would not work due to the spiritual/religious overtones, adherence to sequential steps, and reliance on the concept of higher power. The other four participants also describe that AA as a poor fit due to topical rigidity, the sponsorship process, spirituality, or a perceived lack of practicality. All participants describe a process of experimenting with support groups other than AA and eventually discontinuing association with 12-step groups.

The theme of experimentation as part of the recovery process also emerged in terms of lifestyle and proximity to alcohol. Participants differ in terms of how they individually approach the presence or anticipated presence of mood altering substances. One participant outright refuses to allow alcohol on her property, and two other participants perceive that proximity to alcohol is either a minor concern or no concern at all regarding personal recovery maintenance. Other participants regularly participate in social activities that involve the presence of alcohol. These three participants all express an affinity for dance, music, or art, and they seem intent on maintaining a lifestyle that allows for enjoyment of those activities, regardless of whether alcohol is present. One

participant states that he can “party better” as a sober person, and two other participants clearly state that music or dance will remain part of their respective lives in recovery.

Individualized recovery programs within the three different recovery support groups also emerged as a theme. Although participants described thematically consistent experiences regarding many aspects of the recovery process, each participant detailed unique, individualized recovery journeys, conceptualizations of the recovery process, and maintenance/relapse-prevention plans. All participants described the freedom to develop a personal recovery plan. Several participants commented that many paths to recovery exist and that it is difficult or impossible to offer “blanket advice” to individuals regarding sobriety without understanding individual circumstances.

Textural-Structural Synthesis

Participants experienced a perceived lack of options regarding recovery support program options in early recovery. Participants dealt with this perceived lack of options in a variety of ways. Some participants appealed to counselors for more options, one received an anonymous tip, and the rest searched for options independently. The perceived lack of fit in 12-step program and subsequent association with SMART Recovery, SOS, or WFS led all participants to advocate for options in their respective support groups. All participants stated that they consider the recovery process highly individual and unique. One participant stated that “there are a billion ways to get sober.” Despite the participants’ perception that 12-step groups are a poor personal fit, all participants maintain that 12-step groups are a valid option for individuals seeking recovery. Participants maintain that 12-step meetings possess valuable aspects, namely

the instillation of hope due to shared experience and an initial feeling of belonging in a group of other individuals who struggle with substance use issues.

Several participants note that AA was a “white-knuckle” experience for them because they substituted dependence on meetings for dependence on substances or because AA or “AA-focused” counseling lacked the “proper tools” for maintaining sobriety. Participants apparently interpret the “white knuckle” phrase as the experience of maintaining technical abstinence while holding onto that sobriety so tightly that an individual’s knuckles (metaphorically) turn white, which prevents the individual from doing anything other than simply maintaining technical abstinence without making other significant life changes. Participants experienced white knuckle sobriety as a sign that the AA program was a poor fit, as opposed to believing that they simply were not trying hard enough or practicing honesty with themselves.

Participant interpretations of the white knuckle metaphor seem to contrast the AA suggestion that “those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves” (Alcoholics Anonymous, 2001, p. 58). For several participants, the act of practicing personal honesty meant to abandon the 12-step program in favor of a support group that would allow “honesty” as the expression of spontaneous, subjective perceived truths as opposed to total acceptance of the outlined 12-step path to recovery. It seems that the participants felt controlled and constricted during their respective periods of substance use, and they also experienced 12-step philosophy as controlling or constricting.

Participant perceptions of the recovery process also influence their interactions with newcomers to recovery support groups or people considering the possibility of seeking sobriety. Due to the perception that recovery is an individual journey with various possible paths to success, the participants encourage other individuals to seek out alternatives, experiment, and practice what works on an individual level. It seems that participants incorporate a person-centered, as opposed to a program-centered, approach to interacting with others in recovery.

Summary

Chapter Four included descriptions and interpretations of the researcher's experience with six individuals who maintain sobriety from mood altering substances using the recovery support groups SMART Recovery, Secular Organizations for Sobriety, or Women for Sobriety. The chapter opened with a textural description of each participant's perceptions of the recovery process and a composite textural description. The chapter also included the construction of structural descriptions for each participant and a composite structural description across all participant experiences. The chapter concluded with a textural-structural synthesis regarding participant perceptions of the recovery processes and how participant experiences compare to 12-step recovery.

CHAPTER FIVE: DISCUSSION

Introduction

The purpose of this study was to examine the experiences of individuals who use self-directed, cognitive-based support groups to maintain abstinence from mood-altering substances. The research included interviews with six individuals who utilize the recovery support groups SMART Recovery, SOS, and WFS. Interview questions focused on participant thoughts, feelings, behaviors, and overall experience of sobriety. The research questions in this study were: (1) How do individuals who maintain abstinence through self-directed, cognitive-based recovery support groups perceive the process of recovery/sobriety, and (2) How do participant experiences compare to 12-step recovery as reported in existing academic literature? Chapter Five begins with a summary of the discussion and findings. The next section includes limitations of the research. The chapter concludes with a discussion of implications for practicing counselors, supervisors, counselor educators, and future research.

Summary and discussion of findings

The findings of this research suggest that participants perceive recovery as a process of attaining self-knowledge and achieving freedom from the negative influence of mood-altering substances. Participants describe sobriety as a period of experimentation and as a process of distancing themselves from negative self-perceptions and behaviors developed during their respective periods of substance use. Participants endorse a

philosophy of self-responsibility in recovery and a rejection of imposed values or recovery program structures. Regarding the primary research question "How do individuals who maintain abstinence through self-directed, cognitive-based recovery support groups perceive the process of recovery/sobriety?" participants described the following:

1. The process of recovery begins with an individual choice and a desire to achieve freedom from the negative influences of substance use.
2. The process of recovery includes community and a sense of belonging, both within and outside of recovery support groups.
3. The recovery process culminates in a journey of self-discovery.
4. Specific recovery maintenance tools are necessary to prevent relapse and foster positive self-perception.

The perception that recovery begins with an individual choice seems congruent with a prior study on spontaneous remission. Walters (2000) found that individuals who achieve sobriety without the help of substance abuse treatment, counseling, or support groups cited health concerns, feelings of disgust, and the "will to stop" (p.455) as contributing factors to their respective decisions to seek sobriety. Several participants in this study cited health concerns and dissatisfaction with substance use as motivating factors toward recovery. Also, the issue of will to stop or willpower seems relevant to participant experiences. Jeff claims that willpower is a useful tool as a metaphorical "booster rocket" but not enough to maintain sobriety without action. While not explicitly using the term willpower, Rose and Anna clearly articulate that they made a choice to pursue sobriety. Prochaska and DiClemente (1982) suggest that "human action is freely

chosen and to say anything else determines our choice is to show bad faith in ourselves as free beings" (p. 279).

The issue of freedom seems relevant to existential approaches in substance abuse counseling. Rogers and Cobia (2008) state that existential approaches place less emphasis on substance use and more emphasis on fostering client personal responsibility. Yalom (1980) claimed that humans are responsible for individual choices and charged with creating meaning in a world that has no inherent meaning. Without explicitly stating a preference for existential theory or therapy, participants in this study discussed issues of death, isolation, and existential anxiety/guilt. All participants described past experiences of acting against their authentic selves and efforts in sobriety to reclaim that authenticity. From an existential perspective, guilt arises when people do not act in accordance with their respective authentic selves and instead transfer personal power to an external individual or force (Sartre, 1969; Yalom, 1980).

In terms of community and relation to others, experiences of the three female participants seem consistent with theoretical claims that substance abuse treatment for women should build on relationships and connection with others (Manhal-Baugus, 1998). Kasl (1992) claimed that patriarchal, hierarchical structures are a poor fit for women seeking recovery. While Abigail, Anna, and Rose all described the importance of relationships and connection with others and recovery, Jeff, Louis, and Tim also stated the importance of social connections inside and/or outside recovery support group environments. All participants remain involved with SMART Recovery, SOS, or WFS. However, participants clearly stated that sobriety is a separate issue, even from involvement with recovery support groups.

The process of self-discovery seems relevant to existential issues and the principles of Motivational Interviewing. According to Miller and Rollnick (2002), supporting self-efficacy is a fundamental goal of Motivational Interviewing. It is impossible to predict what might have occurred if participants continued in 12-step programs or 12-step oriented treatment. However, it seems clear from the results of this study that each participant traveled an individualized path toward self-efficacy. Participant experiences also seem consistent with principles of Rational Emotive Behavioral Therapy. Ellis (2000) called REBT an internal control psychology that teaches people to improve relations with other people through self-change. Participants clearly discussed the concepts of self-change and internal control in terms of thought, behavior, emotion, relation to self, relation to sobriety, relation to others, and relations to time/space.

The recovery maintenance tools described by participants seem consistent with theories of habit change (Marlatt & Gordon, 1985), social learning (Bandura, 1977) and cognitive-behavioral relapse prevention (Rawson et al., 1993). Abigail, Anna, Rose, and Jeff all apparently use the techniques of confronting negative self-talk and decreasing irrational thoughts based on Rational Emotive Behavior Therapy (Ellis, 1962). The described experiences of Abigail, Jeff, Louis, and Tim suggest that those individuals reformed habits and taught themselves how to function in situations that feature the presence of alcohol. All participants seem to use self-directed cognitive or written assignments designed to self-monitor recovery maintenance (Gorski, 1989).

The second research question asked “How do participant experiences compare to 12-step recovery as reported in existing academic literature?” The AA basic text

(Alcoholics Anonymous, 2001) describes alcoholism as an illness or a disease. Participants apparently endorsed the concept of alcoholism as an illness. Several participants discussed substance use in terms of "alcoholism," "mental health issues," or described problematic substance use as an "affliction." Several participants personally accepted the term "alcoholic." However, participants also described a perception that alcoholism did not denote a moral or spiritual "disease."

On the subject of the first three steps of the 12-step program (Alcoholics Anonymous, 2001), participants apparently diverged from AA philosophy. Regarding Step One, which relates to powerlessness over alcohol, several participants described a perception that they "could not drink no matter what." No participant used the word "powerless" during the interview process. It is possible that, from a 12-step perspective, participants' admission that they cannot drink is comparable to an admission of powerlessness. However, the participants communicated in terms of self-empowerment and self-responsibility rather than perceived powerlessness.

Based on the findings of this study, it seems reasonable to conclude that participants sought to gain power over their lives rather than admit powerlessness over substance use. Participants seemed to differ from 12-step recovery in terms of belief that a power greater than themselves could restore them to sanity (Alcoholics Anonymous, 2001). Participants described community and a sense of belonging either within recovery support groups or social/family environments. However, participants made no suggestion that they recognize any external higher power. Regarding AA Step Three (Alcoholics Anonymous, 2001), participants strongly disagreed with the concept of turning their will and lives over to God. Several members clearly stated an aversion to the spiritual

components of AA, and the findings of the study indicate that participants rely heavily on self-will and self-knowledge, which contradicts a major component of AA philosophy regarding the impossibility of successfully maintaining recovery through self-knowledge.

While a major theme that emerged in participant stories was a journey to self-discovery, participants described the process of that discovery in non-spiritual terms. Participants did not mention the AA concept of spiritual awakening, and several participants commented negatively regarding the sponsorship component of AA and the predetermined meeting structure of AA groups. Participant experiences also differ from 12-step recovery in terms of asking God to remove shortcomings and taking moral inventory (Alcoholics Anonymous, 2001).

Participant experiences seem consistent with the fellowship component of 12-step recovery. As stated in the review of literature, the positive links between AA meeting attendance (Magura, 2007; McKellar, Stewart, & Humphreys, 2003) and spirituality (Hohman & LeCroy, 1996; Johnsen, 1993; Mason et al., 2009) with sustained abstinence are well-documented. Participants seemed to enjoy relationships with other individuals in their respective recovery support groups. Similar to Alcoholics Anonymous (2000), participants utilized peer networks to "escape disaster" (p. 152).

It seems reasonable to conclude that participant experiences counter the assertion that a spiritual awakening is a necessary component of successful sobriety. Participants apparently evade the dichotomous view that individuals who are unprepared, unwilling, or unable to accept the centrality of a spiritual-based recovery program in their lives are in denial, dishonest, or unable to recover from substance use in a healthy manner. Most participants explicitly stated an aversion to religious and spiritual messages in recovery

support groups but not necessarily an overall aversion to religion or spirituality. Louis claims that he has explored religions throughout his life, and Jeff, a self-described atheist, appreciates the community-based aspects of religion but not superstition or the “magical lingo” of AA. While some researchers endorse the synthesis of cognitive, behavioral, and spiritual components in recovery (Bristow-Braitman, 1995; Warfield & Goldstein, 1996), participants in this study explicitly suggested that sobriety is a separate issue and not necessarily tied to spirituality.

Participants seem to direct attention toward sobriety itself and then proceed with their daily lives from that point, which, on the surface, seems aligned with 12-step principles. However, participants apparently diverge from AA on the point of ultimate responsibility for recovery. Participants do not attribute sobriety to powers greater than themselves. Despite the apparent philosophical differences, participant experiences seem consistent with reported findings regarding perceived well-being and the positive self-image of abstinent AA members (Kairouz & Dube, 2000). It seems reasonable to conclude that, within the context of perceived personal responsibility, well-being, and self-image, participant experiences apparently diverge from reported AA experiences in terms of overall philosophy but appear similar to reported positive relationships between self-efficacy and long-term AA participation (McKellar, J., Ilgen, M., Moos, B. S., & Moos, R., 2008).

The results of this study do not challenge the assertion that spirituality is a crucial component of successful recovery for some individuals. However, participant experiences as described in this study apparently challenge the practice of exclusively referring individuals to 12-step programs regardless of the individual’s worldview,

religious beliefs/non-beliefs, or preference for a secular or spiritual program. As stated in the review of literature, Cashwell, Clarke, and Graves (2009) defined *spiritual bypass* as using spirituality to avoid emotional distress and work in healing one's development. The participants of this study seem to engage in an almost reverse process through bypassing spirituality in order to explicitly confront emotional distress in sobriety. Despite the apparent differences regarding the prominence of spirituality in recovery, participant experiences also shared some themes with the aims of traditional substance abuse treatment.

The Minnesota Model treatment goals are defined by four overarching themes: (1) belief in the possibility of change for alcoholics and addicts, (2) the treatment goals of abstinence from mood-altering substances and improved lifestyle, (3) the concept that alcoholism is a disease, and (4) 12-step/AA principles (Cook, 2008). Belief in the possibility of change clearly emerged as a theme for participants. Also, all participants maintain abstinence from mood-altering substances and perceive an improved lifestyle in sobriety. Participants apparently diverged on the point of alcoholism as a disease. Some participants refute the conceptualization of alcoholism as a "spiritual disease," while others self-described as "alcoholic." As stated in the review of literature, completion of MM treatment has also correlated positively with increased feelings of control over recovery (Morojele & Stephenson, 1992), which seems consistent with participant experiences.

Participants apparently endorse a process of experimentation in recovery, and the findings of this study suggest that participants reject the notion that adherence to strict support group guidelines or attendance of support group meetings are necessary

determinants of sobriety. Tim, Louis, and Jeff believe that recovery support groups augment their respective processes of sobriety, but all three also clearly indicate that sobriety is not predicated on meeting attendance. Anna and Rose both report regular meeting attendance, but they speak in terms of choosing to participate and receiving inspiration from other women in recovery. Abigail regularly contributes to the online SMART Recovery forum, and she describes her recovery in terms of freedom to choose.

The findings of this study suggest that the participants developed creative methods of overcoming obstacles and utilizing individual and community resources in recovery. Abigail and Jeff continue to socialize amidst the presence of alcohol, and they both report arriving at a point where proximity to alcohol is no longer an issue. Abigail enjoys going to a local casino for dancing, and Jeff reports that he “can party better” sober. Louis enjoys music and sometimes goes to jazz bars or other venues that feature alcohol. He reports that “challenging” himself and immersion in experiences that were possibly “perilous” strengthened his resolve and self-confidence. Tim seems barely bothered by the presence of alcohol because he “does not drink no matter what.” Rose keeps her distance from alcohol and prohibits it on her property. The aforementioned experiences seem consistent with the theory of social learning (Bandura, 1977) and the suggestion that relapse prevention methods allow individuals to engage in positive, meaningful behaviors in response to high-risk situations in recovery (Rawson et al., 1993). However, participant experiences seem to diverge from existing relapse prevention literature in terms of perceived risk. Participants describe alcohol as a substance that is no longer relevant in their lives. Several participants state that alcohol

"is not an issue," Therefore, participants feel free to pursue activities that they might otherwise choose to avoid due to perceived high risk of relapse.

While participants differed in how they approach the issue of proximity to alcohol, they perceived the recovery process in similar ways. The findings also suggest that referral options for recovery support groups offer individuals more opportunities to maintain successful sobriety and, when individuals perceive AA as a poor fit personally, to seek out recovery support groups that encourage perceived freedom of choice, independent thought, a sense of belonging, self-discovery, and the promotion of individualized recovery maintenance tools. Despite the apparent incompatibility between aspects of participant worldviews and the core philosophy of 12-step programs, it seems that, similar to reported 12-step experiences, participants found hope, stability, fellowship, abstinence, improved self-image, and self-efficacy in recovery.

Limitations

Participants

While the study purposively selected a total of six individuals from three different recovery support group programs, generalizability and transferability is limited due to the small sample size. The participants self-selected for the study by volunteering after reading a recruitment letter distributed through SMART Recovery, SOS, or WFS. Therefore, it is also possible that participant experiences are not consistent with the typical experiences of individuals who utilize the aforementioned programs. It is also possible that typical experiences are different across each of these programs. However, enough similarities across participant experiences seemed to exist for thematic consistencies to emerge through the phenomenological data analysis process.

The study included a diverse sample in terms of geographic location, gender, age, current employment situation, and socioeconomic status. Participants also exhibited homogeneity regarding race/ethnicity (5 White/Caucasian, 1 Hispanic participant), sexual orientation (5 heterosexual, 1 bisexual participant) and substance use. All of the participants identified alcohol as the primary substance from which they sought to abstain. Some participants mentioned the use of other substances, but participant descriptions consistently focused on alcohol use. It is possible that individuals who seek abstinence from substances other than alcohol through SMART Recovery, SOS, or WFS experience different recovery processes. The homogeneity of the sample according to race/ethnicity, sexual orientation, and substance use should be considered limitations of the study. Also, while not part of the inclusion criteria of the study, all participants described past experience with 12-step support groups. It is possible that individuals who use SMART Recovery, SOS, or WFS without prior experience in 12-step support groups would describe different perceptions regarding the recovery process.

Telephone interviews

Although the researcher utilized a recruitment strategy that included three different recovery support programs, no individuals volunteered who lived within a reasonable travel distance of the researcher's location. Therefore, all interviews took place via telephone. Although the researcher attempted to build rapport with participants before and during the interview process, the fact that no face-to-face interviews took place should be considered a limitation of this study.

Researcher subjectivity

The researcher's subjectivity is also a limitation of the study. I agree with many of the attitudes, perceptions, and philosophical positions expressed by the participants. As stated in the researcher subjectivity statement in Chapter Three, I am in favor of recovery support group options and believe that participation in 12-step groups or reliance on a higher power are not necessary determinants of sobriety. Like the participants, I also believe that recovery is an individualized journey and that sobriety is a self-directed phenomenon. I chose to reveal no personal information about myself to participants until after the completion of an interview. However, my internal alignment with many of the perceptions expressed by participants surely affected my ability to remain objective. While my perceptions and experiences might have contributed positively to the research process, they should also be considered a limitation.

Implications

As stated in the review of literature, more than half of individuals who receive treatment for substance use disorders participate in recovery support groups (SAMHSA, 2011). The majority of substance abuse treatment programs in the U.S. feature a 12-step orientation (Le et al., 1995; Rogers & Cobia, 2008), and individuals are often directed to attend 12-step meetings during or after the termination of treatment (Miller & Bogenschutz, 2007). Few existing studies address recovery support groups other than AA/NA, and almost no studies exist regarding self-directed recovery support groups. Also, few studies exist regarding the subjective experiences of individuals in recovery. The rationale for this study was to address these perceived gaps in academic literature by exploring the experiences of individuals who remain abstinent from mood altering

substances using SMART Recovery, Secular Organizations for Sobriety, and Women for Sobriety.

The findings and interpretations of this study apply to practicing counselors, counselor supervisors, counselor educators, and future researchers of substance abuse counseling issues, specifically within the realm of recovery support group options and relapse prevention/recovery maintenance. The following section describes implications for each of these groups.

Implications for practicing counselors

Practicing counselors should maintain awareness of recovery support group options. Counselors are more likely to refer to AA than any other mutual support program (Fenster, 2005). Counselors should anticipate that some clients will express aversion to 12-step recovery support groups and may seek other support group options. It is recommended that counselors prepare for diversity regarding religious/spiritual (or non-spiritual) orientation, client worldview, and preference (or non-preference) for structured, program-centered recovery groups. It is also recommended that practicing counselors remain aware of the potential negative benefits a dichotomous presentation of continued substance use or adherence to 12-step principles may present for certain clients. Counselors might anticipate that individuals who struggle with 12-step philosophy would benefit from referrals to other recovery support groups such as SMART Recovery, SOS, and WFS.

Clients might reside in areas that feature few or no face-to-face support group meeting opportunities, so web-based resources might bolster recovery efforts. Clients who might experience difficulty arranging transportation to face-to-face meetings might

benefit from receiving information on online recovery support. Also, clients might communicate a preference for online meetings. SMART Recovery participants in this study apparently preferred online, internet-based recovery support to traditional, face-to-face meetings. The online components of self-directed support groups offer the flexibility of “24-hour” support access in forum discussions.

The self-directed support groups mentioned in this study also encourage individuals to engage in cost-benefit analyses or examination of priorities, which apparently promoted empowerment in participant decision making. The self-exploration described in the findings of this study allowed participants to eventually accept primary responsibility for maintenance of sobriety. Whether counselors refer clients to AA/NA, SMART Recovery, SOS, WFS, another recovery support group, or present all of the aforementioned options, participant experiences with support groups and counselors seem to suggest that discussions of spirituality, worldview, locus of control, abstinence, preference for online or face-to-face meetings, and explorations of individual reactions to different support group philosophies might uncover differences regarding best fit for individual clients..

Substance abuse-specific counselors should consider the possibility that self-directed, abstinence-based programs focused on Cognitive Behavioral Therapy, behavior modification, self-empowerment, or skepticism regarding program-centered theories of addiction might benefit individuals who express difficulty accepting 12-step philosophies. Counselors should also anticipate that some individuals will place a higher value on self-reliance and self-responsibility than spiritual issues or adherence to steps in recovery. It is recommended that substance abuse counselors reflect upon personal

perceptions regarding the concepts of denial and resistance in terms of adherence to 12-step philosophy and consider the possibility that clients might seriously seek sobriety and at the same time communicate aversion to 12-step participation.

Counselors might also reconsider historical perceptions of denial, resistance, and dishonesty within the context of traditional substance abuse treatment and 12-step literature. Several participants commented on the perception that an imagined future in 12-step programs would likely entail personal dishonesty. For example, Louis realized that if he remained involved with AA, his ability to relate honestly would clash with a perceived need to "couch" his responses in AA-friendly terminology. Participants described relief at the perceived ability to communicate honestly within self-directed recovery support group environments. Based on described experiences, it seems that participants possessed the strength to maintain sobriety and to "resist" the prescriptions of outlined 12-step philosophy or individual support group members. It is suggested that counselors focus on potential strengths and refrain from presenting clients with a forced dichotomy of either participation in 12-step groups or resistance/denial that leads back to substance use. Participants in this study embraced self-directed paths to sobriety that apparently challenge traditional attitudes towards "resistance" and "denial."

All participants mentioned the importance of increasing awareness about the existence of SMART Recovery, SOS, or WFS. As stated in the *Limitations* section, the self-selection for this study may suggest a difference between participant experiences and typical experiences of SMART Recovery, SOS, and WFS members. However, the self-selection and subsequent interviews also revealed the willingness of the participants to serve as ambassadors of their respective recovery support groups. Participants displayed

working knowledge of the recovery support groups and available face-to-face or online resources. Participant experiences suggested the existence of established recovery support group environments with stable group memberships. It is recommended that, in addition to 12-step support groups, counselors also consider SMART Recovery, SOS, and Women for Sobriety as viable referrals for individuals dealing with substance use issues.

Counselors should maintain awareness of recovery support group resources, including face-to-face meetings, online meetings, and recovery support group message boards. Meeting schedules for AA/NA are readily available online, and free literature is also available through AA World Services. SMART Recovery, SOS, and WFS all feature meeting schedules, support group overviews, and contact information online. Also, both the SMART Recovery and WFS websites feature online meetings and recovery-focused forums. It is recommended that counselors familiarize themselves with these support group options and refer clients according to best fit.

Implications for counselor supervisors and educators

Considering the development of addictions counseling tracks in CACREP-accredited counselor education programs (CACREP, 2009), it seems reasonable to conclude that the counseling field will experience an increase in the number of graduate-level counselors pursuing a specialization in substance abuse counseling. Coupled with the movement to require Master's-level education for licensed substance abuse counselors in many states, adoption of the new CACREP standards place substance abuse counseling at the forefront of issues relevant to current and future counselor educators and supervisors (Hagedorn, 2007). Graduate-level counselors are exposed to a variety of theoretical approaches as part of their education, and graduate-level supervisors

communicate more flexibility in supervisory style than supervisors with less formal education (Reeves, Culbreth, & Greene, 1997). It is possible that the movement to require Master's level education and the development of CACREP-accredited addictions counseling programs will influence the current high rate of 12-step program referrals in favor of increased options regarding recovery support group referrals.

It is recommended that counselor supervisors familiarize themselves with self-directed recovery support groups due to the possibility that younger, graduate-level counselors may perceive that clients become healthy through various means (Reeves, Culbreth, & Greene, 1997). Supervisors are responsible for the development of supervisee skill, knowledge, awareness, and cultural competency. Counselor supervisors should expect to encounter diversity within their respective client bases and also within the supervisee population. Counselor supervisors should consider the possibility that more referral options means increased opportunities for clients to find the best fit for a recovery support group that will augment their respective quests for sobriety.

Counselor educators should anticipate that supervisees will encounter 12-step oriented treatment philosophies during practicum and internship experiences. It is possible that counselors-in-training will not receive information regarding recovery support group options at 12-step oriented practicum and internship sites. Counselor educators might use the findings of this study to inform counselors-in-training about the experiences of individuals who successfully maintain abstinence using recovery support groups outside of AA/NA. Counselor educators might also use the findings of this study to open a dialogue with students regarding theories of addiction and strategies for relapse prevention.

Implications for future research

The findings and interpretations of this study suggest that individuals who utilize the recovery support groups SMART Recovery, SOS, and WFS experience the process of recovery as a self-directed, community-based phenomenon that involves changes in self-perception, altered thinking patterns, modified behavior, and increased self-awareness. The findings also indicate that individuals maintain individualized, self-directed recovery maintenance programs without the explicit integration of spiritually-based, 12-step principles. Future studies might further explore the experience of individuals in each of the three recovery support groups represented in this study. Although all three programs apparently share the theme of self-direction in recovery, the programs feature differences in philosophy. Based on the findings of this study, SOS participants apparently favor a position of sobriety as "a separate issue," and SOS seems to offer no explicit opinion regarding different theories of addiction. It appears that WFS is centered on a message of self-empowerment, changed thinking patterns, and freedom from the past. Participants of this study who utilize SMART Recovery apparently value specific Cognitive Behavioral Tools and web-based components of the support group. Further exploration into the experiences of individuals in each support group or a membership survey might provide clearer descriptions of how individuals experience recovery in SMART Recovery, SOS, or WFS.

Future research might also focus on the experiences of non-religious or self-described atheist or agnostic individuals in recovery. Although the basic AA text (Alcoholics Anonymous, 2001) features a chapter on agnosticism, existing research suggests that self-described atheists and agnostics attend significantly fewer post-

treatment meetings and drop out at higher rates than their self-described religious counterparts (Tonigan et al., 2002). The findings of this study suggested that the spiritual centrality of 12-step programs represent a major obstacle to some atheist and agnostic individuals. Further research might focus on the perceptions of the recovery process in an exclusively non-religious sample.

Further research in this area might also focus on longitudinal studies of individuals who participate in 12-step groups and self-directed support groups in order to determine similarities and differences in relapse-prevention strategies utilized by members of different recovery support groups. The findings of this study suggest that individuals who participate in self-directed support groups utilize specific recovery maintenance strategies based on self-talk, sobriety prioritization, volunteerism, behavior modification, cost-benefit analysis, affirmations, and the acquisition of self-knowledge.

Future research might also explore the phenomena of online recovery support group meetings and web-based recovery support forums. Few studies exist regarding the utilization of online resources in recovery. The findings of this study suggest that participants of SMART Recovery and WFS perceive online meetings and forums as consistent, 24-hour per day recovery support. Research into the online components of self-directed recovery support groups might also provide opportunities for researchers to reach an international target population. SMART Recovery, SOS, and WFS all feature international membership.

Finally, future research might also focus on counselor perceptions regarding the etiology of substance abuse or the processes of recovery and recovery maintenance. Participants in this study suggested that a bias exists toward 12-step programs regarding

counselor and treatment center referrals to recovery support groups. The findings of this study also seem to challenge the 12-step proclamation that self-knowledge does not lead to successful recovery. Future studies might compare how counselors-in-training and practicing counselors perceive the processes of addiction and recovery.

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APPENDIX A: INTERVIEW PROTOCOL

Introduction/warm-up

1. How did you learn about this study?

2. What made you want to participate?

3. Do you have any questions before we get started?

Experience in recovery

4. What is different about you since you got sober/became abstinent?

5. How have your experiences with other people changed in recovery?

6. What are some things that have helped you?
   -Follow up: Internally, what do you believe is the most important thing?
   -Follow up: How about external influences (anything outside of yourself)?

7. How does the recovery support group you use help you remain sober?
   -Follow up: What do you perceive is the most valuable aspect of this program?

8. Where were some obstacles in your abstinence/sobriety experience?
   -Follow up: What were the internal obstacles?
   -Follow up: What were the external obstacles?

9. What advice would you give to someone else who was trying to stop using drugs and/or alcohol today?

Final questions

10. How would you summarize your experience in recovery?

11. What was it like for you to describe your experiences during this interview?

12. What did I not ask you about your experience that you would like to talk about before we finish?

APPENDIX B: RECRUITMENT LETTER

Hello! My name is Robert Kitzinger, and I am a doctoral candidate in the PhD in Counselor Education and Supervision Program at the University of North Carolina Charlotte. I am searching for possible participants for a qualitative, interview-based research study regarding the experiences of people who maintain sobriety with the use of self-directed, cognitive-based recovery support groups.

I am recruiting people who have maintained sobriety over the past year and participate in Secular Organizations for Sobriety, SMART Recovery, or Women for Sobriety. I am also looking for people who have not participated in 12-step support groups such as Alcoholics Anonymous or Narcotics Anonymous within the past year. Your participation would include one audio-recorded interview that should last 60-90 minutes. It is also possible that a second, 20-30 minute interview will occur, but one interview should cover your participation. The interview will be conducted either in person or by telephone, and all of the questions are concerned with your personal experiences in recovery/sobriety. There are no wrong answers because the study is all about *your* perceptions and experiences. All of your identifying information will be kept confidential. I will explain in detail if you choose to contact me about the study.

The purpose of this study is to contribute to the field of professional counseling through describing the lived experiences of people who maintain sobriety through means other than traditional 12-step methods and to provide participants with an opportunity to gain insight into how they experience sobriety. If you participate, you will be compensated for your time with a choice of either a $25.00 Apple iTunes gift card or a prepaid $25.00 Shell gas card.

If you think that you meet the criteria I listed, and you have interest in participating, please contact me via telephone at (704) 277-8661 or email at jkitzing@uncc.edu. Thank you for taking the time to read this message and for considering participation!

Sincerely,

Robert H. Kitzinger, Jr.

APPENDIX C: INFORMED CONSENT FORM

Purpose
You have been selected to participate in a research study that focuses on the experiences of individuals who maintain abstinence from mood altering substances while participating in self-directed, cognitive-based recovery support groups. Information obtained in this study will be used to examine your personal experience of remaining abstinent.

This study is being conducted as part of the requirements for a doctoral dissertation at the University of North Carolina Charlotte (UNCC). My name is Robert Kitzinger. I am a doctoral student at UNCC, and I will be the researcher and interviewer for this study.

Eligibility
You are eligible to participate in this study because you have reported at least 12 consecutive months of abstinence from mood altering substances and you have not participated in 12-step groups such as Alcoholics Anonymous or Narcotics Anonymous in the past 12 consecutive months. You are also eligible because you have participated in a self-directed, cognitive-based recovery support group within the past 12 consecutive months.

Overall Description of Participation
Your participation in this study includes an audio-recorded, 60-90 minute interview that will take place at a site that is mutually agreed upon by you and the primary researcher. It is possible that a second, 20-30 minute follow up interview will also occur, but participation will likely be limited to one interview. After the interview is completed, a typed transcript of the interview will be shared with you for your examination prior to analysis of the interview content. Your participation in the study should not last longer than 60-90 minutes for the first interview and 20-30 minutes for the second interview. The results of this research project will be shared with you upon completion of the study.

Risks and Benefits of Participation
Discussing your past regarding drug and alcohol use might cause discomfort. However, the purpose of the study is to focus on the present and your experience in recovery. The interview will consist of open questions, so you will be encouraged to answer questions in your own words and according to your personal level of comfort. The intended personal benefit is for you to gain insight into your personal experience of sobriety and your perceptions regarding maintenance of your sobriety. The intended professional benefit is to inform counseling professionals of the subjective experiences of individuals

who maintain abstinence from mood altering substances with the use of self-directed recovery support groups.

Compensation
You will be compensated for your time with your choice of a $25.00 Apple iTunes gift card or a prepaid $25.00 Shell gas card at the time of the interview. You are a volunteer. If you choose to participate, there will be no penalty if you choose to withdraw from the study at any time.

Confidentiality Statement
All identifying information about you will be kept confidential. Your name will not be attached to the recording or used during the interview, and no one other than the primary researcher will have access to your identifying information. Audio recordings will be kept in a locked drawer, and typewritten transcriptions will be kept on a password protected computer in the primary researcher's office. Interview audio recordings will be erased, and the master code key that contains any identifying information will be destroyed in the UNCC Department of Counseling office within one year of the initial interview date.

Statement of Fair Treatment and Respect
UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-3309) if you have questions about how you are treated as a study participant. If you have any questions about the study, please contact Robert Kitzinger via telephone (704-277-8661) or email at jkitzing@uncc.edu. You may also contact Dr. Pamela Lassiter, Associate Professor of Counselor Education at UNCC and dissertation chairperson for this study, with any questions via telephone (704-687-8972 or email at plassite@uncc.edu.

Approval Date
This form was approved for use on July 24, 2012 for use for one year.

Participant Consent
I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 21 years of age, and I agree to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the primary researcher of this study.

Signatures

____ __________
Participant Name (PRINT) DATE

____

Participant Signature

____ _________

Investigator Signature DATE

APPENDIX D: DEMOGRAPHIC FORM

Date of interview ___________ Participant Pseudonym _____________

Gender ________ Age ______ Race/Ethnicity ______________________

Sexual Orientation ____________________

Geographic Region (Circle One): U.S. Northeast U.S. Southeast U.S. Midwest

U.S. Southwest U.S. Northwest Other ________

1. What is the highest level of education you have completed (high school, college, etc.)?

2. What is your current occupation?

3. How would you describe your socio-economic status?

4. How long have you been sober?

5. What recovery support group do you use?

6. How long have you been involved with that support group?

7. Have you attended Alcoholics Anonymous/Narcotics Anonymous meetings in the past?

8. If you answered "yes" to Question 8, how long did you participate in Alcoholics Anonymous/Narcotics Anonymous? When was the last time you attended an AA/NA meeting?