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Walden University
2023

Abstract

The Lived Experiences of Stress for People With Alcoholism Striving Toward Recovery

by

Gerald C. Okeke

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

August 2023

Abstract

Recovery from alcohol is an individualized process; therefore, effective treatment necessitates an understanding of the phenomenon from the perspective of individuals in recovery. This study involved an exploration of the lived experiences of stress of 10 individuals with alcoholism in their first-year recovery journey, particularly with respect to access to resources (e.g., helpfulness and availability). Pearlin et al.'s stress process theory and Bandura's social learning theory constituted the study's theoretical foundation; the key concepts of social stress and social learning informed the development of the research questions and the analysis of data. The major themes that emerged were spirituality, hitting bottom, goals, identifying progress and accomplishment, confusion, comparing the past with the present and interpersonal connections. The findings concurred with the wider literature in that they highlighted inadequacies with regard to service provision and the negative impact of exclusion and stigma. A further identified concern was the lack of social support, which was also consistent with the literature. The significance of this study resides in its insights on the potential benefits of program consolidation to treat several addictions. Organizational leaders who currently offer several programs may realize cost savings from consolidation. Such consolidation may also be of interest to academic researchers, public policy makers, healthcare professionals, and patients who have an addiction. The development of programs that are useful to individuals with different types of addiction may increase positive social change through the reach of these programs, enabling more individuals to improve their lives through recovery.

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Chapter 1: Introduction to the Study

Alcohol addiction or alcohol use disorder (AUD) is a disease that has a damaging effect on the entire body, especially the brain, heart, pancreas, mouth, liver, and immune system, Cooper Smith (2019). There is incredible diversity in who alcoholism affects. Alcohol does not discriminate based on gender, sex, age, ethnicity, religion, or profession. It can affect anyone's life with the potential of broken relationships, irreversible body damage, and loss of hope for the future, Cooper Smith (2019). The focus of this research study was on understanding the lived experiences of stress from people with alcoholism striving toward recovery who were in their first-year recovery journey. Understanding such experiences is important for health professionals in planning treatment and preventing relapse. The insight and knowledge gained from the lived experiences of people in their first year of recovery may help health professionals in formulating better models of care for individuals in early recovery, Rick Glantz (2002). This study of lived experience may improve researchers' and practitioners' understanding of the stigma, hurdles, discrimination, and barriers that people experience in their first year of recovery. In addition, the analysis may reveal what helps and what hinders individuals in their first-year recovery journey from alcohol.

In 2016, the harmful use of alcohol resulted in some 3 million deaths and 132.6 million disability-adjusted life years (DALYs) worldwide, according to the World Health Organization (2018). Other data from the organization show that mortality resulting from alcohol consumption is higher than that caused by diseases such as tuberculosis, HIV/AIDS, and diabetes. Among men in 2016, an estimated 2.3 million deaths and 106.5

million DALYs were attributed to the consumption of alcohol. Women experienced 0.7 million deaths and 26.1 million DALYs attributed to alcohol consumption. Yet, despite its negative impact, more Americans than ever before consume alcohol on a regular basis (Domonoske, 2017). Thus, understanding the dangers of alcohol abuse and its impact on society may help individuals to make healthier choices. This knowledge may also help health practitioners and researchers to develop effective treatments for individuals with AUD.

Given the gravity of the problem, getting individuals into treatment is critically important. Recovery from alcohol is an individualized process and necessitates understanding the phenomenon from the perspective of the individual living the experience, Laudet White (2004). Becoming sober is not just about not using alcohol anymore. It is also about establishing a new lifestyle that supports one's recovery. A major part of this process is developing new coping strategies to manage stress, anxiety, and cravings (Melemis, 2015). Understanding some of the common challenges people face in addiction recovery during their first-year experience may provide clearer insight on how to help people move into a life in recovery. Stress is seen as part of everyday life, brought on by less-than-ideal situation or perceived threats that foster feelings of anxiety, anger, fear, excitement, or sadness (Stephen & Wand, 2012). The term *stress* generally refers to the reactions of the body to certain events or stimuli that the organism perceives as potentially harmful or distressful. Such stress-inducing events or stimuli, which are referred to as *stressors*, can be either physical (e.g., a physical attack) or psychological (e.g., occupational or familial difficulties) in nature. Taking on a new job, experiencing a

death in the family, moving across the country, breaking up, or getting married are all situations that can result in psychological and physical symptoms collectively known as stress (Brady & Sonne, 1999). Individual people respond differently to different stressors. An event that is perceived as extremely stressful by one person may be perceived as harmless by another (Brady & Sonne, 1999).

One way that people choose to cope with stress is by turning to alcohol. Drinking may lead to positive feelings and relaxation, at least in the short-term. Problems arise, however, when stress is ongoing, and people continue to try and deal with its effects by drinking alcohol. Instead of calming one's nerves, long-term, heavy drinking can lead to a host of medical and psychological problems and increase the risk for alcohol dependence, Baliunas et al., (2009). Thus, the purpose of this study was to identify the stress sources that may lead those with alcohol dependency to relapse during their first-year recovery journey. In this chapter, I provide an overview of the study.

Background

Substance use poses a threat not only to persons with AUD themselves but also to their family members and society. The cost of healthcare in the United States continues to increase. Some of those costs rise from substance abuse-related expenses, and substance abuse and the treatment for this abuse is costly. The estimated cost of substance abuse in the United States is $700 billion annually, (National Institute on Drug Abuse, 2015). In years to come, the prevalence of mental and substance abuse disorders will likely overtake physical diseases as the leading cause of disability in the United States (National Institute on Drug Abuse, 2015; Substance Abuse and Mental Health Services

Administration [SAMHSA], 2016a). Health care leaders continue to work with the public and government leaders to find ways to address substance abuse problems from multiple angles including prevention and treatment. With insight on how people in their first year of recovery experience stress, medical and mental health professionals may be able to determine the best treatment strategy for returning individuals to sobriety and their family and the society at large to normalcy.

When preventive measures fail, treatment becomes necessary. There are many different substance abuse programs. Some scholars have found evidence of a connection between spirituality and recovery by participants in faith-based programs (Brown et al., 2013; Davis, 2014; Ranes et al., 2017; Timmons, 2012; Walton Moss et al., 2013). The program of interest was a 12-step meeting in Dayton Ohio alcohol recovery program. Although there is extensive research on substance abuse and treatment, there is a lack of research on this abuse from the perspective of affected individuals, according to my review of the literature. In many studies, focus was placed on outcomes, program effectiveness, and abstinence from addictive behavior, with little attention given to program participant experiences (Brown et al., 2013; Davis, 2014; Raneset al., 2017; Walton-Moss et al., 2013). This gap in the literature is concerning because management of substance use disorders is riddled with multiple relapses. Research studies show that 65%–70% of abstinent individuals relapse within 1 year (Kadam et al., 2017). The effects of stress and alcohol cues are linked to alcohol's robust effects on the hypothalamic-pituitary-adrenal (HPA) axis, and there is some evidence that these effects are seen prior to the development of AUDs (Blaine & Sinha, 2017). Moustakas (1994) noted the value

of discovering the essence of an experience from the perspective of affected individuals. I sought to contribute such insight in this study.

Problem Statement

Like many addictions, alcoholism is a chronic relapsing disorder. Despite decades of accumulating evidence of the need to address chronic relapse in treatment programs, little cogent progress has been made (Harris & Koob, 2017). Management of substance use disorders is riddled with multiple relapses. Studies show that 65%–70% of abstinent individuals with alcohol dependency relapse within 1 year (Kadam et al., 2017). A recent meta-analysis of laboratory studies of the effect of stressors on alcohol consumption found small to medium effects of stressors on alcohol consumption and alcohol craving such that exposure to a stressor was associated with greater alcohol consumption and craving (Bresin et al., 2018).

Additionally, stressors place a great financial burden on society. These statistics originated from Australia, Canada, Denmark, France, Sweden, Switzerland, the United Kingdom, and the EU-15. The total estimated cost of work-related stress (WRS) was observed to be considerable and ranged substantially from US$221.13 million to $187 billion. Productivity related losses were observed to proportionally contribute the majority of the total cost of WRS (between 70 to 90%), with health care and medical costs constituting the remaining 10 to 30%. The evidence reviewed here suggests a sizable financial burden imposed by WRS on society, (Hassard et al., 2018). The costs incurred due to being exposed to, and coping with, stressors constitute a major public health concern due to their severity and prevalence. I conducted this study to increase the

knowledge base of recovery, to gain insight into the lived experiences of stress from people with alcoholism striving towards recovery within their first-year recovery journey, and to increase the Understanding of recovery behavior. Identifying relapse predictors by exploring the experiences of those in recovery, specifically within their first year, is a way to add to existing knowledge and to identify additional recovery resources and obstacles.

Purpose of the Study

The purpose of this phenomenological study was to understand the lived experiences of stress of individuals with AUD in their first year of recovery. I recruited the study's 10 participants from 12-step meeting program in Dayton Ohio alcohol recovery program as well as other local Alcoholics Anonymous (AA) groups that were in their first-year alcohol recovery journey. In this qualitative study, I used Moustakas's (1994) transcendental phenomenology methodology to illuminate an understanding of the rich descriptions from participants. Data were gathered by conducting one-on-one video interviews with guided questions to gain a deeper understanding of participants' experiences. Identification of risk factors for stress-induced relapse (e.g., underlying traits that put some more at risk) may help stakeholders in developing more positive and effective solutions to curb relapse.

With insight on substantial key factors, stakeholders may be able to develop educational efforts to assist clients in relapse prevention thus helping to sustain long-term recovery. Knowing the key risk factors helps to ensure better relapse prevention planning with safe and effective plans that lessen the risk of relapse, (Melemis, 2015). I sought a

sample size of between eight and 12 participants, with the final number determined by the obtainment of data saturation. The participants were in their first year of recovery and responded with a willingness to participate, were over 18 years of old, and were able to articulate and describe their perceived stress experience.

Research Questions

I sought to answer three qualitative research questions (RQs) in this study, one primary RQ and two sub-RQs. The questions were as follows:

RQ: What are the lived experiences of individuals addicted to alcohol during their first-year recovery journey?

Sub-RQ1: What are the sources of stress reported by people with alcoholism in their first year of recovery?

Sub-RQ2: What factors make an individual prone to relapse during their first year of recovery?

Conceptual Framework

Social stress theory provides a useful theoretical framework to explain health disparities among persons with AUD striving toward recovery (Dressles et al., 2005; Pearlin et al., 1981). It is a theory that provides a lens for observing, predicting, and explaining individuals' stress experience and their relationship with others within the paradigm of their social network (Babbie, 2004). Aneshensel et al. (1991) described this framework as a social paradigm that leads to people with greater perceived stress tending to have more severe alcoholism. Research indicates that people drink as a means of

finding a temporal solution to their economic stress, job stress, and marital problems (Sadava et al., 2010).

In the absence of social support and coupled with the chronic situation of their stressed predicament, persons with AUD may relapse without much resistance. Thus, there is a need for a social support system from family members, colleagues, friends, and coworkers to help persons with AUD avoid shifting their blame to others and be responsible for their poor choices, Taylor (2011). Such a social support system could involve showing concern, affection, empathy, and acceptance to those with AUD on their recovery journey. Thus, Pearlin’s (1981) social stress theory served as the foundation for the research. Although Pearlin's main focus was on the addictive power of alcohol and how it affects individuals addicted to it during their first year of recovery, the researcher also pointed to alcohol as an unseen disease behind other forms of addiction. Thus, persons with AUD during their first year of recovery need help in making the right choices at the right time. Pearlin further maintained that such help could come from psychological insights and healing. All these aids to provide the working framework to achieve a concrete understanding of what is going on in the participants' experiences.

Nature of the Study

For this qualitative study, I used Moustakas’s (1994) transcendental phenomenology methodology to illuminate an understanding of the rich descriptions from participants. Participants were selected through the distribution of flyers (see Appendix A) at the locations where the target program was operated. These flyers contained a brief description of the study, as well as selection criteria for participation. I

followed a virtual/remote recruiting and interviewing protocol featuring dialogue and observation through one-on-one video interviews with the participants. I followed this protocol to ascertain the lived experiences of stress of people with alcoholism who were striving for recovery in their first-year recovery journey. The participants completed an audio recorded, unstructured, nondirective interview in which they could speak freely during the interview and describe their lived experience.

I used purposeful convenience sample techniques to select participants for the study (see Creswell, 2007). Each participant's responses were compared with the responses of other participants to explore similarities and differences and obtain a general understanding of participants' experiences. The interviews were then transcribed and read. This analysis differs from merely reporting an interview, because it involved the comparison and interpretation of 10 participants' interviews. I sought a clear description of participants' experience through analysis of their responses, from which I developed a composite description of participants' experiences.

Definitions

Recovery: A "process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012). The different stages of sobriety are defined as stable sobriety, which is longer than 5 years; sustained sobriety, which is 1–5 years; and early sobriety, which is the first year (Groshkova et al., 2012).

Relapse: A patient's return to sickness after a period of remission (Mariatt & Donova, 2005). The concept of relapse is embedded in a medical model that views addiction as being a disease (Mariatt & Donova, 2005).

Stress: Physiologically, anything that challenges the body's ability to function in its usual fashion (Stephens & Wand, 2012). The body has developed remarkably complex and interrelated responses that are designed to ward off harmful or dangerous situations brought on by stress and to keep it in physiological balance (Stephens & Wand, 2012). Stress is a part of everyday life, brought on by less-than-ideal situations or perceive threats that foster feelings of anxiety, anger, fear, excitement, or sadness (Stephens & Wand, 2012).

Assumptions

The basic assumption was that the essence of the lived experiences of participants in their recovery possesses commonalities. I did not test a particular parametric measurement. Conducting interviews, I assumed, would allow the participants to express what they perceived as lived experience while in their first year of recovery. I assumed that the nature of reality differs for individuals and that one person's reality does not specify another person's reality. Another assumption was that even though the participants were similar in characteristics and had experienced the same phenomenon, they might have an independent perception of that experience. It was assumed that the participants being interviewed answered the questions honestly to the best of their ability and recollection. It was further assumed that all participants selected from 12-step meeting programs in Dayton Ohio alcohol recovery program voluntarily completed this

study. I further assumed that participants who agreed to be a part of the study were interested in helping advance understanding in the field of addiction recovery and treatment.

Scope and Delimitations

This study's scope was participants from 12-step meeting programs in Dayton Ohio alcohol recovery program. The focus was on current program participants who were in their first year of recovery. I delimited the study by restricting the participation age to between 18 and 75 years of age. I also limited the number of participants to 10 total because of the nature of phenomenological research. Research indicates that five to 25 participants is an optimal range to gain understanding of the lived experiences of participants (Creswell, 2013). Further delimitations included not having participants with issues of mental health or brain injury to not complicate the data; I accomplished this by emailing a demographic questionnaire to participants. The transferability of this study may extend to other similar programs. This research study was delimited by both the methodology used and the literature reviewed.

Limitations

This study was limited to individuals in their first year of recovery. Participants were between 18 years and 75 years of age and were able to articulate their perceived stress experiences. I foresaw potential bias because I have never had addiction before or participated in addiction recovery program. Therefore, I might have misunderstood the emotion and feelings of the participants. To checkmate this, I made sure the recorder was

noise free and that each participant was allotted the same amount of time to express their experiences; and I listened to each of the participants with rapped attention.

Significance

Alcohol addiction is one of the most common and traumatic psychiatric disorders among the general population. Yet, little has been published on what it is like for men and women to experience this disorder, Ranes et al., (2017). The significance of this study resides in the insights it provides on the potential to consolidate programs of specific types of addictions into one approach. Consolidation may have a potential cost-saving benefit for organizations that operate several programs of differing focuses. Such consolidation may be of interest to academic researchers, public policy makers, healthcare professionals, and patients with an addiction. By identifying programs that can be useful to many people struggling with addiction, stakeholders may be able to reach more people and help them to improve their lives through recovery.

Summary

In this chapter, I provided the framework and rationale for the study. The chapter included an explanation of the background and scope of the research and related literature along with statements of the problem and purpose of the study. I described the RQs and the conceptual framework. I defined key terms and discussed the assumptions and limitations of the research. A review of the literature follows in Chapter 2. In Chapter 2, I review contemporary literature related to recovery models and the constructs that have been shown to support successful recovery. Support models are presented, and the case is

made for further inquiry to strengthen the limited body of research associated with the experiences of individuals in recovery during their first year of recovery.

Chapter 2: Literature Review

Introduction

The purpose of this study was to increase the understanding of recovery experiences by exploring a first-year experience of stress in recovery from alcoholism. For this qualitative study, I used a phenomenological approach to answer the RQs about the participants' lived experience in relation to the studied phenomenon. To elicit descriptions of participants' lived experiences of the phenomena in question, I conducted semi-structured, open-ended interviews. I adhered to Moustakas’s (1994) transcendental phenomenology methodology to illuminate an understanding based on the rich descriptions from participants (see also Creswell, 2007).

In this chapter, I review literature related to the study topic. I begin the chapter with overviews of the literature search strategy, theoretical foundation, and conceptual framework. The literature review that follows addresses the first-year recovery journey, recovery support, and recovery resources and management. The literature review also includes a synthesis of the findings and a critique of previous research methods. The last section of the chapter includes a summary that addresses the conclusions drawn from the published literature.

Literature Search Strategy

To find published research on addiction recovery and its effectiveness, I searched online for journal articles in addition to reviewing books and current print journals on the topics of addiction and recovery. The main online database used for obtaining material for the literature review was EBSCOhost, which I accessed through the Walden

University Library, as it searched across multiple databases, including relevant database sources such as Academic Search Premier, PsycARTICLES, PsycBOOKS, PsycINFO, and PsycTests, along with socINDEX and Health and Psychological Instruments. I used the RQs in identifying the key terms for the database searches. The primary keywords I used were *substance abuse and recovery*, *substance abuse and treatment*, *stress*, and *alcohol use disorders*. Other search phrases included *post-acute withdrawal syndrome*, *the association between stress and drinking addiction*, *stress* AND *alcohol craving, relapse risk*, *the experience of early recovery from alcohol use disorder in 12-step*, *lived experience of alcohol addiction*, and *substance use disorder*. *Phenomenology research on addiction*, *brain factors*, *addiction*, and *withdrawal* were also key terms used within the context of the RQs.

Theoretical Foundation

A theory is an explanation of observations (Babbie, 2004) that can clarify how to intervene (Burr, 1995). It can be used in predicting behavior, monitor and guide against relapses for AUD. There are different types of theories. Stress theory is a social theory that explains observations about stress, an aspect of social life, (Babbie, 2004). Theories include concepts that represent classes of phenomena to explain observations. A variable is a concept that is composed of a set of attributes that can differ (Babbie, 2004). For instance, the variable of gender includes attributes such as male and female. The connection of concepts to show their relationships constitutes a conceptual framework or model.

I used the stress process theory propounded by Pearlin et al. (1981) to formulate this study and supplemented the theoretical foundation with the social learning theory founded by Bandura (1977). Pearlin's stress process theory propelled sociological research on how enduring stressors encountered in ordinary daily life leads to the depletion of the very social and psychological resources that might otherwise offset the damaging emotional impact of these stressors. According to social learning theory, people learn from one another through observation, imitation, and modeling (Bandura, 1977). Human behavior is learned observationally, and this learned behavior is retained and is used as a guide for future action (Bandura, 1977). The concepts of these theories (social stress and social learning) informed the development of the RQs and analysis of data, helping me to understand the perceptions of participants in this program.

The social learning theory has been used to understand phenomena in a variety of disciplines, including prescription drug misuse among college students. Watkins (2016) found that those students who had a high proportion of peers misusing prescription drugs also misused drugs, and the frequency of exposure to misuse also played a role in prescription drug misuse. Trujillo et al. (2015) found that the three forms of learning scribed to social learning theory played a role in the perceptions of risky behavior in adolescents and alcohol use. Other researchers have used this framework to explore the relationship between role models, imitation, and mentoring and other behaviors, such as in the training of loss prevention officers, in virtual peer effects on behavior, and in the coaching of athletes (Connolly, 2017; Floridia & Hollinger, 2016; Miller & Morris, 2016).

The connection to these studies is on behavior modeling to influence others. Every individual is immersed in a social environment comprised of their memberships in different social settings that require interaction with its operations, such as family, work, and friends. Stress, therefore, occurs in an instance where the relationship between an individual and their environment suffers from a lack of congruity, defined by Aneshensel (1996) as a state of arousal resulting from the presence of socio-environmental demands that tax the ordinary adaptive capacity of the individual. Thus, as Pearlin and Bierman (2013) observed, stress is not a fundamental characteristic of any number of conditions but arises from dissonance between conditions and an individual's ability to adapt to them.

Past research has shown that people often drink as a means of finding a temporal solution to their economic stress, job stress, and marital problems (Sadava et al., 2010). In the absence of adequate support and due to high stress, they are more likely to yield to alcohol without much resistance. Thus, there is the need for a good support system from family members, colleagues, friends, and co-workers to help persons with AUD avoid shifting their blame to others and instead become responsible for their choices. A quality support system could range from showing concern, affection, empathy, and acceptance to persons with AUD striving toward their recovery, Therefore, Pearlin's (1981) social stress theory will serve as the foundation for the research. Despite the substantial current and projected prevalence of AUD and decades of research into alcohol misuse and AUD, researchers are still unable to provide effective treatment programs for those affected; or put into place successful protective factors to predict and prevent AUD from developing

in at-risk individuals (Harris & Koob, 2017). Though some of the current treatments for AUD are effective, to find more curative or preventative treatments or interventions, the risk factors that cause both the acquisition and maintenance of the disease must be identified and understood. Furthermore, previous researchers have suggested that risk-taking (an individual tendency closely related to impulsivity) is positively correlated with stress-induced craving:- that is, people with greater risk-taking tended to have a larger alcohol craving post-stress (Clay, et al., 2018).

Individual does not live in a vacuum but in a society, and most stresses one passes through comes from the social life and structure. Pearlin (1989) claimed the sociological study of stress "can contribute" uniquely both to an understanding of social life and to an understanding of how the fates of individuals come to be bound to it", and "it is of considerable importance to study social structures and their effects on individual wellbeing" (pp. 254-255). In her dissertation research, Menne (2006) investigated the influence of dementia on an individual's well-being by using the stress process model (SPM) of chronic illness. The SPM of chronic illness is a modification of the stress process model made by Pearlin in 1990. Menne (2006) wrote, "Consideration of illness in stress research identifies unique points for further inquiry, and one point of inquiry is the placement and understanding of illness within a social context. Advancing this line of inquiry allows for the articulation of the relationship between illness-related stressors and outcomes." (p. 22). This can be achieved in my current study because my goal is to investigate the influence of stress factors on the health of individuals.

Conceptual Framework

This qualitative study made use of a phenomenological approach to answer the RQs about the lived experience of the study population. Focusing on descriptions of their lived experiences of the phenomena in question, through semi structured, open-ended interviews, this study used Moustakas's (1994) transcendental phenomenology methodology to illuminate an understanding of the rich descriptions from participants (Creswell, 2007). Moustakas's (1994) qualitative approach is like the heuristics research approach that uses the researcher as the research instrument, though Moustakas's (1990) heuristic research method, allows the researcher to use themself as one of the research participants including the researcher's experiences with the phenomenon. In the data, Moustakas (1990) presented that this use of the researcher was a valid instrument for this methodology and will help to provide the existential lens for exploring lived experiences with the transcendental phenomenology method of qualitative inquiry. As a qualitative research approach, phenomenology explores aspects of human experiences that cannot be quantitatively measured (Creswell, 2007; Leedy & Ormrod, 2013), such as their lived experiences of the phenomenon. The current study explored the experiences of participants that allow the essence of experience of recovery for these study participants to be illumined. In the qualitative context, relationships or emotions may be the focus of the research, while lived experiences of a phenomenon in a program or organizational setting can also be studied (Patton, 2002). Whatever the qualitative phenomenological study seeks to illuminate, it used participants' richly described experiences of the

phenomena that they have lived (Creswell, 2007; Moustakas, 1994; Patton, 2002). On the other hand, quantitative approaches cannot measure these experiences (Patton, 2002).

The methodology and model were driven by the RQs and the learning from the study (Patton, 2002). Patton (2002) uses the foundational question, what is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people? This constituted a useful tool that focuses on the RQs and whether phenomenology is the methodology for answering the questions. In this context, the RQs for the study seek to shine a light on the meanings and structures of the experience of the phenomenon by those individuals experiencing this phenomenon. The goal is to illumine the experience of the phenomenon by gaining an understanding of the experiences of the participants. In this study, the lived experience or phenomenon was the 'Stress for Alcoholics Striving Toward Recovery,' and the 10 participants that were recruited from 12-step meeting programs in Dayton Ohio alcohol recovery program were the group of people who have lived the experience and provided the rich descriptions that were used for this study's data collection and analysis.

Literature Review of Key Variables and/or Concepts

This study used lived experiences of stress from people with alcoholism striving toward recovery as experienced by a sample population of ten participants recruited from 12-step meeting programs in Dayton Ohio alcohol recovery program and other AA group as the main topic regarding performing a comprehensive literature review for the study. This review included the subject of the first-year recovery experience, the recovery support, and the recovery management. The researcher found these topics to be thematic

during the data collection and analysis process of this study. I also found the topics to be important for the discovery process.

Overview of Addiction

Addicts to alcohol may really want to quit or cut down on their abuse. In other cases, they may try, but not be able to do so (Evans & Sullivan, 2001). As an example, addictive drugs like heroin cause changes in the brain's chemistry. As a result, the person begins to need the drug for the brain to function properly. When that drug is not present, the person goes into withdrawal, which can be prolonged and painful. To avoid that, the addicted person constantly thinks about getting the next fix. When people are addicted to alcohol, it tends to take over their lives. Getting used to alcohol will fill their days forgetting family, friends, and work; and they will continue to use the drug and alcohol, even knowing that it is destroying their lives (Glantz, 2002).

Classification of Alcohol Addiction as a Disease

Addiction can span a variety of areas to affect people and those around them. Addiction can be described as the impairment of the ability to abstain from substances or behaviors that starts as a pleasurable experience but progresses towards a compulsive need to continue using a particular substance or engage in specific activities (American Society of Addiction Medicine (ASAM, 2017). Untreated, addiction is a progressive condition that can lead to disability or premature death (ASAM, 2017). The effects of addiction can be both psychological and physical. Physical substance use disorders occur when the body has taken on a physical need for the substance and abrupt attempts to abstain result in severe physical symptoms (ASAM, 2017). Changes are occurring in the

body and mind when addiction begins to manifest and contributing factors can exacerbate the likelihood of addiction (ASAM, 2017). The disease model states that some people develop a distinct physical and psychopathological condition that renders them incapable of drinking or using drugs in moderation. Treatment implications include working with the individual to accept their diagnosis and practice a life of abstinence from alcohol and other drugs (National Institute on Drug Abuse, 2012).

All the body's drives and decision-making process derive from the brain. The physical development of addiction involves the frontal cortex and the connections between memory, reward, and motivation (ASAM, 2017; Ruffle, 2014). Early exposure to substance exposure is a contributing factor in addiction development (ASAM, 2017). In addition to the physical factors of addiction development, genetics are considered to account for about 50% of the likelihood of an addiction to develop (ASAM, 2017). In the case of alcohol dependence, for example, common genetic effects across symptoms of alcohol dependency are an assumption with some validity according to scientists (ASAM, 2017; Palmer et al., 2015). However, the physical factors to addiction development are not the sole contributing factors leading to addiction development. Social contexts also require consideration (Dilkes-Frayne, Fraser, Pienaar, & Kokanovic, 2017). These environmental and social contexts include how locations play a role in consumption patterns, thus leading to an increased risk of addiction (Dilkes-Frayne et al., 2017). Dilkes-Frayne et al. (2017) posited that in addition to understanding the environments and consumption patterns, settings do not always remain static over time and people tend to relocate. Relocating has a role in consumption patterns for alcohol use that can create a

pattern or disrupt or maintain an existing pattern. This is another factor in the consumption patterns and frequency in addiction development. Factors contributing to the development of addictions can be multifaceted. In addition to the physical aspects of the brain responsible for the types of drives associated with addiction, social contexts are shown to have a role in addiction development. Any combination of these factors increases the likelihood of developing an addiction and can lead to a variety of behavioral, emotional, and cognitive changes.

Behavioral, Emotional, and Cognitive Changes Associated With Addiction

The effects of addiction can make changes in a person's behavior, emotions, and cognitive abilities. Behavioral changes may include the excessive loss of time from the addictive substance or behavior with adverse effects on social and occupational functions due to missing work from excessive engagement in the addictive behavior or substance or its after-effects (ASAM, 2017). Cognitive changes, such as the inability to believe that the person's problems are a predictable consequence of their addictive behavior instead placing the blame of their issues on other causes, is common but not obligatory in addiction (ASAM, 2017). Increased anxiety, increased dysphoria, and increased sensitivity to stressors with a feeling of things appearing to be more stressful than usual are some emotional changes that are seen in people with addictions (ASAM, 2017). Emotional changes, along with the cognitive and behavioral changes, can be outwardly manifest for others to see even if the person exhibiting them cannot or is unwilling to see. These mental changes, and the physical changes from alcohol use, can lead to disability and premature death. However, the cessation of addictive behavior, most notably from

the abstinence of an addictive substance, can be a physically unpleasant experience when it comes to the withdrawal from the addictive substance.

First-Year Recovery Journey

Sobriety is defined by the U.K. Drug Policy Commission as "a process of voluntarily sustained control over substance use which maximizes health and well-being and participation in the rights, roles and responsibilities of society" (Groshkova et al., 2012). They go on to define the different stages of sobriety: 'stable sobriety' which is longer than 5 years, 'sustained sobriety' which is 1-5 years, and 'early sobriety' which is the first year (Groshkova et al., 2012). Recovery from addiction to alcohol and other drugs is becoming recognized as a journey that is unique to the individual with many different pathways (Kaskutas et al., 2014; Kelly & Hoeppner, 2015; Notley et al., 2015; White, 2007). Thus far, there has been little evidence about these experiences in Canada. Countries such as the United States, Australia, and the United Kingdom have conducted Life in Recovery surveys to better understand individual recovery journeys (Laudet, 2013; Turning Point et al., 2015; and Best et al., 2015, respectively). Results from all three Life in Recovery surveys suggested that recovery from addiction among the survey respondents were associated with improvements in many areas, including improved financial status, physical and mental health, higher rates of employment and education, fewer interactions with the criminal justice system, higher likelihood of harmonious relationships and family unity, and greater contribution to their communities compared with during active addiction.

The *Diagnostic and Statistical Manual of Mental Disorders* includes AUD as a substance-related and addictive disorder. Symptoms of the alcohol disorder can include various symptoms whether physical and/or mental. Alcohol consumption can lead to symptoms of depression, anxiety, and conduct problems (American Psychiatric Association, 2013). School and employment performance may be affected due to the person with AUD being intoxicated at school or work or having side effects from the large amounts of alcohol consumption (American Psychiatric Association, 2013). Galanter (2014) stated that alcoholism is chronic illness and should be addressed by providing ongoing support/aftercare treatment that requires additional research. According to Galanter (2014), alcoholism is a health problem that needs to be acknowledged by society. By recognizing that this is a mental illness, families, caretakers, friends, and peers can recognize the amount of strength it takes a person with AUD to maintain sobriety.

Research regarding abstinence from alcohol indicates that persons with AUD have a better quality of life after their treatment program. (Picci et al., 2014). Quality of life is based on the "ability to function in physical, familial, social, marital and professional contexts" (Picciet al., 2014). A possible relapse factor for persons with AUD may be stress. The stress levels associated with alcohol relapse may be a high-risk factor (Sinha, 2012). Persons with AUD who continuously consume alcohol develop changes regarding the reward and motivation which can lead to increase in alcohol consumption, stimuli in alcohol consumption and the increase of stress (Sinha, 2012).

Excessive use of alcohol is the fourth leading preventable cause of death in the United States, making its prevention a public health priority (Centers for Disease Control and Prevention, 2015). In 2014 alone, 16.3 million adults 18 years of age and older had an AUD, only 8.9% of whom received treatment (National Institute on Alcohol Abuse and Alcoholism, 2016). In its *Diagnostic and Statistical Manual of Mental Disorders*, the American Psychiatric Association, reclassified substance use disorders, integrating what was formerly referred to as “alcohol abuse” or “alcohol dependence” into a single disorder called “alcohol use disorder” with mild, moderate, and severe classifications (National Institute on Alcohol Abuse and Alcoholism, 2016). Severe AUD (often still referred to as “alcoholism” or “alcohol dependence”) affects multiple aspects of an individual's life as well as their loved ones' lives. Two recent studies revealed that 59–70% of individuals who undergo in-patient treatment relapse after 30 days (Seo et al., 2013; Sinha et al.,2011). Perceived social support has the potential to help or hinder recovery efforts. This may be particularly true for individuals with severe AUD who receive intensive inpatient treatment over the period of detoxification and rehabilitation and are faced with the transition to becoming an outpatient in returning to “normalcy” (Brooks et al., 2016). This transition is associated with many challenges: accessing health services, maintaining motivation for sobriety, and ultimately learning how to re-integrate in their homes and communities as a sober individual.

The relationship between alcohol consumption and perceived social support is complex; perhaps even more so among those with severe AUD. Epidemiological data suggest that social network size and diversity is smaller among those with alcohol

dependence (Mowbray, Quinn, & Cranford, 2014). Moreover, lower levels of perceived social support can influence drinking rates, entry into treatment, and ultimately ongoing sobriety following treatment (Mericle, 2014). The relationship between perceived social support and maintaining sobriety is also demonstrated in AA, one of the most commonly-utilized abstinence-focused self-help groups for individuals with severe AUD. Stevens and colleagues demonstrated a positive relationship between social support and abstinence-specific self-efficacy, sense of community, and AA affiliation, as well as the role of sober living houses (environment) on perceptions of social support (Stevens, Jason, Ram, & Light, 2015).

Addiction treatment can help to manage the emotional, physical, social, and behavioral components of a person's life that are impacted due to the disease of chronic alcohol abuse. Alcohol addiction rehab programs use behavioral therapies, individual and group counseling sessions, medical and mental health support, adjunctive and complementary methods, and support groups to foster recovery.

Support During the First Year of Recovery

For people in their first-year recovery journey, there is a need for a recovery-oriented system of care. Program directors, and treatment professionals, need to understand what kind of support is needed in their recovery journey. Recovery-oriented care includes all sectors of society working together to support recovery for an individual and for members of that person's family (White, 2008). Social services are a critical link in the chain of support, as they can help identify addiction and affected family members, direct individuals to appropriate treatment and recovery support services, as well as

support those already in recovery. White (2009a) stated in his writing that frequently people suffer from substance use disorder, and some seek help, and some do not. There are many paths to recovery, and some people use no professional help or self-help support groups yet are successful in long-term recovery. However, when a person does go to a professional for assistance and support, it is the duty of that professional to access the support needs, give the proper referrals and to always assist in helping to find peers who can help. The role of an addiction professional is a facilitator linking the client to a life of continuing growth and self-recognition that supports a return to wellness by facilitating abstinence and promoting positive alternatives to addictive behavior that leads to long-term recovery. An effective professional does not do for the person what the community can do but should be firm and insist that lifestyle changes include finding a new support system (White, 2009a). McKay, (2009c), showed in his studies that treating alcohol abuse disorders with adaptive continuing care in recovery maintenance improves long-term recovery.

Stress Management as a Part of Relapse Prevention

Stressors have been identified as risk factors for serious medical and psychiatric conditions, including cardiovascular disease (Steptoe & Kivimäki, 2013), Alzheimer’s disease (Sindi et al., 2017), and depression (Hammen, 2005). Therefore, managing stress is a skill that continuously needs to be worked on. Recognizing physical and psychological symptoms will help the individual manage stress better. Someone who is completing addiction treatment programs should make a stress management plan. Stress management is part of relapse prevention. A stress management plan should ask:

- What are my physical signs of stress?
- What are my psychological signs of stress?
- What are situations that cause my stress?
- How can I relax without the use of alcohol and drugs?
- What can I do when I feel stressed?
- What activities can I add to my routine that will de-stress me on a daily basis?

Each source of stress should have a corresponding plan to alleviate symptoms of stress. For example, family conflict may be resolved by attending family therapy to increase communication skills and resolve the conflict. Also, exercise, meditation, journaling and breathing techniques are forms of stress relief that an individual can do daily.

Health Insurance and Medicare Coverage of Addiction Treatment

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 17 million people in the United States had had AUD in 2014. Of those people, less than 2% received treatment for their disorder, and only about 1% got rehab at a specialty treatment center. For many, the cost of health care services for alcohol addiction treatment is a barrier to recovery. These people do not seek help because they believe it is out of their financial reach. Many who deal with alcohol abuse are unemployed or struggling financially. Even for those with steady income levels, the cost of rehab may seem prohibitive when compared to the person's other financial responsibilities. The good news is that it is often possible to cover at least some of the cost of addiction treatment with health insurance. Many plans have provisions that allow certain types of addiction treatments to be covered. Insurance may cover inpatient rehab,

outpatient rehab, and other additional services for the treatment of substance use disorders. Insurance should always be the first means of paying for addiction treatment, as most policies offer at least partial coverage. It is important to bear in mind that different insurance policies provide different coverage levels for alcohol rehab. It can be challenging to figure out what the coverage levels are, what exclusions exist, and whether the specific treatment program that is being considered accepts payment through insurance. Most rehab centers have insurance specialists on staff who can help prospective clients navigate the specifics of their policies. In addition, those who are seeking addiction treatment can contact their insurance provider directly to ascertain coverage specifics.

Medicare Parts A and B include coverage for addiction treatment, including alcohol rehab. According to Medicare Interactive, a website that provides information on Medicare plans, Medicare Part A can help pay for hospitalization for substance abuse treatment, while Part B can help cover treatment for partial hospitalization or outpatient addiction treatment services. In addition, Medicare Part D provides coverage for medications used in treating alcohol addiction, such as naltrexone, if these drugs are considered medically necessary for the policyholder. There is a great deal of published research on treatment and prevention of substance use (White, 2009a), but not as much published research on recovery (White, 2009a). The study of problem associated with recovery may reveal solutions that can be used to help and assist those in recovery to connect and maintain long-term recovery. People in recovery may become advocates for and supporters of others in recovery.

Family Support During Recovery

In the United States, there are recovery homes, recovery work co-ops with employers, recovery high schools, special college recovery programs, and faith-based ministries for recovery. Many of these have been made possible by the mobilization of recovering people advocating for recovery support. In addition to this support, it is important to recognize the importance of family support for the recovering person (White, 2009; Faces & Voices of Recovery, 2010). Family support is important, and especially during the first-year recovery journey (Laudet & White, 2004). Unfortunately, most family members do not know what to do when their loved one is struggling with alcoholism or drug dependence. That is why it is important that family members be included in the continuing care support services (Laudet & White, 2006; McKay, 2009b). Loved ones of persons with AUD in their first year of recovery often feel confused, frustrated, angry, and helpless. They may begin to develop unhealthy ways of coping and they may feel isolated from the people around them, and especially the person in recovery. This stress can have physical, emotional social, and spiritual consequences for both the family member and the person in recovery (Hammond & Gorski, 2005). Family members can alleviate confusion and anxiety and promote healing by identifying how alcohol addiction affects them and learning what they can do to take care of themselves. Loved ones of those with alcohol addiction need to learn that they cannot control the addiction, they did not cause the addiction, and they cannot cure addiction. By becoming aware of the beliefs and experiences that shape their own behaviors, families can identify new, healthy ways of coping with addiction and relationships (McKay, 2009a).

12-Step Programs and Other Help Groups

There are many kinds of support groups and recovery programs available. Many people begin participating as part of a structured addiction treatment program and then continue attending the same groups after treatment concludes. Substance abuse treatment operates through a variety of methods. Some of those ways include outpatient treatment, residential treatment, sober living communities, peer support, 12-step fellowship, and medication (National Institute on Drug Abuse, 2012; SAMHSA, 2016b). Some little introduction to the popular support groups and recovery programs readily available include SMART (Self-Management and Recovery Training) Recovery, Moderation Management (MM),Secular Organizations for Sobriety (SOS),Women for Sobriety (WFS),Al-Anon, and AA's12-step recovery program.

Self-Management and Recovery Training

A non-12-Step program, SMART focuses on a Four-Point Program that helps individuals to build motivation; manage cravings, emotions, and behaviors; and learn how to live a well-balanced life. This program helps people to become self-reliant and uses researched-based techniques to foster and sustain recovery. Participants can join a local group and attend face-to-face meetings as well as receive online and virtual support. A spiritual alternative SMART Recovery programs helps individuals learn and develop skills for positive lifestyle changes to aid in sustaining recovery and sobriety.

Moderation Management

MM takes a different approach to recovery than many support groups as it does not expect full abstinence. Instead, members can continue to drink alcohol in

moderation.MM focuses on eliminating problematic drinking and negative behaviors associated with them. Through the steps Members are asked to keep a drinking diary at first and then to undergo a 30-day period of complete abstinence from alcohol. After that time, individuals are then able to reintroduce alcohol in a responsible manner. Moderation Management accepts that not drinking at all may not be practical for everyone and holds that drinking in moderation may be acceptable. MM teaches tools for managing problem drinking and how to control it. MM offers both virtual and face-to face meetings as well.

Secular Organizations for Sobriety

A nonprofit organization, SOS hosts both online and in-person recovery support group meetings for individuals seeking sobriety and those in recovery. Membership is free and anonymous with the sole goal being for members to support each other in sustaining sobriety. SOS groups are autonomous, free, and open to anyone who wishes to achieve and/or maintain abstinence. SOS groups are secular in nature and therefore not attached to any religion or spiritual group. These recovery support groups are not governed or connected to any outside groups or organizations.

Women for Sobriety

A nonprofit organization focused specifically on the needs of women in recovery, WFS hosts a NewLife Program that uses 13 acceptance statements to help women modify self-destructive thoughts and behaviors for a full and healthy life free from alcohol and drugs. Women are to spend time each morning and each evening thinking about the 13 acceptance statements and how they apply to their lives. These statements help women to

think more positively about themselves and take ownership of their own lives and recovery. WFS meetings provide peer support and aid in changing negative thoughts to more positive ones, thus helping to make changes for the better. By providing a better understanding of the self, a person can then have a more full and balanced life. Coping skills and stress management are also covered through a WFS recovery support group program.

12-Step Recovery Program

The focus of this research work will center on the traditional 12-step recovery program because of its close similarities with the recovery program at the focus of this study. The most popular 12-step program is AA, which had an estimated 2.1 million members as of 2016—because there is no formal membership list, it is hard to provide a more accurate number, (AA, 2017c). At the center of its core program are 12 steps, which guide the recovering addict through the program. Table 1 identifies each of the 12 steps in AA its key point from each step along with an example for completing the step and was adapted from more than one source.

Table 1

Alcoholics Anonymous' 12Steps

Step	Key point	Description	Example
1	Admit powerlessness	We admitted we were powerless over alcohol - that our lives had become unmanageable.	Describe any times that you cannot recall how you got home.
2	Cultivate Hope	Came to believe that a power greater than ourselves could restore us to sanity.	List the positive and negative aspects as you see it of your family's religion.
3	Surrender	Made a decision to turn our will and our lives over to the care of God as we understood him.	How do you feel in general about turning your life over to God?
4	Complete a self-inventory	Made a searching and fearless moral inventory of ourselves.	Describe the faults that you most detest in others. Do you have any of these traits yourself?
5	Confess	Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.	Describe any person who has helped you to see yourself more clearly and objectively in your process of recovery and of life.
6	Be ready	We're entirely ready to have God remove all these defects of character.	Describe some secret GOOD deeds that you have done or would like to do.
7	Ask God	Humbly asked him to remove our shortcomings.	What makes you lose hope? Can you avoid such situations? If so, then how?
8	Amend list	Made a list of all persons we had harmed, and became willing to make amends to them all.	What important relationships did you destroy or damage because of your addictive behaviors?
9	Make amends	Made direct amends to such people wherever possible, except when to do so would injure them or others.	What amends do you think that you have already made? These can include apologies already made, helpful tasks for those that you have hurt, changed attitudes and so forth.
10	Continue inventory	Continued to take personal inventory and when we were wrong promptly admitted it.	What is your plan to allow time for reflection each day?
11	Keep contact	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.	What are your favorite sources of wisdom and knowledge about healthy values?
12	Help others	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.	Have you been able to reach out to another recovering addict? If so, describe the situation and how it feels to you.

Note. Adapted from "Alcoholics Anonymous, "by Alcoholics Anonymous World Services, 2001, p. 59, New York, NY: Alcoholics Anonymous World Services; and "Unhooked," by Eric Dykstra & Bruce Rauma, 2015, p. 223, Elk River, MN: Crossing Church Publishing

AA has been around since 1935 finding its roots in Akron, Ohio but had not yet had the name AA until its first published workbook entitled "Alcoholics Anonymous" in 1939 (AA, 2017b). Its success and membership grew after a series of positive editorials about its success and stories from persons with AUD who had recovered (AA, 2017b). Since that time, several programs have been modeled after its established 12-steps. More specifically, Narcotics Anonymous (NA) followed the same model, but applied to those suffering from addiction to drugs rather than alcohol. AA shares some similarities with faith-based treatment centers like Crossing Recovery of Free Grace Recovery Foundation. Both consist of 12 steps similar in context, though in Crossing Recovery Ministry they are termed "mile-makers," The recovery participants in AA have sponsors while they are called guide in Free Grace (Dykstra & Rauma, 2015).

Both AA and Free Grace Recovery indicate an understanding that addicts are powerless over their addiction and need to turn their lives over to a higher power to be free from the addiction (Alcoholic Anonymous World Services, 2002; Dykstra & Rauma, 2015). AA and Free Grace Recovery also require that individuals perform an accurate self-examination of their lives to establish a root-cause in addition to developing a list of those who they have hurt due to their addiction and attempt to make amends (AA World Services, 2001; Dykstra & Rauma, 2015). The most notable of the differences between the two lies in their target audience. For AA, their focus is on those having an alcohol addiction. Whereas Free Grace Recovery does not place limits on their target audience and will embrace everyone who wishes to be free from whatever vice, addiction, or bad habit they have. It is also important to note that AA has a sister program so to speak

called narcotics anonymous (NA) which utilizes the same 12-step concepts for those with addiction to drugs (Narcotics Anonymous World Services, 1986).

Another critical distinction between AA and Free Grace Recovery is in the vital role of a higher power or God. For instance, AA does embrace the idea of God. However, they do not provide religious services (AA, 2017a). In contrast, religious services are central to Free Grace Recovery including worship and prayer. Alcohols Anonymous, however, encourages religious involvement but does not make it a requirement for being a member. They follow similar models but have some differences. AA provides those with alcohol addictions with a chance to be free from those addictions.

Guiding Principles of Recovery

There are many pathways to recovery, and individuals are unique with specific needs, strengths, attitudes, behaviors, and expectations for recovery, (White, 2009). The pathways are highly personal, and generally involve a redefinition of identity in the face of crisis or in the process of progressive change. In addition, the pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for recovery. Pathways for some may include one or more episodes of psychosocial and/or pharmacological treatment (White, 2009). For others, recovery involves neither treatment nor involvement with mutual groups. In any case, recovery is a lifelong process of change that permits an individual to make healthy choices and improve the quality of their life. While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a degree by others, recovery is fundamentally a self-directed process (White & Laudet, 2004). The person in

recovery is the ‘agent of change’ and has the authority to exercise choices and make decisions based on their recovery goals that have an impact on their recovery process. The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Through this self-empowerment, individuals become optimistic about life goals. Recovery is holistic, and a process through which one gradually achieves greater balance of mind, body, and spirit in relation to other aspects of their life, including family, work, and the larger community.

Each person’s recovery process is unique and impacted by cultural beliefs and traditions. A person’s cultural experience often shapes the recovery path that is right for him or her. Recovery is continual growth and improved functioning. It may at times involve relapse or other setbacks; however, relapse is not an inevitable outcome. Wellness is the result of improved care and balance of mind, body, and spirit, and is a product of the recovery process. Recovery emerges from hope and gratitude, and individuals seeking recovery often gain hope from those who share their search or experience of recovery. They see that people can and do overcome the obstacles that confront them, and they cultivate gratitude for the opportunity that each day of recovery offers. Recovery offers a process of healing and redefinition for self and family. It is a holistic healing process by which individuals, families and communities confront and strive to overcome discrimination, shame, and stigma by advocating for self and others (Hammond & Gorski, 2005). Recovery is supported by peers and allies. A common denomination in the recovery process is the process and involvement of people who contribute hope and suggest strategies and resources for change. Peers as well as family

members and other allies, form vital support networks for people in recovery. Providing service to others and experiencing mutual healing helps create a community of support among those in recovery (Hammond & Gorski,2005).

Recovery involves re-joining and re-building a life in the community (Glantz 2002). This involves a process of building or re-building what a person has lost or never had due to their condition and its consequences. It is building or re-building family, social, spiritual, and personal relationships. Those in recovery often achieve improvements in the quality of their lives, such as obtaining an education, employment, and housing. They also increasingly become involved in constructive roles in the community through helping others. Recovery is a reality; it can, will and does happen. The next chapter will discuss the methods used in this research to describe the lived experience of recovery from alcohol addiction during their first year of recovery by 10 individuals as they will describe their lived experiences in early recovery.

Synthesis of the Research Findings

Addiction in the United States, and its treatment approaches, remains an issue for healthcare leaders. Addictions impact society, families, and the individual with addictions (Al- al., 2015). There has been previous research on recovery programs such as residential treatment, traditional 12-step programs, outpatient programs, and both secular and religious among all the types (White et al., 2012). Once a person decides to discontinue use of an addictive substance, he or she experiences a withdrawal phase.

As Americans are using alcohol at increasingly hazardous rates despite the potential for severe consequences, research into the etiology of AUD is crucial to better

identify those at risk and inform interventions. Stressors have been identified as a risk factor for serious medical and psychiatric conditions, including cardiovascular disease (Steptoe & Kivimäki, 2013), Alzheimer's disease (Sindi et al., 2017), and depression (Hammen, 2005). Stressors place a great financial burden on society, with approximately $187 billion in direct healthcare costs and $5.4 billion in indirect costs (e.g., absences from work) attributable to stressors (Hassard et al., 2018). The costs incurred as a result of exposure to and coping with stressors constitute a major public health concern due to their severity and prevalence. In addition, a recent meta-analysis of laboratory studies of the effect of stressors on alcohol consumption found small to medium effects of stressors on alcohol consumption and alcohol craving such that exposure to a stressor was associated with greater alcohol consumption and craving (Bresin et al., 2018)

Withdrawal can affect people differently based on the type of substance, dosage, and frequency of use (Addictions and Recovery, 2017; Freynhagen et al., 2016). For example, withdrawal from an internet gaming addiction may not have the physiological symptoms associated with substances but may involve restlessness and irritability after discontinuing their playing activities (Kaptsis, King, Delfabbro, & Gradisar, 2016). There are some common symptoms associated with substance withdrawal, especially typical of those ceasing opioids, such as nausea, chills, abdominal pain, diarrhea, anxiety, muscular pain, and insomnia (Freynhagen et al.,2016). Withdrawal symptoms can have short-term phases, as well as phases occurring months to even a couple of years after discontinuing the use of the substance (Addictions and Recovery, 2017). The lingering effects of withdrawal impact sleep patterns, concentration, and energy levels (Addictions and

Recovery, 2017). Recovery from alcohol addiction could be a lifelong journey and that addiction is a chronic disease that affects many populations. Current research conducted by (Blaine & Sinha, 2017) shows that the effects of stress and alcohol cues are linked to alcohol's robust effects on the HPA axis, and there is some evidence that these effects are seen prior to the development of AUDs. A recent meta-analysis of laboratory studies of the effect of stressors on alcohol consumption conducted by Bresin et al. (2018) found small to medium effects of stressors on alcohol consumption and alcohol craving such that exposure to a stressor was associated with greater alcohol consumption and craving. Stressors place a great financial burden on society, with estimated cost ranging from US$221.13 million to US$187 billion, Hassard et al., (2018).

The costs incurred due to being exposed to, and coping with, stressors constitute a major public health concern due to their severity and prevalence.

The literature on AUD, addiction treatment, support/management and the many other aspects of recovery shows the complexity of the phenomenon of recovery. Additionally, the literature on AUD shows how it is one of many diagnoses of addiction specific to the use of alcohol that occurs despite the harmful consequences that are often the result of continuous abuse of alcohol, (National Institute on Drug Abuse, 2010).Again, this highlights the complexity of addiction and recovery from substance use disorder with research indicating that more research—in particular, phenomenological research on persons' experiences of recovery—can help illuminate these topics (Cassar & Shinebourne, 2012; DePue et al., 2014; Grant, 2007; Shinebourne & Smith, 2011). The majority of available research demonstrates that stressor-motivated alcohol consumption

warrants further attention from researchers regarding the mechanisms by which this problematic pattern of alcohol use develops and is maintained. Hence, the purpose of this research was to unveil the stressors causing these relapses through the lived experiences of persons with AUD in their first-year recovery journey. Focusing on the setting of 12-step meeting programs in Dayton Ohio alcohol recovery program and other AA support group, allows the researcher to present the participants' experiences in this study so that the reader can gain an understanding of this population's experiences of recovery.

Critique of Previous Research Methods

Both quantitative and qualitative research on the population of individuals on their first year recovering journey from alcohol is lacking. This lack of research leaves a gap in the understanding of this population and their experiences of recovery along with treatments experienced and the motivation to change their lives. Consequently, more research of this population is warranted. Quantitative research may be able to show support for different approaches to alcohol recovery treatment and the outcomes of each approach but only a qualitative study can illuminate the participants' lived experiences and enable one to gain a better understanding from those individuals who experience the phenomenon. Interviewing persons with AUD in their first-year recovery process from 12-step meeting programs in Dayton Ohio alcohol recovery program may convey themes that show a commonality giving light to these experiences. This may impart a better understanding for those who have not experienced the phenomenon of recovery from alcohol. Exploring qualitative inquiry into this treatment delivery approach may add to the current literature by helping to illuminate how those in their first-year journey of

recovery experience the phenomenon of alcohol, along with their understanding of recovery. Kelly and White (2011) described addiction as a chronic and complex issue and therefore additional experiences of this group can be beneficial in adding to the current literature as individual experiences may show common themes about these experiences which may illustrate the essence of how individuals feel in their recovery stages. Moustakas (1994) noted that the essence of an experience could bring understanding to that experience from those who experience it to those who have not.

Summary and Conclusions

In Chapter 2, I provided the reader with background information to help gain a better understanding of the proposed research by discussing social stress theory and social learning theory at the core of the study which provided a useful theoretical framework to explain health disparities among individuals with alcoholism striving toward recovery in their first year and provided some background on other available support groups and Recovery programs with emphases on 12-step programs used as a model to help understand and give context to the program the participants are reporting their experiences. Reflection was made on Recovery and Recovery support and how they stand to help individuals in their recovery journey. Spirituality was considered to have a place in alcohol recovery process, and literature surrounding this concept was discussed to understand its role in recovery. AA was compared with Free Grace Recovery (a faith-based program), a program with a history and structure like AA and uses 12 steps in administering recovery.

A review of the literature on addiction treatment, recovery, and support suggests that there is a broad range of views about how persons with alcohol and/or substance use disorders might be able to achieve and sustain a state of recovery. There is some degree of common ground in treatment approaches and outcomes, but also revealed in the literature were controversies between differing perspectives at service delivery, social policy, and psychological treatment levels. While this may be true, recovery from alcohol addiction can be observed and appears to be a phenomenon since it is not clear what causes and sustains it. There is an impetus therefore, for tapping into what the participants experiencing the phenomenon themselves said about their experience in recovery. Viewed through a phenomenological lens, their stories may add to knowledge about what sustains recovery and is helpful to the community of those seeking recovery in their first year and those who would help them. Chapter 3 describes the research design including instrumentation, how participants were selected, and the methodology used to collect the data. Chapter 3 also includes information regarding the ethical considerations made for this study and steps taken to ensure participants were protected to the best of my ability as the researcher in addition to the data analyses strategy.

Chapter 3: Research Method

Introduction

The purpose of this study was to gain an understanding of the lived experience of stress among individuals who were in their first year of recovery from alcohol addiction. In conducting this research, I sought to provide insight into this area of recovery through participant experiences and to contribute to the literature on addiction and recovery. I describe the rationale for choosing phenomenology as an approach for the study in this chapter. I also discuss my role as the researcher. This chapter includes discussion of the methodology, including the criteria to participate; the sampling strategy; and the data collection instrument, including the interview protocol that was used to guide the interview process. The organization, storage, security, and analysis of data are also addressed. Chapter 3 concludes with a summary of key points.

Research Design and Rationale

I used a qualitative approach to answer the RQs for the study, which were as follows:

RQ: What are the lived experiences of individuals addicted to alcohol during their period of recovery?

Sub-RQ1: What are the sources of stress reported by people with alcoholism in their first year of recovery?

Sub-RQ2: What factors make an individual prone to relapse during their first year of recovery?

To answer the RQs, I used a transcendental phenomenological approach based on the work of Moustakas (1994). The task of the phenomenologist is to investigate the processes of intuition, reflection, and description. Accordingly, phenomena are not manipulated but rather are permitted to reveal themselves (Moustakas, 1994). The phenomenon under study was stress as experienced by individuals in their first year of alcohol recovery. The participants shared their personal experiences and the meaning of these experiences in their recovery journey.

My reason for using the phenomenological approach was to gain an understanding of the lived experiences of the participants from their own point of view. This allows the researcher to fulfill the intent of the study and address the guiding question. Phenomenology concentrates on the study of phenomena as experienced by the individual, with the emphasis on exactly how a phenomenon reveals itself to the experiencing person in all its specificity and concreteness (Denzin & Lincoln, 2005c). In transcendental phenomenology, as espoused by Moustakas (1994), there are four processes for explaining and understanding experiences. These core processes are (a) epoche, (b) transcendental phenomenological reduction, (c) imaginative variation, and (d) the synthesis of meanings and essences.

Role of the Researcher

The primary duty that I exercised in this study was to be the instrument with which to collect the data. I was not a participant in the target program, and I had no authority over any of the participants in the program nor did they possess any formal or

informal authority over me or have any undue influence over the results of the study. There were no conflicts of interest in this study.

Methodology

Participant Selection Logic

In this study, it was important to use a purposeful sampling strategy. Creswell (2007) defined purposeful sampling as selecting individuals who can purposefully communicate their lived experiences of the phenomena under investigation. I made use of a mixed sampling strategy of intensity and criterion sampling, as described by Patton (2002), to yield information-rich cases to answer the RQs. First, I identified the target population. The target population consisted of persons who experienced stress while in their first year of recovery for alcohol addiction and who lived in a self-help group recovery residence. I selected a self-help group recovery residence, a 12-step meeting program in Dayton Ohio alcohol recovery program that was in my area. The program services focus on alcohol addiction recovery. The sample was a subset of the target population, 10 participants, who were in their first-year alcohol recovery journey.

I selected participants through the distribution of flyers (see Appendix A) at the locations where the program was operated. These flyers contained a brief description of the study, as well as selection criteria for participation. To be accepted as a participants, individuals needed to be between 18 and 75 years old, (b) be able to verbalize their experience in recovery, and (c) be on their first-year recovery journey. Participants wishing to participate voluntarily contacted me through a designated email address or phone number made available on the flyer. Individuals who contacted me for more

information or to volunteer were prescreened to ensure that they met the selection criteria as indicated on the flyer. This was carried out by emailing demographic questionnaire to them to fill in and email back to me. An informed consent form was sent to potential volunteers who met the selection criteria, explaining participation in the study, the potential benefits of the research, and the potential risks and safeguards of the study with notification that it would involve a video chat interview that would be audio recorded. Individuals who wished to participate indicated their consent by replying to this email with the words “I consent.” On receiving the informed consent, I emailed a code number to the participant to be use in place of name together with interview date and information about the video chat setting. The setting of the interview was a comfortable place of the participant's choosing with my recommendation that they choose a quiet, private place with no distractions.

The participants were self-selected volunteers and received a Walmart e-gift card worth of $20.00 for their time spent participating in the personal interview. Saturation was achieved when the addition of more samples does not result in additional perspectives; the sample size selected was within the high midrange (Creswell, 2013) and well above the minimum described by Mason (2010).

Qualitative studies typically require a smaller sample size than a quantitative study and much of the time sample size is determined by the time allotted, available resources, and research objectives (Statistics Solutions, 2017). In this study, the goal was to reach 8-12 participants; however, there was the ability to add more in case of incomplete data or participant withdrawal. Data saturation was important in qualitative

research, including phenomenology, as data saturation can influence the research quality, as well as the content validity, of a study (Fusch & Ness, 2015); therefore, the study design must consider data saturation during data collection. Saturation of data can be a nebulous concept (Rowlands, Waddell, & McKenna, 2015), where the agreement of what constitutes saturation is often in contention. According to Cleary, Horsfall, and Hayter (2014), researchers can base data saturation on the redundancy of information. Though data analysis determines the true measure of saturation (i.e., redundancy), during data collection, the interviewer estimated redundancy when it was noted that no new concepts or themes (i.e., no repetitious data) were seen to be emerging in subsequent interviews (Trotter, 2012). Data saturation was determined during data collection in this study by the researcher being aware of repetitious data and discontinuing further interviews.

Instrumentation

The primary data collection instrument included guided questions that were open ended (see Appendix B) to explore participants' lived recovery experience. The purpose of this research was to answer the RQs, as described in Chapter 1. To accomplish this goal, research was conducted by collecting data through interviews of those who have experienced the phenomenon, analyzing the data using Moustakas's (1994) transcendental phenomenology methodology, including a review of the data for themes showing textural and structural descriptions, so the how and what of the lived experience of stress were described. This process of the research used the researcher as the primary instrument, to interview the participants, using the guiding interview questions. Through qualitative inquiry, the researcher interpreted the interviews that told the stories of

participants in their first-year recovery journey as described by the participants in their own words (Denzin & Lincoln, 2005d; Moustakas, 1994). Before any data analysis, the tape interviews were played and then transcribed. The researcher called each participant and read the transcribed interview to them for clarification and verification. The purpose of this was to make sure that the transcription captures the participant's lived experience just as they intended it to be. Each of the participants was contacted and had their transcribed interview read to them before data analysis began.

Procedures for Recruitment, Participation, and Data Collection

The procedures for recruiting participants for this study included the distribution of flyers to the 12-step meeting programs offered through Dayton Ohio alcohol recovery program. These flyers were distributed through hand delivery to the Outdoor Adventure Center in Adventure Recreation Center in Dayton Ohio. The flyers contained information about the research, selection criteria, and my phone and email information. I also noted that participants who met the selection criteria and subsequently completed the interview process would receive a Walmart e-gift card worth of $20.00 to thank them for their participation. I asked program staff to distribute the flyers to participants of 12-step groups who were in their first-year recovery journey. The participation flyer is in Appendix A.

Video-chat platform was the avenue used to conduct one-on-one interviews with voluntary participants in this research work. Data was collected from a one-on-one video chat and audio recorded. The analysis focuses on the overall statements made by participants as they recalled and shared about their lived experiences of stress during their

first-year alcohol recovery journey. All data collected, the consent forms, audio recordings, demographic face sheets and all confidential material was kept under lock and key. All data collected was kept safe and safely stored in this locked safe in the researcher's home for 5 years after publication of the dissertation manuscript. At that time, the material would be professionally shredded. To answer the RQs under study, I asked 12 open-ended questions during the qualitative interviews (see Appendix B).

The video chat interview started with the researcher fully explaining the study to the participant and reconfirming that the interview would be audio recorded. Tape recordings were particularly important as they show that the interview was indeed conducted as well as capturing the nuance and tone of the interview. The researcher used two tape recorders just in case one should malfunction. This type of interview allows the participant to respond and describe the recovery experience in his/her own words, and from his/her own personal perspective. The setting of the interview was in a comfortable place of the participant's choosing with my recommendation that they choose a quiet, private place with no distractions.

At the conclusion of the interview, the participant received a Walmart e-gift card worth of $20.00 through their email account as a gift and a notification that same avenue might be used to contact him/her, if necessary, for any follow-ups. I contacted the participant to have him or her review their transcribed interview. The participant was asked if he or she has any further questions regarding the study and was encouraged to contact me if any questions should arise later.

Data Analysis Plan

The phenomenological analysis of the data was collected according to the model proposed by Moustakas (1994). First, the researcher affirmed a commitment to epoche, setting aside any prejudgments and opening the interview with an unbiased, receptive presence. Epoche is best described as returning to things themselves, free of prejudgments and preconceptions. This was considered important in being able to gather all the available data during the interaction. Transcendental phenomenological reduction was also practiced. This was the task in that of describing in textual language just what one sees, not only in terms of the external object, but also the internal act of consciousness. The goal of this was to capture the experience as such, the rhythm and relationship between phenomenon and self. Textual qualities were as follows: rough and smooth; small and large; quiet and noisy; colorful and bland; hot and cold; stationary and moving; high and low; squeezed in and expansive; fearful and courageous; angry and calm, and descriptions that present varying intensities; ranges of shapes, sizes, and special qualities; time references and colors within an experiential context. As these data were gathered, the next step in the process was bracketing the topic. In this practice, the focus of the research was placed in brackets, and everything else was set aside so that the entire research process was rooted solely on the topic and question. It was important throughout the interviews to practice what was called in phenomenology, horizontalization. In this practice, every statement would be treated as having equal value. Statements irrelevant to the topic or question as well as those that are repetitive or

overlapping were deleted, leaving only the horizons (the textual meaning and invariant constituents of the phenomenon).

I used imaginative variation to elicit possible meanings by varying frames of reference; employing polarities and reversals; and approaching the phenomenon from divergent perspectives, different positions, roles, or functions. The aim was to arrive at structural descriptions of an experience, the underlying and precipitating factors that account for what is being experienced; in other words, the how, that speaks to conditions that illuminate the what, of experience, asking, 'How did the experience of the phenomenon came to be what it is'? The steps to imaginative variation were as follows:

1. Vary perspectives of the phenomenon from different vantage points, such as opposite meanings and various roles. Used free fantasy variations, considered freely the possible structural qualities or dynamics that evoke structural qualities,
2. Constructed a list of the structural qualities of the experience,
3. Recognized the underlying themes or contexts that account for emergence of the phenomenon,
4. Developed structural themes by clustering the structural qualities into themes,
5. Considered the universal structures that precipitate feelings and thoughts with reference to the phenomenon, such as: time, space, bodily concerns, materiality, causality, relation to self, or relation to others,
6. Integration of the structural qualities and themes into an individual structural description of the experience,

7. Integration of all the individual structural descriptions into a group or universal structural description of the experience, and
8. Synthesize meanings and essences.

The final step in the phenomenological research process was the intuitive integration of the composite textural and structural descriptions into a unified statement of the essences of the experience of the phenomenon. The essence of any experience was never exhausted. The fundamental textural-structural synthesis represents the essences at a particular time and place from the vantage point of an individual researcher following an exhaustive imaginative and reflective study of the phenomenon (Denzin, 2005a; Moustakas, 1994). Prior to the data analysis, the researcher reviewed the audio recordings and transcription to ensure completeness of the transcription. All documents were stored in a fire-proof, locked document safe that was stored in a locked filing cabinet, only accessible to the researcher. Walden University Institutional Review Board (IRB) documents that pertain to the study will be stored for 7 years and then destroyed.

Issues of Trustworthiness

Credibility

Saturation technique was used to assist in bolstering study credibility. Saturation is the adequacy and richness, or quality of the data needed to support a study, and it can vary depending on the type of research (Fusch & Ness, 2015). Interviews were difficult to be quantified concerning reaching saturation; however, saturation was reached when interviews began to reveal no new themes, no new data, no new coding, and the ability to replicate (Fusch & Ness, 2015). Coding throughout the study and after each interview

allowed me to see when the interviews were revealing new information or when there was no further need to do additional interviews. The range of 8 -12 interviews was the goal for the number of participants interviewed. To address reflexivity and to mitigate the potential for unconscious researcher bias, I used a reflexivity journal to log thoughts, observations, and assumptions that occurred during the interview. I asked myself questions at the end of each interview to understand if I understood what was being said based on the interview or if other information was being brought in to help formulate the interpretation.

Transferability

The concept of transferability was built into the study because of the selection criteria of participants. The focus was on experiences of individuals of both genders (male and female) in recovery program participants, so participant variation (without restriction to one gender only) was paramount to the study's success. I seek to obtain full description of their individual experiences within the program. Including this element within the study increased the ability to generalize themes across addiction types within the same program.

Dependability and Conformability

Dependability and conformability were satisfied using audit trails to track the research from beginning to end. An outside auditor could follow this documentation along with raw data to understand my mindset, the rationale for processes, and to understand how the study will be constructed and how conclusions were reached. The tool best suited for this was the reflexivity journal. This same practice of using a

reflexivity journal track the progress of the study and allows for an auditor the ability to reconstruct the study from the notes and raw data.

Ethical Procedures

The potential for ethical concerns in this study was likely as it involved participants in a recovery program whose nature was confidential and anonymous. To overcome this ethical concern, participation, data collection, analysis, and reporting was done in a manner that did not violate the rights of the participants through a breach of their privacy and anonymity. Steps were taken to ensure anonymity and confidentiality. I have been certified by the National Institutes of Health as having completed the training about Protecting Human Research Participants, as an additional measure to protect the welfare of the participants in this study. One method to help address potential ethical concerns was to be honest and up-front with the purpose and structure of the study. Informed consent forms were provided to each participant to inform them of their rights as a research participant. The second method of ensuring participant anonymity was to avoid the use of any names in the final study. A third method was to have each participant read their transcribed interview to ensure he or she agreed with the accuracy. Should a participant wish to remove themself from the study, another participant will be selected to be interviewed to have a robust set of data from which to analyze. It was difficult to design a study free from all ethical concerns; however, scholars can address the potential for these concerns. There were some scenarios that could have arisen that may have presented ethical concerns, and this section outlined the steps I would have taken to address them should they have occurred.

Institutional Permissions

The nature of this study precluded it from obtaining permission from the organization from which the participants would be selected if the extent of involvement of the organization was only to allow distribution of participation flyers. No proprietary data or assistance with participant selection was performed by the Dayton Ohio alcohol recovery program. The collected audio data was transmitted to Rev, a third-party transcription service for a verbatim transcription and return of the data. A confidentiality agreement was sent to Rev for review and signing for them to be bounded by oath of secrecy, considering the nature of the information at their disposal. Before data collection began, the Walden IRB approved the study (no. 10-21-22-0271068).

Participant Withdrawal

A participant may wish to withdraw from the study for many reasons. There may not need to be a reason to withdraw from the study, and participants were informed at the beginning of the study that participation was voluntary, and they may withdraw at any time with no penalty. This included the ability to keep the $20.00 incentive e-gift card after they have completed the interview. All data about the participants who withdrew before the analysis phase will be removed with no negative repercussions to the participant.

Management of Conflicts of Interest

Any new issues of conflict of interest that arises must be disclosed to the participant as soon as I am aware. Also, I would notify the dissertation chair and the IRB of new revelations of conflict of interest. A discussion would occur as to whether to

proceed with the interview of the participant or to seek a replacement participant and not include any data from the participant with whom there may be a conflict of interest.

Management of Breaches of Confidentiality

I took confidentiality seriously, and accidental breaches of confidentiality would be an unwelcome event. Should this event occur, immediate disclosure to the participant will be made along with notification of the dissertation committee and the IRB.

Data Protection

The collected data obtained via audio recording would remain in my custody from the interview site to the location of the safe in which the raw data will be kept until analysis. This raw data would be uploaded to a MacBook Air with a separate partition from other users on the computer to not commingle private or other business use with research data. The computer itself will be password protected before access can be gained to the desktop. The audio source files once uploaded to the computer will be saved in a folder that would be encrypted with 256-bit AES encryption technology, and decryption would require another password. The transcription of the audio files would be done by Rev, a transcription service who had access to the raw audio data to transcribe the files. To assist in the protection of participant data, a confidentiality agreement would be drafted and sent to Rev for review and signing in other for them to be bounded by oath of secrecy, considering the nature of the information at their disposal. The raw data would be retained for 7 years after which they would be destroyed.

Summary

Chapter 3 presented the design of this study including the selection of participants along with considerations for their treatment and rights as participants. This chapter also included several elements of ethical considerations as well as considerations to bolster the study's credibility, transferability, dependability, and conformability. This Chapter presented the methodology used in this study, inclusive of how the use of Moustakas’s (1994) transcendental phenomenology approach of qualitative research was appropriated to answer the study’s RQs. The researcher presented an overview of this methodology, describing its use and its ability to research aspects and experiences of a phenomenon that quantitative measurement cannot obtain. Descriptions of the population and sample were given, along with the sampling strategy and processes used to gather the qualifying participants necessary for the study, using a purposive sample strategy that included a combination of intensity and criterion sampling. This chapter also outlined the study's precautions to ensure participant protection throughout the study. Finally, Chapter 3 presented an overview of the data collection process and data analysis process and concluded with ethical considerations in this study. Chapter 4 will present a description of the study, the researcher, the actual study sample, and exhibit a presentation of the data collected along with its analysis, in a more in-depth and data-centric presentation of the methodology used.

Chapter 4: Results

Introduction

The need to understand stress as experienced by individuals with alcoholism in a 12-step meeting programs necessitated this study. The target of this study was participants from 12-step meeting programs in Dayton Ohio alcohol recovery program. The participants for this study ranged in age from 18 to 59 years and were in their first-year alcohol recovery journey. Chapter 4 includes sections on the research setting, participant demographics, data collection, data analysis, and data management. I interviewed the participants to gain an understanding of their experiences of stress.

Setting

I applied a qualitative phenomenological approach to answer the primary RQ and two sub-RQs, using 12 open-ended questions to direct interaction with the participants. For efficiency, two tape recorders were used to record conversations with participants. Because the interviews were virtual, the participants were able to choose a distraction-free location of their choosing where they felt free to share anything without fear of people intruding. The target program's private residential library, the confession room in the church, and a private local grape shop were some ideal places for this interview. Participants responded to flyers that were posted at the Outdoor Adventure Center in the Adventure Recreation Center in Dayton Ohio. Each interview took between 50 and 80 min. The interview with participants went well without any complaint that would have put a stop to the interview.

Demographics

Recovery period, educational background, ethnicity, sex, and participant age range were some of the demographics collected from participants (see Table 2). All participants were engaged in 12-step meeting programs in Dayton Ohio alcohol recovery program. All were in their first year of recovery.

Table 2

Participant Demographics

Participant no.	Age range	Sex	Ethnicity	Highest educational level
1	31–40	Female	White	Associate degree
2	18–30	Male	White	High school
3	41–50	Female	Multi	Associate degree
4	31–40	Female	White	Associate degree
5	31–40	Male	White	Some College
6	51–59	Female	Multi	Vocational
7	41–50	Female	White	Vocational
8	31–40	Male	White	Associate degree
9	51–59	Male	White	Associate degree
10	31–40	Male	White	High school

Data Collection

Ten volunteers, all currently attending 12-step meeting programs in Dayton Ohio alcohol recovery program, provided the data for this research. The participants met the requirements set forth in the flyer as criteria for selection. I scheduled a one-on-one virtual interview with each based on their convenience. Before their interview, the participants were informed of the scope and nature of the research, the expectations for

participation, and the rights accorded to participants. There was a provision for follow-up interviews if needed. The interviews lasted 50–80 min. For efficiency, two tape recorders were used to record the interviews with the participants. The recordings were later transcribed. Participants were compensated with a Walmart e-gift card worth $20.00.

Data Analysis

I used a transcription company to transcribe the data collected from participants verbatim. I then performed a content analysis of textural material, which was in electronic files. Applying epoché, all data were analyzed with a goal of setting aside any idea of bias and imaginary assumptions. A composite analysis of the 10 participants' interviews was completed to represent them as a whole. To do so, I used the technique of epoché to avoid prejudgments and preconceptions (see Moustakas, 1994). I gave each meaning unit equal value and, from these units, was able to identify emergent themes. To develop descriptions and identify possible meanings, I used imaginative variation, a technique that was introduced by Moustakas. The textural and structural descriptions that emerged illustrate participants' first-year alcohol recovery journeys.

Textural Descriptions

Textural descriptions include participants thoughts, feelings, and taking into cognizance not only what is visible to sight but also invisible perceptions (see Table 3).

Table 3

Textural Themes Present in Participant Responses

Textural theme	Participant
1. Spirituality	1,2,3,5,7,8, and 10
2. Hitting bottom	1,2, 6 and 9
3. Goals	2,4,7,8, and 10

4. Identifying progress and accomplishment	1,4,8,9, and 10
5. Confusion	4 and 10
6. Comparing the past with the present	2,3,4,5,7,8, and 10
7. Interpersonal connections	2,3,5,8,9, and 10

Spirituality

Participant 1 breathed an air of freedom by trusting and believing in God. This brought the energy to go the steps.. Participant 1 shares, “My trust and believe in God gave me the strength and courage to move on with the program”. For Participant 2, believing in God and himself was the greatest walked with him during the program. He believed and had the courage that he can do it by God’s grace. This strong believe gave him a whole new perspective on life “I hunger and thirst for change…God give me the strength to affect these changes,” he shared. Participant 3 has developed a strong spirituality which she held so tenaciously as she shared, “I have embraced God and build a personal relationship with Him, and I know he will help me.” Participant 5 believe and truth in God was a big strength and courage that walked him the recovery journey. He has a wakeup call as he shared, “Kevin …remember God is watching” This to him, serves as a warning to be alert and clean.

For Participant 7, Spirituality was strength and courage for Participant 7 and this carried her along as she shared, “God is faithful and forgiven…he can help me overcome this shit” Participant 8 Spirituality serves a fuel to run the race without which breaking the ice would have been something else as he shared “Knowing how weak I am… I surrendered to my higher power to help me and indeed he helped me.” Spirituality

awakened a new sense of self for Participant 10. It became a real mirror with which he sees his life and to identify areas that needed changes.

Hitting Bottom

The experience of first-year alcohol recovery journey for Participants 1, 2, 6 and 9 began with hitting bottom. Participant 1 believed that drinking alcohol is not a crime. As she shared, “my initial thought was that drinking is a necessity for life to go on.” Participant 2 shared, “Everything was falling apart, and I felt all alone.” Participant 6 surrendered, admitted defeat, and asked for help. “I was stark, raving terrified.” She shared. Participant 9 almost gave up as he shared, “I almost lost consciousness and believing that I cannot walk these steps anymore.”

Goals

For Participant 2 is conscious of setting target and working hard to achieve the desired goal. “I must be clean and sober” he shared. Participant 4 believe strongly not only in goal setting but also exercising possible effort to achieve it as she shared, “I must make it in life.” Participant 7 does not believe in failure. She puts in a lot of energy in whatever task she dives into and achieves a reasonable result. For Participant 8 sees staying clean and sober as his career and he works hard to achieve it. This made surrender to all the learning that are geared to it. To stay in the right frame of mind daily was the greatest that border Participant 10. “My past is past, and the future is what I have, and to live it right, my future starts today.”

Identifying Progress and Accomplishment

This showed up for Participants 1, 4, 8, 9 and 10. Allowing room for personal mistakes that are unavoidable in life and accepting one's limitations was a great tool used by Participant 1 to overcome past relapses. For Participant 4, the verification of progress and accomplishments energized her to stay clean and sober, seeing the progress already made. For Participant 8, constantly living AA Steps 1 and 2 on a daily basis and being alive with the recovery programs was a huge lift to recovery. For Participant 9 and 10, The value of recovery was show cased in the accomplishment made and how tenaciously it is guided.

Confusion

First year recovery experience for Participants 4 and 10 came with confusion. "I was scared, with little or no proficiency in recovery program" shared Participant 4. Participant 10 shared, "I was worn-out with fatigue and not wanting to embarrass myself."

Comparing the Past With the Present

The encouraging progress already achieved was evidenced as shown in the comparing the past with the present for Participants 2,3,4,5,7,8, and 10. This helped in the recovery process for Participant 2, 3 and 4. Thanking God daily after waken up for a new sober day granted is his latest concern, or another day of sobriety," shared Participant 5. There is a huge success recorded comparing the life of yesterday with today for Participant 7, "I have learnt to let go of my horrible past that hunts me down always, I now know am not alone in the whole world" she shared. Participant 8 believed strongly

that the present has more and better news than the past life as shown in her quote, “More credit to my recovery program, it really did give me a new sense of self and I feel like telling everybody that am happy.” Participant 10 cannot trade his present life with his past for he believes that a noticeable improvement has been made and that stands as a big motivator.

Interpersonal Connections

The rate of improvement and cordial interpersonal connections has grown and helped in the first-year journey for Participant 2. Participant 3 decided that she liked this new life as relationships with others as well as interpersonal connections grew. For Participant 5, first year recovery journey was positively induced by identifying with others in recovery, good supportive communication, and sincere feelings of comradeship. For Participant 8, constantly living AA Steps 1 and 2 on a daily basis and being alive with the recovery programs was a huge lift to recovery. For Participant 9, Problem shared is half solved. In accordance to his idea during his first-year recovery journey he quotes, “Communicating my faults with others brings an air of being free and knowing that am not left alone in my decision making.” For Participant 10, being honest with the treatment, fellow participants and the instructors grew interpersonal connections.

Structural Descriptions

Structural descriptions offer a vivid account of the underlying dynamics of the experience Moustakas, (1994). Structural descriptions are based on applying the universal structures of life to the data collected by using imaginative variation. The universal

structures of time, space, bodily concerns, materiality, causality, relationship to self, and relationships with others were all examined (see Table 4).

Table 4

Structural Themes Present in Participant Responses

Structural theme	Participant
1. Relationship to self	1–10
2. Relationship with others	1–10
3. Structure of time	2,3,4,5,7,8, and 10
4. Causality	3,5,6, and 9

Relationship to Self

The structure that was conspicuous during the first-year recovery journey experiences for all the participants was relationship to self. For Participant 1, having faith in herself and telling and believing that recovery is not an impossible task stood her up to overcome most of the challenges.

For Participant 2, relationship to self-emerged as he hit bottom. Drinking, smoking, party, and merriment life was all hell for participant 2 until he entered recovery program. His life changed and became meaningful.

For Participant 3, it was all carelessness, even wanting to end it all. Learning the 12 steps of AA from 12-step meeting programs in Dayton Ohio alcohol recovery program, brought a laudable change and a new embrace to a positive living.

Participant 4 newness of self was developed during the recovery program as to compare with the initial confusion and an altered sense of self as was the case before entering the recovery program.

For Participant 5, the awareness of how a failure his past has been before the recovery journey gave rise to a more determine personality in him with the motto “I must make it” as shared by him.

For Participant 6, Surrender was the watch word; ready to accept corrections and help.

Participant 7 shared, “I became angry at the slightest provocation and can-do silly things before. Thanks, and credit to the program that impacted self-control and dignity.”

For participant 8 “I lost things easily, always angry with myself for any little mistake and will grudge for days unforgiving but with the ongoing program, I have learnt to forgive myself and that mistakes are part of being human.”

For Participant 9, early involvement in alcohol at a very tender age and being in a family that has alcoholism as a problem was the start of many vices for me. Things were going from bad to worst. There was no self-value. Being in the program and sharing with fellow participants and asking questions brought light and dignified self-back.

For Participant 10, Life was firstly threatening with fear, confusion wasting and incurring debts. Being high at all times, wining and dining and losing a lot of money and valuables on daily basis. Being honest, surrendering, and willing to change remolded his self-esteem.

Relationship With Others

Relationship with others emerged as a common structure for all the Participants. Participant 1 acceptance of God into her life serves as an open door for growth. Being a

good listener and sharing her experiences endured her to people love program, and learning to take responsibility for all her actions gives her an aura of freedom.

Participants2, 3 and 4 had a similar approach as concern relationship with others, all made friends with some members who are supportive in the program, being open to the supervisor and most importantly, invocation of God into their life help to speed up their recovery journey.

For Participant 8 relationships with others grew through restored relationships with family and a developed circle of recovery friends. Family and recovery friends became a support system that was a leading factor to success in early recovery. Daily AA meetings and working the 12-steps with a sponsor served as a guide for maintaining sobriety during the first year of recovery. Identification with others in recovery became a contributing factor for success in sobriety.

Participant 8, 9 and 10, having an honest and experience supervisor who understand their paste and follow them with easy made them open themselves well for him to assimilate and help them. Making being clean a strong motive and surrendering to all assignment and putting all in God hand as the author and finisher of everything get the back to their feet with dignity.

Structure of Time

For participants 2,3,4,5,7,8 and 10, time appears as a central structure. This became evident through comparison of Past life with the present life as well as the future. Participant 2 shared,

“The highest and most important achievement that assisted me the most was personal relationship with God which I developed during the recovery period.”

Participant 3 shared, “The treatment program has inculcated a new idea of life in me and my belief now about life is new. “

“The treatment program has imbibed in me never to stoop low to failure but to embrace success as the only option as regard to my past experiences” said participant 4.

For Participant 5, the comparison shows how fruitful being in the treatment program was than when trying to handle issues by herself as she shared, “with the energy, support and counseling I receive on a daily basis, I feel happier and know that am not alone.”

“I have learnt to let go of my horrible past that hunts me down always, I now know am not alone in the whole world” quoted participant 7.

“More credit to my recovery program, it really did give me a new sense of self and I feel like telling everybody that am happy” said participant 8.

Participant 10 was too optimistic about the positive achievement recorded and was not ready to trade it for anything.

Causality

Causality surfaced as one of the central structures with participant 3,5,6 and 9.

Participant 3, realizing her ugly past, resolved with all effort to pursue a more meaningful life and this made her to seek help as she quoted “I have embraced God and build a personal relationship with Him, and I know he will help me.” She added “The

treatment program has inculcated a new idea of life in me and my belief now about life is new. "

Participant 5, not to fall back again to old self formulated a slogan to always remind him when he is about sliding backward as he quoted, "Kevin …remember …God is watching."

For Participant 6, not wanting to be visited again by her past life gave in to anything that brings development she quoted, "Surrender was the watch word; ready to accept corrections and help."

"Communicating my faults with others brings an air of being free and knowing that am not left alone in my decision making" shared participant 9.

Evidence of Trustworthiness

Credibility

Achieving saturation is another way of achieving credibility which was reached in this research work for similarity experiences began to surface after interactions with participant 9. Fusch and Ness (2015) has it that in the presence of no new data, themes or coding, saturation has been achieved.

Transferability

From the targeted population from 12-step meeting programs in Dayton Ohio alcohol recovery program, participants were selected within age range 18 to 59 years and being in their first-year journey and having transferability in mind the study was not restricted to any gender but was all gender inclusive.

Dependability and Conformability

By the use of an audit trail and flexibility journal for this research work, dependability and conformability was ensured.

Results

For a clearer understanding of the commonalities among all participants, the following sections are composites of textural, structural, and the combination of textural-structural themes and definitions.

Composite Textural Description

This composite textural description was formed from the entire group of Individual textural descriptions. The meaning units and the themes of all participants interviewed were studied to represent the experiences of the group as a whole.

Theme 1: Spirituality

A dominant theme that was so conspicuous during the interview was spirituality. Spirituality is the broad concept of a belief in something beyond the self. It strives to answer questions about the meaning of life, how people are connected to each other, truths about the universe, and other mysteries of human existence. This serves as a gateway to growth and newness geared toward recovery. Spiritual maturity paves way to honest with self which is an important factor in recovery.

Theme 2: Hitting Bottom

Hitting bottom is associated with despair and wanting to end it all. The drink one takes as a consolation ceases to be an antidote. This brings a push to look for a better

solution that yields dividends. This serves as an agent of change and a gateway to the recovery journey.

Theme 3: Confusion

Lack of proficiency component in recovery during the first-year journey throw participants into confusion, not knowing what to expect and this is one of the dominant themes among the participants. This could lead to depression. It is beneficial to inculcate educational component in recovery during the first-year journey.

Theme 4: Goals

Another dominant theme goal setting surfaced all the participants hunger and thirst to be clean and sober. The strongest goal for recovery is being in 12-step meeting programs in Dayton Ohio alcohol recovery program and the hunger to make it. To help others and have supportive friends in recovery and become a productive member of society is a vital goal. Having a job and training are among the goals and inspiration for being capable of taking care of self and developing into a fruitful member of society.

Theme 5: Contrasting of Past and Present

Dominant during the interview with the participants is the theme of contrasting the past and present. Some participants were of the opinion that they cannot trade their present life with their past for they believed that a noticeable improvement has been made and that stands as a big motivator to stay clean and sober. “I have learnt to let go of my horrible past that hunt me down always, I now know am not alone in the whole world,” “More credit to my recovery program, it really did give me a new sense of self and I feel like telling everybody that am happy.” These are from hearts that met with improvement.

Theme 6: Verification of Growth and Achievement

Identification of growth and achievement surfaced as one of the themes common to the participants. Here, recovery takes the credit of being the reason for the growth and achievement. Statements were made such as, "More credit to my recovery program, it really did give me a new sense of self and I feel like telling everybody that am happy." These are individuals who have made tremendous progress, growth, and accomplishments.

Theme 7: Interpersonal Connections

One of the strongest themes that surfaced was interpersonal associations. This was conspicuous in associations with others in recovery and the strong support derived from there as depicted by the quote, "Communicating my faults with others brings an air of being free and knowing that am not left alone in my decision making."

Composite Structural Description

To represent the entire group in one piece, all the participants structural description interviews were created, to understand as a group their unified experiences during their first-year journey in recovery. From the textural descriptions, I developed structural themes by using the technique of imaginative variation. Causality, materiality, space, relationship to self and others and possible structures of time were imagined by the researcher. These are common structural groundings associated with textural statistics.

Theme 1: Relationship to Self

Though participants' perceptions vary, lack of confidence and self-esteem shine light on their relationship to self. This brings confusion as to what to expect in the first-

year recovery journey. "I lost things easily, always angry with myself for any little mistake and will grudge for days unforgiving but with the ongoing program, I have learnt to forgive myself and that mistakes are part of being human."

Theme 2: Relationship With Others

References were made by participants on how relationships with others in recovery facilitated personal growth. "I made friends with some members who are supportive in the program, being open to the supervisor and most importantly invocation of God into my affair help to speed up my recovery."

Theme 3: Causality

Some of the statements that portray the theme causality are:

- "I have embraced God and build a personal relationship with Him, and I know he will help me."
- "The treatment program has inculcated a new idea of life in me and my belief now about life is new. "
- "Communicating my faults with others brings an air of being free and knowing that am not left alone in my decision making."

Theme 4: Structure of Time

For clarity, time was visited through past, present, and future. Past involvement is ascertained by weighing the past with the present. This brings memories of hopelessness. Fighting and quarrelling before commitment was made to recovery. They present how much success and growth has taken place and how much life has improved. The future structure of time when making goals now appears significant. "I became angry at the

slightest provocation and can-do silly things before, thanks and credit to the program that impacted self-control and dignity."

Combined Textural-Structural Description

For a united collective experience of the participants in one piece, a combined textural-structural description was formed from the whole group. As propounded by Moustakas "…The texture and structure come together to create fullness in understanding the essences of a phenomenon or experience" Moustakas, (1994). The meaning units and themes of all participants were studied in order to represent the experiences of the group as a whole. Family and lack of job, health issues, legal problems, low self-esteem, and lack of confidence in self are common with most of the participants. A new sense of self was discovered as they advanced in the treatment program. Motive for staying sober and clean varied with each participant. Nevertheless, success and growth were evidence among all the participants as shown in their newness of life as regard relation to people, self and things. Past involvement is ascertained by weighing the past with the present. This brings memory of homelessness, fighting and quarrelling before commitment was made to recovery. The present represents how much success and growth have taken place and how much lives have improved. New senses of self surfaced as recovery experiences progressed. Learning to forgive others and self-surfaced, as to move forward in their recovery process.

Summary

Need to understand stress as experienced by individuals with alcoholism in a 12-step meeting programs in their first-year recovery journey necessitated this study. Data

from participants showed some themes attributable to them, like, spirituality, hitting bottom, goal, identifying progress and accomplishment, confusion, Comparing the past with the present and Interpersonal connections; together with four structural themes, relationship to self, time, causality, and relationship with others. The depiction signifies the experiences of the whole group. It showcase the meaning units that appear from analysis of data. The findings and recommendations are the subject of discussion in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The need to understand stress as experienced by individuals with alcoholism in a 12-step meeting programs in their first-year recovery journey necessitated this study. The participants in this study were engaged in 12-step meeting programs in Dayton Ohio alcohol recovery program. All the participants witnessed withdrawal syndrome in their recovery journey, these were evidenced as they shared their recovery experiences. I created a combined textural-structural description for all participants to represent wholeness. To represent the group experience as a whole, the meaning units and themes of all participants were studied. The composite themes included textural and structural themes. Relationship to self, relationship with others, causality, time, verification of progress and accomplishments, contrasting the past and present, and interpersonal connections were the structural themes. Confusion, goal setting, spirituality, hitting bottom, and staying sober and clean were some of the textural themes that appeared.

Interpretation of the Findings

This research aids in understanding the lived experiences of stress of individuals with alcoholism striving towards recovery, specifically while in their first-year alcohol recovery journey. To achieve this understanding, I collected and analyzed data from 10 individuals in their first-year recovery journey. A combined breakdown of the 10 participants' interviews was created to represent them as a whole. The findings concur to a large degree with the broader literature, as to insufficiency of service provision and odd issues of exclusion and discredit. Eliciting the perspectives of people in their first-year

recovery provides insight that can potentially be used to conceptualize services that meet people's whole needs for long-term recovery. The lived experiences of individuals in their first year of recovery from alcohol is an important contribution and addition to existing knowledge, as the present literature in this area is limited. As described in Chapter 1, there was a need to convey an understanding of the experiences of SUD recovery, pertaining to specific populations and settings. Furthermore, a deep understanding of an experience can only be obtained by studying the experience with data from those who were part of the phenomenon (Creswell, 2007; Moustakas, 1994; Patton, 2002). I developed a combined textural-structural description from participant responses to portray them as a whole. The combined description offers fullness in understanding the essences of a phenomenon or experience (Moustakas, 1994). The meaning units and themes of the 10 participants were studied to represent the experiences of all-in-one piece. For all 10 participants, low self-esteem and lack of confidence caused confusion about what to expect in their first year of recovery. A dominant textural description was the theme of spirituality. Spirituality served as a gateway to growth and newness of self. This newness of self was a key influence towards recovery. Confusion regarding treatment surfaced as one of the themes as it was often experienced by participants, based on their responses. Lack of social support was identified as the contributor and may lead to hopelessness and depression. Social support is the perception and actuality that one is cared for, has assistance available from other people, and most popularly, that one is part of a supportive social network. These supportive resources could be emotional, informational, companionship or tangible support. Support can come

from many sources, such as family, friends, pets, neighbors, coworkers, Organizations or Government. Having an educational component during the first-year treatment could be an antidote for this. All 10 participants reported experiencing low self-esteem and lack of self-confidence in being able to cope with the program in their first year. This should serve as a chief concern for counselors, addiction therapists, psychologists, psychiatrists, and treatment facilities.

The next theme that surfaced among all was relationships with others. This appeared as a supportive factor to success in the first year of recovery. Another textural theme was hitting bottom with feelings of hopelessness and knowing that drinking was the antidote. Hitting bottom to all participants was like one on a state of despair, but it served as a catalyst for change, and this led them on the road to recovery. This pathway was where the relationships with others became so important to all 10 participants as a supportive factor to success in their first-year recovery.

Causality emerged as another theme. Causality surfaced in a variety of ways. For one participant, not wanting to be visited again by her past life gave way to anything that brings development, the learning of empathy, and caring. For another, causality appeared when examining his old lifestyle and verifying his progress. Also, the development of spirituality led to forgiving oneself, learning empathy and caring, giving back to others, and thereby lifting some of the confusion of first-year recovery journey.

Evaluating the past progress with the present presented another vital structural theme. The future structure of time was important for goal setting. Goal setting appeared a great motivator for recovery. To stay clean and sober was the strongest goal as recovery

was the main goal. Goals such as employment and job training are imperative for taking care of self and becoming a creative member of society.

Another dominant structural theme was contrasting the past and present. This created an ordinary reason to stay clean and sober. First year's recovery led to improved relationships. All the participants testified how much improved their present lives are now since making a pledge to recovery. Another dominant structural theme was verification of progress and accomplishments. The utmost ordinary element of this was that credit was given to recovery as the motive for making progress and accomplishments.

The next structural theme that remains dominant was interpersonal connections. The strongest element of this theme was the association with others in recovery. The strengths of this study are that it shows a strong connection to the research and literature regarding long-term recovery management and continuing care for those in first year recovery. Continuing care is treatment that was tailored around the client's symptoms, status, and level of functioning. Continuing care is very individual and is flexible in regard to the duration and intensity; that is the decreasing or increasing of the continuing care. Support was individualized for each client using both scheduled and unscheduled contacts with the client. Something as simple as a telephone call unscheduled can mean a great deal to a client's feelings of his/her needs being met, being connected, and being cared for by a supportive therapist (McKay, 2005).

Limitations of the Study

There are some few constraints envisaged in this research work like lack of considerable financial resources and time constraint for the scope of the study. In addition, qualitative research carries with it the restraint through possible bias of interpretation and explanation of findings and collection of data.

Recommendations

Development of helpful resources for recovering individuals is possible due to many aspects of lived experiences that this study presented. Some likely future research prospects were discovered that can be another research avenue at the completion of this work. These are, accessibility of fund, specifying peer support area of responsibility, institution of family training support system and modernization of aftercare programs, Recovery support services are aimed at eradicating obstacles and opening corridors to recovery. Such services as recovery residences, childcare to increase access to support meetings, sobriety-conducive employment, educational access, debt management and budget counseling and sober fellowship all aid in recovery management. The overall goal of these services is to eradicate obstacles to recovery and to create a sober positive space where recovery can appreciate. Many of these recovery support services can be designed and delivered by peer groups from the recovering community (Faces and Voices of Recovery, (2010).

A shift should be made by alcohol treatment houses to focus their vigor on elasticity and recovery. Recovery is a reality in the lives of hundreds of thousands of individuals and their families. A qualitative study could derive from this study to discover

if family support training helps in the recovery process. A derivative of that study could be to interview families of the recovering individual to discover the impact of the recovery experience on the family system. This is just one of the possible additional avenues of research, but if this area is explored, then recovery support services could be better informed of possible needs of other supportive resource services.

Implications

Judging from this study discovery, potentials for active societal development exist. The discovery offered strengthening of social learning theory and acknowledged some dominant themes which appear from the research deliberations with participants that regardless of the strictness of the alcohol addiction an individual within 12-step programs in Dayton Ohio alcohol recovery can find freedom from them. The 12-step programs in Dayton Ohio alcohol recovery has impacted the participants live in this study. Possibility of societal necessity and advantage to the likelihood of reproduce alike programs to help people who have alcohol addictions but miles away from Dayton Ohio alcohol recovery is possible.

Conclusion

This study sort to understand stress as experienced by individuals with alcoholism in a 12-step meeting programs in their first-year recovery journey necessitated this study. Social Learning Theory propounded by Bandura’s (1977) was used as a theoretical foundation for this research work. This research work is available for all readers. This research work shall serve as a reservoir of knowledge for associates and scholars searching for more proficiency in the area of recovery related problems. There is also an

exposition of what is known to help in recovery, what could be useful but not available, and some likely bottle neck in the first-year recovery journey. Professionals, individuals, and researchers shall have this research work as an important reference.

The participant life narratives brought the originality, the richness and flexibility of the human character for which this researcher is overwhelmingly thankful. This research has been not only an honor and privilege to conduct, but also a renewal of faith in the belief that if given the proper tools for long-term continuing care and maintenance then recovery will be enhanced and longer-term recovery will happen often. The good news is that research shows that progress is being made in recovery maintenance programs (White & Taylor, 2010).

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Appendix A: Sample Flyer

College of Social and Behavioral Sciences

Walden University

VOLUNTEERS! VOLUNTEERS!! VOLUNTEERS!!!

I am looking for volunteers to take part in a research study on lived experiences of stress for people with alcoholism striving toward recovery.

Criteria for participation

Volunteers must meet these requirements:

. Participants must be between 18 to 75 years of age.

. Be currently in attendance in alcohol recovery program.

. Be In their 1st year alcohol recovery journey.

Purpose:

Collection of data through video chat interview on the lived experiences of stress from individuals with alcoholism striving toward recovery who are in their first-year recovery journey.

Appreciation:

A Walmart e Gift Card worth of $20.00

Contact Person:

Gerald C. Okeke

Email address: [redacted]

Phone number: [redacted].

IRB Approval number for this study is 10-21-22-0271068.

Appendix B: Interview Questions

1. How did you make the decision to quit drinking alcohol? Can you tell me about any specific life experiences that were related to your decision to quit?
2. •Walk me through your process of recovery from alcohol? What kind of cravings, hunger or yearning to go back to it do you experience?
3. •Tell me about the specific persons or groups that you experienced as helpful during your early months?
4. •Tell me about what you needed to do to quit drinking alcohol?
5. •How would you describe your current priorities?
6. •How would you describe your current support systems?
7. •Has there been changes in your family members or significant others? If so, how have their changes affected your recovery?
8. •What available resources have been helpful?
9. •What resources were not available, that you think could have been helpful?
10. •Has spirituality played a role in your recovery? If so, how would you define spirituality?
11. •Overall, is there anything I have not asked that you would like to add about your experiences in recovery?
12. •What is your personal definition of successful recovery?