

Whiskey & tangerines: An ethnodrama exploring a couple's transition from alcoholism to long-term recovery.

by

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B.A., University of Windsor, 2003
M.S., Texas A&M University - Corpus Christi, 2012

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Special Education, Counseling, & Student Affairs
College of Education

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2018

Abstract

According to SAMHSA statistics, about 22 million people in the US meet the criteria for a Substance Use Disorder (SUD), with alcohol use disorders (AUDs) being the most prevalent form of SUD. Of those with SUDs, only 10% or two million receive formal treatment. It is estimated that 64% of those completing treatment for SUDs relapse within the first year of sobriety. However, for individuals who manage to make it five years without relapsing, the risk of relapse reduces to 14%, suggesting that the needs of individuals in short-term recovery differ from those in long-term recovery.

It has also been found that family involvement in the treatment and recovery process is beneficial to individuals in recovery. However, SUDs contribute to elevated levels of stress and dissatisfaction in couples and families, which puts them at high risk for divorce or dissolution prior to individuals seeking treatment. For families who remain intact until the individual completes treatment, the transition to a recovery lifestyle that supports the individual's recovery presents a different set of challenges. Additionally, lingering frustrations and resentments from the period of active addiction may also serve to destabilize the couple or family, contributing to the high levels of divorce among those recovering from SUDs. In short, few couples are able to sustain their partnerships through active addiction, and the transition to recovery. While these couples are in the minority, their successful experiences can provide valuable insight into the recovery process.

The present study examines the successful transition from active addiction to long-term recovery for one such couple. In particular, the study investigates the shifting narratives related to family roles, couple-hood, communication, alcohol, alcoholism, and recovery. The data is presented in the form of an ethnodramatic script. Ethnodrama is used to engage audiences both

on emotional as well as informational levels. While ethnodrama may not provide specific answers, it is intended to provoke awareness, insight, and discussion by allowing audiences to vicariously experience the represented lives of the participants.

Following the ethnodrama, an analysis of the script is presented, incorporating narrative theoretical frameworks so that the ways in which narratives function to facilitate (or frustrate) change within the individuals as well as the dynamics of the couple relationship can be expanded. The result of this analysis is the production of a Narrative Change Model, which can be useful in understanding the ways that narratives operate within the transition from active addiction to long-term sobriety and may have broader implications in explaining the narrative mechanisms behind other, more subtle change processes.

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Acknowledgements

Many people were influential in producing this dissertation. First, I'd like to thank my committee: Doris Carroll, Jia Liang, Sally Bailey, and Sandra Stith for their valuable support and guidance. I'm also grateful to Sally's ethnodrama students for their expert feedback.

Additionally, I thank Karrie Swan for getting the ball rolling on this project and Manuel Zamarripa for introducing me to narrative therapy and setting me on this path in the first place.

I'd also like to acknowledge my family: My father who thinks I'm getting a degree in entertaining alcoholics, my uncle who says that they already figured all this stuff out back in the seventies, and my mother who has been steadily proud of me even if she isn't really sure exactly what it is I've been doing these last few years. I'm grateful to all of them for instilling me with thoughtfulness, reflexivity, curiosity, an interest in literature, and a healthy (if somewhat odd) sense of humor when I was young. I've appreciated their encouragement, support, and ability to keep me grounded through this process, and throughout my life.

I'd like to give a shout-out to The Rolling Stones, Neil Young, Parquet Courts, The Replacements, All Them Witches, Animal Collective, Thelonious Monk, The Tragically Hip, and countless other musicians who served as my constant companions while I wrote, as well as to all the campy old 80s action and horror movies I watched when my brain needed a break.

Finally, thank you to Sumita Bhattacharyya for the egg curries and chicken biriyanis, and also for giving birth to Kakali Bhattacharya, my wife, who deserves the greatest acknowledgement of all for being with me from the very beginning of my graduate journey, supporting and encouraging me every step of the way, keeping me sane, and driving me to keep going when I wanted to give in. There simply would be no dissertation without her, and to thank her properly for everything she's done would require a whole other dissertation.

Dedication

To Alex, someone I never met, but whom I wish I would have had the opportunity to get to know. To Charlie, whom I also never met, but nevertheless provided the impetus for this study. To Deborah, whom I have met, and know for a fact is a really very nice, kind, supportive, and wonderful person. And most of all to my wife and best friend, Kakali, with whom I've been hanging out for over a decade and have gotten to know pretty well.

Chapter 1 - Introduction

In 2011, I completed the majority of the internship for my master's degree in Counseling at a residential treatment facility for drug and alcohol dependence. As a student with very little experience in counseling, I initially had no special interest in treating Substance Use Disorders (SUDs) over any other disorder. I had taken the addictions counseling classes, and I had the knowledge and skills to work with them, but not much attraction to the population itself. There was little in my personal background that drew me towards counseling addicts. However, my peers assured me that the place had a great reputation as an internship site and needing to gain contact hours with clients somewhere in order to complete my degree, I agreed to volunteer at the treatment center.

If there's one thing that stands out to me about my time at the center, it was the sense of community I found there. While no community is entirely free of disputes and disagreements, the overall feeling I got was one of support and positivity between the clients, the counselors, and the other staff. People were genuinely invested in seeing each other succeed. Personally, I felt a huge amount of respect and admiration for clients overcoming very difficult life-circumstances (of which SUDs were often only one aspect) and making positive changes for themselves. I came to see it as an honor to be part of that journey as a counseling intern.

However, several clients mentioned that only an alcoholic can ever truly understand – or worse, *help* - another alcoholic. Hearing statements like these made me feel like an outsider, providing services under false pretenses. I'm not in recovery, much less an alcoholic. In fact, I don't have any particular issue with drinking or even with being occasionally intoxicated. However, I had been a smoker for 10 years and the experience of being addicted to nicotine allowed me to gain insight into the experiences that my clients had been going through.

While I was honored to be working with people who were trying hard to turn their lives around, I also witnessed several clients who discharged (or “graduated”) from the program being readmitted a few months later after a relapse. My supervisor, who had worked at the center for years, said that while interns came and went she often saw the same faces of the clients over and over again. While she was sad to see that they hadn’t succeeded in their recovery outside the center, she was comforted knowing that they’d at least come back to where they needed to be. As long as they were there at the center, they weren’t dead, and they weren’t using. They were getting help.

In the US, nearly 10% of the population meets the criteria for a substance use disorder, but only 10% of those receive treatment (Substance Abuse and Mental Health Services Administration (SAMHSA), 2018a; US Department of Health & Human Services (USDHHS), 2016). While, relapse rates depend on several factors including type of substance and personal and environmental factors, it is estimated that over 60% of individuals who receive treatment will relapse within the first year of recovery (Dennis, Foss, & Scott, 2007). While research has been conducted heavily in risk and preventative factors for forming addictions, the course of addictions, and treatment modalities, little research has been done on what happens to clients *after* they leave treatment, particularly for those in long-term recovery.

In my experience working with recovering addicts at the treatment center, many expressed anxieties about graduating. The treatment center, it seemed, was great at detoxifying clients, building a supportive community, guiding them through the twelve steps of recovery (AA, 2001), and providing clients with a safe, caring environment to build skills for relapse prevention. However, many clients were unable to achieve long term recovery when they returned to their lives outside the protective environment of the treatment center.

In order to facilitate the transition, the center used a system of graduated treatment, which follows the recommended continuum of care outlined in the recently released Surgeon General's Report on Addiction and Treatment in the US (USDHHS, 2016). During the initial stage of detoxification, clients were restricted to the facility and closely monitored by staff. Periods of detoxification lasted from a few days up to a couple of weeks depending on the substance and the severity of its abuse. In the second level of treatment, clients kept a tight schedule of group and individual counseling, exercise, educational classes, and structured leisure and social activities. However, on weekends, clients were given free time. They could apply for a pass to visit family outside the facility, and family were allowed to visit clients in the facility. This period of treatment could last up to three months, depending on the client. Some would progress faster than others, and a significant number would discharge prematurely from the program. The third level of treatment encouraged clients to reintegrate into society through employment. These clients were assisted in finding work outside of the facility. Most would spend the day outside, and then return after work for meetings, counseling, meals, and to sleep. This third stage could last another three months, though the duration depended on the needs of the client, as well as the availability of funding. Finally, some clients were able to transition to an off-site halfway-house. This setting provided them with a relatively safe, supportive, and stable environment in which to live, surrounded by others in recovery, but also allowed them more freedom and responsibility for their own lives. These clients could return to the center for meetings and periodic outpatient counseling sessions as needed, though these were not mandatory. However, space in the house was limited, and demand was high. Few residents in treatment were admitted. Many returned to live with family members.

My role as an intern was to provide family counseling on the weekends to clients and families who desired it. When I started the position, I was under the illusion that once addiction was treated in an individual, they would return to supportive and loving families who would be grateful that addiction was no longer in their lives and look after the client's best interests to support their recovery. However, experience quickly corrected this misconception, as I worked with families who harbored deep resentments and mistrust after years of suffering abusive and neglectful behavior from the addict. In some cases, families were unaware of the deep work clients were doing in treatment and accused the client of “vacationing” in rehab, while they were left to look after family affairs. These were not the nurturing, supportive families I had imagined.

As a counselor supporting my client, it was tempting to take the side of the recovering addict and to pathologize families as dysfunctional or problematic. However, it was important to remember that while clients may have been only sober for a month or so, family hostilities were often pent up over years in response to the devastation caused by addiction. The wife of one client once told me that it felt like her husband had been cheating on her for years, not with another woman, but with a drug. It was difficult for her to forgive, even after the “affair” had ended. If the response from families seemed harsh, it was at least understandable.

Furthermore, while I saw families on weekends, they did not undergo the same intense treatment that clients of the center did. The result was that while clients underwent extreme personal changes, the family system often remained the same and continued to relate to the client as if they were in active addiction. Thus, I came to see working with partners and families was a vital part of recovery.

Nationally, family therapy services are offered by 81.6% of treatment centers (SAMSHA, 2014. This data was not reported in the 2017 survey of treatment facilities). However, only

16.2% of these centers report that family therapy is used by more than three quarters of their clients. Conversely, 50.8% of centers that offer these services report that they are used by less than a quarter of the clients. Couples counseling is offered by 59.2% of treatment centers, but similarly 70.1% report that it is used by less than a quarter of clients, while only 5% report that it is utilized by more than three quarters of clients. These differences are at least partly explained by the differing needs of individual clients. Certainly there are many clients in recovery programs who are single, and the priority of rebuilding/reinforcing family relationships can depend on a number of variables (e.g., geographic proximity, other family members in active addictions, etc.). Even so, these statistics seem to indicate a higher emphasis on individual responsibility for addiction and less on systemic factors that can serve to either maintain addictive behaviors or reinforce and support sobriety.

Subjectivity

According to Peshkin (1988), there is no research that is without subjectivity. Everyone possesses a unique set of values and worldviews from which they understand the world and conduct their research. For Peshkin, subjectivity is not something to be avoided or obscured through myths of objectivity. Instead, he writes, "I would actively seek out my subjectivity. I did not want to happen upon it accidentally as I was writing up the data. I wanted to be aware of it in the process, mindful of its enabling and disabling potential while the data were still coming in, not after the fact" (p. 18). Acknowledging the researcher's subjectivity allows them a greater degree of reflexivity (Tracy, 2010), which produces transparency and credibility.

In this study I have attempted to make no secret of the subjective lens which I have brought to the research. Given the broad social-constructionist framework which guides the study, it would be intellectually irresponsible to deny my role in the production of meaning from

the data. Qualitative scholars (Bhattacharya, 2017; Peshkin 1988), often refer to research from an *embodied* perspective, as opposed to the disembodied or objective perspective. In other words, research is conducted by people who inevitably possess unique subjectivities from which they perceive and interpret the world. In qualitative research, it's often said that the researcher themselves is the instrument of data collection and analysis (Creswell, 2013). Therefore, it is as important that readers understand the subjective positioning of the qualitative researcher as it is for quantitative researchers to provide validity and reliability data for their instruments.

I began this chapter with a discussion of my subjective positionality towards recovery, which described my experiences working in a treatment center as an intern and discovering an entry point to the experiences of my clients through my own addiction to nicotine. Furthermore, I noted that I am not personally nor politically *anti*-drinking. I believe in the ability of the majority of people to drink responsibly, while recognizing that drinking is problematic for some people. It is important that readers are made aware of my subjective positions regarding alcohol and alcoholism so that they can make informed readings of this dissertation.

Furthermore, readers should be aware that the production of the ethnodrama (Saldana, 2011) is a form of arts-based research (Barone & Eisner, 2012, Leavy, 2015). Ethnodrama involves a creative process which is inherently subjective in shaping the data to be theatrically engaging. Thus, the representation of the findings within the ethnodrama is very much a co-construction between myself as researcher, myself as playwright, and the participants' accounts of their experiences. Considerations for constructing the play will be discussed further in chapter three.

In the remainder of this chapter, I will provide an overview of the state of alcoholism and treatment in the US. I will then present a rationale for this study, followed by the research

purpose and questions that will guide the study. Additionally, I will summarize the theoretical framework for this study, as well as briefly describe the methodology. Finally, I will provide operational definitions used within this dissertation in order to help guide readers through the language of addiction and recovery.

Study Background

Beginning with European colonization, alcohol has had a tangled and frequently problematic with the developmental history of the United States (Philips, 2014; White, 2014). In the early years of American history, alcohol was prized as a healthy alternative to water which was untreated and often contained harmful bacteria. Furthermore, alcohol was valued for its medicinal qualities, its role in religious ceremonies, as well as for its function as a social lubricant. However, alcohol was also involved in colonization and slavery and the dark legacies of discrimination that followed.

In the nascent years of American history, what is now referred to as Alcohol Use Disorder (APA, 2015), was largely believed to be a matter of personal preference or appetite. Habitual drunkenness, as it was called, was related to the sin of gluttony, rather than being recognized as a disorder in itself. The “invention” of alcoholism did not occur until the early 19th century (Levine, 1978), popularized by the writings of Dr. Benjamin Rush who posited that consumption of alcohol led to a compulsion to drink amongst some of his patients (White, 2014). Rush prescribed abstinence from spirits and a focus on spirituality as the solution for alcoholism. His ideas were picked up by the temperance movement, which advocated for the abolition of alcohol. A century later, the temperance movement finally culminated in federal prohibition in 1920. Meanwhile, American society and the role of alcohol within it had changed dramatically since the early 1800s in response to a number of forces such as industrialization, urbanization,

the abolition (and lasting legacy) of slavery, the rise of unions, and the growth of the women's suffrage movement. The 18th amendment severely restricted the production, transportation, and sale of alcohol in the US. However, rather than resolving the problems of alcohol in society, prohibition only pushed them underground, promoting the rise of smuggling, black markets, and organized crime (Philips, 2014). Alcohol prohibition laws were finally overturned in 1933. Since then, the focus on dealing with alcohol has generally shifted from implementing large-scale social policies to working with individuals afflicted with AUDs, leading to the rise of modern organizations and treatments including Alcoholics Anonymous (AA, 2001) and the development of the Minnesota Model (White, 2014).

The last National Survey on Drug Use and Health (NSDUH) was conducted in 2017 (SAMHSA, 2018a) using interview data from more than 68,000 individuals aged twelve and up. According to the results of the NSDUH, 140.6 million Americans had consumed alcohol within the past month, with 66.6 million exhibiting binge drinking behaviors in the past month (federally defined as five or more drinks on a single occasion for men, and four or more drinks on a single occasion for women). 16.7 million individuals were identified as heavy drinkers, defined as engaging in binge drinking on five or more days of the week.

Among under-age drinkers, 61% were involved in binge drinking, and 12.5% identified as heavy drinkers (SAMHSA, 2018a). Juxtaposing these figures with national averages (47.4% of drinkers binge drinking, and 11.9% heavy drinkers), it is clear that binge drinking is more frequent amongst teens than adults. However, only 10% of teens between 12 and 17 years of age consumed any alcohol within the past month, while it was estimated that 51.7% of all Americans twelve and older consumed alcohol. Thus, drinking is less prevalent among teens, but those adolescents who do engage in drinking are more likely to engage in binge drinking behaviors.

Binge drinking seems to decrease with age. However, the ratio of heavy drinkers to those who have consumed any alcohol in the past month appear to be stable across the ages, with 12.5% of underage drinkers, and 11.9% of all drinkers being identified as heavy.

Furthermore, the NSDUH (SAMHSA, 2018a) estimated that 19.5 million Americans aged 12 or older, met the DSM criteria for a substance use disorder diagnosis. AUDs accounted for almost three quarters of these diagnoses (14.5 million). In total, the NSDUH estimates that 20.5 million individuals are in need of treatment for substance use disorders. However, only 4 million individuals actually received any form of SUD treatment in the past year, including 2.5 million receiving treatment services from specialized facilities. In other words, only 12.5% of individuals needing specialized SUD treatment actually received help. Of those who did not receive treatment, the NSDUH estimates that only 1 million (or 5.7%) perceived a need for treatment. Therefore, 94.3% of individuals who meet the diagnostic criteria for a SUD are not interested in seeking treatment.

In the US there were approximately 13,585 treatment facilities in operation in 2017 (SAMHSA, 2018b), an overall decrease of 814 from the previous year. Additionally, there has been a marked turnover in the field, with 10-15% of facilities closing their doors, and a similar number of new facilities replacing them. Private, for-profit treatment facilities have been increasing from 29% of all facilities in 2007 to 36% in 2017. Private non-profit facilities still account for the majority of treatment providers but have declined from 58% to 53% during the same ten-year time frame. The remaining 11% of treatment facilities are represented by various levels of government (Federal, 2%, State, 3%, Local, 5% and Tribal, 1%). While for-profit facilities account for 36% of all facilities, they serve 41% of clients and have experienced the biggest increase in clients since 2007. In contrast, non-profit facilities have remained fairly stable

in the total number of clients served but decreased their overall share of clients from 55% to 49% between 2007 and 2017.

In terms of treatment modalities, the majority of facilities (82%) provide outpatient treatment, while 23% provide residential treatment and 5% provide hospital inpatient treatment (SAMHSA, 2018b). Of those facilities that provide residential treatment, 56% reported utilization rates between 90 and 100%. In other words, all or most of the available beds for clients were taken. On the other hand, 36% of facilities had utilization rates between 50% and 90%, while 8% were operating at under 50% capacity.

Though AUDs account for nearly three quarters of individuals who meet the criteria for a SUD diagnosis (SAMHSA, 2018a), they comprise just over half of individuals in treatment for addictions (53%, including 37% with polysubstance disorders that include alcohol) (SAMHSA, 2018b). Meanwhile clients treated for drug abuse alone increased from 36% in 2007 to 47% in 2017). Furthermore, 50% of clients with SUD diagnoses, also present with a comorbid mental disorder requiring clinical attention (e.g., Depression, Anxiety, PTSD, etc.). Nearly two thirds (63%) of clients in treatment have made one or more prior attempts at treatment (SAMHSA, 2018c).

Of those who enter treatment facilities, 43% on average complete treatment (SAMHSA, 2018c). The highest rates of treatment completion are for those receiving detoxification services (67.8%), followed by short-term residential treatment (56%). Outpatient services reflect the lowest completion rates (32.1-35.5%) and the highest rate of clients dropping out before completion (31.8%). Therefore, while in-patient treatment tends to be more expensive, it is also more effective in treating addictions than out-patient services.

In addition to treatment, a number of individuals with an AUD experience a phenomenon known as “spontaneous” or “natural” recovery in which they are able to become sober without assistance (Sobell, Ellingstad, & Sobell, 2000). Often, spontaneous reduction of alcoholic symptoms comes in response to life events such as motherhood (Dawson, Grant, Stinson, & Chou, 2006; Matusiewicz, Ilgen, & Bonhert, 2016). However, research and writing on natural recovery indicates mixed results and raises questions about validity and reliability (Bischof, Rumpf, Meyer, Hapke, & John, 2007). In particular, the “big book” of AA questions the authenticity of alcohol dependence in individuals who are able to achieve remission without AA (AA, 2001, p. 20; Paik, 2006).

Research on recovery is limited. Much of it has been focused on the effectiveness of 12-step groups and programs (US Department of Health & Human Services, 2016) in supporting and maintaining recovery. Nevertheless, a study by Dennis, Foss, and Scott (2007) found that individuals were at the highest risk for relapse (64%) in the first year following treatment, while those who were able to sustain recovery for five or more years significantly reduced their risk of relapse (14%) suggesting that there is a change process operating within the “maintenance” stage of recovery to produce a more stable sobriety. Little of the literature has focused on the influence of families in long-term recovery, though research on subtypes of spontaneous recovery has found that social support is a major factor in preventing relapse (Bischof, Rumpf, Meyer, Hapke, & John, 2007). Even less research was discovered examining the influences of recovery on couple or family dynamics.

Rationale for the Study

Studies describing risk and protective factors for alcoholism are plentiful (Enoch, 2006; Popovici, & French, 2013; Zemore, Ye, Mulia, Martinez, Jones-Webb, et al., 2016), as are those

which examine treatment and outcome variables (O'Farrell, Schreiner, Schum, & Murphy, 2016; Webb & Toussaint, 2018; Wild, Cunningham, & Ryan, 2006). However, it is clear that relapse remains a major issue following treatment (Dennis, Foss, & Scott, 2007; Maisto, Hallgren, Roos, & Witkiewitz, 2018). Nearly two thirds of individuals receiving treatment for substance use disorders have had one or more attempts at treatment (SAMHSA, 2018c). Furthermore, Dennis, Foss and Scott (2007) have shown that the risk for relapse is at its highest (64%) in the year following treatment and that the risk steadily declines for up to five years at which point it stabilizes around 14%.

Research specifically focusing on recovery in families and couples is limited (USDHHS, 2016). Alcoholism has been documented as contributing to a number of family issues including violence (Friend, Langhinrichsen-Rohling, & Eichold, 2011; Wu, El-Bassel, McVinney, Hess, Fopeano, et al., 2015), neglect (Kroll, & Taylor, 2003; Orford, 2012), mistrust (Scherer, Worthington Jr., Hook, Campana, West, et al., 2012), adultery (Baucom, Snyder, & Coop Gordon, 2009), and unhealthy family roles (Wegscheider-Cruse 1989). Given the stress endured by families with a member in active addiction, it may be unsurprising that alcoholic marriages result in lower marital satisfaction (Dethier, Counerotte, & Blairy, 2011) and are at a higher risk for dissolution. (Waldron, Heath, Lynskey, Bucholz, & Madden, et al., 2011) than those unaffected by SUDs. Furthermore, divorce and separation are also frequent during and after treatment as spouses struggle to adjust to life in recovery and regain trust in their partners (Scherer, Worthington Jr., Hook, Campana, West, et al., 2012). Furthermore, family members may have suppressed anger and resentment in order to address more immediate concerns (Fichter, Glynn, Weyerer, Liberman, & Frick, 1997). Once the added stress of living with an active alcoholic is removed through treatment, suppressed negative emotions often boil-over in

family members. Thus, the period directly following recovery can be highly turbulent, contributing to a higher than average rate of divorce or separation (Osterman, Sloan, & Taylor, 2005). Couples and families who have remained intact throughout the period of addiction, and the transition to long-term sobriety are relatively rare, and their experiences tend to be marginalized by narratives that portray addiction as hopeless, and those who stay with an addicted partner as being personally weak or codependent (Asher, 1992). Investigating the change process that couples undergo as they successfully transition from active alcoholism to long-term sobriety can contribute to an understanding of ‘what works’ (DeShazer & Berg, 1997) in recovery, as well as provide an alternative narrative to the hopelessness that is typically imposed on families in addiction.

Research Purpose & Significance

The purpose of this study is to explore the narrative change process in families with a member in long-term recovery from addiction. The findings of this study are represented as an ethnodrama (Saldana, 2011), which expands the audience for the research beyond academia, making it accessible to communities of recovery. Furthermore, ethnodrama creates a visceral window into the lives of the participants, engaging audience members on both an emotional as well as informative level (Barone & Eisner, 2012; Leavy, 2015; Saldana, 2011).

At the outset of this study, I intend to tell a success story as a counter-narrative to stories in which addiction is depicted as hopeless. While, I believe it is important to explore the participants' experiences of active addiction in order to understand the challenges they have faced, the focus of the study is on how they have triumphed and overcome these challenges. I apologize for spoiling the ending at this early stage, but the story presented in chapter four concludes on a generally positive note. However, as is often the case, the ending of the story may

be less interesting than the journey that the characters have taken to get there. It is the journey that is the substance of the research.

The findings from this study provide insight into how couples narratively re-story themselves from 'couple in addiction' to 'sober couple.' The knowledge gained from this study may be useful to practitioners designing interventions to support long-term recovery. The study may also be significant to clients themselves, as well as their families, who may be able to transfer findings from the ethnodrama to their own particular contexts. Finally, as mentioned above, it is the intention of this study to contribute to destigmatizing narratives of hope and optimism around recovery, which were called for by the recent Surgeon General's report on addiction & recovery (US Department of Health & Human Services, 2016).

Research Questions

Based on the rationale and purpose described above, the following questions guide this study:

- How do participants describe their experience of recovery from alcoholism as individuals and as a couple?
- What do the participants attribute as key influencers to their successful transition to long-term recovery and their sustained relationship as a couple?
- How do individual and couple narratives develop and function within the change process from alcoholism to long-term recovery?

Theoretical Framework

Three interwoven theoretical frameworks have shaped the present study. At an onto-epistemological level, the research has been informed by the work of Deleuze and Guattari (1987). In particular I have utilized their metaphorical concepts of the “Machinic Assemblage”

and “Body without Organs,” applying them to the examination of the shifting narratives of participants. These metaphors are useful in describing the ways that narratives grow and change across time and context in order to produce new meanings from the same events.

Narrative inquiry (Clandinin & Connelly, 2000; Kim, 2016; Riessman, 2008) provides a mid-level theoretical framework informing the research framework. Narrative inquiry is a form of qualitative research that does not separate the experience, from the contexts in which it was lived, told, relived, and retold (Clandinin & Connelly, 2000). In other words, narrative inquirers attend not only to the content of participants’ narratives, but also the contexts that produce the story, and the way they influence how the story functions in the retelling. Freytag’s (1894/2007) model of the classic plot structure was used as a basis for analyzing the shifting structure of the participants’ narratives about couple-hood, family, and alcoholism as they transitioned from active addiction to long-term recovery.

The final theoretical framework involved in this study is narrative therapy (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990), a substantive approach applying narrative theory to the practice of counseling. Narrative therapy provides a way to conceptualize the dynamics of the couple in this study, and the ways in which they become un/stuck in their stories, preventing or promoting growth as individuals and as a dyad.

These three theoretical frameworks will be described in far greater detail in chapter two. However, it should be noted that by selecting *these* frameworks, I am simultaneously omitting a number of other possible frameworks for examining the same topic. For example, I am not examining recovery from a critical race or feminist perspective. No doubt, these alternative frameworks can provide valuable perspectives, and generate equally rich findings. However, it is not possible to use every potential lens on a phenomenon all at once without becoming

completely overwhelmed by the scope of the study. Thus, it is important for qualitative researchers to be selective in their frameworks and focus on inhabiting a single perspective (Bhattacharya, 2017; Creswell, 2013). Furthermore, while this study is intended to describe and conceptualize the experiences of the participants within a narrative theoretical framework, it is not intended or equipped to prove or determine the superiority of narrative therapy over any other approach to treating addictions or sustaining sobriety.

Methodological Frameworks

This study falls under the broad methodological umbrella of humanities-oriented qualitative research. "The central purpose of humanities-oriented research has been the exploration and understanding of forms of human existence," (AERA, 2009, p. 482). With a focus on the experiences of families in recovery from addiction, this study is situated squarely within the domain of humanities-oriented research. Humanities oriented research utilizes interpretive methods for understanding the histories, meanings, values, and beliefs that construct the lived-experience of participants.

The goal of qualitative research is to create transferability rather than generalizability (Bhattacharya, 2017). Unlike generalizability, which is a property of the research itself, transferability is a co-construction between the study and each individual reader. While it is impossible to predict what individual readers will find interesting or applicable to their own particular circumstances, qualitative researchers can employ a number of techniques (Creswell, 2013; Tracy, 2010) to make the research credible, rigorous, transparent, richly detailed, and accessible, thereby increasing the potential for transferability.

As mentioned earlier, narrative inquiry (Clandinin & Connelly, 2000; Kim, 2016; Riessman, 2008) was the theoretical framework that guided the study. In accordance with

narrative inquiry, the experiences of the participants are presented in a narrative or ‘storied’ format, in which they are presented within a context, and linked through plot. Additionally, narrative inquirers are also interested in the ways that storied experiences are retold and how they function to produce meanings for the teller and audience.

Where narrative inquiry provided a broad orientation to this qualitative study, case study (Stake, 1995; Yin, 2009) provided a framework to guide the research design. A case study involves a focus on a particular bounded system, such as an event, organization, location, and so forth (Stake, 1995; Yin, 2009). Case study researchers are less interested in general phenomena than how the phenomena were experienced within a particular context. There is some natural overlap between narrative inquiry and case study, as all stories are *about* something and whatever they are about could constitute the case. Therefore, case study was selected as an appropriate design for this study. Rather than examining recovery in a general sense across multiple couples, this study focuses on the transition from addiction to recovery of one particular couple in order to gain a deep understanding of their experiences.

The findings of this study are represented in the form of ethnodrama (Saldana, 2011), which falls under the broader category of arts-based research (ABR) (Barone & Eisner, 2012; Leavy, 2015). ABR combines rigorous qualitative research with concern for the aesthetic qualities whereby the art may produce a powerful experience in audience members. These aesthetic experiences may allow audience members to engage with the research on both a cerebral, as well as an emotional level, thereby increasing the transferability of the research. Quality arts-based research should be incisive, concise, coherent, generative, significant, and evocative (Barone & Eisner, 2012).

Data for this study primarily comes from in-depth semi-structured interviews (Kvale & Brinkmann, 2009) with the participants, both jointly and individually. Naturalistic observation of the couple engaged in a typical couple activity (watching football on TV), as well as geographic observations, field notes, journaling, memory sites, and supplementary documents and artifacts provided additional sources of data and contributed to the triangulation or “crystallization” of the data (Richardson & St. Pierre, 2004; Tracy, 2010). The data was analyzed using an inductive, ethnodramatic writing and narrative analytic processes to produce an ethnodramatic script detailing the participants’ experience of transitioning from active alcoholism to recovery. Finally, a subsequent “reading” of the play through the narrative theoretical lens informed by Deleuze and Guattari (1987), Freytag (1894/2007), and narrative therapy (Freedman & Combs, 2006; Parry & Doan, 1994; White & Epston, 1990), resulting in the development of a Narrative Change Model. Methodological considerations for data collection and analysis are described in depth in chapter three, while the findings are presented in chapter four.

Operational Definitions

The language of addictions can be confusing, as terms are often used interchangeably. For example, “alcoholism” as a term did not come into use until the nineteenth century. Prior to this point, alcoholism was referred to as habitual drunkenness, and those who were habitually drunk were derogatorily called “drunkards” (Levine, 1978; White, 2014). As the conceptualization of “habitual drunkenness” as an affliction beyond the control of the drinker rather than a matter of personal choice and unrestrained appetites began to take hold in the popular understanding of habitual drunkenness, the terms “alcoholic” and “addict” gained traction. Recently, the DSM-IV (APA, 2000) referred to alcoholism as “alcohol dependence,” while the next edition, the DSM-V (2013) has renamed the same issue as an “alcohol use disorder.” Individuals in the recovery

community may use any of these terms (sometimes interchangeably) to describe their addictions or themselves as addicts. Therefore, it is important to provide operational definitions used in this study in order to provide a linguistic common ground between the participants, readers, and myself, the author of this dissertation.

- **Alcohol Use Disorder (AUD):** This study relies on the diagnostic criteria described in the DSM -V (APA, 2013) to define AUDs. These criteria include increased tolerance, cravings, preoccupation with drinking, inability to cut down in spite of negative consequences, and interference with other areas of life. In places, the terms habitual drunkenness, alcoholism, addiction, and dependence are used to denote the same concept using variations on the language within context.
- **Alcohol Use/ Abuse/ Dependence:** Revisiting, the DSM-IV (APA, 2000) diagnostic criteria, it may also be useful to distinguish use from abuse from dependence. Many people are able to use alcohol responsibly. Having an occasional drink or two does not qualify as abuse if it does not produce any harmful effects for the drinker or anyone else. The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2018) defines moderate drinking as between one and two standard drinks per day. In contrast, alcohol abuse, related to binge drinking, is defined as over-consumption of alcohol producing a state of marked intoxication. The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2018) defines more than four drinks for women and five drinks for men within a two-hour period as binge drinking, which can be considered abuse of alcohol. NIAAA (2018) defines heavy drinking as binge drinking on five or more days in a month. However, while heavy drinking may be a precursor or sign of dependence, it is not

equivalent. In order to qualify as dependence or an AUD, the behavior must meet the diagnostic criteria provided by the DSM V (2013).

- **Active Alcoholism:** Active alcoholism, or active addiction to alcohol are used in this study to describe the period prior to treatment when the alcoholic was regularly engaged in problematic drinking behaviors. Because alcoholism is often conceptualized as a chronic and incurable condition, the word “active” is used to distinguish this stage of alcoholism from the managed form of alcoholism that exists in recovery.
- **Quitting:** To quit using alcohol is a physical act of ceasing the behavior of drinking. While one may intend to quit forever, quitting can refer to any period of time. For example, one might quit drinking for one night, and return to it the next day.
- **Abstinence:** Abstinence involves a sustained avoidance of alcohol over time, often involving a conscious choice or decision not to drink.
- **Sobriety:** Sobriety is a lucid state of consciousness unimpaired by alcohol or other drugs.
- **Recovery:** Recovery refers to a major change in lifestyle and worldview to support and maintain one’s sobriety. Thus, quitting may be seen as superficial, behaviorally-oriented first-order change, while recovery reinforces the behavior of abstinence with an internalized commitment to second-order change (Watzlawick, 1978).
- **Detoxification:** Detoxification is a process in which alcohol is eliminated from the body. Because physical withdrawal symptoms from alcohol can be potentially deadly, detoxification often occurs under medical supervision, and can last three to fourteen days for severe AUDs (Hayashida, 1998).
- **Treatment:** Treatment for AUDs differs from detoxification. Treatment is usually recovery-oriented, with the goal of sustained sobriety (Hayashida, 1998). Treatment

options can include outpatient and inpatient settings and incorporate a variety of services from structured counseling and psychoeducational experiences, to regular check-ins online (French, Salome, & Krupski, 2000; SAMHSA, 2018b).

- **Lapse/ Relapse:** In the context of alcoholism, a lapse (also known as a slip) refers to any occasion when an individual in recovery drinks any amount of alcohol. A lapse can range from a sip to a single binge. Relapse refers to a complete return to the alcoholic lifestyle. A lapse often precipitates a full-blown relapse, but many recovering alcoholics may recognize the danger and seek help before sliding into relapse.
- **Lived Experience:** Lived experience refers to the direct personal experiences one has in interacting with the world.
- **Narratives:** In the context of this study, narrative refers to a storied interpretation of lived experience. Narratives serve to explain and link events, experiences, and observations in ways that make them meaningful and related (Holstein & Gubrium, 1999a; Kottler, 2015). In other words, we are narratively pattern seeking in order to make sense of the world around us. Furthermore, we tend to cognitively operate on this assumption of the world as full of meanings, which are imposed on our lived experiences in a state called “hyperreality” by Baudrillard (1994).
- **Social Discourses:** Narratives that exist outside of the self are described in this study as social discourses. Social discourses are multiple and excessive in number compared to lived experience, which tends to be singular (Holstein & Gubrium, 1999a). For example, in relation to the personal lived experience of drinking alcohol, social discourses may include narratives relating alcohol to partying and

good times, as well as those that produce an understanding of alcohol as potentially dangerous (among many others).

- **Personal Narratives:** Personal narratives are internalized narratives which are formed at the intersection of lived experience with social discourses. While all social discourses (within the awareness of an individual) may intertextually influence the formation of the personal narrative, not all social discourses will have equal salience to the individual. Thus, there is an executive process involved in selecting, rejecting, modifying and synthesizing social discourses in relation to lived experience to produce a personal narrative around any given subject. It should also be noted that one person's personal narrative may provide a social discourse for another person and vice versa.
- **Narrative Thickness:** The thickness of narratives refers to the extent to which they have been internalized and supported by lived experiences. A thin narrative is one that an individual lives without necessarily believing in it. A thick narrative is one that individuals have internalized. For example, one may go to church out of a sense of tradition (a thin narrative) or because of a deep personal belief in religion (a thick narrative).
- **Narrative Inertia:** Narrative inertia refers to the tendency of narratives to persist even when they no longer fit the lived experiences of individuals. For example, someone who chooses to leave a church may struggle with the narrative inertia regarding the role of church in his or her spiritual life. Thicker narratives tend to carry a greater force of inertia which makes them more resistant to change.

Chapter Summary

This chapter began with a narrative describing my personal experiences working with addicted clients and their families at a treatment center during my master's internship, followed by a discussion of the role of subjectivity within this study. I then provided background on the state of alcoholism and treatment in the US, drawing heavily on government statistics from SAMHSA and NIAAA, as well as a short overview of the literature reviewed in chapter two, thereby producing a rationale for conducting this study. Next, I presented the purpose of the research, and the questions that guide the study. Following the research questions, I provided brief descriptions of the theoretical (elaborated on more fully in chapter two), and methodological frameworks (described at length in chapter three). Finally, I concluded the chapter with a list of operational definitions in order to clarify the terms that are used in this dissertation.

In the next chapter, I will present a review of the available literature related to alcohol, alcoholism, and treatment in the US, and elaborate on the theoretical frameworks that inform this study. Chapter three will present an in-depth description of the methodology including, methodological frameworks, participant selection, as well as data collection and analysis procedures. The findings of the study will be presented in chapter four in the form of an ethnodramatic script titled *Whiskey & Tangerines*. Following the script, a narrative analysis of the play will be provided informed by the theoretical lenses described in chapter two, in which I develop a narrative change model to conceptualize the ways that narratives functioned within the participants' change process. In the final fifth chapter, I present a discussion of the findings as well as the significance and implications for counselors, counselor-educators, and the larger recovery community. Finally, I describe the limitations of the present study and suggest directions for future research.

Chapter 2 - Literature Review

This chapter offers a literature review of the historical overview of alcohol and addiction followed by a summary of six broad categories for understanding models of addiction, their conceptualization, how they are used in clinical practice, and associated empirical studies. Next, theoretical frameworks are presented highlighting three macro-, meso-, and micro-level ontoepistemological, methodological, and substantive frameworks that inform the study. Following the theoretical frameworks discussion, this chapter includes discussion about alcohol and family dynamics supported by conceptual and empirical literature. The review of literature regarding recovery from alcoholism is discussed next. Finally, the chapter offers the synthesis of the literature identifying the rationale for the current study while situating the current study within the broader landscape of relevant issues.

Historical Overview

History of Alcohol

The human use of fermentation processes to produce alcohol predates recorded history (Philips, 2014), and has been found in civilizations from Africa to Asia to Europe to South America, each of whom had developed particular customs and regulations regarding its use. Alcohol was frequently associated with religious rituals and festivities. Additionally, it was used for health and medicinal purposes. In particular, diluted alcohol was often preferred to water as a means of hydration since local water sources were often polluted with harmful bacteria.

Europeans, in particular, developed methods for distilling alcohol to make high-powered spirits. Spirits played a major role in the European exploration and colonization of the rest of the world. Foremost, spirits occupied less space than other forms of alcohol and were therefore easier to transport (Philips, 2014). Being able to transport more (or more concentrated forms of)

alcohol allowed Europeans to travel further abroad, and wherever they went, they brought their hard-drinking habits with them. Where most people produced alcohol, which ranged from 3-7% of the beverage, European alcoholic beverages were often between 30-50% alcohol.

Alcohol was used both as a commodity for trade, as well as a means for exploitation. The native peoples of North America were particularly susceptible to the influence of European liquor. A global anomaly, few North American tribes had developed any form of alcohol and were totally unfamiliar with its effects (Philips, 2014). European colonists took advantage of the natives' naivety by including alcohol in trade and pact meetings, in which they would get native leaders intoxicated to the point where they would make decisions and concessions to their own disadvantage that they would not have otherwise made sober (Philips, 2014).

Alcohol played no less of a role in the slave trade in Africa than it did in the exploration (and exploitation of the inhabitants) of Canada by the Hudson's Bay Company (Philips, 2014). Pre-colonial Africans had developed beer and wine with about 3% alcohol was used in social, legal, and religious settings. Drinking was widespread, though drunkenness was discouraged. However, during the slave trade, rum of 40% alcohol or more was employed by colonists to entice African traders into providing slaves (Christmon, 1995). A young healthy man was roughly equivalent to twenty gallons of rum, though European colonists would often get the African traders drunk to gain advantage in their dealings in a similar fashion as they had done with indigenous populations in North America.

In the US, laws prohibited the sale or supply of alcohol to both slaves and freed men on the grounds that African Americans could not be trusted with liquor, and inebriation would make them less likely to accept their positions of servitude (Christmon, 1995). However, exceptions were plentiful. During holidays, and especially at Christmas, alcohol was freely provided to

African American slaves, who were encouraged to drink to excess and engage in acts of debauchery for the entertainment of White owners. Owners would place bets on which slave could hold the most liquor (Christmon, 1995). Thus, patterns of prohibition with periodic bingeing were established without any middle ground among slaves.

At the same time as merchants and traders had created an influx of alcohol to the indigenous communities of North America, others began to worry about the effects of alcohol on these populations (Levine, 1978; Philips, 2014; White, 2014). Native Americans did not share European's sensibilities about avoiding the sin of drunkenness. For Natives, alcohol held no religious or cultural significance, and the purpose of drinking was to become intoxicated (Philips, 2014). There was also concern about the mixing of races while drinking. Fears grew among European settlers about drunk Indians becoming violent and unruly and raping White women, and so on (Philips, 2014; White, 2014). While there is little evidence that Native Americans were actually more susceptible to violence and crime than Europeans under the influence of alcohol (Philips, 2014), prejudices persisted, and many colonizers attempted to regulate indigenous people's access to alcohol. Nor were the colonists alone in their objection to the consumption of alcohol by Natives. Tribal leaders had witnessed the effects of alcohol on their communities and petitioned European colonists not to sell or provide alcohol to their people (Philips, 2014). However, these protests were to little avail since European business profited on the sale of alcohol, and European government thrived on the taxes levied on these transactions (Philips, 2014; White, 2014; Yates & Malloch, 2010). In fact, the taxation of alcohol went a long way to paying debts incurred during the war of American independence on both sides. Similarly, alcohol taxes were a major part of financing both the Confederate and Union's war efforts during the American Civil War.

Early White Americans' worries over the abuse of alcohol was not limited to the abuse of indigenous populations, but also excessive consumption among their own people (Levine, 1978; Philips, 2014; White 2014). Americans drank regularly, and they got drunk (Levine, 1978). They had carried with them from Europe an aversion to water, despite much of the water in North America being clean and pure (Philips, 2014). Furthermore, many of the early settlers were men who were far from home (and the supervisory influences of family or community) with little to occupy their leisure time and an abundance of available alcohol (White, 2014). Several religious leaders began to speak out against alcohol (Levine 1978; White, 2014). Drunkenness was conceived as a form of gluttony, which also enabled other sins such as rage, blasphemy, and adultery. Thus, while drinking was related to sin, it was *sin* rather than drinking that early anti-alcohol advocates were opposed to.

At the turn of the 19th century, the spiritual concerns of religious leaders began to be echoed by the medical community. Physicians had first-hand experience dealing with the effects of alcohol on their patients which ranged from physical complaints to madness (White, 2014). Benjamin Rush, a doctor and one of the earliest secular proponents of temperance, was the first to conceptualize the cause of alcoholism to be alcohol itself. He noted that the more alcohol his patients drank, the more susceptible to alcoholism they became. It was an important distinction, because in contrast to the prior model of addiction which put the individuals' sinfulness at the center of their addiction, Rush characterized the alcoholic as a victim of the influence of alcohol. Therefore, the solution to alcoholism was abstinence from alcohol, as opposed to moral reform (White, 2014).

The temperance movement latched on to Rush's position, rallying against alcohol itself as evil and corrupting. It is interesting to note that these early temperance advocates were not a

unified movement (Levine, 1978; White, 2014). Most (including Benjamin Rush) believed that hard spirits were comprised of a different kind of alcohol from beer and wine. In popular and even medical opinion, beer and wine were considered to promote good health when taken in moderate amounts (Philips, 2014). Furthermore, some temperance advocates preached total abstinence, while others preached moderation. Class and race distinctions also grew over who was better able to hold their liquor, leading to further discrimination against lower classes and minority races. Over the next century, the popularity of the temperance movement waxed and waned, almost disappearing during the Civil War before finding a resurgence during the reconstruction era, and finally culminating in the 18th amendment in 1919 prohibiting the manufacture, sale, and transportation of alcohol (White, 2014).

Several factors may have been involved in the changing attitudes towards alcohol. One factor may involve the rise of the popular novel. In the late 1700s, just as Western society was violently turning away from monarchic dynasties to more democratic forms of government, literature was also making a pivot from the heroic to the domestic as the focus of plots in the Romantic and Victorian eras (Armstrong, 1987). This turn was in response to greater numbers of people becoming literate, increased prosperity, and more leisure time. Commoners (as opposed to clergy and nobility) began to write stories of their own experiences. In doing so, the archetypal character of the drunkard transformed from a comic figure (e.g., Shakespeare's Falstaff), into one of pity and tragedy (Norton, 2017). One branch of this new literature, temperance novels, focused expressly on the drunkard as a moral hazard (McGowan, 2014). Alcoholics were portrayed as uncontrollably monstrous individuals who would sink to whatever depths the author could imagine. Temperance novels tended to be heavy-handed in their message, but their

exaggerated sensationalism in detailing the sins and moral depravity of drunkenness appealed to many readers (McArthur, 1989).

Another major influence on alcohol in America was the industrial revolution. Prior to industrialization, the majority of alcohol production was done in private residences and taverns with huge variations in style and quality between them (Philips, 2014). Unfortunately, competition led to many unscrupulous practices. Alcohols could be watered down or adulterated with the addition of any number of herbs or chemicals to mask or augment its taste, color, clarity without regard to whether those additives were poisonous (e.g., plaster added to wine, or strychnine to beer). Industrialization provided standardization, ensuring uniform quality while mass production was more efficient and less expensive. While regional variations on beer, for instance, could be relatively hit or miss, a Budweiser in Houston would taste more or less the same as a Budweiser in St. Louis, and one could be relatively sure that neither would cause them to be ill.

Along with industrialization during the 1800s, labor became increasingly centralized in factories in urban areas. Industrialists quickly recognized that drunk employees were prone to irresponsibility and making expensive errors, including getting themselves killed or maimed on the job (Levine, 1978; Philips, 2014; White, 2014). Increased costs and lost productivity cut significantly into company profits. Therefore, not only was it of interest for employers to regulate the drinking behaviors of their employees while on the job, but some employers went as far as to attempt to regulate how much employees were allowed to drink in their free time (Philips, 2014).

Ironically, the wages promised by factories to lure workers to the city also provided workers with more money to spend on alcohol, which they did. Bars, taverns, and pubs sprung

up all over urban areas to serve the growing demand (Philips, 2014; White 2014). These places provided more than access to liquor and beer. They also gave employees a space to gather outside of the work. As workers gathered and commiserated about unfair treatment and labor practices, they began to collectivize, leading to unions which threatened the power of factory owners and profitability of their factories. Therefore, the new bourgeois industrialist class had good reason to oppose access to alcohol in the working class.

Immediately following the civil war, alcohol consumption among African Americans was lower than it was among Caucasians (Christmon, 1995). Nevertheless, the image of the unrestrained, drunk, sexual and violent Black man persisted among Whites (Kulesza, Matsuda, Ramirez, Werntz, Teachman, et al. 2016), particularly in temperance movements in the South, leading to further discrimination, and Jim Crow restrictions on alcohol consumption.

Even today, stereotypes and stigmas against minority populations as “drug-crazed and dangerous” persist (Kulesza, Matsuda, Ramirez, Werntz, Teachman et al., 2016) leading to a greater criminalization of minorities on drug charges. In 1995 SAMHSA estimated that non-Whites accounted for about 16% of drug users but were represented in over a third of drug-related arrests (Langan, 1995). Researchers have found higher incidences of alcohol abuse among African American and Latinx populations and note that these populations face a greater confluence of risk factors than Caucasians including discrimination, prejudice, and poverty, reflecting systemic structures of discrimination in Western society (Zemore, Ye, Mulia, Martinez, Jones-Webb, et al., 2016).

In the later 1800s, many African Americans in the American South migrated North to escape economic exploitation and political persecution, as well as to seek work in factories (Christmon, 1995). It was in the North that patterns of alcohol use in African Americans began to

mirror those of Whites – and for similar reasons. Men were alone, far from home, with money to spend, and tended to gather in taverns together to drink and socialize (Christmon, 1995).

A final factor in shifting attitudes and discourses around alcohol were outbreaks of cholera in New York State, and throughout the Erie waterway (Philips, 2014). The pandemic led to government initiatives to provide sanitized water to residences in urban areas. While the availability of clean water was unlikely to dissuade anyone from drinking recreationally, it did at least provide a viable alternative to beer for hydration (Philips, 2014), and removed a very important barrier to regulation.

Support for prohibition had been growing in the US since the civil war. It was believed that prohibition would strengthen America, boost the economy, and lead to a healthier and more moral society (Philips, 2014). Following the first world war, many States and Counties had enacted a variety of prohibition laws, creating a confusing patchwork of policies. In 1919, the US federal government enacted the 18th amendment making it illegal to manufacture, sell, or transport alcohol of any kind (exceptions were made for medicinal, industrial, or religious use) creating a uniform national policy, which lasted until 1933, when prohibition was finally repealed.

Contrary to stimulating the economy, the immediate impact of prohibition was to put the majority of the alcohol industry out of work (Philips, 2104) – from breweries to taverns and retailers. Farmers who produced crops used for alcohol production, and other auxiliary workers involved in the supply chain were also significantly impacted, and governments at all levels faced steep declines in revenues that would have been generated by taxes on alcohol sales.

While prohibition policies cracked down on the production of alcohol, they did little to address the popular demand for it. Illegal distilleries began to spring up all over the US, and a

black market for liquor quickly emerged, eager to fill the demand (Philips, 2014; White, 2014). Without regulation, some distillers reverted to adding harmful adulterants to their products to mask their inferior quality. In addition, neither Canada nor Mexico had outlawed the production or export of alcohol. Large-scale smuggling operations kept the supply of alcohol flowing along the Northern and Southern border states. Similarly, ships from Europe loaded with wine and liquor would wait outside American waters for flotillas of small private fishing boats to meet them under the cover of night and transport their cargo ashore. In spite of the new law, America was far from dry during prohibition.

Furthermore, enforcement of prohibition laws in the US was poor (Philips, 2014) and bordered on unworkable. Police were underfunded and ill-equipped to deal with the massive influx of alcohol. Secret drinking establishments called ‘speak-easies’ sprang up all over the country, particularly in urban areas. One speak-easy might be found and shut down, but a new one would quickly emerge to replace it. Corruption spread through the police force in the forms of bribery, intimidation, and drunkenness, leading to high turn-over, and low morale. Rather than create a more moral society, prohibition had created the conditions for criminal organizations to thrive. Drinking was driven underground into secret speakeasy clubs, or in the privacy of individual homes. Towards the end of the 1920s, it was becoming increasingly obvious that prohibition as a national policy was a failure (White, 2014).

Apart from the reversal in public sentiment towards alcohol, another major factor in repealing prohibition was the great depression beginning in 1929. When Franklin Roosevelt was elected in 1932, part of his platform had been to repeal prohibition under the belief that restoring the alcohol industry could provide a much-needed boost to the economy (Philips, 2014). However, Roosevelt was cautious not to revive the days of rampant American drunkenness. His

administration introduced regulations and oversights of the alcohol industry in order to maintain quality and discourage over-consumption.

After 13 years of prohibition, alcohol reemerged in American society in a mostly positive light (Philips, 2014). Meanwhile, speak-easy culture during prohibition had made public drinking almost fashionable. Speak-easies, and later, bars and clubs began to compete for customers, including women. Prior to prohibition, politics of respectability prevented most women from patronizing saloons, and women's drinking was mostly done in secret at home. However, with prohibition along with the early women's rights movement, women became sought-after customers. Bartenders began to experiment with mixology, creating drinks that appealed to individuals who didn't care for straight liquor or beer. Furthermore, bars began to incorporate music and other forms of entertainment to attract customers. Drinking had gained an air of respectability in American culture.

The failure and repeal of prohibition represented a major political blow to the temperance movement. While some States and Counties remained dry until as late as 1966 (e.g. Mississippi), most of America had acknowledged the place of alcohol in society (Philips, 2014). Rather than complete abolition of drinking, authorities focused on containing the negative consequences of drunkenness (White, 2014) such as drunk driving and domestic violence, while attempting to promote a culture of responsible drinking.

While the frequency and volume of drinking in America has decreased by as much as half since its height in the 1800s (Philips, 2014), drinking has become a normalized part of American society. The prevalence of binge drinking seems to be increasing at alarming rates in particular amongst younger people (Rooke & Hine, 2011; SAMHSA, 2018a). The lowering of inhibitions and sexual promiscuity related to intoxication that was feared by old temperance

advocates is actually sought by some modern drinkers (Labrie, Hummer, & Pederson, 2007; Norberg, Norton, Olivier, & Zvolensky, 2010). In many parts of American popular culture, rather than being discouraged, drunkenness is actually celebrated (Primack, Nuzzo, Rice, & Sargent, 2011). It remains to be seen how the modern drinking culture will shape future attitudes and policies about alcohol.

Early History of Treatment

For as long as people have been drinking, there have been warnings about the consequences of overconsumption (Philips, 2014). In the short-term, excessive drinking could lead to lowered inhibitions, sinful or antisocial behaviors, vomiting, passing out, and hang-overs. Over the long-term drinking has been associated with organ disease and decreased cognitive and emotional functioning, relational difficulties, poverty, destitution, and death (Brion, D'Hondt, Pitel, Lecomte, Ferauge, et al., 2017; NIAAA, n.d.). Socially, alcohol has been linked to social unrest, disorder, lost productivity, lost discipline, and military defeat (Philips, 2014; Popovici, Homer, Fang, & French, 2011; USDHHS, 2016). While drinking was believed to provide health and well-being, drinking to excess has always been problematic, and individuals who regularly drank excessively were counterproductive to society (Philips, 2014; White, 2014).

For most of American history, habitual drunkenness (what we refer to today as alcoholism) was considered a personal vice, and individuals were expected to take responsibility for their own moral affairs (White, 2014; Yates & Malloch, 2010). A drunkard could lose money, family, home, health, and so forth, but that was their own business. Where drunkards were derelict in their civic or professional duties, or caused some social offense, they would be punished accordingly, just the same as anyone else under law (Levine, 1978; White, 2014). To be found excessively drunk was cause for social disapproval, but it was the actions of the

drunkard, rather than the state of drunkenness that were of most concern to American law and society (Yates & Malloch, 2010). Therefore, drunkards who were unable to support themselves (or were unsupported by family) were usually dealt with through the justice system, and frequently ended up in prison. There are very few references to addiction in literature prior to the 18th century (Levine, 1978; Yates & Malloch, 2010). Rather, habitual drunkenness was blamed on an unregulated appetite.

Conceptions of alcoholism began to change in the late 1700s. Physicians and clergy to whom the care for drunkards often fell, began to observe that these individuals often did not wish to drink, and sincerely desired to remain abstinent (White, 2014). After each episode of drunkenness, they were truly repentant. However, drunkards reported that they felt *compelled* to seek out alcohol and were unable to keep from drinking themselves into a state of madness (Levine, 1978; White, 2014). Thus, Benjamin Rush, one of the earliest proponents of temperance, characterized alcoholism as an affliction of the will, rather than a personal moral failing. The cause for addiction, according to Rush, was located in the bottle, rather than within the individual (Levine, 1978; White, 2014; Yates & Malloch, 2010). In other words, Rush viewed the drinking of alcohol itself as the source of alcoholism. The cure for alcoholism, according to Rush, was total abstinence from hard spirits. To induce abstinence, Rush did not prescribe a single method, but pragmatically favored whatever he believed would work, including vegetarianism, religious conversion, shaming, substituting beer or tea for liquor, or the use of cold-water baths (White, 2014). As the temperance movement gained momentum, a number of supposedly medicinal remedies for alcoholism were concocted and sold to the general public. If the buyer was lucky, these remedies would only be ineffectual. Often, they were

adulterated with poisonous ingredients, alcohol, or other addictive drugs such as morphine that left the user in worse health than before, and in some cases led to death (White, 2014).

Rush also proposed the creation of 'sober houses,' to confine and treat alcoholics through moral education (White, 2014). The idea of a place specifically for care of alcoholics was particularly revolutionary in that it acknowledged that alcoholics were a distinct segment of the population who were not served well by the contemporary legal system. Furthermore, hospitals, at this period in American history were still fairly rare and were often reserved for “morally worthy” patients, which typically excluded drunkards (White, 2014).

While Rush proposed the creation of sober houses in the early 1800s, it wasn't until the 1870s when the first formal institutions for the care of inebriates were built and staffed. Initial demand for these institutions was high, and by 1902, there were over a hundred facilities in operation in the US (White, 2014). The quality and services provided by recovery facilities varied considerably (White, 2014; Yates & Malloch, 2010). Some were little more than ‘dry’ hotels where residents could live in an environment free from alcohol. Other institutions included medically supervised detoxification, and programs for religious reform.

This initial iteration of recovery institutions was short-lived for several reasons. The US government had little interest in regulating the new industry and even less interest in subsidizing the care of alcoholics (White, 2014). Therefore, these institutions had to rely on private payment from their clients, many of whom had become destitute due to their addiction. To remain solvent, it was necessary to cut costs to the point where the services being provided were substandard. Soon a number of scandals were publicized in relation to the disreputable of recovery institutions. These scandals involved corruption, embezzlement, neglect of patients, maltreatment, non-treatment, keeping unsanitary conditions, physical abuses, and the over-use of

physical and pharmaceutical restraints (White, 2014). Additionally, the public became discouraged with the high rates of relapse among the supposedly reformed, suggesting that the costly programs of recovery provided only a short-term solution at best. Public support for recovery institutions soured, and by 1920, just as prohibition came into effect, most recovery centers had closed their doors (White, 2014).

The Development of Alcoholics Anonymous

As most institutions specializing in rehabilitating alcoholics disappeared, the temperance movement was still alive. However, after the fall of prohibition, the movement shifted from advocating for broad social policy to helping individual alcoholics overcome their alcoholism, usually centering religion as the cure for addiction. Consequently, many of the temperance organizations were church-based community groups, such as the Oxford Group, which was a direct antecedent to Alcoholics Anonymous (AA) (White, 2014).

Interestingly, the relatively young field of psychiatry had little to say on addictions. Sigmund Freud believed that addiction was a superficial manifestation of an underlying psychodynamic conflict rather than a subject for clinical intervention in itself (White, 2014). Freud's disciple Carl Jung attempted to treat a patient's alcoholism for a year, before describing the case as untreatable by psychiatry or medicine. Jung famously declared that the only possible cure for the patient's addiction would be a spiritual awakening, or in other words, divine intervention (White, 2014).

The founder of AA, Bill Wilson, was an alcoholic who had been involved off and on with the Oxford Group for years but was unable to sustain recovery through his involvement (AA, 2001). While he was not an atheist, he was wary of the religiosity and evangelizing of the Oxford

Group. Its members were expected to present themselves as orderly upstanding Christian citizens, both in public and at meetings in order to uphold the reputation of the group. It seemed to Wilson that promoting the Oxford group's public image of respectability was frequently of a higher priority than the recovery of its members (White, 2014).

In 1934, Bill Wilson had been hospitalized for alcohol related medical problems. While there, he underwent what Carl Jung had pessimistically referred to years earlier as a "spiritual awakening" (AA, 1953; AA, 2001). Wilson claimed to have been touched by God, to whom he had given his will, and in return received the strength to overcome his alcoholism. Elated by the miraculous contact with his higher power, Wilson began to share his story with others, first inside the Oxford Group, and then directly to other active alcoholics. While Wilson was attempting to convince other alcoholics to recover generally without much success, he discovered that the act of talking about and *living* his own example of recovery was at least helping to keep him sober (AA, 2001).

Slowly, Bill Wilson began to build a group around his own vision of recovery. Wilson was disinterested in religious proselytizing or projecting an artificial public image of any sort. He preferred that the group kept a low profile, eventually leading to the name "Alcoholics Anonymous" (White, 2014). Rather than orderly and respectable, meetings were often boisterous and loud. Members would gather in Wilson's living room and share candid personal stories about drinking and recovery. The group was described, even by themselves, as a "rag-tag bunch of nameless drunks" (White, 2014; Yates & Malloch, 2010). However, Wilson's group's lack of pretention and general disregard for respectability was at odds with the propriety and moral righteousness of the Oxford Group, leading to a schism.

During informal meetings, the initial group worked out a program for recovery (AA, 1953). In doing so, they imported many of the values of the Oxford Group such as surrender, honesty, confession, unselfishness, obedience to God's direction, and sharing witness (White, 2014). These became the foundations for the *12 steps and 12 traditions* (AA, 1953). The steps and traditions were combined with a number of compelling essays and personal anecdotes, including Wilson's own story of recovery in a book titled *Alcoholics Anonymous* from which the organization took its name (AA, 2001). Interestingly, the group had not had any use for a name until that point and was often referred to as "Wilson's group" even though they themselves espoused a leaderless, non-hierarchical structure (AA, 1953; White, 2014).

The "*big book*" (AA, 2001), as it became informally known, was first published in 1939 with the ambition of spreading the 12-step recovery program and reaching alcoholics across the US. However, the company that first published *Alcoholics Anonymous* engaged in a misdirected marketing campaign aimed at the medical community, rather than the alcoholic community, which resulted in a total of only two orders (White, 2014). Reviews of the book criticized its anecdotal nature, and the lack of scientific evidence to support the program. The organization bought back the rights to the book, *Alcoholics Anonymous*, and chose to directly distribute it to group members, whom by 1941 numbered 8000 across the US. AA is now the biggest recovery organization in the world and is estimated to include 2,090,000 members worldwide (AA, 2017).

Modern Treatment

With the development of AA, as well as advances in medical and psychological understandings of alcoholism, interest renewed in treatment or "rehab" centers beginning in the late 1940s in Minnesota with the foundation of the Pioneer House and Hazelden Farms as well as

a reconceptualization of treatment for alcoholism at Wilmar State Hospital (White, 2014). Collaboration between professionals working at these institutions led to the formation of the Minnesota Model for treatment.

The Minnesota Model was founded on the principles of AA and broke with prevalent psychoanalytic approaches for treating addicts which had failed to make much headway (White, 2014). The new approach focused on alcoholism in itself, rather than on psychodynamic personality traits. It also shifted away from a moralistic understanding of alcoholism as related to a personal failing of character in an individual, and avoided using shame, degradation, and punishment to obtain sobriety. Alcoholism was conceptualized as a multidimensional, progressive, and chronic disease affecting physical, psychological, social, and spiritual domains of the individual (Maltzman, 2008; White, 2014). Though alcoholism was not considered curable, the model for treatment was to address all of these areas in order to effectively manage the symptoms of the disease and keep it from developing. This holistic approach also demanded care for the dignity and respect of clients on the part of clinicians, as well as between each other (White, 2014). Recovered alcoholics were often trained and employed as counselors because their experience in addiction and recovery allowed them to identify with the clients (and vice versa) (Yates & Malloch, 2010). Counseling groups were designed to promote sharing, support, and interpersonal connection, rather than psychoanalysis. Lectures provided knowledge, skills, and encouragement for those in recovery to maintain their sobriety. Finally, clients were exposed to formal AA meetings while in treatment and encouraged to continue attending the after being discharged (Kingree, & Thompson, 2011).

The Minnesota model developed and expanded within the state during the 1950s and 60s, and then spread across the US in the 1970s (White, 2014). Prior to the 1970s, few states

offered anything like the services provided at Hazelden and the other institutions in Minnesota, though demand for recovery services was no less than it was fifty years earlier when the first recovery institutions disappeared. The model was disseminated largely through professional conferences and literature, as well as through AA networks, and the testimony of former clients, bringing thousands of hopeful alcoholics to Minnesota in search of help.

Developing in concurrence with the Minnesota model were a number of experimental treatments, which included hypnosis, vitamin therapy, tranquilizers, amphetamines, mood stabilizers, hallucinogens, Antabuse (designed to make the user violently ill when combined with alcohol), and asphyxiation by carbon Dioxide (Maltzman, 2008; White, 2014). Most of these approaches were discredited as either ineffective or potentially harmful to clients. However, some previously dismissed methods such as hallucinogen therapy have regained attention in recent years (Bogenschutz & Forcehimes, 2017). Findings from these studies, suggest a potentially effective form of treatment, but far more research is needed to determine the mechanisms through which change is achieved, the efficacy relative to standard treatment models, as well as the risks involved in such treatment. In short, renewed research into psychedelic therapies is not yet at a point to be practical in clinical settings.

Modern federal initiatives to address addiction (to drugs and alcohol) in America began in earnest in the 1960s under the presidencies of John F. Kennedy, and then Lyndon Johnson (White, 2014). By 1967, an alarming report on the state of alcoholism in the US was produced, along with recommendations for addressing it (Cooperative Commission on the Study of Alcohol, 1967). These included increased funding for the development of community-based (as opposed to prison-based) detoxification and treatment centers, as well as other resources such as outpatient treatment and public education. As treatment centers began to spring up around the

US, most looked to the already successful Minnesota institutions as models for operations (White, 2014).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) were created in 1970 and 1972 during the Nixon administration, demonstrating that dealing with addiction in the US was a bipartisan issue shared by Democrats and Republicans (White, 2014). The growth of treatment facilities was explosive. While there were just a few facilities (mostly in Minnesota) dedicated to addiction recovery in the 1950s, more than 2400 programs had been created by 1977, and over 9000 treatment programs were operating by 1991 serving 1.8 million individuals (White, 2014). In that time recovery developed from a loose network of independent support groups to a community with its own culture, and language. By the 1980s, recovery culture was even gaining visibility in popular culture (e.g. Ted Danson's character in the TV series Cheers, or the very public recovery of former first lady Betty Ford). The public exposure did much to put a positive and relatable face on a previously stigmatized condition (White, 2014).

However, the modern growth of the recovery industry has not been without its dangers. Many recovery programs are privately run for profit (SAMHSA, 2018b), and there is concern that profitability motives may interfere with decisions that are in the best interests of recovering addicts as they did in the early 1900s (White, 2014). One of the biggest issues facing treatment was differential access. Many who required addiction services were unable to afford them. Until very recently health insurers were reluctant to enroll customers with a history of drug or alcohol abuse, even if they were otherwise healthy. These policies left many of the most needy having to pay out of pocket (White, 2014). The issue of profitability left many beds unfilled, not because of a lack of demand, but a lack of money.

In addition, Alcoholics Anonymous and the twelve-step model have been the target of several criticisms. Many atheists and agnostics object to AA's centralization of a spiritual awakening as the key to recovery (Tonigan, Miller, & Schermer, 2002). Others find the concept of surrendering the will to be disempowering (Herndon, 2001). For some, acknowledging and embodying the identity of alcoholic is too absolute and totalizing (Winslade & Smith, 1997), ignoring other salient aspects of an individual's personhood. And for others still, AA is perceived as being too rigidly dogmatic, and promoting institutional thinking that overrides personal agency (Paik, 2006).

While AA is the largest recovery organization in the US, and has established branches around the world, it is not 100% effective for everyone, as evidenced by continually high rates of relapse amongst those who have been in the program. Several competing recovery models have been developed including Rational Recovery (Schmidt, 1996), which primarily focuses on identifying and challenging negative or "alcoholic" thoughts and self-talk, as well as Moderation Management whose goal is not complete abstinence from alcohol, but maintaining responsible drinking habits (Kosok, 2006). Little research exists to date comparing the effectiveness of these alternative recovery programs with AA. Furthermore, these organizations are relatively small compared to AA, and may be difficult to locate.

The history of alcoholism and Treatment in the US shows an imperfect, complicated, and evolving understanding of alcohol and alcoholism. The hazards of addiction to alcohol have existed in political and social tensions with the roles that alcohol has played in American society, and the development of the country, including the exploitation of vulnerable populations, and the generation of profits and revenues both on government and entrepreneurial levels. The period of prohibition demonstrated the futility of a blanket government policy restricting the availability of

alcohol to the general population. It also shifted thinking about addiction towards a more individual orientation, aiding those who were particularly affected by alcoholism find sobriety. In doing so, there was a movement away from a strictly moral model combining denial, abstinence and prayer, toward a more humanistic approach in which alcoholics were encouraged to accept their alcoholism as a personal condition, and to cope with and manage it through a 12-step program of lifestyle change. The Alcoholics Anonymous program has been incorporated into the majority of modern treatments, though it has not presented a perfect solution or been immune to criticism. Alternative forms of treatment have been developed, which may challenge AA as the *only* approach to recovery, though none of them appear to be in a position to replace 12-step-based models as the dominant approach in the US, and most lack research evidence to support their relative efficacy at this time.

Below, I will shift from a historical perspective on the development of alcoholism and treatment in the US and review several prominent models for explaining and conceptualizing addiction from psychological perspectives. I will briefly describe some of the treatment options associated with them.

Models of Addiction and Treatment Options

Based on the historic overview of alcoholism and recovery, one can reasonably infer that the concept of addiction has not been stable or fixed throughout history. The result has been the development of multiple and competing models to describe addiction and explain its pathology. While some of these models are grounded in scientific inquiry, the others are more prevalent in popular discursive awareness. In this section, these models are presented to highlight issues regarding addiction, treatment, and recovery. However, please note, that an organized and comprehensive taxonomy of all available modular concepts on alcoholism is not possible, nor is

it within the scope of this dissertation. Further, to complicate matters, many views are hybridized and may fit multiple categories without being fully contained in any. For example, a narrative model of addiction (described more thoroughly later in this chapter as one of the theoretical frameworks guiding this study) could be viewed as a combination of both social and cognitive perspectives, instead of just being conceptualized as a social or a cognitive construct.

Additionally, the models described in this section focus primarily on alcoholism. Other chemical and behavioral addiction models may (or may not) share commonalities with alcoholism but are beyond the scope of this study. Finally, there is no universal agreement as to which of the models presented might be the most comprehensive, accurate, or effective in understanding and treating alcoholism, though each certainly has its advocates and adherents. Thus, below is an imperfect attempt to classify a broad and contested field of discourses.

Choice Models

This section presents the moral and exchange models of addiction which emphasize the role of personal choice and decision making. According to the moral model, alcoholism is a choice or preference (West & Brown, 2013). The earliest conceptualization of ‘habitual drunkenness’ attributed it to unregulated appetites (Orford, 1985). The Latin root of addiction is “addicere” which literally translates as “to favor” (Haldipur, 2018). A person got drunk regularly, simply because they wanted to (Levine, 1978; Philips, 2014; White, 2014; Yates & Malloch, 2010). This desire for alcohol can be traced to its pleasurable qualities; its ability to relax the body and mind, and to promote socialization and feelings of well-being when consumed in moderate amounts (Phillips, 2014). According to the moral model, the drunkard desires the effects of drunkenness. If one drinks to excess, it is because of an excessive appetite

for a state of drunkenness. In other words, the moral model considers alcoholism to be a matter of unrestrained pleasure-seeking.

For Christians in early America, an unregulated appetite for drink was similar to an unregulated appetite for food or anything else – it was the sin of gluttony (White, 2014). Furthermore, Christians recognized the relationship of drunkenness to other sins such as adultery, blasphemy, violence, and so on (Levine, 1978). However, for the majority of Christians at the time, the focus was on sin, rather than drunkenness (Levine, 1978; Philips, 2014; White, 2014; Yates & Malloch, 2010). Immorality was viewed as a choice, and drunkenness was a matter of giving in to temptation (Mercadante, 2015). Therefore, from the perspective of the moral model, the solution was not specifically to avoid alcohol, but to avoid sinning through moral reform and prayer.

While moral models have largely been dismissed by the addiction and medical communities, they still hold a place in popular thought. Frank and Nagel (2017) note that alcoholics are often considered to be individuals with a weak moral character who easily, selfishly, and irresponsibly give in to temptation. Moral models position the person at the center of their addiction. However, the moral model also points to addiction as a socially constructed phenomenon (Poikolainen, 1982), and begs the question: Whose morality? For moral models, it would seem that only the drinking behaviors which are socially disapproved of are associated with alcoholism. Those whose drinking does not disturb or offend social sensibilities may be seen as ‘moral’ or normal drinkers. However, there is large variation in how drinking behaviors are perceived, and what might be considered ‘normal’ in one social context, could be excessive or problematic in another (Nguyen & Neighbors, 2013; Phillips, 2014; Raitasalo, Knibbe, & Krause, 2005). To take an example from another form of addictive behavior, one study found

that perceived addiction to pornography (regardless of the amount of actual use) was related to religiosity (Grubbs, Exline, Pargament, Hook & Carlisle, 2015). The greater the amount of moral disapproval attributed to pornography, the more likely the participants were to view lower levels of use as addiction. In other words, the threshold for addiction is often based on social values of the immediate community of the individual. This finding suggests that the term ‘addiction’ may be applied too liberally to behaviors which are socially undesirable or distasteful.

It is important, however, to understand addiction from the addict’s perspective, rather than imposing societal values and assumptions on them (Burrell & Jaffe, 1999; West & Brown, 2013). Understanding the addict’s perspective allows for understanding how the addict informs and makes specific choices based on their histories, experiences, and values. While some may disapprove of drinking or drug use, others may perceive these behaviors as moral and normal, and may go so far as to challenge the normalcy of abstinence (e.g. Chauvin, 2012). Thus, morality and decision-making are subjective and situated.

Focusing on the values of the alcoholic, another model can be used for understanding addictive behavior. In addition to the moral models, exchange models can also be included within the broad category of personal choice models (West & Brown, 2013). According to the exchange model of addiction, the drinker performs a deliberate and rational cost-benefit analysis of the decision to drink and finds the relative subjective value of drunkenness outweighs the imagined consequences (West & Brown, 2013). At the root of the exchange model of addiction are distorted valuations, which prioritize drinking over other needs and obligations in one’s life. Thus, treating addiction according to an exchange model involves a revaluation of drinking and other life domains. However, valuations are also subjective and situated within social constructions, and therefore the way values are prioritized requires further examination.

In addition to desire and value, some pharmaceutical approaches to treatment of alcoholism also incorporate elements of choice. The prescription of disulfiram (Antabuse) to alcoholics has been used to assist them in making the decision to quit drinking. The drug is designed to raise the physiological cost of drinking, in the form of becoming violently ill, thereby outweighing the benefits of drinking (Dronsfield & Ellis, 2012). Another drug used in treating alcoholism, Naltrexone, functions by blocking the most desirable neurological effects in the brain, thereby decreasing the pleasure value of drinking (Parks Thomas, Wallack, Lee, McCarty, & Swift, 2003). The use of pharmaceuticals, then, creates a chemical rebalancing of the exchange by maximizing the costs (Disulfiram) and/or minimizing the benefits (Naltrexone) of using alcohol, creating circumstances that support a rational decision not to drink.

Therefore, choice models emphasize an individual's power of will and rationality over the decision to drink or not to drink. The individual is thereby held responsible for the choices that they have made which lead to their addiction. This conceptualization of alcoholism resonates with individualist cultures, often epitomized by the United States (Levine, 1978; White, 2014). Ironically, individuality requires morally conforming to the collective cultural values of independence and self-reliance.

Biological Models

Biological models of addiction locate the cause of addiction within the physical body of the alcoholic. The models discussed in this section include genetic, disease, and neurological models. Around the turn of the 19th century, a new conceptualization of alcoholism began to emerge, based on medical research. According to Benjamin Rush, the cause of alcoholism was not sinfulness or desire, but the ingestion of alcohol itself (Levine, 1978; White, 2014; Yates & Malloch, 2010). Rush had observed patients whom he believed sincerely did not wish to drink,

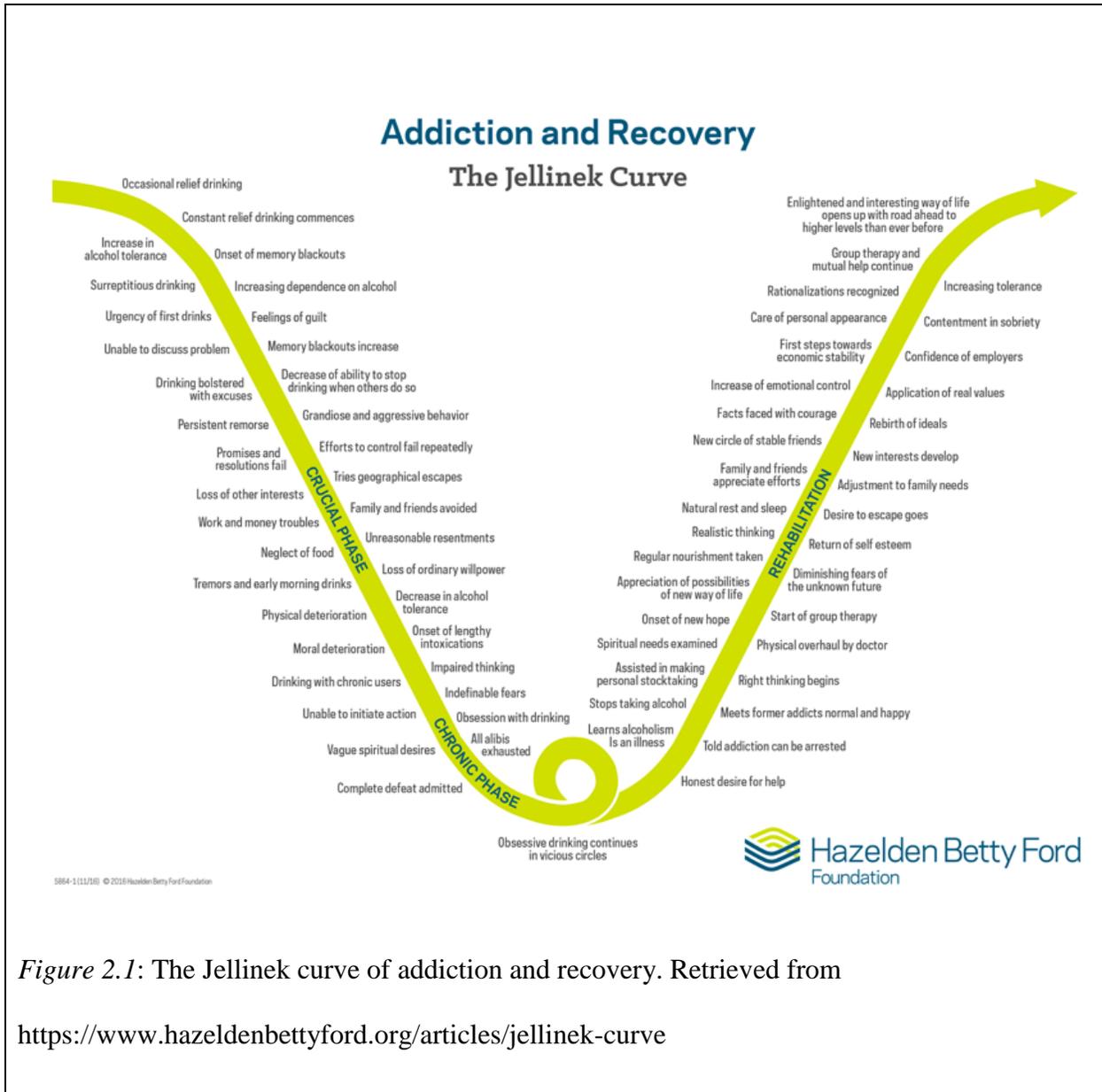
and were truly repentant for their drunkenness, but were compelled to do so against their wills because of the effect of alcohol on them. Thus, the solution to alcoholism was abstinence.

This view was revolutionary in the way that alcoholics were treated. They were no longer seen as sinners, but as victims who had suffered a poisoning, and required help to get better (Yates & Malloch, 2010). The reconceptualization and externalization of addiction alleviated at least some of the moral stigma experienced by alcoholics. It also served to expose the real challenges and tragic circumstances faced by alcoholics in trying to control their drinking.

Of course, not everyone who drinks (even heavily) becomes an alcoholic. While some in the growing temperance movement during the 1800s and the first third of the next century called for total abolition of alcohol from society, other branches were more concerned about those whose drinking was problematic (White, 2014). They had little concern about those who could moderate or *temper* their alcohol consumption. For this group, it became important to discover what separated “normal” drinkers from alcoholics (Babor, 1996).

One pattern that was evident was that drinking runs in families and seems to be passed down from generation to generation (Lieb, Merikangas, Hfler, Pfister, Isensee, et al., 2002). Towards the later part of the 1800s, there was a growing popular fascination with eugenics, and many began to speculate that what separated addicts from non-addicts was genetic (White, 2014). Some of the more extreme views of the temperance movement around the turn of the 20th century advocated that alcoholics be forbidden to procreate in order to breed alcoholism out of society (Philips, 2014). While a genetic predisposition for alcoholism remains part of the popular consciousness, modern geneticists have yet to discover a single ‘drinking gene’ (Rietschel & Treutlein, 2013). Nevertheless, twin studies suggest that susceptibility to alcoholism may be at least partly genetic (Anthenelli & Shukit, 1998). If alcoholism is hereditary, it offers only a

partial explanation. There are many cases of children of alcoholics who do not become alcoholics themselves, as well as children of non-alcoholics who develop alcohol use disorders.



Another biological-based model of addiction is the disease model. It is one of the most prevalent models today for understanding alcoholism. One of the early proponents of the disease model was E. Morton Jellinek, who headed an alcohol research center at Yale University (White, 2014). Jellinek’s studies attempted to classify alcoholics and systematically determine the course of their disease (Jellinek, 1960). The result of his work was the “Jellinek curve” (Figure

2.1)(Jellinek, 1960). The downslope of the curve shows alcoholism as a progressive disease starting with occasional social drinking and deteriorating into obsessive drinking with common milestones including feelings of guilt, isolation from friends and family, and financial troubles. The upslope of the curve describes rehabilitation in which the alcoholic quits drinking, and everything that was lost in their addiction is restored to them.

The disease model found favor with Alcoholics Anonymous, and has captured the public attention (AA, 2001; White, 2014). However, the model is not without detractors. The biggest objection to the model from the medical community is that it is metaphorical in nature and does not meet the literal medical criteria for a disease (Griffell & Hart, 2018; Holden, 2012). On the other hand, even as a metaphor, alcoholism is often compared to a chronic condition (McKay & Hiller-Sturmhoffel, 2011) such as diabetes, which is incurable, but nevertheless, manageable. Secondly, there is concern that the ‘disease’ concept ameliorates personal responsibility for the addiction and disempowers those attempting to manage it (Winslade & Smith, 1997). There is some evidence for this, as one study (Wiens & Walker, 2014) concluded that using the ‘chronic disease’ model to describe alcoholism reduced participants sense of agency over managing their drinking, and contrary to popular assumptions, did little to prevent the stigma and shame associated with the diagnosis. Nevertheless, while the disease model may be mostly metaphorical, it can be a *useful* metaphor for conceptualizing addiction if not applied too narrowly, literally, or rigidly.

In recent years, neuroscience has gained increasing attention in the psychology field. It has been able to describe substance addictions in terms of their stimulating or blocking production of certain neurotransmitters, thereby locating addiction specifically in the physical chemistry brain. Neuroscientific theories of equilibrium posit that the use of alcohol or drugs

creates a chemical imbalance, which the body attempts to compensate for (Longo, Volkow, Koob, & McLellan, 2016). For example, alcohol targets dopamine receptors, a neurochemical related to positive feelings of reward and accomplishment. This targeting leads to an over-production of dopamine, which is why moderate drinking is often experienced as pleasurable. However, when the brain senses that it is being flooded with dopamine, it naturally cuts back on natural production. When the artificial stimulation of dopamine is discontinued, the lack of dopamine results in feelings of being unmotivated and lethargic, characteristic of the hangover experience following a period of heavy drinking (Longo, Volkow, Koob, & McLellan, 2016). The more frequent heavy drinking binges are, the more the brain anticipates that its dopamine needs will be externally stimulated, and therefore, becomes trained to regularly produces less and less of the substance. Thus, continuous heavy drinking leads to a) a need to continue drinking in order to feel normal, and b) a need for greater amounts of alcohol over time to achieve the desired effect, which are symptomatic criteria for diagnosing an addiction (APA, 2013). Therefore, while a desire for the sensation of intoxication may prompt initial alcohol use, over time, the state of addiction creates a physiological dependence by physically altering neurological and biological systems. In severe cases, physical withdrawal from alcohol often requires medical supervision to prevent harm or death due to the resulting chemical imbalance created by depriving an alcoholically adjusted body from alcohol (Perkinson, 2004). Treatment options promoted by those who are situated in the biological models tend to focus on abstinence and pharmaceutical/medical interventions (DiClemente, 2003).

Biological models locate the cause of addiction within the body. As an alternative to Choice models, biological models may alleviate personal stigma and blame for alcoholism. However, as discussed in this section, critics state that biological models also tend to portray

alcoholism as fatalistic, and thereby disempower alcoholics from taking steps to address the disorder. Nevertheless, this section demonstrates that there has been a significant amount of evidence, particularly from neuroscientific sources, depicting the effects of alcohol on the body and brain. While neuroscientific models provide convincing evidence for the biological mechanics that produce and sustain addictions, they do little to describe the lived experience of addictions. Nor do they fully account for the diversity of experiences with alcohol and alcoholism.

Spiritual Models

Alcoholics commonly report that their motivation for drinking is to fill a “God-shaped hole” (Hagedorn & Hartwig Moorehead, 2010). Spiritual models often attribute alcoholism to a lack of purpose or meaning in one’s life or worldview (Carrol, 1993; Jacobson, Ritter, & Mueller, 1977; Waisberg & Porter, 1994) as well as numbing consciousness against existential anxieties and the fear of death (Johnson, Griffin-Shelley, & Sandler, 1977; Wisman, 2006).

From ancient times, alcohol has been associated with gods and used in religious rituals around the world (White, 2014; Philips, 2014). Excessive drinking and intoxication has also been linked to sinfulness (Philips, 2014; White, 2014; Yates & Malloch, 2010). However, Carl Jung was the first to formally conceptualize alcoholism as a ‘spiritual ailment’ in an existential sense (White, 2014). In 1932, Jung accepted an American patient named Rowland Hazard for treatment of his alcoholism (White, 2014). After a year of working with Hazard, Jung had been unable to resolve the issue using his (at the time) cutting-edge psychoanalytic methods. Finally, Jung declared that short of a spiritual awakening, Hazard was a hopeless case. Discouraged, Hazard returned to the US. Several months later, after joining the Oxford group, Hazard had the kind of spiritual experience that Jung had pessimistically prescribed and attributed that

experience to his subsequent recovery. Very quickly, the view of alcoholism as a spiritual ailment was integrated into the AA philosophy of recovery (AA, 2001).

According to a review of 265 books and articles on spirituality in addiction treatment, the concept of spirituality tends to be poorly defined across the field (Cook, 2004). However, thirteen common elements were found: 1) An emphasis on interpersonal relationships; 2) A belief in a transcendent dimension to life; 3) Humanity as distinctly privileged or special; 4) The existence of an intangible soul or inner core within people; 5) An emphasis on meaning and purpose in life; 6) Truth and authenticity; 7) An emphasis on values; 8) A rejection of materiality, or accumulating material possessions; 9) Distinguishing spirituality from religiosity; 10) Holistic wellness (including spiritual wellness); 11) An emphasis on knowledge of self and spirit; 12) Creativity; and 13) Consciousness and awareness (including spiritual awareness). Despite the many diverse understandings of spirituality in literature and in practice, these 13 elements provide a broad general delineation of the spiritual domain within recovery.

While the emphasis on spirituality and achieving a spiritual awakening in Alcoholics Anonymous (AA, 2001) has been a barrier for agnostics and atheists joining the organization, research has found that non-believers have similar levels of success as believers in their recovery (Tonigan, Miller, & Schermer, 2002). Though researchers have concluded that the spiritual (specifically religious) factor may not be as important to recovery as popularly assumed (Kelly, 2017), it should also be noted that the third step of the twelve-step program describes God “as we understood Him.” (AA, 2001). This provides broad leeway for interpreting “God” as a higher power (Kurtz & White, 2015), allowing for secular understandings to stand along more traditional religious beliefs (Kurtz, 2017). Furthermore, the big book notes that a spiritual awakening need not happen all of a sudden as it did for Bill Wilson (AA, 2001). For many

members, it is more of a gradual process requiring that spiritual prejudices be set aside, and individuals remain open and receptive to the possibility of spiritual experience in whatever form it takes. Nevertheless, Alcoholics Anonymous (2001) insists on the necessity of spiritual belief and makes clear that while the notion of “God” or “Higher Power” may be defined differently by each individual, there is no room for atheists in AA, and that recovery is impossible without a spiritual awakening.

On the other hand, concern has arisen about spiritual bypass in recovery, in which psychological, physical and emotional issues are ignored, while individuals over-focus on spirituality (Cashwell, Glossoff, & Hammond, 2010; Picciotto & Fox, 2018). It is vital for individuals in recovery to focus on holistic healing, incorporating all domains of wellness, and establishing balance (Cashwell, Bentley, & Yarborough, 2007; Myers & Sweeny, 2005). While attention to the spiritual domain of recovery may be an important factor in treatment, it cannot be the whole of treatment because this approach ignores other issues that need to be addressed in recovery.

Given the above discussion, it is necessary to distinguish spirituality from any particular religious movement (Gall, Malette, & Guirguis-Younger, 2011). While religions can provide a tool for discovering sense of purpose and meaning for individuals in recovery, it would be a mistake to equate atheism with nihilism. Secular versions of a higher power can include belief in Nature, Science, the Universe, Life, or Collective Humanity. Therefore, the emphasis in AA on spirituality need not be a barrier to atheists or agnostics in using a twelve-step model to obtain recovery.

Intrapersonal/Cognitive/Behavioral Models

Intrapersonal models of addiction focus on intangible psychological constructs such as emotion, personality, cognition, and motivation. Personality models are another persistent popular group of theories, lacking conclusive evidence to support them (DiClemente, 2003). Unlike, biological models, personality traits are abstract constructs which are difficult to empirically measure, and the existence of several different personality models such as the Meyers-Briggs Type Indicator and the Five Factor Model, suggest that there is not even a stable psychological definition of personality. While the idea of an “addictive personality” as explanation for addiction has been firmly rebutted (Amodeo, 2015; Berglund, Roman, Balldin, Berggren, Eriksson, et al., 2011), the notion of certain personality traits representing risk factors for developing addictions remains compelling. For example, someone who is high in the trait of ‘novelty-seeking’ may be more likely to try illicit drugs (Foulds, Boden, Newton-Howes, Mulder, & Horwood, 2017). However, the correlation between personality traits and development of substance use disorders is limited and less than explanatory, especially when motivation and drug use expectancies are not considered (Amodeo, 2015). Therefore, a fixed understanding and labeling of addictive personalities is suspect.

While one may be skeptical of addictive personality, there is evidence that addictions may arise through attempts at coping and self-medication (West & Brown, 2013). Self-medication and coping models treat addiction as a symptom of an underlying issue. The earliest conceptions of this kind of model date back to Freud who viewed addiction as the manifestation of a psychodynamic conflict rooted in childhood experiences, but not as a focus for clinical attention in itself (White, 2014). More modern perspectives view substance use as motivated by a desire to correct or cope with aversive mental or physiological states. For example, depression

and alcoholism are found in treatment to be frequent comorbid disorders (Fowler, Liskow, & Tanna, 1980; Sedlacek & Miller, 1982; Thase, Salloum, & Cornelius, 2001). One does not have to dive too deeply into the music of John Lee Hooker to find that drinking away the blues is often prescribed in pop-culture. On the other hand, depression may also be *caused* by alcoholism (Thase, Salloum & Cornelius, 2001), or related to the life events and challenges of recovery (Fowler, Liskow, & Tanna, 1980). Thase, Salloum, and Cornelius (2001) recommend treating the addiction first before working on depression issues. Meanwhile, other approaches have been integrated into addiction treatment such as Dialectical Behavior Therapy (DBT) (Dimef & Linehan, 2008) and mindfulness practices that teach tolerance and acceptance of negative emotional states (Slomski, 2014).

In addition to personality traits and emotions, intrapersonal models may also focus on thoughts and cognitions. Cognitive models focus primarily on identifying and correcting negative, harmful, or irrational thought patterns, particularly when these thoughts represent potential triggers for relapse (DiClemente, 2003). Furthermore, thought patterns may be indirectly related to relapse by supporting negative emotional states and disorders, such as depression, anxiety, or low self-esteem, which is then coped with by drinking. Treatment for detrimental thought patterns is commonly executed through Cognitive Behavioral Therapy (CBT). Cognitive Behavioral Therapy (CBT) has been demonstrated as effective in working with alcoholism and comorbid disorders such as depression (Brown, Evans, Miller, Burgess, Mueller, 1997; Hides, Carroll, Cattania, Cotton, Baker, et al., 2011).

Learning to identify and challenge automatic alcohol-related cognitions, also known as “stinking thinking” or “drunk voice,” is an important aspect of many treatment programs, that

focus on harmful self-talk. Harmful self-talk in recovery tends to be self-sabotaging, by reassuring the individual of their powerlessness over alcohol and undermining their self-efficacy. Brown, Evans, Miller, Burgess, and Mueller (1997) conducted a study on alcoholics with comorbid depression and discovered that feelings of worthlessness, self-pity, and depression are common in recovering addicts. Further, they found that a second way in which self-talk can impair recovery efforts is by rationalizing addictive behaviors as necessary, positive, or deserved. Due to the temptation to drink, Brown et. al (1997) rationalized that the alcoholic mind will attempt to justify and ‘trick’ the individual into a relapse. At times, the influence of the alcoholic voice is subtle, manipulating situations to create opportunities for drinking. At other times it takes the form of rationalizing powerful cravings. In treatment alcoholics learn to clearly hear and dispute these kinds of alcoholic self-talk messages and to construct positive messages in their place (Brown, Evans, Miller, Burgess, & Mueller, 1997). Thus, altering thinking patterns is critical in recovery, and CBT is helpful and demonstrated to be effective in facilitating cognitive reframing.

To engage in cognitive reframing, one must first examine the motivations of clients, including their expectancies for treatment from their own perspectives (Burrell & Jaffe 1999; West & Brown, 2013). DiClemente (2003), describes the trajectory of an alcoholic recognizing that their behavior is problematic, and then contemplating, planning, and acting to change it. Those who are pressured socially to enter treatment tend to be less engaged in the change process and less optimistic about its outcomes (Watzlawick, 1978; Wild, Cunningham, & Ryan, 2006). The Motivational Interviewing technique of Miller & Rollnick (2012) aims to develop intrinsic motivation for change within the client.

In addition to motivation, routine plays another strong role in maintaining addictions from a behavioral perspective. Behavioral conditioning is a concept that can be traced back to Skinner (Ruan & Wu, 2013). Skinner developed the notion of operant conditioning in which a particular reaction to a neutral stimulus was reinforced by rewards and punishments. The use of drugs and alcohol produce strong psychological, physiological, and sometimes social rewards, which reinforce and create patterns of use (Winger, Woods, Galuska, & Wade-Galuska, 2005). In fact, the expectancy of drug use can lead individuals to anticipate and mimic the effects of actual use, producing what is referred to as a placebo effect (Dolinska, Dolinska, & Bar-Tal, 2017). For example, in seeing the image of a bottle of liquor, alcoholics may anticipate the taste and feeling of drinking it to the point that they may exhibit symptoms of intoxication without actually drinking.

Alcoholics also consciously make a list of ‘triggers’ or cues associated with drinking so that they may avoid or manage them in a way that disrupts and extinguishes the learned patterns of behavior (Zironi, Burattini, Aicardi, Janak, 2006). For example, if an alcoholic associates cooking with drinking, they may avoid cooking at home, or consciously substitute a non-alcoholic beverage for the alcoholic one while cooking in order to disrupt or alter the previous pattern. Identifying triggers is an important part of preventing relapse and thus a part of treatment using behavioral conditioning.

Intrapersonal models of addiction are addressed by many of the approaches commonly used to treat addictions today, such as Motivational Interviewing (Miller & Rollnick, 2012), CBT (Brown, Evans, Miller, Burgess, & Mueller, 1997) and DBT (Dimef & Linehan, 2008). These therapeutic approaches actively engage with the individual psychological aspects of addiction by

shifting patterns of thinking and promoting strategies for coping with or managing cravings and/or negative emotions/cognitions and associated behaviors.

Social/ Environmental Models

In contrast to intrapersonal models, social and environmental models focus on the relationships, interactions, and influences between people and their environment. Picking up where the genetic model left off, there has been speculation that alcoholism was inherited environmentally rather than genetically (Enoch, 2006). A study found that children of alcoholics who witness drinking at home as being normalized, internalize alcohol-positive messages from parents, and have a tendency to grow up to be alcoholics themselves in later life (Belles, Budde, Moesgen, & Klein, 2011). However, alcohol-related messages from immediate family members are only a single environmental factor. While families may represent the most immediate environment in an individual's social-ecological sphere, they are not alone in their social influence (Bronfenbrenner, 1979). Social messages about alcohol are also provided by community and larger popular culture in the West (Primack, Nuzzo, Rice & Sargent, 2011). Alcohol has long been integrated with social customs including religious ceremonies, holidays, birthdays, marriages, funerals, watching sports, night life, and other general social gatherings (Philips, 2014). Moreover, researchers have found that childhood stressors including abuse and/or neglect, bullying and witnessing marital aggression seem to predict the development of alcoholism later in life (Enoch, 2006; Finger, Kachadourian, Molnar, Eiden, Edwards, et al., 2010; Kim, Catalano, Haggerty, & Abbott, 2011). Thus, it is necessary to focus on the social discourses and their developmental effects on children in relation to alcoholism later in life.

In addition to home life, peer pressure has also been found to encourage adolescents to drink and to promote positive attitudes and expectancies towards alcohol (Cumsille, Sayer, &

Graham, 2000). Furthermore, peer pressure may also actively discourage individuals from abstaining. Chauvin (2012) found that there was an expectation for binge drinking in college fraternities, and fraternity members believed that declining to drink would place their social status within the fraternity in jeopardy. Therefore, the effect of peer pressure on drinking can be either positive or negative, contingent on how people relate to their social and environmental contexts (Cleveland, Harris, Baker, Herbert, & Dean, 2007; Labrie, Hummer, & Pedersen, 2007). While some peer groups may place a high value on alcohol and drinking, others may discourage it or simply give drinking less priority than other activities.

In addition to peer pressure, the influence of larger cultural and environmental cultural contexts may also serve to support or discourage addictive behaviors. Lee Robins (1993) conducted studies with Vietnam veterans who had developed heroin habits while overseas. She discovered that many of the heroin addicted veterans were able to quit using with little intervention once they returned to the U.S. She posited that social norms, price, and the relative unavailability of heroin were factors in discontinuing the drug use. Primarily, she believed that it was the social context in the U.S. that discouraged their heroin use, compared to the cultural context in Vietnam during the war where social attitudes towards drug use were (unofficially, at least) more permissive. Therefore, many veterans were able to spontaneously recover from their addictions on returning to the U.S.

The argument for the influence of social and environmental contexts on substance use disorders has been supported by scholars who advocate that major life events and role changes may also provide an impetus for spontaneous recovery (Dawson, Grant, Stinson, & Chou, 2006). For example, parenthood – particularly motherhood – has been linked to a cessation of heavy or frequent drinking. (Matusiewicz, Ilgen, & Bonhert, 2016; Powers, Anderson, Byles, Mishra, &

Loxton, 2015). Therefore, it seems that social context and environment play a role in substance abuse by encouraging or discouraging addictive behaviors.

Where environmental models examine the relationship between an individual and the environment, systems theory looks at the interactions between a group of people belonging to a specific social context (Kim & Rose, 2014). Kim and Rose (2014) elaborate that systems theory looks at how elements within a system interrelate and affect each other. Systems are thought to resist change and seek homeostasis. Therefore, when one element unbalances the system, other elements may act either to influence the element to return to a balanced state, or else compensate for the disequilibrium by altering their own behavior. For example, a family system with an alcoholic mother may attempt to influence the mother to stop drinking and may compensate for the imbalance in the family system by hiding signs of the alcoholism from the public in order to maintain a façade of functionality as a family system.

Systems models provide a perspective on how families and communities can serve to sustain addiction, and may be resistant to recovery efforts, which may be viewed as positive for the individual but destabilizing to the system as a whole. In the early days of treatment, family was generally kept at a distance (White, 2014). However, more and more, addiction is becoming viewed as a family issue, requiring treatment for not only the addict themselves, but the family as a unit (Chan, 2003; Roozen, de Waart, & van der Kroft, 2010; Rowe, 2012).

As evidenced by the discussion above, individual interactions within a social system, group, or environment shape the way people think about substance use and addiction. These forms of perception also inform the kind of treatment that might be appropriate for people who are recovering from alcoholism. One could argue that CBT might be an appropriate treatment

here because it would allow the cognitive reframing of one's relationship with their social and environmental contexts and substance abuse, although this may not be the only treatment option.

Transtheoretical Model

The Transtheoretical Model (TTM) (DiClemente, 2003; Prochaska, DiClemente, & Norcross 1992), also known as the 'stages of change' model, has frequently been applied to conceptualizing addiction treatment. Unlike the other models presented in this section, the TTM does not describe the etiology or pathology of addiction (hence the name "transtheoretical"). It does, however, provide a useful conceptualization of how clients navigate the change process, as they transition from addiction to recovery. The model includes five stages: 1) Pre-contemplation in which the addict may recognize some problems with their behavior, but is not considering treatment; 2) Contemplation, in which the addict is seriously considering treatment, but has not committed to it; 3) Planning, in which the addict has committed to treatment, and is making preparations for the next stage; 4) Action, in which the addict is actively working on change in treatment; and 5) Maintenance, in which changes made in treatment are maintained and reinforced (DiClemente, 2003).

Moving through the stages may require applications of various therapeutic approaches at different times. Motivational Interviewing (Miller & Rollnick, 2012), may be helpful in earlier stages of the model, while more action-oriented therapies (e.g. CBT, Solution-Focused) may be appropriate for the middle stages. According to the TTM, treatment for addictions usually ends at the transition from the action stage into maintenance (Lawson, Lambert, & Gressard, 2011). At this stage, clients develop strategies for relapse prevention and may transition from inpatient to outpatient treatment, with sessions gradually tapering off as clients become self-reliant in sustaining their sobriety.

Though treatment ends, recovery does not (DiClemente, 2003). Most modern conceptualizations of addiction view it as a chronic and incurable condition (Rasmussen, 2000). A passage in *Alcoholics Anonymous* describes a case of an addict who abstained from drinking for decades, only to spark a full-blown relapse from a single tentative drink (AA, 2001). For recovering addicts, the maintenance stage is life-long, requiring constant vigilance. Surprisingly, though maintenance forms the vast majority of the addict's experience of recovery, little addictions research has focused on the fifth stage. Lawson, Lambert, and Gressard (2011) call for a greater focus on developing long term strategies for maintaining behavioral changes made during treatment. In other words, they acknowledge the importance of going beyond abstinence-oriented behavioral changes and working to achieve lifestyle and worldview-oriented changes.

Early versions of the TTM (Prochaska, DiClemente, & Norcross, 1992) included a sixth stage: Termination. In this stage, the client had successfully implemented changes, and no longer had to work at maintaining them. However, Prochaska et. al determined that this final stage did not reflect the chronic nature of addiction, and future versions of the model omitted it (DiClemente, 2003).

While acknowledging that addictions are not curable in a traditional sense, it may nevertheless be worthwhile to revisit this sixth stage. Dennis, Foss, and Scott (2007) conducted a study in which they followed 1162 people for eight years to examine the relationship between the duration of abstinence and rates of relapse. They found that rates of relapse decline dramatically over five years following treatment, from 64% in the first year to 14% after five years of sobriety. Given that these findings demonstrate that more people relapse within short-term recovery, it is reasonable to assume that long-term recovery represents a different and more

stable stage of recovery. Therefore, recovering alcoholics in this long-term recovery stage would have different needs and concerns than those in the maintenance stage of change.

DiClemente (2003) warns that the transition is not necessarily linear as the model may make it appear and that clients regularly return to previous stages. For example, a client who has arrived at the action stage, may discover that the actions they had planned are ineffective or unsustainable and drop back to the planning or even contemplation stages. It is not uncommon for individuals to make several attempts at changing before finding a strategy that works for them. It is therefore important for therapists working with these clients to not become discouraged by failed attempts to change, but to remain encouraging, supportive, and non-judgmental.

Conclusion

None of the above models provides an adequately full explanation for the development, path, or remission of alcoholism, but each can be seen as contributing unique pieces to a comprehensive understanding of a multifaceted concept and experience (DiClemente, 2003; Kalant, 2010). It is likely that many different factors influence the development and course of alcoholism and that each may produce moderating effects on the others within a complex system. Therefore, clinicians advocate for a biopsychosocial approach to treatment that combines elements of several models (Walde, Urgenson, Weltz, & Hannah, 2002; Wallace, 1989). However, the exact nature of their interactions is not completely understood and may vary from individual to individual (DiClemente, 2003). Furthermore, effective approaches to treatment must take client and clinician variables into account.

While the plethora of models may provide frustration for clinicians seeking the *right* approach to conceptualizing and treating addictions, a broad understanding of the multiple ways

that addiction can be understood may allow for a pragmatic integration and combination to meet individual client needs, with a recognition that SUDs may be as varied as the individuals who experience them. This idea will be expanded on in the section below describing the theoretical frameworks that guide this study.

Theoretical Frameworks

Three theoretical frameworks inform this study (Figure 2.2: Theoretical Frameworks). The macro-level theory provides a broad, ontological, epistemological level of understanding. This level of theory is informed by two specific concepts from Deleuze and Guattari's (1987) work: *The Machinic Assemblage* and *The Body Without Organs*. Given that this is a macro-level theory, it informs how people understand their own lives through the process of meaning making. Specifically, these works highlight how meaning and reality are not fixed concepts. However, problems arise when individuals become stuck in rigid, fixed, and singular ways of being and knowing (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990).

The purpose of using Deleuze and Guattari's (1987) work in this study is not to privilege a particular way of knowing in relation to the recovery process nor to determine which treatment approach or intervention is superior to another in achieving recovery. Instead, the writings of Deleuze and Guattari (1987) allow for a fluid understanding of how individuals and couples negotiate their experiences of addiction, treatment, and recovery by exploring the possibilities of meaning making and growth. Specifically, using a Deleuzian framework allows for an expanded view of how addiction and recovery can be understood within the field of Counseling. Details about the application this framework to addictions counseling are explained in a section later in this chapter.

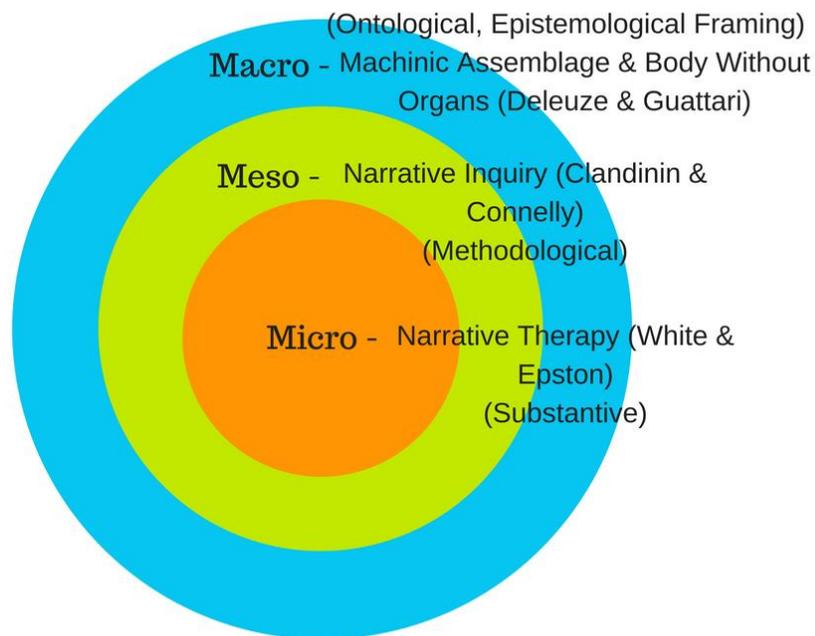


Figure 2.2: Theoretical Frameworks

At the meso-level, this study employs narrative inquiry (Clandinin & Connelly, 2000; Kim, 2016; Riessman, 2008). Like several other frameworks in qualitative research (such as phenomenology, feminism), narrative Inquiry functions as both a theoretical and a methodological framework. It allows for tracing changes in perspectives, behavior, attitudes, of individuals, as well as shifting interpersonal relationships and dynamics with family and community over time and context. Doing so provides a deep and detailed understanding of the experiences of couples in recovery in a storied format. This framework is explained in greater detail in a section later in this chapter.

The micro-level substantive theory that informs this study is narrative therapy (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990), which is the therapeutic application of narrative theory. Narrative therapists enter into a collaborative relationship with

clients (Anderson & Goolishian, 1992), often playing the role of a benign editor (Parry & Doan, 1994) while respecting the authority (in all senses of the word) of the client over the (re)construction, or (re)storying of the narratives of their own experience. Narrative therapists assist clients in examining and interrogating their stories. Together, they explore the sources, allusions, metaphors, genres, and so forth employed in their construction, and investigate how those aspects serve to maintain or limit problem-saturated narratives (White & Epston, 1990). Narrative therapists suggest possibilities or narrative experiments for reframing and re-storying clients' narratives that are preferable to the problem-saturated narratives that clients initially present and more aligned with their lived experiences. In this way, clients become unstuck from fixed and singular ways of knowing. They are able to expand their perspectives, becoming flexible and adaptable in their means of meaning making. As the substantive framework for this study, a narrative therapeutic lens is used to conceptualize the narrative transition of a couple from active addiction to alcohol to long-term recovery.

While these three frameworks are presented separately for descriptive purposes, within the study there is considerable overlap, intersection, and entanglement of the tenets from each. In the following sections, the structure of each framework is described, offering common examples to make it accessible, and discussing its applicability to the current study.

Machinic Assemblage and Body Without Organs

Deleuze and Guattari (1987) use the metaphors of the *machinic assemblage* and *body without organs* to describe the nature of ideas or concepts and how they operate. These metaphors provide an ontological and epistemological perspective for the present study. The notions of machinic assemblage and body without organs are relevant to thinking about how narratives function within a social constructionist paradigm. In particular, these ideas are applied

in the present study to conceptualizing the narrative transitions involved in journeying from active addiction to alcohol to long-term sobriety. Furthermore, they inform how one can engage in the narrative inquiry process, as well as collaborating in a narrative therapeutic relationship. In this section I discuss these ideas in further details.

For Deleuze and Guattari (1987), a machine is an *assemblage* of components. Put simply, a machine has many parts that come together in a certain way to achieve a certain objective. Therefore, machines are goal-oriented. The components of the machine work together systemically- acting on or being acted on - to produce a certain effect or outcome. For example, a car is a kind of machine built from many different components that work together to move passengers and/or cargo from one location to another.

Since a machine is a collection of components, it can also be taken apart or *deconstructed* (Figure 2.3). Keep in mind that there are machines inside of machines. For instance, a car machine contains an engine machine which itself includes piston machines, and so on. Furthermore, a car could be considered a machinic component which in combination with roads, creates a larger machine (or system) of traffic-ways that mesh across the country. Since machines are goal-oriented, a machine can be evaluated on its ability to produce a desired effect. If we take the goal of traffic-ways as moving people around from place to place, a car functions very well as a component within the machine to produce that effect. A road without cars is generally less effective in meeting transportation goals. Similarly, the majority of cars do not function well as devices of transportation without roads. However, each may serve some other goal. A car without a road may still form adequate shelter from the elements, and a road without cars can still produce an effective break in a forest fire.

In taking apart the components of a machine, one can replace, reorganize, or modify the components, reassembling and reconnecting them in new ways to create a new machine to meet new objectives. For example, a car may be designed to move from point A to B as quickly as possible, or it may be configured to maximize the comfort of its passengers, or to be able to transport heavy cargo, or even to go off-road. Each of these objectives will require a slightly different assemblage of the car machine. If one is a skilled and resourceful mechanic with access to the required components, one might be able to modify any given car to meet any of these specific objectives. Thus, the car is not a fixed and singular machine, but can be altered and fluid in its essence.



Figure 2.3: Deconstructed race car by artist Paul Veroude on display at Mercedes-Benz World Museum in Surrey, UK, demonstrating the concept of “Machinic Assemblage.” Image retrieved from <https://wordlesstech.com/mercedes-benz-f1-display/>

Narratives are another sort of machine – one whose function is to produce meanings (Holstein & Gubrium, 1999a). The machinic components of narratives include personal lived experiences in combination with social discourses (Holstein & Gubrium, 1999a, White & Epston, 1990). For example, a person’s narrative of alcohol exists at the intersection of their personal experiences with alcohol and the messages that others (on a personal or abstract level) convey to them about alcohol. Just as cars as a systemic collection of components, can be evaluated within the larger context of traffic-ways, the meanings produced by narratives can be evaluated within a larger context of a person’s life-goals (e.g. to be happy, good, satisfied, etc.). Thus, one might question whether a particular narrative is effectively contributing to the creation of a *good life*, however that might be defined by the individual.

The metaphor of the machinic assemblage (Deleuze & Guattari, 1987) opens possibilities for re-storying that allow individuals to become unstuck from singular and fixed ways of knowing, being, and constructing meaning. The machinic assemblage involves the combination of a machine and an objective. However, a basic ontological assumption of social constructivists is that change is constant, and therefore in order to be successful, a narrative machine must be responsive to the changing and fluid goals and demands of the present context. In other words, machinic assemblages require periodic updating or else they become obsolete.

From a narrative perspective, we can view an alcoholic as having constructed a narrative machine from various social discourses and lived experiences to meet the goal of drinking. Typically, these kinds of machinic assemblages are highly effective at achieving their objectives. However, they are fixed and singular in their purpose - to consume alcohol - but are too specialized to meet other objectives, such as taking care of personal or family responsibilities. Furthermore, the narrative machine that consumes alcohol typically produces toxic byproducts

that are harmful to the individual and their social environment, similar to the way that cars produce exhaust and pollute the environment. When an addict enters treatment, the way that the drinking narrative machine is configured is no longer applicable to the goal of recovery. Therefore, this machine (the narrative identity of an addict) needs to be reconfigured. The component parts need to be pulled apart, examined for their usefulness, updated if necessary, and realigned to new objectives congruent with recovery. In other words, in treatment alcoholics are involved in upgrading the machinic assemblage of the narrative self.

Within a narrative therapeutic relationship, alcoholics can examine how personal narratives are constructed, and how they function to maintain the addiction. They are able to confront the detrimental parts of their identity, such as feelings of hopelessness or purposelessness, which keep them locked in a singular or fixed truth. However, As Parry & Doan (1994) note:

The importance of the re-vision phase of the therapy cannot be over-emphasized.

It is one thing to be a catalyst in the deconstruction of clients' or families' mythology; it is another to provide them with the opportunity to revise their stories in such a way that these will be more in line with what they want. To omit the re-vision process is to leave the clients in a state of 'psychological free fall.'

Alternately stated, it is to leave them outside of a story (p. 45).

Leaving a machine in pieces is leaving it broken. Therefore, therapists must work collaboratively with alcoholic clients to rebuild or re-story personal narratives that are preferred, nearer to their lived experience, and better able to achieve and sustain the goals of recovery. In the language of Deleuze & Guattari (1987) this narrative restructuring process is referred to as "deterritorialization" and "reterritorialization." In other words, it is a process of deconstructing

familiar ways of knowing in order to reorganize cognitive structures and produce new ways of knowing.

Related to machinic assemblage is the metaphor of the *body without organs* (BwO) (Deleuze & Guattari, 1987). The body without organs is imagined as a loose, shifting, and expanding *exteriority* or perimeter containing no fixed internal structure. The body without organs is not empty, but it has no anchoring essential center to organize its content. “The BwO is opposed not to the organs but to the organization of the organs called the organism” (Deleuze & Guattari, 1987, p. 158). The center of the BwO is fluid, defined by the constantly changing boundaries of the body. Deleuze and Guattari use this metaphor to describe the postmodern nature of an idea or concept as something which is organic and desires to grow and evolve and become something other than what it is; to become an *other*.

To provide an example, consider the 1980s B-grade horror film, *The Blob* (Harris, Kastner, & Russel, 1988, Figure 2.4). In the movie, a meteorite crashes in rural America containing maybe an ounce of the unknown substance from which the movie takes its title. The audience quickly discovers that this amorphous blob is alive and omnivorous, as it begins to consume everything that comes into contact with its expanding periphery. It engulfs other entities into itself – animals, people, objects - growing at a horrific pace. While the blob originated from the meteorite, it contains no fixed center. Its body continues to expand in multiple directions, as it overruns a nearby town in its desire to grow and become other. Those whom it consumes appear to float somewhat freely around in changing relationships with each other as they are incorporated into this monstrous body without organs.

For Deleuze and Guattari (1987), ideas desire to grow and evolve organically, and are hungry for what they lack - specifically other ideas or ‘bodies,’ which they can be ‘plugged into’

to form a machinic assemblage (Deleuze & Guattari, 1987). In the preceding paragraph the body without organs concept consumed and incorporated the movie, *The Blob* (or conversely, the horror film has consumed and incorporated Deleuze and Guattari’s work), which is now floating freely within the bounded idea of the BwO in relation to every other thought contained within the BwO concept. Thus, the BwO idea as a whole grows, evolves, and becomes an *other*.

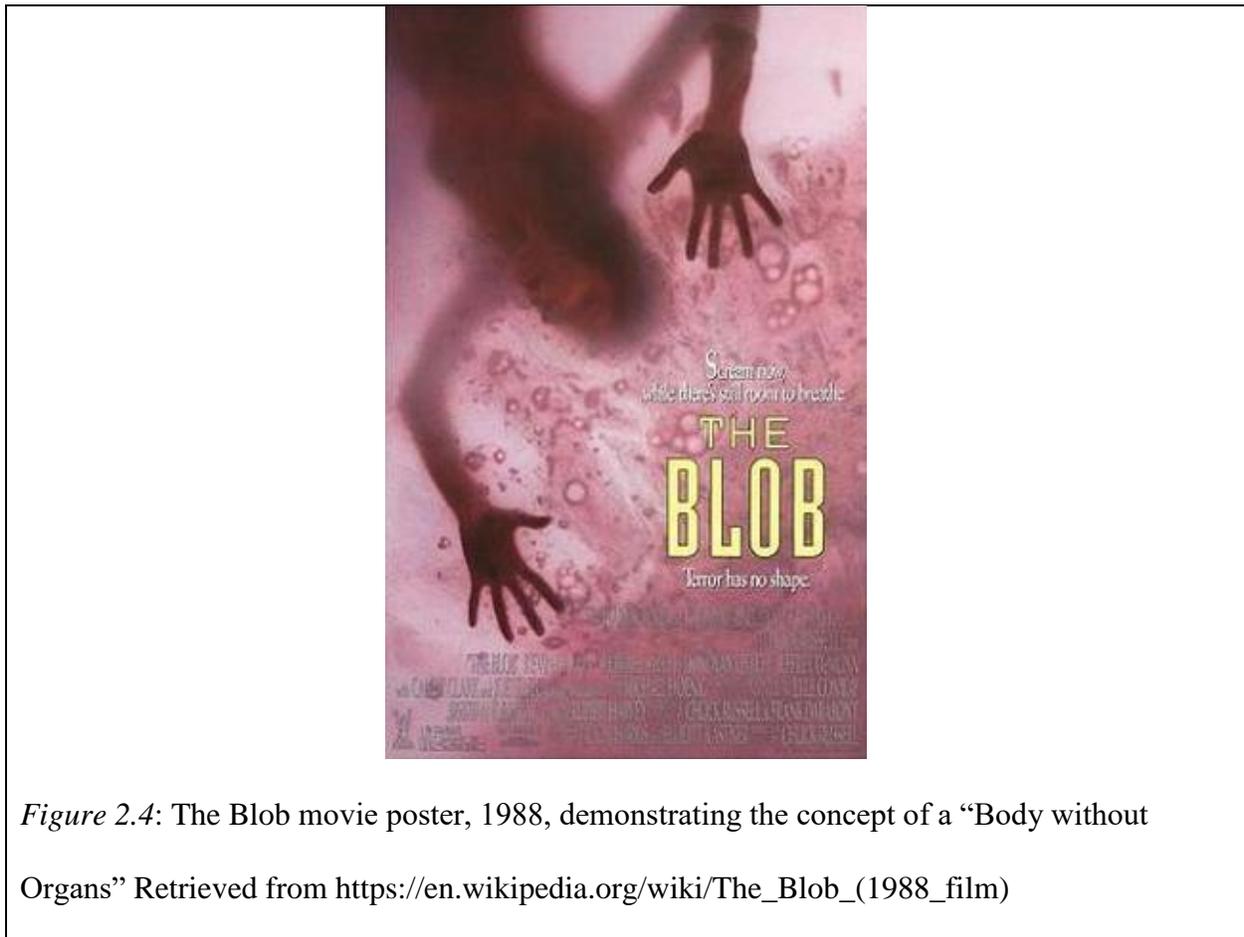


Figure 2.4: The Blob movie poster, 1988, demonstrating the concept of a “Body without Organs” Retrieved from [https://en.wikipedia.org/wiki/The_Blob_\(1988_film\)](https://en.wikipedia.org/wiki/The_Blob_(1988_film))

It is possible to extend the body without organs metaphor to the lives of individuals. Biologically speaking, a human body grows and consumes and becomes an *other*. There are distinct qualitative differences in a body between infancy, adolescence, adulthood, and old-age, and micro-differences within bodies on a day to day level (e.g. the growing of hair, skin, nails, changes in stomach content, bone density, blood sugar levels, etc.). At the same time, people

consume and incorporate various personal life-experiences and social discourses, which are unified within the narrative of the *self* (Bluck and Alea, 2008; Brochner, 1997); an expanding and evolving body without organs.

The narrative self, like any story, requires change and motion across time to produce a relation of states, in other words to become an *other*, which is different from the previous state. For example, a hero who sits at home, and continues to sit at home, and does nothing other than sit at home is not much of a hero in not much of a story. To become a narrative, the hero must become other than the hero who sits at home. He must leave his seat, leave his home, slay a dragon, rescue captives, and so forth. He must change states, and *live*. As bodies without organs, narratives grow and develop in ways that are often unpredictable – they desire to *live*.

In the discussion of bodies without organs and narratives of addiction, it is necessary here to distinguish substance use from addiction. One might use hallucinogens or cannabis or alcohol or other substances to alter their consciousness or ‘expand their mind.’ While these experiences may not be considered ‘healthy’ from a clinical perspective, or even pleasurable (such as with the case of a ‘bad trip’ or a hangover), the novelty of these experiences do serve to grow and develop the narrative self (Oksanen, 2013). However, alcoholism and addiction produce the opposite of development. Addiction does not desire growth or to become an *other*. Addiction only desires itself, producing habit, routine, and repetition (Malins, 2004; Oksanen, 2013). As demonstrated in the (un)heroic narrative above, there is no story in stasis. The body’s organs become fixed and its potential becomes reduced to a singularity – the addicted body.

Deleuze and Guattari (1987) refer to forces which act on the Body without Organs to organize and affix it as “The judgment of God.” They write:

The BwO is that glacial reality where the alluvions, sedimentations, coagulations, foldings, and recoilings that compose an organism – and also a signification and a subject – occur. For the judgment of God weighs upon and is exercised against the BwO; it is the BwO that undergoes it. It is in the BwO that the organs enter into the relations of composition called the organs. The BwO howls: “They’ve made me an organism! They’ve wrongfully folded me. They’ve stolen my body!” The judgment of God uproots it from its immanence and make it an organism, a signification, a subject. (p. 159)

An essential understanding of a narrative freezes the organs of a BwO in particular relationships to each other, transforming it into an organism. The narrative becomes stabilized and routine, to the point of rigidity. For example, an individual whose narrative self is defined as an alcoholic limits the potential for becoming an *other* to the extent that this *other* may contradict the alcoholic self-narrative. Treatment and recovery, then, are processes by which routines are broken and possibilities for movement, growth, and living are expanded. To do so requires a metaphorical evisceration of the addicted body in order to keep the organs in play. Deleuze and Guattari (1987) write:

You invent self-destructions that have nothing to do with the death drive.

Dismantling the organism has never meant killing yourself, but rather opening the body to connections that presuppose an entire assemblage, circuits, conjunctions, levels and thresholds, passages and distributions of intensity, and territories and deterritorializations. (p. 160)

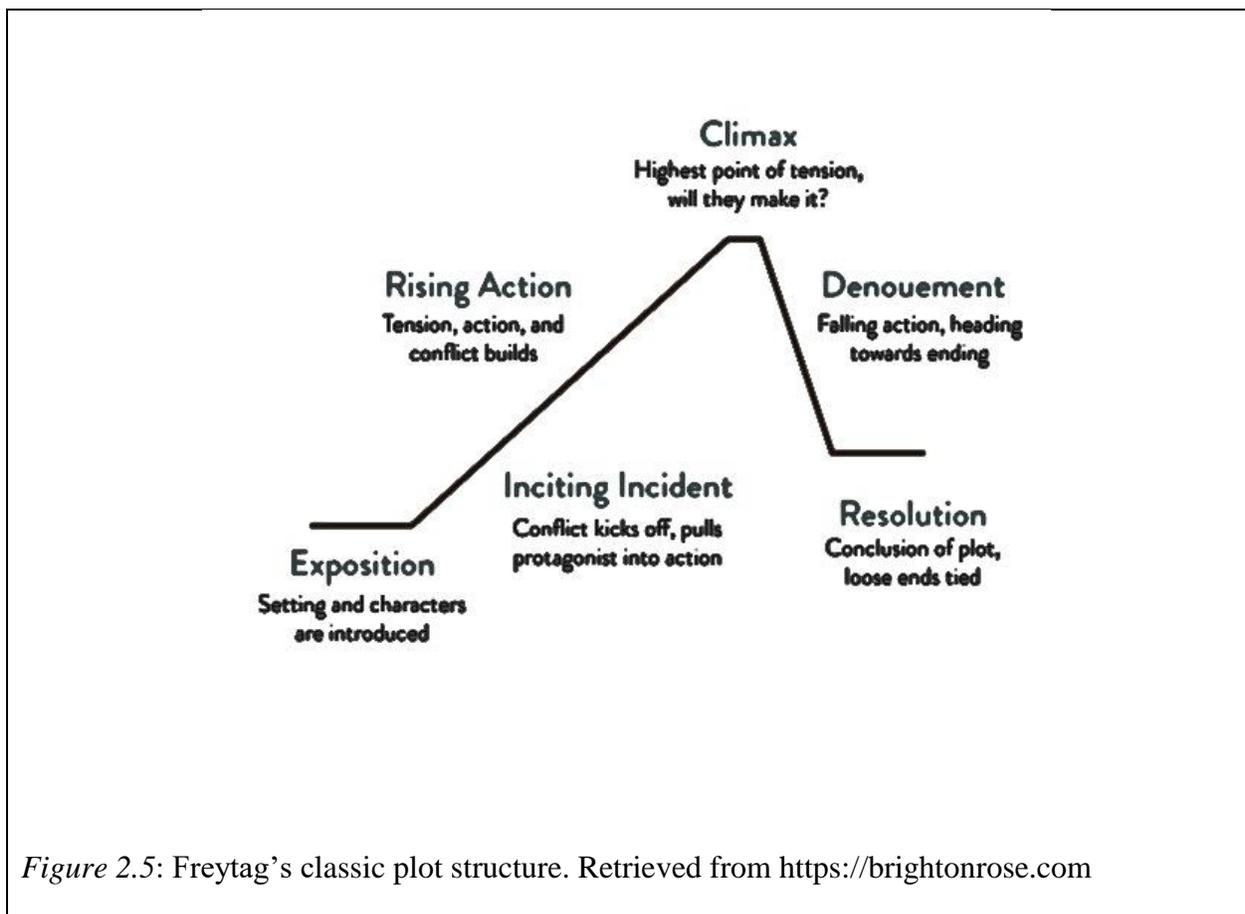
Applying Deleuze and Guattari’s above reflection to alcoholism, treatment, and recovery, one could argue that treatment is a process which allows the body to become unfixed as an organism

and regain the fluidity of its organs. In other words, treatment breaks routines and old ways of being for an addict, allowing the possibility of connecting to new recovery narratives and becoming an *other*, something different from before. It should be noted that new recovery narratives are also fluid, always transitioning into new ways of being and becoming. Therefore, the individual in recovery may never be fully complacent in any fixed identity as ‘recovered.’ To sustain the recovery narrative, it must remain flexible in order to adjust to the constant change that accompanies growth and development over time (i.e. in recovery, never fully recovered or cured).

Narrative Inquiry

Narrative inquiry (Clandinin & Connelly, 2000; Kim, 2016; Riessman, 2008) provides the meso-level methodological framework in this study for theorizing a couple’s transition from active alcoholism to long-term sobriety. Narrative inquiry is informed by, and cannot be completely divorced from, various theories about narratives and literature under the broad umbrella of social constructionism (Kim, 2016). A pattern found within narrative theories is that people experience their lives as *storied*, and they live through the stories they tell about themselves and the world (Holstein & Gubrium, 1999a; White & Epston, 1990). A story is a way of organizing and establishing meaningful connections between what would otherwise be experienced as random, disjointed, and unrelated episodes, events, or perceptions. As a way of knowing and communicating information, stories predate the invention of mathematics. For example, ancient cave paintings depict storied knowledge of places to forage for food or dangers to be avoided. Computer coding manuals tell different stories about the operation of modern technology (Kottler, 2015). Thus, constructing stories is an ancient human practice that has taken various forms throughout history and encompasses much of human thought.

Narrative theories, broadly speaking, do not focus on understanding a phenomenon excerpted from the context and social milieu in which it is lived and experienced (Kim, 2016). This kind of extraction deletes narrative context, which is critical for the construction of narrative meaning. Unlike phenomenologists, narrative inquirers are less concerned with what constitutes a particular phenomenon than they are with how the phenomenon is narratively experienced by participants (Clandinin & Connelly, 2000). Therefore, narrative theories focus on the entire storied construction of experience rather than abbreviated and extracted parts of the experience.



This study leans on the classic narrative plot structure (Figure 2.5) developed by Freytag in the mid-1800s (Freytag, 1894/2007; Kim, 2016) in order to explore the ways in which people in recovery from alcoholism story their lived experiences. The classic plot structure has six

components that help trace the storied form of a lived experience. The first stage of the classic plot structure is the *Exposition* or *Introduction*. In this initial stage, a status quo is established detailing what is normal in the lives of the characters. For example, in the life of an alcoholic, the status quo may be drinking heavily every day, without realizing the harm he might be causing to himself and his family. Once a state of normalcy is established, there comes a point of *Conflict* or an *Inciting Incident*, which serves to disrupt the status quo. For example, the alcoholic gets arrested for driving under the influence of alcohol. The conflict leads to the next stage of the plot, the *Rising Action*. During this stage, there is increasing tension and escalating complications. For example, once an alcoholic gets arrested for driving under the influence, their car maybe impounded, they may experience trouble at work, and conflict at home. Typically, the protagonists are challenged and tortured by various circumstances that prevent them from returning to the status quo or achieving goals.

The rising action culminates in the *Climax*, representing a breaking point of maximum tension. In the climax, the protagonist typically faces their greatest challenge and experiences a catharsis or revelation that reverses their fortunes. For example, in the alcoholic plot developed so far in this section, the wife of the alcoholic gives him an ultimatum to either get treatment or get a divorce. Due to the severity of the ultimatum, and perhaps some soul-searching, the alcoholic admits that he has a problem with alcohol.

Falling action or *Dénouement* follows the climax. The protagonist begins to use his new knowledge/ abilities/ perspective/ good fortune (etc.) to undo the complications encountered during the rising action stage. As events de-escalate the narrative tension is reduced from the height of the climax. For example, the alcoholic enters treatment and sincerely works towards sobriety. The final stage of the plot structure is *Resolution*, where a new status-quo is established

as a result of the changes made during the *Falling Action* stage. For example, the addict returns home sober and works on recovery, which becomes the new normal or the new status-quo. While the classic plot structure with defined points and stages describes a majority of stories, modern works often challenge or subvert this structure in a number of ways. Thus, the classic plot structure is not universal or absolute.

Combining the macro level theoretical influences of the machinic assemblage and body without organs with the narrative inquiry framework, it must be noted that narratives are not understood as fixed, essentialized, or singular stories that can be objectively verifiable or replicated. Instead these stories exist in their location, situatedness, multiplicity, and fluidity. Like a body without organs, narratives are capable of organic growth. Any point in the narrative plot structure can represent a new introduction or status quo state, creating multiple narrative tentacles or *lines of flight* in the language of Deleuze and Guattari (1987). These multiple lines of flight produce an overall narrative structure that is more of a fractal than a line. This is an important point to consider when working with recovering alcoholics. A multitude of narrative possibilities exist to get them unstuck from the routine ways of knowing and behaving, and each narrative thread may intersect with others to produce a narrative fabric constituting a life-story.

In this chapter, narrative inquiry is explained in relation to the substantive matter of alcoholism, treatment, and recovery. However, narrative inquiry is also the methodological framework of this study. Therefore, its specific methodological influence is delineated further in chapter three.

Narrative Therapy

Narrative therapy is the application of narrative theory to counseling (Combs & Freedman, 1990; White & Epston, 1990). While, there are several techniques associated with

narrative therapy, such as externalization, and finding exceptions (White, 2007), narrative therapists resist being reduced to a collection of manualized interventions (Wallis, Burns, & Capdevila, 2011). Instead, interventions are often produced spontaneously in session as experiments in re-storying, invoking a kind of linguistic playfulness in the sense of Jacques Derrida (1967/1998) and Roland Barthes (1977/1998). Tentativeness is a central characteristic of the narrative therapist (Freedman & Combs, 1996; White & Epston 1990). Revisions to stories are suggested as possibilities, rather than prescribed as remedies. In that sense, the narrative therapist is often in the role of a benign and collaborative editor (Parry & Doan, 1994), respecting the authority of the client in developing their own narratives. Narrative therapists often take an attitude of “not knowing” towards clients’ stories, allowing them to describe and tell stories on their own terms, rather than assuming and imposing their clinical or ‘expert’ knowledge on client narratives (Anderson & Goolishian, 1992; White & Epston, 1990). This respect for the expertise of clients on their own experiences makes narrative therapy an inherently multicultural approach (Semmler & Williams, 2000).

Narrative therapy involves more than simply allowing clients to tell stories. The narrative therapist listens for and investigates the ways that stories are constructed, and the way they function socially to produce meanings (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990). When stories don’t function to support the lived experiences of clients, they can be interrogated, deconstructed, and revised to create preferred narratives that are nearer to the subjective realities of clients (Freedman & Combs, 1996; Parry & Doan, 1994). At the heart of narrative therapy is a sense of playfulness and creativity as narrative possibilities are developed and explored.

Because narrative therapy is more of a philosophical orientation than a systematic set of techniques and prescriptions (Wallis, Burns, & Capdevila, 2011), it can be difficult to conduct rigorous randomized controlled trial studies to evaluate its effectiveness (O'Connor, Meakes, Pickering, & Schuman, 1997). Consequently, few reliable randomized controlled trial (RCT) studies exist to support it. Of those that were available, narrative therapy has been found to be comparable to Cognitive Behavioral Therapy in its effectiveness at reducing symptoms of depression (Goncalves, Ribeiro, Silva, Mendes, and Sousa, 2016; Lopes, Goncalves, Fassnacht, Machado, & Sousa, 2014; Seo, Kang, Lee, & Chae, 2015).

Rather than RCTs, evidence to support the efficacy of narrative therapy tends to take the form of qualitative case studies which abound in narrative therapy texts (e.g. Freedman & Combs, 1996; White, 2007; White & Epston, 1990). Narrative therapy has been effectively used to treat a number of issues including PTSD (Erbes, Stillman, Wieling, Bera, & Leskela, 2014), ADHD (Looyen, Kamali, & Shafieian, 2012; Robinson, Jacobsen, & Foster, 2015; White, 2007), video game addiction (Graham Jr., 2014), eating disorders, (Scott, Hanstock, & Patterson-Kane, 2013), and nighttime bed-soiling (White & Epston, 1990).

Of particular relevance for the present study are studies examining narrative approaches to addiction treatment. A narrative group for alcoholics focused on writing autobiographies (Szabo, Toth, & Pakai, 2014). Autobiographies were shared in the group, and authors were given feedback and suggestions for revision with special attention to the language used in describing their lives. Language of agency was encouraged instead of passive language (e.g. "I decided" in place of "I had to"). Authors were also asked to avoid using negative and totalizing descriptions of themselves and to increase the frequency of positive and social words and phrases. Where appropriate the word "and" was replaced with "so," creating a greater sense of causality,

continuity, and ‘plot.’ After revising and re-sharing autobiographies, the researchers found significant decreases in hopelessness and increased problem-solving abilities.

Another study investigated a narrative group conducted with older adults in Canada who were in recovery from alcohol (Gardner & Poole, 2009). The group members were also instructed to write guided biographies and share them in the group. The participants experienced the group as positive and motivating. In particular, they noted that examining their lives from a storied perspective allowed them to externalize problems and reimagine their relationship to their addictions, alleviating feelings of personal guilt, and promoting hopefulness and self-efficacy. The idea that multiple stories were available to tell and that they were agentic in deciding which to give voice to was experienced by participants as both liberating, and empowering.

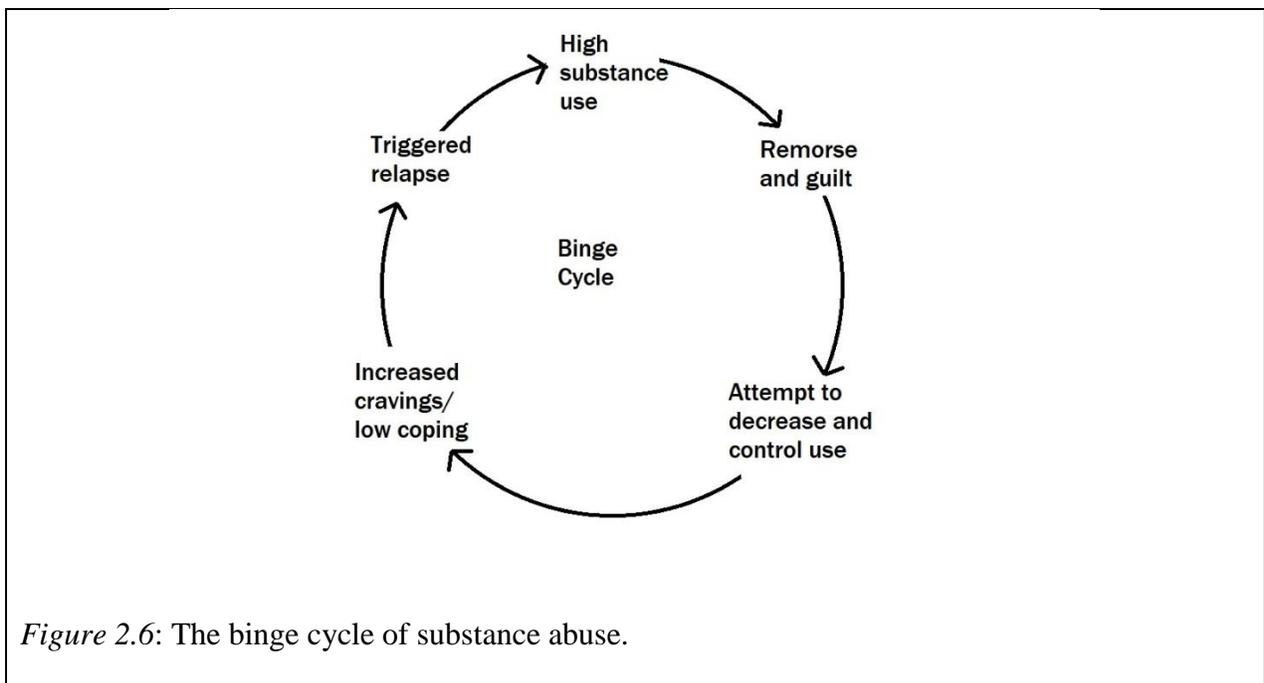
The purpose of the present study is not to demonstrate the efficacy or superiority of narrative therapy in relation to other approaches. To do so, would itself be antithetical to the fundamental assumptions and values that guide narrative therapy (Wallis, Burns, & Capdevila, 2011). Instead, this study aims to use the narrative lens to examine the change process for a couple transitioning from alcoholism to long-term sobriety. Implications of the findings for narrative therapists will be discussed in the fifth chapter of this dissertation.

Alcohol and Family

The impact of alcoholism is not limited to the alcoholic themselves, but can affect the entire family system (Barnard, 2007). In families that struggle with addiction, the issues surrounding substance use are often centered, thereby focusing attention on the individual who is using. Meanwhile, while other family members frequently suffer, they do so at the margins as the addict and their addiction occupy the spotlight (Barnard, 2007; Scherer, Worthington Jr., Hook, Campana, West, et al., 2012). The centering of addiction can be difficult for all family members,

including the addict. While the needs of some family members may be ignored, the alcoholic member of the family may feel that an unfair or unwarranted amount of attention is being placed on them as if they are under constant surveillance from the family and have restricted independence (Barnard, 2007). The focus on the alcoholic and their behavior may also distract from other important priorities in the household, such as paying bills or taking care of children. As basic responsibilities are put aside, they pile up, adding to the overall stress of the family (Orford, 2012).

While simply attending to the alcoholic family member may draw on family resources (both physical and emotional), trust issues can also add strain on families of alcoholics. Trust within alcoholic families tends to be minimal with all members on guard at all times (Barnard, 2007; Scherer, Worthington Jr., Hook, Campana, West, et al., 2012). Often, alcoholics fall into a cycle of remorse and relapse (Figure 2.6) (Scott, Foss, & Dennis, 2005). This pattern quickly erodes the family's faith in the alcoholic's apologies and promises. At the same time, it also produces increased guilt and hopelessness in the alcoholic.



While trust in the alcoholic is repeatedly tested and broken, family members will often be in disagreement with each other about how best to manage the alcoholic member (Barnard, 2007). Some members may take more of a care-taker role towards the alcoholic, while other members may wish to entirely cut contact with the alcoholic. As different family members work at different ends and consequently undermine each other's efforts to produce stability within the family system, issue of conflict and mistrust may also develop between non-alcoholic family members.

In addition to family stress, one of the biggest concerns typical in families with alcoholic members is not the drinking itself, but the transgressive behaviors that accompany the drinking. At the forefront of these concerns is the threat of physical violence. Children of alcoholic parents may be between two and thirteen times more likely to be victims of abuse compared to children of non-alcoholic parents (Christoffersen & Soothill, 2003). Children who have been abused are at increased risk for developing an alcohol use disorder later in life (Lown, Nayak, Korcha, & Greenfield, 2011).

In addition to child abuse, intimate partner violence (IPV) is also a concern among alcoholic couples. According to one study (Friend, Langhinrichsen-Rohling, & Eichold, 2011), over two thirds (67.4%) of domestic violence cases involved alcohol. While the association between IPV and AUD is established (Chartier & Caetano, 2012; Wu, El-Bassel, McVinney, Hess, Fopeano, et al., 2015), studies also indicate IPV as a predictor of drinking problems as a means of coping (Overup, Dibello, Brunson, Acitelli, Neighbors, 2015; Weinsheimer, Schermer, Malcoe, Balduf, & Bloomfield, 2005).

It is not true that every alcoholic becomes violent, however, alcoholism increases the risk of violence, particularly among men who suppress negative emotions (Norstrom & Pape, 2010).

Overall, women appear to be less prone towards violence, and in cases of female IPV, that violence is often protective or retaliatory against an aggressive male in order to protect themselves or their children (Johnson, 2010). However, alcohol has been found to influence the severity of violence in cases of female to male IPV (McKinney, Caetano, Rodriguez, & Okoro, 2010). Therefore, when working with alcoholic families, it's critical to assess for the presence of IPV.

Apart from aggression and IPV, alcoholism has also been associated with criminality in the US (Popovici, Homer, Fang, & French, 2011). The association between alcohol and crime puts children at higher risk for witnessing or becoming involved in crimes. It also creates uncertainty as to whether the alcoholic individual will end up in prison, placing additional stress on the family (Barnard, 2007). Furthermore, in communities, a 20% increase in the density of alcoholic outlets in a neighborhood is related to increased crime rates by 3.9% for rape, 4.1% for robbery, and 4.3% for assault (Toomey, Erickson, Carlin, Lenk, Quick, et al., 2012). However, it is difficult to determine the causal direction of this correlation.

While the link between violent and criminal behavior and alcoholism has been supported in research, physical harm to families may also be due to irresponsible behaviors even if those behaviors are not intentionally malicious (Orford, 2012). For example, alcoholics may drive while intoxicated putting themselves, passengers in the vehicle, and others on the road in jeopardy. According to the website of the National Highway Traffic Safety Administration (NHTSA, 2017), there were 10,496 alcohol-related fatalities (including 214 children under 14) on American roads in 2016 or roughly one person every 50 minutes. While it is unlikely that impaired drivers intend to cause harm, their actions can lead to injury and/or death for themselves, and others.

Neglect of responsibilities creates yet another potential for harm in alcoholic families (Barnard, 2007; Orford, 2012). Children of alcoholic parents are more than three times likely than children of non-alcoholic parents to not be properly fed, clothed, or supervised (Dunn, Tarter, Mezzich, Vanyukov, Kirischi, et al., 2002). Money may be diverted from providing necessities for the family in order to support the alcoholic member's drinking, and financial problems may be further exacerbated if the alcoholic member is unable to gain or hold employment (Barnard, 2007; Orford, 2012). Unemployment is also linked to higher levels of problematic drinking (Backhans, Lundin, & Hemmingson, 2012; Popovici & French, 2013), creating a potential cycle of reinforcement. Furthermore, bills may go unpaid leading to the disconnection of services, such as phone or electricity, and the neglect of household chores may lead to unsanitary living conditions (Barnard, 2007; Kroll, & Taylor, 2003; Orford, 2012). These forms of negligence add to the problems experienced by families of alcoholics.

Neglect may also be of an emotional nature (Barnard, 2007). Attachment issues in children of alcoholics are not uncommon and can impair adult relationships (Kearns-Bodkin & Leonard, 2008; Kelly, Nair, Rawlings, Cash, Steer, et al., 2005). Alcohol dulls individual's abilities to properly recognize emotion in faces, voices, and music (Korneich, Brevers, Canivet, Ermer, Naranjo, et al., 2012), which can contribute to emotional incongruence between husbands and wives and even greater conflicts. Furthermore, marital satisfaction and self-esteem tends to decline for both members in couples with an alcoholic husband (Dethier, Counerotte, & Blairy, 2011). Women married to alcoholic men are at an elevated risk for depression compared to other women (Homish, Leonard, & Kearns-Bodkin, 2006). Homish, Leonard, and Kearns-Bodkin, (2006) note that depression seems to be correlated specifically to the existence of alcohol-related marital issues, but not the frequency or intensity of drinking. The worst period of dissatisfaction

appears to occur just prior to an episode of binge drinking, rather than after (Dunn, Seilhamer, Jacob, & Whalen, 1992), suggesting that marital dissatisfaction may be a trigger for drinking. According to a study on drinking motivation, marital conflict produces depression or negative affect, which prompts the alcoholic to cope with their emotions by drinking, which provokes even more alcohol-related couple problems (Lambe, Mackinnon, & Stewart, 2015). It is possible that couples may learn the relational patterns that lead to heavier drinking and provoke episodes of conflict as a way of defusing marital tension (Scherer, Worthington Jr., Hook, Campana, West, et al., 2012).

As marital tension rises and marital satisfaction declines, alcoholism can prompt infidelity in both members of a couple (Baucom, Snyder, & Coop Gordon, 2009). Alcohol can serve to lower inhibitions in the drinking member increasing their susceptibility to an affair (Hall, Fals-Stewart, & Fincham, 2008). Furthermore, with a high level of conflict and low marital satisfaction within the partnership for both partners, members of the couple may seek emotional/romantic support or surrogates outside of their primary relationship to compensate for what is lacking in the marriage. Affairs may also be undertaken as a means of getting revenge for other perceived transgressions or to end the relationship altogether (Baucom, Snyder, & Coop Gordon, 2009).

Marriages tend to dissolve when there is a large discrepancy in drinking patterns between partners. However, when partners are matched in their drinking (either high or low), their marriages seem to be more stable (Osterman, Sloan, & Taylor, 2005). In other words, if two partners are heavy drinkers, they typically have less conflict within the relationship than when partners are mismatched in their drinking habits. Nevertheless, the presence of alcoholism in one

or both partners in a marriage places it at greater risk for dissolution (Waldron, Heath, Lynskey, Bucholz, & Madden, et al., 2011) than non-alcoholic couples.

Given the above discussion, it seems evident that alcoholism affects more than the individual alcoholic. The cited research literature demonstrates that one member's drinking produces stress on the entire family. Family symptoms of addiction may include violence, conflict, mistrust, impaired communication, enabling behaviors, emotional repression, infidelity, isolation, and unpredictability (Barnard, 2007; Krajicek-Bartek, Lindeman, & Hokanson-Hawks, 1999; Orford, 2012). These issues contribute to overall stress and are detrimental to family functioning and dynamics.

Wegscheider-Cruse (1989) developed a classification of roles in an alcoholic family in order to describe the family dynamics in these families: The enabler, the hero, the scapegoat, the mascot, and the lost child. Though alcoholic families are considered dysfunctional, these roles allow the family to adapt to and cope with the alcoholism. The enabler is characterized as a caretaker for the alcoholic family member, attempting to shelter them from the consequences of their drinking and to maintain an outward appearance of family functionality. The hero compensates for a dysfunctional home-life by seeking success outside the home such as in athletics or a profession. They are driven by a need for approval – particularly from the family – rather than an internal desire for achievement, and they can sometimes come to harm by pushing themselves too hard or taking on too much. The scapegoat often acts out, getting themselves into trouble, such as fighting, using drugs, getting into legal trouble, and so on. It is believed that their behavior is an attempt to gain attention from the family who are otherwise focused on the alcoholic. The mascot is often sensitive to emotions and conflicts within the family, and therefore, has become an expert at defusing tension, usually by joking around or being friendly.

The mascot is typically well-liked, but socially anxious and avoidant of confrontations. The lost child tends to be quiet and fade into the background. They learn to be self-sufficient from an early age. They may escape into fantasy or spend most of their time away from home. Each of these roles are seen as adaptive and compensatory for the instability within an alcoholic family.

Vernig (2011) offers a critique of these classifications, especially when he states that the popularity of these classifications is not grounded in generalizable empirical studies.

Furthermore, Logue, Sher, & Frensch (1992) caution that the classifications lack specificity, creating a possible “Barnum effect.” In other words, the roles may be so general and common, that individuals may easily identify with several of the roles, even if they do not come from alcoholic families. Vernig (2011) also warns that the use of these classifications in recovery communities is misguided due to the lack of empirical evidence.

In addition to common family roles, families may also develop overt or covert rules and behaviors to allow them to continue to function. These may include keeping up appearances in public, keeping secrets, taboo subjects (such as never openly talking about the drinking), patterns of interpersonal interactions, restrictions on emotional expression, and so forth (Barnard, 2007; Fichter, Glynn, Weyerer, Liberman, & Frick, 1997). While these rules bring a sense of stability to the family, they often center the alcoholic and enable them to continue drinking. Thus, alcoholism becomes the central organizing feature of alcoholic families.

Family Treatment for Alcoholism

White (2014) offers an extensive history of alcoholism and treatment in the US. He states that in the early years of rehabilitation from alcoholism, family members were considered bad influences on clients and disruptive to treatment goals. Therefore, alcoholics were often treated in relative seclusion, and family members were discouraged from participating or even visiting

until the alcoholic was ‘cured.’ However, families often provide the immediate social environment for alcoholics (Bronfenbrenner, 1979) and are therefore highly influential on their sustained recovery. Frequently changes that have been undergone in treatment to support sobriety are undone by family members who have not changed.

The importance of addressing family issues in treatment is becoming more and more evident, and families are becoming more involved in the recovery process (O’Farrell & Clements, 2012). Behavioral Couples Therapy (BCT) has shown promising results in relation to treatment for alcoholism for both men and women (O’Farrell & Schein, 2011; O’Farrell, Schreiner, Schum, & Murphy, 2016; Winters, Fals-Stewart, O’Farrell, Birchler, & Kelley, 2002). Behavioral Couples Therapy focuses on creating support for abstinence within the couple as well as improving communication patterns and engaging in positive activities together in order to repair and strengthen the relationship. Engaging the support of the spouse/partner in recovery increases chances of sustained abstinence (O’Farrell & Schein, 2011). Behavioral Couples Therapy was also found to significantly decrease the prevalence of IPV following treatment, although it was unclear to what extent this decrease was a direct effect of the therapeutic approach and to what extent it was due to decline in drinking behavior (O’Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004). Nevertheless, a high level of caution should be used when deciding to treat couples for IPV issues because discussion of those issues in therapy could potentially lead to further violence at home (Stith, McCollum, & Rosen, 2011).

In addition to reducing instances of IPV among alcoholic couples, BCT can also be used to address family patterns of interaction, such as inappropriately expressed anger, which may potentially derail recovery. Anger and resentment are common among family members of the alcoholic but have often been suppressed as the family attempted to manage and accommodate

the alcoholism (Fichter, Glynn, Weyerer, Liberman, & Frick, 1997). It is common for anger and resentment to surface as alcoholics become sober (Haverford & Thiess, 2014). Therapists working with families can guide emotional expression, as well as work with family members on responsibility-taking and forgiveness (Krentzman, Webb, Jester, & Harris, 2018; Webb & Toussaint, 2018). Therefore, not only is the involvement of family in treatment for alcoholism beneficial to the individual with the alcohol use disorder, but it is also helpful in healing the family.

Family treatment options provide support for the recovery process and address underlying family dynamics that may sustain the addiction or derail recovery efforts (O'Farrell & Clements, 2012). Family treatment also allows family members to gain insight into the recovery process, rather than be left in the dark. Finally, family therapy facilitates emotional expression between family members in a managed environment. While SAMHSA's (2014) survey of treatment facilities indicates that most facilities offer family treatment services, these appear to be under-utilized by clients.

Recovery from Alcoholism

While literature examining the risk and resilience factors for addiction, the etiology and pathology of addiction and modes of treatment and outcomes, are prevalent (Perkinson, 2004; Rowe, 2012; Scott, Foss, & Dennis, 2005), little attention has been given to recovery over the long-term. In other words, while research on this topic could potentially inform the study in the most relevant manner, the available literature is scarce. Therefore, the information presented in this section is indicative of the deficit in the literature on sustained recovery.

As established earlier, long-term recovery is more stable than short-term recovery. Recall Dennis, Foss, and Scott (2007) determined that within the first year of recovery individuals had

an 64% chance of relapse. However, after five years, the risk for relapse decreased to 16%, and then appeared to stabilize after that. This finding suggests that recovery continues to be an ongoing developmental process after treatment is completed and that long-term recovery constitutes a different stage from early recovery.

Szabo and Gerevich (2013) conducted an analysis of autobiographical writings, comparing a group who had relapsed twice within a year and a group with two years of sobriety. In the analysis, they found that individuals with two years of recovery tended to use more social words (i.e., words that describe social connections), than those who had relapsed. This finding suggests that those in recovery value social connections and bonds. It is possible that establishing supportive relationships helps to produce stability in recovery. Thus, being engaged in a community of recovering alcoholics, such as AA, can provide support for maintaining sobriety not only for the short-term as individuals work through the 12-steps, but also over the long-term (Cleveland, Harris, Baker, Herbert, & Dean, 2007).

Related to social connectedness, members of AA also seem to develop spiritual practices, which provide them with a sense of purpose and life-satisfaction (Spalding & Metz, 1997). In particular, the practice and attitude of gratitude is highly valued within the AA community (AA, 2001). This practice of gratitude may contribute to an overall sense of well-being by orienting the individual to the present moment, focusing on what they have, rather than what they have lost or do not have (Webb & Toussaint, 2018).

If little has been written on individuals in long-term recovery, less has been written on the experiences of families with a member in recovery. The lack of literature may perhaps be due to the prevalence of divorce among addicted couples (Waldron, Heath, Lynskey, Bucholz, Madden, et al., 2011). One study from 1985 was located describing a reduction in marital conflict between

wives and husbands in long-term recovery (Roberts, Floyd, O'Farrell, & Cutter, 1985). This study found that husbands spent more time actively talking to their wives, and wives interrogated their husbands less and were more trusting in comparison with newly sober couples. These findings suggest that long-term recovery may lead to improved communication within couples or perhaps that couples with stronger communication are more likely to succeed in recovery.

Another study, conducted by Callan and Jackson (1986) found that children of recovered alcoholics scored similarly to a control group on self-esteem, family satisfaction, and locus of control assessments, and higher than those with actively drinking parents. These findings optimistically indicate that the longer the alcoholics stay sober, the more stable couple and family relationships become, in turn, facilitating positive child development. Thus, while alcoholism may be incurable, it may be possible to repair the damage caused to families by AUDs.

As mentioned above, the relative scarcity of research on families in recovery may be attributable to high rates of divorce related to alcoholism (Waldron, Heath, Lynskey, Bucholz, Madden, et al., 2011). Couples who remain intact to the point at which the individual with the AUD seeks treatment are often strained to the breaking point in adjusting to the lifestyle transition to sobriety (Smith, Homish, Leonard, & Cornelius, 2012). While the prevalence of divorce may leave only a small percentage of couples and families that have survived recovery, they are nevertheless an under-researched population. Humphreys, Moos, and Cohen (1997) support the need for more research on families and couples in long-term recovery when they state:

Given that alcoholism is a chronic, context-dependent disorder, it is not surprising that short-term interventions have little long-term impact. Social and community

resources that are readily available for long periods are more likely to have a lasting influence on the course of alcoholism. (p. 231)

Partners and family members of recovering alcoholics are likely to be able to provide the kinds of social resources recovering alcoholics need to stay sober, so long as their relationships are repaired and remain intact.

Synthesis of the Literature

Indicated by the evolving history of alcohol and alcoholism in the US, as well as the discussion of the multiple ways in which alcoholism has been conceptualized both popularly and professionally, it is apparent that alcoholism as a concept is at least partially a social construct, with its meaning dependent on personal experience intersected with social, political, historical, and cultural contexts. The contemporary models for understanding addiction, many of which overlapped in some places and contradicted each other in others, revealed that there is no unified and comprehensive understanding of AUDs, but a complex web of factors with differing saliences for different individuals. Thus, an effective treatment would require the integration of multiple perspectives and a flexible responsiveness to the needs of the individual. Furthermore, while the alcoholic is often at the center of alcohol (and treatment) narratives, the effects of alcohol extend beyond the individual, systemically impacting the families (and often communities) that surround them. Family members often re-story their ideas of family around the alcoholism in order to achieve a sense of stability, even if it is an overall dysfunctional and unsustainable stability that produces a large amount of stress on individual members and the system as a whole.

Where possible, empirical studies were offered as support, leading to the discussion of alcohol and family and recovery. The bulk of research on alcoholics and their families seems to

be problem-focused, with little written on those who have succeeded in establishing long-term recovery with families intact. Yet, what little is written suggests that there is value in exploring families in long-term recovery. These families have the most stable record of surviving alcoholism, creating healthy family relationships, and facilitating positive child development. Researching these couples and families may potentially allow for the discovery of processes of healing that could provide lessons for other families facing similar challenges and circumstances.

Deleuze and Guattari's (1987) metaphors of the Machinic Assemblage and Body without Organs can be applied to describe the changing and growing narratives around alcohol, as couples and families transition from active addiction to recovery, and will be useful in guiding the study.

Chapter Summary

In this chapter I described the history of alcohol, and including its often troubled, exploitive, and evolving role in the development of American society. I also traced the growth of the temperance movement in the US from the early 1800s to prohibition and the influence of the movement on treatment and recovery organizations such as Alcoholics Anonymous. I then described a variety of models used to understand alcoholism, including alcoholism as choice, biological models, spiritual models, cognitive/intrapersonal models, behavioral models, social/environmental models, and the transtheoretical model for change. I noted that addiction is a complex phenomenon not adequately explained by a single model but requiring a holistic treatment approach that incorporates and integrates several models to fully address it. Next, I discussed the macro-, meso-, and micro-level theoretical frameworks that guide this study. At the broadest level, I have used the philosophical work of Deleuze and Guattari (1987) as an ontological and epistemological lens for understanding the fluid and evolving nature of

narratives. Narrative inquiry provided a methodological framework for examining the structure of participants' narratives and understanding how they function and evolve both relationally within the couple and intrapersonally in the transition from active alcoholism to sobriety. Finally, narrative therapy provides a substantive framework for understanding and conceptualizing the dynamics within the couple as they engage in the change process. A brief overview of issues common to families of alcoholics was provided to explain some of the challenges families may face in addition to dealing with the addiction itself. These issues often place a large amount of strain on relationships and can have lasting effects, particularly on children, that impact future relationships. Nevertheless, treating family concerns, and especially adjustment from addiction to recovery appears to be an under-researched area. I concluded the chapter by stating my intention to fill the gap in the literature with the present study exploring how a couple has successfully transitioned from active alcoholism to long-term recovery.

In the following chapter, I will outline the methodology used to answer these questions, including a discussion of the methodological frameworks employed in designing the study, the process of selecting participants, collecting, analyzing and representing the data, and considerations for the ethics and rigor of the study.

Chapter 3 - Methodology

Introduction

The purpose of this methodology chapter is to outline the methodological decisions and processes that shaped the findings of the research. By transparently guiding readers through the methodological moves made in the research, readers will be informed and equipped to make knowledgeable evaluations of the credibility and transferability of the research findings.

Qualitative Research and its Role in this Study

Research is composed of four elements: methods, methodology, theoretical perspective and epistemology (Crotty, 1998). Traditional research has operated from a positivist epistemology, in which the aim of research is to discover objective and observable truths about the universe that are patterned and predictable, allowing for the generalizability of findings across broad populations. In other words, the findings of traditional research aim to be true for most of the people most of the time. Qualitative research arose as a criticism of the limitations of positivism. It was situated within the context of subjective human experience in which meaning was constructively produced rather than objectively discovered (Bhattacharya, 2017; Creswell, 2013). Strauss and Corbin (1998) define qualitative research in relation to quantitative research as any methodology which relies on linguistic interpretive practices rather than statistical analysis to derive meaning from data.

Qualitative research has long been the focus of questions of legitimacy within the broad paradigm of the social sciences (Denzin, 2009). The neoliberal push for standardization and “evidence-based practices” systematically marginalized the perspectives, voices, and experiences of those who failed to conform to generalizable means. However, qualitative research examines and should be evaluated within the complex historical, contextual, and political milieu in which

it is conducted/ consumed. In other words, the broad and rich focus of qualitative research methods may provide insights and produce forms of knowledge that quantitative research with its narrow employment of the scientific method may not be capable of (Denzin, 2009). Thus, while quantitative methods are well established and provide generalizable findings, qualitative methods also occupy a legitimate place within the production of research knowledge. Qualitative research methods are employed in describing and understanding the intangible subjective human experiences within the broad social, historical, and political contexts which influence and are influenced by them.

Qualitative Research in Counseling

While qualitative research has gained prominence in some areas of social science research, its acceptance within counseling literature is still limited (Morrow, 2007). Ray, Hull, Thacker, Pace, Swan, et al. (2011) found that only 5% of articles published in a 10-year review of 15 ACA-affiliated journals used qualitative methods, compared to 26% of articles using either quantitative or mixed-methods approaches. Nevertheless, qualitative researchers point to an alignment between the qualitative focus on human experiences and the basic nature of the counseling process (Merchant & Dupuy, 1996; Morrow, 2007). Thus, there is a call for further diversification of research methods and greater representation of qualitative research in counseling journals.

In addition to the general lack of representation of qualitative methods in counseling research, Hays, Wood, Dahl, and Kirk-Jenkins (2016), also draw attention to a poor understanding of methodological rigor in qualitative counseling research as a cause for concern. The deficit in rigor may be related to the underexposure of counseling researchers to qualitative methods and methodological research. Denzin (2009) argues that while qualitative research has

managed to gain legitimacy in social science research, the current (and contested) neoliberal push for ‘evidence-based practices’ has often relegated qualitative research to the position of a ‘second tier’ methodology behind traditional quantitative research. Therefore, there is a demand, not only for qualitative research in general, but *rigorous* qualitative research to inform future qualitative counseling researchers. The issue is not of the inferiority of qualitative to quantitative methods, but the relative difference in the quality of their particular applications to counseling research. Drawing from qualitative research methodology as a field (e.g. Bhattacharya, 2017; Creswell, 2013; Denzin, 2009; Strauss & Corbin, 1998, etc.), some authors have attempted to delineate criteria for publishing rigorous qualitative research in counseling journals (Hays & Wood, 2011; Hunt, 2011; Morrow, 2005).

Arts-Based and Humanities-Oriented Research

As this study aims to deeply explore and represent the richness of the lived experiences of the participants, it is guided by a humanities-oriented, arts-based approach to research (AERA, 2009).

Throughout its history, the central purpose of humanities-oriented research has been the exploration and understanding of forms of human existence. In pursuit of this general purpose, humanities-oriented research undertakes investigations into the relationships among reason and emotion, the ethical life, the good life, the just society, the characteristics of the good citizen, and concepts of self, knowledge and its grounds, and the arts and their appreciation. (p. 482)

Examining the development of family narratives of recovery and sobriety falls under an investigation into concepts of self, knowledge, and its grounds. Qualitative research with its focus on subjective experiences, as noted above, is particularly suited for conducting humanities-oriented research.

Furthermore, this study takes an arts-based research (ABR) approach to conducting qualitative research. One of the goals of ABR is to disrupt taken-for-granted ideas by opening new

perspectives that may otherwise be unavailable to audience members. By presenting new perspectives on a given issue, ABR may encourage an audience to take some form of action, such as shifting attitudes or empathies, prompting discussion and reflection, or engaging in specific behaviors (Barone & Eisner, 2012). Therefore, in addition to educating an audience about socially significant issues, ABR also provokes an emotional engagement, allowing audience members to vicariously experience the lives of participants (Leavy, 2015).

It is necessary that an ABR project be incisive and insightful rather than superficial, getting to the heart of the subject (Barone & Eisner, 2012). This requires an in-depth understanding of participants' experiences on the part of the researcher in order to accurately represent them for audience members. Furthermore, a successful ABR study should be concise and coherent. Aesthetic elements with an ABR product must work together harmoniously so that audience members are not distracted or bored by too many superfluous details that detract from the overall effect produced by the piece (Barone & Eisner, 2012). As Saldana (2011, p. 69) notes, "Theatre is life - with all the boring parts taken out." Producing ABR requires the selectivity and arrangement of the details of participants' accounts to create a work that is vivid, sharp, and incisive. The process of creating ABR often involves highlighting or foregrounding and amplifying certain details in order to make them accessible to and resonate with audiences, while other details may be muted or edited out to produce a work that is both rich and dynamically engaging to audiences (Barone & Eisner, 2012; Saldana, 2011). By doing so, the work may vividly bring to life the perspectives of participants that are otherwise marginalized, allowing audience members to gain an empathic understanding of what it's like to walk in the shoes of the participants.

Application to the study

This qualitative inquiry is intended to develop co-constructed in-depth insights between the participants and the researcher (Denzin & Lincoln, 2008; Saldana, 2015). The purpose of this

study is to explore and describe the narrative change process in a couple with a member recovering from alcoholism. It seeks to address the following research questions:

- How do participants describe their experience of recovery from alcoholism as individuals and as a couple?
- What do the participants attribute as key influencers to their successful transition to long-term recovery and their sustained relationship as a couple?
- How do individual and couple narratives develop and function within the change process from alcoholism to long-term recovery?

Answering these questions requires a qualitative research methodology focused on the in-depth examination and representation of the subjective lived experience of participants (Merriam, 1995).

Conclusion

Arts-based approaches to qualitative research aim to engage audiences on both informative and empathetic levels by providing a rich and vivid view into the lived experiences of participants. The purpose of ABR is not necessarily to provide distinct solutions to problems, but instead to prompt awareness, discussion, reflection, and possibly action in audience members. This study seeks to explore and represent the experiences of a couple transitioning from a life of active alcoholism to long-term recovery as a way of producing empathy and insight into the lives of the participants. At the same time, this study also serves as an instrumental case study (Flyvbjerg, 2006; Stake, 1995) for examining the ways in which narratives operate in the change process.

Frameworks & Approaches

This study employs several embedded methodological frameworks and approaches to guide the research (Figure 3.1). The overall theoretical framework for the study is narrative theory, informed by the work of Deleuze & Guattari (1987). The theoretical framework, described in detail in chapter two provides an onto-epistemological lens for the research. The application of narrative theory to research produced the methodological framework, narrative inquiry, guided in particular by Clandinin & Connelly (2000), Kim (2016), & Riessman (2008). Narrative theory also informs the substantive framework, narrative therapy, which is the application of narrative theory to the counseling process. In turn, the tenets of narrative therapy influenced the design of the research (case study), the analysis process (narrative analysis), and data representation (ethnodrama). These methodological and substantive frameworks and approaches and their applications to the research will be described in greater detail below.

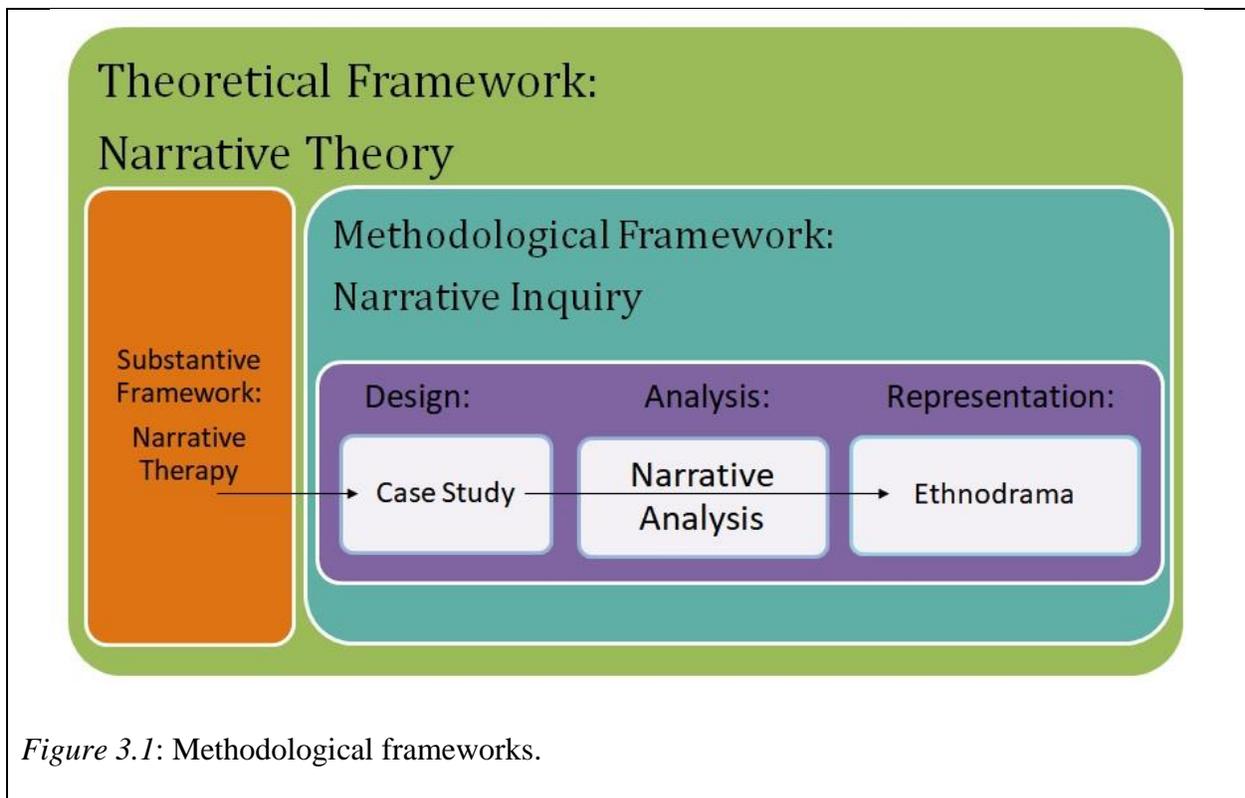


Figure 3.1: Methodological frameworks.

Narrative Inquiry

Through narratives, we are able to connect otherwise seemingly random and isolated events and give them meaning (White & Epston, 1990; Holstein & Gubrium, 1999a). Thus, narratives are at the root of our experience of the world. "Narrative is one of the few human endeavors that is widely spread as a basic aspect of human life and an essential strategy of human expression" (Kim, 2016, p. 6). Narratives have been around longer and incorporate most other forms of knowledge, including scientific knowledge (Kottler, 2015). From ancient cave paintings that related good places to hunt and dangers to be avoided to the principles of software design in the digital age, the production and sharing of narratives have formed an important part of our evolution as a species. By telling narratives, we create ourselves (Holstein & Gubrium, 1999a). Through listening to narratives, we transcend the bounds of our own experience, and share in the lived experiences of others (Kim, 2016).

Narrative inquiry involves an exploration of the lived narratives of participants. This goes beyond a mere re-telling of stories and involves an attempt to make sense of these stories as *lived* by the participants (Clandinin & Connelly, 2000). Narrative inquiry concerns itself with not only the events in a narrative, but also the contexts in which the narrative was socially constructed. Thus, it is important for narrative inquirers to attend to plot structure, character, genre, theme, chronology, and intertextual influences. They must also consider both the social context in which the narrative has been told by participants and that in which it is being read/heard by the researcher. Therefore, narrative inquirers must be self-reflexive about a) their role in influencing the telling by participants of a particular story in a particular way and b) the ways in which they themselves make meaning of the stories told by participants (i.e. interpreting the data) (Riessman, 2008).

Clandinin and Connelly (2000) conceptualize narrative inquiry in terms of three dimensions: 1) Interactional (personal & social); 2) Temporal (past, present & future); and 3) situational (place, environment). We can explore the ways in which stories are produced between ourselves and others, how they are situated in time, and the context that surrounds their construction.

Interactional: The narratives of couples and families are co-constructed and enacted between individual members (Holstein & Gubrium, 1999b; Clandinin & Connelly, 2000). As a researcher, I also play a role in the ways that narratives are presented to me (Blee, 1998; Riessman, 2008). It is important to note how each actor in the narrator/ audience relationship shapes the ways that narratives are told and experienced. For example, I would expect different kinds of stories from participants if I presented myself as distant and disinterested, rather than open and caring. The presence of domestic abuse in the relationship would undoubtedly affect the kinds of stories participants felt safe sharing.

I was able to build rapport with the participants by describing my own experiences of being in a long-term relationship, working in a residential addiction treatment clinic, and my past addiction to nicotine and the challenges of quitting that substance. In establishing some commonality between myself and my participants, I was able to put them at ease, as well as to model an attitude of openness, vulnerability, and frank honesty. Furthermore, during the interviews, I was able to observe the interactions between the couple providing me with another source of data about their relationship, which I took into account in my analysis.

Temporal: Narratives of recovery may be told from a present perspective looking back, or from a past perspective looking ahead to the present, or even into the future envisioning a couple that is becoming. Clandinin and Connelly (2000) note that the researcher is always

"entering in the midst" of a story that is in progress and trying to make sense of what's going on. This couple existed before I contacted them. They will continue to exist, storying and re-storying themselves, being storied and re-storied by others, long after this study has been published. The participants in this study frequently contrast their relationship now with how things used to be, as a narrative device to emphasize the changes they had made. However, this telling produced a chronology that was choppy, episodic, and at times blurred the past and present. The narrative researcher is responsible for puzzling out a narrative chronology that is, if not completely linear, at least coherent and easy for an audience to follow (Clandinin and Connelly, 2000).

Situational: Researchers attend to the contexts in which stories are constructed. Narratives are not produced in a vacuum, but are surrounded by multiple competing social, historical, and cultural narratives. The availability of these 'other' narratives depends on the awareness of the individual who selects, processes, and assembles them in such a way to explain their present lived experience. Situational factors can include cultural and cross-cultural influences, who is present during the story-telling, where the story-telling takes places, and so on.

None of this process can be conducted outside of socially constructed contexts, involving a complex interaction of multiple author-text-audience subject positions: The interaction between participant and researcher, participant and story/data, researcher and story/data, researcher and research text, researcher and research audience, research text and research audience, participant and social/cultural/historical milieu, researcher and social/cultural/historical milieu, research audience and social/cultural/historical milieu, and between the different social/cultural/historical milieus at each point of interpretation. Each of these positions contains a distinct subjectivity in

dialog with all the others. Thus, even when the telling is unidirectional, narratives are always conversational.

Since this study examines the development of narratives of a couple in recovery, narrative inquiry makes natural sense as a methodological framework. Using this framework, the goal of the study is to explore the narratives of the couple as they transitioned from active addiction to alcohol to long-term recovery. The narrative accounts of participants' experiences will be treated as a whole, rather than fragmented into themes in order to preserve the narrative contexts in which they are embedded (Riessman, 2008, p. 12).

Case Study

Narrative inquiry is essentially a form of case study. A story is always a story *about* something, which is the case being studied. Therefore, case study (Stake, 1995; Yin, 2009) was selected as an appropriate design to answer the research questions. Yin (2009) writes, "In general, case studies are the preferred method when (a) 'how' or 'why' questions are being posed, (b) the investigator has little control over events, and (c) the focus is on a contemporary phenomenon within a real-life context." This study examines how a couple re-storied themselves following a member's recovery from addiction, and therefore fits the criteria for using a case-study design.

Individual case studies have historically provided the foundation for research and theory in therapy, dating back to the psychoanalytic approaches of Freud (Barker, Pistrang, & Elliot, 2016; Mcleod, 2010). These cases studies provided rich, detailed reports of therapists' work with individual clients. While case studies and case examples remain prevalent in therapeutic literature (e.g. Kennedy & Gordon, 2017; Lawson, 2017; Rochat & Rossier, 2016), their status in mental healthcare research has been undermined by a push from managed care initiatives for

“evidence-based practices” which prioritize randomized controlled trials over descriptive single-case designs (Morgan & Morgan, 2009), prompting debates about what constitutes “evidence” in therapeutic practice (Larner, 2004) . Nevertheless, descriptive case studies are well-aligned with the practice of counseling, providing therapists with rich insights into clinical processes and issues which may not otherwise be captured in a large-scale study (Barker, Pistrang, & Elliot, 2016; Mcleod, 2010). Furthermore, the assumption of ‘uniqueness’ is shared by qualitative researchers (Bhattacharya, 2017; Creswell, 2013) and narrative therapists (White & Epston, 1990; Wallis, Burns, & Capdevila, 2011), discouraging the practice of over-generalizing the results of randomized controlled trials. Instead, these orientations create a preference for qualitative or naturalistic case-studies in order to document the complex and distinct nuances that differentiate one client or case from another (Mcleod, 2010).

The defining aspect of a case study is the case (Stake, 1995). The case for this study is the development of the couple’s narrative from “couple in addiction” to “couple in recovery.” The unit of analysis in this study is each participant’s individual narrative of this transition. Researching a single couple allows for an in-depth analysis of their experiences related to the development of their recovery identity. This case was selected as a paradigmatic case (Flyvbjerg, 2006), illustrating the narrative therapy paradigm. It is used to examine and illuminate the narrative change process in couples recovering from addiction. It is also an instrumental (rather than intrinsic) case study, since the findings from this study are not limited to the specific case under research but may be potentially transferrable to other families in similar circumstances (Stake, 1995).

Yin (2009) notes that case studies are guided primarily by research questions and secondly by propositions. A proposition can be helpful in guiding the researcher towards looking

for certain kinds of data within the case, rather than attempting to capture *everything*. The proposition that guides this case study is based in the narrative therapeutic approach (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990). It is that couples who are successful in maintaining recovery from addiction create “couple-in-recovery” narratives as alternatives to the previously lived “couple-in-addiction” narrative. Therefore, this study is not concerned with the *entire* experience of being a member of this couple but attends particularly to narratives that focus on addiction and recovery as they are lived and experienced in the context of this family.

Case study was selected as an appropriate research design for its alignment with narrative inquiry and narrative therapy practice. Examining a single case allowed for an in-depth exploration of the experiences of the participants within the complex context of their lives and social environment while preserving and honoring the uniqueness of those experiences.

Participant Selection and Gaining Access

Participant Selection Criteria

This study focuses on the post-treatment experiences of a single couple (n=1). Merriam (1995) makes the case for n=1 qualitative research in that it allows a greater depth and uniqueness to emerge from the inquiry. She highlights the difference between generalizability in quantitative research and transferability in qualitative research. Generalizability involves accuracy of findings within a sample when applied to a population with the intention that what is found in a study should be true for most of the people most of the time. Transferability, on the other hand, makes no claims on the truthfulness of one person’s experience for any other person. Rather, it aims to present findings that can be of potential value and relatability to readers, though it is impossible to fully determine what each reader will be able to find of value in the

report. Therefore, the selection of participants was purposefully criterion-driven (Bhattacharya, 2017; Cleary, Horsfall, & Hayter, 2014; Creswell, 2013).

The criteria for selecting participants was that at least one member of the couple must have experienced an addiction to alcohol and/or other substances, for which they had received formal treatment (either inpatient or outpatient services). The addicted participant must have been at least 18 at the time of treatment. The search for participants was not limited to alcoholism but was open to any substance use disorder. Individuals who experienced “spontaneous recovery” from their substance use disorder (e.g. Zimmerman & Zeller, 1992) were not considered for this study. Furthermore, individuals with behavioral addictions such as gambling or over-eating were also not recruited.

The individual who had received treatment must have had at least five years of consecutive sobriety at the time of the study. While relapse is unfortunately a common occurrence in addiction treatment and recovery, research has shown that the chance of relapse decreases from 64% within the first year of recovery to 14% after five years of sobriety (Dennis, Foss, & Scott, 2007). Therefore, the participant's last use of the substance(s) for which they received treatment was a minimum of five years prior to the study. Active addiction in either partner was considered a criterion for exclusion from the study. However, responsible use of legal substances such as nicotine, caffeine, or alcohol in the case of potential participants who did not identify as alcoholics was not a barrier to inclusion in the study.

In order to investigate the transition from addiction to long-term recovery, it was necessary that the couple relationship must have existed prior to receiving treatment and has remained intact to the point of the study. Couples who separated were not sought for the study nor were couples that formed during or after treatment. The suspected presence of domestic violence

within the couple were criteria for excluding participants from the study. Race, gender, age, sexuality, number of children, ethnicity, SES, former substance(s) of choice, prior attempts at recovery, and criminal history were not factors in selecting participants. However, for practical reasons, the participants needed to be accessible to the researcher for observation and face to face interviews in English.

Gaining Access to Participants

The search for participants began immediately following IRB approval of the study (Approval #: 8909). Initially, the goal was to recruit between one and three couples to the study in order to produce a composite narrative of their experiences. To start, I contacted personal acquaintances who had previously disclosed to me their involvement with communities of recovery. I presented them with a letter briefly detailing the aims of the study and the criteria for selection. I asked these contacts not to identify (and “out”) individuals in recovery to me, but instead asked them to provide my contact information to anyone they knew who met the criteria. As an alternative, I also provided a form in which potential participants could voluntarily provide their own contact information to me through my acquaintance. This intermediary position in identifying potential participants was called a “liaison.”

While many of my acquaintances expressed interest in the study, few knew of any couples who met the criteria. I expanded my search by creating a list of addictions professionals and community contacts from online resources such as Psychology Today (<https://www.psychologytoday.com/us/treatment-rehab>) and Area 25 KS (ks-aa.org/meetings). In total, 43 letters were sent to liaisons. However, the predominant narrative that emerged from the effort to locate participants was that few couples survive addiction, and fewer still remain together following treatment. The search for participants lasted over two months. In the end, only two

couples were identified that met the criteria for the study. However, one of the two couples had issues with availability and was unable to commit to the study. Therefore, the study was conducted with a single couple.

Initial contact was made by phone to describe the study, verify that the participants met the criteria for the study, and to gauge their interest in participating. The participant (given the pseudonym Michael in this study) was eager to take part in the study as a way of spreading the message of recovery. During the phone call, he directed me to a blog he published about his own experience with recovery. We agreed on a date to meet in person at the participants' home, complete the informed consent process, and begin data collection.

On arriving at the home of the participants, Michael met me in his driveway. He was immediately friendly and welcoming, extending his hand to shake as I climbed out of my car. As he directed me towards the house, he struck me as the sort of person who was not content to sit idle for long. He introduced me to his wife (given the pseudonym Mia in this study), who had a more low-key presence, which complimented Michael's energy. Michael explained that they had asked someone to look after their children for the entire day to give me a chance to get whatever I needed from them without interruptions. Though Michael and Mia had agreed over the phone to multiple meetings, Michael informed me that something had come up which made this the only opportunity I would have for data collection in the near future. Grateful to have any participants to research, I agreed to conduct all of the face-to-face interviews and observations at once but asked if I could follow up with the couple by phone or e-mail if any new questions arose during my analysis of the data. They both verbally consented to continued contact for the purposes of following-up on new lines of inquiry which emerged from the data, as well as to

periodically conducting member checks to verify the accuracy of the data analysis and representation.

Ethics

Ethics is an important issue in any research study (Guillemin & Gillam, 2004). There are no studies conducted in the social sciences, which do not face some ethical challenges, from the treatment of participants to the implications of the research. Researchers are ethically obliged to consider the ethical dimensions of their research and to manage ethical risks of conducting their studies. However, "the potential harms to participants in qualitative social research are often quite subtle and stem from the nature of the interaction between researcher and participant. As such, they are hard to specify, predict, and describe in ways that ethics application forms ask for and likewise, strategies for minimizing risk are hard to spell out" (Guillemin & Gillam, 2004, p. 272). While unable to anticipate every possible contingency, I was able to prepare for what seemed like the greatest risks and continued to informally assess for possible harms during contact with participants, including follow-up phone calls.

The over-arching maxim in most codes of ethics (ACA, 2014; AERA, 2011) is nonmaleficence. In other words, researchers should endeavor to do no harm in conducting their research. Harm may take many forms including physical, emotional, financial, or social (Guillemin & Gillam, 2004). To protect participants, the proposal for this study was developed under the supervision of a guiding committee of graduate faculty and was reviewed and approved by the Institutional Review Board of Kansas State University (IRB) (Approval #: 8909). The IRB oversees research with human subjects and provides ethical guidelines to protect their welfare.

Managing Potential Relapse

Of foremost concern in this study was the potential for relapse in the participant in recovery from alcoholism. It was judged that the risk of relapse involved in participating in the study was no greater than would be involved in the participants' everyday lives. The participant is a regular attendee and speaker at AA meetings, in which sharing his story with others is a major component (AA, 2001). Prior to the study, he had also written an online blog about his recovery experiences. Therefore, disclosing these experiences was not out of the ordinary for the participant.

Furthermore, the criteria of at least five consecutive years of sobriety was designed to significantly reduce the risk of relapse. Research has shown that a period of abstinence of three to five years decreases the risk of relapse from 64% to 14% (Dennis, Foss, & Scott, 2007). However, it is important to note that this risk is still significantly greater than 0%. To that end, a list of resources local to the participant for individual counseling, couples counseling, addiction counseling and treatment was prepared and provided to the couple. Michael also had his own AA sponsor, sober-contacts, social resources, and a relapse prevention plan that he could depend on in a moment of crisis. In addition, during the informed consent procedure and regularly throughout the study, the participants were reminded of their right to withdraw from the study at any time and encouraged to prioritize their recovery needs ahead of the research. I was able to informally follow up on the participants' recovery status during member checks after two months and seven months. The couple reported that they are still doing well.

Managing Potential Violence

A second ethical consideration unique to this study involved the link between addiction and domestic violence (Christoffersen & Soothill, 2003; Klostermann & Fals-Stewart, 2006; Wu,

El-Bassel, McVinney, Hess, Fopeano, et al., 2015). While it was not the focus of this study to explore issues of violence, there was a possibility that the participants had experienced incidences of violence during their period of addiction. According to Kansas Law, it is necessary to report the abuse of a minor (Kan. Stat. § 38-2223, 2006). No minors were present at the time of data collection, and no disclosure of child abuse was given by the participants. To check for the presence of partner-directed violence, each member of the couple was interviewed individually and in private. During the interview, I asked directly about violence, abuse, and intimidation in the relationship. Though the couple had experienced intense conflicts and described “atomic tantrums” during the period of drinking, these did not cross the threshold of being physically threatening to either of the participants. Further, they stated that nothing disclosed during their joint or individual interviews provided them with cause for fear of retaliation from the other partner.

Membership Roles

It was ethically important to reflect on my own position as the researcher. While I have had experience working with members of the communities I am studying, I am not a legitimate insider to these communities. Therefore, it was important to be cautious in the ways that I related to and represented their experiences. Using member checks and peer debriefing (Bhattacharya, 2017; Creswell, 2013; Spall, 1998) strategies were helpful verifying the accuracy of the representation of the experiences of individuals in recovery from alcoholism.

Furthermore, it was necessary to respect that there were some aspects of the participants’ experience which I, as a cultural outsider, did not have access to. For example, I am aware of the colonizing history of men of European descent researching cultures not their own and presenting inauthentic, harmful, and racist stereotypes of those cultures through the misunderstandings

inherent in their limited perspectives (Bhattacharya & Gillen, 2016). I cannot escape the fact that I am a white man from a predominantly Anglo-Canadian culture, so the onus is on me as a researcher to acknowledge and be sensitive to the limits of my cultural understandings. Therefore, after consultation and thoughtful discussion with my dissertation committee members, I have avoided using a culturally critical lens in this study in order to take care not to misrepresent or distort cultural nuances that are outside of my awareness. However, for the sake of transparency, I feel that it is necessary to draw the reader's attention to the omittance of details which could be relevant to a culture-specific reading of the work. As a cultural outsider both to Alcoholics Anonymous and the ethnic heritage of the participants, I have taken steps to reflect on the limits of my understandings, to gain affirmation of the authenticity of my representation where possible, and to avoid imposing an outsider perspective on a culture not my own.

Confidentiality

Maintaining confidentiality of participants in all research is ethically paramount and contributes to the validity (or trustworthiness) of a study (Creswell, 2013). However, because qualitative research involves an in-depth exploration of the lived experience of participants represented in rich detail, rather than aggregated statistical results, maintaining the anonymity of participants can be challenging. Protecting the identities of participants often requires the use of pseudonyms and the altering or omission of identifying details. Omitting particular cultural details about the participants also helps to guard their identities from over-curious readers. However, those who are familiar with the participants may still be able to identify them based on the description of the findings. In some cases, fictionalization is another strategy that can be used to disguise participants (Leavy, 2015). Thus, the experiences and actions of participants may be retold in ways which are similar enough to the real story to capture their meaning or significance

without being verbatim representations of the actual events. For example, a physical altercation with customers at a place of employment can be transformed to a physical altercation with neighbors without sacrificing the significance of the altercation in the greater narrative (neither of these events apply to the participants in this study).

Data Collection

Data for this study took several forms including interviews, observations, archival documents, e-mails and phone calls with participants, peer debriefings, journaling and researcher reflections, and memory sites. Incorporating multiple sources and types of data is a strategy for increasing rigor in a qualitative study called triangulation or crystallization (Tracy, 2010). Each of the types of data collected will be described in detail below, and examples will be provided.

Interviews

The primary source of data for this study were three semi-structured in-depth interviews with the participants. The first interview was conducted jointly with both members present, and the second and third interviews were conducted individually with each member. Prior to meeting the participants, I developed a broad interview guide with interview questions and sub-questions covering parts of the clients' story I predicted might be valuable in responding to the research questions. For example, one of the questions and sub-questions I planned to ask are shown in

Figure 3.2:

1. Tell me about the decision to enter treatment.
 - a. What let you know that this step needed to be taken?
 - b. Who made the decision?
 - c. What was considered in making the decision?
 - d. What were your feelings about the decision at the time?
 - e. What do you think making this decision said about you as a couple? As individuals?

Figure 3.2: Interview question example.

Creating an interview guide was useful in strategizing which topics needed to be covered in the interviews. However, during the interview itself, the guide was rarely consulted, and questions were phrased spontaneously in an informal conversational style (Bhattacharya, 2017; Kvale & Brinkman, 2009). At the end of the interview, I looked at the questions on the guide to make sure I had not overlooked an important area for discussion. Figure 3.3 provides an excerpt from the raw transcripts in order to demonstrate the conversational flow of the interviews.

MIA: I was ready to go. I mean I had a place to go. I had my plan. And I was going to go. If he stayed, I was going to go. If he left, I was going to let him go. So, I had a plan. If he was going to stay, everyone was ready for me to be there. I was going to talk to him- not yell at him, just tell him, you know, I had to. There's no yelling at him, because if you do, you get it back. So, I knew I just had to tell him. I had to be calm about it, and I had to tell him.

PAUL: So, it sounds like it got to a point where it was almost like – not like an emotional decision, but almost like a rational, logical kind of decision.

MIA: Yes. It was very rational. I knew I had to be rational. Because nobody was being rational, you know what I mean? [laughing] To stay was being irrational, and I knew I had to do it for my daughter. She was young. And I knew I had to.

PAUL: And do you remember what led you to that decision?

MIA: He was riding around drunk. And I was like, 'kill yourself, but she doesn't deserve that.' So that was my decision.

MICHAEL: I remember that day. Honestly, I'd gotten drunk twice that day. I started drinking when I woke up. My daughter went to school, and I started drinking as soon as I woke up.

Figure 3.3: Transcript excerpt demonstrating conversational interview style.

In the spirit of conversation, I also allowed the participants to ask questions of me. The purpose for doing so was to share power with the participants during interviews in order to build trust and rapport (Bhattacharya, 2017). Furthermore, if I as a researcher expect my participants to be vulnerable and honest in disclosing their experiences to me, it is fair that I model that vulnerability to them. Figure 3.4 shows a brief exchange in which Mia interviewed me:

MIA: So, you're not an alcoholic or whatever...?

PAUL: No. No, I'm not. But my 'drug of choice,' I guess, was tobacco. I smoked for about 10 years from when I was 17 until I was 27.

MIA: Wow. And you stopped?

PAUL: I quit, yeah.

MIA: Cold turkey?

PAUL: Yeah, more or less.

MIA: That's how I was, too.

PAUL: So, I met my partner, and she was kind of allergic to cigarettes...

MIA: Yeah, I've heard of that.

PAUL: So, it was either I'm going to get rid of the girl, or I'm going to get rid of the smoking habit, and it was like I just can't be that guy who won't give it up, so... It was tough, but you know, I did it, and uh...

MIA: Anything that you make a habit, and then quit, it's outstanding just to be able to not do it again. Like, make a choice.

Figure 3.4: Transcript excerpt demonstrating reciprocal interviewing.

Self-disclosures during the interview also served as micro-member checks in real time. Using self-disclosures, I was able to verify and correct the accuracy of my understanding of their experiences by relating them to my own.

PAUL: ...One of things I was thinking about, when I was working with the families, a lot of the time spouses- some of them got kind of resentful because 'you're in here in treatment, and now I'm stuck with all of the responsibilities.'

MIA: That came, yes. That was there.

MICHAEL: [Laughing]

MIA: But it was always there. It was there before. So, it was just... the only thing that was different was when he was in treatment it was like 'wait, he's getting help. I am not going to complain about this. If I do feel it, it's not right right now because he's getting help right now, and that's the best thing he could be doing for us, so I really don't have anything to complain about.'

PAUL: That's sort of the sense I got from you: He's out of harm's way, he's getting help, he's safe here.

MIA: He's good where he's at.

Figure 3.5: Transcript excerpt demonstrating self-disclosure as an interview technique.

Interviews were audio recorded using a laptop and were subsequently transcribed.

Observations

I also conducted an informal observation of the couple engaged in a typical activity (watching football on TV) to gain a sense of their personalities, mannerisms, and the way Michael and Mia related to each other. Observations were conducted passively, in as unobtrusive a way as possible (i.e., as a 'fly on the wall') (Angrosino & Perez, 2003; Lofland & Lofland,

1995; Spradley, 1980). Clandinin & Connelly (2000) warn that novice researchers often make the mistake of trying to observe everything all at once (and consequently miss much that is valuable). They recommend that researchers take a more relaxed and natural approach to observation in order to gain a general impression of the environment and the interactions between individuals.

The observation was not electronically recorded, but notes were made immediately after leaving the participants' home. The purpose of the observation was primarily to gain a sense of 'character,' which could be referenced in the writing of the ethnodrama script. Similarly, I spent some time driving around the community to get a sense of the environment in which the story was to take place. Figure 3.6 is an excerpt from my notes on observing Michael and Mia's town.

Arriving at the edge of town, I come across an environmental protest. Pickets and people briefly block the road until the police quietly move them back to the sidewalks. There's little resistance among the protestors, and it seems like this dance has been going on all day. A mile or two later, I come to the four blocks or so that constitute "down town." This isn't one of those falling-apart forgotten rural places left to decay I've often come across in my wanderings through the countryside, but a revitalized community attracting tourists with its small-town charm. At the main street intersection, there's another crowd. This one seems to be waiting for a seat at some busy café. Two blocks more, and the classic rural Americana vibe fades into a more contemporary grey blight of Wal-Mart parking lots and fast-food neon. Faded American flags on warped paint-flecked porches, steel barred liquor store windows and gas stations. Weeds and broken glass. Aluminum side trailers with wandering dogs and a tired looking young woman holding a crying baby

with one arm while wrestling grocery bags from the trunk of an old dented car with the other.

I make another turn, beneath green trees and past mid-century bungalows. The grass is darker, healthier, maintained. The flags brighter. The dog I see here is on a leash clutched by a roadside jogger in full athletic attire including sunglasses and headphones. I slow my car, searching for the right number, and find it on a corner house across the street from a middle school. There are two cars in the driveway. As I pull to a stop at the curb, a stocky man with greying black jaw-length hair and glasses comes around the corner of the house. He's wearing a pair of black plastic-framed glasses, jeans, and a Pixies' Monkey Gone to Heaven T-shirt. Climbing out of the car, I remember hearing a Pixies song (a different one) on shuffle on my iPhone as I drove out here and smile at the coincidence. He's smiling, too, friendly, outgoing, handshaking. We introduce ourselves, and he invites me into his home.

Figure 3.6: Field notes excerpt describing participant's town.

These notes were made in a subjective impressionistic manner, capturing not only the objective details that I observed, but also the feelings and thoughts the sights provoked in me. Doing so allows me to present a richer picture of the place, which audiences may connect with. As mentioned above, the purpose of the observations was to gain a sense of character (both of the participants and their environment) which could be used to help construct an engaging ethnodrama.

Notes and Journals

Field notes were taken sparingly during interviews and observations so as not to distract the participants or myself from being present in the interview (Kvale & Brinkmann, 2009). However, immediately after leaving the participants' home, I stopped at a nearby Subway restaurant, and spent an hour and a half journaling from memory in order to record my own subjective impressions from collecting data (Figure 3.7).

The individual interviews began with Mia, who seemed more relaxed in an individual setting – this is common in my experience as a counselor, but also maybe an indication that she had become more comfortable with me over time. She responded to my questions in a more conversational tone, offering examples and illustrations with less prompting.

Michael was second, also appearing slightly more relaxed with me, but also less energetic, as if he were tiring of these interviews. Given that we were conducting them all in a single meeting, I felt I was becoming tired, too.

Holding space takes energy.

During both individual interviews, I found myself following the prepared guide more. Perhaps this was because I had initially planned to conduct these interviews on separate days and was not entirely prepared for them. However, I think the interviews were still conversational and productive. I didn't sense a loss of rapport or a 'shutting down' of either of them.

Both participants in their individual interviews commented that they had found these interviews to be a positive experience and beneficial to their own thinking about their relationship. Each of them expressed that they'd like to talk

like this more. I offered to research family/couples therapy resources in their area and e-mail them a list. They said they'd be happy to get a list, but worried about finding time.

Figure 3.7: Field notes excerpt describing individual interviews.

In making these field notes, it was my intention to capture my own thoughts, impressions, and hunches that had occurred to me during the interviews. Since the interviews had been audio recorded, recalling what had been said was not a vital concern. These notes also prompted me to review specific parts of the transcript more closely in my analysis and added to my interpretation of them.

In addition to the field notes taken after the interviews and observations, I have continued to journal throughout the entire study from the point of conceiving the proposal through the stages of analysis and representation. This self-reflexivity may also be considered a source of data informing the study. Clandinin & Connelly (2000) note:

as inquirers we, too, are part of the parade. We have helped make the world in which we find ourselves. We are not merely objective inquirers, people on the high road, who study a world lesser in quality than our moral temperament would have it, people who study a world we did not help create. On the contrary, we are complicit in the world we study. Being in this world, we need to remake ourselves as well as offer up research understandings that could lead to a better world. (p. 61)

It is important to note how the narratives of participants become intertwined and entangled with our own personal narratives as researchers. These may not always be socially desirable narratives, but narrative inquirers must be courageous in acknowledging and accounting for - at least to themselves if no one else - the influences of their own experiences in constructing

meaning of the participants' narratives. The following is a poetic fragment from my journal which was included in an early draft of the ethnodrama script, but was later removed for aesthetic reasons:

Happy Hour

Diving the wreck of the modern man in
Glass bottom bottle, end of the road tavern,
Where the last ramshackle rock band plays
A steady dirge for the good old days, and we
Mourn the broken promises of our fathers'
Misspent youth, lost futures, scattered like
Peanut shells across checkered linoleum floor,
Awaiting the dust broom of forgetfulness,
To sweep us away into peaceful oblivion,
Where there are no expectations left to fail,
And our suffering is for ourselves alone.

Figure 3.8: Journal excerpt demonstrating an attempt to “come alongside” Michael as an ethnodramatic character.

This poem was ultimately cut from the final script for aesthetic reasons. As author Stephen King (2000) advises in his book *On Writing*, “Kill your darlings, kill your darlings, even when it breaks your egocentric little scribbler’s heart, kill your darlings” (p. 213). However, it was helpful to write it in order to explore Michael’s frame of mind while he was in the midst of his alcoholism. The poem contains a sense of bleak hopelessness and despair that accompanied Michael’s feelings of emptiness and lack of purpose. It also points to generational influences, whether the failings of a literal father figure or simply the irresponsibility prior generations,

which have contributed to a general dissatisfaction and pessimism among millennials. Though the poem is clearly *my* response to the data, it is an attempt to empathize with Michael's perspective as an alcoholic.

Memory as a Data Site

As mentioned above, narrative researchers should not discount the relevance of their own experiences as data which can help them to analyze and make meaning of their participants' experiences (Hofsess, 2013; McAdams, 2001; Vagle & Hofsess, 2016). In this study, my own experiences with alcohol, addiction to nicotine, my family and romantic relationships, and especially my work with recovering addicts and their families as a counseling intern provided me with insights into the experiences of the participants, allowing me to create an authentic, realistic, or at least believable representation of these experiences that can engage and connect with other individuals who have undergone similar experiences with alcohol or addiction to other substances and recovery.

For instance, in another of my journal entries, I meditated on the military acronym SNAFU (Situation Normal: All Fucked Up), and how it related to my own experiences growing up in less than ideal family circumstances and taking it all in stride as "normal," even though on looking back, it was anything but. In maybe the most innocuous example, I grew up around smoking men. My father smoked cigarettes, as did my step father, and my uncle on my mother's side. My grandfather on my father's side was a regular pipe smoker. Tobacco smoke was a constant presence in my household, and therefore I accepted it as normal (I still associate the smell of cigarettes with home, even though all of the smokers in my life have since quit or passed away). When I was a teenager, I stole a pack of my stepfather's cigarettes and tried one myself. Even though the first cigarette made me sick, the narrative of smoking men persisted and

eventually led to a pack-a-day habit, which continued even after I moved out of my parents' home and started hanging out with mostly non-smokers.

Considering the development of my addiction to nicotine provided me with memory data that allowed me to gain insight into Michael's addiction to alcohol and how difficult it is to escape the "normal" narrative of drinking. Michael confided in the interview that alcohol addiction was present in his own family and prevalent within his immediate community, making heavy drinking behaviors appear normal. Reflecting on my own memories was instrumental in both developing an empathetic understanding of the character of Michael in the ethnodrama, as well as in developing the Narrative Change Model that resulted from the analysis of the ethnodrama. The ethnodrama and Narrative Change Model will be presented in greater detail in chapter four.

Documents and Other Research Artifacts

Documents (such as participant journals, written reports, etc.) and artifacts (such as photos, objects, etc.) can also provide useful sources of data for qualitative researchers (Bhattacharya, 2017; Creswell, 2013). Two kinds of documents were used as data in this study. The first form of documents were those that related directly to the participants. These included a blog kept by Michael, books used by Mia to cope with Michael's alcoholism (e.g., *The Bible*), and the website for the treatment center to which Michael was admitted. These documents provided contextual information which was used to produce data triangulation along with interviews and observations.

The second kind of documents used in this study were documents related to AA and recovery that were not specifically provided by Michael or Mia. Examples of these kinds of documents included *The Big Book* (AA, 2001), other written accounts of recovery experiences

(e.g. Brand, 2017; Chapman, 1980), and unpublished psychoeducational materials from my former internship site. As a cultural outsider to the alcohol recovery process, these resources were helpful in providing insight into Michael and Mia's experiences, which was necessary in writing an ethnodramatic script in a way that would resonate with individuals in recovery.

Conclusion

While the primary source for the ethnodrama came from Michael and Mia's accounts of their experiences obtained during interviews, multiple sources of data were collected to provide contextual background and insight into those experiences. Furthermore, using multiple data sources provides triangulation or crystallization. The purpose of crystallization in qualitative research is not confirmatory, but expansive (Tracy, 2010). It is not my intention to reduce narratives to a single verifiable truth, but to examine narratives from multiple angles in order to gain and represent a broader and more holistic understanding of the experiences of both participants.

Data Analysis

Data was analyzed using multiple approaches including traditional inductive analysis (Bhattacharya, 2017; Saldana, 2009), ethnodramatic analysis (Saldana, 2011) including a process of writing as inquiry (Richardson & St. Pierre, 2004), narrative analysis through the theoretical frameworks of Deleuze and Guattari's (1987) machinic assemblage, and Freytag's (1894/2007) classic plot structure.

Traditional Inductive Analysis

Transcription of interviews can be thought of as an initial stage of data analysis and transformation (Kvale & Brinkmann, 2009) in which the researcher reinterprets the data from an audible media into a written one. At the same time transcription forces close-listening to the

language of the interview – both the language of the participants and of the researcher. Getting close to the data increases the researcher’s familiarity with it. Close-listening, can also allow the researcher to attend to the paralinguistic elements of speech which can modify and add nuance to the content of what is being said, such as tone of voice, pace of speech, pauses, sighs, interruptions, and so on.

Beginning with transcription, and increasingly with each subsequent reading of the transcripts, the researcher is able to get a clearer idea of what is being talked about in an interview. While Saldana (2011) notes that ethnodramatic analysis tends to avoid the traditional qualitative process of coding and categorizing, I determined that a preliminary thematic analysis of the transcripts was useful in identifying the topics, issues, and themes to be presented within the play. Therefore, inductive analysis provided a first step towards reducing and refining data.

The traditional method of inductive analysis involves “chunking” the data into units of meaning (Creswell, 2013). The size and composition of these chunks depends on the needs and ends of the researcher (Bhattacharya, 2017; Saldana, 2009). Some, such as those interested in the nuances of linguistic analysis, may divide a transcript into phonemes, while others with a broader focus may work at the level of paragraphs or passages. In this study, I chunked the data based on informational content, with chunks varying in size from a single word to several sentences.

When data was chunked, it was annotated, summarizing what was being communicated by the participants and recording my own thoughts and responses to what was being said. To provide an example, one chunk came from the individual interview transcript with Michael. Michael stated, “But like I said, I’ve done speaker meetings and stuff before, and the more you say the story out loud, the more understanding you get about it.” I annotated this statement with the comment: “In retelling the story, Michael is able to learn new things about it. Telling is

transformative.” Within the annotations, I allowed the participants’ words to become entangled with my own thoughts in order to produce an empathic understanding of their narratives (Vagle & Hofsess, 2016) as well as to make space for emerging theoretical insights which could guide the construction and subsequent analysis of the ethnodramatic script. Thus, the annotation was largely an intuitively guided process of interpreting and co-constructing meaning from participants’ statements without an a priori set of codes to direct it (Bhattacharya, 2017; Creswell, 2013; Saldana, 2009). In total 768 annotations were made from the data (see Table 3.1 for a more detailed description of the interview data).

Table 3.1

Summary of Interview Data

	Hours	Words/Lines/Pages	Annotations
Joint Interview	1:49:52	16119/1060/53	553
Individual Mia	0:30:02	5087/339/10	119
Individual Michael	0:41:10	5091/335/10	96
Total	3:01:04	26297/1734/73	768

With the original transcript data chunked and annotated, I began to loosely code and categorize the annotations I had made. The coding and categorizing process is one in which researchers identify and organize patterns in the data to arrive at conclusions or themes (Bhattacharya, 2017; Creswell, 2013). Coding can take a variety of forms, depending on the needs of the research (Saldana, 2009). While identifying general themes was a useful and necessary step in the analysis of data for this study, I was also cognizant of criticisms of the coding and categorizing process as being reductive and rooted in a post-positivist paradigm (Barbour, 2001; Maclure, 2013). Thus, rather than coding in a traditional sense, similar ideas were summarized and synthesized into statements, which were then grouped and arranged into categories based on their conceptual relationships to one another. One of the categories that

emerged from this process was related to the role of an audience in Michael's narrative transition (Figure 3.9: Categorizing excerpt to demonstrate the inductive analysis process).

Audience
For Michael
Mia
Particularly during the interview for this study
An opportunity for Mia to find out about Michael's experiences
Frequently uses the phrase "she knows"
Challenges negative and totalizing narratives about Michael
Even when drinking, there were good times
Sees Michael as essentially a good person
Others in the community
Outside AA
AA attendance may seem selfish
Neglectful of family
Counters that being drunk is neglectful
AA involves taking responsibility
Mia in particular denies that she cares about others' opinions
At the same time, social validation of her marriage would be nice
An affirmation of her choice of partner
Reciprocally, social validation may boost Michael's self-esteem
Thereby making him a better husband
Others in recovery
Sharing as thickening narratives
Acceptance
Step 5
Normalization
Intertextual identification
#metoo

Figure 3.9: Categorizing excerpt to demonstrate the inductive analysis process

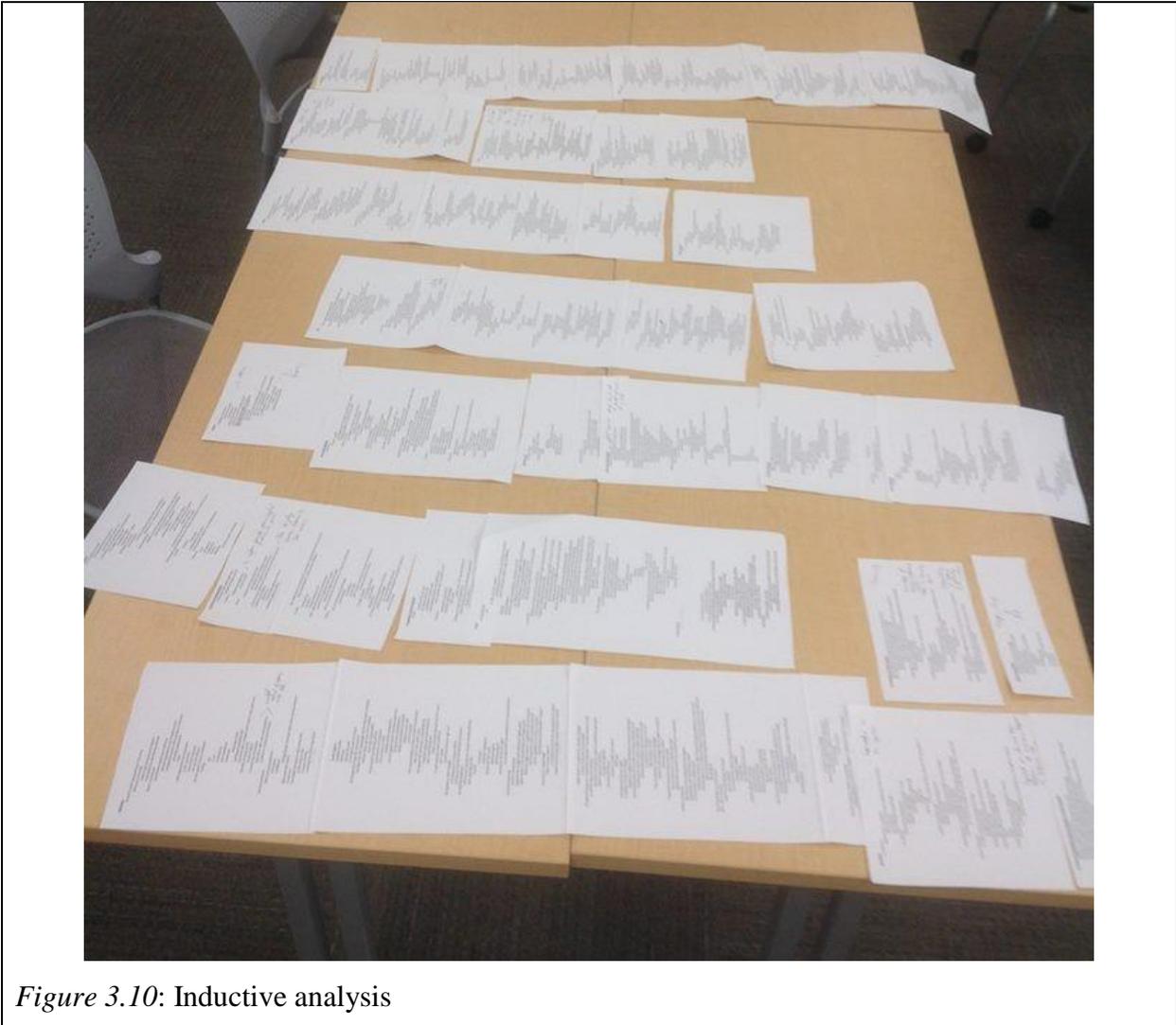


Figure 3.10: Inductive analysis

This categorization process yielded 27 categories across 31 pages. The product of the initial categorization was printed and organized spatially to further identify cross-category linkages, allowing for a reduction in the number of categories and a broadening of themes to be presented within the play (Figure 3.10). This process of refinement left five broad themes: 1) Recovery: Learning & Community; 2) Communication & Forgiveness: Blocks and Connections; 3) Identity & Stigma; 4) Marriage: Conflict, Control, Trust, & Partnership; and 5) Narrative Shifts: “The story is the same but the meaning changes.”

Ethnodramatic Analysis & Data Representation

The identification of themes provided a means of organizing the ethnodramatic script according to the topics which needed to be depicted within it. Following the inductive analysis process, I returned to the original transcripts and began to rechunk the data along the lines of plot (Clandinin & Connelly, 2000; Leavy, 2015; Saldana, 2011), searching for distinct events described in the data. This time, chunks were typically at the level of narrative passages and exchanges between the participants as they retold stories of their experiences of addiction and recovery. The second round of chunked data was organized to produce a chronological order to events. Moving between chronology and themes allowed me to produce a rough plot outline (Table 3.2):

Table 3.2

Plot Outline

<p>Pre-treatment</p> <ul style="list-style-type: none">○ Scene 1 – A fight○ Scene 2 – Ultimatum <p>Treatment</p> <ul style="list-style-type: none">○ Scene 1 – Detox – Admitted a problem○ Scene 2 – First meeting – Came to believe in a higher power○ Scene 3 – Spiritual Awakening – Turned will over to higher power○ Scene 4 – You have to change everything – Fearless moral searching○ Scene 5 – Visit with Mia – Admitted wrongs○ Scene 6 - ? – Ready to remove defects○ Scene 7 – Mia consults with sisters – Asked to remove defects○ Scene 8 - ? – List of those harmed○ Scene 9 - ? – Make amends○ Scene 10 - ? – Continued to take inventory○ Scene 11 – Pre-grad anxiety – Continued to live according to HP○ Scene 12 – The road home – Spread this message <p>Post-Treatment</p> <ul style="list-style-type: none">○ Scene 1 – Establishing a routine○ Scene 2 – Mia’s not in AA○ Scene 3 – The party○ Scene 4 – Falling off the Pink Cloud

Revising the relationship

- Scene 1 – Trust, Another fight, Not always wrong
- Scene 2 – The right reasons
- Scene 3 – Clearing the air

Long-Term Recovery

- Scene 1 – A purpose
- Scene 2 – Commitment

Readers should note that this initial plot outline does not completely reflect the ethnodramatic script presented in chapter four. For example, an early idea to present each of the twelve steps as a short scene in the treatment process became problematic in light of the data that I could draw from and the fact that several of the steps are overlapping (e.g., Step 5: Were entirely ready to have God remove all these defects of character, and Step 6: Humbly asked Him to remove our shortcomings). Creating the outline was part of the creative developmental process, which guided the writing of the script. However, using writing as a form of inquiry (Richardson & St. Pierre, 2004), required remaining open to new narrative directions which might arise spontaneously in the writing process. Therefore, while creating an outline provided useful direction, it was not strictly adhered to as new insights and inspirations emerged from the writing process. It should also be noted that the narrative chronology of the ethnodramatic script is not an exact chronology of events as the participants in this study experienced them. For example, in order to create an ethnodrama which would be engaging to participants, the disputes and offenses of fifteen years of an alcoholic marriage were condensed into a single night (the first two scenes).

Drawing on the earlier inductive analysis as well as the transcripts and other forms of data I had collected, I began to write around each scene. As noted earlier, writing itself can be considered a form of inquiry and analysis (Richardson & St. Pierre, 2004). The act of writing

prompts deep contemplation and reflection on a topic. The writing process allows room for meditation, exploration, and revision, which differentiates it from speech processes which are temporal and ephemeral (Chandler, 1995; Zamel, 1982). Writing creatively can produce a deep empathetic understanding of participants' worldviews as the writer inhabits their perspectives in order to convincingly reproduce them for an audience. Popular author Stephen King (2000) advises that authors should "love your villains as much as your heroes" (p. 198). Doing so prevents them from becoming flat or two-dimensional. Meanwhile Kurt Vonnegut (1999) instructs authors that "every character should want something, even if it is only a glass of water" (p. 3). Therefore, to write convincing characters, it is important that the author understand their desires, motivations, and rationalizations for acting in the ways that they do. To write a character whose actions stem from being "evil" or "an alcoholic" is a drastic, superficial oversimplification. From a narrative inquiry perspective, the act of writing can provide deep insight into the experiences of participants (Leavy, 2015; Richardson & St. Pierre, 2004).

Recalling that the goal of ABR is to engage audiences both on an emotional as well as intellectual level (Barone & Eisner, 2012), it was necessary to give thought to how best to represent participants lived experiences in a *theatrical* way. While much of the narrative change process occurs as interior shift in cognition, the medium of the theatrical performance does not lend itself well to interiority. In an ethnodrama, actors must *express* their interiority and do it in a way that is plausible and engaging within the context of the play (Saldana, 2011). Therefore, metaphors and other narrative embellishments were used to highlight and amplify the emotional content of the experiences in order to appeal to the audience. For example, in the interview, Michael described his experience in detox as follows in Figure 3.11:

Mia told me that the treatment center couldn't get me a bed until next week. I mean, the alcoholic mind was already taking over, and she was like, 'I'm going [away] with my folks this weekend. I'm going to be gone all weekend.' ... I was like 'great, you're going, and I'm not going to go to treatment until next week, so... yeah, and I was already like the trip to detox was going to get everyone off my case for a few weeks, so I'm good... And I realize that that's all the alcoholic mind wanted. And there was a lady there... and she was leaving... and I was like 'Can I ride back to [town] with you?' because I knew what was about to go down. I was going to get drunk that weekend, all weekend long, and wait for her to come home, and then the next week go, 'no, I'm good, I'm alright. I don't need to go to treatment. I'll just not drink. I'll just be a good guy... [But] I was going to get drunk that night.'

Figure 3.11: Transcript excerpt describing Michael's intention to drink.

Taking artistic license, I developed this passage into a fantasy scene in which Michael returns home after his stay in detox and imagines himself as a responsible drinker and family man. Meanwhile Mia pleasantly takes care of the household chores in a stereotypical sitcom-esque domestic scene. By juxtaposing this scene of domestic bliss with the previous scenes of intense conflict between Michael and Mia, the audience is led to understand that Michael is maintaining a delusional narrative to justify his addiction that is almost entirely incongruent with the lived experience the audience has just witnessed. Thus, the theatrical representation deviates from Michael's account, but highlights and amplifies the emotional content of his statements (Barone & Eisner, 2012; Leavy, 2015; Saldana, 2011), producing a more engaging scene for audience members.

Member checks and peer debriefings were used to confirm the accuracy and plausibility of characters. After completing a draft of the script, I was able to have students from the drama department at Kansas State University conduct a cold-dramatic reading. The purpose of the reading was to gain feedback from actors and individuals with theatre experience about the performability of the writing. By doing a cold reading, in which the actors had not seen or rehearsed the script beforehand, I was able to hear how the lines would naturally be interpreted by others, which provided a check on the clarity of the writing.

Following the reading, I solicited feedback from the actors about their experience with the script. The actors reported that they had felt comfortable and had been able to portray the characters with relative ease. They were also able to identify several lines in the script which were problematic in the way they were phrased and suggest possible revisions to improve them. Overall, however, the response to the script was positive. Finally, following the reading a couple of individuals in attendance disclosed their own experiences with addictions – either directly, or with someone they were close to, and noted that the script was highly relatable to their own experiences.

Narrative Analysis

The construction of the ethnodrama creatively represented the experiences of the couple and their transition from addiction to recovery. However, to fully answer the research questions that guided this study, it was necessary to produce a *reading* of the play. It is important to note that to make a reading is an act of interpretation involving a co-construction of meaning between the text and the reader (Iser, 1980). Producing one interpretation does not prevent alternate interpretations from being made at different points in time or from different perspectives (Sontag, 1966/1998; Wolf, 1992). However,

it is necessary to claim *a* position, namely my own subjective position, which I have informed with interlocking theoretical frameworks based on the works of Deleuze and Guattari (1987), Freytag (1894/2007), and narrative therapists (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990). These frameworks provided me with a theoretical lens through which I could produce a reading of the ethnodrama allowing me to respond to the research question of how narratives have operated within the participants' experiences to produce and sustain the change from active alcoholism to long-term recovery while maintaining their relationship as a couple.

Conclusion

While data analysis has been described here in a distinctive, linear way for ease of understanding, the actual process was messy (Bhattacharya, 2017; Dawson, 2006; Mellor, 2001), with inductive, ethnodramatic, and narrative analyses evolving concurrently. Each analytic method interacted with the others and with the theoretical frameworks that provided an interpretive lens for findings. Furthermore, the production of the ethnodrama incorporated creative writing approaches which also expanded opportunities for producing knowledge from the data (Richardson & St. Pierre, 2004). Finally, it is necessary to acknowledge the transformative nature of writing the experiences of the participants in order to create an ethnodrama which will be theatrically engaging and entertaining to an audience. To that end, details were altered, amplified, muted, synthesized, embellished, and arranged to highlight the emotional and thematic resonances of the play, thereby creating a greater number of entry points for audience members to vicariously experience the lives of the participants (Barone & Eisner, 2012; Saldana, 2011).

Trustworthiness & Rigor

Tracy (2010) outlines eight criteria for evaluating the quality of qualitative work. She acknowledges, that qualitative research is a diverse field and perhaps not all of the criteria will apply to every study. Methodologists have warned against a too-rigid application of criteria for rigor in qualitative research as potentially restrictive and reductive (Barbour, 2001; Trainor & Graue, 2014). However, if used cautiously as general guidelines, the criteria may be helpful in guiding the development of rigorous research (Trainor & Graue, 2014). Each of the eight criteria will be outlined below and their application to the proposed study discussed.

Worthy Topic: A topic is worthwhile when it has a usefulness and appeal beyond the mere creation of knowledge (Tracy, 2010). The US Surgeon General's office released a report in November of 2016 addressing the epidemic of addiction in America. In the report were calls for destigmatizing addiction, which is a barrier for seeking treatment, and a greater focus on recovery beyond treatment in order to sustain changes. This study was created with an awareness of the surplus of negative addiction stories in social discourse. Addicts are often portrayed as destructive and monstrous in popular culture. In these stories (e.g., *Sid and Nancy*, *Requiem for a Dream*), they often end up destitute, dead, or in prison. However, these stories don't reflect the lived experiences of millions of addicts living successfully in recovery. The stories of these individuals are ones of hope and optimism. It is possible for life to improve and for people and families to overcome addiction and live positive lives. In proposing this study, I have been intentional about telling *this* story.

Rich Rigor: According to Tracy (2010), rigor is derived from research design, data collection and analysis procedures that are grounded firmly in theory. This study is rooted in narrative theory, which holds that people's lives are storied (Holstein & Gubrium, 1999a). Thus,

creating change in clients' lives involves a re-storying process (Parry & Doan, 1994; White & Epston, 1990). The goal of this study is to explore the ways in which narratives of alcoholism and couple-hood systematically change with the formation of the recovery narrative.

Sincerity: Tracy (2010) relates sincerity to other terms such as self-reflexivity, vulnerability, honesty, trustworthiness, and transparency. In an earlier chapter, I presented a section disclosing my own subjective positionality in relation to the topic. In doing so, I have attempted to be candid and transparent about my experiences, attitudes, and opinions so that readers may get a clear sense of the perspective from which the study has been developed. Furthermore, it can be said that an author cannot completely separate themselves from their writing. As I noted earlier, it was necessary for me to entangle the participants' experiences with my own in order to represent an empathetic and authentic representation of them. Audiences may judge whether I have been vulnerable in my writing.

Credibility: Denzin (1978) discussed the concept of triangulation in terms of convergence on truth from multiple data sources, researcher perspectives, or other forms of replication logic, which produces some degree of validity for qualitative studies. This conception has since been criticized for reflecting a positivist perspective on qualitative data analysis that doesn't fit well with the post-structuralist assumptions that guide modern qualitative research (Tracy, 2010). The process of triangulation has been reframed as "crystallization." Richardson & St. Pierre (2004) described the crystal as a figure which was multifaceted, able to produce different reflections and refractions as it was observed from different angles. Thus, multiple data sources are no longer inspected for convergences on a single truth but are instead investigated to produce a multiplicity of perspectives, which creates a deeper and more nuanced holistic understanding of the phenomenon under investigation (Tracy, 2010).

In this study, crystallization is achieved through the use of multiple participants (Michael and Mia), and multiple sources of data (interviews, observations, documents, other elicitations). The data obtained sometimes represents competing or even contradictory viewpoints. However, I do not attempt to erase the tensions between them by collapsing them into a single truth which privileges one perspective over another (e.g., the individual in recovery over the spouse). Instead, I have worked to preserve these multivocal tensions and points of contrast in my representation of the findings (Tracy, 2010). Furthermore, as researcher in the midst, I also monitored the presence of my own voice in the production of the narrative. While I resisted the urge to position myself as the judge or arbiter of truth, it would also be disingenuous to deny my own subjectivity in constructing the findings. Therefore, the only solution was to take postures of transparency, self-reflexivity, and vulnerability (Tracy, 2010). Specifically, I have attempted to foreground the *constructive* nature of this research as being socially produced in a particular context from a particular perspective. In this way, participants are informed of the perspective from which conclusions have been produced and are better able to make judgments of the credibility of those conclusions.

Resonance: By producing an ethnodrama (Saldana, 2011) informed by the standards of ABR (Barone & Eisner, 2012), my goal is to produce research which is highly resonant, aesthetically appealing, and emotionally engaging, in addition to highlighting the issues relating to a couple adjusting to recovery from alcoholism. I have attempted to follow the old writing adage of showing rather than telling. I've done so by creatively elaborating and editing the raw data obtained from the participants into a coherent narrative and using metaphors and symbols to produce moments of emotional resonance that mere observable facts could not have produced (Combs & Freedman, 1990). The resonance of the script was assessed through member checks, a

dramatic reading by students in the theatre department, as well as through my own self-reflexivity as a creative writer. However, it will ultimately be up to each individual audience member to decide what subjectively does or does not resonate with them.

Significant Contribution: There are several contributions this study may make. First, as noted above, this study may help to destigmatize addiction and recovery and to provide a positive alternate narrative to those that dominate social discourse which portray addiction as hopeless. Additionally, this study seeks to provide insights for clinicians and other professionals working in the addictions field, as well as for recovering addicts and their families, about how families may positively support the project of recovery. With the information generated by this study, professionals may be able to tailor effective interventions to help couples through treatment and afterwards in order to prevent relapse and sustain the sobriety of the recovering addict. Finally, this study examines recovery from a narrative lens. As such, it is paradigmatic of the re-storying process discussed by narrative therapists (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990), using recovery as an obvious example of this process of change and development. Therefore, this study may contribute to building a base of evidence for the narrative therapy approach.

Ethical: In order for any study to be rigorous, it must be conducted ethically. In constructing and conducting the study, I consulted both the American Counseling Association Code of Ethics (ACA, 2014) and the American Educational Research Association Code of Ethics (AERA, 2011). The highest maxim of these codes is to do no harm. Notably, harm can take many forms apart from physical risks. I took care to consider the social, emotional, and relational risks to participants and judged that these would not be greater than they would encounter in their everyday lives. Nevertheless, I prepared resources to help them manage any emotional

trauma that emerged during the study and diligently inquired about the safety and security of participants in a private individual setting.

Meaningful Coherence: Tracy (2010) states that a coherent study “Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other.” Developing the script in this study involved intersecting the participants’ experiences with my own as well as the academic and theoretical literature, in order to produce a realistic representation of the couple’s transition from addiction to recovery. These connections were made with the guidance of the research questions kept in mind. Therefore, this study meets the criterion of being meaningfully coherent.

Chapter Summary

This chapter provided an in-depth exploration of the methodological considerations involved in the study. It began with a broad overview of qualitative research methods including arts-based research (Barone & Eisner, 2012; Leavy, 2015) and their applicability to the present research. I then reviewed the methodological frameworks guiding the design and data collection strategies before describing the process for selecting and gaining access to the participants and the way that potential ethical issues were managed in order to prevent harm to the participants. Next, I detailed the kinds of data collected for this study and how they contributed to answering the research questions. The data types collected for this study included interviews, observations, notes and journals, memory, and documents. I then described the processes by which the data was analyzed and transformed into findings. These findings included an ethnodramatic script portraying the experiences of the participants as they transitioned from active alcoholism to long-term recovery, as well as a subsequent reading of the script through a theoretical lens informed by Deleuze and Guattari (1987), Freytag (1894/2007), and narrative therapists (Freedman &

Combs, 1996; Parry & Doan, 1994; White & Epston, 1990). Finally, I discussed the ways that the methodological choices made in this study added to the overall quality of the study and aligned with Tracy's (2010) "big tent" criteria for qualitative research rigor.

The next chapter will begin with a short orientation to the ethnodrama as a deviation from the traditional format of counselor education dissertation writing. It will be followed by the ethnodramatic script entitled "Whiskey & Tangerines." Finally, a narrative analysis of the play will be provided examining the ways in which narratives have operated during the change process from active alcoholism to long-term recovery.

Chapter 4 - Research Findings

Introduction

In this chapter, I will present the findings from my study in the form of an ethnodramatic script (Saldana, 2011) titled *Whiskey and Tangerines*. The purpose of using playwriting as opposed to a more traditional form of qualitative representation is to establish an emotional engagement with an audience which may include members outside of academic scholars. Under the umbrella of Arts Based Research (ABR) (Barone & Eisner, 2006; 2012), ethnodrama aims to invoke an empathetic connection to the characters and their concerns.

It is important to differentiate participants who are real people living real lives and characters who are the experiences of those people represented on the page or stage. While qualitative researchers attempt to achieve data saturation in order to gain a holistic understanding of their participants experiences, this ideal goal always ultimately falls short. Though it might seem a stupidly obvious statement, researchers should note that the questions asked in an interview will shape the responses that one receives. The questions an interviewer can ask - and the variations on how those questions are asked - are near infinite, yet because of time constraints (an interview cannot go on forever), interviewers must be selective in their queries, and inevitably some details of the 'whole story' will be missed. Thus, character representations necessarily differ from the lived experiences of participants. Furthermore, even the most literal transcription of the participants' words is a co-constructive act of transformation and fictionalization, inviting audience members to imaginatively fill the gaps between what has been said in order to reproduce an understanding of the meanings and experiences of participants' lives (Iser, 1979).

The play presented here is not a literal transcription of participants' interview statements. Rather, there have been literary moves on the part of the researcher to achieve several objectives beyond a verbatim reprinting of interview transcripts. In orienting scholarly readers to the presentation of findings, I believe that it is important to be as transparent as possible about these literary moves. Foremost is an ethical concern for the anonymity of the participants. Pseudonyms have been assigned and specific details of their experiences have been obscured or fictionalized in order to protect their identities.

Secondly, to create believable characters of depth, it was necessary to "come alongside" participants. Coming alongside is a narrative inquiry practice recommended by Clandinin & Connelly (2000), in which the researcher develops an empathetic understanding of his or her participants' stories by entangling them with his or her own personal experiences. For example, while I am not myself an alcoholic, I have been able to use my experience of addiction to nicotine as an entry point into the participants' experiences of being addicted to alcohol. Furthermore, in my life, I've had my own experiences of being severely drunk and subsequently hungover, which I could apply to understanding Michael's experience of drunkenness. I have been in a committed relationship for over a decade, and while our conflicts and challenges may be somewhat unique, the fact that we have them is fairly common and creates a partially shared experience with the participants in this research. Finally, because of my review of literature and experiences working in a recovery center, I have gained a broad awareness of the kinds of issues that individuals and couples undergo in addiction and recovery, which provides me with insight into the particular experiences of the couple in this study. Rather than dismissing or bracketing these experiences, it has been necessary to integrate them into my understanding of the

participants experiences. In doing so, I am better equipped to produce a plausible script which may resonate emotionally with audiences.

Additionally, for reasons of aesthetics, cohesion, and incisiveness, artistic license has been taken with the details of the story (Barone & Eisner, 2012; Kim, 20016; Saldana, 2011). I have edited, and arranged the details presented to me through my data collection to create a coherent, concise, and incisive narrative (Barone & Eisner, 2012). For example, I have summarized the numerous problems and conflicts the participants experienced over many years of alcoholism into a single conflict portrayed at the beginning of the play. I have also used metaphors and other literary elements to highlight and amplify certain aspects of their recovery experience and to present a depiction that rings truer to the spirit of the subjective and emotional experience than was expressed in interviews. The script has been reviewed by the participants, as well as peers who are familiar with addiction and recovery in their own lives, to verify that the essence of their own experiences has been preserved and portrayed accurately.

While this script has been formed through qualitative research processes and is embedded within this academic dissertation as a presentation of my research findings, it is also intended to be able to stand alone as performable piece for a general public audience. Therefore, the formatting of the script intentionally deviates from APA (2009) style and instead conforms to typical playwriting style (Downs & Wright, 1998).

Following the script, I will return to APA (2009) format as I conclude this chapter by presenting an original model describing narrative change, through which I will provide an analysis of the play. In doing so, I will examine how multiple and entangled narratives have operated to shape the experiences of the individuals and couple as they transitioned from active alcoholism to long-term recovery.

WHISKEY & TANGERINES

By Paul Maxfield

Kansas State University, 2018

CAST OF CHARACTERS

Lead Characters

MICHAEL... An alcoholic

MIA... Michael's Wife

Rehab Group

COUNSELOR JOE... Counselor

FRANK... Older group member

KEITH... Confrontational group member

DOMINIC... Younger group member

GLENN... Quiet group member

Mia's Family

NICOLE... Mia's sister

GAVIN... Nicole's husband

TONY... Mia's father

JUSTINE... Mia's mother

Supporting Characters

OFFICER DAVE... Police officer

OFFICER GEORGE... Police officer

NURSE... A detox nurse

DRIVER... A driver for the recovery center

VOICE... The voice of Michael's father

NEIL... A recovering alcoholic

DRUNKS... Neil's companions, a man and a woman - no speaking lines.

NEW GROUP- 4 men, no speaking lines

SETTINGS :

A shabby living room

A detox center dormitory

A group counseling room

A recovery center cafeteria

Counselor Joe's Office

An evening backyard barbecue

A dark bar in the afternoon

PROLOGUE

(SPOTLIGHT FRONT CENTER STAGE.
MICHAEL walks to the light. He is middle aged, working class, overweight, with longish hair, which he has a nervous habit of running his fingers through. He's dressed in a surplus army jacket with 80's/early 90's college/alt rock band logo badges sewn on it (e.g., Nine Inch Nails, Dead Kennedys, Nirvana, Metallica, etc.) vintage band t-shirt, and a pair of jeans.)

MICHAEL

(Addressing audience)

I don't know, man... I don't know nothing, really... *(Long contemplative pause.)* All I know is just what I experienced. I can tell you about that, I guess... you know, for whatever it's worth. But if you came here looking for answers, keep looking, because I haven't got 'em. All I can tell you is that I don't know what I'm doing most of the time, and I'm scared as hell I'm going to screw it all up. But I'm doing the best I can, takin' it one day at a time, and I guess that's really all anyone can do. So far, it's been working for us... more or less. That's more than can be said for a lot of other people around here. I've seen addiction tear families apart. I've seen people getting into trouble, going to jail, you know, or going into the hospital... and sometimes they don't come out, you know? I've

MICHAEL (Cont.)

buried people, man. At *least* one a year. And relationships? I don't know anyone who's stayed married through it all and come out okay on the other side of recovery together... Except for us, you know? And you come here asking "What's your secret?"

(*Scoffs.*) I honestly couldn't tell you. We just never gave up on each other. Call it commitment, or perseverance, or just sheer stubbornness, whatever, but we're still together. I was a career alcoholic from my first drink at fifteen years old to my last at thirty-five. That's twenty years, and fifteen of them were with Mia. The things I put her through, I wouldn't have blamed her if she did leave...

(Pause. MICHAEL shakes his head.)

No, I probably would have blamed her at the time. But looking back... I have to be honest these days, especially with myself - you know, fearless personal moral inventory - I lied, I stole, I was selfish, I was a bully. I'm not proud of those things, but I did them. I had to own them before I could let them go. Fifteen years putting up with my shit, and then five more trying to figure out how to be in recovery together. Man... We never really looked back at the whole thing like this before. No one ever really asked us about it. Kinda puts it all into perspective. I mean, I guess I must have told everything a thousand times at meetings and everything, but not really all together like this. And it's funny, you know, every time I tell it, it's like the story's the same, but the meaning always changes. Know what I mean?... Anyway, let's start at the end; the night of my last drink.

(MICHAEL exits.)

END OF SCENE

SCENE 1

(A door slams. MICHAEL enters from stage right. His movements suggest that he is moderately inebriated. He becomes progressively more drunk throughout the scene. He removes his jacket and tosses it to one side of the sofa. MICHAEL then walks to the other side and collapses backwards onto the sofa. A mostly-full bottle of bourbon and an empty glass rests on the side table next to the sofa. He eyes the bottle for a beat, sighs loudly, picks up the glass and examines it. He grunts to himself and pours a large drink. Offstage, there's the sound of a car pulling up outside, and a car door opening and closing.)

MIA

(O.S., calling)

Michael? Michael are you home?

(MICHAEL sighs loudly again and drains about half his drink.)

MICHAEL

(To himself)

Here we go again.

MIA

(O.S.)

No, I'm fine. Really. Just go home. I can take care of this. It'll be alright. Thanks for taking the kids tonight.

(Offstage there is the sound of car doors closing and the car pulling away. MIA enters from stage right to find MICHAEL slouching on the sofa with his drink in his hand.)

MIA

Michael! What the hell? You just took off. We looked all over for you.

MICHAEL

You expect me to just put up with their shit?

MIA

What shit?

MICHAEL

Come on, Mia. You heard the way your father was talking. He thinks I'm a loser.

MIA

He never said that.

MICHAEL

He didn't have to. I got the message loud and clear. And your mother... Your mother! With all her questions, (*mimicking.*) "How's the job search Michael?" "Have you given any thought into going back to school?" "Do you and Mia need us to help out again this month?" She's always trying to rub my face in it.

MIA

I'm sure that's not what she meant.

MICHAEL

And you! You're always defending them! Always taking their side!

MIA

They're my parents, Michael.

MICHAEL

(*Angrily*)

And I'm your husband, Mia. Or did you forget that? For richer or poorer, sickness and health, and all that other crap until death do us part.

MIA

I didn't forget.

MICHAEL

You're supposed to be on my side.

(MICHAEL slaps his chest.)

My side!

MIA

I am on your side. We all are.

(MIA sits on the sofa next to Michael, pats his knee.)

MIA

My family doesn't hate you, Michael. They just want to help us.

MICHAEL

I don't need their help.

(MICHAEL drains the rest of his drink.)

I don't need anyone's help.

MIA

(Sarcastically)

Yeah, you're doing just fine on your own. For God's sake Michael, look at yourself. You promised you weren't going to drink today.

(MICHAEL defiantly picks up the bottle. MIA attempts to grab it away from him, but he snatches it back, turns his back to her, and pours himself another drink.)

MIA

You promised!

MICHAEL

I only had a couple.

MIA

Bullshit! Every day it's the same. You sleep 'til noon, spend the afternoon nursing your hangover and doing God-knows-what, and then you drink yourself into a stupor again all-night long.

MICHAEL

So what? I got it under control. I even cut back.

MIA

For a couple of weeks. Then you went back to just how you were before.

MICHAEL

Yeah, but I'm drinking Evan Williams instead of Maker's Mark. So, you know, I'm saving us money if you think about it.

MIA

Don't be stupid.

MICHAEL

You know what your problem is? You don't know how to relax. Here, come have a drink with me.

(MICHAEL offers his glass to MIA, who shoves it back towards him, spilling some of the liquor on his shirt. MICHAEL looks down at himself, and then at MIA with a shocked and offended expression.)

MICHAEL (*Cont.*)

What the hell!?! You used to be fun, you know. (*Softening.*)
Remember, we used to stay out all night partying. Just the two
of us. What happened?

MIA

I grew up, Michael. We had kids. Someone had to be an adult
around here. So, I stopped drinking. But you never did.

MICHAEL

The kids? (*MICHAEL looks around.*) Where are the kids?

MIA

They're staying with my parents. I didn't think they should be
here tonight.

(*MICHAEL inches closer to MIA on
the sofa.*)

MICHAEL

Oh yeah? So, you're saying we've got the place to ourselves?

(*MICHAEL places his hand on MIA's
thigh and leans in to kiss her.
She squirms away from him.*)

MIA

I'm not in the mood.

(*MICHAEL attempts to make another
move on MIA, but MIA escapes his
reach and stands. MICHAEL loses*

his balance and spills the rest of his drink onto the couch.)

MIA (Cont.)

I said no!

(MICHAEL frowns into his empty glass.)

MICHAEL

You never want to anymore.

(MICHAEL reaches for the bottle and refills his glass.)

MIA

Don't you think you've had enough?

MICHAEL

(Muttering)

Not nearly enough.

(MICHAEL takes a large drink, and then tops off his glass again. Sets the bottle back on the table.)

MIA

Stop it, Michael.

(MIA snatches the bottle from the table before MICHAEL can grab it.)

MIA (Cont.)

Just stop!

(MICHAEL quickly stands and takes an aggressive step towards MIA. MIA flinches and steps back. MICHAEL appears surprised by her reaction, shakes his head as if to clear it, and then sits back down on the couch.)

MICHAEL

(Dejected)

Fine, take it.

(MICHAEL picks up his glass and drinks. MIA shakes the bottle at MICHAEL.)

MIA

You know what this is? Do you? This was supposed to be a new pair of shoes for Katie. She's outgrown the last pair. She keeps complaining her toes are squished and her feet hurt. So, I took her to the store today, and she picked out a nice new pair. You should have seen how excited she was... until we got to the register, and I discovered that the fifty dollars I'd set aside was gone. Gone! She was in tears, and what was I supposed to tell her?

MICHAEL

(Shouting)

You're blaming me?

MIA

Who else?

MICHAEL

I didn't steal your money.

MIA

(Shouting and pointing)

Liar! Just stop lying, Michael. You'd rather get drunk than keep shoes on your children's feet.

MICHAEL

Yeah? I'm a liar? Then how come Katie was showing me her new shoes before dinner and how they light up when she walks?

MIA

I had to get my mom to buy them. And you know how mom loves to spoil Katie. I told her not to.

MICHAEL

Just trying to throw it in my face, again - I'm a loser who can't even support his own family, right? And you never stick up for me to them. *(Yelling.)* Well, I'm not going to take it anymore.

MIA

(Shouting back)

Hey! You think I like busting my ass at work every day just to keep us afloat? You think I like always having to ask my parents for money every month just so that we can keep the lights on and the kids fed? I keep telling them it's just temporary, just for

MIA (Cont.)

a little while until we can get on our feet. Every time I have to go to my father and ask for help with the heating bill or the groceries - every time I promise myself, this will be the last time. We'll change, we'll do better, we'll make it, so we don't have to beg from them anymore. And each time I make that promise, the more I know it's just another lie. I know it, and he knows it. And he knows I know he knows. I can hardly even look him in the eye anymore.

MICHAEL

Yeah, well, I do my part around here, too, you know.

MIA

Yeah? (*Scoffs.*) Like what?

MICHAEL

I look after the kids and the house while you're gone all day.

MIA

Yeah, sure. I'm the one who gets the kids up and ready in the morning. I'm the one who makes sure Katie gets on the bus. Then I go to work, and I spend all day worrying myself sick about whether you're really looking after Harmony, but we can't afford a nanny to take care of her. And God knows what you do all day, but I'm terrified that I'm going to come home one of these days and find our house has burned down with you and the kids inside it.

MICHAEL

What are you so worried about? We always talk during your lunch break, and everything's always fine.

MIA

*(Becoming increasingly emotional
as she speaks.)*

The reason I call you is because I *have* to. You make me check up on you. I don't know if you're still asleep or what's happening. And I can tell half the time that you're drunk when you answer, and I just *pray* that nothing bad happens to the kids while I'm gone. But I can't quit or take time off because I'm the *only* source of income in this household. If I don't work, we either starve, or we become totally dependent on my parents. And you've already made it perfectly clear how unacceptable that is to your manhood or whatever. And even with everything I do for us, we still come up short every month... because of this.

*(MIA shakes the bottle at
MICHAEL.)*

But God forbid I ask *you* to give anything up. No, instead I had to beg to get overtime hours at work, just to bring home some extra money for us. And when my boss finally agreed, you know what happened?

*(MICHAEL sits silently, staring
stone-faced at MIA.)*

Instead of working overtime, I got a call from Katie's school, and had to leave early to pick her up, because you couldn't even do that right.

MICHAEL

(Muttering)

Stupid nosy teacher.

MIA

She said you were drunk.

MICHAEL

I wasn't!

MIA

She said she could smell it on your breath.

MICHAEL

It was just one or two. It wasn't a big deal. I wasn't drunk.

MIA

I never felt so embarrassed.

MICHAEL

She overreacted.

MIA

I had to talk to her for an hour just to convince her not to call child services on us.

MICHAEL

Everyone's so goddamn sensitive these days.

MIA

Don't you get it, Michael? They could have taken our children away from us!

MICHAEL

You don't think I know that? I'm not stupid, Mia. I just made a mistake. One mistake, alright? That's all. What do you want from me? I'm not perfect. You've made that abundantly clear. I'm sorry. I wish I could live up to your expectations or your parents' expectations or whatever. But I'm a screw up. Is that what you want to hear? I'm useless and can't do anything right.

MIA

You know that's not what I want to hear.

MICHAEL

Yeah, well, you're not so perfect yourself, you know. Every chance you get, you're always nagging, criticizing, and picking at me. You make me feel like I'm three inches tall.

MIA

I have to be like that with you. It's the only way I know how to reach you anymore. You never listen. You just do whatever the hell you feel like. All you think about is yourself. (*Shouting.*) You and this damned bottle!

(MIA hurls the bottle at the stage breaking it.)

MICHAEL

What the hell did you do that for?!

MIA

Because I'm your wife, and I'm tired of coming in second to your whiskey. It gets all your love and attention, and there's nothing left for me, and I'm tired of feeling so lonely all the

MIA (Cont.)

time. God, I can't even talk to anyone anymore without worrying whether I'll end up being embarrassed.

MICHAEL

I knew it! You're ashamed of me.

MIA

(Beat.)

No, I'm ashamed of me. I allowed this to happen. I put up with it. I settled for it. And worse, I allowed the kids to be exposed to it... And I'm afraid that if I tell anyone, they'll know what an awful mother I am. So, I can't have any friends - No one ever comes over. I'm alone, and always hiding and apologizing and making up excuses for you, and I'm sick of it!

MICHEAL

Yeah, well, I'm sick of you blaming everything that goes wrong on me. You always walk all over me.

(MICHAEL drains the last of his drink, stands, throws the glass across the stage, and picks up his jacket from the couch.)

I'm tired of being everyone's doormat. I'm not always wrong, you know. Sometimes I get to be right, too.

(MICHAEL heads for the door.)

MIA

Where are you going?

MICHAEL

In case you hadn't noticed, babe, we're out of whiskey.

(MICHAEL exits, slamming the door. Offstage, the sound of a truck starting and peeling out of the driveway. MIA collapses on the sofa looking bewildered and exhausted. She begins to sob as the lights go down.)

END OF SCENE

SCENE 2

(The sound of a doorbell ringing insistently. Lights come up on the same living room scene. The broken glass has been cleaned up and a couple of suitcases are sitting in the middle of the living room. MIA enters from the left crosses to the right of the stage. She looks through the eyehole in the door.)

MIA

(whispering to herself)

Shit.

(MIA quickly fixes her appearance, and then opens the door to admit MICHAEL accompanied by two police officers: DAVE and GEORGE. They appear to be the same age as MICHAEL. The officers appear to be supporting MICHAEL who is so drunk he can barely keep on his feet. His face is dirty, his hair is a mess, and his clothes have grass stains on them.)

OFFICER DAVE

Hi, Mia.

MIA

Hi, Dave, George.

OFFICER GEORGE

We found him over at the high school. He was on the football field shouting and running around.

OFFICER DAVE

Technically, it was trespassing, but there was no real harm done.

OFFICER GEORGE

Just a noise complaint.

OFFICER DAVE

He did make us tackle him, though.

MICHAEL

(Drunken, shouting)

Touchdown!

OFFICER GEORGE

(Soothing tone)

Yeah, buddy. Nice one.

OFFICER DAVE

(To MIA)

Anyway, we figured maybe you'd want to look after him.

OFFICER GEORGE

Small community. Everyone in everyone else's business. You know how it is. Better to keep the gossip to a minimum.

MIA

No, I appreciate that. Thanks.

OFFICER DAVE

Besides, it saves us the trouble of taking him in, processing him, and all of that.

(OFFICER DAVE and OFFICER GEORGE
walk MICHAEL over to the sofa.
MICHAEL collapses onto it.)

MICHAEL

(Sing-shouting)

Breakin' rocks in the hot sun. I fought the law and the law won.
I fought the law and the law won.

OFFICER GEORGE

His truck is still over at the school. You'll probably want to go pick it up tomorrow morning.

OFFICER DAVE

Technically, he wasn't drinking and driving when we found him, but obviously we couldn't allow him to drive himself home in this condition.

OFFICER GEORGE

We're not going to ask how he got there.

MIA

I understand. Thanks, guys.

MICHAEL

(Singing louder.)

I needed money 'cause I got none. I fought the law and the law won. I fought the law and the law won.

OFFICER DAVE

Well, it was good seeing you again, Mia.

OFFICER GEORGE

Yeah. Wish it could be under different circumstances, but...

OFFICER DAVE

(Pitying)

Take care of yourself, alright? And if you ever need anything... Well, you know.

MIA

Thanks.

(MIA escorts DAVE and GEORGE to the door.)

MICHAEL

(Calling after)

Thanks for the lift, fellas.

OFFICER GEORGE

No problem, Michael. You just sleep it off now.

MICHAEL

Yessir, officer. *(Shout-Chanting.)* De-fence! De-fence!

OFFICER GEORGE

You got it, buddy.

OFFICER DAVE

G'night.

MIA

G'night.

OFFICER GEORGE

G'night.

(OFFICER DAVE and OFFICER GEORGE
exit. MIA returns to MICHAEL.)

MICHAEL

Man, those guys... Good guys. Known them since high school. Used
to play football together. Remember that?

MIA

Michael...

(MICHAEL stands unsteadily.)

MICHAEL

What've we got to drink around here, anyway?

MIA

Nothing.

MICHAEL

Nothing you know of... (*Scoffs.*) What do you know, anyway?

MIA

Michael, listen...

(MICHAEL goes to the trophy case and searches.)

MICHAEL

Dave, he was tight end, and George used to be the baddest linebacker around, man. And I played running back... Here, look at me.

(MICHAEL hands an old football photo to MIA. She barely glances at it.)

(*Insistent.*) Look!

MIA

I've seen it a hundred times before.

(MICHAEL takes the photo back and gazes admiringly at it.)

MICHAEL

I know, but... man! I used to be in great shape back then. Damn. It's hard to believe that was me.

MIA

Michael...

(MICHAEL replaces the photo and pulls a small bottle from behind a framed newspaper article.)

MICHAEL

Aha! Told ya.

(MICHAEL spins the cap off, and takes a long drink.)

MIA

Listen, Michael...

MICHAEL

(Singing and shuffling)

Left my baby and it feels so bad. Now my race is run. She's the best girl I ever had.

(Spins around MIA as if breaking a tackle, trips over the suitcases, and falls backwards onto the sofa.)

Oh shit!

MIA

Stop, Michael.

MICHAEL

(Going for the big finale.)

I fought the law, and the law won! I fought the laaaawwww, and the laaaawwwww woooooonnn!

(MICHAEL takes another big drink from the bottle, and then belches loudly.)

MIA

Shut up, Michael! Shut up! Shut up! Shut up! Shut up! Just shut the hell up!

(MICHAEL looks at MIA stunned.)

For God's sake! I just need you to shut up and listen for once.

MICHAEL

(Pouting)

Why do you have to be such a goddam buzzkill all the time? Huh?

MIA

I'm trying to talk to you... I don't even know why. You probably won't even remember this in the morning... But I need to say what I've got to say to you.

MICHAEL

Well, shoot. Whenever, you're ready...

(MIA takes a deep breath to steady herself and sits next to MICHAEL on the sofa.)

MIA

We can't go on like this.

MICHAEL

Whaddya mean?

MIA

I... I mean, I can't go on like this anymore... with you.

MICHAEL

But why not?

MIA

Look around you, Michael. This isn't how people live.

MICHAEL

It's how we live. It's fine. It's a hell of a lot better than lots of folks have it around here.

MIA

This isn't an argument. I'm not telling you this, so you can talk me out of it. I'm telling you just, so you know. I never expected that our lives would turn out like this when we got married. I don't know what I expected, but it wasn't this. I always thought that whatever problems we'd face, I'd at least be able to trust and respect and *like* my husband. And then I told myself, that it was okay, I could tolerate it... maybe even if I worked hard enough, I might be able to get you to change. But I know I can't control you. God knows I've tried. But you're your own man. You've always been that way. So, if you're going to kill yourself with this.

(MIA gestures to the bottle in
MICHAEL's hand.)

MIA (*Cont.*)

I guess... there's not really anything I can do to stop you... But
I'll be damned if I'm going to let you put my children in harm's
way.

(MICHAEL stands suddenly,
unsteadily.)

MICHAEL

(*shouting*)

They're my children, too!

MIA

Then why don't you act like it? What kind of father turns up
drunk at their child's school? What kind of father passes out on
the sofa while their youngest is crying in the crib? What kind
of father would rather buy a bottle of whiskey than a pair of
shoes for his child? Huh? Tell me.

(*A silent pause as MICHAEL takes
another drink and stares at MIA
with a look of hatred in his
eyes.*)

MICHAEL

See, I told you this is all your parents fault!

MIA

My parents? They don't have anything to do with it.

MICHAEL

Every time we visit, they're always trying to poison you against me.

(MICHAEL takes a drink, then falls back onto to the sofa.)

Everyone's against me. Everyone's been against me my whole life. I thought you were different, Mia. Don't you remember how it was when we first got married?

(MICHAEL caresses MIA's face. MIA pulls away.)

MICHAEL

It was like you and me - two against the world, and we didn't care what anyone else thought, because we would just do our own thing. What happened to us?

MIA

It hasn't been two against the world for a long time, Michael. Just one. One person working, coming home to look after the kids, and take care of the house, to make dinner. One person cleaning up after her drunk husband, making sure he's okay, and hasn't hurt himself or anyone else. One person taking all the responsibility, trying to make everything work, and somehow keep it all together. I can't depend on you for anything, so all I've got left to depend on is me. Just me alone, and you know what?

MIA (Cont.)

I'm tired. I am exhausted. Do you understand? I've been doing all I can - *For us.*

MICHAEL

So that's it, you don't love me anymore?

MIA

It's not like that.

MICHAEL

Did you ever?

MIA

Of course, I do. If I didn't love you, it would be so much easier to sit by and watch you destroy yourself. Why, Michael? Why do you hate yourself so much? I wish, for just one day, you could see what I see in you. You're better than this. And for fifteen years, I've been waiting for you to realize it, because I've loved you, and I believed in you, even though you didn't believe in yourself. But we've got two little girls. They didn't ask for this, and they don't deserve to watch their father drink himself to death. Anyway, I've given this a lot of thought because I didn't want to make this decision from emotion. You can do what you want, but we can't stay here anymore... Not like this.

MICHAEL

So, you're leaving? You're moving back in with your family?
(MIA nods.) And then what?

MIA

I don't know.

MICHAEL

Will you come back?

MIA

I don't know.

MICHAEL

Are we breaking up?

MIA

(Frustrated)

I don't know, Michael. *(Tearing up.)* All I know is we can't go on like this. Something has to change, because this...

*(MIA picks the bottle from
MICHAEL's hands.)*

This isn't working. It's killing you, and it's killing us. And me and the girls, we can't be part of that anymore.

*(MIA tosses the bottle back to
MICHAEL.)*

But you do what you've gotta do, and we'll see where we all end up.

(MIA stands.)

I've got a few more things to pack for the kids.

(MIA gestures to the open suitcases on the floor. MICHAEL seems to notice them for the first time, and a look of shock comes over his face.)

MICHAEL

What? You... You're really serious?

MIA

I'll go to my sister's tomorrow morning.

MICHAEL

What am I supposed to do?

MIA

I guess you'll figure that out whenever you're ready. (*Pause.*) I really hope you do before it's too late.

(MICHAEL stands and watches as MIA moves to exit stage left. MICHAEL attempts to sit back down on the couch, misses, and lands on the floor. MIA turns back, looks with disgust, and exits. MICHAEL unsteadily sits up with his back resting against the sofa. He holds the bottle in front of his face.)

MICHAEL

(To the bottle)

Et tu, Bruté?

(MICHAEL scoffs and begins to raise the bottle. Just as it touches his lips, he pauses, then lowers it. He swirls the remaining bourbon around - about two fingers, staring deeply into it for a few seconds. Emotions of desire, then anger, then regret, and finally despair cross his face. Finally, he looks in the direction MIA had exited.)

MICHAEL (Cont.)

(To the bottle.)

Shit. You used to be a lot more fun, too, you know? And even when you weren't as fun, you were there for me. Then you know, when the kids came along and stuff, you helped me get through the day and keep my shit together. But this isn't fun anymore. It's like big parts of me keep slipping away. *(Becoming emotional.)* And I don't even know where they go to. Oh God, what's the point of this? I don't know why I keep coming back to you, when all you do is keep bringing me down and screwing up my life. You've got everything. What the hell else do you want from me, you selfish bastard? Quit feeding off me!

(MICHAEL looks at the bottle again, then shakes his head. He sets it down on the coffee table, and slowly gets to his feet. And takes a few steps towards where Mia exited.)

MICHAEL (Cont.)

(*Shouting.*) Mia!

(MICHAEL pauses and takes one last look towards the bottle. After a beat, he continues towards the exit.)

Mia! You need to get me into detox right now.

(MICHAEL exits.)

END OF SCENE

SCENE 3

(Light comes up on the left side of the stage, where MICHAEL is lying on an old steel-framed bed with a single mattress. He sits up and swings his legs over the side, his head hanging as he stares at the floor for a minute. He looks sick, weak, and exhausted. Beside the bed is a white porcelain sink and mirror. To the back of the stage is a window frame with bars over it.)

MICHAEL

(To the audience.)

It was so obvious that even *I* couldn't deny it anymore. I needed to get a handle on my drinking... Desperate times call for desperate measures. I agreed to go to detox...

(NURSE enters from the right, and busies herself taking MICHAEL's blood pressure, heart rate, and temperature.)

I'd been through the spin-dry cycle before. It was always bad: the headaches, the feeling like you're going to puke your guts out, or maybe just crawl out of your skin, being drenched in sweat, exhausted, unable to sleep, shaking so bad you can barely feed yourself. Nurses constantly bugging you, taking measurements, asking about this and that, but your mind is just

MICHAEL (*Cont.*)

drifting so you can barely pay attention... You just tell them whatever you think they want to hear so maybe they'll leave you alone.

(MICHAEL irritably waves the NURSE away who gives him an offended look before exiting.)

And then there's the edge, the anxiety, the absolute terror that comes over you as the fog you've been under for years begins to fade, and you start to get your first clear glimpse of the total wreckage your life has become.

(MICHAEL goes to the mirror, appraises himself, then turns away in disgust.)

But all of that pales in comparison to the deep constant nagging thirst that strong coffee just can't quench.

(MICHAEL walks to the window.)

The first night I was there, I was seriously considering jumping out this window just to get a drink... And it's on the third floor! (*Laughs, then pauses and reflects.*) There was a part of me that would have even been okay with smashing my brains out, because at least then the thirst would be over.

(MICHAEL turns from the window.)

MICHAEL (Cont.)

But I didn't... And you know what kept me going? It wasn't Mia or the kids... even if that's what I told myself and anyone else who'd listen. Really, though, I was just looking forward to my next drink. I knew if I could stick it out for a week, and get it under control, Mia and everyone would get off my back. Sure...

(Lights up on the living room scene on the right side of the stage, down on the detox scene on the left of the stage. Cheesy sitcom-esque music plays. MIA is waiting. She runs to MICHAEL and kisses him. MIA leads him to the sofa. There is a newspaper lying there. MICHAEL picks it up, scans through it, and then folds it over to address the audience again. Meanwhile MIA leaves to the left of the stage to fetch MICHAEL a drink.)

MICHAEL

I knew things could be better. Maybe I'd find myself a job, and I'd only drink in the evenings. Just a few to relax from an honest hard day's work...

(MIA returns with a tall glass of bourbon on the rocks, and hands it to Michael, then she exits again. MICHAEL puts his feet up on the table, and contentedly sips his drink.)

MICHAEL (*Cont.*)

Mia in the kitchen making dinner. The kids playing quietly in the other room. An image of domestic bliss to make us forget all about this ugly little episode. That was the idea that kept me going through detox.

(MICHAEL places his drink on the side table, stands and walks back to the left side of the stage where the lights come back up on the detox scene and go down on the home scene. Music fades out.)

I never intended to go to treatment. I mean, I applied, but I knew they'd be full. They were always full. There was a waiting list for months. I figured if I had months, I could smooth things over with Mia, and we could just forget about it. I'd already arranged for a ride with another of the patients. She wouldn't even need to go out of her way. She could just drop me a few blocks from my house, by the liquor store on the highway. I could walk from there. And if this week without alcohol hadn't earned me the right to a drink or two when I got home, I didn't know what would.

(NURSE enters from stage right followed by DRIVER.)

NURSE

Michael, your ride is here.

MICHAEL

Didn't they tell you? I'm good. I got a ride home with Beverly. It's not a problem. Thanks, anyway.

NURSE

You didn't get the good news?

MICHAEL

Huh?

NURSE

A bed at the treatment center became available just this morning.

MICHAEL

(Dismayed)

I... uh... I didn't know... I mean... I really appreciate it and all, but I can't go now... I'm not ready... I've got too much to do at home...

NURSE

(Skeptical)

Mhm, like what?

MICHAEL

But what about my stuff?

NURSE

What stuff? Come on. Look at you, dude. I bet you could fit everything you own in a couple of garbage bags. Stop kidding yourself.

MICHAEL

It's just so sudden. I wasn't expecting it.

DRIVER

Listen, pal, no one can force you into treatment if you don't wanna go. But there are hundreds of other people who need that bed just as bad as you. You really gonna throw away this chance? For what? Be honest with yourself now; soon as you get outta here you're going right back to where you were before, ain't ya? All this detox won't mean shit. You know it as well as I do. You got a chance here to do something real, to make some real change in your life, and all you gotta do is go out and sit in the back of that van out there.

(A long pause as MICHAEL considers his options.)

Shit, man. It's not that hard. If you ain't ready, you ain't ready. Like I said, we got lots of people waiting on beds who is ready. I can't sit around here all day waiting on you to make up your damn mind. Good luck, pal.

(DRIVER turns and walks toward the exit.)

MICHAEL

(Urgent)

No! Wait! I'm coming.

(MICHAEL rushes to catch up to the
DRIVER. Both exit stage right.)

END OF SCENE

SCENE 4

(Lights up on front center stage where four men are sitting in the 6 chairs. Under the chairs are copies of the "Big Book." The men are GLEN, KEITH, DOMINIC, and FRANK. Their appearance is haggard. They seem tired, surly, and uncomfortable. MICHAEL enters from the left and sits in one of the unoccupied chairs. He looks around at the other men. MICHAEL grunts. The men grunt back. Then all hang their heads staring at the floor. After a beat, COUNSELOR JOE enters from the left. He's young, professionally dressed, and looking chipper and energetic in contrast with the other men who are slouched in their seats, looking bored and irritable.)

COUNSELOR JOE

Good morning! How are we all doing this morning?

(The men grumble unenthusiastically.)

As you see, we've got a new group member joining us; Michael.

(The men grumble again. Michael waves half-heartedly.)

COUNSELOR JOE (Cont.)

Great. So, we should probably go over the rules of the group again for Michael. What's rule number one? Anyone?

(Pause. COUNSELOR JOE looks around expectantly at the men who seem reluctant to speak.)

Frank?

FRANK

(Sighing impatiently)

This is Vegas.

COUNSELOR JOE

Meaning...?

FRANK

Whatever is said in the group stays in the group.

COUNSELOR JOE

Right. Confidentiality. Great. What else? Dominic?

DOMINIC

No bullshit. Keep it real.

COUNSELOR JOE

Uh huh. We want to be supportive of the group, but we also want to hold each other accountable. One of the biggest issues with addiction is dishonesty. We lie to others, we lie to ourselves, and a lot of the time we don't even realize we're doing it. So, this group can act like a mirror reflecting you back at you, encouraging you to get honest with yourself. What else? Keith?

KEITH

(Eyeing GLENN)

Everyone talks.

(FRANK & DOMINIC nod in agreement, also looking at GLENN.)

GLENN

What? I don't always have something to say.

DOMINIC

This ain't no damn A.A. meeting where you can just sit back and listen to everyone else talk.

KEITH

Yeah, man. No one likes it, but everyone else is putting their shit out there. It's not fair for you to keep all your shit to yourself.

FRANK

It's part of the process, Right, Joe?

(COUNSELOR JOE nods.)

FRANK (Cont.)

So, if you're not going to share what's going on with you, what's the point of even being here?

COUNSELOR JOE

So, what I'm hearing from the group is that they'd like Glenn to share more. You believe that it will be helpful for Glenn's recovery, and it would also help others in the group feel comfortable. Is that right?

(Nodding from the group members.)

What do you think, Glenn?

GLENN

No, I understand. And I'm serious about my recovery. It's just sometimes, I have a hard time putting my thoughts into words.

COUNSELOR JOE

Uh huh. Well, maybe we can work on giving you more space to do that. Alright? But let's get back to Michael for a minute. Michael, can you tell us a bit about what brought you to the treatment center?

MICHAEL

Well, a week ago my wife and I were having this huge fight, and-

KEITH

Bullshit!

MICHAEL

(Shocked.)

What's bullshit? It's true!

KEITH

It's bullshit. You're not here because you fought with your wife, man.

(MICHAEL Looks puzzled.)

FRANK

What's the first step?

MICHAEL

Step?

DOMINIC

Jesus! Dude doesn't even know the steps.

COUNSELOR JOE

Okay, let's go easy guys, it's his first day.

FRANK

The first of the twelve steps...

MICHAEL

Oh, uh, admit that you have a problem...

KEITH

(Reciting from memory.)

"We admitted we were powerless over alcohol and that our lives had become unmanageable."

MICHAEL

Yeah, I mean, sure. I admit it: I have a problem with alcohol, and I know it's causing trouble in my life.

DOMINIC

Bull-shit, dude!

MICHAEL

(Defensive.)

Damn! What the hell is your guys' freaking problem?

KEITH

(Enunciating each syllable.)

Pow-er-less... Un-man-age-ab-le...

FRANK

You wouldn't be here unless somewhere inside you, you recognized you *need* to be here. None of us *want* to be here, but there's no other option. You get it? The other option is death.

COUNSELOR JOE

Hang on, guys. Listen, Michael, I want you to do something for me, alright. How many hours are there in a week?

MICHAEL

Hours?

COUNSELOR JOE

Yeah.

MICHAEL

(Calculating)

Seven times twenty-four... One hundred forty... One hundred sixty... eight. Right?

COUNSELOR JOE

That's right.

GLENN

That was fast.

DOMINIC

Dude didn't even need a calculator.

COUNSELOR JOE

Okay, now, I want you to think of a typical week for you. Be honest. How many hours would you say you spend drinking?

MICHAEL

(Hesitant.)

On average... I guess... maybe... eight, nine a day.

COUNSELOR JOE

And you drink every day?

MICHAEL

Most days.

(MICHAEL looks around at the skeptical faces of the other group members.)

MICHAEL (*Cont.*)

Fine. Every day, yes.

COUNSELOR JOE

So, nine times seven is...

MICHAEL

Sixty-four.

COUNSELOR JOE

Sixty-four! That's over one third of your week. A full-time job is only forty hours. And then think about all the time that you spend either preparing to drink or trying to find money for alcohol or dealing with the consequences of your drinking, like the hangovers, or fighting with your wife. Let's be conservative... another fifteen? Twenty hours a week? Am I close?

(MICHAEL nods.)

So, we're talking about nearly eighty-five hours - about half of the week - spent on drinking. Now we're up to two full-time jobs, and a bit of overtime on top. Except you don't get paid to drink, do you?

GROUP MEMBERS

(*In unison.*)

No.

COUNSELOR JOE

You've got to pay to get drunk. You pay with your money.

FRANK

You pay with your health.

GLENN

With your family.

KEITH

Your dignity.

DOMINIC

Your soul, man.

COUNSELOR JOE

And eventually you'll pay with your life.

MICHAEL

(Defensive.)

I get it! You think you're telling me things I don't know already? Shit.

COUNSELOR JOE

No, we know you know. And do you know how we know?

(MICHAEL shakes his head.

COUNSELOR JOE maintains eye contact with MICHAEL.)

Frank, what was your number?

FRANK

Eighty-nine.

COUNSELOR JOE

Dominic?

DOMINIC

Seventy-four.

COUNSELOR JOE

Keith?

KEITH

Eighty-five.

COUNSELOR JOE

Glenn?

GLENN

When I was really on the stuff, ninety-six.

(COUNSELOR JOE taps his chest.)

COUNSELOR JOE

Eighty-three... You see? We've all been where you are. They say only an alcoholic can really understand what other alcoholics have been through. Well, you're surrounded by alcoholics here. We get it. You don't have anything you need to hide from us. You've just got to stop hiding the truth from yourself, and the truth is you can no longer tolerate what your life has become because of alcohol.

(MICHAEL nods.)

COUNSELOR JOE (*Cont.*)

And you've done everything in your power to get your drinking under control, haven't you?

MICHAEL

Yes.

COUNSELOR JOE

And nothing has worked, has it?

MICHAEL

No.

COUNSELOR JOE

And you've pretty much run out of ideas of what to do about it.

MICHAEL

(Becoming emotional.)

Yes.

COUNSELOR JOE

And that is what brought you here, correct?

MICHAEL

Yes.

COUNSELOR JOE

Okay. So, I want you to take a minute. Reflect on that. And when you're ready, repeat the first step back to us.

(MICHAEL looks down, picks up his
"Big Book," wipes his eyes,
pauses, then reads.)

MICHAEL

We admitted-

KEITH

(*Interrupting.*)

"I," Michael. "I admit..."

MICHAEL

Fine! *I* admit *I* am powerless over alcohol, and that *my* life has
become unmanageable.

COUNSELOR JOE

And do you want to get sober?

(MICHAEL looks around at the other
faces in the group, and sighs.)

MICHAEL

Honestly?

COUNSELOR JOE

Mhm.

MICHAEL

I... I don't know... (*Pause.*) I mean I know I should want to, but...

FRANK

You're scared.

(MICHAEL looks at FRANK with surprise.)

MICHAEL

How?... I mean, yeah, man. When you get down to it, I guess that's it.

DOMINIC

That fear is a real bitch, man. You know what I'm saying? We all got it. We all gotta deal with it.

COUNSELOR JOE

What's your fear, Michael?

MICHAEL

I've been drinking since I was fifteen. I don't really know any other way to be. Can I even handle my life without alcohol?

COUNSELOR JOE

Of course, you can. That's the whole point of treatment. You're here to learn a new way of living. A better way.

KEITH

It's like they say in the meetings - When you really want what we have, you'll take the steps to get it.

MICHAEL

(Hesitant)

Yeah, but... what if I let myself want it - like, *really* want it? And what if I try? What if I give all I have? And what if that's still not enough? What if I find out that being a drunk is all I'm really capable of? I mean, I've been a screw-up my whole life. Why wouldn't I screw this up, too?

FRANK

Yeah, well, there's at least one way to guarantee that. Look around, man. There aren't any chains on the doors. You can go whenever you want. Or you can stay here and at least try to get sober.

GLENN

You know, just because you've been doing the wrong thing your entire life doesn't mean you have to keep doing it. Every moment is an opportunity to do the next right thing.

COUNSELOR JOE

Listen, Michael, I'm not going to tell you recovery is easy. For most of us it's the hardest thing we've ever done. It takes courage and faith. Like you said, all you've ever known is alcohol, so you've got to take it on faith that there's something else out there for you... Just know that we and millions of other people in recovery have all been where you are now. We took the step. We chose life. We survived. Do you really think you're so uniquely screwed up that you're destined to fail where millions of people before you succeeded? Trust me man, you're not that special. All you have to do is try.

MICHAEL

So, that's it? That's all you've got? Try to get sober? What kind of bullshit counseling is that?

COUNSELOR JOE

Look, I've been doing this long enough to know it's pointless to argue with drunks who aren't ready to listen. But I know you're hearing me, all the same. I can't make you change. No one here can. All I can do is let you know there's another option to the way you've been living. And if that doesn't make sense now, maybe it'll make sense to you some time before it's too late. Sometimes all you can do is plant your seeds and hope. I've got hope for you, man, even if you don't. At the very least, you're here, which means you're not out there, and that's something. The rest can fall into place whenever you're ready.

(Lights down.)

END SCENE

SCENE 5

(Lights up on living room scene on the right side of the stage. MIA is sitting on the sofa with her sister NICOLE. They're drinking coffee.)

NICOLE

I don't understand. You've seen this before. How much longer are you going to put up with it?

MIA

It hasn't been like this before. He's really trying. He promised it was going to be different this time.

NICOLE

I've heard that before, too.

MIA

I know, but you haven't seen him since he started treatment. It's like he's a different person. I can actually talk to him.

NICOLE

I just don't get it. I mean, a couple of weeks ago you were ready to take the kids and move in with us. We had everything ready.

MIA

I know. You're a good sister, Nicole. But it's just that... I mean, I'm not ready to give up. It's not fair to the kids to just pull them away from everything they know. And it's not fair to me, either. This is my home, too. He shouldn't just get to drive me out of it.

NICOLE

Life's not fair.

MIA

You sound like dad.

NICOLE

Doesn't mean it's not true.

MIA

Well, fair or not, I just feel like it's got to be *my* choice. I don't want to let him or you or mom and dad or anyone else to decide for me.

NICOLE

We're just worried about you.

MIA

I know... Thanks.

(MIA smiles at her sister.)

Actually, it's kind of funny, but this past week I've been feeling better than I have in a long time.

NICOLE

Sure. Michael hasn't been around to drive you crazy.

MIA

(Laughing.)

Yeah. And I know exactly where he is for a change. And what he's doing. *(Pause, becoming serious.)* And that he's getting the help he needs.

NICOLE

And what about you? What do you need?

MIA

I don't know. I mean, I've gotten so used to making do and taking care of everything around here by myself... Even with Michael in rehab, it's almost as if it's just life as usual.

NICOLE

I'd hardly call the way you've been living "usual." God, Mia, this can't be the way you dreamed your life would turn out when you were growing up.

MIA

Yeah, well, who the hell ever did grow up to be a rock star princess marine biologist, anyway?

NICOLE

You know what I mean.

MIA

You don't see Michael. All you see is the whiskey, because that's all he's been showing anyone. But I know there's a good man inside him. He's smart, and funny, and kind, and he'll do anything for his family. When we drive somewhere, and we're talking, and it's just me and him, we have the best conversations. (Pause.) Do you remember when we were kids, and I was first dating Michael, and he gave me that Neutral Milk Hotel CD for my birthday? I played it for you, and you hated it.

(NICOLE grimaces and nods.)

I couldn't understand how you just didn't get it. I tried so hard to convince you how great it was. I kept playing it over and over because I wanted my big sister's approval. And all you said was that they couldn't sing or play their instruments... It drove me crazy! I talked to Michael about it, and I remember he told me, "The world is divided into people who get Neutral Milk Hotel, and those that don't. And we're in the minority, but that's cool because it makes it more *our* thing." Michael's like that. He's amazing, but either you get him, or you don't. Most people don't. But I really do... Anyway, I don't know what it will be like when he gets home, but I want to see for myself.

NICOLE

You've always been that way.

MIA

What way?

NICOLE

I mean... not stubborn exactly, but like you never take anyone's advice, you know? You always have to find out for yourself. So, I know there's nothing I can say to convince you. But it's hard, you know? All you let me do is watch while you keep putting yourself in these situations where you just keep getting hurt. I hate it.

MIA

I'm sorry, but I'm not ready to give up. When we got married, I made a vow to stay with him. Even with all the drinking and everything, I never stopped feeling that way for him. And it's just... I don't think I could live with myself if I didn't give us every possible chance.

NICOLE

Just know that you've always got a place to go whenever you're ready. You and the kids.

MIA

You don't even have to tell me. I know. *(Pause.)* Thanks, Nicole.

(MIA hugs NICOLE. Lights down.)

END SCENE

SCENE 6

(Darkness. A steady 4/4 drumbeat begins. Other drummers join in, rhythmically improvising around the beat. Lights up on the GROUP MEMBERS sitting in their chairs, beating the drums. They begin to recite the 12 steps.)

GROUP MEMBERS

(Chanting in unison.)

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

Two: We came to believe that a Power greater than ourselves could restore us to sanity.

Three: We made a decision to turn our will and our lives over to the care of God *as we understood Him*.

Four: We made a searching and fearless moral inventory of ourselves.

Five: We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

Six: We were entirely ready to have God remove all these defects of character.

Seven: We humbly asked Him to remove our shortcomings.

Eight: We made a list of all persons we had harmed and became willing to make amends to them all.

Nine: We made direct amends to such people wherever possible, except when to do so would injure them or others.

Ten: We continued to take a personal inventory and when we were wrong promptly admitted it.

DRUMMING MEN (*Cont.*)

Eleven: We sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

Twelve: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

(The drumming fades to a low volume, but continues. The lights dim. Spotlight on MICHAEL who stands and walks to the front of the stage.)

VOICE

(*O.S. Over the drumming.*)

Whenever you're ready...

MICHAEL

(*Confused.*)

Huh? Ready for what?

VOICE

Whenever you're ready to get out of the way...

MICHAEL

What?

VOICE

You can let me do my thing. It's alright. I've got this.

MICHAEL

Wait!... Hello?...

(MICHAEL returns to his seat. The volume of the drumming rises steadily, reaching crescendo, and then stops abruptly. The lights come up.)

DOMINIC

...My whole life, everyone's always been telling me God wants this, and God hates that, and these people are going to heaven, and those people are going to hell. Even as a kid, I didn't know what I believed in, but I knew I didn't believe in *that*. So, I got in here, and I started working the steps. All of a sudden they're like you gotta get in touch with God, and I was like "Nah, man. I'm good." Know what I'm saying? But they're like, you gotta. So, I went to Joe with it, because I didn't know what else to do. I was scared like if I couldn't "get right with God" like my folks were always saying, I was gonna fail treatment. So, I'm talking to Joe, and I was like, "I really want to get sober, but this shit doesn't make any sense to me." And he goes, "Okay, what *does* make sense to you?" And that kinda made me stop and think a minute, like "What do you mean?" And he said, "It says here 'a higher power as *you* understand him' - not your parents, or anyone else. How do *you* make sense of it?" And I hadn't really thought about it that way, like, "I get to choose?" So, I just kept praying - not to God, but maybe to like the universe, I guess. And the more I prayed, the more I got this idea that *something* was listening, because otherwise, you

DOMINIC (Cont.)

know, what was I praying to? I mean, was I just talking to myself, you know? So, then there's this accountability to whatever it is that's watching over you like an audience. Shit, even if it's just in my imagination - I'm pretty sure it's not waiting around to see me die drunk. I mean, watching me get wasted all the time has got to be boring as hell - and I actually lived through that shit! (*Chuckles.*) Anyway, I still don't really know what my higher power is - It's not like this perfect idea that I've got all figured out, but at least it's mine, and it feels *real* to me.

COUNSELOR JOE

Great. Thanks, Dominic. Anyone else want to share about their higher power?

MICHAEL

I guess it's been kind of the same for me. I was never really religious. My family didn't go to church or anything. So, I've been struggling with the whole higher power thing, too. But like they say, you've just got to fake it 'til you make it. So, we do meditations every morning and night. And every time, I'm just sitting there, you know, waiting for something to happen... and nothing... My mind just wanders.

COUNSELOR JOE

Where does it wander to?

MICHAEL

It's just this memory from when I was a kid. My dad used to take me hunting with him way out in the country. He had a pick-up truck he'd take off-road and listening to all his empties

MICHAEL (Cont.)

rattling around in the back - I used to love that noise. Anyway, when I was twelve, he decided to teach me to drive the truck. Out in the middle of nowhere, there was no traffic to run into or cops to pull us over. So, once I got the basics down, I thought I was pretty hot shit. I didn't want to listen to him anymore. Well, you can probably guess what happened, but it wasn't too long until I got stuck in a patch of mud. I was trying to power through it, you know, but the tires just kept spinning and spraying dirt all over the place. I started panicking. Then I looked over at my dad, and he was just sitting there, drinking his beer, kinda laughing to himself. I hated him for it. I really wanted to show him I was a man who could manage the truck, but he was looking at me like I was just this dumb little kid. Finally, he said, "Whenever you're ready to get out of the way, you can let me do my thing." I remember how much it hurt - like, *physically* hurt - to swallow my pride, and let my dad take over. I remember he looked at me, and I guess he could see I was trying hard not to cry. He just said "It's alright. I've got this." So, I got out and he took over and got the truck out. I remember, the whole time, he was never mad or worried. He just handled it. *(Pause.)* I mean, I know I'm supposed to be praying to God or whatever, but I just keep thinking about that time.

(The GROUP laughs.)

What? Why is that funny?

GLENN

It's the forest for the trees, man.

KEITH

Your higher power is talkin' to you. But you're so busy looking for something else, you can't even see it.

DOMINIC

(Laughing.)

Yeah, dude. You're like "Where's my higher power?" And it's waving its arms in your face, like "Look, man, I'm right here!" And you're still like, "Where is it? I don't see it."

MICHAEL

I thought I was supposed to get like this big psychedelic flash of light and to see eight-armed Jesus riding a unicorn or something.

FRANK

They don't treat alcoholism with LSD anymore. You know that, don't you?

MICHAEL

No, I get that. But it's only a memory. You know, it's just in my head. It's not like a vision from God or anything.

GLENN

Isn't it?

MICHAEL

Is it?

FRANK

What would be the difference?

COUNSELOR JOE

It's a memory that means something to you, right?

MICHAEL

Yeah, I guess.

COUNSELOR JOE

What does it mean?

MICHAEL

Just that I'm always trying to power through whatever it is and that doesn't always work. It keeps me stuck.

COUNSELOR JOE

Uh huh.

MICHAEL

(Slowly.)

And maybe, like I just need to get out of the way of whatever it is that's supposed to happen instead of trying to force my own way. And sometimes, that means giving up control.

KEITH

Don't take this the wrong way, but that's maybe the first thing you've said since you've been here that didn't make me think you were completely full of shit. There just might be hope for you after all.

GLENN

(Contemplative.)

Hmm.

COUNSELOR JOE

Glenn?

GLENN

Huh?

COUNSELOR JOE

It seemed like you just had a thought.

GLENN

Yeah, well... I was just thinking... Like, Michael, you say this voice or memory or whatever. It keeps telling you to get out of the way, right?

MICHAEL

Yeah.

GLENN

I mean, when you're saying, it's nothing, it's just a memory- Or you're asking whether it's real? Isn't that you just getting in the way again? In the end does it really matter if it's just a memory or a message from God or whatever?

MICHAEL

I... I guess not.

COUNSELOR JOE

What might it look like if you were to get out of the way? What would you do differently?

MICHAEL

I guess I'd stop questioning everything. I'd trust the program.

FRANK

So, why don't you give that a shot? Maybe let the program be your higher power until you get a better idea.

(COUNSELOR JOE sits forward and claps his hands loudly.)

COUNSELOR JOE

Okay, good session today. Sometimes it may not seem like it, but you guys are making progress. Keep working on your workbooks. Seriously, don't slack off on those. You can always come find me if you need help. Otherwise, have a good lunch, and I'll see you all tomorrow.

(Everyone gets up to leave. FRANK claps MICHAEL on the back as they exit. lights down.)

END SCENE

SCENE 7

(Stage left is a cafeteria scene. FRANK is sitting alone at one of the tables, slowly peeling a tangerine. There are two more tangerines on his tray. MICHAEL enters holding a tray with lunch, he looks around, spots FRANK and heads to the table.)

MICHAEL

Is it alright if I sit here?

(FRANK grunts and gestures to the seat, not taking his eyes off the tangerine. MICHAEL sits.)

Fish sticks and fries again, huh?

FRANK

Mhm.

(MICHAEL unenthusiastically pushes his fish through a puddle of ketchup, and holds it up, examining it in the light. He takes a bite, chews and swallows quickly. FRANK continues to fixate on the tangerine.)

MICHAEL

So, you got anyone coming to visit after lunch?

FRANK

Nope.

MICHAEL

That sucks, man. Sorry. My wife Mia is coming. She was supposed to come last week, but something came up - her mom got sick, or at least that's what she says. I don't know. I feel like something's always coming up that takes her away from me. I mean I know, I can't always be like the center of attention, but it's like come on, it's a pretty big coincidence that her family always needs her when she's supposed to be spending time with me, you know?

FRANK

Ah.

MICHAEL

I mean, I'm in here, working my ass off to get sober, you know, so I can be a better husband and father. She has no idea. You'd think the least she could do is show some support..

(MICHAEL slowly takes notice of
FRANK's attention to the
tangerine, as he speaks.)

But her family is always distracting her with one thing or another..

FRANK

Hm.

MICHAEL

Okay. What's the deal with that orange?

FRANK

It's a tangerine.

MICHAEL

Alright. What's the deal with that tangerine? You've been peeling it forever.

FRANK

I met a guy once who used to say that eating a tangerine is real enlightenment.

MICHAEL

(Laughing.)

What?

(FRANK pauses his tangerine peeling to look at MICHAEL.)

FRANK

It's true. Here, try it.

(FRANK tosses a tangerine to MICHAEL, then resumes peeling his own tangerine.)

MICHAEL

I've had a tangerine before.

FRANK

Have you?

MICHAEL

Yeah, man. We used to get cases of them around Christmas when I was a kid. I don't remember any of them being the secret key to Nirvana, though.

(Michael quickly peels the skin from the tangerine and pops a couple of segments into his mouth. He keeps eating as he talks.)

Anyway, I'm pretty sure her whole family hates me. They're always looking down on me. - Okay, I've got to be honest, I really haven't been the greatest husband. But I'm really trying to get better now.

FRANK

Where are you now?

MICHAEL

What do you mean? I'm right here.

FRANK

No. You're with your wife, out with her family, miles away from here. What happened to your tangerine?

(MICHAEL looks down to find only a couple of segments left in his hand.)

MICHAEL

I ate it.

FRANK

You consumed it.

MICHAEL

Sure, what's the difference?

FRANK

When you consumed it, you barely even noticed it. It was just a thing to put inside your body. Your mind was elsewhere. Here try again.

(FRANK tosses the last tangerine to MICHAEL.)

This time, take your time, focus. Hold it in your hands, feel the texture of the skin.

(MICHAEL turns the tangerine over in his hand, rubbing it.)

Smell it.

(MICHAEL raises the tangerine to his nose and inhales loudly.)

MICHAEL

It smells clean... fresh... like summer.

FRANK

Mhm. Now start to peel it... slowly.

(MICHAEL begins to peel the orange, following FRANK's instructions.)

Feel the spray of citrus oils as you dig your fingers into the skin... Take your time... Now pull the halves apart. Listen to them whisper as they separate... Good. Now take one of the segments... Hold it between your thumb and finger. Squeeze it gently. Feel how it resists your pressure... and when you're ready, you can put it in your mouth.

(MICHAEL puts the tangerine segment into his mouth and closes his eyes.)

Don't chew. Just feel it. Let your whole mouth experience it. Okay, now you can start to chew it. Slowly. Let the juices explode over your tongue as you bite down. Can you feel it?

MICHAEL

Yes.

FRANK

Can you taste it?

MICHAEL

Yes.

FRANK

And where are you now?

(MICHAEL opens his eyes and looks surprised.)

MICHAEL

Here... Really here.

FRANK

And the tangerine?

MICHAEL

(Admiringly.)

I've never had a tangerine like this before.

(FRANK nods, knowingly.)

FRANK

Mhm... You know, they keep saying 'take it one day at time,' or if you can't do a whole day, then an hour, or a minute. Commit to not drinking just in this minute. But it helps if you're actually living right here in the minute. Not an hour from now, or a day in the past, or a mile away, but right here, right now. You know what I mean?

(FRANK stands.)

FRANK (*Cont.*)

Anyway, it's almost time for visitors. Enjoy your time with your wife, alright?

MICHAEL

I will. Thanks, Frank.

(FRANK exits. MICHAEL continues to contemplate his tangerine, sucking on one of the segments. After a moment, MIA enters in a rush, dressed in scrubs, looking flustered. She crosses the stage to meet MICHAEL who stands to greet her.)

MIA

Oh my god, Michael, I have had the *worst* day. Angela, the new assistant, screwed up the paper work, and we had to spend hours fixing her mistakes, and then just as I was about to leave, we had an emergency case, and I had to stay back another half hour to handle that, and I didn't even have time to go home and change, I just came straight here, but I was driving too fast, and I got pulled over, and they just gave me a warning, but you know how they are-

(MICHAEL interrupts MIA with a tender hug.)

Wha-?

MICHAEL

Shh...

(MIA's body is stiff at first, but then relaxes. The couple stay embraced for a moment. Finally, MICHAEL lets go. They sit down at the table.)

MIA

What was that about?

MICHAEL

Nothing...

(MICHAEL breaks off a segment of tangerine and offers it to MIA.)

Here.

(MIA accepts it, looking puzzled, and puts it in her mouth. The lights go down.)

END SCENE

SCENE 8

(A mildly cluttered, but comfortable looking office. COUNSELOR JOE is seated at a desk, working on his computer. To one side, there's a stack of files, and a large coffee mug. There's a knock on the door, and MICHAEL appears, looking sheepish.)

MICHAEL

Hey. Got a minute?

COUNSELOR JOE

Sure. Just gimme a second.

(COUNSELOR JOE finishes typing the last few lines of the report, then closes the file, and shuts off the monitor.)

Okay. Come on in, Michael. Have a seat.

(MICHAEL enters and sits.)

What's up?

MICHAEL

Well, it's just... I just wanted to say, I know I've been kind of one foot in and one foot out with this whole thing.

COUNSELOR JOE

Mhm. I know you've been resistant... or maybe uncertain is a better word.

MICHAEL

Uh-huh.

COUNSELOR JOE

I also get the sense that you're a pretty bright guy.

MICHAEL

I guess so. I mean, I like to read. And I went to college for awhile. I even got straight A's in all my classes- though I was drunk most of the time.

COUNSELOR JOE

I've often found that the intelligent ones have the most trouble... at least at first. In some ways, it helps to be stupid about recovery. When you tell a stupid person they can't drink anymore, they simply accept it as a fact, you know? A smart person is going to ask why not? They're going to look at all the different options and conduct a cost-benefit analysis on each of them, trying to find the best possible outcome. You know what I mean?

MICHAEL

(laughing.)

Yeah, I guess that's what I've been doing.

COUNSELOR JOE

Of course, we already know what the best possible outcome is, and that's sobriety. But intelligent people feel like they need to take the long way to reach that same conclusion.

MICHAEL

That's kinda dumb.

COUNSELOR JOE

It can really be a difficult path, because the smarter you are, the better you're going to be at coming up with justifying your drinking. But it's just the alcoholic brain. It's afraid. It knows what you want to do to it, and it's fighting for its life. It'll fight dirty, too. But keep in mind, Michael, the alcoholic brain only wants to drink. It doesn't care about you or the people you love. It will step on you and them to get what it wants. Even now, you can see what it's done in your life. And the question I want you to ask yourself now is are you okay with it?

MICHAEL

No.

COUNSELOR JOE

Are you going to let your alcoholic brain get away with what it's been doing to you? To your family? Are you just going to allow it to push you around? Would you tolerate this kind of treatment from anyone else?

MICHAEL

No!

COUNSELOR JOE

But you're going tolerate it from yourself?

MICHAEL

No. Not anymore.

COUNSELOR JOE

And are you ready to do something about it?

MICHAEL

Yes! I'm ready! Just tell me what I need to change.

COUNSELOR JOE

Well, that's easy. Just one thing.

MICHAEL

What?

COUNSELOR JOE

Everything, man.

MICHAEL

(Pause.)

What do you mean?

COUNSELOR JOE

It's not enough to just stop drinking. If you want recovery, you've got to change everything about the way you've been living. Here, look at this.

(COUNSELOR JOE pulls a well-worn, dog eared copy of the Alcoholics Anonymous book from his bookshelf. He opens to the page outlining the 12 steps, and hands the book to MICHAEL.)

COUNSELOR JOE (*Cont.*)

Read it.

(MICHAEL reads with his finger scanning the page.)

MICHAEL

It's just the steps. I've read this already.

COUNSELOR JOE

Uh huh. How many of the steps explicitly mention alcohol?

MICHAEL

Um... The first one and... the last one talks about alcoholics but not really alcohol.

COUNSELOR JOE

Right. Here's the thing: This program isn't really about alcohol. It's a way of living for people with alcoholism. Because without changing your lifestyle, you're just setting yourself up to get outsmarted again and again by that sneaky, manipulative alcoholic brain of yours. You understand?

MICHAEL

Uh huh.

COUNSELOR JOE

But the program doesn't work if you don't work it. There's nothing supernatural about the twelve-steps, alright? You can't just recite them like a magic spell and expect everything to change. It doesn't work that way. The steps are a guide, but the work is yours to do. Growth is always hard work, but the reward is your life. You've got to believe that it's worth it. Are you worth it, Michael?

MICHAEL

(Considering, then nodding.)

Yeah. I think so.

COUNSELOR JOE

Don't just think it, be it. I'm telling you, man, I've only known you a few weeks, but I can see that you sober, man, you've got so much to offer this world. But you drunk, that's not much use to anyone, including yourself. So, I'll ask you again. Are you ready to commit to working the program?

MICHAEL

Yes. I'm ready. I want this.

COUNSELOR JOE

Good.

MICHAEL

(Pause.)

Thanks for being patient with me.

COUNSELOR JOE

Like I said, sometimes you just plant your seeds and wait for them to grow. I'm glad to see you're finally ready to start sprouting.

(Lights down.)

END SCENE

SCENE 9

(Group therapy scene with MICHAEL,
COUNSELOR JOE, KEITH, GLENN,
FRANK, and DOMINIC.)

MICHAEL

You know, it's funny. When I first got here, I couldn't wait to get out again. Now that I'm about to go home, all I wish is that I could stay a little longer. I don't know if I'm ready for this.

KEITH

It's like they say - you don't have to go home, but you can't stay here.

MICHAEL

Maybe I'll just go out and drink, so I can come back here.

KEITH

Come on, man. Don't say that.

MICHAEL

Sorry, it was just a joke. But, I feel safe here, you know. There's structure and there's support... security. In here, I feel confident, like, "yeah, I can do this." I've never felt like that about anything before. But that's in here. Out there...? That's where alcohol lives, you know?

DOMINIC

You ever play any MMORPGs?

MICHAEL

M... M- what?

(The rest of the group looks puzzled. DOMINIC rolls his eyes.)

DOMINIC

(Slowly.)

Massive Multiplayer Online Role Playing Games. You know, like World of Warcraft, or Guild Wars? (Pause. Dominic rolls his eyes.) What? Y'all still playing Pac Man? Well, there's these computer games where thousands of people log into this fantasy world. The place where everyone starts the game is called the spawning point. That's where you learn how to use the controls and how to play the game. It's always crowded with all these annoying newbs crashing around into each other and asking a bunch of dumb questions. That's what rehab is like, man. I mean, I know we're all newbs here, and everyone's gotta learn somewhere, but you don't want to stay at the spawning point forever. It's boring. If you really want to build your character, you gotta get out, go on quests, beat enemies, and actually do some stuff. You know?

MICHAEL

Sure, I get it.

COUNSELOR JOE

You know, Michael, you've definitely struggled with faith in your time here. Faith in the program, faith in a higher power, even faith in yourself, and your ability to get sober. This is another one of those leaps of faith - faith that you have the

COUNSELOR JOE (*Cont.*)

tools and the potential to succeed on your own. You have a plan for discharge - what you're going to do as soon as you get home?

MICHAEL

(Nodding.)

Ninety meetings in ninety days, right? The first one within the first twenty-four hours.

COUNSELOR JOE

And you have strategies for dealing with temptation and avoiding triggers?

MICHAEL

Uh huh.

COUNSELOR JOE

You have a sponsor who can continue working with you in your recovery.

MICHAEL

Yes.

COUNSELOR JOE

And you have a contingency plan for if you slip up to keep a lapse from turning into a full-blown relapse.

MICHAEL

Right.

COUNSELOR JOE

So, you've got the tools you need to be successful.

FRANK

But you've still got the fear. That alcoholic brain trying to drive you into panic, telling you you can't do it.

GLENN

I think we've probably all got the fear.

FRANK

All I know is either you can let the fear chase you around, make you avoid everything you need to be doing, or you can lower your head and run straight at it. And when you stand up to your fear, a lot of the time it'll back down. It isn't really anything, just a bluff.

DOMINIC

That fear ain't nothing but a chicken-shit bully.

KEITH

What is it about leaving that you're really afraid of anyway? Is it the act of opening the door?

MICHAEL

No.

GLENN

What about just walking outside?

MICHAEL

Of course not.

DOMINIC

Maybe you're afraid of your wife.

(Laughter from the group.)

MICHAEL

Not usually.

COUNSELOR JOE

So, what do you think the root of this fear actually is?

MICHAEL

I mean, if I had to say, it's... I mean now that I'm thinking about it, it's always kinda been there - Even when I was drinking, you know? It sounds kind of weird, but it's a fear of.. freedom.

FRANK

And responsibility.

MICHAEL

Yeah... Shit... You know, that was the thing about being a drunk- I knew how to do it. I was good at it. And no one really expected much from me. Hell, I didn't expect much from myself. And now, I can't be nothing anymore. I have to be *something* - Someone with a purpose. That's what's scary - I don't know if I'll ever be as good at anything as I was at getting drunk.

COUNSELOR JOE

Like the last step says: "We tried to carry this message to other alcoholics." Okay? Your sobriety is carrying the message of hope to others who need it, whether you mean to or not. Just that alone gives you a purpose. And being sober, you have the

COUNSELOR JOE (*Cont.*)

potential to be even more than that. Just take it one day at a time and keep working the steps.

MICHAEL

Thanks. And don't take this the wrong way, but I hope I never see this place again.

COUNSELOR JOE

(Laughing.)

Well then, in that same spirit, good riddance to you all.

(The men stand and shake each other's hands. COUNSELOR JOE hugs MICHAEL. They head for the exit.)

And seriously, good luck to each of you. Don't hesitate to reach out if you need anything. I'll be here for you.

(Lights down.)

END SCENE

SCENE 10

(Lights up on left front stage.
MICHAEL enters, looking back over
his shoulder. He carries a copy of
the AA book in one hand, and waves
with the other.)

MICHAEL

(To audience.)

So, I left treatment with the Big Book and a list of local AA meetings, planning to take it one day at a time. I'd done the soul scouring work, getting real honest with myself, and confronting all those shadowy parts that I'd rather not admit to. I'd even started to believe in something larger than myself that could maybe guide me through my life. I felt like a new man. And amazingly, I could even feel the grasp of alcohol loosening on me. Instead of constantly thinking about getting a drink, I was only thinking about it a few times a day - and when I did it was more with a feeling of dread than desire. I knew I could resist those cravings - ride them out. And if worst came to worst, I had a network of people who could talk me down. For once in my life, it seemed like maybe the future was something more than just an empty length time before I died.

(MIA enters from stage left. MIA
and MICHAEL embrace. They begin a
slow walk to stage right.)

MIA

(To audience.)

I picked him up from the rehab center. I didn't know what to expect. I mean, I'd visited him a few times, but that was just for a couple of hours at a time. Now we had to be husband and wife again full time. I was happy and nervous and excited and terrified and just a lot of feelings all at once. I could tell that he'd changed. Physically, he looked better, healthier. He'd lost some weight. There was more colour in his face. And when he talked, he really talked. He talked a lot about recovery and being sober and how great it was to have people around who really understood him. I hadn't seen him so passionate about anything for a long, long time. And there was part of me that wondered if he could be as passionate about me as he was about his recovery.

MICHAEL

I remember on the ride home, I looked at Mia, and I just got hit with this wave of like, guilt and gratitude. I saw her, and I saw everything I'd put her through over the last fifteen years: the lying, the broken promises, the fighting, the neglect, disappearing for days at a time, keeping secrets, stealing, all of it. I mean, I'd already acknowledged it when I was making a list of the people I'd harmed, but just being in her presence then, and having the sheer immensity of all of it come crashing down on me all at once...

(MICHAEL gets choked up, wipes tears from his eyes.)

MICHAEL (*Cont.*)

And she never gave up on me. She stayed with me through everything. I was just in awe of that strength. Honestly, I don't know that I could have done the same for her if the tables were turned, and that made me feel like maybe I was unworthy of her love.

(MICHAEL speaks directly and sincerely to MIA.)

I can only begin to imagine how hard it's been to live with me. I'm sorry for everything I've done wrong in our marriage... which is basically everything...

(Small laughs from MICHAEL and MIA.)

But I want to be a better man, and I'm going to do everything in my power to be deserving of you.

MIA

I'm just happy to have the real you back again - the man that I married. I always knew you were there, and I always believed that you'd come back again... if you wanted to. (*To audience.*) Now, here he is: The Michael I've always wanted. And what is it I'm feeling? Gratitude, sure. But beneath that...? Resentment. Jealousy. Rage. God! For fifteen years I'd tried to change him and gotten nowhere. Then this group of strangers comes along, and all of a sudden he decides he wants to get sober for them? Why wasn't I enough? What was I missing?

(Lights up on right side of the stage showing the living room scene.)

MICHAEL

Then we got home. Home where the carpet was stained and frayed and needed vacuuming. Home where the furniture was still worn and scarred with cigarette burns. Home where the phone company had already cut us off, and the electric company was threatening to do the same. Home where Mia's old Nissan had been sitting in the driveway, leaking oil, and waiting on a new battery for over a year. Home with the hole in the bedroom wall that I'd made one night with nothing else to remember it by except hospital bills in collection for fixing a broken hand. Home with the children wanting food and wanting attention and wanting something to do and wanting and wanting and wanting all the time. Home where Mia was dead tired on her feet. Home where I went without chicken fingers because the kids were still hungry. Home where sobriety had only made our problems more clear, but hadn't actually solved any of them... I was home.

MIA

(laughing.)

It was one of those things that was so crazy you had to laugh to keep from crying. Michael was looking around at our house and everything, and it was like he was seeing it for the first time. You know, he'd been so checked out of everything when he was drinking, and now he was just coming to the realization, like,

MICHAEL

(Finishing Mia's sentence.)

We actually live here?

MIA

Yeah. Welcome home, babe.

MICHAEL

(To audience.)

It was surreal. Everything was familiar, but I had never really noticed how much we'd let things get out of hand. And of course, I've got the alcoholic brain chatter running the whole time, *(Whispering.)* "Hey! You don't have to deal with this. A couple of drinks and everything will go back to normal." But looking around, I knew I didn't want normal anymore. We could do better than normal. I owed it to Mia to do better. *(To MIA.)* Why don't you let me help out a bit around here?

(MICHAEL begins to pick up the children's toys and put them in a corner.)

MIA

Those don't go there!

(MIA picks up the toys and moves them. Meanwhile MICHAEL begins to straighten up a few stray magazines, and put them on the shelf.)

That's not where they belong!

(MIA begins organizing the magazines. MICHAEL retrieves a broom from off stage and begins to sweep the floor.)

MIA (*Cont.*)

Not like that!

(MIA irritably snatches the broom away from MICHAEL.)

MICHAEL

What the hell, Mia?

MIA

When you offered to help, I didn't think you were going to create more work for me. Why don't you just go sit down. Have a- (*Pause as MIA catches herself.*) have a glass of juice or something, and just let me handle it like I always do.

MICHAEL

Hey, listen. You don't have to treat me like I'm the enemy or something. We're on the same side, you know, so we can keep trying to both be right, or we can sit down and actually figure this thing out.

(*Pause. MIA and MICHAEL cool down.*)

MIA

I'm sorry. It's just... I got used to taking care of everything around here. I have a way of doing things, and it's hard to change that.

MICHAEL

Yeah. Trust me, I know how hard it is to change a habit.

MIA

You never used to be interested in any of this. I used to have to guilt the hell out of you just to get you to lift a finger. So... It just feels weird. It's kinda like you're stepping on my turf.

MICHAEL

Yeah, I get it. (*To audience.*) I was finally ready to step up and start taking responsibility, but there wasn't anything left for me to take responsibility for. Everything that needed doing at home was already being done, and there was no place for me there. So, I looked outside. There were meetings. I went to a lot of those. Ninety in ninety days. And I tried to establish a routine: Get up at six, meditate, eat breakfast with the family, get my daughter off to school, then take myself to the gym by nine for a workout. In the afternoon, I gave myself projects - I got on youtube and figured out how to fix the hole in the wall in the bedroom. Then I put a new battery in Mia's car and changed her oil. Just general chores around the house that I'd neglected when I was drinking, but doing that stuff actually made me feel good. Unfortunately, there was only so much that needed doing - and only so much that I *could* do. I learned that lesson the hard way when I busted the cold water tap trying to fix the leaky faucet in the kitchen.

(MICHAEL pulls the faucet completely off the sink. MIA scowls at him and points towards the door. MICHAEL slinks off to the side of the stage, and then begins to walk towards the front of the stage.)

MICHAEL (*Cont.*)

Now, listen, the town we live isn't exactly a bustling metropolis. We got a McDonalds on one side of town and a Dairy Queen on the other side with a Mexican and Chinese restaurant in between. There are two stoplights, four churches, and six bars. And if you want to go see a movie, you've got to drive about thirty minutes to get to a theater. So, what I'm saying is there's not a lot of opportunities here for work. Add the fact that everyone in town knew me as a drunk- I couldn't even get an interview. But I knew I had to fill up all those empty hours in the afternoons that I would have spent drinking, or I'd start up again. I did what I could to stay busy. I had an old lawnmower in the garage, and I fixed it up. Then, I started going door to door offering to mow lawns. It wasn't a lot of money coming in, but it was enough that we could pay off what we owed for electricity and the phone. We weren't felling as stressed about how we would make it from paycheck to paycheck. Things were starting to look up a bit. You know, it wasn't a big change, and it wasn't all at once, but you could tell they were getting better if you looked at them the right way.

(Lights down.)

END SCENE

SCENE 11

(A backyard barbecue, 4th of July. NICOLE is chatting with her husband GAVIN. NICOLE already seems a little tipsy. MIA's father, TONY, is behind the grill. Her mother, JUSTINE, is preparing a table with buns, condiments, and a large ice bucket full of beer and a couple of bottles of wine. Everyone is drinking).

MIA

(O.S.)

Are you sure it's alright? We don't have to if you're not up to it.

MICHAEL

(O.S.)

No, look, I said I'd go, and I will. You don't have to treat me like this little fragile baby, you know. I'm capable of making my own decisions and taking responsibility for myself.

MIA

(O.S.)

It's just that I know how hard it is for you to be around my family, and everything...

MICHAEL

(O.S.)

Just let it drop, okay. If I need to leave, I'll say so. But give me the chance at least to prove I can handle it. Come on, let's go.

MIA

(O.S.)

Fine. Just don't blame me later for whatever happens.

(MICHAEL and MIA enter. Everyone else seems to stop to take notice of their presence. JUSTINE hurries towards the couple.)

JUSTINE

Mia! We're glad you could make it. Michael, you're looking well.

MIA

Hi, mom.

MICHAEL

Thanks, Justine.

JUSTINE

Come in. Make yourselves at home. Do you want a drink? (*Gestures to the ice bucket.*) We've got beer, wine... oh... er...

(JUSTINE looks at MICHAEL, embarrassed.)

JUSTINE (Cont.)

Sorry, I'm just not used to... I also picked up some soda for the kids. It's in the house. I could get you one.

MICHAEL

Thanks. I'm good.

MIA

I'd love a soda, mom.

JUSTINE

Sure! Great! I'll be right back.

(JUSTINE exits in a hurry. MICHAEL and MIA cross to TONY at the barbecue.)

MIA

Hi Dad. Whatcha cooking?

TONY

Got some burgers here, and chicken marinating over there. Also, some sausages.

MIA

Wow, that's a lot of food!

TONY

Yeah, well, I figured it was something of a celebration. Gavin just got promoted to site director at the casino... and well... Michael graduated from treatment. Graduated? Is that what they call it?

MICHAEL

Sure. Technically they call it completion or getting discharged, but lots of people say graduation. I guess it sounds better.

TONY

Well, either way, I guess congratulations are in order.

(TONY reaches out his hand and
MICHAEL shakes it.)

MICHAEL

Thanks, Tony.

(JUSTINE returns with a can of
soda for MIA.)

MIA

Thanks.

TONY

(To JUSTINE.)

I was just congratulating Michael on graduating from recovery.

JUSTINE

Yes. We were very surprised.

TONY

Honestly, we never thought you'd go all the way through with it.

JUSTINE

But we're very happy that you did.

MICHAEL

Yeah, well, I think maybe I owe you both an apology. I know that my drinking and the things I did while I was drunk were hard on you both, and I know that you've been worried about Mia, and I just want to say that I'm sorry that I put you through that. I don't know if I can really make up for it all, except by being a better person, and living a better life.

TONY

Is this part of that thing where you're supposed to go around making amends to everyone?

MICHAEL

Yeah, that's part of my recovery. But I'm not just saying sorry to cross you off a list. I sincerely want to apologize for what my drinking has done to you. I mean it.

JUSTINE

Well, if it helps you to not drink, then we forgive you... Don't we, Tony?

TONY

Sure. For Mia's sake, let's just call it water under the bridge.

MICHAEL

I mean, it's not-

TONY

(Sternly.)

Water under the bridge, Michael. Okay?

(MICHAEL glances at MIA who subtly shakes her head.)

MICHAEL

Yeah, okay, Tony. Water under the bridge.

(TONY claps MICHAEL on the shoulder.)

TONY

Good man. It'll probably be another ten minutes or so before the burgers are ready. Why don't you go say hello to your sister and congratulate Gavin on his promotion?

(TONY turns his attention to the grill. MIA and MICHAEL walk over to where NICOLE and GAVIN are chatting. As they approach, GAVIN anxiously tries to conceal his beer behind his back.)

GAVIN

Oh, uh, hi Michael... Mia.

MICHAEL

Hey Gav. Tony was just telling us about your promotion. Congratulations, man.

(MICHAEL extends his hand to shake GAVIN's. GAVIN reaches out, realizes he's still holding his beer in his hand and laughs nervously.)

GAVIN

Sorry about that.

(GAVIN puts the beer down and shakes MICHAEL's hand.)

MICHAEL

No problem. That's good news.

GAVIN

Thanks, man.

MIA

Well, Michael's also got a new job.

NICOLE

You?

MICHAEL

Uh...

MIA

He's the CEO of an upcoming landscaping company.

GAVIN

Oh yeah?

MICHAEL

I started a lawn-mowing business to bring in some extra money.

NICOLE

(laughing.)

Oh! You had me for a minute.

MICHAEL

Well, they told me that I needed to keep myself busy after I discharged, so...

GAVIN

Yeah, because you just did that rehab thing, right?

MICHAEL

Mhm.

NICOLE

And how's that going?

MICHAEL

Good... good...

(MICHAEL and MIA exchange a look.)

Well, I mean, we're still figuring things out, but you know, it's been one hundred and eighteen days since my last drink.

GAVIN

Wow, that's great. So, do you think you're cured now?

MICHAEL

No. It doesn't work like that. It's kind of like being diabetic, you know? Once you've got it, it never really goes away, and you've just got to manage it. Except instead of taking insulin shots, I've been going to meetings.

NICOLE

God! A hundred and eighteen days! I don't think I could go that long without drinking.

MICHAEL

You don't have to.

GAVIN

But doesn't it bother you that we're here drinking in front of you like this?

NICOLE

I'm not going to stop just because he has a problem. It's his problem.

GAVIN

Nicole. Come on.

MICHAEL

No, it's alright. She's right. I can't expect everyone else to change their behavior for me. Actually, I kinda wish people would stop acting awkward around me. I mean, I'm in recovery, not you.

NICOLE

See?

MICHAEL

I mean I'm probably not gonna want to hang around too long if everyone's drinking, but I can say hi, have a burger, you know? I'm not going to turn into some kind of werewolf or something because other people are drinking.

(Awkward pause. NICOLE takes a defiant sip of her drink.)

NICOLE

So, how come Mia's not drinking?

MIA

I don't feel like it.

NICOLE

Or is it because you're not allowed to drink anymore?

MICHAEL

She can drink if she wants. She's her own person. She can make her own choices.

MIA

I just want to do what I can to support Michael. If me not drinking helps him to not drink, then that's what I want.

MICHAEL

You don't have to.

NICOLE

I wonder... What would it take?

MICHAEL

What would what take?

NICOLE

You said you weren't cured, but you could be around alcohol, but Mia isn't allowed to drink around you.

GAVIN

Nicole...

MIA

That's not what I meant.

NICOLE

So, I'm just wondering what would make you fall off the wagon.

GAVIN

Nicole, come on.

MICHAEL

To be honest, I don't really know. I don't really want to find out either. All I know is that in this moment, I'm choosing not to drink.

NICOLE

I mean, could you have just one drink?

GAVIN

Nicole, that's enough.

NICOLE

One sip?

MICHAEL

(Incredulous.)

Are you actually trying to get me to relapse? That's pretty low... even for you.

NICOLE

I just want to know. Because you've put my sister through fifteen years of hell. And we've all had to sit by and watch her suffer because she's too damned stubborn to just kick your drunk ass to the curb. If you can't even handle a few questions, how in the hell are you going to handle real life?

MIA

Nicole, stop!

NICOLE

I mean, how can you even trust him? After all this time and everything he's done to you. I just want to know... Has he really changed? I mean for God's sake, the man can't even promise that he'll never drink again. All he says is *(Mocking tone.)* "In this moment I'm choosing not to drink." Bullshit! What about the next moment, and the one after that?

MICHAEL

I'll face those when they come.

NICOLE

And we're just supposed to hang around and see what happens? How long do you expect us all to walk on eggshells around you? I'm not going to put up with it and neither should my sister.

MIA

I'm not walking on eggshells.

NICOLE

You are! It's so obvious, the way you're always defending him. You can't even let yourself relax and enjoy a drink on the fourth of July at your own family's home because you're worried you're going to set him off.

MICHAEL

I never asked her to defend me.

NICOLE

Because you were too drunk and stupid to care. Now you go around apologizing like it's supposed to fix anything. Well, if you want my forgiveness, you're going have to prove yourself, buddy.

(NICOLE pokes MICHAEL in the chest.)

Let me see it. A hundred and eighteen days isn't shit compared to what you've put us through.

GAVIN

Come on, Nicole. Maybe we should go check on the kids.

(GAVIN attempts to take NICOLE's hand, but she snatches it away, staring angrily at MICHAEL.)

MICHAEL

No, you guys stay. It's about time for me to leave, anyway.

(MICHAEL turns to exit.)

NICOLE

Sure, run away. It's what you've always done, leaving Mia alone to clean up your messes.

(MICHAEL pauses, turns back.)

MICHAEL

Everything you said is right, Nicole. I'm an alcoholic, and I can't promise I'll stay sober forever. All I can do is promise I'm not going to drink today. I guess that makes me an easy target. But I'm not always wrong, you know. And I'm not going to put up with your shit anymore. You or your family. I'm really trying to be a better person... What about you?

(MICHAEL exits. Lights down.)

END SCENE

SCENE 12

(Living room. MICHAEL is sitting on the sofa. Offstage the sound of a car pulling up and car door closing.)

MIA

(O.S.)

Michael... Michael are you home?

(MIA enters, looking worried.)

Oh, thank God! I was worried that you'd... I was just worried about you.

MICHAEL

It's fine, Mia. Say it; You were worried I was drinking.

MIA

It's not-

MICHAEL

I thought about it.

MIA

But you didn't.

MICHAEL

No. But I wanted to. I really did.

MIA

(Repeating with emphasis.)

But you didn't.

MICHAEL

No. I didn't.

MIA

Listen, I'm sorry about Nicole. She just had a little too much to drink, and I guess she'd been keeping everything bottled up over the years, and it just exploded.

MICHAEL

Can you just tell me what I need to do for everyone to be able to trust me?

MIA

I... Uh...

MICHAEL

Or how long I need to be sober before anyone will believe in me?

MIA

It doesn't work like that.

MICHAEL

Why not?

MIA

I don't know. It just doesn't. There's no check list or time frame. I can't just flip a switch to go from not-trusting to trusting. It's just this thing that has to happen on its own time.

MICHAEL

This sucks so much.

MIA

I know. I don't like it either. It's not like I want to not trust you, Michael. You're my husband, and I know you're trying. But there were fifteen years where the alcohol had you lying and stealing and being horrible. It's hard to shake that, you know? I want us to get past it, because I've seen sober Michael for a few months, and Sober Michael is so good, but I don't know that he's going to last. I keep expecting at any moment that it's all going to fall apart again. So, when I come home and you're telling me you're thinking about drinking... I love that you're being honest with me, but if I'm going to be honest with you, too, it scares the hell out of me.

MICHAEL

I'm not drinking.

MIA

Yeah, this time. For today. But when I made my vows to you, they were until death do us part. You can't make that same promise to me. I'm always going to be one drink away from losing you. And that terrifies me, because I don't know what's going to set you off. I didn't want to admit it in front of Nicole, but she's right. I'm constantly watching what I say and do so I don't

MIA (Cont.)

upset you. I've never been this quiet little mouse whose been afraid to speak my mind until now. And I can't keep swallowing my feelings like this. It's not healthy.

MICHAEL

What are we supposed to do now? Break up? After everything I've gone through for you? For us? What the hell did I even get sober for?

MIA

No! Don't you dare lay that on me, Michael. I can't be responsible for you staying sober. That's not fair. Whether I stay or go, that's *my* choice. If you stay sober that's up to you.

MICHAEL

So, what then? You're choosing for both of us?

MIA

I don't know. I thought you going to rehab was going to fix everything, but here we are right back where we started.

MICHAEL

You know, maybe I'm not the only one with a problem. Did you ever think of that?

MIA

What do you mean?

MICHAEL

You. You're addicted just like me.

MIA

Don't be stupid, Michael.

MICHAEL

I'm serious. You don't drink, but I think you're just as dependent on my drinking as I was. It made you feel needed and important and like you were in control. And then you could go around patting yourself on the back for being the martyr of this family. But don't you see? It's the same problem, trying to control everything that isn't in your control. In AA they say, "Let go and let God."

MIA

I'm not in AA. That's your thing.

MICHAEL

But there's Al-Anon, you know, for family members and stuff. It could really help.

MIA

No.

MICHAEL

Trust me, if anyone knows how hard it is, it's me. But just take the first step. Admit that you have issues, too.

MIA

No, Michael.

MICHAEL

And I mean, if you took a real good clear look at yourself - you know, a fearless and searching moral inventory - I bet you'd recognize it. You just need some guidance from other people who have been through what you've been through.

MIA

(Shouting.)

I'm not going to Al-Anon, Michael! So, stop selling it.

(MIA takes a deep breath and approaches MICHAEL.)

Listen, I know AA has been good for you. I've seen how you've changed. And believe me, I'm grateful. But I've been living your life for years. Everything I did was arranged around taking care of you while you were drinking, playing damage control, and keeping things from getting worse than they were. And somehow, they just kept getting worse anyway. So, you can't imagine how relieved I am that you're sober now... but...

MICHAEL

But what?

MIA

I'm still living around you and your life. Except it's not drinking, it's recovery. Everything is AA slogans and twelve steps with you these days. I'm glad that works for you, but it's not *my* life. I have to be living *my* life or else this isn't going to work. Don't you get that? Recovery is your thing, and I support you one-hundred percent in it, but I'm not going to let you push it on me. You've got to let me be me for once.

MICHAEL

And I want us to be together. Jesus, Mia, you're my wife, and I just want you to share in this experience that is like so important to my life right now. AA is so good for me, and I know Al-Anon would be good for you, too. Then you'd have a totally different perspective, you know, and we'd be closer because we'd actually have a common interest.

MIA

But it's not a common interest, Michael. It's your interest and now you want to make it my interest. Even worse, you're trying to make me feel like a terrible wife for not being interested. But I'm not. And I'm tired of pretending that I'm as into all this as you are. Besides, when's the last time you took interest in something that I liked? Huh? Do you even know what I like? No, because everything always has to be about you. You make me feel like a supporting character in my own life. But I'm not just your little sidekick that you can boss around. I'm my own person, and you need to respect that.

(MICHAEL is angry, clenched jaw,
tight fist.)

MICHAEL

I... I can't deal with this right now. If I don't get out of here, I'm going to blow up. And then I don't know what will happen.

MIA

(Shouting.)

I told you not to put that on me. You're feeling some kind of way, that's on you. You figure out what you need to do to get yourself under control and work out your own shit instead of trying to tell me what to do all the time.

MICHAEL

I need to go see Joe.

MIA

Go, then!

(MICHAEL puts on his jacket and exits. MIA sighs and looks tired. Lights down on living room.)

END SCENE

SCENE 13

(Lights up on Joe's office. Joe is sitting behind his computer.

MICHAEL is seated across the desk from him.)

MICHAEL

It's so frustrating. She just doesn't get it, and I don't know how to make her understand.

COUNSELOR JOE

What? You wish that she was an alcoholic like you, just so you could have an easier time at home?

MICHAEL

No, man. That's not what I mean. I wouldn't wish it on my worst enemy.

COUNSELOR JOE

Alright, well, to begin with, why don't you try understanding something: You're an alcoholic and you need AA.

(MICHAEL rolls his eyes.)

Yeah, man. I got that.

COUNSELOR JOE

And they're not. There's nothing that they need to change or understand. And you can't make them. They're going to be whoever they're going to be. You just need to worry about you.

MICHAEL

But what if she leaves. Even when I do everything right, I still come out on the losing end.

COUNSELOR JOE

That's how she goes sometimes. God grant me the serenity to accept the things I cannot change, the courage to change those I can, and the wisdom to know the difference.

MICHAEL

Jesus. Everything in AA is goddamn bumper sticker slogan! I need some real advice.

COUNSELOR JOE

Yeah? Well, why don't you start by looking at what you're doing.

MICHAEL

Me? I'm doing good. I'm going to meetings, I'm working the steps, I'm keeping my routine, I'm staying busy. I've even got a job now.

COUNSELOR JOE

Sure. And you're setting up the conditions for your relapse.

MICHAEL

What? How?

COUNSELOR JOE

Are you even listening to yourself? "I wish she would understand." "I don't know what I'd do if she broke up with me." "I can't do anything right." It's your alcoholic brain talking. Don't you get that? How far is it from, "If you leave, I *might*

relapse," to "When you leave, I'm *going* to relapse"? to "Please leave, so I can relapse." And then when it happens because your alcoholic brain manipulates the situation into a self-fulfilling prophecy, hey, you've already got your excuses, you've got your reasons, all you need is a bottle.

MICHAEL

Shit!

COUNSELOR JOE

Remember that first meeting? You were talking some nonsense about coming to rehab because of your wife?

MICHAEL

Yeah.

COUNSELOR JOE

And the group called you out pretty damned quick, didn't they?

MICHAEL

Yeah. They made me recite the first step: I admitted I was powerless over alcohol and that my life had become unmanageable.

COUNSELOR JOE

Right. You're the alcoholic. It's your responsibility. But here you are putting your sobriety on your wife, or her family... anyone but yourself. And when they inevitably let you down, like people do, you've given yourself an out. You see? You're getting sober for the wrong reasons. There's really only one reason to get sober and that's because being drunk is no longer acceptable... regardless of any of the other circumstances in your life.

MICHAEL

You're saying I'm still on step one?

COUNSELOR JOE

You ever hear the old zen proverb, "If you meet the Buddha on the road, kill him?"

MICHAEL

No. What does that mean?

COUNSELOR JOE

It means when you think you've got it all figured out, you're just fooling yourself. You've got to keep going because it's all about the journey, not the destination. Get it?

(MICHAEL shakes his head.

COUNSELOR JOE pulls his old battered copy of Alcoholics Anonymous from his book-shelf, and waves it at Michael.)

Any idea how many times I read this book?

(COUNSELOR JOE flips through the pages showing dog ears, highlighting, underlining, pen notations in the margins, etc.)

MICHAEL

I don't know.

COUNSELOR JOE

Yeah, I don't know either. I lost count. It's a lot, though. And every time I read it, it's the same story, the exact same words as before, but I'm always finding something new in it. The meaning keeps changing because we keep changing. Now do you see?

MICHAEL

(Puzzled.)

I guess... Sorta...

COUNSELOR JOE

Listen, Michael, you've been riding the pink cloud.

MICHAEL

(Laughing.)

What?

COUNSELOR JOE

You know, you get out of rehab, you're actually sober for the first time in God knows how long, and things are starting to look up. You're feeling like a new man, and you're starting to get your life sorted out. And that weight of being drunk all the time is finally off you. That's what we call the pink cloud.

MICHAEL

Ah.

COUNSELOR JOE

But you need to understand, that pink cloud is going to evaporate. Sooner or later, something's gonna come along and blow it away. And that's when the real work is going to start. Good or bad, life is going to go on. You can ride with it if you

COUNSELOR JOE (*Cont.*)

keep working the program. Or if you've given all your power away to everyone else, it's just going to sweep you under.

MICHAEL

So, what am I supposed to do about Mia?

COUNSELOR JOE

From the sound of it she wants the same thing as you. You know, trust goes both ways. If she's going to trust you, maybe you could try trusting her, too.

MICHAEL

What are you saying?

COUSNELOR JOE

It's like that old joke: How do porcupines make love?

MICHAEL

How?

COUNSELOR JOE

Carefully.

(A small laugh from MICHAEL.)

I didn't promise it was a good joke. But the fact is, like most alcoholic couples, both of you have a history of being on the defensive with each other. She's had to guard against you when you were drunk. And you had to protect yourself from the way she needed protect herself. So, you were both in an arms race, you know? The quills were up. And now you want to reconnect? Well,

COUNSELOR JOE (*Cont.*)

one of you is going to have to back down and make yourself vulnerable.

(The phone on the desk rings.)

Hold on.

(COUNSELOR JOE answers the phone.)

Hello?... Yes... Uh-uh... oh...

(COUNSELOR JOE looks upset.)

Oh no... No... Really?... Shit... Yeah... Okay... Okay... Thanks for letting me know... Sure... Bye.

(COUNSELOR JOE hangs up the phone.)

MICHAEL

That didn't sound good. Everything alright?

COUNSELOR JOE

I guess you'll hear it sooner or later. It was about Frank.

MICHAEL

Oh. How's he doing?

COUNSELOR JOE

He died last night.

MICHAEL

Oh my god... How?

COUNSELOR JOE

Lost control of his car. Went right through a guard rail and ended upside down in a ravine.

MICHAEL

Shit.

COUNSELOR JOE

They said they found a bottle of Four Roses in the vehicle.

MICHAEL

(Distressed.)

No... No way, man. He was the one. Out of all of us, I thought that he was the one that was supposed to make it. He always seemed like he had it all figured out. I *believed* in him.

COUNSELOR JOE

What are you feeling now?

MICHAEL

Shocked... lost... angry.

COUNSELOR JOE

What's behind the anger?

MICHAEL

I feel... betrayed. I believed in him and he let me down. He let us all down.

COUNSELOR JOE

And what else?

MICHAEL

I'm... I'm scared, man. Okay? I'm scared. I mean, if Frank couldn't manage his recovery, what hope do I have?

COUNSELOR JOE

What hope? Every hope in the world, Michael. Every hope, because you're still here, and you're still sober. Look, I know it's a lot to process. I know it hurts like hell, and the alcoholic brain is telling you to run away from it, to numb yourself to it, but you need to allow yourself to feel this.

MICHAEL

(Tearing up.)

It feels... so much. I... I don't know if I can deal with it.

COUNSELOR JOE

It's too much to carry around with you, so let it go. Don't fight it. Turn your will over to your higher power, and let it flow through you.

(MICHAEL's emotions gradually intensify from holding back tears to a loud unrestrained cathartic howl. Lights down on Joe's Office.)

END SCENE

SCENE 14

(A bar, mid-day, quiet with few patrons who look old, weary, drunk, and unkempt - All men, except one woman who sits at the bar in conversation with another patron, NEIL. MICHAEL sits at a table alone. In front of him is a glass of whiskey, half a bag of tangerines, and a pile of peels. He stares for a minute at the whiskey, then reaches for another tangerine to peel slowly. TOM the bar tender is keeping an eye on MICHAEL as he polishes the bar with a rag. Finally, TOM approaches MICHAEL.)

TOM

Hey, Mike, you alright?

(MICHAEL looks up as if being awoken from a reverie.)

MICHAEL

Huh?

TOM

It's just you been sitting here an hour, and all you've done is eat a bunch of oranges.

MICHAEL

Tangerines.

TOM

Okay. Tangerines. What I'm saying, though, is that this bar is for paying customers, and you ain't drinking.

MICHAEL

Fine.

(MICHAEL taps the rim of his glass.)

Another.

TOM

Another? You ain't even touched this one.

MICHAEL

Another, Tom.

(TOM sighs, goes behind the bar, and pours MICHAEL a second drink. He returns to MICHAEL's table and places the second glass of whiskey beside the first.)

TOM

Look Michael. I know you been in rehab. I figure it ain't any of my business whether you're on or off the wagon. Just don't expect me to save you from yourself, alright? I've got a job to

TOM (Cont.)

do here. And you? You're just a customer, just like any other regular in here. Got it?

MICHAEL

Yeah. You know, that's why I like you, Tommy. Everyone's been treating me like some little kid who can't even make decisions for himself. At least you respect a man's right to self-determination. Cheers to you.

(MICHAEL raises his glass to TOM, then sniffs the drink, admires it, and sets it back down with slow reluctance. MICHAEL slides a few dollars across the table to TOM and returns his attention to peeling another tangerine. TOM picks it up, counts it, shakes his head, and goes back behind the bar. He looks once more at MICHAEL, shakes his head again. TOM picks up the phone and dials. Pause.)

TOM

Yeah, hey... Mia?... It's Tom, over at Tommy's Cave... Yeah. He's been here about an hour... No... no... but I think you better come down here and get him anyway... Uh huh... Well, I'm not making any guarantees... Alright, see you soon.

(TOM hangs up the phone and goes back to wiping down the bar. MICHAEL continues staring at the whiskey glasses in front of him and peeling his tangerines. At the bar, NEIL says something to the female, provoking her to shove him hard enough to knock him off his stool. The other patrons laugh and cheer as he gets to his feet. MICHAEL observes this, shakes his head and sighs. As NEIL climbs back onto his stool, MIA appears in the doorway.)

MIA

(To Tom.)

Where is he?

TOM

Back there.

MIA

Is he drinking?

TOM

Nah. He's just been sitting there peeling those friggin' oranges.

MICHAEL

(Calling across the room.)

They're tangerines, you goddamn narc!

TOM

Whatever. I ain't never kicked a sober person outta here before, but go home, Michael. You're creeping everyone out.

(MICHAEL glances around the bar.)

MICHAEL

(*Sarcastically.*)

Yeah, I'm really spoiling the ambience of this dump.

(TOM waves dismissively.)

TOM

Yeah. Yeah.

(MIA crosses the stage and sits across from MICHAEL. MICHAEL barely looks up from the tangerine in his hand.)

MIA

Michael, what the hell are you doing in here?

MICHAEL

Figuring some things out. You know, I haven't been in this place for almost a year? But I always felt like I did my best thinking here.

MIA

Over a couple of double whiskies?

MICHAEL

They're untouched. Have one if you want.

MIA

I don't want to drink.

MICHAEL

Tangerine?

MIA

No, Michael. I just want you.

MICHAEL

I don't know what that is anymore. I feel like I used to know.
But now...

MIA

What are you talking about?

MICHAEL

Remember I told you about Frank?

MIA

Yeah.

MICHAEL

He was like the one guy who seemed to have it figured out, you know? And I was like, "if I can just be more like that guy..." Because he gets it... He *gets* it, you know?

MIA

Yeah, you told me.

MICHAEL

Frank's dead.

MIA

Shit.

MICHAEL

They found his car at the bottom of a ravine. Apparently, he was drinking.

MIA reaches across the table for MICHAEL. MICHAEL puts down his tangerine and allows MIA to take his hands.)

MIA

Michael... I'm so sorry...

MICHAEL

Yeah, me, too. He was the one guy I looked up to, and if he can't make it... I mean, rationally, I know he was in rehab just the same as me. He wasn't perfect. He was dealing with his own shit. But I *wanted* to believe in him. I thought, you know, if I could believe in him, I could believe in me. And now he's gone.

MIA

And you're still here.

MICHAEL

Why does everyone keep saying that?

MIA

Because it's true.

MICHAEL

Is it though? I mean, who am I supposed to be anyway?

MIA

You're supposed to be you, Michael.

MICHAEL

I don't know what that means. When I was drinking, I never really gave any thought to it, you know. I was just some screwed-up drunk. It didn't make me happy, but at least I knew where I stood. There's something reassuring to being on the bottom, you know? Like that song says, "Freedom's just another word for nothing left to lose." I miss the comfort of being that hopeless case that everyone had pretty much given up on.

MIA

I've never given up on you, Michael.

MICHAEL

(Scoffs.)

Yeah, I know... I've been thinking about that, too. I can't figure it out. I put you through a lot of shit over the years, Mia. Far more than I had any right to expect you to take. If I were you, I'd have been long gone years ago. But you've stayed. Why?

MIA

I don't know if you remember... It was when I was first pregnant with Katie, and we were living in that old piece of shit trailer, because it was all we could afford.

MICHAEL

(*Chuckles.*)

Yeah. In my mind it was going to be a palace as soon as I got around to fixing everything up... I guess I never really did though.

MIA

Do you remember the night we got broken into? I thought I heard a noise and woke you up. I was so scared, but I remember the look in your eyes. There wasn't any fear. It was determination - you were going to protect what was yours, and that included me and the baby. It was just a split second, and then you were gone. You didn't have a gun or a knife. You weren't even wearing anything except your boxers, but you went chasing after the robber, running down the road shouting for him to come back so you could beat his ass. If you'd had your shoes, I bet you would have caught him, too.

(MIA and MICHAEL chuckle at the memory.)

That look you gave me just before you got out of bed told me that nothing - *nothing* comes between you and what's yours. That's the Michael that I believe in. Brave, determined, loyal, willing to fight for what he loves. And over the years, I'd catch glimpses of him from time to time. Just enough to let me know you were still there, somewhere under all the alcohol and shit. Then you went into rehab, and I started to see more of the real you, and I thought finally, this is who I've been waiting for all this time.

MICHAEL

I'm sorry. I don't see it. I'm not brave. I started drinking when I was fifteen, and then I was lost for twenty years. And now, here I am a forty-year-old man, but in my mind, I'm still fifteen. Except nothing else is like it was when I was fifteen. I don't have the body of a fifteen-year-old. I've got a wife, and a family to look after. I'm working and paying taxes and trying to be an adult. I mean, I look around, and everyone else had that twenty-five years to grow up. I'm so far behind, and I don't know what I'm doing. And then just when I'm starting to get things figured out, this thing with Frank... and I...

(MICHAEL begins to sniffle and
tear up.)

MIA

It's okay.

MICHAEL

(*Emotional.*)

It's not, though. Oh my God, Mia, it hurts so much. Frank, and my Mom, and all the years I lost, everything I used to know... Christ, I can't even trust my own brain anymore. You don't even know what it's like to have to constantly second guess yourself all the time... It's just coming down on me all at once, and I don't know if I can take it. (*Sobs.*) And the only thing that ever helped me get through it is the same thing that's been trying to kill me. I don't know what to do.

MIA

Come home. That's the first thing. You don't belong in here, Michael. Not anymore.

(MICHAEL wipes his face with a napkin.)

MICHAEL

No, you're right. I keep looking at these guys here. (*Gestures to the other patrons.*) I know these people. They're my people... They used to be, anyway. You know, they come here day after day. They tell the same stories, the same jokes. You come here twenty years from now, and they'll still be here. Them or someone like them. It's like they're passing time, running out the clock on their lives. And I'm thinking, you know, what's the point of going on like that? But I know the point - it's to get to the next drink. In a way I kind of envy them, you know? They've got such a clear sense of purpose. But I don't want that anymore. It's an empty life. I'm made for something more than whatever this (*Gestures to the glasses of whiskey.*) can give me.

(Pause. MICHAEL reaches across the table, seeming like he's reaching for the glass of whiskey, but he takes MIA's hands instead.)

You know, I feel so unsure of everything in my life. But one thing I am certain of is you. You're my constant. You've been with me through everything. And I know that we've still got a lot of stuff to work out, but I don't ever want to give up on us. We'll figure out a way to make it work, okay?

MIA

Okay, Michael. Come on, let's get out of here.

(MICHAEL and MIA stand. They walk toward the exit. As they pass the drunks at the bar, MICHAEL pauses.)

MICHAEL

(Reciting quickly and dramatically.)

"We shall not cease from exploring, and the end of all our exploring will be to arrive at where we started and know the place for the first time" for what a pile of shit it really is.

(The DRUNKS boo and heckle MICHAEL.)

MICHAEL

There's more to life than this. There's a world out there, and you're sitting here like shadow people. Whenever you're ready, you can come out and see it for yourself.

TOM

Get the hell outta here! You're banned for life, ya bum! This bar's for real customers.

(The DRUNKS cheer TOM and continue to grumble at MICHAEL. TOM leans over the bar, and gestures for MICHAEL to come closer.)

TOM

(Quietly)

Seriously, you got a second chance. Don't blow it. Go be someone, man. Good luck.

MICHAEL

Thanks, Tom.

(MICHAEL and TOM shake hands. The DRUNKS continue to mutter and grumble. MIA and MICHAEL into a bright flash of light, which fades to dark except for a single spotlight at the front of the stage.)

End scene

EPILOGUE

(MIA walks to the spot light at front center stage.)

MIA

It's been about five years since that day. Michael says it was the real first day of his recovery. He's been volunteering at the recovery center, driving the van and running a group. I guess he thought he better make all that we've been through count for something. The guys there really look up to him, and that's been good for his self-esteem.

(Lights up on group counseling scene. MICHAEL is surrounded by a new group of four guys.)

MICHAEL

So, you take all the hours you spend in a week drinking and getting ready to drink or trying to fix the stuff you did when you were drunk and all of that. Count it all up, what's your number? It's been five years since I had a drink, but I can still tell you mine. It was eighty-five.

(NEIL enters, looking uncertain.)

Can I help you?

NEIL

They told me I could join this group.

MICHAEL

Alright, man, what's your name?

NEIL

Neil.

MICHAEL

Alright, Neil. There's a chair there.

(NEIL takes a seat. MICHAEL
glances at him curiously.)

You look familiar... Did you used to drink down at a bar called
The Cave?

NEIL

Yeah... I actually I remember seeing you in there. You were saying
something about being a shadow person... and I don't know... that
just really stuck with me for some reason. Well, I'm sorry it
took awhile, but I think I'm finally ready to give it up and
come out into the light like you were saying.

MICHAEL

There's nothing to apologize for, man. Sometimes it's just about
planting seeds and waiting for them to grow. And when it's time,
you'll do what you need to do. Whenever you're ready...

(Lights down on the group scene.
Spotlight returns to MIA.)

MIA

I don't know what else to tell you. I mean, I know you came here because there's not a lot of couples who stay together through addiction and recovery, and we did that. You say, we're a success story, like we've figured something out that no one else has, but I don't feel like an expert or anything. Honestly, we never had any idea if we were doing the right thing, the wrong thing? It's not like life comes with an instruction manual, you know? It's just been trial and error to find out what worked for us. And we're still working on it. My brother-in-law got Michael a job as landscape manager at the Casino. My family has been slowly warming up to him the more that they see he can be responsible. And the kids are doing well. He really loves spending time with them, and he's turned out to be a really great dad. I wouldn't say we're perfect, though. We still have our fights and problems. We're still learning to live with each other. But every once in a while, even after all this time, you know, I discover something new about Michael. Out of the blue, he'll do something - like he was teaching Katie how to make hamburgers on the barbecue the other day - just the way he was so patient with her - and it makes me stop and think, "huh... yeah, I like that about you..." The more I notice little things like that, the more it helps to trust that this is who he really is. I still worry that the old alcoholic Michael will come back. I don't know if I'll ever get over it. But there's nothing I can do about it.

(MICHAEL enters and walks to MIA.)

In the meantime, I'm just happy to have today with the Michael I love.

(MICHAEL stands next to MIA, takes her hand. She looks down and then gives MICHAEL a loving look. After a pause, they both look back out at the audience and smile.)

MICHAEL

I'm ready.

END

Narrative Analysis of the Play

In this section, I will attempt to show the way that narratives have operated through Michael and Mia’s transition from a marriage dominated by alcoholism to one in which Michael has been able to achieve long-term sobriety. I wish to demonstrate that the narrative change process occurs in several stages over a period of time and can extend long past the point of discharge from treatment. Figure 4.1 presents a visual overview of the narrative change process. It should be noted that this image represents only a single narrative thread, while our lives are actually a fabric of entangled narrative strands.

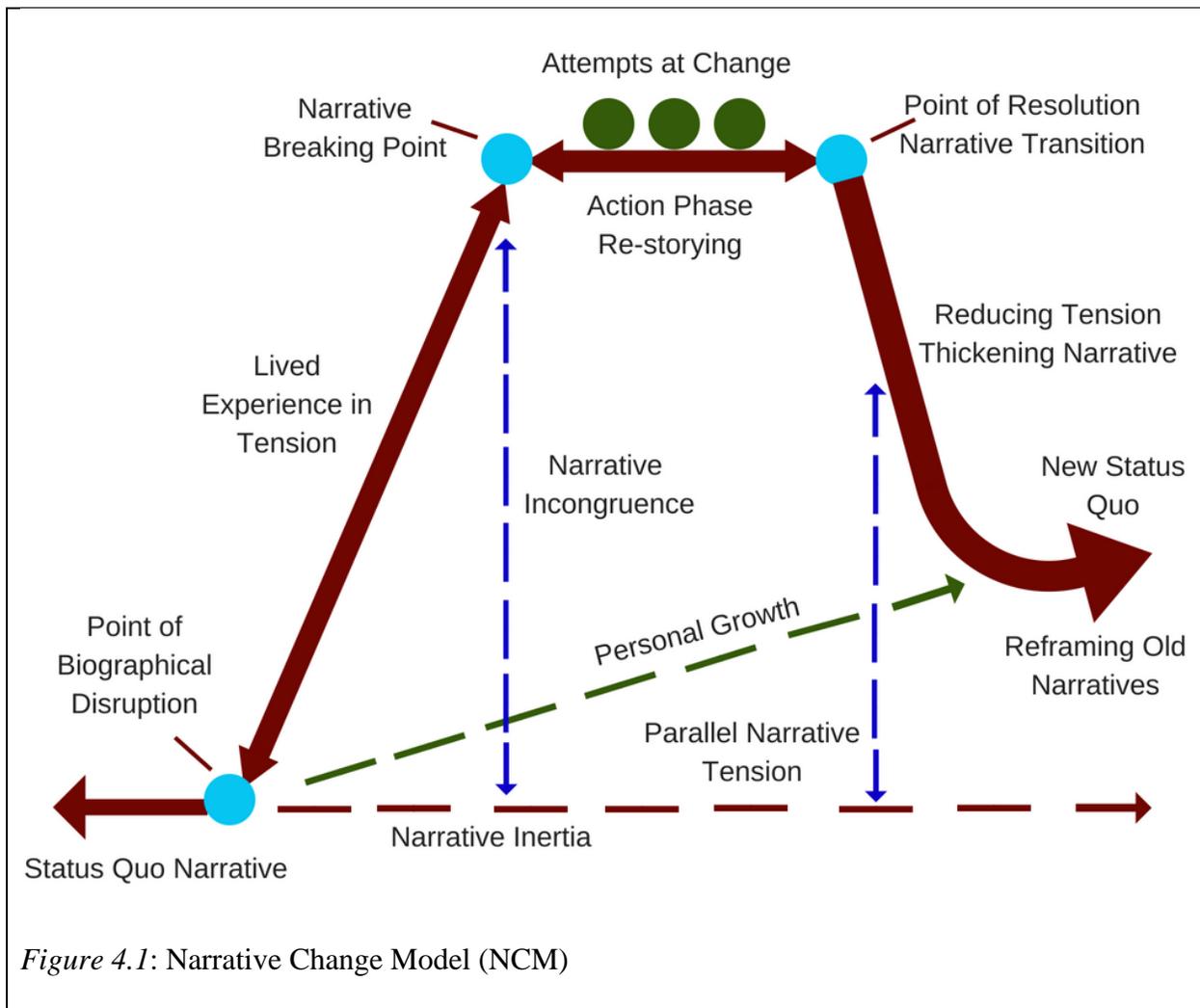


Figure 4.1: Narrative Change Model (NCM)

According to narrative theory, we understand ourselves and the world through the stories that we tell about it (White & Epston, 1990; Holstein & Gubrium, 1999a; Kottler, 2015). Internalized narratives are formed at the intersection of our personal lived experience of the material world, and an ever-shifting combination of social discourses (or narratives which exist outside of ourselves) on any given topic. Of course, not every social discourse will have equal salience in forming an internalized narrative. Some may be accepted, others only partially accepted, and others rejected entirely. There are also many discourses that exist in society which are outside of our personal sphere of awareness. Furthermore, the multiple social discourses we rely on may be combined and synthesized in relation to our lived experiences in unique and novel ways to produce an internalized narrative which creates meaning and explains what we have experienced (Figure 4.2).

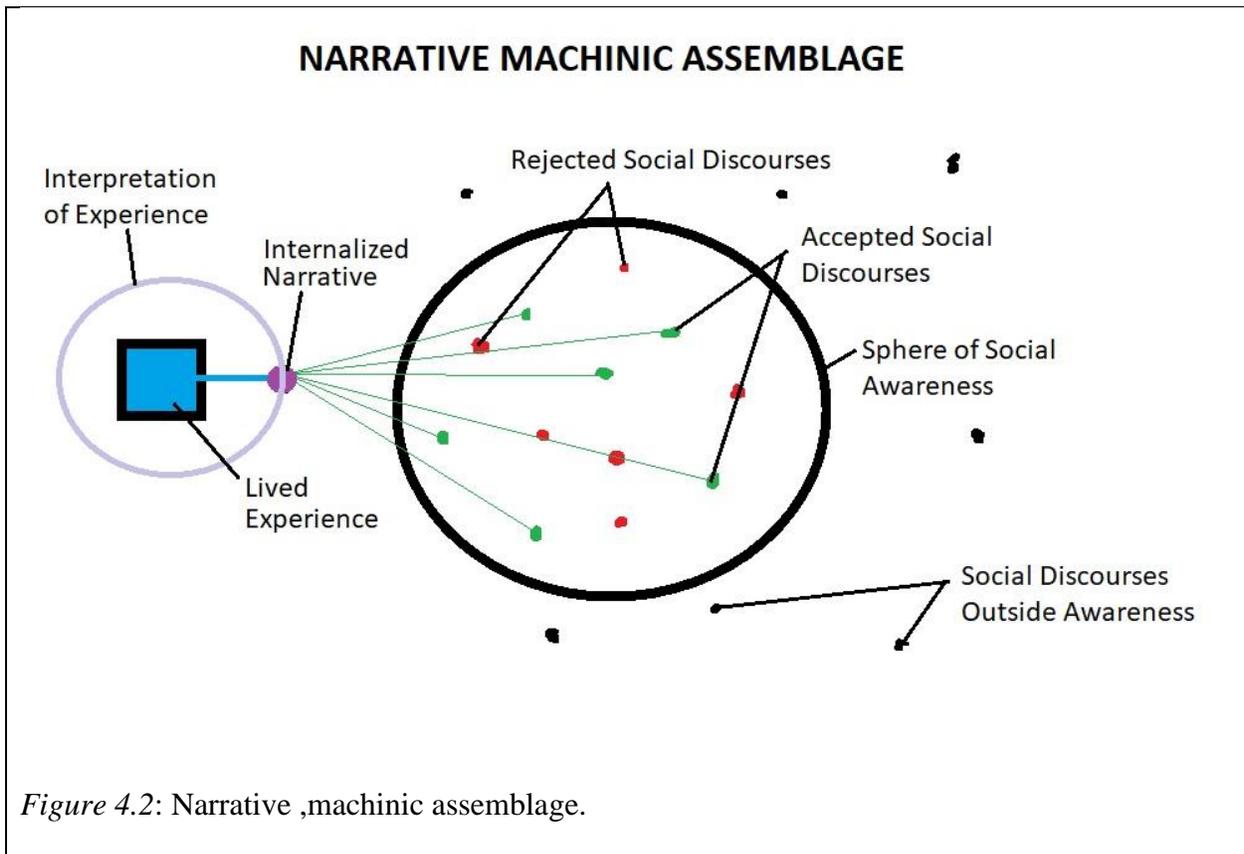


Figure 4.2: Narrative ,machinic assemblage.

To put it in Deleuzian terms, narratives are a ‘machinic assemblage’ – an unstable organization and fitting together of various parts and pieces towards accomplishing particular goal in a particular moment (Deleuze & Guattari, 1987; Malins, 2004). The overarching goal of a narrative machine is to explain and create meaning of our lived experiences, which would otherwise seem random, arbitrary, and disconnected. However, what narratives specifically explain and how they explain it is constantly changing in relation to our developing lived experience over time. Nevertheless, we depend on a congruence between internalized narratives and lived experiences in order to function in the world. When narratives are incongruent with and fail to adequately account for lived experience, we experience psychological distress, similar to the concept of cognitive dissonance (Festinger, 1957).

Low levels of narrative incongruence are normal and natural. Our personal narratives are always in tension with multiple social discourses within our awareness at any given time. These social discourses can both challenge our own lived experiences and often contradict each other. Social discourses can provide a useful check against our own subjectivity, verifying or correcting what we believe, so that our narratives are not ours alone, but can be said to be socially constructed. For example, a belief that the world is flat has to contend against and account for the many social discourses that insist that it is round.

At the same time, we also exercise our own critical evaluative agency in determining which social narratives we accept and reject and which have greater or lesser salience in relation to our lived experience. However, problems arise when a particular social narrative overpowers or dominates our internalized narratives in ways that do not accurately reflect or explain our personal lived experiences (White & Epston, 1990). For example, in the play (SCENE 6), the character Dominic, one of the men in recovery discusses the discrepancy between his parents’

views about religion and his own. This incongruence initially presented a barrier for Dominic in progressing through the twelve-steps of AA, because for Dominic the narrative of higher-power was formed by his parents and was in conflict with his own understanding of spirituality.

Another theme that runs throughout the play involves the narrative incongruences between what a marriage is *supposed* to be (SCENE 5), as informed by social narratives, and the lived experience of the marriage between Michael and Mia, which in many ways falls short of the internalized narratives they tell about marriage. Similarly, Michael enters treatment with a number of erroneous preconceptions based on social discourses about rehabilitation and recovery, which are then countered by the lived experience of being in recovery (SCENE 4). After leaving treatment, in the barbecue scene (SCENE 11) in which Mia's sister Nicole expresses skepticism about the authenticity of Michael's recovery, we see that the social discourses about recovery continue to conflict with Michael's lived experience.

The second form of narrative incongruence occurs when once-functional narratives have been outgrown or become obsolete. Early in the play (SCENE 1), Michael asks, "What the hell!? You used to be fun, you know. Remember, we used to stay out all night partying. Just the two of us. What happened?" Mia responds, "I grew up, Michael. We had kids. Someone had to be an adult around here. So, I stopped drinking. But you never did." At twenty years old, the narrative of partying all night and having fun fit with Michael and Mia's lived reality. However, over time, Mia matured and developed a "grown up" narrative. The arrival of children provided a point of biographical disruption. The partying narrative was no longer sustainable in relation to the lived experience of being responsible for raising children. While Mia was able to adapt her narrative to her changing lived experience, Michael held on to the old narrative of partying and drinking. The discrepancy between Michael's partying narrative and the lived experience of

being an adult and a father was highly problematic for the couple and also for Michael's sense of himself.

Over the course of the play, Michael gets sober and begins the process of recovery from his alcoholism. In a very literal and concrete sense, sobriety for Michael is the behavior of not drinking, which is qualitatively different from his previous behavior of drinking for hours every day. While Michael's lived experience has changed – he's no longer drinking – he and the other characters in the play struggle to overcome the narrative inertia of “drunk Michael” (Figure 4.3). Narrative therapists distinguish between thin and thick narratives (Parry & Doan, 1994; White, 2007; White & Epston, 1990). Thin narratives tend to be experience-distant and accepted without critical interrogation, while thick narratives are deeply internalized beliefs supported by lived experiences. Typically, narrative therapists will interrogate and deconstruct thin narratives with clients in order to understand how they were formed and how they function in the lives of clients in ways that are oppressive (White, 2007). However, within the change process, an individual is often moving from a thick narrative to one that is very thin. Yet, due to its inertia – the past experiences that gave it mass - the thick narrative remains in competition with the new narrative, even if it no longer represents the present lived experience.

In either case of narrative incongruence, there is a discrepancy between the lived experience of the individual and the narratives that they hold about these experiences. When confronted with narrative incongruence, there are three possible actions available to the individual experiencing it. The first is to simply ignore or endure the incongruence. It is possible to tolerate low levels of contradiction in our narratives, particularly when those narratives are not central to our identity. When narrative incongruence is more salient to our sense of self, we may

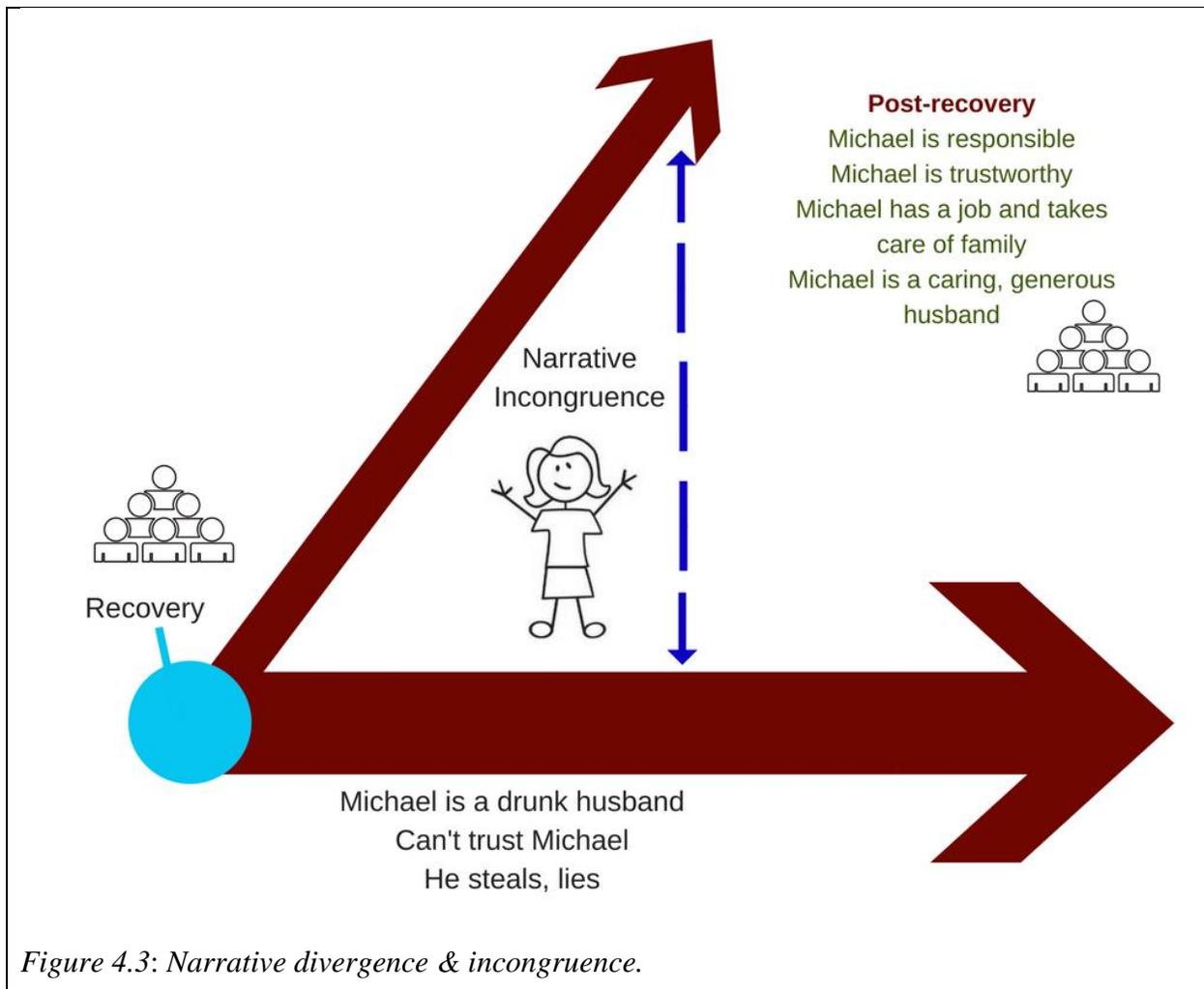


Figure 4.3: Narrative divergence & incongruence.

choose to limit our awareness through avoidance or refusing to give it conscious attention. In the play, we see Michael literally running from social discourses which conflict with and challenge his own personal narrative. Prior to the beginning of the play (SCENE 1), Michael has escaped from a dinner at Mia's parents' home in which he felt judged for his drinking and his failure to support his family. The first scene concludes with Michael abruptly leaving the argument in search of more whiskey rather than resolving the argument with Mia. Even after treatment, Michael ends a conflict with his sister-in-law, Nicole by walking away (SCENE 11). By removing himself from these conflicts, Michael reduces their immediate salience, and thus reduces the distress of the narrative incongruence which he experiences.

Another form of avoidance evident in the play is the use of alcohol to dull awareness of the distress (Wisman, 2006). While, I'm not suggesting that narrative incongruence is the cause of alcoholism (which is beyond the scope of this study to determine), Michael notes the importance of alcohol in his life as a method of coping with emotional distress (SCENE 14). Reciprocally, Michael also acknowledges that his drinking contributed to his low self-esteem, which he then dealt with by drinking more. In the pre-treatment examples noted above, when Michael escaped from the conflict, he sought out alcohol to soothe himself (SCENE 2). The pattern returns again at the conclusion of the play when Michael finds himself sitting in a bar in response to Frank's death (SCENE 14).

Ignoring or tolerating the distress tends to be a temporary and only partial solution for dealing with the distress of narrative incongruence. The reason for this is, as mentioned earlier, that lived experience is unstable and constantly changing. Thus, the distance between the narratives we hold and our lived experiences is always growing or shrinking to some extent. In some cases, the narrative incongruence may resolve itself on its own without effort on the part of the individual. When Michael left the house at the end of the first scene, it may have represented a minor point of biographical disruption for the couple, but Michael returned later on (escorted by police), and therefore the lived experience of Michael's presence in the home was restored to the normal narrative without Michael or Mia having to do anything out of the ordinary (SCENE 2).

Frequently, however, the incongruence grows over time without resolving itself, and the gap between the narrative and the lived experience becomes wider. At this point, there are two options left for managing narrative incongruence. Individuals may actively attempt to return their lived experience to the narrative "normal," or in other words remedy whatever has diverted their

life from the status quo so that they may resume the ‘life as usual’ narrative. Alternatively, individuals may decide to abandon the old status quo narrative, and establish a new “normal” narrative around the present lived experience.

Returning lived experience to “normal” can be tempting. As mentioned earlier, the “normal” narrative is often thick and familiar, carrying a sense of inertia. We have experience living the “normal” narrative, even if these narratives are problematic. For example, Mia had complained that she was overwhelmed with having to take care of all of the household responsibilities, as well as being the sole provider (SCENE 2). However, after Michael is discharged from treatment, he attempts to help around the house, and meets resistance from Mia (SCENE 10). Though Michael is ready and able to contribute to household chores, Mia is not ready to modify her “normal” narrative to reduce her role in the home and make space for Michael. Even though Mia experienced Michael’s drinking as negative, they had at least established clear roles and patterns of interaction within the drinking narrative. In seeking treatment, Michael has destabilized the familiar “normal” narrative within the couple.

The draw of the “normal” narrative is perhaps most clearly demonstrated in the detox scene (SCENE 3). Rather than being a step towards sobriety, Michael views detox as a way to enable him to continue the drinking narrative, “I was just looking forward to my next drink. I knew if I could stick it out for a week, and get it under control, Mia and everyone would get off my back.” The strength of the “normal” narrative of alcoholism is so intense that Michael is willing to endure a temporary abstinence including the intense negative physical and psychological symptoms of withdrawal in order to return to it.

Interestingly, Michael’s “normal” narrative to which he wants to return is very distant from his lived experience of drinking. Michael fantasizes about a life in which his drinking is not

problematic, and he is able to drink responsibly. In the fantasy, he is employed, and his marriage is free of conflict (in fact, Mia is gladly serving him). Everyone is happy and healthy, and Michael feels satisfied with himself and his life. However, the audience learns that Michael is actually planning on a drinking binge as soon as he is discharged, which we have already witnessed as problematic for the couple. The scene ends as the nurse and driver challenge Michael's narrative and call out his true intentions. After rebutting Michael's dishonest excuses for not being ready for treatment, the driver reminds Michael of his lived experience of drinking, and how incongruent it is with the fantasy. By having his attention drawn to the vast incongruence, Michael reaches a breaking point.

The breaking point occurs when the discrepancy between the lived experience and the narrative is too large to sustain a connection between them. The narrative no longer supports or adequately accounts for the lived experience of the individual. While the point of biographical disruption diverts lived experience from the narrative, it is at the breaking point when individuals acknowledge the need to change and re-story their narratives, or in other words, to construct a "new normal." This prompts action in attempts to change and resolve the tension. In Mia's case, arriving at the breaking point in which she decided to leave Michael was the result of narrative tension building gradually over time until she was no longer able to tolerate living with her husband. For Michael, multiple sudden breaking points almost overlapping their biographical disruptions propelled him into action. First was Mia's announcement that she was leaving, which prompted him to go into a detox program (SCENE 2). Then the attack on his narrative incongruence by the nurse and driver motivated him to accept treatment for his alcoholism (SCENE 3). However, it was not until Michael was well into treatment, that he committed to recovery (SCENE 9)

An attempt at resolution is an imagined alternative to the status quo narrative. It is important to note that individuals can and often do make more than one attempt to resolve their problems. Many of these attempts fail, and failure can drive people back to attempting to live the old familiar narrative again for lack of viable options. The feeling of having “tried everything” without resolving the problem can lead to a state of learned helplessness and despair (Shaghaghya, Saffarinia, Iranpoor, & Soltanynejad, 2011). According to Parry and Doan (1994), it is not enough to deconstruct former narratives. “To omit the re-vision process is to leave the clients in a state of ‘psychological free fall.’ Alternately stated, it is to leave them outside of a story” (p. 45). Though Michael has agreed to enter treatment and recognizes that his drinking narrative is unsustainable in relation to his lived experience, he is not ready to abandon it (SCENE 4). In SCENE 3 Michael admits that he has previously attempted quitting by going through detox, “I’d been through the spin-dry cycle before.” Thus, Michael’s present narrative of recovery is one of failure, futility, and frustration, an unobtainable ideal, while detox is understood as a tool to remove pressure from others rather than a means to achieve sobriety. The new narrative of recovery, which is intended to replace the drinking narrative is thin and outside of Michael’s lived experience. Therefore, even though Michael has reached a breaking point with the narrative incongruence between his drinking narrative and his lived experience of drinking, he experiences ambivalence about adopting the recovery narrative. In fact, the two narratives seem to run parallel in tension with one another, with Michael caught between (Figure 4.4).

The period of treatment can be seen as thickening Michael’s recovery narrative in order to make it livable. Narratives are thickened based on lived and vicarious experience (Parry & Doan, 1994; White, 2007). A new narrative may initially lack lived experience, though narrative therapists

will often seek out prior life experiences that serve to support and thicken the new narrative. For example, belief in a higher power is a cornerstone of the twelve-step model (AA, 2001). Michael claims not to believe in a higher power, having grown up outside of religion (SCENE 6). However, he recalls a memory of turning his will over to his father when he got his father's truck stuck in the mud. Even though Michael's father is not literally God; the memory forms a foundation for Michael of conceptualizing his understanding of a higher power. Michael is able to progress through the steps by making the steps relatable to his personal experience.

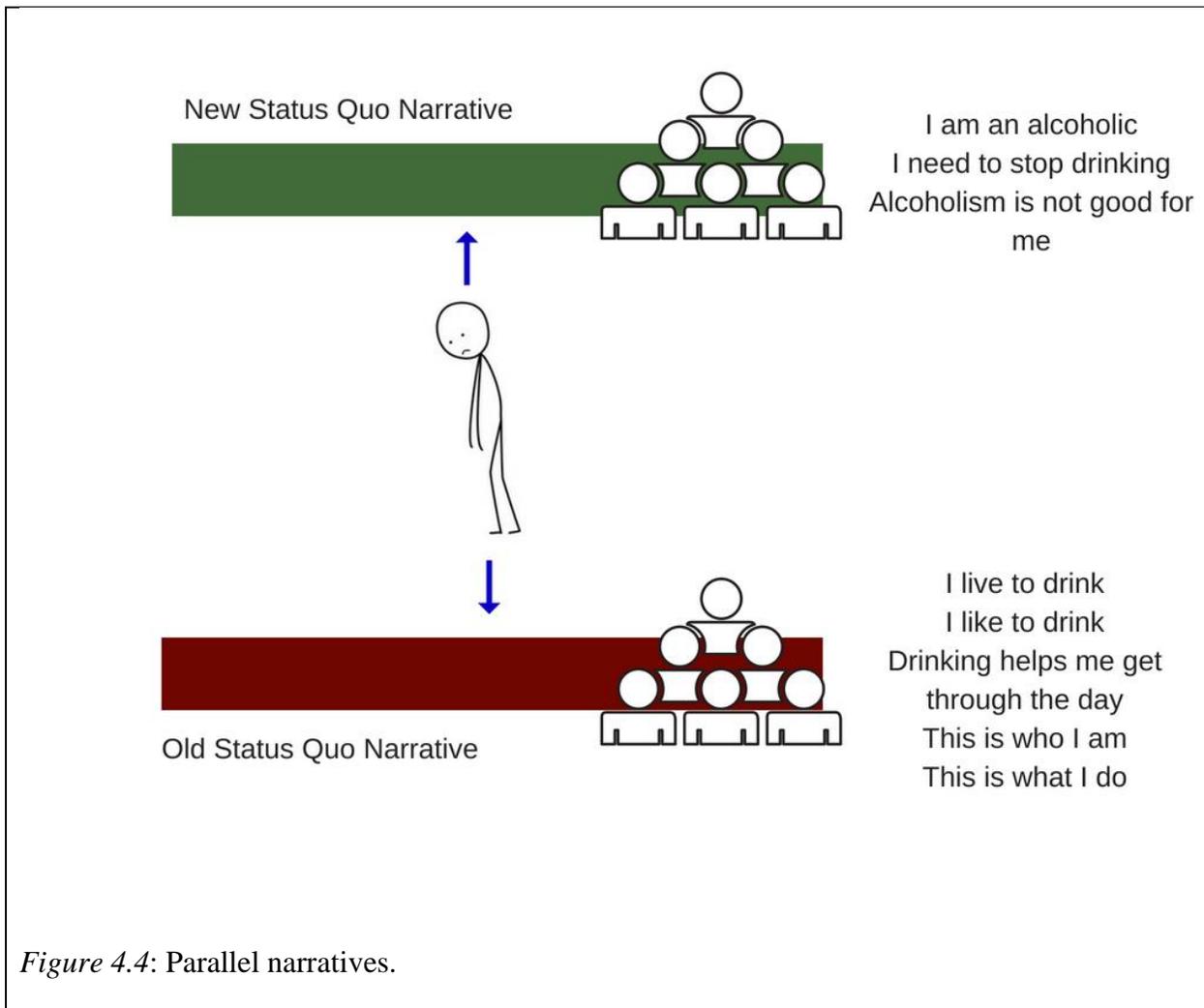


Figure 4.4: Parallel narratives.

Michael also relies on the vicarious experiences of others in the group. At first, Michael is mistrustful of the group, because they aggressively call him out on his avoidant language (SCENE 4). However, the group reveals its authority over Michael's narrative by linking their own stories to his, showing their similarity. Counselor Joe has each of the group members state the number of hours per week they spent drinking before sharing his own number. He then informs Michael, "We've all been where you are. They say only an alcoholic can really understand what other alcoholics have been through. Well, you're surrounded by alcoholics here. *We* get it. You don't have anything you need to hide from us." Being able to relate to the other men in the recovery group facilitates incorporating their narratives into the machinic assemblage of Michael's own recovery narrative. In particular, Michael identifies Frank as someone who is a knowledgeable model for recovery when Frank teaches Michael about mindfulness in the form of peeling a tangerine (SCENE 7).

Recall that internalized narratives are formed at the intersection between personal lived experience and social discourses within our awareness. For Michael, accurate social discourses of recovery largely existed outside of his awareness. The discourses that he was aware of regarding recovery tended to be distant from his lived experience of actually being in recovery. The sharing of stories between group members expands Michael's awareness of salient discourses with which he can assemble his own recovery narrative. The more that stories are shared, the greater number of narrative possibilities become available to him.

As Michael continues in treatment, he begins to build a preferred narrative that is *liveable*. He is able to identify as the protagonist of the recovery narrative - to see and desire himself in that role. Michael meets with Counselor Joe to tell him he's ready to commit to recovery (SCENE 8). Counselor Joe responds that in order to do so, he has to change his entire

lifestyle. Recovery involves more than a commitment to the behavior of not-drinking. As Counselor Joe points out, only the first of the 12 steps speak about alcohol. The remainder prescribe a program for living. The stories of Bill W. and others in AA (AA, 2001) provide a narrative model for the program.

While Michael is actively building a new recovery narrative in treatment, Mia has fewer opportunities to assemble a similar narrative outside of treatment. She notices the changes in Michael based on their brief visits, but she has trouble incorporating these into a plausible narrative and expects that he will revert back to his old ways eventually (SCENE 5). This narrative of mistrust in Michael's sobriety is supported by previous attempts at quitting, even going through the detox program, only for Michael to relapse after a few weeks. A comparison can be made to Watzlawick's (1978) first and second orders of change. First order change involves a superficial behavioral change which is often externally motivated, while second order change accompanies behavioral change with a shift in worldview and is internally motivated. Michael's previous attempts at sobriety were strictly behavioral without an accompanying shift in narrative. However, unbeknownst to Mia, Michael's treatment has focused on establishing second-order change; narrative change to support and sustain the behavioral changes of quitting and staying sober. Because the second-order changes of treatment are occurring mostly outside of Mia's awareness, it is difficult for her to construct a thick narrative on the changes in Michael's behavior.

Despite Michael's shift in treatment to a preferred recovery narrative as his "new normal," his old drinking narrative remains in competition. Michael is aware of the tension between these narratives and worries that he will be drawn back to the drinking narrative without the support, security, and supervision of the treatment center (SCENE 9). However, he also

recognizes that if the recovery narrative is going to grow, he cannot remain ‘in treatment’ indefinitely. He must leave and live his new story. Through lived experience he is able to thicken the new narrative, eventually finding employment for himself as a lawncare specialist (SCENE 10). It is interesting that Michael’s lived experience in long-term recovery reflects the lifestyle he imagined in his fantasy while in detox (SCENE 3), except that it is no longer centered on alcohol, but recovery.

Despite Michael’s narrative shift, others - including Mia and Mia’s family – not only continue to operate under the previous drinking narrative but threaten to pull Michael back to the old narrative as well. At one point after returning home, Mia becomes frustrated with Michael, and almost tells him to go drink, but catches and corrects herself, telling him to have a glass of juice (SCENE 10). During the family barbecue scene (SCENE 11), the family acts awkwardly around Michael, fearing that doing or saying the wrong thing will cause him to relapse. Michael asks that everyone act normally around him. He assures them that he is “not a werewolf,” who is going to lose all control of himself at the sight of alcohol.

While Michael has made a personal narrative shift to recovery, he still wishes to maintain as much of the status quo narrative as possible. However, narratives are not neatly arranged in separate strands. There is a great deal of ‘entanglement’ between narratives, and it is virtually impossible to change one narrative without disturbing others. Just as personal internalized narratives are formed at the intersection of our lived experience and an assemblage of social discourses within our awareness, personal narratives also operate in socially discursive ways to shape the narratives of others. In other words, Michael’s new recovery narrative introduces a biographical disruption and narrative incongruence for others in his life. This disruption of the “normal narrative” is maybe expressed most clearly by Nicole’s mistrust of Michael. She seems

to test the stability of this thin narrative through an aggressive challenging of the authenticity of Michael's recovery (SCENE 11). While Mia attempts to support and defend her husband against her sister's accusations, she later affirms them in a private conversation with Michael (SCENE 12), as she attempts to disentangle her own narrative from his. The inertia of the familiar drinking narrative is strong, and it remains a challenge to the newly formed recovery narrative.

Michael visits with Counselor Joe to vent frustration about his family's misunderstandings of recovery and to get advice (SCENE 13). Counselor Joe tells him that recovery and working the 12 steps is Michael's responsibility, not anyone else's, and it's a lifelong process. He notes that every time he returns to the *Alcoholics Anonymous* book, he reads it from a different perspective and gains new meanings from it even though the printed words don't change (echoing a statement made in the prologue). This suggests that narratives are never essentially fixed or singular but are always growing and multiplying through rhizomatic lines of flight (Deleuze & Guattari, 1987) through which they are constantly becoming an *other*. Developing the recovery narrative is about the process rather than the goal of sobriety and is therefore an endless task.

Though Michael has made a narrative shift from the drinking story to the recovery story and thickened it through lived experience, he continues to struggle with the unresolved tension and competition between the parallel narratives. The biggest challenge to his recovery narrative comes with the shocking news of the death of his role model for recovery: Frank (SCENE 13). Michael notes that Frank's recovery was intertextually linked with his own, saying, "He was like the one guy who seemed to have it figured out, you know? And I was like, 'if I can just be more like that guy...' Because he gets it... He *gets* it, you know?" If recovery is Michael's new "normal" narrative, Frank's death represents another jarring biographical disruption and

divergence between the narrative and lived experience. Michael is overwhelmed by the emotional distress caused by the narrative incongruence. He begins to fall back to his old and trusted method of coping – after leaving Counselor Joe’s office, he finds himself in a bar, staring at a glass of whiskey (SCENE 14). However, somewhere along the way, Michael has also acquired a bag of tangerines. This scene provides perhaps the most visual representation of Michael’s narrative struggle. The audience can sense Michael’s temptation to take a drink, balanced by his determined focus on peeling the tangerines – a mindfulness technique he had learned in treatment from Frank. As Frank’s death has diverted Michael’s recovery narrative, Michael expresses feelings of being “outside of the story,” and not knowing who he is supposed to be. The recovery narrative no longer provides a strong parallel tension with the previous drinking narrative for Michael, and it would seem that Michael is in serious risk of relapsing.

While Michael is struggling with the narrative conflict of whether to drink or not and what that means for his sense of self, Tom the bartender complains that Michael is not drinking, and therefore not generating revenue. Consequently, Michael orders a second drink, seemingly raising the stakes of his decision. Tom warns Michael that he is not invested in Michael’s recovery and refuses responsibility for Michael’s decisions. His interest is in making money from his customers. Michael responds that he is grateful for Tom’s respect for his personal sense of choice. In this moment, it is possible to see that in spite of Michael “working the steps,” his narrative of recovery has largely been dominated by the social narratives of others – those of his treatment group and his family. There has been a level of narrative incongruence between these externally imposed narratives and his lived experience of recovery that has prevented him from truly internalizing the recovery narrative as his own. In other words, he has been living in

accordance with others' expectations of what he *should* be doing in recovery, rather than forming and following his own authentic narrative.

Michael watches the other patrons in the bar (SCENE 14), recognizing his past-self in them: drunk in the mid-afternoon, with little other ambition in life. He admits to Mia that this former narrative had an appeal. There were feelings of freedom and comfort that came with an absence of expectations. However, from Michael's current subjective position in his recovery narrative he begins to transform or re-story the old drinking narrative so that it is no longer compatible with the present. For Michael, returning to his prior drinking lifestyle has become experience-distant. While he can identify the narrative of his past self with the patrons in the bar, he cannot identify his present narrative with them.

In contrast to the previous scene in which Counselor Joe has described recovery as a narrative of growth where "the story is the same, but the meaning changes," Michael describes the other patrons as stagnant (SCENE 14), a story that never evolves: "They come here day after day. They tell the same stories, the same jokes. You come here twenty years from now, and they'll still be here. Them, or someone like them." This statement aligns with Deleuze and Guattari's notion of the addicted body as one that is frozen in routine, desiring only itself, rather than to become an *other* (Deleuze & Guattari, 1987, Malins, 2004). When Mia tells Michael that he doesn't belong here, it is not only that he shouldn't be hanging out in a bar, but that this narrative is no longer his. In re-storying the drinking narrative from the perspective of his present narrative, Michael is able to realign the narratives and resolve the tension between them. The new narrative has become thicker and more experience-near, while the old one has become thinner and more experience-distant (Figure 4.5). Michael marks this moment as the true first day of his recovery.

The ending of the play purposefully evokes Plato’s Allegory of the Cave in which a number of prisoners are chained inside a cave so that all they are able to see are shadows on a wall. One of the prisoners escapes and explores the real world, and then returns to inform the others of their mistaken ideas about reality, only to be heckled and attacked by those who remained chained. For Michael, his journey to recovery has shown him that a life of drinking was shallow and unsatisfactory. Thus, he quotes the famous T.S. Elliot verse, “We shall not

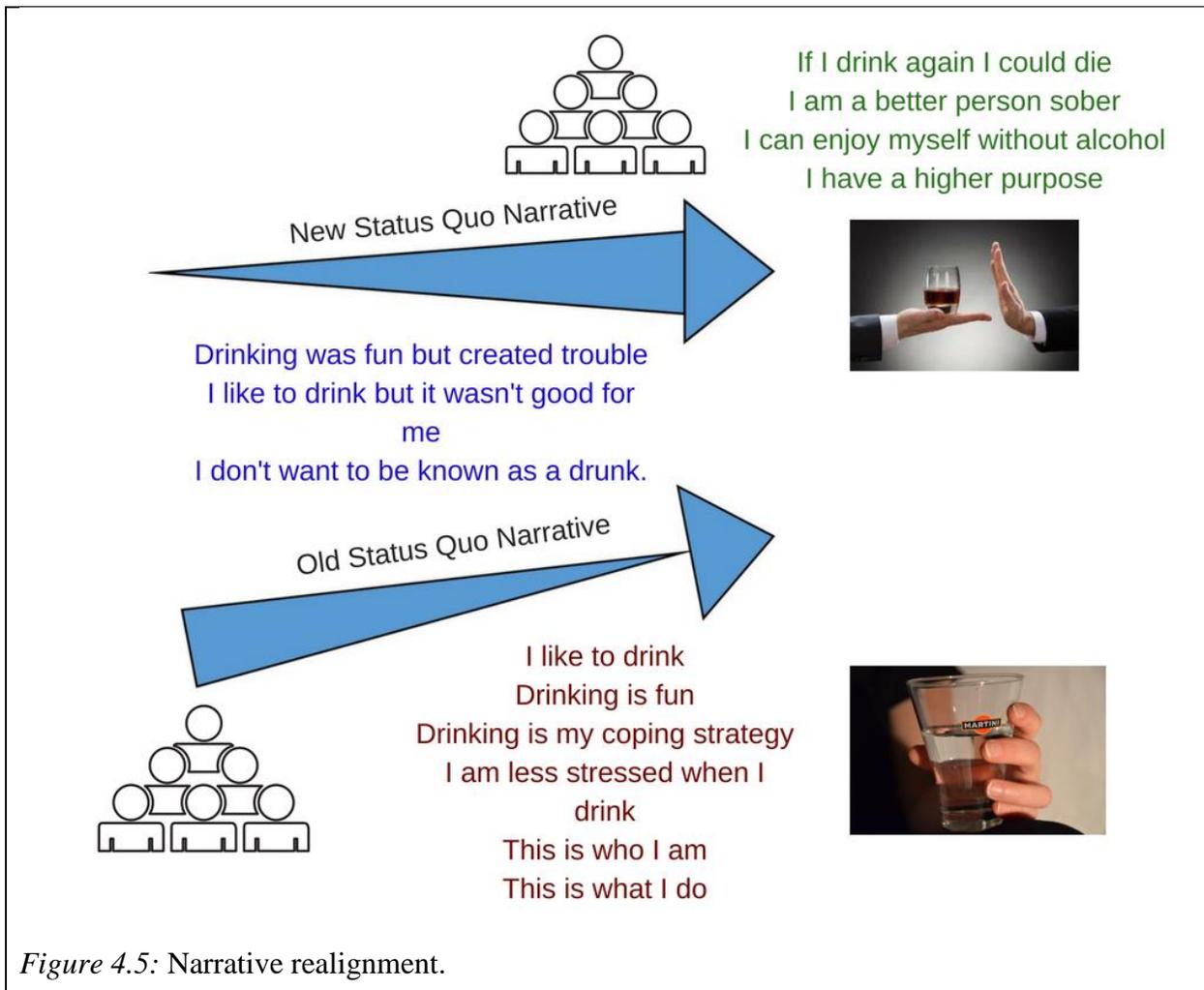


Figure 4.5: Narrative realignment.

cease from exploring, and the end of all our exploring will be to arrive at where we started and know the place for the first time,” and appends, “for what a pile of shit it really is.” Thus, Michael reframes the poem to mean that rather rediscovering a sense of wonder in the old status quo, his journey to recovery has illuminated the fact that the drinking narrative is no longer

satisfactory or acceptable to him. Michael is finally able to reject it. In keeping with the twelfth step, he shares his new perspective with the other patrons, saying, “There’s more to life than this. There’s a world out there... you can come out and see it for yourself.” Like Plato’s escaped prisoner of the cave, Michael is met with disinterest and heckling. Michael’s recovery narrative is too distant from the current experiences of the other patrons.

The epilogue finds Michael five years later, leading a recovery group of his own. His own recovery narrative has been thickened with five years of experience. In the short scene within a scene, Michael reproduces Counselor Joe’s approach by asking the members to account for the number of hours spent drinking and establishing a commonality between them. As one of the bar patrons from the previous scene appears to join the group, there is an echo of Counselor Joe’s statement earlier in the play about planting seeds of hope and being patient. In this brief exchange, we see that Michael has found value in his experiences. Not only is he able to extend his narratives to influencing the narratives of other alcoholics, but he is also meaningfully embedding his experiences within the greater social narrative of the tradition of recovery. He has become a part of something larger than himself. While he is helping others transition from addiction to recovery, he also finds an audience that supports and thickens his own narrative of recovery.

In summary, while behavioral change can take place spontaneously, the narrative change process typically occurs over an extended period of time. Problems arise when the individuals encounter a point of biographical disruption which causes their lived experience to deviate from their narratives of “normal.” Through the course of recovery, individuals can experience many points of biographical disruption which divert their lived experience in unexpected directions. The narratives in these new directions tend to be underdeveloped and “thin” compared to the old

thick narratives which are supported by an accumulation of lived experiences. The inertia of the old narratives carry them forward in competition with new thin narratives of change, and individuals often attempt to return the conditions of their lived experience back to “normal.” However, the distance between the present lived experience and the “normal” narrative often becomes too great to sustain. Individuals then reach a breaking point with the old narrative, prompting problem solving action to establish a new “normal” narrative that is near to the present lived experience to replace the old narrative. However, due to narrative inertia, thick old narratives tend to remain in tension and competition with the relatively thin new narrative. To resolve this narrative tension, it is necessary to reframe or re-story the old narrative from the perspective of the new in order to realign it with the present lived experience. In doing so, the old narrative can become thinner, allowing the new narrative to gain dominance. While it’s possible to trace a single narrative strand, the change process does not occur in isolation. Any narrative is entangled with a myriad of other narrative threads within an individual, and social discourses outside of the individual producing a broad narrative fabric. Therefore, change in one narrative strand is likely to systemically influence change (and tension and resistance) in others.

Chapter Summary

In this chapter, I presented an ethnodramatic script depicting the experiences of my participants as they transitioned from living with active alcoholism to long-term recovery. The script addressed issues of conflict and trust within the couple (and extended family members), as well as the difficulties experienced in shifting narratives. Michael, Mia, and their extended family had to overcome the inertia of the drinking narrative and thicken the narrative of recovery. While treatment and recovery communities like AA provide an individual model for Michael’s recovery, there were fewer models for couples in long-term recovery, leaving them

challenged in resolving their relationship issues. These issues included a division of domestic roles and responsibilities, responsibility for maintaining sobriety, resolving conflicts, communicating, emotional vulnerability, dealing with jealousy issues, and uncertainty about sustaining abstinence. Michael and Mia relied on the strong narrative of commitment to family cohesion as a way an anchoring of their relationship leading them to remain together and work through the challenges of recovery.

Following the ethnodrama, I provided an examination of how narratives have operated in the play to prompt action or sustain patterns of behavior. Problems arise when narratives diverge from lived experience, and tension grows with the magnitude of narrative incongruence. When narratives fail to explain the lived experience of participants, or conversely the lived experience can no longer sustain the narrative, individuals reach a breaking point that prompts them into problem-solving actions. Individuals can attempt several failed resolutions to the problems, before finding one that is “livable.” However, new narratives often start “thin,” while old narratives remain thick and familiar. Individuals are often caught in tension between these two narratives and experience an ambivalence about committing to either. To resolve the tension, it is necessary for the individual to thicken the new narrative and to re-story or transform the old narrative from the perspective of the new narrative. In doing so, the old narrative becomes experience-distant, and loses its influence on the new narrative.

Chapter 5 - Conclusions and Implications

Introduction

This chapter provides a discussion of the findings presented in chapter four, including how findings fit with and contribute to the existing literature. Potential implications for practitioners, counselor educators, and those in the recovery community are provided, and the overall significance of the study is described. The chapter then notes several limitations of the study, which may be addressed by future research. Finally, the chapter will conclude with my personal reflections on the research, and how conducting this research has impacted me.

The impetus for this study came from my experience working at a drug and alcohol recovery center in Texas. I was moved by my clients I was seeing, each of them having hit some form of “rock bottom,” and finding the strength, courage, and optimism to claw their lives back from the devastation of drugs and alcohol. I was drawn to the *community* of those in treatment and how they supported and cared for each other as fellow travelers in recovery.

On the weekends, clients received visitors, and I conducted family and couple counseling sessions. The sessions were a voluntary supplement to the regular addiction-focused program that clients underwent during the rest of the week. It was immediately evident to me that all of the work that clients had done in treatment to get sober was just the tip of the iceberg for the healing that partners and families of addicts required. Research on relapse supports the conclusion that post-treatment care is needed to sustain sobriety and restore family stability (Barnard, 2007; Callan & Jackson, 1986; Dennis, Foss, & Scott, 2007). While I could empathize with the lingering conflicts, resentments, and mistrust that family members expressed in sessions, I could not help feeling frustrated for the clients with whom I had worked. It seemed that the optimistic and humble clients I knew as a counselor were not the same “monsters” that

the family described. Of course, I had only seen clients working hard towards their recovery, and I did not observe them in the in the years preceding treatment when they would have been at their worst. However, I realized that families were running parallel narratives to the clients in treatment – often hanging on to the previous narrative of addiction. Family members saw the individual in recovery for maybe a few hours a week, during visitations, while the clients were living their new recovery 24/7. Therefore, as clients were undergoing major narrative developments in treatment, families and their dynamics outside the treatment facility went largely unchanged.

When I think of families who have remained intact throughout the transition from active addiction to recovery, few examples come to mind. In popular media (such as movies and television), there are plenty of stories of addiction destroying families and leading to tragedy. Those that feature characters in recovery don't often focus on family and frequently depict the character relapsing. For those who are attempting to recover from addiction as a family, there are few positive models available. Therefore, it has been my intention in this study to present a success story in which a couple survives the transition from active addiction to long-term recovery without dissolving the family. In addition to understanding the narrative change process for couples in recovery, it was my hope to provide those couples with a new narrative possibility in which change and survival of the family are possible.

Responding to the Research Questions

Readers will recall that the purpose of this study is to explore the experiences of a couple with a member who has transitioned from active addiction to alcohol to long-term sobriety. The following research questions guided the research:

- How do participants describe their experience of recovery from alcoholism as individuals and as a couple?
- What do the participants attribute as key influencers to their successful transition to long-term recovery and their sustained relationship as a couple?
- How do individual and couple narratives develop and function within the change process from alcoholism to long-term recovery?

Responses to these research questions are entangled with each other, as is common in qualitative research (Bhattacharya, 2017). Often, a specific response to one question can become an answer to another research question. This entanglement is an indication of a carefully constructed, thick, rich, descriptive study, where specific detailed information can be pertinent for multiple research questions.

To examine the ways that narratives operated in the change process described in the ethnodramatic script presented in chapter 4, I developed the Narrative Change Model (NCM) (Figure 5.1). This model was adapted from Freytag's (1894/2007) classic plot structure model of literary analysis (introduction, complication, rising tension, climax, denouement, and resolution) in dialogue with broad ontological, epistemological, methodological, and substantive narrative theories (Deleuze & Guattari, 1987; Kim 2016; White & Epston, 1990) described in chapter 2, to describe the process of change from a narrative perspective. Figure 5.1 is identical to Figure 4.1 presented in chapter 4. It is used in this chapter as a way to frame the responses to the research questions.

The NCM provided a way of conceptualizing the narrative movements, evolutions, tensions, and negotiations of the characters as they transitioned from active addiction to recovery. Applying the model to a reading of the ethnodramatic script produced a lens through

which it was possible to answer, demonstrating the description of recovery from alcoholism, key influencers in recovery, and the process of negotiating narrative changes in recovery.

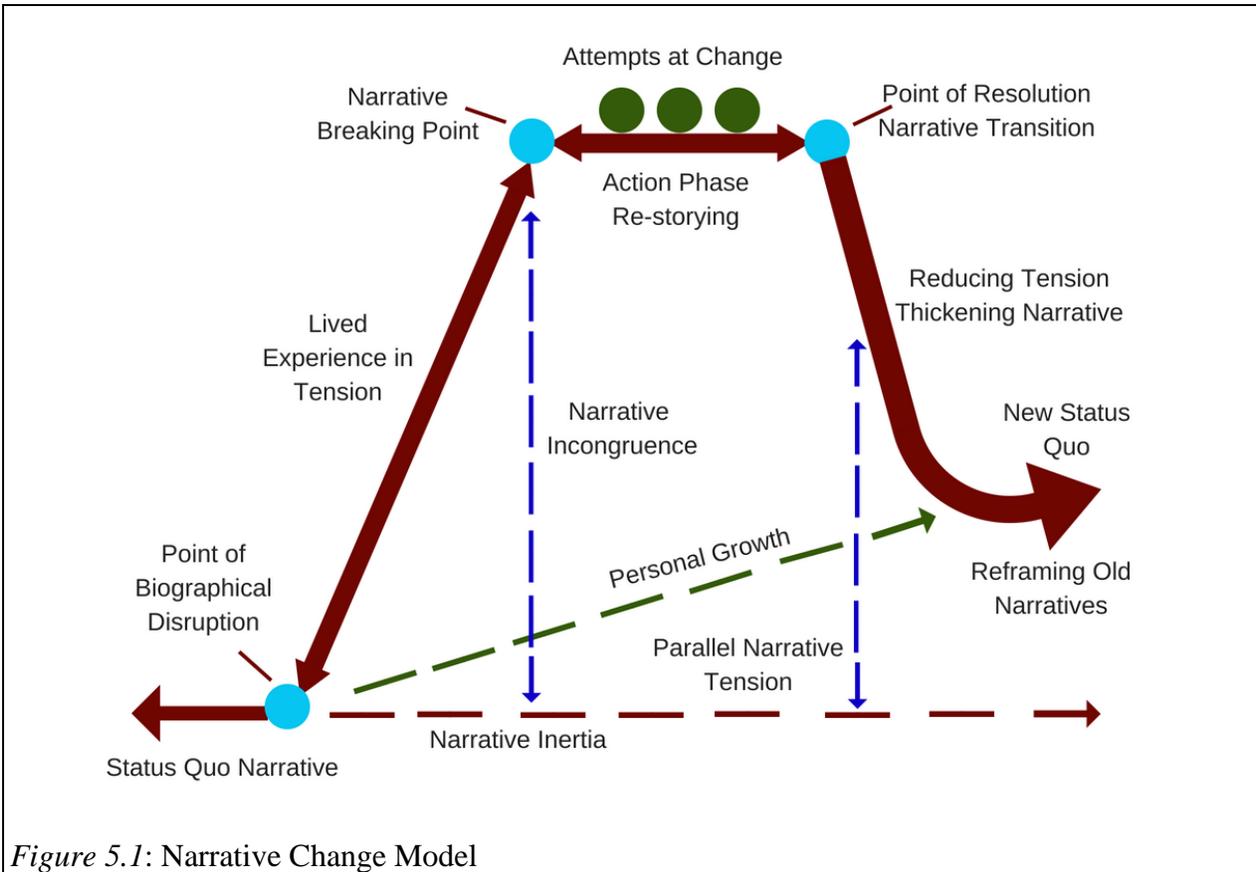


Figure 5.1: Narrative Change Model

Individual Narrative Change

It is important to understand that all stories are excerpted from the totality of the lived experience of a person. In other words, stories have a beginning and end. However, the beginning of the story is not the beginning of experience. Thus, the term “status quo” was used to describe the introduction. “Status quo” denotes “life as usual,” with the inference that there has been a patterned experience to support the sense of normalcy. In other words, “status quo” implies that there has been narrative prior to the beginning – a back-story. The backstory in this study allows the reader to understand what was normalized for Michael and Mia before moving on to the next critical point in the Narrative Change Model, which is the Biographical

Disruption. Thus, the first SCENE 1 of the ethnodrama begins on the final night of Michael's drinking. Through the dialogue between him and Mia, the audience is made to understand that his level of drunkenness is not a random or sudden event but has been life as usual for the couple for several years. Therefore, the couple's narrative about Michael's drinking was thickened with years of experience which represented their status quo or state of "normal," before hitting a point of biographical disruption.

Michael's routine of drinking was reinforced by several evolving narratives and social discourses that thickened over time. For example, in the early days, the purpose of drinking for Michael was to party and have fun. After the birth of his child, the purpose of drinking was to ease stress and stay balanced. However, even the discourses around the utility of drinking wore thin. Drinking existed simply for its own sake. It had become routine.

According to Deleuze and Guattari's (1987) concept of the machinic assemblage, meaning is produced in relationships, or in other words, a machine is understood, not in itself, but what it *does* to other machines. To use a reference from popular culture, the opening scenes of the film *The Gods Must Be Crazy* (Uys, 1980) demonstrate shifting assemblages. In the beginning, a pilot is drinking Coca-Cola from a glass bottle. The bottle in combination with the pilot and the contents produce a machine in which the bottle operates as a container. When the bottle is emptied of its contents, its meaning changes. It becomes litter, an object to be discarded. The pilot tosses the bottle out of the window. In its descent, the meaning of the bottle changes again, now a dangerous projectile to be avoided by the people below. The people below have become new components in machinic assemblage with the bottle. The social discourse in which the bottle is a container – specifically for cola – exists beyond the awareness of the African tribe that discovers it. Instead, they invent a number of new assemblages, including bottle as tool,

bottle as toy, bottle as musical instrument, etc. In each iteration, the bottle as machinic assemblage, seeks out and makes itself available to new connections and combinations to produce meaning.

In contrast, the addicted body (Deleuze & Guattari, 1987, Malins, 2004) desires no connection but to itself. Its goal is only to reproduce itself, rather than to become an *other* in combination and relation to other machines. Thus, when Michael addresses the bottle in the second SCENE 2, he notes that drinking no longer serves the purposes it used to. It seems to exist purely for its own sake. Michael refers to it as a “selfish bastard,” and tells it to “quit feeding off me.” In this brief monologue at the end of the second SCENE 2, the audience may observe a shifting and reconfiguration of the narrative assemblage that produces meaning from drinking. The machine that incorporates the motivation, “because it’s fun,” as a narrative component to produce drinking, relies on different lived experiences and social discourses than the machine that produces drinking from the narrative component “coping with feelings of emptiness.” Finally, Michael relies on yet another set of social discourses and experiences in combination to produce a narrative of the drinking assemblage as broken or pointless. In other words, the final machinic assemblage of drinking produces no desirable effects in combination with the other machinic assemblages (family, self-worth, etc.) in Michael’s life. Instead, it uses Michael as a component to reproduce itself, creating a narrative feedback loop, “I drink because I drink because I drink...”

Within a narrative therapy context, the alcohol narrative machine can be externalized from the person (White & Epston, 1990). In other words, it is addiction to alcohol that is the problem, not Michael as a person. Separating the person from the problem allows individuals to disentangle the problem from their identity and to interrogate their relationship to it. It is

important to keep in mind that assemblages are bi- (or multi-) directional (Deleuze & Guattari, 1987), best understood in terms of the interactive relationships between the components. In other words, a machinic assemblage derives its meaning not from what it *is*, but what it *does* in relation to other machines. Therefore, the problem is not Michael, but the assemblage: Michael + alcoholism. In viewing the issue this way, a therapist might inquire into the influences of the alcoholism on Michael's life (White, 2007). To put it differently, rather than asking how Michael has produced alcoholism through his personal choices and behaviors, a narrative therapist could ask how alcoholism has worked to produce a particular narrative version of Michael's self.

However, it is imperative to note the interconnected nature of machinic assemblages. There are machines within machines, and each individual component may have multiple connections to many different machinic assemblages. The alcoholic assemblage (Michael + alcohol) was also plugged into the family assemblage ([Michael + alcohol] + family). While the alcoholic assemblage desired only itself, its assemblage within the family machine created malfunction and strain. In other words, the evolution of Michael's drinking became detrimental to his role as a father and husband, as well as the overall function of his family. Thus, the Machinic Assemblage of Michael's addiction was at odds with the Machinic Assemblage of the family system, leading to the next stage in the Narrative Change Model (Figure 5.1).

In the NCM, the biographical disruption (referred to in the classic plot structure as "the complication" (Freytag, 1894/2007)) is the point where the lived experience deviates from the status quo narrative, creating a schism. The family status quo narrative is disrupted by Mia's ultimatum in SCENE 2 two when she threatens to take the children and leave Michael. At this point, the possibility of losing his family sharply deviates from the narrative of having a family.

While Mia's ultimatum provides a sharp and immediate example of a biographical disruption, the divergence of lived experience from the status quo narrative can often be subtle, developing gradually over time, due to changing circumstances which render machinic assemblages obsolete. For instance, in the beginning of Michael and Mia's relationship, both members of the couple enjoyed drinking and partying. However, "growing up" created a biographical disruption for Mia where adult responsibilities, such as childcare and work, diverged from the partying narrative. In the first SCENE 1, she counters Michael's accusation that she isn't fun, saying, "I grew up, Michael. We had kids. Someone had to be an adult around here. So, I stopped drinking. But you never did." Mia adjusted her narrative assemblage around drinking to be aligned with adulthood and motherhood, gradually deviating from the party-narrative of her youth. In this exchange the divergence can actually be observed in the difference between her narrative and Michael's towards drinking.

According to the NCM, increasing incongruence between the status quo narrative (life as normal), and lived experience (life as it is) produces a rising tension. This rising tension is a psychologically uncomfortable state, conceptually similar to Festinger's (1957) cognitive dissonance, in which two contradictory thoughts are held at the same time. It often arises in discrepancies between the way things are and the way they ought to be. For example, as Michael's drinking remained the same, Mia's "adult" narrative lead her to take on the bulk of household responsibilities, as well as to become the sole earner for the family. The lived experience of performing under strain became the new status quo for Mia. At the same time, her lived experience of family gradually drifted away from the narratives she held about how family ought to be. This discrepancy was highlighted by Mia's sister Nicole in SCENE 5 when she states, "I'd hardly call the way you've been living 'usual.' God, Mia, this can't be the way you

dreamed your life would turn out when you were growing up.” Mia’s initial response is to minimize the relevance of a preferred narrative, replying, “Yeah, well, who the hell ever did grow up to be a rock star princess marine biologist, anyway?” This response challenges the social discourse that adult life should match childhood expectations which Nicole is attempting to impose on Mia’s lived experience. However, towards the end of the scene, Mia acknowledges the gap between her preferred narrative of marriage and the lived experience of being married to Michael. However, she again rejects Nicole’s pressure to leave him, by invoking her marriage vows, and saying, “I don’t think I could live with myself if I didn’t give us every possible chance.” Mia is thus caught in a narrative tension between her dissatisfaction with her marriage and the importance of her marriage vows. As much as there is a discrepancy between the lived experience of her marriage to Michael and her preferred narrative of marriage, Mia imagines that diverging from the narrative of marriage vows would create even more narrative tension, and therefore she is willing to tolerate the lesser tension of an unsatisfactory marriage and give it “every possible chance.”

The narrative breaking point is the point at which the status quo narrative can no longer account for the lived experience. The old narrative is no longer livable, and therefore, the relationship between the old status quo narrative and the present lived experience breaks. The breaking point is experienced as a narrative crisis, leaving individuals “outside of a story” (Parry & Doan, 1994, p. 45). This state of crisis is also a prompt to take action. It is frequently when clients reach this point that they come to therapy in search of solutions to their issues and for alcoholics may be analogous to “rock bottom.”

For Mia, the narrative of what marriage is supposed to be was no longer able to account for or explain why she was so unhappy in her own marriage to Michael. Mia recognized that the

family machinic assemblage was malfunctioning, due to a defective component - Michael's alcoholic assemblage. The initial action resulting from Mia's breaking point was to threaten to take the children and leave. Michael presses Mia for details about what will happen next, to which Mia responds that she doesn't know. "All I know is we can't go on like this. Something has to change, because this... This isn't working. It's killing you, and it's killing us. And me and the girls, we can't be part of that anymore." The breaking point has left Mia in a narrative limbo with a status quo narrative that is unlivable and no new narrative to replace it. It should be noted that Mia did not come to this breaking point suddenly, but gradually arrived at it over the span of many years.

In contrast, Mia's ultimatum to Michael presented him with a biographical disruption that was almost immediately intolerable to the narrative of being a husband and father. The threat of Mia leaving made the assemblage of the drinking and family narratives unworkable. In a sense, Mia's ultimatum was a wrench thrown into the machinic assemblage of Michael's drinking, forcing him to take action to correct the malfunction. Michael went into action to resolve the tension by volunteering to enter detox.

While Freytag's (1894/2007) classic plot structure describes rising tension leading to a narrative point of climax, the NCM views the action stage as a rocky plateau. The breaking point prompts individuals to take action to resolve their narrative crises; however, individuals may attempt many resolutions before finding one that works and successfully establishes a new status quo or "normal" narrative to rival the old one. Readers of the ethnodrama can see that Michael's path through treatment was not entirely smooth. His initial action to resolve the crisis brought on by the breaking point was to go into an alcohol detoxification program. Yet, even as he described how unpleasant the experience of alcohol withdrawal was, he still fantasized about his next

drink. Michael confided that he had been through alcohol detox programs several times before when his drinking had gotten out of hand. Detox by itself was not effective solution to resolve the issues within his family. For Michael, detox was not a way of disassembling himself from alcohol, but instead, it was an attempt to modify, mend, or clean the alcoholic narrative so that it was less incompatible with the family assemblage. In SCENE 3, he states, “I knew if I could stick it out for a week, and get it under control, Mia and everyone would get off my back.” By making an effort to cut back, Michael imagines that he will be able to continue drinking. He further comments, “if this week without alcohol hadn’t earned me the right to a drink or two when I got home, I didn’t know what would.” Thus, Michael has reconfigured the narrative of detox from an assemblage for producing sobriety to one that not only enables but justifies his continued drinking.

Michael’s previous attempts at detox had succeeded or failed, depending on what the object of the machinic assemblage of detox was. If, for Michael, detox was a way of relieving family pressures to quit drinking, it seemed to be effective, at least as a short-term solution. In this case, Michael was attempting to realign his lived experience with the old status quo narrative, or in other words, return to normal. However, as was established by Mia’s ultimatum, “normal” was no longer an acceptable narrative for the family. Therefore, to realign Michael’s lived experience with the previous status quo narrative would disrupt Michael’s family narrative. However, Michael’s entrance into a treatment facility does at least partly realign her lived experience with her narrative of a positive marriage. Thus, she is able to come down from the breaking point and resolves to give Michael “every chance.” She tells her sister Nicole in SCENE 5 that Michael has changed, and reiterates in SCENE 14,

That's the Michael that I believe in. Brave, determined, loyal, willing to fight for what he loves. And over the years, I'd catch glimpses of him from time to time.

Just enough to let me know you were still there, somewhere under all the alcohol and shit. Then you went into rehab, and I started to see more of the real you, and I thought finally, this is who I've been waiting for all this time.

Thus, for Mia, Michael's recovery is a matter of returning to normal. However, for Michael, the old "normal" or status quo narrative has drifted out of reach of his lived experience and is no longer accessible. As noted, to return to "normal" in terms of Michael's drinking is to jeopardize his family. However, there's another normal represented in the second SCENE 2 of the play. Michael nostalgically laments the loss of his teenaged athletic physique, in spite of being in his mid-30s with his adolescence irretrievably behind him. This represents a case in which a formerly functional narrative (that of being a teenage athlete) has grown obsolete over time and no longer relates to the lived experience of the present.

Michael's alcoholic narrative had been *thickened* with years of experience to the point that it had been fixed in stasis. In other words, the drinking narrative was all that Michael knew. Certainly, there are many alternative narratives to Michael's drinking narrative, but these existed either outside of his awareness or appeared so distant from his lived experience as an alcoholic, that they seemed unrealistic or unavailable to him. At the breaking point, narratives of sobriety and recovery are a new territory as yet to be constructed. Individuals at this point are in a very fragile and precarious position. The narrative uncertainty was demonstrated in the script by Michael's ambivalence and hesitancy to fully engage with the treatment process and transition into recovery (SCENE 4). When asked whether he was ready to get sober, Michael very honestly answered that he was unsure and frightened. For Michael, the narrative of drinking had been so

complete that it blocked out alternatives, and Michael had difficulty contemplating a life without alcohol.

The point of resolution in the Narrative Change Model (Figure 5.1) occurs when the individual takes a successful action that allows them to develop new ways of being. The machinic assemblage of the self becomes reconfigured to produce a new narrative, one in which the alcoholic component is reconfigured or updated in conjunction with a new narrative component of recovery. Where the breaking point represented a need to break from the old status quo narrative, the resolution is a transition to a new “normal” narrative that replaces it. This transition can take time and multiple attempts. DePue, Finch, and Nation, (2014), distinguish “Rock Bottom” from “Turning Points” in recovery. As noted, Rock Bottom represents a breaking point in which addiction is no longer sustainable, and the individual recognizes a need for change. Turning points, on the other hand, are a commitment to change, similar to the resolution point in the NCM. For Michael, the breaking point came in SCENE 2 with Mia’s ultimatum, however there have been multiple turning or resolution points in Michael’s recovery. The first came in SCENE 3, when a spot in treatment opened and Michael hesitantly made the decision to go. The second turning point for Michael occurred in SCENE 8, when Michael visited Counselor Joe and confirmed that he really wanted to change. The third and ultimate turning point in Michael’s recovery came at the end of the play (SCENE 14), when Michael recognized that the former narrative of alcoholism no longer applied to his present lived experience. In the NCM, resolution does not necessarily indicate successful recovery, but a resolution of the crisis of being “outside of a story” (Parry & Doan, 1994, p. 45) introduced by the breaking point. Resolution is the beginning of the new status quo narrative.

Deleuze and Guattari's (1987) concept of the *body without organs* overlaps with the machinic assemblage, in which components (organs) may be rearranged, removed, replaced, and reassembled in potentially infinite configurations. The *organism*, in contrast to the *body without organs*, is a body in which the organs are in fixed relation to one another (Deleuze and Guattari, 1987), limiting their potential to become an *other*. The addicted body, with its rigidly patterned, routinized and habitual consumption of alcohol or other substances is an *organism* (Deleuze and Guattari, 1987; Malins, 2004; Oksanen, 2013). It is as if all of the components of the machinic assemblage had been welded into position. Where the body without organs is adaptable and capable of growth, the organism is stubbornly structured to remain the same. In order to transition to a new narrative, Michael must first make himself a body without organs, capable of changing. He must loosen and dislodge the organs of his addiction, dismantling the addiction organism, becoming unstuck from the old habitual routines and narratives, and desiring to become something else: an *other*. The scenes describing Michael's treatment depict the work involved in dismantling the organism of the alcoholic self to produce a body without organs capable of becoming *in recovery*. The metaphor of self-evisceration may be apt in describing the difficulty and emotional discomfort in the process of personal deconstruction for individuals with AUDs. As Counselor Joe advises Michael in SCENE 8, "The only thing you have to change is everything." While necessary, the work of personal deconstruction should not be dismissed as an easy or painless process.

The transition to the resolution stage begins when the alcoholic begins to develop a new narrative to replace the old drinking narrative (Malins 2004; Oksanen. 2013). However, if one does not drink, what does one do? If one is not a drinker, then who are they? Questions like these need to be answered to the satisfaction of the individual with the AUD in order to progress past a

merely behavioral sobriety and truly enter the process of recovery as a re-storying of the self. In narrative therapy, the therapist and client collaborate on the re-storying process (Anderson & Goolishian, 1992; White & Epston, 1990). The therapist plays the role of a benign editor, suggesting possible revisions and narrative potentials to the client (Parry & Doan, 1994). Narrative therapists operate from a position of not knowing (Anderson & Goolishian, 1992; White & Epston, 1990), respecting the authority and expertise of the clients over the construction of their own narratives. The goal of re-storying is not a denial of the past, but a reframing or reimagining of potential interpretations of past events and their possible effects on present narrative construction (Freedman & Combs, 1995; White, 2007). As Michael says in the prologue, “the story is the same, but the meaning changes.” To tell a story differently is to tell a different story.

The re-storying process was introduced to Michael in group counseling sessions led by Counselor Joe. Counselor Joe and the other group members presented new social discourses as component for constructing new narratives of alcoholism and recovery. However, developing a stable narrative of being in recovery does not happen all at once, but is a gradual process that evolves over time. As Michael progresses in treatment, new narrative components are made available to his awareness for constructing the machinic assemblage of recovery. For example, one of the other group members in the treatment center introduces the concept of mindfulness to Michael, which becomes a major component of his recovery assemblage.

As an alternative to the status quo narrative, a newly constructed preferred narrative is initially thin or unsupported by lived experience (Freedman & Combs, 1996). The new narrative of Michael’s recovery is less familiar than the old narrative of drinking. Despite the alcoholic having broken with the status quo narrative, the narrative remains in competition with the new

narrative of recovery. In the ethnodrama, Michael's narrative of recovery continues to be challenged by the old narrative of drinking, even after he has completed treatment successfully. Thus, the narrative change process extended beyond treatment, as the recovery narrative was gradually thickened by lived experience – both directly and vicariously.

It is important to note that narratives do not exist independently, but in intertextual relations to one another. Intertextuality is a literary term describing the influence of one text on the reading and interpretation of others (Allen, 2011). For example, it is not possible to understand the narrative of Michael's alcoholism in itself, because it exists in relation to other narratives of alcoholism – such as *A Liar's Autobiography* by Graham Chapman (1980). These two narratives exert a reciprocal influence on their interpretations. In other words, a reader inevitably compares and contrasts the experiences of Chapman with those of Michael. A reading of one influences how meanings are constructed from the other (and vice versa) (Allen, 2011; Iser, 1979).

One of the greatest challenges to Michael's narrative change came with the death of Frank (SCENE 13). Frank's recovery had become a model for Michael's recovery. His death, due to drunk driving, severely troubled Michael's confidence in his own recovery assemblage. Michael confided to Counselor Joe,

No... No way, man. He was the one. Out of all of us, I thought that he was the one that was supposed to make it. He always seemed like he had it all figured out. I *believed* in him... I feel... betrayed. I believed in him and he let me down. He let us all down.

This passage demonstrates the intertextual linkages between stories of recovery. When Michael's narrative of recovery was thin, he relied on Frank's recovery narrative as a guide for developing

his own (SCENE 7). Frank's narrative was so fundamental to Michael's own internalized recovery narrative, and his death was such a shock that it led Michael to question whether he could continue to live the recovery story. In SCENE 14, Michael goes to a bar and contemplates whether to return to the old narrative of drinking or continue in the uncertain recovery narrative, literally demonstrated by a choice between a glass of whiskey and a bag of tangerines. While at the bar, Michael recognizes how distant the drinking narrative seems from his present lived experience of sobriety. He is able to re-story his past self from the perspective of his present self-assembly, thereby resolving the narrative tension between them.

Narrative Change in the Couple

While internalized narratives operate within individuals to produce meaning from lived experiences, narratives also interact within family systems (Madigan, 2011). In families with alcoholic members, the alcoholism frequently becomes the central organizing theme around which other narratives are organized (Barnard, 2007; Orford, 2012). For example, as Michael became less dependable because of his drinking, Mia took on a greater amount of responsibility in the family. She was the sole provider, as well as the primary caregiver of their children at home. Added to these responsibilities, Mia also attempted to take care of Michael and limit the negative impact of his behavior. Thus, for Mia, her roles and responsibilities in the family were largely organized in relation to Michael's alcoholism. Similarly, Nicole also orients her relationship with her sister in relation to the AUD. She becomes a source of support and fierce protector, at one point antagonizing Michael (SCENE 11) in order to defend her sister. It is possible to see the intertextual influence of these narratives: Michael's old alcoholic narrative has influenced the reading of Nicole's sister-narrative as one of defender. At the same time, Nicole's sister-defender

narrative influences the way that Michael's alcoholism is read (e.g., as something from which Mia needs protecting).

As Michael progresses in his recovery, Mia attempts to decenter his role in the narrative organization of the family. During an argument (SCENE 12), Michael suggests that Mia should attend an Al-Anon group to work through her own issues. Mia resists him:

I've been living your life for years. Everything I did was arranged around taking care of you while you were drinking, playing damage control and keeping things from getting worse than they were... I'm still living around you and your life.

Except it's not drinking, it's recovery. Everything is AA slogans and twelve steps with you these days. I'm glad that works for you, but it's not *my* life.

The exchange echoes the conflict in the first scene in which Michael invites his wife to have a drink in order to solve her "not fun" problem. Michael insists that having a common interest will bring them closer together as a couple. Mia responds:

But it's not a common interest, Michael. It's your interest, and now you want to make it my interest. Even worse, you're trying to make me feel like a terrible wife for not being interested. But I'm not. And I'm tired of pretending that I'm as into all this as you are... Everything always has to be about you. You make me feel like a supporting character in my own life. But I'm not just your little sidekick that you can boss around. I'm my own person, and you need to respect that.

Narratively speaking, Mia recognizes that Michael has been imposing his narratives on her lived experiences. In rejecting his insistent urges to attend Al-Anon, Mia is engaged in what Bowenian therapists would describe as differentiation (Bartle-Haring & Lal, 2010). From a narrative lens, Mia deconstructs the influence of Michael's social

discourses on her internalized narratives so that she can begin construct narratives that are nearer and more authentic to her own lived experience. In doing so, she resists enmeshment, asserts her independence within the relationship, and establishes narrative boundaries between herself and Michael. Differentiation is believed to be an indicator of healthy relationships (Bartle-Haring & Lal, 2010).

Counselors must consider the intertextual influence of family systems on the narrative transition. Systems that resist the transition can challenge recovery narratives (Kim and Rose, 2014). However, supporting the recovery narratives of an individual member requires a reconfiguration of the machinic assemblages of the family narrative. In other words, as an individual's narrative of alcoholism changes to one of recovery, the family narratives which have been organized around the alcoholic narrative must also change or risk the relapse of the individual. Therapists can play an important role in facilitating the re-storying of the assemblages of family narratives to facilitate the recovery of alcoholics by helping families, to externalize, interrogate, deconstruct, and reauthor narratives of family membership and the role of alcohol within the family (Madigan, 2011).

Within the alcoholic family system, the intertextual narrative relationships become compensatory. Michael's drinking narrative threatened to destabilize the family assemblage. Therefore, Mia compensated by altering her responsibility narrative to accommodate for Michael's defective responsibility narrative. The resulting behavior for Mia was that she took on additional responsibility in order to sustain the family functioning – i.e. becoming sole earner, repairing the consequences of Michael's drinking, and so on. The more that Michael's drinking narrative contributed extra stress to the family system, the more it reinforced Mia's work narrative. In other words, in order to compensate for Michael as a defective component within

the machinic assemblage of the family, Mia took more and more responsibility onto herself. However, compensating for others placed a greater strain on her personally, and threatened to burn her out.

While Michael was in treatment, and beginning the re-storying process of recovery, Mia remained outside of the process, occasionally getting only glimpses of the changes in Michael while he was in recovery. Thus, while Michael was undergoing a narrative change process to transfer from active addiction to recovery, Mia's narrative remained more or less the same. The divergence between narratives was shown in SCENE 10, in which Michael attempted to take responsibility for his share of the household chores. Mia was unwilling to give up her role as the primary caregiver within the home and became irritated with Michael stepping on her domestic territory.

The discrepancy between narratives in the couple produced a threat to Michael's sobriety. Without the drinking narrative, Michael was in search of new narratives to take its place. Part of the drinking narrative involved a narrative about Michael's irresponsibility around the home, and Mia being overburdened by having to take all the responsibility. In establishing a new narrative of 'recovery,' Michael attempted to re-story himself as a responsible member of the household as an alternative to the old status quo drinking narrative. However, the development of the 'sober Michael is responsible' storyline was impeded by the inertia of 'Mia as the sole caregiver' narrative. This impediment may have again left Michael feeling "outside of a story" (Parry & Doan, 1994, p. 45), which could provide the impetus for returning to the old familiar narrative of drinking. Instead, Michael developed a new responsibility narrative outside of Mia's narratively established domestic domain; he began a landscaping business to earn extra money for the family. Doing so allowed Michael to reauthor himself as a meaningful contributor to the

household. Therefore, the conflict between Michael and Mia's domestic responsibility narratives was eased.

Just as Michael and Mia were negotiating the re-storying of their own individual identity narratives and the relationship of those identities within the larger context of their marital narrative, Mia's family were also thrown into narrative transition by Michael's recovery. While the extended family was supportive of the idea of sobriety, they were resistant to change, and struggled with accommodating Michael's new narratives of sobriety. Their reluctance to change was demonstrated by several awkward interactions with Michael during the barbecue scene (SCENE 11). Justine, Mia's mother, nervously apologizes for having alcohol available at the barbecue, as if Michael will be uncontrollably drawn to it. She then suggests that he might prefer one of the sodas she bought for the kids, with the subtle insinuation that Michael is of the same status as a child. Tony, Mia's father conveys a sense of contempt for Michael's recovery by juxtaposing it with Gavin's promotion. When Michael attempts to make amends to him, Tony treats it as a superficial formality rather than a sincere apology and accepts it with an undertone suggesting that nothing has been forgiven. Gavin, Mia's brother-in-law, attempts to hide his beer as Michael approaches, and then makes a clumsy attempt to excuse his drinking in front of Michael. Nicole, who is already inebriated becomes outright hostile towards Michael, clearly stating what is on everyone else seems to be thinking – they don't trust or believe in Michael's sobriety narrative.

While Michael has made a great personal effort to transition from an alcoholic narrative to a recovery narrative, the inertia of the alcoholic narrative remained strong in the extended family. The family lacked models for supporting Michael in recovery, and for Nicole in

particular, resisted revising her narrative to accommodate Michael's new recovery narrative. She states, "I'm not going to stop just because he has a problem. It's his problem."

Family systems seek homeostasis or stability (Kim & Rose, 2014). To accept and accommodate Michael's narrative of recovery would have been destabilizing to the narratives of other family members, and to the family as an entire system. It would have required them to move from a narrative that was thick, familiar, and well lived, into a narrative that was thin and uncertain. Therefore, to stay balanced, it was important that the family resist the changes, and continue to story Michael as an out-of-control alcoholic. Furthermore, families lack models for successful transition into recovery, and often need to build new recovery narratives largely from trial and error.

Summary

A narratively analysis of the ethnodramatic script allowed for the development of a Narrative Change Model (NCM) to explain the ways that narratives functioned to produce change. Based on Freytag's (1894/2007) classic plot structure, the NCM begins by establishing a 'status quo' or state of normalcy. A point of biographical disruption diverts the lived experiences of individuals from the "normal" story, producing an increasing distance and tension between them. Low to moderate levels of tension are often tolerable, and in some cases the divergence is temporary with lived experience returning back to normal on its own. However, in other cases, the narrative distance between lived experience and the status quo narrative becomes so great that they are completely incompatible – the current lived experience no longer supports the old status quo narrative. The point at which this happens is referred to in the NCM as the Narrative Breaking Point. This breaking point often precipitates a narrative crisis in which individuals find themselves to be "outside of a story" (Parry & Doan, 1994, p. 45). Individuals then attempt to

resolve this crisis through actions which may or may not be successful. Logically, there are two options available to individuals at this point, continue doing what they've always done (realign the lived experience with the old status quo narrative) or do something else (construct a new narrative around the present lived experience). While the status quo narrative may be narratively "thick" or familiar and supported by prior lived experience, it may not always be accessible or sustainable from the position of the present lived experience. On the other hand, while developing a new normal or status quo narrative that is more aligned to the present lived experience may be the preferable outcome, these new narratives are relatively "thin" or unsupported by lived experience and difficult to trust. Thickening a narrative involves accumulating experience (both direct and vicarious) to make it more viable. In the meantime, the inertia of the old status quo narrative often carries it forward in its previous trajectory, creating tension and competition with the new status quo narrative. The tension is resolved when the new status quo narrative has become thickened enough to become familiar and trustworthy, and the old status quo narrative can be reframed from the position of the new state of normal.

While the NCM demonstrates change along a single narrative thread for a single individual, narratives do not exist in isolation, but are entangled in a broad socio-narrative fabric with intertextual (Allen, 2011) relationships between each other. Thus, narrative change in an individual (i.e., transitioning from alcoholism to recovery) produces narrative influences in family systems. Family narratives may systemically work to facilitate or frustrate the narrative change of an individual member. Narrative family therapists can work with the families of individuals to revise and align narratives in ways that produce stability and sustainability both for the family system and for the individual's efforts in recovery.

The Narrative Change Model in a Counseling Context

As mentioned earlier, no narrative exists independently within a vacuum. As the NCM is itself a kind of narrative to produce meaning from lived experience, it is important to situate it in relation to the counseling literature reviewed in the second chapter. Specifically, I describe how the NCM fits with other existing models of alcoholism, comparing it in particular to the Transtheoretical Model which has been widely applied to addictions counseling (DiClemente, 2003; Prochaska, DiClemente, & Norcross, 1992). Secondly, I discuss the narrative change model in relation to family dynamics and family systems theory, describing the intertextual nature of narratives. Finally, I apply the NCM specifically to the process of recovery from alcoholism. In particular, I use the narrative lens to examine how individuals and couples can successfully transition from active alcoholism to long-term recovery.

Narrative Change Model and Existing Models of Alcoholism

The narrative model of alcoholism bridges several of the models described in chapter two. In particular, the narrative lens blends cognitive and environmental ideas. However, in contrast to environmental models that seek to explain alcoholism in terms of environmental influences, narrative theories emphasize the personal agency of the individual in selecting and evaluating social discourses. While any number of social discourses about alcohol exist in any given environment, individuals do not passively accept all of them without question. Rather, individuals decide how credible and salient each social discourse is in relation to their own experiences (Kottler, 2015).

I constructed a Narrative Change Model (NCM) to describe change using narrative theory. This model is a combination of literary plot structure and narrative theory that helped elaborate, analyze, and explain the experiences of the participants in this study. The NCM

bridges social, environmental, choice, and cognitive models, while not dismissing or minimizing the roles of biology, intrapersonal, and behavioral factors, which play roles in the development of addictions. Similar to cognitive models, the NCM focuses on the thoughts of the individual, examining the stories they tell themselves and others about their lives. However, by incorporating a social constructivist perspective (Anderson & Goolishian, 1992) NCM aims to work within the subjective paradigm of a client, rather than to correct the “irrational thinking” of a client in relation to an objective reality. In other words, the focus is not on whether the internalized narratives constructed by clients are objectively right or wrong, but how they *function* within the client’s overall worldview to produce meanings that are congruent with their subjective lived experiences.

According to the narrative approach, internalized narratives are produced from a co-construction between lived experience and the social discourses which intertextually influence the interpretation of that lived experience (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990). For example, social discourses, or messages in our social environment, regarding alcohol shape the way that individuals think about their experiences with alcohol. A person who grows up in a family in which alcohol abuse is normalized is more likely to experience an alcohol use disorder themselves (Lown, Nayak, Korcha, & Greenfield, 2011). At the same time, personal experience and internalized narratives around alcohol influence the interpretation of social discourses. While many social discourses may exist within an individual’s awareness, not all discourses have equal salience. Individuals exercise personal agency in evaluating whether to reject or incorporate social discourses into their internalized narratives, and how applicable or salient these discourses are in relation to their lived

experiences. The recognition of personal agency is critical to avoiding the determinism inherent in some environmental models (Smith, 2008).

Furthermore, by recognizing that the machinic assemblages (Deleuze & Guattari, 1987) that produce meanings around alcohol are not fixed in their configuration allows narrative therapists to work with clients in reconfiguring narratives to produce new alcohol-related meanings that are less problem-saturated (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990) than the narratives of addiction. Put simply, narrative therapists may assist clients in re-storying alcohol-related narratives by foregrounding discourses that support sobriety, deconstructing discourses that sustain alcoholism, and drawing new recovery discourses into the awareness of the individual and assisting them in integrating these discourses into a preferred personal narrative of recovery that is authentic or near to the client's lived-experience.

Tracing the history of alcoholism as a concept suggests that it is at least partly the product of social constructionism (Levine 1978; Philips, 2014; White, 2014) with the social discourses around alcohol and alcoholism, changing over the decades in response to shifting political, cultural, and environmental contexts. However, the roles that the biological and physiological effects of alcohol on the body should not be dismissed in conceptualizing AUDs. In fact, the NCM is not intended to stand alone as the sole explanation for the etiology of addictions. Rather, I created it to describe the change process of transitioning from addiction to stable long-term sobriety from a narrative perspective. As such, the NCM is more comparable to the descriptive Transtheoretical Model of Change (TTM) (DiClemente, 2003; Prochaska, DiClemente, & Norcross, 1992) than it is to more explanatory models.

The TTM (DiClemente, 2003; Prochaska, DiClemente, & Norcross, 1992) is a five-stage model intended to explain how clients' needs changed as they moved through the process of

change from pre-contemplation to maintenance (DiClemente, 2003). Similar to the TTM, the NCM also describes the change process in stages. Below, I will present a comparison of the TTM with the NCM (Table 5.1).

Table 5.1
Comparing TTM and NCM

NCM Stage	TTM Stage	Description	Example
Status Quo	Pre-Contemplation	Life as usual – may recognize problems, but not considering change.	Active alcoholism, drinking with, no plan to stop.
Biographical Disruption		Lived experience deviates from status quo narrative, either gradually, or marked by a particular event	Drinking interferes with work responsibilities.
Rising Tension	Contemplation	Increasing discomfort with “life as usual” story, begins to seriously consider the need to change, but with ambivalence towards taking action.	Widening discrepancy between problems resulting from drinking and narrative of ‘having it under control.’
Breaking Point		A point of narrative crisis in which the previous story no longer adequately accounts for lived experience. Prompts action	“Rock bottom” experience in which drinking narrative is no longer tolerable.
	Planning	Individual makes plans and prepares to act.	Alcoholic makes plans to quit drinking.
Action	Action	Individual acts to resolve problem/tension. Both models acknowledge that several attempts may be required.	Alcoholic actively attempts to stop drinking, perhaps by entering treatment.
Resolution		The individual acts in a way that successfully reduces narrative tension creating a new narrative to replace the old status quo	“Turning point” in which alcoholic commits to sobriety, and develops internalized narrative of recovery.
Thickening	Maintenance	Maintaining changes made, and thickening the new narrative with lived experience until it becomes the new status quo or state of “normal.”	Life after treatment, developing a recovery lifestyle that becomes the new normal.
Reframing		Individual reframes old status quo narrative from the position of the new status quo, thereby resolving remaining narrative tensions.	Re-stories the meaning of drinking to be in alignment with internalized recovery narrative.

The narrative status quo stage of the NCM is similar to the pre-contemplative stage of the TTM (Prochaska, DiClemente, & Norcross, 1992), in which individuals may be dissatisfied or vaguely aware of a problem but have no intention of changing. The TTM model describes the next stage as contemplation. However, the NCM describes the impetus for the transition to the next stage as a point of biographical disruption in which lived experience deviates from the status quo narrative. In other words, life as experienced by an individual begins to differ from the “life as usual” story, which was evident in Michael’s situation when Mia was growing impatient and intolerant of his drinking. The result of the disruption in NCM is a growing tension in relation to the growing divergence between narrative and experience. The expanding divergence leads to a breaking point at which the status quo narrative no longer tolerably supports the lived experience. In Michael’s case that was when Mia threatened to leave him.

The contemplation stage of the TTM (Prochaska, DiClemente, & Norcross, 1992) occurs when individuals begin to seriously consider the need for change. Motivated by the desire for change, the individual in the planning stage of the TTM begins to envision, plan and prepare to make the change. Carrying out the plans constitutes the action stage of the TTM. In contrast, the NCM considers planning a form of action, and therefore not a separate stage. Diclemente (2003) warns that the TTM is often not experienced as a linear process, and that individuals may move back and forth or spiral around the stages. Similarly, the NCM reflects that the action stage is frequently turbulent and may require several attempts at acting before discovering an action that sufficiently provides a reduction to the narrative tension.

Michael had several failed attempts to address the conflict in his family due to his alcoholism. At one point in his fight with Mia at the beginning of the play, Michael states that he has cut back on his drinking by substituting his regular brand of whiskey for a cheaper brand.

The line is intended to be humorous because Michael is falsely equivocating his reduction in spending on alcohol with a reduction in his consumption of alcohol. The absurdity of the argument is clear to Mia and to the audience. The TTM (Prochaska, DiClemente, & Norcross, 1992) concludes with the Maintenance stage in which the individual sustains changes made during the action stage. According to the NCM, however the old status quo narrative remains in competition and with the new narrative developed in the change process. So long as the old status quo narrative remains a potentially viable option, it provides opportunities for relapse. In Michael's case, the narrative conflict occurred between his thin sobriety narrative and the previously held thick narrative of drinking.

The post-change stages of the NCM describe a process of thickening the new narrative with lived experience, and being able to re-vision (Parry & Doan, 1994) the old narrative from the subjective perspective of the new narrative. For Michael, the re-visioning of the alcoholic narrative occurred in the bar-scene (SCENE 14) as he observed several other patrons getting drunk and realizing that his former drinking narrative was no longer applicable to his present self. Re-visioning the former drinking narrative relieved the narrative tension that Michael had been experiencing since treatment and made returning to the drinking narrative least likely. Therefore, the NCM extends past TTM's maintenance stage, accounting for the way that maintenance of sobriety changes over time.

Because of its onto-epistemological grounding in social constructivism, narrative theorists tend to resist presenting totalizing, dominant, or singularly essentializing narratives which produce rigidity, stifle personal growth, and prevent the individual from becoming an *other*. (Wallis, Burns, & Capdevila; 2011; White & Epston, 1990, Winslade & Smith, 1997). As such, rather than providing an explanatory narrative of the change process from active

alcoholism to long-term recovery to the exclusion of other theories, the NCM is better understood as an interpretive lens for conceptualizing change – one of several possible lenses. In particular, the NCM is comparable to the TTM (DiClemente, 2003; Prochaska, DiClemente, & Norcross, 1992), following a similar trajectory. However, the Narrative Change Model provides additional stages, such as the biographical disruption, and breaking point, which help to describe the way that individuals transition between stages of the TTM. Furthermore, the NCM extends TTM's maintenance stage by describing how individuals transition from an unstable short-term recovery to a more stable long-term recovery as evidenced by the findings of Dennis, Foss, & Scott (2007).

Narrative Change Model and Family Dynamics

Narratives of alcoholism are not limited to the alcoholic themselves, but extend to and are reinforced or challenged by other family members through intertextual linkages within the family system (Broderick, 1993; Rosenblatt, 1994). Issues of violence, emotional neglect, neglect of responsibility, and stress are typical among families with alcoholism (Barnard, 2007; Friend, Langhinrichsen-Rohling, & Eichold, 2011; Lambe, Mackinnon, & Stewart, 2015). Furthermore, as the alcohol use disorder occupies a central thematic role in organizing the family, the family structures itself to maintain a level of functionality and stability by compensating for the alcoholic (Barnard, 2007; Broderick, 1993; Rosenblatt, 1994; Scherer, Worthington Jr., Hook, Campana, West, et al., 2012). Family structures can reinforce alcoholism, create unhealthy attachment and behavior patterns in children which can be carried into adult life, and promote isolation of the family system from other social systems and sources of support (Krajicek-Bartek, Lindeman, & Hokanson-Hawks, 1999; Orford, 2012).

Michael's alcoholism created distress for Mia by influencing her to take both the roles of primary care-giver within the household and sole wage-earner. Additionally, Mia was forced to compensate for Michael's erratic behavior, such as smoothing things over at their daughter's school when Michael attempted to pick her up while inebriated. Mia complained about how Michael's alcoholism prevented her from having friends over to visit and even created strife within her family. Thus, Michael's alcoholism narrative became centralized within the family system, while Mia and other family members organized themselves in relation to it.

From a narrative perspective, it is important to take into consideration the complexity and entanglements of family narratives. That is, families are not operating in unison under a single-family narrative, but family narratives are a social construction composed of a thick web of individual narrative threads. These threads produce the family as a "body" in the Deleuze and Guattarian sense (1987). A body is a system with a flexible, permeable exterior boundary and an indeterminate interiority. When family narratives are in flux adapting to and influencing other narratives, the family can be described as a body without organs – not signifying an emptiness, but an unfixed essence. However, just as the machinic assemblage of alcoholism creates stasis within the individual, it tends to freeze family members in patterns of relating to each other that enable and support alcoholism but limit the potential for growth or becoming an *other*. The force of homeostasis in a family keeps families fixed in their patterns of interaction and freezes their narrative assemblages. When a family member attempts to make a change, it is a destabilizing event for the entire family system. For example, Michael's recovery produced a conflict with Mia about roles and responsibilities within the house, with Mia being reluctant to allow Michael to perform household chores, to which she had been accustomed for years.

Because families are systemic and intertextually linked, the actions of one member can produce points of biographical disruption for others, diverting them from their own status-quo narratives. For example, Michael's efforts to gain sobriety disturbed the family's narratives around alcohol, producing tension and awkward interactions (SCENE 11). The initial response to a biographical disruption is to return the lived experience to the status quo narrative – in other words getting back to normal. Though Mia's family supported Michael's abstinence from alcohol in principle, they did not wish to – or lacked the ability to – re-story themselves as a family in relation to his recovery narrative, and therefore resisted his narrative change.

Readers should consider that as the addiction narrative recedes as a central organizing theme for families, other neglected issues gain increased prominence (Haverford & Thiess, 2014). For example, while Michael was in active alcoholism, the family faced financial strain, but these issues were mostly marginalized by Michael's drinking. As Michael began recovery, the financial problems were still present, and in need of attention, and without the distraction of Michael's drinking, they became a central concern for the family (scene 10). As demonstrated in the ethnodrama, there is a narrative tension developed between individuals' expectations for recovery, and what recovery actually accomplishes. Mia complains in scene 12 that she had believed that Michael's recovery would solve their marital issues. The lived experience of the couple was that treatment for alcoholism solved Michael's drinking, but the other problems in the couple's lives remained. The frustrations that individuals and couples feel in having to still deal with these outstanding and neglected issues (in addition to the aftermath of the addiction), can be overwhelming. The frustration may also trigger relapse or marital separation.

Although the problems that couples face in recovery can be large, they may be reminded that these problems are far more manageable when the couple is sober instead of drunk. Money

remained an issue for Michael and Mia following his treatment. However, where Michael spent most of his day intoxicated at the start of the ethnodrama (SCENE 1), by the end, he had started a lawncare business (SCENE 10). Being sober allowed Michael to bring in extra income and alleviate some of the financial stress on the family.

For clarity, the NCM diagram (Figure 5.1) depicted the change process following a single narrative thread. However, the reality is that any given narrative strand is relationally embedded and entangled with multiple other narrative strands. Those using the NCM should consider intertextual relationships between narrative strands, or in other words, the ways in which one narrative influences and is influenced by other narratives within the fabric of the family system as well as broader social systems. Furthermore, family systems theory allowed for indirect intervention in family issues (Broderick, 1993; Rosenblatt, 1994). By altering one influential narrative in the system, new social discourses may be brought into availability, and the salience of the social discourses that serve to support or limit the alcoholic narrative may be changed. For example, Mia's threat to leave Michael created a change to the family narrative which troubled and destabilized Michael's drinking narrative.

The connectedness and intertextual influence of narratives within a family system, provides a reason to work with families as a whole in recovery. It is not enough to create change in an individual without assisting other members in adjusting to the change. Counselors can assist families in developing narratives that support and encourage (or at least do not threaten to undermine) the changes in the individual. Working with families may be most important in the earlier stages of recovery when the recovery narrative is still thin and fragile. Supportive families can serve as important audience members to the new story of recovery, feeding back on the narrative construction, and thereby thickening and strengthening it.

Thus, in summary, findings from this study contribute the family dynamics literature by highlighting the ways in which family narratives maybe in tension with each other. These tensions often create conditions that impede recovery. While many treatment centers offer family services, the majority of these services are underutilized (SAMHSA, 2014). Therefore, it is advisable to extend clinical focus beyond the individual in recovery, as well as to incorporate the family in treatment for individual substance use disorders in order to assist them in transitioning to a recovery lifestyle. Given a family system's resistance to change, prior narratives that comprised a family's status quo often carry an inertia that keep certain family dynamics in stasis. When in stasis, the process of narrative change for the individual in treatment is severely challenged until the family dynamics shift to accommodate the new sobriety narrative.

Narrative Change Model and Recovery

The review of literature on addiction and recovery that informs this study found that addictions research focused primarily on risk and preventive factors for addictions and on demonstrating the efficacy of various treatment modalities for various populations. Where research focused on treatment outcomes, these outcomes were often measured among individuals in short-term recovery, ranging from a month to two years post-treatment (Dennis, Foss, & Scott, 2007). Furthermore, much of the available research specifically examining the process of recovery is dated, having been conducted sometime between the 1970s and 1990s. As a research topic, the general *process* of recovery seems to have lost popularity, and the focus of addictions research seems to have shifted to examining the relative impacts of particular variables on treatment such as race, gender, comorbid disorders, and so on.

Research examining long-term recovery from alcohol for individuals was limited in its availability. However, the available research suggested that long-term recovery differed in its

concerns from short-term recovery (Roberts, Floyd, O'Farrell, & Cutter, 1985; Szabo & Gerevich, 2013). A key study informing this dissertation found that the risk of relapse reduces significantly over a period of five years of sobriety after which it stabilizes (Dennis, Foss, & Scott, 2007). Another study found that children with fathers in long-term recovery experienced less attachment issues later in life than children with alcoholic fathers (Callan & Jackson, 1986). These studies support the notion that long-term recovery is distinct from short-term recovery for individuals in recovery and their family members. This study aimed to investigate how individuals and couples transition into long-term sobriety.

The findings from this study suggested that the narrative work of transitioning to recovery extends beyond the completion of treatment. While Michael had made the narrative transition from drinking to recovery, the recovery narrative remained thin and in competition with the former drinking narrative. It was through accumulating lived experience in the “real world” outside of treatment that Michael was able to thicken the recovery narrative. At first, the recovery narrative was distant to Michael's experience – someone else's story or an institutional discourse – that of AA and the 12 steps. Early in his recovery, Michael relied on others to model recovery for him, in particular Frank. Michael was able to pattern his recovery narrative after those of the others he'd seen, adopting their narratives to construct his own. However, as Michael began to live the recovery narrative, he was involved in revising it in relation to his social environment, aligning it with his own lived experience of recovery. This “fine-tuning” of the narrative to fit Michael's personal and unique lived experience is a process of *internalization* (as opposed to externalization), which is necessary to thickening the recovery narrative. While there are many variations in the social discourses around recovery from which Michael was able

to draw from, internalization involved taking personal ownership/authorship of the recovery narrative, making it reflective of his own unique lived experiences.

Though Michael had internalized and thickened the narrative of recovery, his previous alcoholism narrative remained in competition and tension with it. It was not until he had internalized the recovery narrative, that he was able to reframe his previous drinking narrative in the perspective of his present lived experience (sobriety). From this new narrative vantage point of recovery, Michael was able to see the old narrative as no longer applicable to his life. In the ethnodrama script, this reframing happened in the final scene (SCENE 14) in which Michael wrestled with, and ultimately, rejected his identity as an alcoholic. In watching other drunks in the bar, he realized that being drunk was no longer his story. The alcoholism narrative had become too distant from his present lived experience. It belonged to a different version of himself that he had externalized in the process of becoming an *other*.

Furthermore, just as Michael was struggling to assemble a new “recovery-self,” relying on the social discourses and lived experiences gained from treatment, Mia and the rest of the family struggled to adjust to Michael’s recovery. A feature found in both Michael and the family was the issue of trust. Using Michael and Mia’s experience, it can be argued that regaining trust from family members after years of abusing it while in active addiction is a gradual process. There is no set time-frame or list of tasks to be completed to restore trust. The slowness with which trust is rebuilt in couples and families can lead to frustration in all members. For the individual in recovery, the lack of trust undermines the recovery narrative.

Mistrust is a major obstacle to recovery and reestablishing cohesion in families in recovery (Barnard, 2007; Scherer, Worthington Jr., Hook, Campana, West, et al., 2012). This study demonstrated that both the individual in recovery and their family members are often

dissatisfied with narratives that support mistrust and suspicion. Mistrust creates uncertainty, which must be met with an expenditure of energy towards vigilance against possible transgressions or disappointments (Scherer, Worthington Jr., Hook, Campana, West, et al., 2012; Scott, Foss, & Dennis, 2005). As seen in scene with Nicole at the family barbecue (SCENE 11), the level of mistrust in family members may lead them to test the strength of the recovery by attempting to provoke a relapse. In dialogue with Michael following his completion of treatment, Mia noted that she preferred to trust him, but the lingering narrative of the addiction challenged the development of a trust narrative. Just as Michael's recovery narrative required lived experience to thicken and fortify it, the narrative of trust within the family required lived experience in order give it substance. Until the story was thickened enough for family members to provide a *livable* alternative to the alcoholism narrative, the mistrust of Michael would persevere. As Mia notes within the play, there was no set timeframe or checklist for reestablishing her trust in Michael. It could only be accomplished through the accumulation of lived experience that challenged the narrative of Michael as untrustworthy. However, couples therapists should note that while mistrust is an issue within the relationship, both members share a common goal of overcoming it.

While a single qualitative study cannot compensate for the lack of literature on couples in recovery from alcoholism, this study aimed to begin that process by bringing attention to the need for research focusing on how individuals and families adjust to the narrative transition from active addiction to long-term recovery, including the ways that relationship dynamics support or undermine recovery efforts over time.

While Michael relied on Frank and others in recovery for a model for his own individual recovery narrative, there were a lack of models for how to be in a relationship in recovery that

were readily available. Michael and Mia noted that their process for recovery as a couple had largely been a matter of trial and error. Thus, their experiences presented within the ethnodrama present a model for couples in similar circumstances. In crafting the ethnodrama, it was my intention to tell a story that honors the success of individuals and couples who have managed to survive addiction and provides hope and encouragement for those facing similar circumstances as an alternative to those which portray addiction as hopeless for families.

Implications

According to Tracy (2010), a research topic is worthwhile when it has a usefulness and appeal beyond the mere creation of new knowledge. Key stakeholders for this study included professionals who work with alcoholics in treatment and provide follow-up services, counselor education programs who train therapists to work with people suffering from substance abuse disorders, and individuals in communities of recovery, including those in recovery themselves as well as the families and friends who support them. The implications of this study for each of these key holders is provided below.

Implications for Communities of Recovery

The purpose of this study was to explore the experiences of a couple transitioning from active alcoholism to long term recovery. The ethnodrama was based on the experiences of an actual married couple. The goal of the ethnodrama was to recreate the participants' experiences in a way that was both enlightening and engaging to a general public audience, while relatable to the recovery community. By doing so, I hope to introduce new social discourses that demystify and destigmatize the recovery process.

In creating the ethnodramatic script, I intended to present a model of what successful long-term recovery as a couple might look like, thereby expanding the narrative possibilities for

constructing their own recovery narratives. Michael and Mia noted that much of their journey to recovery had been made by trial and error. However, by examining and representing what worked for the couple and how they addressed the challenges they faced, the ethnodrama may provide some guidance for couples attempting to navigate their own experiences of recovery together.

Finally, it has been my intention from the initial conceptualization of the study to tell a success story. My criteria for selecting participants for this study was a couple who had remained intact throughout the transition from active addiction to long-term sobriety. In addition to discovering the narrative processes involved in the couple's journey to recovery, I have also deliberately created this story as an alternative narrative to the many problem-saturated social discourses which portray relationships with addicted members as doomed and hopeless. Certainly, those pessimistic discourses are valid for many who have confronted addictions. However, it is necessary to avoid totalizing narratives which limit the ways that any given phenomenon can be experienced. In other words, there is not a single story of families in addiction, but an ever-expanding multiplicity of possibilities for constructing addiction narratives, which allow for optimism and the possibility of a path back from "rock bottom" as an alternative to those which describe only doom and despair. Depicting Michael and Mia's successful transition to recovery may provide hope and encouragement to those who are in recovery themselves.

Implications for Treatment

In-patient treatment programs for addiction in the US, such as that described in the ethnodrama, generally rely on the Minnesota model, based in the principles of AA and the twelve-step recovery program (White, 2014). These facilities provide intensive treatment

typically between 90 days up to a year (Volkow, 2018). During this time, treatment usually includes relapse prevention strategies (Rasmussen, 2000; Volkow, 2018). Follow-up care may be offered to those who successfully complete treatment programs for several months following discharge. Frequent attendance at AA meetings is often recommended in order to sustain their recovery (Kingree, & Thompson, 2011). While family services are offered many treatment facilities, these services are largely under-used (SAMHSA, 2014). These facilities have varying degrees of success in treating substance use disorders, and preventing relapse (SAMHSA, 2014). Therefore, it is challenging to point at any one type of treatment and claim that to be the sole answer for producing sustained sobriety.

The Narrative Change Model (NCM) Narrative theory bridges several models for conceptualizing and understanding addictions, including cognitive and social models. However, like the DiClemente's Transtheoretical Model (DiClemente, 2003), the NCM is a descriptive, rather than prescriptive model. Within the context of this study, the NCM is only intended to provide a way of understanding how narratives operate to facilitate (or frustrate) change. Therefore, it is beyond the scope of this study to make specific recommendations for the treatment of individuals in recovery based solely on the NCM. However, several clinical suggestions may arise from the findings of this study, which may be applied to treatment.

Foremost, the NCM provides a useful way of conceptualizing the transition from active alcoholism to recovery. Attending to the ways that client narratives are structured and how single narrative threads interact with others held by the individual and by spouses and other family members can provide insight and direction for therapy.

The NCM is not at odds with 12-step models for treatment, but it may provide a new way of considering the underlying narrative psychological mechanisms that produce change. As

mentioned in the ethnodramatic script, 12-step programs can be considered a program for living with alcoholism, rather than a manual to remedy alcoholism. To do so, it is not enough to co-construct any story. If narrative theory holds that we live at the intersection of the stories we tell, and those that are told of us, then a preferred narrative has to be one that is *livable* for the individual. In other words, it must be sustainable, plausible, and experience-near. Thus, 12-step programs provide opportunities for re-storying alcoholism in a way that is near to the lived experience of alcoholics in recovery. For example, the first step involves an acknowledgement of the individual's powerlessness over alcohol (AA, 2001). This step externalizes alcoholism from the individual, and restories the individual as someone who has been a victim rather than a perpetrator of alcoholism. Given that AUDs (APA, 2013) include symptomatic features of a preoccupation with alcohol, a lack of control over drinking, and repeated failed attempts to cut back or quit, the narrative of powerlessness may be fairly near to the lived experience of alcoholics. As individuals "work the steps" of the 12-step program, they develop an alternative lifestyle narrative to their former drinking narratives. Treatment, from a narrative perspective, involves an internalization of the preferred recovery narrative and training to make it livable.

AA meetings and other groups, in which group members share their experiences of alcoholism and recovery, are also compatible with the narrative approach. Sharing stories calls multiple social discourses into the awareness of the individual, thereby expanding their own possibilities for constructing or assembling preferred narratives that align with the individual lived experience of recovery.

The findings of this study point to a narrative change process that extends past treatment and relapse prevention. Given that recovery narratives are at their thinnest and most fragile in short-term recovery, counselors should take care to strengthen or thicken narratives established

in treatment, by connecting and supporting them with lived experiences. Thickening may also involve including families in treatment to address the family system as a whole. Family members can serve a valuable role as an audience for the client's new stories, thickening them with retellings and feedback.

Finally, incorporating Deleuze and Guattari's (1987) notion of the machinic assemblage into narrative therapy suggests that therapists should be broad collectors of all kinds of stories. Stories are the materials which narrative therapists work with. They can provide social discourses for expanding the narrative possibilities of clients and can be applied comparatively or metaphorically (Combs & Freedman, 1990). The stories that counselors collect can be thought of as extra parts that can be used to upgrade clients' narrative assemblages, similar to the way that installing a new graphics or sound card in a computer can replace a broken part and enhance the computer's capabilities in particular directions. Thus, counselors should take time to watch movies, read novels, talk to others, and so on. Accumulating stories provides counselors with an archive of social discourses which can be fit into the narrative assemblages of clients to produce new meanings. However, sticking with the computer metaphor, it is never wise to force-fit components into places that don't accept them for risk of damaging the hardware. Therefore, when narrative therapists share stories with clients, it is always done in a tentative manner rather than imposing a new dominant narrative over the lived experience of the client (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990).

Implications for Counselor Education

Counselor educators have an ethical duty and an accreditation mandate to train counselors who are effective in working with addicted clients. Understanding addiction issues is a requirement of almost every area of counseling specialization in the CACREP standards

(2016). Whether counselors specialize in addiction treatment or work in clinical mental health, addiction is a prevalent mental health issue affecting millions of Americans (USDHHS, 2016) and will inevitably become a clinical concern. Thus it is imperative that counselors be adequately prepared to work with these issues regardless of specialization.

Counselor educators can incorporate findings from this study into addictions, family therapy, and mental health courses, providing students with insight into conditions and life challenges which they may not have direct experience. Becoming familiar with addiction experiences can help counselors in training to avoid stigmatizing individuals in recovery, and to form stronger therapeutic bonds with clients facing and/or recovering from addictions. Furthermore, the Narrative Change Model expands the theoretical base of narrative therapy. It may therefore be incorporated into core counseling theory courses, as well as courses which specialize in teaching narrative therapy techniques and approaches. While the topic of addiction presents a large scale form of change in which the dynamics of narratives are more readily observable, it is possible that the NCM could be applied generally to many different forms of change, such as grief and loss, or occupational transitions. Teaching students to use the NCM can provide them with another means for case conceptualization and thinking about their work with clients – one which is particularly aligned with the narrative therapy approach.

Methodologically, this study also has implications for counselor education. While quantitative research methods tend to dominate the counseling field, their narrow focus on specific measurable variables fails to capture the richness and depth of the experiences of clients (Merchant & Dupuy, 1996; Morrow, 2007). Quantitative research can provide clinicians with useful evidence-based practices that inform treatment plans or interventions (Miller, Sorensen, Selzer, & Brigham, 2006). However, the essence of the work of a counselor is in creating warm,

caring, empathetic, safe, and non-judgmental therapeutic relationships that facilitate clients relating open and honest narratives about their experiences (Speight, 2012; Wampold, 2015). Qualitative research and ethnodrama in particular, can provide insight into the experiences of distinct populations and present a large diversity of perspectives (Barone & Eisner, 2012; Saldana, 2011; Speight, 2012). Qualitative studies like this one can expand the worldview of students, providing them with insights into diverse lives, perspectives, and experiences, and allowing them to connect to and work with a broader range of clients; a view shared by many seasoned counselors (Ronnestad & Skovolt, 2003).

Finally, the NCM can be applied to understanding student-to-professional counselor development as one of biographical disruptions and narrative transitions. Developmental models of counselor education (Gibson, Dollarhide, & Moss, 2010; Ronnestad & Skovolt, 2003) describe stages that individuals transition through from “lay helper” to “seasoned professional” in their evolving identity as counselors. At different stages, counselors hold different narratives regarding professional identity. Ronnestad and Skovolt (2003) found that those at the lay-helper stage tend to view counseling as a matter of giving advice, and therefore hold the narrative that a counselor should have the answers to clients’ issues. On the other hand, they found that seasoned professionals are more focused on building a therapeutic alliance with clients. Furthermore, Gibson, Dollarhide, and Moss, (2010) found that novice practitioners (i.e., Masters-level practicum students) often rely on models and highly structured interventions when first seeing clients. As they grow in their roles, counselors in training rely more personal intuition and are more prone to spontaneity in their counseling sessions. They internalize their professional identities as counselors rather than seeking external guidance and approval. Thus, from an NCM perspective, the counseling profession for novice counselors is often a thin and

experience-distant narrative. However, as they gain lived-experience in providing counseling, as well as support from peers and professors, their professional identity narrative is re-storied in ways that are aligned with their experience, thereby thickening the narrative. Understanding the professional development process through a narrative lens – as a story of change and growth - may help counselor educators to better guide students in constructing professional identities that are near to their unique subjective experiences of counseling. Thus the NCM can be used to trace the ways that these narratives of professional identity evolve over the course of professional development, thereby providing greater insight into the process for counselor educators.

The implications from this study for counselor education are to expand the theoretical, conceptual, and methodological frameworks in the training of clinicians in working with addictions by incorporating narratives within a holistic treatment perspective. Furthermore, counselor educators may consider incorporating literary works into their curriculum as a way of exposing counselors in training to diverse perspectives and experiences that they may encounter in the field. Acknowledging that counseling *is* a narrative practice, students may attend not just to the content of novels and other literary works, but also how they have been constructed, and the ways that the tropes contained within them are designed to produce effects on readers. By exploring and becoming familiar with the literary elements of narrative, students may become more skilled at interpreting and working with clients' narratives.

Significance of the Study

This study has enhanced the understanding about the recovery process from alcohol use disorders. It addressed a shortage in the research literature focused on shifting family dynamics and sustaining sobriety after treatment in order to establish long term recovery. Given the high rates of relapse in alcoholism, particularly in the earlier period of recovery (Dennis, Foss, &

Scott, 2007; Maisto, Hallgren, Roos, & Witkiewitz, 2018; SAMHSA,2018c), this study provided insight into understanding the processes behind what works to keep couples together during the transition from active alcoholism to long-term recovery, by examining recovery from a narrative lens.

The Narrative Change Model (NCM) advances narrative therapy by focusing on the ways that narratives operate during the alcohol recovery transition and change process. The NCM combines established practices of narrative therapy and narrative inquiry with theories from literary studies to make sense of the ways that stories are constructed, deconstructed, reconstructed, and revised to resolve narrative tensions. The NCM accounts for the ways in which change occurs within individuals and their families recovering from alcohol use disorders following treatment, and provides an explanation for the motivations that move individuals through the model from initial problem-saturated status quo narratives to the successful development and thickening of a new recovery status quo narrative.

Furthermore, literary narratives typically depict growth and development in the protagonist as a result of their experiences within the story. For example, in Erich Maria Remarque's (1928) classic novel, *All Quiet on the Western Front*, the young protagonist is recruited into the German army with nationalist rhetoric and promises of adventure, but through experience becomes disillusioned to the horrific realities of war. The character at the end of the novel is no longer the naïve and innocent boy met at the beginning. Both Freytag's (1894/2007) classic plot structure and the NCM show the conclusion/new status quo on a different level than the introductory/old status quo stages. Similarly, there is obvious development in the character of Michael as he transitions from active alcoholism to long-term sobriety as a result of the personal experiences described in the ethnodrama.

While the transition from active alcoholism to long-term recovery provides a pronounced example of narrative growth and development, similar processes are active throughout the lifespan on a generally smaller scale. Therefore, the NCM suggests that personal growth in general is a result of process of narrative conflicts and their resolutions occurring repeatedly across the lifespan. Thus, narrative therapists not only attend to alternative narratives that allow clients to become unstuck from problematic narratives, but also those that offer the potential for growth in preferred directions.

This study described the ways that narratives are assembled in the interaction between lived experience and social discourses to produce meanings around alcohol and drinking. In the study, I found that developing a recovery narrative involved calling on different social discourses around addiction that supported sobriety and undermined the previous drinking narrative. Many of these social discourses existed outside of Michael's awareness at the beginning of the play and had to be brought into his awareness through treatment and counseling sessions. Similarly, there were no models for being a couple in recovery that were available to their awareness. While Michael was able to rely on treatment and a community of recovery to help develop an individual recovery narrative, there were no such resources for the couple. Without the narrative component of a model, the couple was left with the difficult task of developing their own discourses to produce meanings around being a couple in recovery.

Now that their experiences have been described in the ethnodrama, the play itself provides a social discourse which other couples adjusting to recovery may incorporate into their own 'couple-in-recovery' narrative assemblages. Thus, this study challenges deficit and hopelessness narratives of addiction by depicting a story of success, and thereby creating the narrative possibility of optimism – that recovery from alcoholism as a couple is possible.

Finally, on a methodological note, this study employed creative methods in researching and representing the experiences of the participants in a way that allows for empathetic engagement and insight into their life stories (Barone & Eisner, 2006, Clandinin & Connelly, 2000; Kim, 2016). The foundation of counseling involves actively listening to and engaging with clients' stories within the context of a safe and empathetic therapeutic relationship (Speight, 2012; Wampold, 2015; White & Epston, 1990). I would therefore assert that counseling *is* narrative in nature. Thus, creative methods are congruent with producing research that reflects the counseling process, providing counselors, counselor educators, and counselors in training with insights into the lived experiences of clients they would expect to meet in practice.

This study makes significant contributions to the fields of counseling and counselor education. It extends our understanding of the recovery process, provides a discourse of hope and optimism to individuals in recovery, advances the theoretical perspectives of narrative therapy, and expands space for creative approaches to inquiry in counseling research that are reflective of counseling practice.

Limitations

While a study can have its significance, it can never be void of limitations. For this study, one of the limitations was resided in the challenge I faced when locating intact couples who were willing to participate in this study. While, I was able to generate rich data from interviewing a single couple (Cleary, Horsfall, & Hayter, 2014; Merriam, 1995), having additional participants could have provided varied perspectives, and thereby creating a more comprehensive account of the transition from active alcoholism to recovery. In order to compensate for the small sample size, I conducted in-depth inquiry and analysis into the participants' experiences, which included the production of a 130-page ethnodrama. The participants themselves commented on the depth

and richness of the inquiry, as interview questions prompted them to consider their experiences in theretofore unexamined ways. In addition, using Clandinin and Connelly's (2000) process of "coming alongside," I integrated my own subjectivities and prior experiences of working with clients in recovery to inform my analytical perspectives.

Time provided another limitation in this study. Ideally, the collection of data would have taken place in real-time, following a couple as they transitioned from alcoholism to recovery. However, it would be impossible to accurately predict which couples would last five or more years in sobriety and which would not. Furthermore, conducting a longitudinal study in real-time could not be accommodated in the time frame for this research. Therefore, retrospective interviews provided the story as they told it at the time of data collection. Retrospective interviews have been criticized because of the nature of reconstructive memory (Campbell, 2006), in which specific details may be added, altered, or omitted based on the context of their retelling (Clandinin & Connelly, 2000). Thus, this study did not reproduce a strictly verifiable account of the participants' experiences, but through narrative to represent and emphasize the salient aspects of these experiences using metaphors, composite scenes, and other creative processes. The script was member-checked with the participants and debriefed with peers who have experienced the recovery process to ensure its fidelity to the key aspects of the recovery experience. Furthermore, I have alerted readers to the co-constructed nature of the ethnodrama between the researcher and the participants in several places within this dissertation.

Because of scheduling, access to participants was limited. I had initially intended to meet with the participants on multiple days to conduct interviews and observations over the span of several weeks. However, on contacting the participants they requested that data collection take place in one day. The participants made arrangements for childcare to facilitate the interviews,

but their busy lives did not permit opportunities for multiple engagements, despite consenting to do so earlier. Therefore, all of the data were collected in one day with only small breaks between the joint couple interview, each individual interview, and the observation of the couple. Having had more time between data collection sessions would have allowed for reflection on the data collected in each session and a subsequent reshaping of interview questions or observation protocols to adapt to emergent findings. This request was made by the participant due to unexpected, emerging competing demands on their time and their initial underestimation of their agreement of time commitment for this study. However, to compensate for the lack of multiple days of inquiry, I stayed in touch with the participants and verified transcripts, analytic insights, and final findings so that I can at least remain accurate in my understanding of the narratives shared. Further, since small sample-size studies in qualitative research cannot be generalized, the value of such studies lie in demonstration of depth of insights, analysis, understanding, and representation (Bhattacharya, 2017). To the extent that was possible, I have demonstrated such depth in this study.

Finally, I have been transparent about my positionality in relation to the alcoholic community. Though I have experienced addiction to and withdrawal from nicotine, I am not an alcoholic. Therefore, I am largely an outsider to the alcoholic experience and to recovery culture. Some members of Alcoholics Anonymous claim that only an alcoholic can ever really understand another alcoholic (AA, 2001). I have been considering this statement as I conducted this research. To some extent, I suppose it is a legitimate argument. In spite of my attempts to “come alongside,” and empathize with the participants as recommended by Clandinin and Connelly (2000), I will never know what it is like to *really* be them or live as they do. However, this same criticism could be applied to all studies. With perhaps the exception of

autoethnography, the researcher can never fully occupy an insider perspective in regard to their participants' experiences. Attempting to at least come close to an empathic insight, I have relied on my own personal experiences of being addicted to nicotine and quitting smoking, working with recovering alcoholics in a clinical setting, as well as my own relationship experiences and so on, as entry points for connecting to the participants' experiences. As noted earlier, I also relied on member checks, and peer-debriefers (; Bhattacharya, 2017; Creswell, 2013; Spall, 1998) who experienced alcoholism and recovery to evaluate the authenticity of how the participants and their experiences were represented in the ethnodrama.

Future Research Possibilities

This study focused on exploring the narrative transition of a couple from addiction to recovery. While the findings produced significant contributions to the literature and the field of counseling, studies often raise more questions than they answer. Based on the findings, implications, and limitations of the present study, certain calls for future research become inevitable.

The findings from this study are based on an in-depth exploration of the experiences of a single couple recovering from alcoholism and therefore are not aimed towards generalizability. Future research may conduct additional case-studies with other couples or individuals in long-term recovery to further understand the recovery process from alcohol use disorders as well as other substance use disorders and behavioral addictions.

Additionally, this study examined recovery through a narrative lens. While this focus can provide significant insights for narrative therapists, it does not account for *all* domains of addiction. In particular, combining narrative with critical lenses (e.g., critical race theory, gender theory, queer theory, etc.) can allow researchers to focus on the variations and nuances of

population-specific experiences and issues related to addiction and recovery. Conducting research from critical perspectives may contribute to understanding the ways that recovery is differently lived and storied by diverse demographics.

The analysis of the ethnodrama in chapter four resulted in the development of the Narrative Change Model (NCM) to describe the way that narratives operated in the transition from addiction to recovery. However, In the discussion, I argued that this model is not endemic to addictions and can be applied to understanding any process of narrative change. In particular, I discussed the possible application of the NCM to understanding the process of counselor development. Hypotheses may be generated based on the NCM, and future studies are needed to validate or challenge the veracity and generalizability of the NCM across diverse populations and issues.

Finally, the present study examined couples who stayed together as they transitioned from active alcoholism to long-term recovery. However, it could be beneficial to explore the experiences and reasons for divorce and separation in post-treatment couples. The combination of the experiences of those who remain together and those who split following treatment can begin to point the way to understanding what works and what does not in maintaining families while narratively transitioning to recovery.

Researcher Reflections

Early in my master's studies in counseling, I was experiencing a disconnect between my personal worldview and the tenets of cognitive behavioral therapy as they were being presented to me in my classes as a systematic approach for correcting clients' irrational thoughts. My advisor at the time, Dr. Manuel Zamarripa, loaned me a book titled *Story re-visions: Narrative therapy in the postmodern world* (Parry & Doan, 1994). Reading this book provided me with an

approach to counseling that integrated my ontoepistemological views with my background in literary studies. Finding my theoretical orientation to counseling, I became newly excited and energized towards my studies.

Narrative therapy examines how socially constructed narratives influence the ways in which clients live. Influenced by Foucault's (1979) work on criminal justice and power, narrative therapists claim that clients often become stuck in and dominated by problem-saturated narratives that attempt to discipline their bodies and punish them for deviating from norms which are connected to power structures (White & Epston, 1990). The work of the narrative therapist is to examine the ways that dominant narratives oppress individuals and work with them to deconstruct and revise these harmful stories in ways that are more congruent to the lived experiences of the individual. Thus, narrative therapists are sensitive to their power within therapeutic relationships, and cautious about imposing their own meanings and understandings on their clients' narratives. Narrative therapists operate from a position of "not knowing" (Anderson & Goolishian, 1992), which situates the client as the expert and author of their own stories. The role of the narrative therapist is akin to that of a benign editor (Parry & Doan, 1994), suggesting experiments to clients for editing or re-storying their narratives in ways that are more reflective of their lived experiences.

Narrative therapists have commonly attended to languaging processes, such as externalizing the problem, avoiding totalizing accounts of issues, and discovering unique outcomes to client narratives (White, 2007; White & Epston, 1990). Furthermore, narrative therapy literature has examined the power of metaphors within the counseling context (Combs & Freedman, 1990; Rosenblatt, 1994). However, little attention has been paid to other basic literary elements of stories, such as plot, setting, character, genre, narrative voice, audience, and so on,

and how these could be used to affect narrative change in clients. Examining how these elements operate within client narratives and how they may be used to assist clients in the re-visioning process could be the next step in developing the narrative therapeutic approach.

In this study, I have focused specifically on plot by adapting Freytag's (1894/2007) classic plot structure to describe the change process of individuals and family members transitioning from active alcoholism to long term recovery. Inherent in the transition is personal growth as the individual becomes an *other*. However, the NCM acknowledges that growth is often accomplished through the resolution of narrative tension or, in other words, tension and struggle are necessary for producing narrative growth and personal development.

In this study, I found myself awed by witnessing the positive changes people have made to overcome the powerful forces of addiction. It was an honor to play a role in the reformation of addiction narratives, even if that role is only as an attentive audience to their story. Given the findings of this study, I was alerted to the importance of the role of supportive audience members in strengthening and thickening new fragile narratives. Thus, narrative therapy should not end at re-storying client narratives, but should incorporate the thickening of narratives.

As I have been writing this dissertation, my current advisor, Dr. Doris Carroll, has guided me towards providing greater clarity in my methodology. She has reminded me from time to time that qualitative ethnodramatic research has not been seen very much in the counseling field. My response has always been, "Don't you think it's about time?" This study itself may be a kind of biographical disruption of the research in counseling but working through the narrative tension of a novel approach may produce growth in the field.

This study has been several years in the making from the first stages of conceptualization until now as the final revisions are being made to the dissertation. During that time, I have

described my research to dozens of colleagues at professional conferences and other meetings who inquire about what I have been up to. The response has been entirely positive – not only because the topic is worthwhile, but because presenting my findings as an ethnodrama pushes the envelope of what research can look like in counselor education. Many have expressed interest in seeing the final product when it is produced. It seems to me that there is a general hunger in counselor education research to expand beyond traditional ways of knowing in order to involve more qualitative and arts-based approaches, since these approaches are well aligned to the actual work we do as counselors.

Conclusion

This study aimed to describe the experiences of a couple transitioning from active alcoholism to long-term recovery in order to discover how narratives of change have operated to influence recovery in the individual with the substance use disorder as well as his spouse. I determined that the most appropriate way to describe the recovery of the participants was to show their experiences through ethnodrama. Ethnodrama provides audiences with an emotional as well as intellectual engagement with the issues of recovery by allowing audience members to vicariously experience their lives (as represented on the stage). Ethnodrama also allows the findings of this study to become accessible to multiple audience within and outside academia.

As a narrative therapist whose role is primarily to assist clients in investigating reframing oppressive and problem saturated narratives, it was inevitable that I would conduct this study through the lens of narrative inquiry. In particular, I was interested in understanding how narratives functioned within the change process which is at the heart of therapy.

Furthermore, it is easy to cast judgment on and stigmatize addicts with ongoing deficit narratives including lack of self-discipline, immorality, and poor judgment. However, a basic

tenet in counselor education is that counselors offer an unconditional positive regard to their clients (Frankel, Rachlin, & Yip-Bannicq, 2012). This study is a representation of unconditional positive regard for addicts, specifically the participants, so that the challenges of addiction can be explored openly and honestly, and addicts are humanized and not demonized.

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