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An Inquiry Into The Meaning And Significance Of Sobriety As Described By Recovering Alcoholics.

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Herban, Nancy Lynn

AN INQUIRY INTO THE MEANING AND SIGNIFICANCE OF SOBRIETY AS DESCRIBED BY RECOVERING ALCOHOLICS

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AN INQUIRY INTO THE MEANING AND SIGNIFICANCE OF SOBRIETY AS DESCRIBED BY RECOVERING ALCOHOLICS

by

NANCY L. HERBAN

A DISSERTATION

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Science in Nursing
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ABSTRACT OF DISSERTATION
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Title AN INQUIRY INTO THE MEANING AND SIGNIFICANCE OF SOBRIETY AS DESCRIBED BY RECOVERING ALCOHOLICS

To determine the meaning and significance of sobriety as experienced by recovering alcoholics, a descriptive study was designed utilizing the phenomenological approach. Twenty subjects (10 men and 10 women with a minimum of one year's sobriety experience by self-report) were requested to volunteer to be participants in the study. Certain demographic data were collected, and 17 of the 20 subjects submitted a chronolog of their sobriety life-experience. Issues pertaining to reliability and validity were considered and enhancement measures were taken. The data were analyzed and interpreted utilizing "bracketing," a type of analysis appropriate to qualitative data, to search for themes and patterns.

The study revealed that the subjects were able to document their experience. From the data that emerged, a definition of sobriety, with associated characteristics/attributes, was conceptualized. The subjects were able to communicate the significance of the experience to the researcher. The subjects were all members of Alcoholics

Anonymous and the data may well be a reflection of the AA philosophy.

Furthermore, the data revealed role, from an interactionist perspective, as an appropriate theoretical perspective for viewing alcoholism and its antithesis, sobriety. Thus, the Social Definition Paradigm is presented as being applicable to this concept and for utilization in nursing research and practice.

The data revealed that sobriety constitutes a role change of greater magnitude than may have been considered previously. Therefore, the model was refined to include the term role transformation.

Abstract Approved by: Committee Chairman Kathleen C Brown RN PhD

Program Director [illegible]

Date 11-26-86 Dean of Graduate School Kenneth Boozer

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CHAPTER I

Introduction

Alcoholism has reached epidemic proportions in the United States. The impact of the disease reaches into every activity of living. The cost in terms of human life is staggering and almost impossible to assess, not only in terms of morbidity and mortality of the individual but also in terms of the effects on others. There are approximately 22 million alcoholics in the United States alone. It is estimated that an average of five other persons are affected by any given alcoholic. If this is true, then some 100 million persons are affected by the disease.

Accidents are the leading cause of death in the age group 1 to 44. Alcohol-related deaths and injuries are widespread ranging from traffic accidents to occupational as well as recreational deaths and injuries. For example, there are 500 deaths per week from alcohol-related traffic accidents, and 650,000 persons per year are injured as a result of alcohol-related traffic incidents (Podalsky, 1985). Podalsky and Richards (1985) suggest that 10% of occupational accidents are alcohol-related, even though the data are not available to make precise judgments.

Occupationally, alcohol abuse affects the employer in the areas of increased turnover and lower productivity as well as in increased medical costs. Swint and Lairson (1984) estimate aggregate costs in the range of $87 to $92 billion dollars for 1983. These dollars include costs of lost production, use of health care services, motor vehicle accidents, and arrests for alcohol abuse.

Effects of alcohol abuse on the family are related not only to the spouse dyad but to the children born and unborn. At least 27 to 32 million children in this country are being reared in homes where one parent is an alcoholic (Triplett & Arbeson, 1983). Many of these children will never be identified as having problems that are alcohol-related, and many may well continue the cycle of alcohol abuse as adults (Pilat & Jones, 1984).

Domestic violence is a complex phenomenon but often involves the use of alcohol. The impact of situational stressors and precipitating factors is often escalated by alcohol abuse. Lehmann and Krupp (1984) reported that, during a 6-month period, 55.2% of calls related to domestic violence made to a community-based hotline reported the involvement of alcohol. These investigators were concerned about the lack of assessment and referral for the alcohol problem. They found only 5% of the referrals were to agencies that provided services for the alcoholic and the family.

Over the past 10 years, alcohol has been identified as a teratogenic drug. Children born of mothers who drink may have a variety of birth defects, ranging from the complete fetal alcohol syndrome (FAS) to those children who are mildly affected. The effects continue into adolescence, and FAS has now been termed the most frequent teratogenic cause of mental retardation (Steissguth & LaDue, 1985). With a mid-range FAS incidence rate of 1 in 600 live births the total treatment cost for these children would be $2.4 billion (Harwood & Napolitano, 1985).

Benefits derived from treatment and prevention of alcohol abuse have both human and economic dimensions. A variety of strategies have been and are being implemented in the treatment of alcoholism. Even with the wide varieties of treatment modalities available, however, only 30 to 60% of recovering alcoholics remain sober (Heinemann & Smith-DiJulio, 1982).

Much has been written about the disease concept, the impact on others, and the differences in treatment modalities. The nursing literature, for example, reveals discreet areas of investigation such as the impact of recovery on the family (Estes & Grisham, 1982) and the physiologic withdrawal syndrome (Hoffman & Estes, 1984).

Statement of the Problem

Wallace (1982) describes alcoholism as a disjunctive concept. This viewpoint is demonstrated in the literature

with Jellinek's (1960) typology of alcoholism as well as the publication of the Criteria for the Diagnosis of Alcoholism (National Council on Alcoholism, 1972).

With the confusion surrounding the concept of alcoholism, it is not surprising to find a similar state of ambiguity relating to the term sobriety. Sobriety as the antithesis of alcoholism apparently represents a value not fully understood by all. It is estimated that of those who seek treatment only 30 to 60% will remain sober (Heinemann & Smith-DiJulio, 1982). People are responsible for their choices, but perhaps the attractiveness of the sobriety experience has not been effectively communicated to recipients of care if such a small percentage remain sober.

Little can be found in the scientific literature dealing with the concept of sobriety. A survey of the literature suggested a variety of indicators of sobriety such as abstinence from alcohol, productive living, and improved social and family relationships. Few definitions, however, were provided that afforded true insight into the nature of the phenomenon.

Clarification of the meaning of sobriety could afford nurses an opportunity to develop nursing strategies which enhance or facilitate the achievement and maintenance of long-term sobriety for the alcohol dependent person. "The nursing profession, emphasizing a reverence for clients' experiences, is concerned with the quality of life and the

quality of the nurse-patient relationship" (Oiler, 1982, p. 178).

Statement of Purpose

The purpose of this research was to identify the meaning and significance of sobriety as described by recovering alcoholics. Thus, the questions were posed: What is the meaning (characteristics/attributes) of sobriety as described by the recovering alcoholic? What is the significance of sobriety as described by recovering alcoholics?

Definition of Terms

For the purposes of this study the following terms were defined:

recovering alcoholics: men and women (adults, 18 years or over) who have been chemically-free from alcohol and mood-altering drugs except for caffeine and nicotine for a minimum of one year, as evidenced by self-report, and who are capable of writing in the English language.

sobriety: the definition that emerges from analysis of data collected from biographical sketches and unstructured interviews elicited from recovering alcoholics.

meaning: those characteristics/attributes derived from analysis of the biographical

sketches/interviews collected from the recovering alcoholic.

significance: the valuations that emerge from analysis of qualitative data collected from the recovering alcoholic.

Theoretical Framework

Johnson (1968) suggests that three types of knowledge are required for the practice of nursing. The knowledge of order, which is considered to be concerned with that which is normal; knowledge of disorder, or that knowledge which is concerned with deviations from normal; and knowledge of control, or the knowledge that is concerned with the strategies or interventions designed to facilitate the restoration of order. But how is that knowledge to be structured?

Knowledge is organized within certain structures in a manner which enhances testability and application. Thus, conceptual frameworks are derived from the particular manner in which knowledge is structured. The theoretical perspective selected for this project is multidimensional and multiparadigmatic and is presented diagrammatically in Figure 1.

The literature indicates a broad agreement among scholars as to core concepts relevant to nursing (Fawcett, 1984). The presence of these central concepts supports existence of a metaparadigm for nursing. A metaparadigm is "a statement or groups of statements identifying . . .

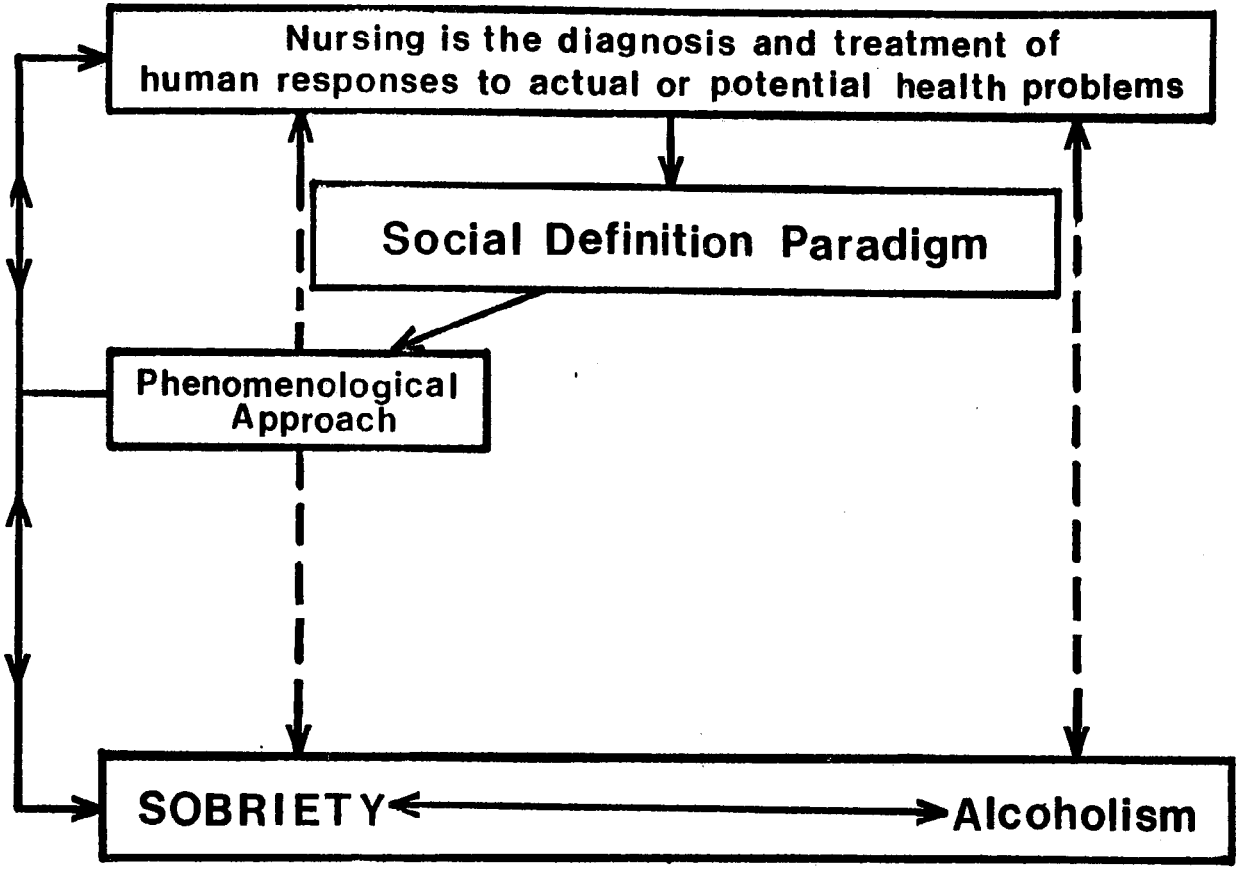

Figure 1. A theoretical framework for the investigation of sobriety.

relevant phenomenon" (p. 84). Eckberg and Hill (1979) explain that a metaparadigm "acts as an encapsulating unit, or framework, within which the more restricted . . . structures develop" (p. 927).

ANA Social Policy Statement. From among those statements listed by Fawcett as documenting the consensus of central core concepts, this researcher has selected the American Nurses' Association (1980) definition of nursing as exemplifying a metaparadigm for nursing. The definition of nursing as presented in the ANA Social Policy Statement is consistent with Masterman's (1970) definition of a metaparadigm as a philosophical set of beliefs. This statement, "Nursing is the diagnosis and treatment of the human response to actual or potential health problems" (p. 9), is capable of serving as a framework from which more "restrictive structures" develop.

> The phenomena of concern to nurses are human responses to actual or potential health problems. Any observable manifestation, need, condition, concern, event, dilemma, difficulty, occurrence, or fact that can be described or scientifically explained and is within the target area of nursing practice is of interest to nurses. . . . Human responses to health problems . . . are often multiple, episodic, or continuous, fluid, and varying, and are less discrete or circumscribed than medical diagnostic categories tend to be. (ANA, 1980, pp. 9-10)

As a framework for the present study, the metaparadigm of nursing as the diagnosis and treatment of the human

responses to actual or potential health problems structured the conceptualization and design. In relation to the meta-paradigm certain assumptions were drawn from the ANA Social Policy Statement definition of nursing:

1. Humans are capable of responses.

2. Humans have actual or potential health problems.

3. Nursing is the diagnosis and treatment of the human response.

4. It is within the purview of nursing to recognize the human response.

Corollary assumptions, then, were drawn as related to the problem under review:

1. Alcoholism represents an actual and potential health problem.

2. Sobriety represents a human response to alcoholism.

3. Sobriety is not clearly defined in the scientific literature.

4. Knowledge of sobriety would be classified as knowledge of order.

5. Appropriate diagnosis and treatment of sobriety are difficult when no definition exists.

Social Definition Paradigm. Refinement of the meta-paradigm occurs at the level of the paradigm or disciplinary matrix. The disciplinary matrix does not represent the total view of the discipline, but rather represents the viewpoint or perspectives of a specialty area within a

discipline. The Social Definition Paradigm (Ritzer, 1980) has been chosen as a disciplinary matrix.

Basic to the Social Definition Paradigm is the premise that man is an active creator of his own social reality. Ritzer states, "something occurs in a man's mind between the time a stimulus is applied and the response is emitted and it is this creative activity that is the concern of the social definitionist" (p. 90). This is consistent with the assumption that control over behavior comes from an internal reservoir within the individual (Magoon, 1977).

The sociological paradigm provides a philosophical perspective by which man and responses are viewed. Acceptance of man as an active creator of his own reality not only provides the perspective by which man and his response to health problems are viewed but determines the focus by which such philosophical stances will be implemented in practice. The Social Definition Paradigm subsumes three theories: action, symbolic interaction, and phenomenological sociology.

The theories associated with the construct/artifact paradigm provide the tools by which puzzle solving can take place. The phenomenological approach provides methods for research.

Phenomenological approach. The phenomenological approach provided the direction for the research design and methodology. Even Ritzer (1980) had difficulty in

determining whether phenomenological sociology is a theory, a method, or an approach. The results are described as introspective and empirical, thus influenced by history and setting. The techniques are geared toward providing an empirical and naturalistic description of meaningful social actions.

From a "holistic" perspective, "we must first conduct an inquiry that brings us closer to the phenomenon . . . in all its complexity" (Carini, 1975, p. 5). Research methodology is determined by the question to be asked. Aristotle, as cited by Dillon (1984), stated, "the kinds of question we ask are as many as the kinds of things we know" (p. 328). He (Aristotle) classified such questions into four categories. Of these, two are of concern to the present paper: "whether a thing exists," and ". . . what is the nature of the thing" (p. 328). Dillon's classification scheme consists of 17 categories with a variety of subgroups. Questions to be asked are "first order categories of questions describing the properties of a phenomenon" (p. 330). Therefore, questions of existence, instance, substance, character, function, and rationale could be asked.

To answer questions of the "first order" it is necessary to discover the individuality of the assigned meaning. Persons respond or react to each other in a manner consistent with the meaning assigned to the behavior. Understanding in an interaction is attained through shared

meanings. Yet meanings are not always the same. In the words of Eliot (1943), "words strain . . . decay with imprecision, will not stay in place" (p. 19). Cup does not mean the same to a golfer as to a thirsty man. Morris (1977) considered meaning as varying situationally and must always be sought anew. Thus, human action or behavior is context-dependent. Yet, much of what is done and labeled scientific is context-stripping in that an attempt is made to test generalities by removing subjects from the normal setting (Mishler, 1979). The strength of qualitative methodology, in this instance phenomenology, is this process of discovery--"to know about" rather than to "know." To know about requires first-hand knowledge and a "commitment to represent the participants in their own terms" (Lofland, 1971, p. 4). There is a commitment to describe what is going on as factually and as descriptively as possible. Thus, phenomenology offers a qualitative approach that is a fitting method for investigating questions arising from clinical practice.

Assumptions

The following have been identified as assumptions for this research:

1. Experiences have both meaning and significance for man and can be described (Rose, 1962).

2. Nursing is the diagnosis and treatment of human responses to actual or potential health problems (ANA, 1980).

3. Alcoholic recovery is a process (Brown, 1985).

4. Persons do act as self-observers.

Significance

The proposed research could make contributions to nursing theory and research. For instance, one example of the research generated by this project would be to assess and evaluate the nursing definition as delineated by the ANA Social Policy Statement as a possible metaparadigm for nursing. The social policy definition of nursing may provide the consensual base that Conway (1985) considers as being needed for agreement to be reached "on the puzzles and phenomena central to nursing" (p. 76).

This researcher, however, differs from Conway (1985) in the belief that the Social Definition Paradigm does provide directions for research within the discipline. Man as the creator of his own reality, the underlying premise of the Social Definition Paradigm, provides a philosophical basis for research based on the theoretical constructs Ritzer (1980) considers inherent in the paradigm. Qualitative research can lead to the delineation of further questions and selection of hypotheses for further testing using quantitative methods. The proposed project, with the intent to describe the meaning and significance of a human response,

should result in patterns and similarities that contribute to nursing's knowledge of order.

Through an analysis of the concept of sobriety, it is hoped to achieve a heightened awareness and increase the level of understanding of the term. Gaining sobriety is a human response to an actual health problem; maintaining sobriety is a human response to a potential health problem--the problem of alcoholism.

Professional nurses, though still ambivalent toward alcohol consumption and the alcoholic (Naegle, 1983), have become more aware of the magnitude of the problem. The impairment of the nurse (an estimated 40,000 nurses are alcoholic [Jaffe, 1982]) as well as the increased incidence and recognition of the problem among recipients of care (it is estimated that as many as 30% to 50% of medical-surgical hospital admissions could have a secondary diagnosis of alcoholism [Brodsley, 1982]) have had an impact on the consciousness of the professional.

Increased understanding of the phenomenon of human responses can lead to advancement of nursing knowledge and improvement of strategies for diagnosis and treatment. Such research can contribute to knowledge of order, disorder, and control.

In addition, the professional with a greater understanding of the ultimate goal of treatment would be able to translate the goals and objectives of treatment to families

and significant others as they struggle to understand the "alcoholic member" and to understand their own place in the treatment and recovery process. Others, whether the professional, family member, or significant others, though not able to achieve the goal for the client, may certainly be a force in the facilitating or the sabotaging of the treatment process.

So the question is raised, what is this quality that seemingly cannot be defined but can be recognized? How can appropriate and effective nursing strategies (interventions or treatments) be planned or implemented unless the human response to illness-wellness is understood?

Finally, increasingly nursing schools are becoming aware of the problem of alcoholism and are including relevant content in the curriculum. An awareness of sobriety as the human response to the disease would contribute to the current content, as already provided, with regard to diagnosis and treatment.

Summary

Nursing has been presented as a multiparadigmatic discipline and as possessing knowledge of order, disorder, and control. These concepts are considered to be applicable to the alcoholic client. The knowledge of alcoholism and the alcoholic is certainly knowledge of disorder. It would appear, however, that little is known of order or control in relationship to the alcoholic if the relapse rate is 30% to

60%. Knowledge of order is necessary to arrive at appropriate applications of knowledge of control. The relationship of the model, nursing knowledge, and the concepts under discussion are depicted in Figure 2.

Nursing, as the diagnosis and treatment of the human response to actual or potential health problems, provides a metaparadigm (set of beliefs) for further organizing and structuring knowledge, as well as providing direction for nursing actions. Refinement of the metaparadigm, at the level of the disciplinary matrix (Social Definition Paradigm), provides direction for categorizing or explaining the nature of the human response or the health problem (knowledge of order and disorder). The theories within the Social Definition Paradigm provide avenues for translation of knowledge into action as a means for solving the puzzle. Phenomenological sociology serves as a means of investigating the human response.

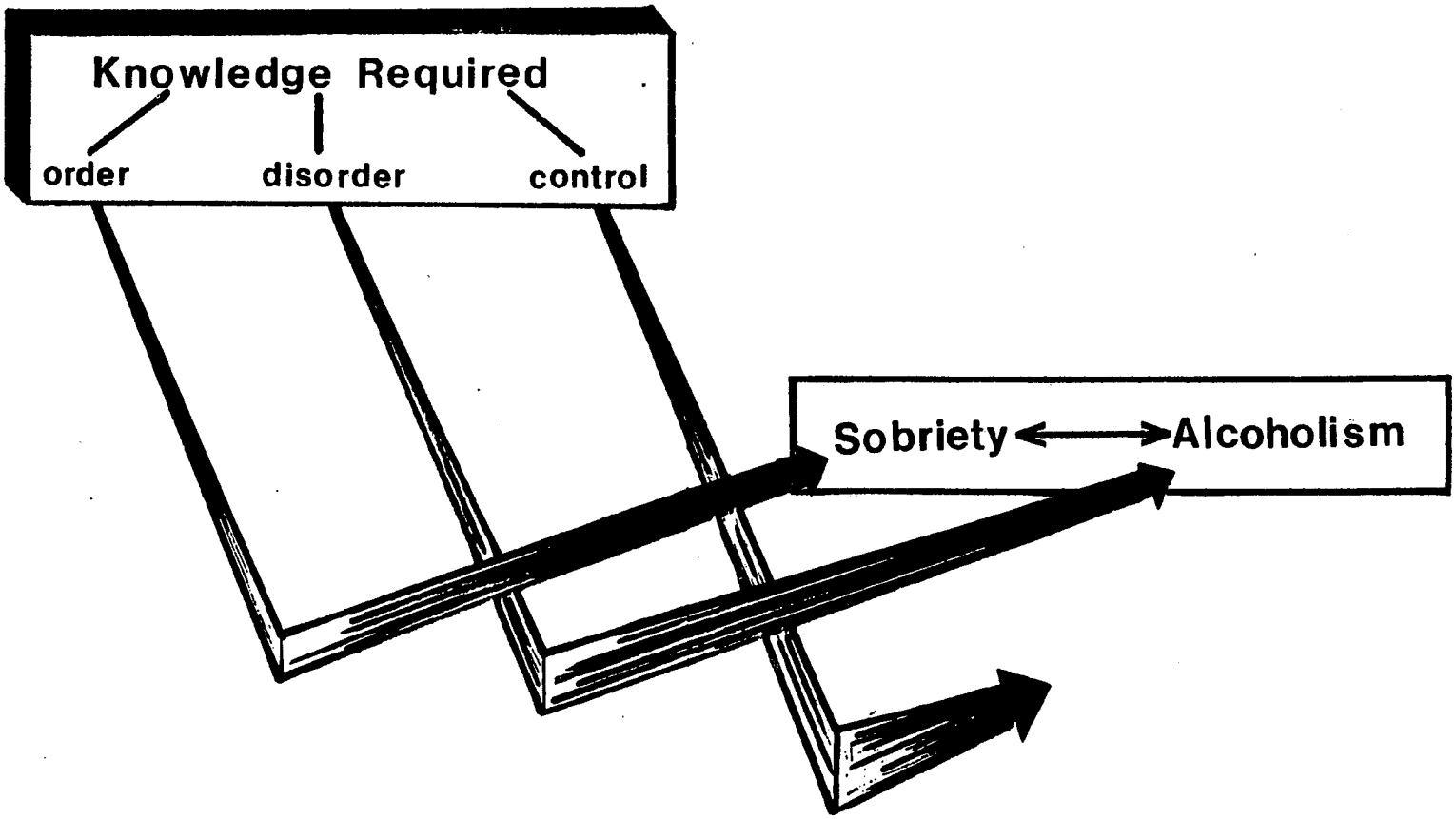

Figure 2. Relationship of nursing knowledge and the concept of sobriety.

CHAPTER II

Review of the Literature

Describing the concept of sobriety is elusive at best. With the classification of sobriety as a disjunctive concept it was not surprising to find a dearth of scientific articles on the subject. Wiseman (1981) spoke to the difficulty in the operationalization of the term. In that manuscript, this difficulty was seen as a consequence of the diverse variations of the concept as well as certain variables that impinge upon the attainment and maintenance of sobriety. A review of the scientific literature revealed only a few articles that addressed the concept in any manner that could be considered a holistic approach. The literature reviewed, representing the past 25 years, will be presented in chronological order: the 1960s, 1970s, and 1980s. The disciplines represented are medicine, social work, sociology, psychology, and nursing.

1960s

Stewart (1960), in his book, Thirst for Freedom, defined sobriety as "an action of insights and skills far beyond mere abstinence . . . " (p. 2). He viewed sobriety as a process--"a goal and an adventure" (p. 2). The

material for the book was gathered from personal talks and his private practice in a variety of clinics in the United States, Canada, and the United Kingdom. The primary purpose of these talks was to show that sobriety was more than mere abstinence; in fact, sobriety was viewed as a positive and creative adventure. This adventure, within oneself and among others, brings three gifts--grace, peace, and fellowship. Grace was defined as the loss of the desire to drink. Peace was an acceptance of life that was enduring and had a certain quality of life that encompassed knowledge of freedom. This freedom allows for the daily practice of empathy through relationships with others.

Gerard, Saenger, and Wile (1962) conducted a follow-up study of 299 clients from the Connecticut Commission on Alcoholism. They were particularly interested in those who had been abstinent for at least one year prior to the follow-up study. Data were collected using a structured interview schedule. The purpose of the study was to empirically clarify questions relative to the relationship of general adjustments to abstinence, to describe what the abstinent person was like, and what was the significance of abstinence. Those who had remained abstinent for a minimum of one year (55) were divided into four categories: (a) overtly disturbed, (b) inconspicuously inadequate personalities, (c) the AA successes, and (d) the independent successes.

The overtly disturbed (54%) were defined as those "whose abstinence is sustained in the context of an unstable state" (Gerard et al., 1962, p. 104). These individuals were found to be angry, dissatisfied or resentful, restless, unable to relax, and spent inordinate amounts of time at work or social activities of a community nature. There might or might not be signs of psychiatric illness. The inconspicuous inadequate personalities (24%) had ". . . functioning characterized by meagerness of their involvement with life and living" (p. 105). These persons appeared to be more fearful and sad than happy, and had no particular purpose or goals in life. Abstinence is maintained by a very limited perspective on life. The AA success (12%), on the other hand, ". . . have made a spectacular shift in their lives through a successful identification with AA" (p. 106). The researchers expressed the concern that these persons were now as dependent upon AA as they had been previously upon alcohol. These persons did not appear particularly negative or tense. The independent successes (10%) ". . . have achieved a state of self-respecting independence, . . . of personal growth, . . . and of self-realization" (p. 107). The researchers described these persons as striving independently toward self-realization rather than being institutionally supported. They were also considered as more alive and interesting persons. It was apparent for these researchers that being abstinent did not

automatically assure successful living. Factors identified as being associated with becoming abstinent were fear of dying, displeasure with having a drinking problem, and a long association with Alcoholics Anonymous. The abstainers, however, did not attribute their decision to cease drinking with any particular supportive person such as the therapist, family group, a priest, or a friend. The researchers concluded

> . . . much remains to be learned about the treatment of people with drinking problems, not only from the perspective of bringing them to abstinence, but also from the perspective of helping them to achieve a more stable and mature level of psychosocial adaptation. (Gerard, 1962, p. 111)

1970s

It is Bateson's (1971) argument that the sobriety of the alcoholic is characterized by an unusually disastrous variant of the Cartesian dualism, the division between Mind and Matter, or in this case will, or "self," and the remainder of the personality. This conclusion was based on a small sample of alcoholic patients with whom Bateson worked between 1949 and 1952. It was that author's opinion that cybernetics and system theory provided a new epistemology for viewing alcoholic addiction. Bacon (1973) did not use the term sobriety in his essay but spoke to the recovery process. However, recovery was considered as a change in lifestyle that was continuous rather than static. Small and Wolf (1978), as cited by Melvin (1984), viewed recovery from

the perspective of Maslow's studies on self-actualization. Three stages of self-actualization were outlined for abstinent alcoholics in their study of the newly sober. The first stage was one of catharsis with the emphasis on retrospection or an attempt to discover buried emotions. The second stage was one in which the client acquired new insights through self-exploration, and the behavior was characterized by increased risk-taking. The final stage was described as a time of experimentation with change and growth. The treatment goal was to foster the self-understanding that will enable the alcoholic to gain therapeutic growth and to live more effectively.

1980s

In a study designed to report the effects of significant others (76 wives and 30 men alcoholics) on the sober behavior of alcoholics, Wiseman (1981) defined sober as referring "to all conditions under which an alcoholic can be nonintoxicated" (p. 108). The three stages were: (a) brief sobriety, lasting from several hours to a few days; (b) sobriety accompanied by withdrawal as a result of complete abstinence; and (c) longer-term abstinence following withdrawal. It was concluded that, ". . . sobriety for alcoholics is a period of personal and social sensitivity . . ." (p. 124).

Rosen (1981), in viewing the relationship of psychotherapy and Alcoholics Anonymous, appeared to equate

sobriety with abstinence and functioning well in society. It was considered that some studies looking at emotional stability illustrate that abstinence alone, for some clients, was inadequate. Again there was no clear-cut definition of the concept, and often the term was used ambiguously--for those who were abstinent as well as for those who had experienced some personal growth experiences. Three phases of recovery were described: (a) the period of detoxification; (b) the period of giving up drinking, of attaining and maintaining sobriety; and (c) the period when personality and value differences reappear. Rosen considered psychotherapy as helpful in Phase 3, particularly with those in AA who are questioning "Is this all there is?" The therapist can help the patient distinguish between increasingly independent behavior and mere obedient abstaining from alcohol.

Carruth and Pugh (1981) viewed recovery as a form of the grief process, the loss of alcohol being the loss of a significant relationship and the process as similar to the grieving process that accompanies any loss. Three stages and the accompanying behaviors were described: Stage 1, apprehending the loss; Stage 2, attempting to deal with the loss; and Stage 3, final restitution and resolution of the loss. The recovering alcoholic, during Stage 2, realizes and begins to face the life-changes inherent in sobriety.

In Stage 3, the ultimate goal is for the individual to grow toward self-reliance and independence.

In 1984, Melvin reported the results of a project aimed at learning more about how the ex-alcoholic fares after the attainment of sobriety. The underlying intent of the study was to increase knowledge, thereby assisting clinicians to facilitate more effectively the achievement of sobriety. Melvin examined data obtained from persons who had opportunities for experiencing sobriety. Melvin interviewed 10 subjects (volunteers from AA [6 women, 4 men], mean age 40.4 years, mean length of sobriety 6.7 years). The research was viewed by the author as revealing the process of sobriety as resembling or paralleling the growth process as described by Erikson. Three stages were identified: Starting Over (Erikson's, Basic Trust); Reality (Erikson's, Autonomy); and Reaching Out and Sharing the Growth (Erikson's, Self Determination). Even though Melvin considers sobriety as not being synonymous with recovery, no definitive statement was made as to what sobriety is. Melvin does suggest that the long-term experience of sobriety may be a growth experience.

Melvin (1984) also mentioned in the paper the work of Small and Wolf (1978) and their use of Maslow's studies on self-actualization and abstinent alcoholics. There is no reference, however, to parallels or dissimilarities between the studies. It is unfortunate that Melvin does not define what sobriety is, even in the context of this paper.

Brown (1985) describes the data gathered using an open-ended questionnaire to gain information from 80 (40 men and 40 women) recovering alcoholics. The subjects were all participating in AA; the average age for males was 38 years, for females was 42 years; and subjects had varying lengths of sobriety. The purpose of the original research was to "determine what the basic views and issues were in recovery" (p. 27). Brown concluded that recovery was a process and could be based on the developmental framework of Piaget.

As a result of her research, Brown (1985) described a multidimensional development model. The model was considered to have the potential for the development of a set of therapeutic tasks. Moreover, it was concluded that abstinence and recovery were ignored in earlier models. Like the other authors, Brown found there was no agreement either on theoretical formulations or as to what happens after abstinence.

Summary

The consistent conclusion from the review of the literature was that sobriety may not be synonymous with recovery or merely abstinence. The readings revealed descriptions of sobriety as a variety of processes such as growth (Erikson), self-actualization (Maslow), cybernetics, developmental (Piaget), or as a process of grief resolution.

Additional stimulus for this research was that no consistent model or framework for viewing sobriety was

found. Confusion and ambiguity persist as a phenomenon is described without being defined. Yet it is not particularly surprising, for, as a recovering alcoholic stated, "I don't know if I can define it, but I can certainly recognize it" (T. McC., personal communication, April, 1985).

CHAPTER III

Research Methodology

The purpose of this research was to identify the meaning and significance of sobriety as described by recovering alcoholics. The purpose was achieved in the following manner.

Design

For the purposes of the present study and to be consistent with the philosophical stance, the phenomenological approach was selected as the overall design. Such an approach allows for the investigation of a phenomenon from the viewpoint of the person who has indeed experienced the phenomenon.

Phenomenology, as an approach, can be viewed as an excursion and an adventure in discovery. Ritzer (1980) described phenomenology as ". . . . an imagination that presents a rather unique way of approaching the constitution of social reality . . . it is not objectivist, or static . . ." (p. 109). Phenomenology, as method, is basically ontologic, a form of descriptive analysis. Phenomenology examines the world as experienced (Bogdan & Taylor, 1975; Thune, 1977).

Qualitative methods are descriptive and holistic. The methods are aimed toward discovery. Knafl and Howard (1984) describe four purposes of qualitative research: instrument development, illustration, sensitization, and conceptualization. Instrument development and illustration are seen primarily as a part of larger quantitative studies. The purpose underlying this research is sensitization and conceptualization. Sensitization is used to "sensitize the reader to the viewpoint of a particular group" (p. 20). Conceptualization is used to "introduce the reader to conceptual or theoretical significance of the subject matter" (p. 27).

A defining characteristic of phenomenology as method, is the principle of bracketing. This bracketing or epoche is initially to refrain from judgment, to look at the data without predetermined bias, and then to speak from the standpoint of what emerges from the data. Bracketing or epoche has been described as having different steps or phases. Bracketing is the ability to put aside attitudes and assumptions and to try to grasp the meaning of the phenomenon as it is lived by the people involved. It involves the ability to play the role of the other, to use imagination and feeling (Morris, 1977). Basically, bracketing has three steps or phases. The first is a profound disbelief in the theories and taken-for-granted assumptions handed down from other traditions and then

analyzing and describing what is seen (Morris, 1977). The second epoche is done to discover the significance for the individual. Lastly, questions are asked as to what does it mean for human beings in general.

Selection of Subjects

Setting. The geographical setting from which the sample was drawn was northeast Mississippi within a 60-mile radius of the researcher's home. The data for the study were collected at the homes of the participants. The subjects were all members of Alcoholics Anonymous.

Characteristics. The sample consisted of 20 recovering alcoholics (adults, 10 men and 10 women, over 18 years of age) who by self-report had been chemically free for a minimum of one year prior to the collection of data and were able to write in the English language. The subjects were volunteers. The population was selected from the group attending Alcoholics Anonymous in three cities in northeastern Mississippi.

Within two weeks of receiving permission to collect data (April 12, 1986) the sample had been selected. Only one person who was approached preferred not to participate on the basis that the time involved might conflict with the management of other health problems.

Protection of Human Rights

Both anonymity and confidentiality were maintained. The responses and names were coded. The permission form with the identifying code number was secured in a locked file to assure confidentiality. Any reports of the investigation will not include data by which an individual could be identified. The necessary information was submitted to the Institutional Review Board (IRB) for approval prior to data collection. The consent form is attached (Appendix A).

Data-Gathering Process

Field procedures. After the subjects had volunteered to participate in the project, each subject was asked to complete a short demographic form and a biography or chronology of their sobriety experience. This demographic form included the directions for the completion of the biographical data (Appendix B). Upon completion of the biographical data and the initial reading of the material, taped interviews were conducted in one case in order to amplify/clarify any areas of confusion on the part of the investigator.

Nineteen participants completed the demographic data form. One participant, after repeated telephone calls that were not returned, was deemed lost to the study. That subject was replaced. Thus, 20 demographic forms were completed. The subjects appeared to have no difficulty in completing the form. In fact, the subjects often added qualifying information such as the difference between the

age beginning drinking and the age when they considered "alcoholic drinking" as having begun.

The original plan for the subjects was for them to submit a written document describing their sobriety experience. The documents submitted varied in length. Four individuals submitted a tape recording of their experiences, rather than the written document. These tapes were submitted because of the subjects' perceived difficulty in writing due to lack of education, current illness, or the lack of time as with professional persons who found dictating an easier, quicker method.

In the researcher's judgment, this deviation from the original plan in no way altered the intent of the research, particularly since the possibility of a subsequent taped interview was included in the original design. The tapes were identified by the subject's research number to protect their anonymity.

Seventeen documents were received by June 26, 1986. Two of the three volunteers who did not submit documents gave as the reason for noncompletion "not enough time, or family responsibilities." The researcher was not able to locate the other person.

Time schedule. The project consisted of four phases: Phase I--Pre-Data Collection; Phase II--Data Collection; Phase III--Data Analysis and Interpretation; and Phase IV--Preparation of Report.

Phase I consisted of those activities that were required prior to data collection. Included in this phase were such activities as submission of the proposal to IRB, gaining entrance into the proposed sites, and the solicitation of the volunteers.

Phase II consisted of the activities required to collect the data. These activities included the distribution of the short demographic form and giving instructions regarding the data required. This also included the time required for the taped interviews.

Phase III included data analysis and interpretation. Because of the nature of the study this phase also included the activities related to reliability and validity.

Phase IV included the activities related to the writing of the report. This included the writing of the report and the preparation of any material required for the presentation of the report.

The Gantt chart demonstrates the time table for completion of the investigation (Appendix C).

Data Analysis and Interpretation

Descriptive statistics were used to describe the group and their demographic characteristics. The biographical data were analyzed using methods consistent with the purpose of the study. The nature of the research was such that it was impossible at the initiation of the study to state the

nature of the themes or patterns that would emerge from the data.

Seventeen subjects submitted either the written document or a taped discussion, and one subject submitted both for review. The analysis of the data included several steps:

1. Reading or listening to each document in its totality. This initial review of the documents was not done until a majority of the documents were submitted, in an attempt to reduce any bias associated with what had been read previously.

2. Grouping of content into the large themes as they emerged from the documents.

3. Recording on cards specific statements that demonstrated the themes (Knafl & Howard, 1984).

4. Reading and rereading the documents.

5. Contemplative time. This is the time for concentrating on the experience; to attempt to grasp the meanings that are present in the data. Oiler (1982) considers this phase as "intuiting . . . [to look] at the experience with astonishment . . . to become absorbed in the phenomenon" (p. 180).

6. Sorting and collating the cards into the final themes and patterns.

7. Conduct the three phases of bracketing: what it means for the researcher, what it means for the individual, and what it means for the world in general.

Reliability and Validity

Issues related to reliability and validity are concerns voiced by critics of qualitative research and methodology. These issues have not gone unheeded by proponents of the approach. Knaack (1983) states a basic assumption of the phenomenological approach is ". . . that analysis proceeds from the researcher's context or perspective of the data" (p. 112). Thus, basic questions of reliability will deal with both the source of the data and the researcher. Did the data source truly represent the concept of phenomena, and did the researcher have the ability "to get it all down"? Magoon (1977) suggested using "multiple observers with the same focus" (p. 668) as a means of increasing reliability. To enhance the reliability of the study, an individual was selected to read the materials and to compare the codes, themes, or patterns as identified by the researcher.

The person selected was a Vocational Rehabilitation counselor experienced with alcoholics. The documents were read independently of the researcher. The findings were closely aligned with those of the researcher. The joint discussions of the data were informative and facilitated understanding of the concept of concern.

Truth, as determined by phenomenologists, ultimately rests on the direct experience of individuals (Benoliel, 1984). With this statement in mind, certain questions may be asked: (a) Are those who have lived the experience able to recognize the findings as truth? (b) Is the experience recognizable from a description of the experience? (Oiler, 1982). Magoon (1977) suggests, as a means of validation, involvement of some of the study participants. To enhance the validity of the study a member of the group was to have been chosen to assist the researcher in verifying the observations and patterns.

Rather than having one person read the document, however, a decision was made to have a group meeting of the participants at which time the findings were discussed with the group. The group meeting contributed to the researcher's hope of truly capturing the essence of the concept. The group was vocal in mentioning gaps and providing further input into the analysis and interpretation of the data.

Limitations

The following possible limitations were identified for this project:

1. The researcher's ability to set aside (bracket) experience/assumption/knowledge.

2. The researcher's ability to listen.

3. The researcher's ability to enable the subject to adequately describe phenomenon.

4. The subjects' ability to describe the experience.

The phenomenological approach was an appropriate method for eliciting data regarding the human response--in this instance, sobriety. The subjects that participated did so freely, and the documents appeared to be honest appraisals of their experiences. The researcher was not overly concerned with some of the problems often inherent in some forms of qualitative research such as "going native" as she did not live with nor was she in constant contact with these individuals. The researcher was a known observer and had used a "gatekeeper" to gain access to the settings to elicit participation in the research. It is the opinion of the researcher that entry into the settings or solicitation of the volunteers would not have been as easily accomplished without such "pre-existing relations of trust" (Lofland, 1971, p. 95). As a graduate student, to use Lofland's (1971) terminology, the researcher was, in all probability, deemed as an "acceptable incompetent" by the subjects. The researcher was not an alcoholic, was a professional, and was a student, thus it was easy to assume for the subjects the role of "one who is to be taught" (p. 97). Thus the participants were willing, almost eager, to share their experience.

The findings revealed that the subjects could recall and were able to put words to their experience of sobriety. This was not surprising, as AA members are expected to relate their life history to others (Alcoholics Anonymous, 1976, p. 58). Cain (1986) views this "story-telling" as a mechanism for self-understanding, as well as a means for assisting newcomers in the group.

Bracket I: What it means for the researcher is included here, as Bracket I deals with the researcher's subjective experience as well as with how the researcher coped with the possible limitations. To set aside past experiences was not always an easy task. Coping took the form of actively "tuning out" of past experiences and to "listen actively" to what the documents were saying. This "tuning out" required a conscious effort to block internal stimuli and to concentrate totally on the documents.

The problems associated with this type of research did not go unnoticed. There was a feeling of constant vigilance during the analysis to keep this experience free from coloration or bias by the researcher's prior experience. The researcher was concerned as to the ability to complete successfully Bracket II: What it means for the individual. After working with alcoholics on a daily basis for four years, the ability to set aside the knowns (experiences and knowledge) and to examine the data with objectivity was a concern of the researcher. The putting aside of the

theoretical was considered to be less of a problem than the experiential, as the intuitional response of the researcher to the literature review was much the same as the prior researchers--there had to be something more.

Patience was a lesson to be learned, as time was necessary to allow the data to speak for itself. This contemplative time was a requisite for listening with the third ear--to hear at all levels of perception. Patience was required to wait until the facts seemed to be "all there" before moving from the data to meaning and significance.

The researcher was impressed, even humbled, with the willingness of the subjects to share and the honesty with which they shared their experiences. It was a privilege to be allowed to enter into "another's world of experience," for the conduct of this research was certainly a journey into the experience of the other.

Summary

The research design for an investigation of sobriety has been presented using qualitative methods, in particular the phenomenological approach. For this present study the purpose of the qualitative methodology was for sensitization and conceptualization. Results in terms of the sample selection, data-gathering process, data analysis, reliability and validity, and limitations, were presented.

CHAPTER IV

Analysis and Interpretation

Alcoholism has been studied in great detail over many years. However, knowledge relating to the antithesis, sobriety, is sadly lacking. This research project sought to answer the questions: What is the meaning (characteristics/ attributes) of sobriety as described by the recovering alcoholic? What is the significance of sobriety as described by recovering alcoholics?

Sample Profile

The sample profile is provided to describe the sample and is not intended to describe recovering alcoholics as a group or to make any inferences from the information gleaned from the sample. The subjects were selected from northeast Mississippi within a 60 mile radius of the researcher's home. All the subjects were participants in the program of Alcoholics Anonymous.

The 17 subjects ranged in age from 34 years to 72 years. Sixteen of the subjects were Caucasian and one was Black. Protestant was listed as the religion of choice for 10 subjects, Catholicism was the choice of 4 subjects; and none or other was listed as the choice of 3 subjects.

Sixteen subjects had completed high school or above. The males were all married, while the majority of the female subjects were single.

Subjects related their drinking as beginning during the teenage years. One of the females listed her drinking as starting after she was 30 years of age, and one female reported that "alcoholic drinking" did not begin until about 35 years of age. Seven subjects had gained their sobriety through Alcoholics Anonymous, and 10 had been involved in some form of organized treatment center, either a hospital-based program or a recovery house. Of those who had been in treatment, only 2 required a repeated treatment experience. The length of sobriety reported ranged from 1 to 26 years, with an average of 7.0 years.

Three subjects related no known family members as being alcoholic or problem drinkers. A variety of family members was listed as alcoholics such as father, uncle, and grandfather. Of interest is the fact that only 1 male listed the mother as the alcoholic, while 4 females listed their mother as an alcoholic. The father of 4 male subjects and 4 female subjects was listed as the alcoholic. Six subjects reported taking regular medication such as chemotherapy, hormones, or anti-hypertensive drugs. These prescription drugs would not have interfered with the relating of their experiences.

Data Analysis

Seventeen documents were presented for analysis. The documents varied in length from a single page to 6-8 typewritten pages or an hour tape. The analysis of the written documents took the form of reading and rereading the documents and searching for common themes that would evolve or emerge into a pattern. The four tapes were listened to repeatedly for the same purpose. The reporting takes the form of the "bracketing" that was done by the researcher, specifically, Bracket II: What it means for the individual. Material from Alcoholics Anonymous has been placed in the appendices as a means to assist the reader to understand references made by the subjects.

A look at the past. The subjects often included descriptions of their past lives as a means to place the present in perspective. The data described their past lifestyles as having the following characteristics or attributes:

1. Continued drinking in spite of increasing problems with self, others, and situations. This was documented by health problems, such as being told of changes in liver function, family conflicts often ending in divorce, job demotions or firing, and repeated driving violations such as driving under the influence. As one subject related:

> . . . Conditions over a number of years became worse and worse. My wife and I went to marriage

> counselors, she was seeing a psychiatrist, we got counseling from our pastor. Things did not improve and my drinking became worse. I finally went to a medical doctor who stated that my liver was being damaged by my drinking. About the same time, my boss talked to me about my drinking and its effect on my work. . . .

2. Patterns of alcohol usage to cope/solve problems arising from activities of daily living. None of the subjects deliberately set as a goal becoming an alcoholic. The drinking patterns varied. As the drinking years progressed, alcohol was viewed as providing "instant relief" from pain (emotional, spiritual or physical) and as a means of "coping with reality." As one subject related, "drinking was the ONLY solution to problems."

> . . . I was afraid to live and scared to die. It was like an impending doom. . . . I have never been able to stay sober before because I didn't know that I had a choice. . . .

> . . . I functioned in a very hectic environment--the booze gave me the added push to pull it off--I was reluctant to let go of that--I wasn't too sure I could function in the high pressure job I had without it. . . .

3. Feelings of alienation. During the years the alcoholic drank, the subjects expressed having feelings of loneliness, of not belonging, of being alone, and of being rejected by the family and God.

4. Feelings of low self-esteem. These feelings of alienation and rejection led to behavior that was characterized as "rebellion against past training," as well as

feelings of "insecurity," "low self-esteem," and "self-pity." These feelings were expressed as:

> . . . I was less than nothing when I drank. . . .

> . . . I only remember feeling I was where I was supposed to be, to be fitting in, to be at peace, at special moments of my life. This was because I depended for this sense of peace and belonging on others and on external circumstances. And when I did not have it, I was unhappy with myself and my circumstances, and with those around me. Ultimately, it was this unhappiness which led to my use of alcohol in increased measures to try to gain what I thought I needed. . . .

5. Thought and behavior patterns associated with characteristics 3 and 4. As the feelings of guilt, fear, and shame increased, life was characterized by being in "constant turmoil" filled with anger, resentment and hatred. Depression and suicidal ideation were not uncommon.

> . . . I seriously thought and talked of suicide, but lacked the guts to do it. But drinking myself to death was too slow and painful. . . .

The drinking days were characterized as being progressively "intolerable" and "unmanageable." The final "wet" years, for many, had been a search and a "struggle" to find the means to quit drinking, with many stops and starts. The subjects had tried a variety of strategies--psychiatry (sometimes with the addition of antabuse), religion, and pastoral counseling--before finding AA. Alcoholics Anonymous was either the only form of treatment or was an adjunct

to a structured treatment program, but was viewed almost always as a "last resort."

> . . . I told the counselor I am an alcoholic and she said she couldn't help me--I would have to go to AA. Now I really was scared. I had no idea what to expect but I thought the worse. I thought I had really done it now. . . Somehow I got to a meeting that night feeling sorry for myself that I had "come to this." Ugh! Repulsion!

The final days had led to the loss of jobs, friends, family, and most importantly the "loss of self-respect."

These individuals had finally come to the realization that they had to drink. As one subject related,

> . . . I am an alcoholic and we alcoholics, defenseless under our own power, have to drink when something happens. When anything happens good, bad or indifferent. And we have to drink when nothing happens. . . .

The point, however, was reached, for each of the subjects, where they felt "completely defeated"--"physically, mentally and spiritually broke."

A look at the present. The subjects reported the journey into sobriety was entered into with fear and trepidation.

> . . . No alcoholic likes change in their lives--we want things to stay the same old way they've always been. We're scared to death to adjust to all these changes being made in our life. . . .

The subjects found their way to AA through the urgings of colleagues, family, or through self-referral.

The fellowship of Alcoholics Anonymous provided an environment that was nurturing, supportive, and conducive to personal growth. There are no dues for membership--only a sincere desire to quit drinking.

> . . . They were laughing and joking and hugging and talking like they were enjoying themselves. I felt as if I really belonged. I felt as if I had come home. They accepted me. No matter what I had done they loved me--they told me so. It has been a long time since anyone had told me that. It had been a long time since anyone had acted glad to see me. . . .
>
> . . . [after a slip] I felt so humiliated. They asked me to read How it Works and I stuttered, cried, fell over words and didn't think I could finish it but they made me do it without judgement or criticism, just love and concern. They were all very very supportive. . . .
>
> . . . From the very first, I recognized in AA some people who had something I wanted--sobriety. It was important to me that there seemed to be so many different kinds of folks at the AA meetings. I did not fit in well at first, and did not feel close to anyone, but as a group they did make me feel welcome and I did feel they knew what they were talking about. . . .
>
> . . . But, I saw people who had what I wanted, so I was willing to do what they told me to do. . . .
>
> . . . I rubbed shoulders with the successful people in AA. I admired them--I saw something in their faces, a kind of glow, I saw the fear was being removed from them. . . .

Family and friends were not always supportive and were more often than not skeptical of these changes that were coming about in this other person. For some, families represented a positive force. For others there was discord, separations, divorce, and remarriages to cope with during the early years of sobriety. Those who experienced family as a positive force had family members who had been active in AlAnon either prior, during, or after the recovery process began.

> . . . The support I have received from my husband has been tremendous. I do not believe I could have achieved 4 years without it. . . .

Friends were not always supportive and the subjects found they had to make new friends and associates.

> . . . In the first few months I felt very fragile and vulnerable, and she was my primary buffer and the major person in my support system. (still is!) She was, and is, supportive and loving, and I could tell her anything . . . She was my surrogate sponsor until I found one/two/three in AA. . . . The rest of my support system was invaluable to me. I picked up new supporters, people I had known for years crossed my path and said "I'm behind you" and people I had never known before . . . who says we live as entities unto ourselves, in an uncaring, unfriendly world. Bull!

Initial concerns of many of the subjects dealt with whether the "program" would or would not work. Yet, as one subject expressed, "I had never felt as if I knew how to live and here were 12 steps like a recipe. I latched onto them and was gung ho."

> . . . I latched on to the simple things AA had to offer--the simple truths. The program has been so simple; filled with so much meaning--I call it classic. . . .

Initially, the fears were associated with all the concomitant changes, including the acceptance of being an alcoholic. Sobriety was not an instant happening. The first year, in particular, was described as being one of confusion and indecision. Some characterized this period as, "I was dry--not sober." For some, the compulsion/obsession to drink was "instantly removed" but for others, "I'm still fighting a drink, and fighting other things."

> . . . I'm not drinking, but I don't understand my feelings. . . .

> . . . I don't know when the obsession to solve my problems with drink left, but I know it was shortly after I started taking the third step. I think that's the turning point for most of us . . . .

This first year was a time of becoming aware and acknowledging feelings. Several considered that "fear accompanied everything I did." Another related it as "I was afraid to live and afraid to die." There were fears associated with brain damage from alcohol abuse (proved wrong), mental problems, as well as the fear of drinking again. ". . . if I took the first drink, I'd never be able to get sober." Other fears were related to the willingness to make the "commitment it took to gain sobriety."

> . . . The first few days I was really scared I would have D.T.'s, . . . the mental anguish was excruciating. I felt guilt, remorse, self-hate, anger, self-pity, I hated God for doing this to me or allowing this to happen. I think I ran the gamut on negative feelings. . . .
>
> . . . Initially I was very fearful as evidenced by my hostility, arrogance, and defiance. . . .

Sobriety appears to be an individual achievement without a specific time frame or limitation. As one subject described, "there are levels of sobriety, it depends on the person and how much they want to change."

For some, then, it is as if the self congeals at some point, while others have through their experiences and their desire gained a fluidity of self that allows for continued growth and change. This fluidity does not allow for a passive battering of the self by the tides of life, but is based on an active acceptance of life on life's terms (the ups and downs) and upon making choices and decisions based on reality.

Characteristics/Attributes of Sobriety

During the analysis phase, it became increasingly evident, that like alcoholism, sobriety was a disjunctive concept. The characteristics and attributes reported varied in number as well as in the reported depth of the experience. It was apparent from the data that the individual creates what the experience (sobriety) means for him.

Taking into consideration the variations among individuals, certain characteristics and attributes of what constituted this entity called sobriety emerged from the data. These were:

Abstinence. Abstaining from alcohol is a critical characteristic. The journey to sobriety, this new life, begins with the cessation of drinking. The majority of the subjects did not believe in "slips." Some had tried "controlled drinking" to no avail, and as one subject expressed,

> . . . Concerning slips, I had one after 10 months in the program. There is no other reason other than I decided to see if I could drink like a normal person . . . At this point I realized that again I was alcoholic--I could not & never would be able to drink like a normal person--this is something any drunk must believe 100% if he intends to stay sober. . . .
>
> . . . Sobriety is . . . the mind under no influence other than that of a spiritual program . . . .
>
> . . . To be quite honest I'm scared to death of picking up that first drink again, because I know that if I do I'll be dead. I've already hit rock bottom and I honestly don't feel like I have another chance at life. The only thing that would be left for me, would be to die, the grave. . . .

Sobriety is considered to be more than mere abstinence. Abstinence, only, is being dry. This state of dryness does not imply the personal growth that is considered inherent in sobriety.

> . . . someone could take step one--admit and accept--and abstain; but they would only be "dry" . . . .

Acceptance. Acceptance took several forms: (a) acceptance of being an alcoholic, (b) the acceptance that the subjects could not "handle the problem" themselves, and (c) acceptance of and by others.

> . . . it was hard for me to accept the fact I was an alcoholic; I began to make these changes because I was sick and tired of living in hell, and I wanted to stay sober more than I wanted to stay drunk. . . .

> . . . I feel like, for me, I really have to accept that I am an alcoholic before I can began to do something about it. If I'm only admitting I'm an alcoholic, then I'm lying to myself and everybody else therefore I going to have a relapse. . . .

Accepting that they were not and could not be self-sufficient was expressed as,

> . . . I began to accept in a grudging way that I couldn't recover on my own. I had tried too many times and failed. I knew what I had to do . . . .

> . . . I thought I could handle my drinking problem all by myself and that I didn't need nobody's help. I could do it on my own. But I was wrong. So I gained sobriety by reaching out for help . . . .

The first step of the AA program (Appendix D) speaks to a person's powerlessness over alcohol and the unmanageability of their lives. It was this sense of powerlessness and hopelessness that brought them to AA as the last resort.

> . . . The first step revealed to us our hopelessness--particularly if no help was available. . . .

> . . . I realized I had never taken the first step those first three months because I was thinking in the back of my mind maybe I'm not really an alcoholic. That last drunk convinced me. I accepted it. Not overnight but I knew in my gut that I could not drink alcohol if I wanted to live any semblance of a sane life. . . .

Acceptance of the self by others was given unconditionally in the fellowship of AA. For some this was a new and different feeling--this sense of belonging.

> . . . as a group they made me feel welcome. . . .

> . . . I felt as if I really belonged. I felt as if I had come home. They accepted me. . . .

Dependence on a higher power and reliance on spiritual principles. If the alcoholic, could not "recover on [his] own," where could he go for help? Belief in, or a willingness to believe in, some higher power that could provide help is the essence of the second step of the program. The members of the AA fellowship demonstrated through their behavior that something worked.

To perceive God as understanding, loving, and forgiving required new thinking, as the god of the drinking years had been a "bookkeeper, a punisher, a judge." He had been sought and the subjects had felt rejection and alienation.

> . . . The second step gave hope for ourselves. It was important to listen to others . . . and if it worked--there is hope. . . .

> . . . initially I was not sure that Aa would work for me--particularly since I did not know if there was a "God" or, if there was, whether I believed in "him." Again, I was told "all it takes is to be willing or just be willing to be willing." This was all I needed to know to begin. . . .

> . . . God as we understand him--not the Baptist God or the Presbyterian God, but God as you understand him--some sort of higher power--we're not selling religion, personally I choose God. . . .

> . . . Slowly but surely I began to accept God back into my life and I started to let him manage it for me, because I knew I couldn't. . . .

> . . . the alcoholic is a person out of control
> . . . we have to get hold of something that will allow us to have choices--once we start a 1-to-1 relationship with the god of our understanding we realize we have choices. . . .

> . . . In the third step I handed my will and life over to the care of God. I did this exactly as the Big Book suggests--I got down on my knees with a friend and prayed the third step prayer. I found this difficult and embarrassing but I was willing to do what ever I had to do to recover. Shortly after doing this the obsession left me and has not returned. . . .

Continued sobriety was described as being "contingent upon a daily spiritual program." This daily program assisted in dealing with all problems of living.

> . . . The insanity of not only drink but the emotional turmoil and negative feelings, if [we are] not on a spiritual grounding, the old ways and old behaviors will return. . . .

> . . . My slip came about because . . . I got away from my "higher power" and took back control of my life. Thanks to AA and my previous treatment I was aware of my actions and was able to take positive steps to again get back on the program . . . .

> . . . The lesser problems have been approached in the AA fashion--thinking them through, arriving at a tentative decision based on what I feel is right (God's will?), waiting and, if I have no strong feeling to the contrary, implementing the decision when the times comes. . . .

> . . . I have, however, learned a few things in 2 1/2 years, [one of] the two most important being: 1) That there is a God who can help with my drinking problem and my problem of self. . . .

Freedom. Freedom was described as not only the freedom from, as in the obsession to drink, but also as a freedom to live. This freedom "from" as well as the freedom "to" was expressed as,

> . . . a feeling of release or freedom from the need to drink. . ..

> . . . one word . . . freedom--especially the freedom from fear . . . freedom to do things in my life I was unable to do in the past . . . fear of failure was less. . . .

> . . . Life for me today is good. I have become more at ease with myself, with other people and with my Creator. I know a freedom that I have never known before. I don't want to go back to "yesterday". . . .

Choices. Consistently, the drinking years were described as a time of "not knowing I had choices." These

choices were concerned not only about the use of alcohol, but with regard to other behaviors, persons, and situations.

> . . . This same God gave me the power to make choices, and will help with my choices if I but ask. My most frequent prayer is that God help me make the right choices. . . .
>
> . . . grateful not for the material things I have in life, but just for being able to have a choice to stay sober on a day to day basis. . . .
>
> . . . I know that today I have choices. I never knew that before. My choice is to go for the best my program of recovery has to offer--that is to be joyous happy & free. . . .
>
> . . . without sobriety I have removed all options which may lead to a comfortable existence during my brief stay on this planet. . . .

Changes (perceptions of self and others). This new life required changes in thinking and perception. Change was viewed as "scary" but necessary for this new way of life. Sobriety was described as a:

> . . . byproduct of the way we think and live. Sometimes its good, sometimes pretty good but always much better than what we was doing before . . . .
>
> . . . I also learned that if I intended to stay sober for any amount of time, I would have to change in all areas of my life. . . .

Subjects described their perception of "self" as changing to now "being important enough to be concerned about."

> . . . I have a new feelings of self-respect that I never had in the past. . . .

Increasingly, they were able not only to trust themselves and their own judgment but to trust others.

Honesty (self, others, God). Being honest with self, others, and God, was seen as a means to facilitate growth and change. The subjects learned about their behavior and considered the consequences by taking an inventory. The honest, personal appraisal in the completed inventory was then confessed to another person, as well as to God. Later, that confession was translated into action by making amends to those whom the alcoholic may have harmed.

> . . . The rest is action. We make a decision to turn our will over, we take the inventory, we admit to God and another our shortcomings . . . in the inventory, you see where you have moral character defects--we're not talking about immoral character defects--but moral character defects--where you're selfish, self-centered, get angry real fast, have these pity parties--but if you will make a decision in third step . . . then you can gain peace with God and peace with self. . . .

> . . . You got to get the garbage out--and that's all it is--old stuff--that we don't want anyone to know . . . I have to get rid of it, have to get rid of the bad feelings I had toward others and toward my own self. . . .

> . . . I decided that if I did not do something about the emotional pain and character defects I would go back to drinking again and so I completed a searching and fearless moral inventory. . . .

> . . . you can't give away what you don't have. I have no peace, but I have not done a 4th step . . . .
>
> . . . After taking the fifth step I experienced a great peace. Now I could look at any human being in the eye because there was someone who knew everything there was to know about me. . . .
>
> . . . told I needed to settle up with some of my creditors. . . .
>
> . . . I also reached the point where I could become more honest about my past. I went to see the new boss I got about my first year of sobriety and talked to him about my past problem and got good support and acceptance from him. . . .

Service. While the alcoholic, by individual admission, is selfish and self-serving, the person experiencing sobriety is not only aware of personal needs but is cognizant of the needs of others. Some subjects were concerned with being more "useful in this world."

> . . . This carry the message [12th step] . . . is what service is all about; ministering to other alcoholics (either wet or dry), speaking, going to meetings. . . .
>
> . . . I think that's why it is so important for me to work with other alcoholics because it keeps me knowing but for the grace of God go I. . . .

Transformation. Although personal growth was a descriptor, the most powerful term that was used to describe the achievement of sobriety was transformation.

> . . . Sobriety is not a negative avoidance of alcohol. It is a positive action of personal

> transformation . . . a continuous effort at personal growth and transformation. . . .
>
> . . . The Great Healer and the Great Doer, the Great Transformer of AA is the God as we understand Him. . . .

The future. Sobriety, as the product of living this new way, had its rewards. The consequences were described in terms of the new found freedom and confidence of others, as well as "the golden years." Yet, sobriety was not viewed as a shield from the vicissitudes of life. As one subject described it,

> . . . I would not want anyone to believe that since I have been sober that I have been shielded from the pain, difficulty, & loss that is part of life for everyone. I have had my share of all of these things. I'm sure I will have more, but if I stay close to AA (people) and the God of my understanding I will not have to get drunk about them. . . .

Working the program also brought about the realization of the promises as stated in Alcoholics Anonymous (Appendix E). As one subject stated,

> . . . I could not recognize that things were happening to me, not on my schedule, but on a better schedule. The promises on page 83-84 of the big book were coming true. . . .

Continued sobriety was described as being dependent upon "working the program," going to meetings, and helping others. The AA program was considered the "mainstay" of maintaining sobriety and was considered a spiritual program.

> . . . The AA program is not an intellectual program. It is much like learning to ride a bicycle--you have to get your ass up and start pedaling--if you don't nothing is going to happen, and it takes time. . . .
>
> . . . I am increasingly convinced that continued sobriety (abstinence) is contingent upon working a daily spiritual program which consists of specific daily actions centering on steps 10, 11, 12. Specific things I do even when I do not feel like it, even when it is raining, even when I am on vacation, weekdays, weekends, summer and winter, year in and year out. . . .

For the recovering alcoholic, sobriety means "life," that second chance that may never pass this way again. As was noted, sobriety was "a gift from God that brought my mind from the bottom of mental anguish to the serenity of acceptance"--"I could not live without it"--"without sobriety nothing else counts." Thus, sobriety represents the ultimate value: LIFE!

Definition

The subjects defined sobriety in a variety of ways. The following definition is a composite of their definitions:

> Sobriety is a lifestyle, without chemicals, actively chosen and individually created, consisting of constructive positive changes in behavior and attitudinal patterns. A life of sobriety is characterized by abstinence, dependence on a higher power, choices, freedom, acceptance, honesty and service. The fruits of sobriety are humility, love, and peace of mind. This personal transformation requires a re-education of the mind, reliance on spiritual principles, and

changes in all areas of life: physical, emotional and spiritual.

Summary

Seventeen research subjects submitted documents for analysis and interpretation. The analysis took the form of "bracketing" in terms of what sobriety meant for the individual. The subjects validated the documentation during a group meeting.

The subjects were able to document what the experience (sobriety) meant to them. From the data it was possible to form a set of characteristics and attributes of sobriety. From the definitions provided in the documents, a composite definition was conceptualized.

CHAPTER V

Discussion, Conclusions, Implications, and Recommendations

Discussion

Qualitative research methodology is a journey in discovery. Aamodt (1983) discusses four dimensions that emerge as a result of qualitative (inductive) research. Three of these dimensions are: (a) the development of constructs or variables for Level I Theory: in this case, a definition of the term with its meaning and significance for those experiencing the concept; (b) context: in this instance, the meaning and significance as related to the AA experience; and (c) contributions to nursing: the detailed observations of the meaning such as the characteristics and attributes of the object or event under study to facilitate nursing interventions and the conceptualization that is necessary for building nursing theory. These dimensions as a means of examining this research experience are congruent with Bracket III: What it means for the world in general.

Conceptualization/Sensitization

Commonly, sobriety has been viewed as a lifestyle not only free from alcohol, but grim, sedate, and proper. The

American Heritage Dictionary (1982) defines sober as " . . . to make serious, grave or thoughtful . . . to become settled or quiet . . . or to become sober after being drunk" and sobriety as "the quality or state of being sober" (p. 1159). It was Fielding (1953) who coined the phrase, "sober as a judge . . . be sober in all things . . ." (p. 128). Much folklore arose about sobriety, and the ancient Greeks wore amethysts to protect their sobriety (Frazer, 1922).

The subjects in this study were not particularly grim or sedate. The documents expressed feelings of happiness and contentment, of "being happy, joyous, and free." These descripters are more congruent with Plato's usage of the word sophrosyne. ". . . he sets in order his own inner life . . . and at peace with himself . . . then he begins to act" (Kaplan, 1951, p. 301). The subjects described a life of balance; not an end, but of becoming. Achievement of perfection is not expected, but progress toward the goal is the mark of a successful recovering alcoholic. It is a lifestyle that is self-created out of the chaos and ashes of the past.

The subjects spoke to the concept of freedom, of being released from the obsession to drink. This attitude of freedom does not allow individuals to forget the chains that bound, but gives them the freedom to act as "free" men. "Every lifestyle . . . is based on a personal decision of

choice" (Solomon, 1972, p. 212). So the recovering alcoholic makes a conscious, daily choice not to take the first drink. The recovering alcoholic stops blaming others, stops manipulating/using others and takes the responsibility for personal health and happiness.

This freedom demands choices. Man chooses according to the evaluation that he makes of situations and circumstances. "Once one faces the possibility that there are more ways of living, of perceiving, of becoming, than one's own way, there is no turning back. One must make decisions, perhaps painful decisions" (Morris, 1977, p. 87). The choice of sobriety becomes the ultimate value--for to drink is to die.

The terminology used to express the feelings experienced in sobriety are in direct contrast to those expressed when still practicing active alcoholism. These feelings expressed were self-respect and self-acceptance; choices in relation to all decisions in life; responsibility for self; growth and self-discovery; a quality of life that has purpose and positive relationships with others; and coping without chemicals.

From this analysis sobriety can be viewed as a process of becoming--a way of life. Sobriety is a lifestyle characterized not just by abstinence, but by the individual's internalization and exhibition of different attitudes, values, and behaviors.

Alcoholics Anonymous, the fellowship and the program, were identified as vital forces in gaining and maintaining sobriety. From the reports, it is anticipated there would be a greater understanding of both these aspects: the fellowship that provides a support group, and the program that provides the guidelines for the new way of life.

The Model: Role--An Interactionist Perspective

As was noted in the literature review, no consistent framework or definition existed for the study of the phenomenon of sobriety. The data reported here could have been made to "fit" the studies done previously. These studies described sobriety as a growth/developmental process (Brown, 1985; Gerard, Saenger, & Wile, 1962; Melvin, 1984). However, clinical observations and discussions with clients contributed to the feeling of "something missing" in these models. This "something more" had been alluded to by several of the previous researchers. The statements, categories, and feelings expressed by the subjects can be applied to role theory from an interactionist perspective.

A major difference between symbolic interaction and other areas of sociological thought is in the treatment of the concept of role. Rose (1962) defines role as ". . . a cluster of related meanings and values that guide and direct an individual's behavior in a given social setting" (p. 43). Thus, roles are not only defined but are created, mastered,

or modified as a result of interactions. In relation to the present study, then, sobriety could be viewed as a role--a reality--that persons actively create.

This process of role creation, mastery, or modification, to be effective, is continuous and undergoes constant modification as necessary. Role-taking, in this context, is congruent with Turner's (1966) commentary on role-taking. Roles, then, are not "neat little packages of behavior controlled by a set of rules; rather, these roles are perceived as relationships between what a person does and what others do" (Lambert & Lambert, 1981, p. 11).

Thornton and Nardi (1975) described four stages in role acquisition: anticipatory, formal, informal, and personal. Role acquisition occurs after anticipation, learning expectations (anticipatory, informal, formal), and by formulating, reacting, and reconciling these expectations. Lambert and Lambert (1981) maintain that an unsuccessful acquisition will result in a sense of powerlessness.

Role insufficiency: The practicing alcoholic. Meleis (1975) described any difficulty in role acquisition as role insufficiency. Role insufficiency could occur as a result of poor role definition (anticipatory), lack of knowledge of role behaviors (anticipatory, informal, formal) or a refusal to enact the role (personal).

The documents revealed terms and feelings of the subjects that validate the use of role insufficiency as an

appropriate term for the practicing alcoholic. As human beings they expressed feelings of inferiority, of being an outsider in life, of having a sense of impending doom, of negative thoughts, of feeling and being morally and spiritually bankrupt, of experiencing depression and suicidal ideation. Then came the pleas for help.

Meleis (1975) described the feelings demonstrated in involuntary role insufficiency as "anxiety, depression, apathy, frustrations, powerlessness, unhappiness and/or aggression and hostility" (p. 267). Thus the feelings expressed by the subjects of this research are congruent with the model.

The documents described struggle with "self-acceptance" and with "feeling good about self." It is only through the internalization of the "generalized other" that an individual develops an integrated self-concept with the ability to be self-critical (Sarbin, 1954).

Role supplementation. Benne (1976) queried, "Through what processes do men and women alter, replace, or transcend patterns of thinking, valuation, volition, or overt behavior by which they have previously managed and justified their lives into patterns of thinking?" (p. 26). Meleis (1985) describes any activities aimed at facilitating the change from role insufficiency to role mastery as role supplementation.

There are primarily three strategies in role supplementation: role modeling, role rehearsal, and reference group interaction. The documents revealed the subjects had participated in activities that could be categorized by the three types of strategies. In fact, the "superficial" attitudes toward the role supplementation activities led to the "slip" or relapse.

Role modeling occurs when an individual is able to imitate and understand a role a significant other is observed enacting (Meleis, 1975). Examples cited by the subjects validating role modeling were the use of peer counselors (recovering alcoholics), time spent talking with the sponsor or wise confidant and ultimately helping others.

Role rehearsal is defined as a time when

> The individual mentally enacts his role, anticipating in imagination the responses of significant others . . . role rehearsal enables the individual and other in a . . . situation to master the behavior and sentiment associated with the transitional roles. . . . (Meleis, 1975, p. 286)

These subjects had invested time to imagine the new role. Sarbin (1954) describes this as engaging in "as if" behavior. "This conceptual process cannot be performed if the person lacks the ability to bind time and tension, a function of the development of the self" (p. 199). Some of the subjects had been involved in structured treatment programs that separated them from everyday stress. Thus they had the time to concentrate on self, on the

identification of changes that were necessary, and were given tools for bringing about the changes, as well as the opportunity to practice the new skills in a semiprotected environment. For the others, self-discipline, coupled with the desire not to drink and the daily working of the program of AA, facilitated the imaging of the new role.

Reference group interaction refers to the significant other and/or others who may reinforce the new roles. Turner (1966) describes three usages of "reference group": (a) "a group with which one compares himself in making a self-judgment," (b) "the source of an individual's values" . . . and (c) "a group whose acceptance one seeks" (p. 157).

All the subjects expressed the support they had received through attending Alcoholics Anonymous. Alcoholics Anonymous certainly meets Turner's usage of "reference group." The group is one in which the person seeks to be like "the winners," the program becomes the way to realize a new value system, and certainly the person seeks and receives the acceptance of the group.

Role mastery: The recovering alcoholic experiencing sobriety. Successful role enactment is known as role mastery. Sobriety, as the antithesis of alcoholism, is role mastery. The "something more" alluded to in the literature would appear to be the magnitude of the role change. Sobriety is not role transition, or a passage from one stage to another, but rather a complete realignment of the person

with a new set of role behaviors, a change in nature and character which is role transformation.

Sobriety, as viewed from the perspective of the individual experiencing such, revealed a role change of greater magnitude than in the opinion of the researcher is commonly considered. The three-dimensionality of the illness (physical, emotional, spiritual) describes the magnitude of the role change that is necessary. The documents spoke to the finding of self--the transformation of the "persona"--the totality of being that is necessary for this new life to occur.

The documents spoke to a "personal transformation" and to a "re-education of the mind." Sobriety, then, as a role, is that which is actively created and mastered. Role transition may well be an appropriate term for roles that are added on, but it is opined that, in certain instances, a more appropriate term, as in this case, the change from practicing alcoholic to a person experiencing sobriety is indeed role transformation.

Conclusions

The synthesis of the data to arrive at a definition with the characteristics and attributes of one who is experiencing sobriety, at least in the context of AA, is an example of the outcomes of research designed to answer the question, "What is this thing, or factor-isolating theory?" (Diers, 1979). The relationship of the concept to the model

is designated as Level 2 activity, or factor-relating theory.

The findings as related to the model and the recommended refinement to include the concept of role transformation completes and redefines the model as presented in Chapter I: Introduction. Nursing was presented as a multiparadigmatic discipline requiring knowledge of order, disorder, and control. These concepts are considered applicable to the knowledge required to intervene with the alcoholic client. The relationship of nursing knowledge and the concepts under discussion are depicted in Figure 3.

While still drinking, the alcoholic exhibits behavior which could be labeled as role insufficiency (knowledge of disorder). The abstinent alcoholic has difficulty in the areas of human response to self, to family, to others. Any treatment program would have as a component activities aimed toward role-supplementation (knowledge of control). The recovery period, this time of gaining and maintaining sobriety, could be interpreted as a process of role mastery (knowledge of order). Thus sobriety represents both a human response as well as role mastery. Knowledge of order, or what constitutes role mastery, is necessary to arrive at appropriate application of knowledge of control.

Nursing, as the diagnosis and treatment of the human response to actual or potential health problems, provides a metaparadigm (set of beliefs) for further organization and

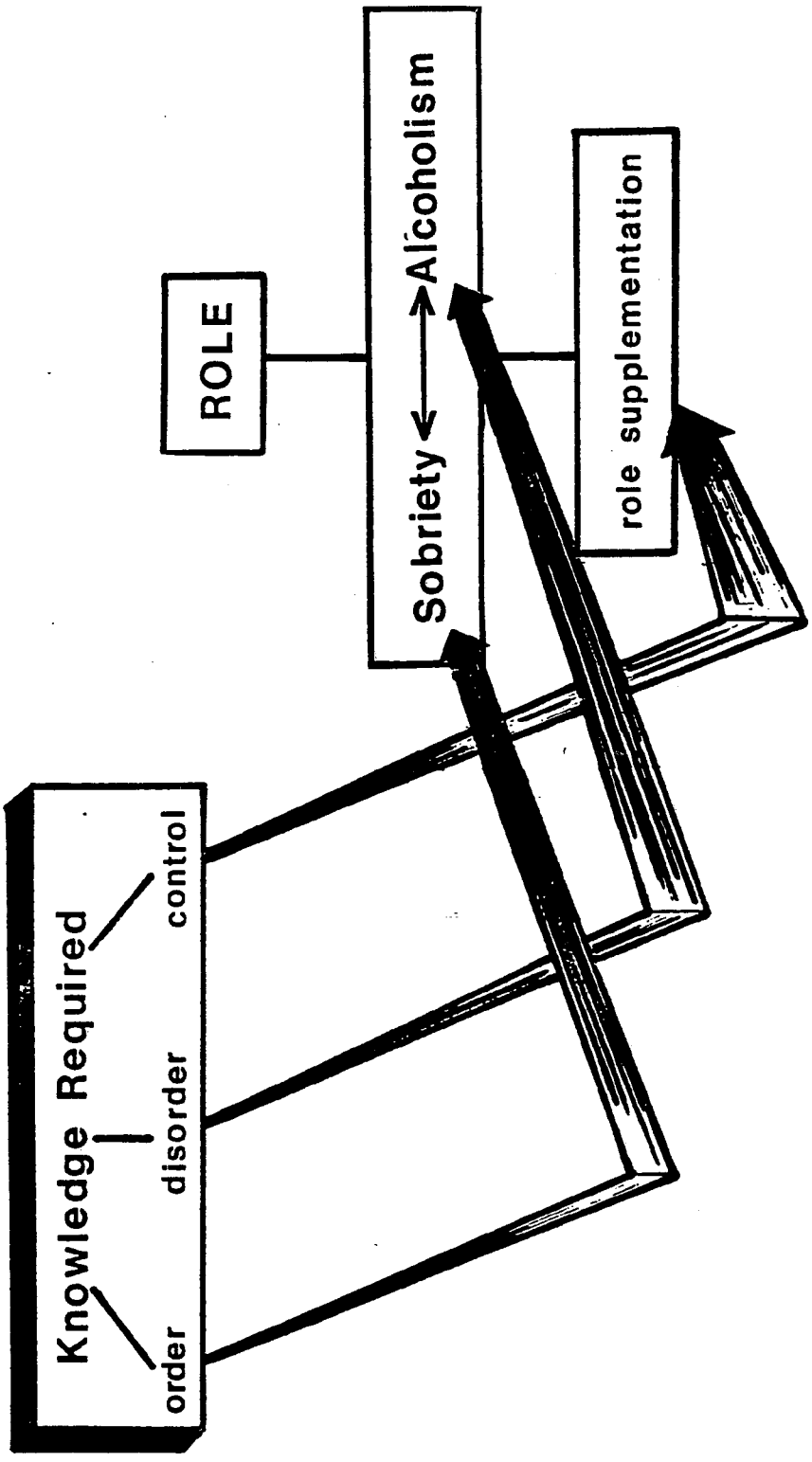

Figure 3. Required nursing knowledge.

structuring of knowledge as well as providing direction for nursing actions. Refinement of the metaparadigm, at the level of the disciplinary matrix (Social Definition Paradigm), provides direction for categorizing or explaining the nature of the human response to the health problem (knowledge of order and disorder). The theories within the Social Definition Paradigm provide avenues for translation of knowledge into action as a means for solving the puzzle. Phenomenological sociology serves as a means of investigating the human response. The findings were consistent with and completed the theoretical perspective (Figure 4). Symbolic interaction did provide a theoretical basis for the most restrictive level for puzzle-solving; that of role. Role, as a creation, refers to those meanings (behavior) that evolve from human interaction. Within this framework nursing recognizes role insufficiencies (disorder) and responds with role supplementation activities (knowledge of control). This knowledge of control is particularly useful to the nurse clinician as she designs and implements nursing strategies.

"Any conceptual model is valid insofar as it is reasonably sound with regard to the particular anthropology employed (i.e., man as developing, adapting, interacting)" (Zbilut, 1978, p. 129). The material as presented is considered, therefore, a valid conceptual schema for the

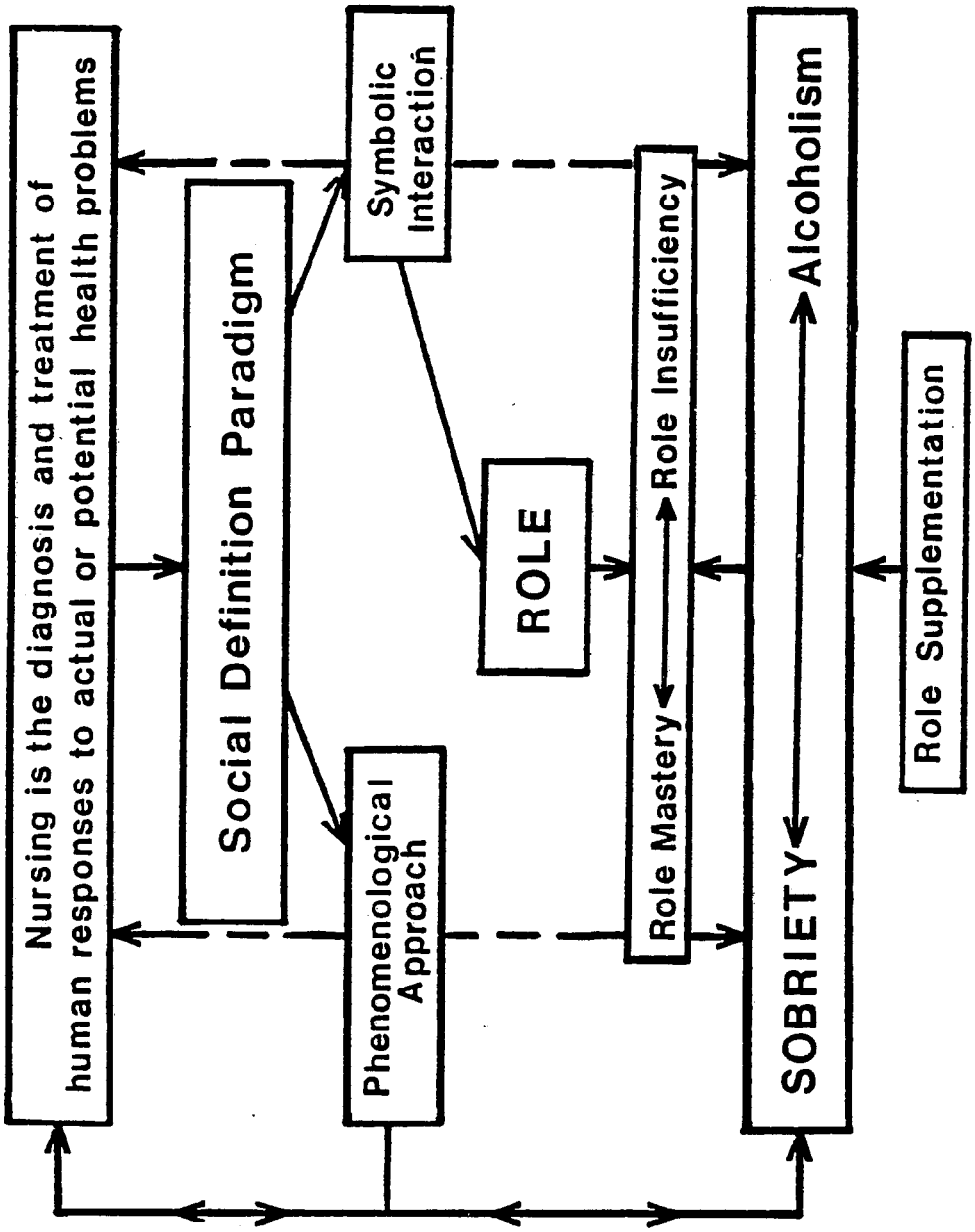

Figure 4. Nursing, Social Definition Paradigm, and sobriety.

investigation of sobriety and has resulted in increasing knowledge of order.

Implications

Gulino (1982) was concerned that the facets of human experience which are subjective in nature are not perceived by the nurse or become distorted due to her empirical perspective. Gulino concludes that it is possible to gain "insight into those aspects of man that are unique to the individual and which elude scientific scrutiny if we open ourselves to approaches that are concerned with man's subjectivity" (p. 353). The discovery of the meaning (the definition, characteristics/attributes) of sobriety, as well as the significance (the ultimate value--life), has import for nursing, particularly in the areas of research, practice, and education.

This study sought to gain insight into and awareness of a human subjective experience. The project demonstrated the value of seeking reality from the perspective of the individual experiencing the phenomenon. Much of what we know about abstract human responses is derived from our own singular experience. The product of this research, the meaning and significance of sobriety, was not the result of an intellectual exercise, but rather was derived from the perspective of those who had experienced the phenomenon.

This basic research could lead to further investigations in several areas. Both qualitative and quantitative

methodology could be used in the continuing investigations into the nature of this phenomenon. Qualitative methodology, grounded theory or ethnomethodology, could be employed to discover if there is a theory of sobriety, and what is the structure or rules whereby this reality is made manifest. Quantitative studies could be conducted to develop tools by which to measure the characteristics, and exploration of the interrelationships of the characteristics and their relative magnitude. Quantitative studies, then, would amplify the "representativeness, frequency, and correlation of the knowing founded" (Lofland, 1971, p. 6) on the qualitative studies.

It is the opinion of this researcher that the definition as presented has promise for understanding and intervening in the treatment of the alcoholic. The apparent need for the "self" to be disassembled and reassembled for sobriety to occur has impact for the helping professions in terms of identifying a framework for treatment activities. It is the judgment of this researcher that the model as presented has positive implications for nursing practice. Therefore, it is recommended that nursing's role in both preventive as well as therapeutic role supplementation activities be explored. Meleis (1975) has suggested that the earlier role supplementation activities begin, the less the degree of role insufficiency. Thus the identification of those at risk for the development of alcoholism and the

appropriate and timely interventions to prevent role insufficiency would be classified as illness prevention activities. In the treatment phase, further exploration of role supplementation activities could be made, perhaps utilizing Lewin's re-education model (as cited in Benne, 1976). To prevent the relapse syndrome, the need would be to identify deficit areas and to intensify activities during follow-up and aftercare to deter role insufficiency and to reinforce the positive strategies.

Alcoholism is a chronic illness: thus, like all chronic illnesses it is subject to relapse. The subjects of this research, in the majority, do not believe in "slips," or the relapse phenomena. Of those that have had problems, they found the "slips" occurred prior to the unconditional acceptance of the fact they were "powerless over alcohol" or they drank again in response to a person or to a situation (as out of anger or frustration). As one individual stated, the program "was my medicine to help keep my disease arrested." Research into the relapse phenomena would lead to the identification of clues or warning signals that could be vital in the prevention of relapse.

We are aware of the diabetic who overeats or does not take the medication out of anger or as a means of manipulating or controlling others. Certainly the hypertensive or the diabetic is just as "powerless" over his or her illness, and perhaps this concept could be used to assist in managing

such problems. This framework would certainly be a valid one upon which to base practice and research into the human response system.

Increasingly, in the educational setting, content is being included in the curriculum relevant to alcoholism. This study provides data relevant to the proposed outcome of the treatment process. A model has been presented that can be utilized in the classroom setting to describe not only knowledge of disorder, but of order and control.

Sobriety, as presented by those experiencing such, represents the ultimate value: life. With increased awareness of this human response to an identified illness, improved strategies for the intervention in the prevention, treatment, and aftercare of alcoholics might be forthcoming. It is difficult to plan appropriate strategies when the outcomes of treatment are not fully understood. The impact of Alcoholics Anonymous on these individuals cannot be taken lightly. Greater understanding of this support group and its impact should lead to more client referrals to this source of help either as a primary source of treatment or as an adjunct to other forms of therapy.

Recommendations

The following recommendations are made as a result of this study:

1. Further investigation of the nature of the concept of sobriety using both qualitative and quantitative approaches.

2. A comparative study of sobriety be made between those who have gained sobriety through Alcoholics Anonymous and through other treatment modalities.

3. An exploration be done of the concept of role transformation in other chronic illnesses.

4. An exploration be made of strategies that would fulfill the criteria for therapeutic role supplementation activities.

5. An exploration be done of the relapse phenomena with implications for practice.

6. An exploration be made of preventive activities-interventions targeted toward high-risk populations.

7. An exploration of the concept of sobriety and its corollaries in other 12-Step Programs, such as Over-Eaters Anonymous.

Summary

Sobriety as a concept has been discussed in relation to historical definitions and perspectives. Differences were noted as described within the context of this sample.

Role, from an interactionist perspective, with the components of role insufficiency, role mastery, and role supplementation, was consistent with the discovered data. Sobriety, as the human response, the outcome of role

supplementation activities targeted toward the alcoholic, constitutes role mastery. The AA fellowship and program have been shown to be examples of role supplementation activities.

In the researcher's judgment, the change from alcoholic to the person experiencing sobriety constitutes a change of greater magnitude than can be accounted for by the term role transition. Therefore, the model is refined to include the term role transformation.

Sobriety has been placed within a nursing framework as a human response to a chronic illness. This study constituted Level 1 (factor-isolating) as well as Level 2 (factor-relating) activities. Implications for nursing have been suggested in terms of further research and application to nursing practice.

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Appendix A

Subject Consent Form

Subject No._____

Nancy Herban, a doctoral student in nursing at the University of Alabama at Birmingham, is studying the concept of sobriety. In order to do this study she needs biographical data from recovering alcoholics who have achieved a minimum of one year's sobriety. This study may produce data that will be helpful during the alcoholic treatment process as well as during the period of follow-up and aftercare.

The study has been explained to me and if I agree to participate I am aware that:

1. I will complete the biographical data as requested. She has explained to me that the names will be separated from the responses and the names will be coded and locked so my confidentiality will be protected as much as possible. I understand that all care and consideration will be taken in the written report to protect my anonymity.

2. I will also participate in interviews using a tape recorder to assist her in clarifying any questions she may have regarding my experience as I have written.

3. Participation in this research is voluntary. I have the right to refuse to participate and the right to withdraw later.

4. If I have any other questions I am free to contact her at any time.

I have received a copy of this form to keep.

Date	Subject's Signature
Date	Investigator's Signature
Date	Witness Signature

Appendix B

Subject No._____

Sobriety Study

Date: ____ ____ _____

DEMOGRAPHIC DATA:

1. Age:_____ 2. Race: ____ ____ ____
C B O

3. Sex: ___ ___ 4. Religion: _____
M F

4. Educational level_____ 6. Marital Status_____
(years completed)

DRINKING HISTORY:

7. Age began drinking: _____

8. Number of years of sobriety (current experience):_____

9. No. of times in treatment: _____

10. Final form of treatment: Hosp.___, ARC___, AA only___, Other_____.

11. Were there family members who were alcoholic or problem drinkers? _____ If so, what was the relationship? _____.

12. What medications are you currently taking? _____

_____

INSTRUCTIONS FOR THE PREPARATION OF BIOGRAPHICAL DATA:

WRITE A HISTORY RELATED TO YOUR EXPERIENCE IN GAINING AND MAINTAINING SOBRIETY; YOUR FEELINGS, THOUGHTS, YOUR STRUGGLES, HOPES AND FEARS, AND WHO AND WHAT WAS IMPORTANT. INCLUDE ANY INFORMATION ABOUT "SLIPS," FAMILY PROBLEMS, AND HOW YOU FELT AND DEALT WITH THE PROBLEMS DURING THIS TIME OF YOUR LIFE.

WHAT DOES SOBRIETY MEAN TO YOU, HOW DO YOU DEFINE IT, AND WHY IS IT IMPORTANT?

Appendix C

Time Schedule

ACTIVITIES	MAR	APR	MAY	JUN	JUL	AUG
Phase I: Precollection						
Proposal approved	———					
Submit proposal to IRB	———					
Gain entrance to clinical site		———				
Solicit participation			———			
Phase II: Data Collection						
Data collection				———		
Phase III: Data Analysis & Interpretation					———	
Data Interpretation						———
Phase IV: Preparation of Report						———

Appendix D

The 12-Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

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Appendix E

The Promises of the Big Book

We are going to know a new freedom and happiness. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and we will know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves.

Are these extravagant promises? We think not. They are being fulfilled among us--sometimes quickly, sometimes slowly. They will always materialize if we work for them.

Alcoholics Anonymous World Service. (1976). Alcoholics Anonymous (3rd ed.). (pp. 83-84). New York: Author.