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UNIVERSITY OF ALBERTA

NATIVE CANADIANS' EXPERIENCE OF RECOVERY FROM CHEMICAL DEPENDENCY

BY

LINDA JOAN MASSIMO 

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION

IN

COUNSELLING PSYCHOLOGY

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled NATIVE CANADIANS' EXPERIENCE OF RECOVERY FROM CHEMICAL DEPENDENCY submitted by LINDA JOAN MASSIMO in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology.

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Mary Ann Bibby, M.Ed.

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Date: January 3, 1993

Dedication

To my mother, Joan Nuttall Massimo, who taught me the importance of having faith in the potential of others;

To my daughters, Maria Meequon and Melina Meewapun Laboucan-Massimo, who show me the importance of demonstrating faith in the potential of others on a daily basis; and

To all recovering people, everywhere, who are involved in the never-ending process of discovering their own potential.

Abstract

Little qualitative study of chemical dependency recovery among Native North Americans has been completed. At the same time, high rates of substance abuse exist. Recently, a movement toward recovery and healing has begun among Native people. The purpose of this study was to understand and document the experience of chemical dependency recovery that is taking place among Native people, from the perspective of the recoverers.

Six Native Canadians, ranging in age from 22-51, were interviewed. A grounded theory approach was used to collect and analyze data.

Four stages of recovery emerged from the participants descriptions. The stages were: Entering Recovery - recognition, acceptance, and receiving help; Early Recovery - building a sober lifestyle; Middle Recovery - working on deeper issues; and Late Recovery - reaching balance and continuing growth. Four themes were identified: utilizing resources and doing the work, the importance of others, psychospiritual changes, and the importance of Native spirituality and culture. The stages and themes important in the participants' recovery were incorporated into an integrated model of recovery which encompassed external, internal, behavioural, and interpersonal aspects. Psychological and spiritual dimensions were also integrated in this model.

Findings were compared with chemical dependency

recovery literature and literature specific to Native recovery and counseling. Native participants' recovery was similar to chemical dependency recovery within the general population, in its broader patterns and themes. However, involvement in Native spirituality and culture became important by the Middle Recovery stage, following stabilization of sobriety. A process of discovering and defining one's cultural identity and healing traumas related to cultural loss also took place. These aspects distinguished the Native participants' recovery experience from recoverers in general. Implications for helping professionals, program planners, Native communities, and people in recovery as well as possible areas of future research are suggested.

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and family. From this, I gained an understanding and appreciation of traditional Cree culture and the strong interconnectedness between people within this culture. I also gained a painfully intense awareness of the trauma experienced by Native people due to the encroachment of outside forces upon traditional Indian culture and lands.

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CHAPTER ONE
INTRODUCTION

Purpose of the Study

The purpose of this study was to explore the process of recovery from chemical dependency as it is currently experienced by Native Canadians. Through the use of in-depth interviews, it attempted to answer the following questions: What is the experience of Native Canadians who have overcome chemical dependency? What factors are important in facilitating this change? and Is there a common process involved in the experience?

Chemical dependency may be defined as dependence on or addiction to psychoactive substances such as alcohol, marijuana or cocaine. This state usually results in excessive use and lack of control over use of psychoactive substances, as well as the creation of problems in numerous areas of the individual's life (Milhorn, 1990). Psychoactive substances are those drugs which have mood-altering properties (Cox, Jacobs, Leblanc, & Marshman, 1983).

Recovery from chemical dependency may be defined as the cessation of psychoactive substance use (abstinence), with the accompanying rebuilding of functional social relationships, and the restoration of physical, emotional, mental, and spiritual health (Milhorn, 1990). The process involves changing addictive behaviour patterns to nonaddictive, positive coping ones.

For the purposes of this study, Native Canadians were

defined as individuals having some Canadian Indian blood who identified themselves as being Native.

Need for the Study

Alcohol and other drug abuse among Native North Americans has reached alarming proportions and produced devastating consequences. It is estimated that 75% of Native deaths in Canada due to accidents, poisoning, and violence are related to alcohol abuse (National Native Alcohol and Drug Abuse Program [NNADAP], 1985). For every non-Native, there are five Native Canadians who die from such deaths. For every non-Native Canadian who dies in an accidental fire, there are 30 Native Canadians who die in accidental fires. It is estimated that 90% of accidental fires in Native homes in Canada involve alcohol use (NNADAP, 1985). Eighty percent of deaths among young Native people, age 16 to 35, are linked to alcohol and drug use, while the majority of suicides are considered to have some connection to alcohol and drug use (NNADAP, 1985). Recently, the use of psychoactive substances, particularly solvents, has been reported among Native children, as young as five to eight years of age (NNADAP, 1985). As well, a significant number of Native children are being diagnosed with physical and psychological effects attributed to maternal alcohol abuse during pregnancy (NNADAP, 1985). A number of Native organizations, as well as a number of studies, have identified substance abuse as the leading health problem

confronting Native people today (Beauvais & LaBoueff, 1985; French, 1989; French, 1990; Nechi Institute, 1985).

Countless studies have documented substance abuse problems among Native people (Manson, Tatum, & Dinges, 1982) and many have postulated possible factors related to a high incidence of chemical dependency in Native communities (Beauvais & LaBoueff, 1985). However, few have documented the rising movement toward recovery from chemical dependency among Native people. During the past 20 years, numerous strategies and innovative programs to alleviate substance abuse have been initiated (Medicine, 1982). Many of these have been conceived, designed, and operated by Native people and are based in Native values and the cultural context of Native communities (Hodgson, 1987; NNADAP, 1985). An increasing number of Native individuals and Native communities have found ways to overcome chemical dependency (Willie, 1989) and have experienced intense healing and phenomenal psychological change processes. Many of these individuals and communities have gone on to share their knowledge and experiences to help others (Alkali Lake Indian Band, 1986; Nechi Institute on Alcohol and Drug Education, 1987).

Most of the information about this process of chemical dependency recovery among Native people is known through informal networks and popular media. Little is documented in formal studies. A few studies have quantitatively assessed

characteristics related to positive outcome for Native people following substance abuse treatment (Westermeyer & Neider, 1984; Westermeyer & Peake, 1983). However, qualitative or in-depth analyses of the recovery process among Native North Americans is lacking. There has been an overemphasis on studying the problem, rather than instances of the solution (Medicine, 1982). The same is true in the chemical dependency field generally. Very few qualitative studies of the recovery process are available. At the same time, there is a great need for this type of information among helping professionals, Native communities and the public at large.

It is for this reason that recovery from chemical dependency among Native Canadians was chosen as a research topic. A qualitative approach was required to document the actual process and to understand the richness of the experience of recovering Native Canadians. Such documentation provided a data base with which other Native and recovering people could compare their experiences. This research also provided a forum for recovering people to "tell their story" and share their experience of hope and positive change. Such sharing further illuminated the paths to positive change, as well as the role of helping relationships in the healing journey.

The specific aim of this research project was to describe the process of chemical dependency recovery from

the perspective of Native Canadians who have undergone such a process. An attempt was made to address the following issues: (a) What factors facilitated recovery?; (b) Were there turning points in the process, and, if so, what were they and what seemed to facilitate these turning points?; (c) What aspects of counseling and therapy were helpful in the change process?; (d) What were some obstacles to positive change?; (e) What skills or processes were helpful in maintaining sobriety and positive changes?; and (f) What elements and stages were common among participants?

CHAPTER TWO
REVIEW OF THE LITERATURE

Introduction

Because little qualitative research about the process of chemical dependency recovery among Native people is available and because of the importance of understanding the context of therapeutic change and of Native culture and history, three areas of research will be reviewed. The first will relate to chemical dependency recovery and sobriety among Native people. The second will address recovery and change of addictive behaviours in the general population. The third will be a review of studies related to counseling approaches and therapeutic interventions effective in Native communities.

The Literature

Indian Sobriety and Recovery from Chemical Dependency

As stated earlier, there is a dearth of formal documentation about the Native North American experience of chemical dependency recovery. Medicine (1982) provides one of the few forays into qualitative analysis of Indian patterns of sobriety. Her work analyzes the patterns of Lakota individuals who ceased drinking while living in their home community. Many of these individuals would be termed "self-changers" (Prochaska & DiClemente, 1986), as most did not undergo formal treatment or take part in support groups. Her analysis is based on ethnographic observations and data from earlier studies in which abstainers were asked what

helped them decide to quit drinking and what helped them stay sober.

Medicine found that a recurrent theme in Lakota decisions to stop drinking was a total discouragement and "tiredness with an obnoxious situation" (Medicine, 1982, p. 204). This sounds familiar to the Alcoholics Anonymous (AA) phrase "sick and tired of being sick and tired", often invoked to describe the turning point when one decides to quit drinking.

Rejecting a life of disorganization due to alcohol use and trying to take on a productive life seemed to be at the centre of the sobriety process for the Lakota people (Medicine, 1982). Medicine observes that this process was a painful one; due to the heavy drinking and social pressure of friends in the community, these individuals socially isolated themselves to maintain sobriety. There appeared to be no community groups or few networks to support sobriety.

Medicine (1982) also found that a period of introspection and self-awareness was a necessary step leading to sobriety. This process fit well with traditional psychotherapeutic practices of the Lakota, which emphasize examining one's own actions, self-actualization, individual autonomy and the individual's responsibility to make change. This period of introspection parallels the "contemplation" stage elucidated by Prochaska and Diclemente (1986) in their studies of individuals who have changed addictive behaviours.

Medicine (1982) also comments on the use of traditional rituals and ceremonies by Lakota to achieve and maintain sobriety and as an alternative to drinking. Others have documented this trend as well (Jilek, 1982). Medicine conjectures that awareness and revitalization of traditional practices, as well as movement toward self-determination may be positive forces in countering substance abuse in Native communities in the future. Although not extensively documented in the formal chemical dependency literature, the integration of traditional Native healing practices, such as the use of elders and traditional rituals, into chemical dependency treatment and other areas of Indian mental health is a successful and growing trend (Attneave, 1985; Heinrich, Corbine, & Thomas, 1990; LaFromboise, 1988; LaFromboise, Trimble, & Mohatt, 1990; Long, 1986; Murphy & DeBlassie, 1984; Red Horse, 1982).

Some quantitative analyses of Native client characteristics related to positive treatment outcome for alcoholism have also been completed. In a ten year follow-up of American Indian alcoholics treated for one to three weeks in hospital, a more positive treatment outcome was associated with compliance with treatment recommendations, marriage, less parental loss or childhood foster home placement, and a preponderance of Indian friends as compared to non-Native friends (Westermeyer & Neider, 1984). The latter finding appeared to be related to the fact that those

whose condition deteriorated had alienated their Indian family and friends.

Further analysis of the follow-up data indicated that those who had achieved two years of sobriety tended to have stable employment and/or be married, suffered from less depression, and had stronger interpersonal relationships than those who had not attained sobriety (Westermeyer & Peake, 1983). In the general population, stable marriage or work situations at admission to treatment have been found to be associated with better treatment outcomes (Bromet & Moos, 1977). Sober individuals in Westermeyer and Peake's study also provided help to other alcoholics, as well as served as positive role models in the community (Westermeyer & Peake, 1983). In another study, identification with nondrinking Native staff and less facility with English appeared to be related to successful treatment outcome in a five day treatment program (Ferguson, 1970).

The importance of interpersonal relationships, and the maintenance of relationships conducive to sobriety and reduction of those that militate against abstinence appears to be an essential theme of recovery for Native North Americans. This is generally an important consideration in chemical dependency recovery, but may be an even more significant factor in Native communities due to the extremely relational nature of Native North American culture. Numerous writers have commented on the strong

interpersonal relationships within Native communities and the importance of interpersonal networks (LaFromboise, 1988; Murphy & DeBlassie, 1984; Thomason, 1991). Some therapeutic approaches have even been designed to utilize this inherent strength among Native groups (Attneave, 1969; Red Horse, 1982; Speck & Attneave, 1973).

The Change Process and Addictive Behaviours

Although many popular books have been written about how to achieve and maintain sobriety, only a few qualitative studies were found in the formal literature that investigated the chemical dependency recovery process. One of these (Amodeo & Kurtz, 1990), focused on cognitive processes related to abstinence. In the study, White male interviewees were asked specific questions about precipitants and factors related to maintenance of abstinence. The second (Hunt & Seeman, 1990) explored women's process of recovery from alcoholism through in-depth interviews.

The male participants reported that the main cognitive set at the time of their decision to quit drinking was an awareness that their lives were in crisis (Amodeo & Kurtz, 1990). Most also reported two or more motivators as helpful in maintaining sobriety. These included support from others and fear of losing their family. A variety of treatment approaches, such as attendance at a treatment program and involvement in AA, were also reported to be useful.

Hunt and Seeman (1990) compared two sets of women in their study - those just entering treatment and those who had maintained sobriety for five years or more. Like the men in Amodeo and Kurtz's study at the beginning of recovery, the first group were living in crisis. The recovered women, however, had stable lives and a clear sense of self. They had also reassessed old relationships and established new ones. As in Westermeyer and Peake's (1983) study, these women had shifted from receiving help to being individuals who helped others. Here again it seems the importance of interpersonal relationships was significant.

MacDonald (1983) directly investigated the effect of interpersonal relationships on the recovery process. He interviewed 93 women one year or more after treatment to assess their degree of recovery and type of personal networks. He found the number of close, emotional supports was predictive of sobriety, while the number of dysfunctional relationships in terms of maintaining sobriety, were predictive of negative treatment outcomes. The number of life problems reported at admission to treatment was also associated with negative outcomes.

Because marriage and involvement in a family setting has shown to be predictive of positive treatment outcome, Cronkite and Moos (1980) compared the treatment outcome and numerous pre, post and treatment variables of 120 clients two years after treatment, who returned to family settings

following treatment. This enabled them to determine the complex interrelationships of factors operating in recovery other than marriage and family involvement. They developed a comprehensive path analysis of the recovery process linking pre, post and treatment characteristics with treatment outcome.

Cronkite and Moos (1980) found that coping abilities were strongly related to abstinence. The presence of major life stressors was negatively related to abstinence. However, coping skills helped minimize the effect of stressors in many cases and there was a delicate interplay between stressors and coping skills in recovery. The majority of variance in treatment outcome remained unexplained, however, and the authors suggest that research is required to identify other important factors such as nonfamily related environmental resources (for example, social supports).

Evidently, the process of changing addictive behaviours can be very social in nature (Orford, 1986). Even "self-changers" who had quit drinking on their own (without formal treatment, counseling or help of a support group), identified external influences such as the persistent support of family members as key factors in their abstinence (Tuchfield, 1981). These "self-changers" also cited humiliating events as instrumental in their decision to quit. They also reported a gradual increase in religious

commitment during abstinence.

As can be seen in the latter study as well as in Medicine's (1982) and others, recovery from substance abuse may often involve a spiritual aspect (Amodeo & Kurtz, 1991; Orford, 1986). Spiritually-loaded processes, such as self-liberation, a new sense of life, commitment to change, and a greater awareness of self and others are perceived to be important factors by those who change addictive behaviours (Orford, 1986).

Ten processes related to addictive behaviour change have been identified and supported by studies on recovery from addiction (Prochaska & DiClemente, 1986). These studies include retrospective, cross-sectional, and longitudinal studies of self-changers, as well as empirical and theoretical analyses of therapy approaches and change during therapy. Seven of these processes: consciousness-raising, self-liberation, social liberation, self-reevaluation, environmental reevaluation, dramatic relief, and helping relationships, all have a strong spiritual and introspective component. Helping relationships, consciousness-raising, and self-liberation were the three highest ranked processes of the ten across studies of various types of addictive behaviour change (Prochaska & DiClemente, 1986). Helping relationships and consciousness-raising were used more in addictive behaviour change which involved spiritual and psychic distress than in behaviour changes such as weight

control.

Prochaska and DiClemente (1986) have identified four stages of change found in studies of addictive behaviour change within which the ten change processes take place. These studies included development of an instrument for assessing the stages of change with clients entering therapy, replication studies of psychiatric patients, and longitudinal studies of self-changing smokers, as well as others. The stages consist of: (1) precontemplation, in which the individual has not yet begun to confront the addiction and the ten processes are not much used; (2) contemplation, in which the individual begins to observe, reflect upon, and confront the effects of the addiction. During this phase consciousness-raising is extremely important; (3) action, in which the individual begins to change behaviours. Self reevaluation is continued in this phase and helping relationships, reinforcement management and self-liberation, or the belief that one can change, are important; and (4) maintenance, in which changes are maintained and strengthened. Counter-conditioning, stimulus control, and the conviction that maintaining change gives one a sense of self valued by self and others are all important.

Developmental or environmental changes that occur in the individual's life often instigate the movement from the precontemplative to the contemplative stage (Prochaska &

DiClemente, 1986). The importance of external events in effecting change has been noted generally in therapeutic processes (Lazarus, 1980). Individuals often do not pass through stages of the addictive change process in linear fashion, but may relapse and reenter the contemplation stage to begin the change process again (Prochaska & DiClemente, 1986). In Prochaska and DiClemente's transtheoretical model, therapeutic relationships, interpretations and understanding of events, and skill acquisition and use have all been found to be instrumental in effecting change (Prochaska & DiClemente, 1986).

Prochaska and DiClemente (1986) also discuss the various levels of psychological problems that may need to be addressed in addictive behaviour change, depending on the history of the individual. The further back in one's history are the original determinants of problems and the more connected problems are to the developing sense of self, the more one must eventually move from the outer symptom level to the inner intrapsychic level (Prochaska & DiClemente, 1986). Thus, later stages of recovery may come to include childhood issues of emotional, sexual or physical abuse, abandonment or family alcoholism. "The deeper the level that needs to be changed, the longer and more complex the therapy is likely to be" (Prochaska & DiClemente, 1986, p. 18). Following initial recovery and changes in addictive behaviour, then, in-depth healing stages of long-term

recovery may be necessary.

Therapeutic Approaches Congruent with Native Culture

Experimental studies and clinical experience have elucidated counselor characteristics and some therapeutic approaches effective and culturally suited to facilitating positive change processes among Native people. Such considerations may be important to the chemical dependency recovery process. Therefore, a summary of these findings will be presented here.

Trust and perceived trustworthiness appear to be fundamental in counseling Native people (Heinrich, Corbine, & Thomas, 1990; LaFromboise & Dixon, 1981; Thomason, 1991; Trimble & Fleming, 1989). The basic counselor attributes of empathy, genuineness, respect, caring, congruence, warmth and an awareness of the importance of human potential are especially important (Trimble & Fleming, 1989).

Many researchers studying Native Americans and counseling "conclude that Indians tend to value trust and understanding more than almost any counselor attribute" (LaFromboise & Dixon, 1981, p. 135) and may be sensitive to untrustworthy cues (LaFromboise & Dixon, 1981). LaFromboise and Dixon's study (1981), in which American Indian high school students rated counselor-client interactions, showed that trustworthiness and culturally appropriate communication were rated higher than counselor ethnicity. Trustworthy behaviour involved keeping promises and

confidentiality, expressing interest and acceptance, not changing the subject and accurate paraphrasing. Culturally appropriate communication involved cultural understanding, absence of ethnic stereotyping, and sharing of information through self-disclosure.

Building trust and acceptance and allowing the counseling relationship to develop slowly (Trimble & Fleming, 1989), ie. pacing rather than pushing, are important considerations. A relaxed approach to time (Heinrich, Corbine, & Thomas, 1990) and relaxed social conversation (Thomason, 1991) and avoidance of intrusive questions (Darou, 1987; Heinrich, Corbine, & Thomas, 1990; Thomason, 1991) are important at first. Patience is generally a valued trait. Time is allowed to be part of the process rather than seen as a competitor to be raced against. Allowing time for silence (Heinrich, Corbine, & Thomas, 1991) and inner reflection (Katz, 1981; Thomason, 1991), and restatements and general leads (Richardson, 1981) may all be useful when counseling Native people.

In Native communication styles there is less need to put everything in words as in the dominant culture (Katz, 1981). Nonverbal communication is important (Darou, 1987; Heinrich, Corbine, & Thomas, 1990; Katz, 1981) and Native people may scorn those not skilled at perceiving nonverbal cues (Darou, 1987). Anger and disagreement may not be expressed directly (Darou, 1987).

An open-minded attitude (Trimble & Fleming, 1989), as well as flexibility and an adaptable approach (Richardson, 1981; Trimble & Fleming, 1989) are essential. The counselor must be willing to go beyond what is done in a conventional office setting (Trimble & Fleming, 1989) and respond to the immediate needs of a situation, whether this involves the family or the larger community. An understanding, respect and positive utilization of extended family and community networks is necessary (Heinrich, Corbine, & Thomas, 1990; Red Horse, 1982; Trimble & Fleming, 1989). Concreteness (Darou, 1987) and awareness of present realities, as well as availability (Trimble & Fleming, 1989) to provide assistance are important.

Native cultures tend to encourage egalitarian values; therefore confident humility (LaFromboise & Dixon, 1981; Thomason, 1991), and warm, friendly helpful relationships are suitable. Sharing is of great importance (Katz, 1981) as is a good-natured, philosophical sense of humor.

Relationships with others are a priority in Native communities. A sense of connection with the group and identification with a larger body of experience and something greater than oneself are very important (LaFromboise, 1988; Murphy & DeBlassie, 1984; Thomason, 1991). For this reason self-help support groups and support networks in the community may be important in facilitating change (Thomason, 1991).

A number of studies and successful therapeutic programs have documented the use of support groups with Native individuals (Ashby, Gilchrist, & Miramonetz, 1987; Long, 1986; Red Horse 1982). Role modeling, one feature of support groups, is important in Indian cultures (LaFromboise, Trimble & Mohatt, 1990), as well as in chemical dependency recovery. Some therapists have successfully incorporated cultural and family networks into the group healing process (LaFromboise, 1988; Red Horse, 1982), as well as elders and traditional cultural teachings and culturally relevant activities (Ashby, Gilchrist, & Miramontez, 1987; Red Horse, 1982).

Darou (1987) and others give examples of traditional healing practices being used successfully in combination with psychotherapy. Although not extensively documented in the formal literature, the use of traditional Indian rituals, ceremonies, and healing practices is a promising (LaFromboise, 1988; Long, 1986) and growing trend in emotional healing for Native Canadians.

Spiritual vision, the finding of meaning and purpose, concepts of balance and rebirth, and the use of symbolic metaphors are important in traditional Native philosophies and healing approaches (Heinrich, Corbine, & Thomas, 1990). Working from and gaining awareness through the unconscious, as well as spiritual aspects of therapeutic change are essential (Darou, 1987). The spiritual dimension of Native

approaches (LaFromboise, 1988; LaFromboise, Trimble, & Mohatt, 1990) and the transforming aspect of Indian ceremonies are important to consider (LaFromboise, 1988).

Among Native people, personal power and inner spiritual support may be more related to self-esteem, than are external status and a sense of power over others (Darou, 1987). Generally, traditional Native healing approaches involve a high degree of introspection and action (LaFromboise, 1988).

While a general awareness of Native cultural values is necessary when counseling Native Canadians, one must also be cognizant of tribal, community, and individual differences. Knowledge of a particular community or tribal culture, its history and the present day influences affecting its members is essential (Heinrich, Corbine, & Thomas, 1990).

One must also be aware of the various levels and types of identification the individual, family, or community may have with Native or tribal culture and the level of acculturation to majority culture (Trimble & Fleming, 1989). Some individuals, families, and communities are more traditional, others more acculturated and still others bicultural. Within a culturally aware frame, one must recognize the uniqueness of the cultural background and identification of the individual and accommodate therapy to this. For some individuals, ethnic identity issues and conflicts may be significant and need to be addressed

(Heinrich, Corbine, & Thomas, 1990; Katz, 1981; Marchand, 1990). The effects of racism must also not be overlooked (Darou, 1987).

Summary

In summary, there is some documentation of counselor characteristics and therapeutic approaches effective in the Native community. Investigators have also quantitatively assessed factors related to chemical dependency treatment outcome and some models of change in addictive behaviours, based on quantitative assessments and clinical practice, have been suggested. However, little in-depth documentation of the process of recovery from chemical dependency, especially among Native North Americans, has been undertaken, despite the fact that the movement toward such recovery is growing.

Hunt and Seeman's (1990) interviews of women experiencing recovery from chemical dependency provides an initial use of in-depth interviews to understand the recovery process, specifically among women. However, there may be patterns and factors specific to Native North Americans that need to be elucidated. It has been noted that treatment failure rates tend to be higher (Neale Query, 1985) and utilization of mental health services lower (LaFromboise, 1988), among Native North Americans, given mainstream treatment approaches.

Medicine's analysis (1982) of Native patterns of

sobriety is based primarily on other researchers' data, not on first-hand interviews, and focuses on self-changers who remained abstinent, not necessarily those experiencing a full recovery process which included later psychotherapeutic change. For this reason, her work provides a preliminary starting point only, and further in-depth study is required. As numerous researchers emphasize, abstinence is a narrow measure of recovery and there are many other tasks involved in the recovery process (Amodeo & Kurtz, 1991; DeSoto, O'Donnell, & DeSoto, 1989).

As well, more research is needed to establish criteria for success and failure in chemical dependency recovery (Amodeo & Kurtz, 1991; DeSoto, O'Donnell, & DeSoto, 1989) and more research of subpopulations of recoverers is required (Amodeo & Kurtz, 1991). Experts in the field indicate the need for investigation into the recovery process itself (DeSoto, O'Donnell, & DeSoto, 1989; Maisto, O'Farrell, McKay, Connors, & Pelcovits, 1989). Numerous researchers emphasize the particular need for research aimed at exploring and discovering experiences that lead to better treatment outcome in Native North American substance abusers (Neale Query, 1985; Silk-Walker, Walker & Kivlahan, 1988; Weibel-Orlando, 1989).

The objective of this research project was to provide such study and to learn more about successful chemical dependency recovery as experienced by Native Canadians. The

factors influencing this change, as well as aspects of the process itself were explored.

CHAPTER THREE
METHODS AND PROCEDURES

Introduction

Questions related to the dynamic and multidimensional process of chemical dependency recovery cannot be readily answered using a quantitative research design, especially since knowledge about the factors which influence these processes among Native populations is limited. Additionally, a quantitative design cannot elucidate the chronological sequence of events or fully document the complex nature of the participants' experiences. However, "qualitative methods can give the intricate details of phenomena that are difficult to convey with quantitative methods" (Strauss & Corbin, 1990, p. 19). A qualitative design was therefore chosen to "flesh out" the experience of the participants, from their perspective.

Theoretical Framework

The study design was based on a grounded theory approach (Stauss & Corbin, 1990), since the research question focused on process, an understanding of similarity across cases, the active role of individuals, and the interrelationships between action, conditions, and meaning (Blumer, 1969). Grounded theory assumes that processes are fundamental to social phenomena and attempts to elucidate these processes, as well as link the interactional sequences of which they are composed.

This approach uses a systematic set of procedures to

develop an inductively derived theory about a phenomenon, which is grounded in the data and actual experiences of the participants (Strauss & Corbin, 1990). Rather than being predetermined prior to data collection, hypotheses and concepts emanate from the data collected; therefore, they are grounded in the data.

However, both inductive and deductive methods of data collection, analysis, and hypothesis generation are utilized (Strauss & Corbin, 1990). Throughout the research process, emerging concepts and hypotheses are examined in light of new data to guarantee they are valid conceptualizations and representations of the phenomenon under study. Therefore, following initial data collection, data collection and analysis take place concurrently, with later data collection being influenced by earlier analyses.

The Research Process

Data Collection

Data was collected through formal in-depth, semi-structured interviews. An interview guide was developed (Appendix A) and was utilized to assist in the interview process. To allow the participants to tell their story, the interview guide proceeded from broad, open-ended questions to more specific open-ended questions. The latter allowed for the gathering of necessary details that may not have otherwise emerged from the initial telling of the story. The number and type of questions varied from one interview to

the next, thereby allowing for refinement of the interview questions as research progressed. Following each interview, modifications were made to the interview guide, especially during the early phase of data collection. Usually these modifications and general suggestions for the next interview were based on observations or realizations made in field notes.

All interviews were tape recorded and transcribed. Field notes served as further sources of data. Field notes were used to describe behaviour and setting during interviews, as well as researcher impressions.

Interviews were conducted either in the participant's home, the researcher's home, or in the Education Clinic at the University of Alberta, whichever the participant preferred and whichever would allow for uninterrupted time. Interviews took 1 to 1 1/2 hours.

Prior to the interview, the study was briefly explained to the potential participant. Upon agreement to participate, a time for the formal interview was arranged. At the beginning of the interview session, the study was more fully explained, and informed consent was explained and obtained (Appendix B). Following this, a framework or context for the topic was set, to ensure that the researcher and participant had a common understanding of the topic to be discussed.

Before beginning the actual interview, demographic data was collected about the participant (Appendix C). Questions

related to the cultural background of the participant's family generated much discussion and information. Therefore, following the first interview, this portion of the session was audiotaped as well.

There were differences in data collection between interviews with earlier participants and with later participants. As consistent patterns and themes began to emerge in analysis, later interviews became more focused, following use of the initial open-ended question. Known as theoretical sampling, this approach helped verify and flesh-out aspects emerging from earlier data collection and analysis. Due to the consistency in stages, patterns, and categories emerging by completion of the interview with the fourth participant, interviews with the fifth and sixth participants were especially focused. Perhaps because of this, or perhaps because of the younger age of the participants, the fifth and sixth participants' interviews contained fewer metaphorical and descriptive stories, and provided shorter, less involved, more basic factual responses.

Follow-up telephone interviews were completed with the first three participants interviewed, in order to clarify sequential timelines, statements made, and patterns, and interpretations emerging from data analysis. Greater detail related to phases of recovery and cultural identity processes was forthcoming from these telephone interviews.

Telephone follow-ups became less necessary as interviewing progressed. Conversations with participants in later interviews became more focused and clarification was sought during the initial interview in areas found to be important in interviews with previous participants. Telephone follow-up was also less necessary with later participants because patterns similar to those found in earlier interviews were emerging and participants were validating statements made by previous participants.

Length of participant's s riety also influenced the need to clarify or gather more information, in either follow-up interviews or within the interview. Participants with longer periods of sobriety had more phases, changes, and completed tasks to discuss.

Interviewing ceased with the sixth participant as redundant themes continued to emerge at this time, and no new information regarding general processes was forthcoming.

Locating and Choosing Participants

Participants interviewed were Native Canadians who had undergone a recovery process for chemical dependency. All were of Native ancestry and identified themselves as being Native Canadians. All had attended treatment for chemical dependency at some time and had been sober and drug-free for more than one year. All were adults and currently sober and drug-free. Participants chosen were those who were willing to take part in the interview process and who were able to

articulate their experiences (Colaizzi, 1978). Those selected were also individuals who were recommended or known to be involved in a positive recovery experience.

Therefore, those chosen provided an intensity sample (Patton, 1990) - individuals who had clearly experienced chemical dependency, received help and been able to maintain sobriety over an extended period of time. They were able to provide an accurate and descriptive picture of what it means to experience chemical dependency and therapeutic recovery from substance abuse. This type of purposeful sampling - initially choosing participants who are relatively similar and likely to represent the phenomenon - is common in grounded theory studies. It allows for development of theory about the phenomenon as it exists in those circumstances or situations (Strauss & Corbin, 1990).

Generally, the researcher was interested in documenting the emotional healing process of Native Canadians at this time in history. Recovery from sexual and physical abuse are two other current areas of intensive healing efforts in the Native community. However, chemical dependency was chosen as a basic starting point to narrow the field and because the researcher was aware that recovery from chemical dependency is often an initial step in the healing process.

Participants were, in part, obtained through an informal network known to the researcher, of Native people who had undergone a recovery process related to chemical

dependency. Contacts within the Native community and chemical dependency recovery community were also utilized to locate suitable participants. All participants currently reside in or near a large Canadian city, although most were originally from Native communities across Canada.

Six individuals were interviewed. Because this study investigated depth rather than breadth of the recovery experience, and participants provided information-rich cases, participant numbers could be small (Patton, 1990). As well, variation in the recovery experience per se was not targeted. Rather, understanding of similarities and crucial aspects of successful recovery was the goal.

Theoretical Sampling

During data collection and analysis, theoretical sampling, an important aspect of the grounded theory approach (Strauss & Corbin, 1990) was utilized. This involves sampling or gathering incidents and aspects of the phenomenon on the basis of concepts emerging from the data. It may include open, relational, variational and discriminative sampling (Strauss & Corbin, 1990). Open sampling was accomplished purposefully rather than systematically. Relational and variational sampling were also done purposefully, as individuals were chosen who would maximize opportunities to elicit data related to potential variations in the dimensions of categories. Discriminate sampling was also purposeful, for as interviewing

progressed, questions and interviewing approach used maximized opportunities for verifying the storyline.

More specifically, theoretical sampling was accomplished by selecting later participants who were different from earlier participants in some way. This allowed observation and analysis of whether and what patterns were consistent across cases, despite differences in characteristics such as age, marital status, and status as a parent. For example, the fourth participant was chosen to include a participant who did not have children because a pattern was emerging in the data related to participants' children. What happened for an individual without children, therefore, needed to be investigated.

The fifth and sixth participants were chosen because of their age. Younger participants were needed to compare similarities and differences in their recovery process, with the recovery of older participants who had been interviewed earlier. Participants were also chosen to encompass varied lengths of sobriety and substance use. This allowed observation and analysis of possible changes with length of recovery or possible differences related to length of substance use. As previously described, later interviews became more focused, in order to pursue and verify patterns, as well as "flesh out" categories that were consistently emerging in data collection and analysis.

Data Analysis

Data was coded and analyzed for patterns, descriptions, common themes, and relationships, utilizing the constant comparative method of analysis, following procedures outlined by Strauss and Corbin (1990). The constant comparative method allowed the researcher to build a working model of common factors and change processes across cases. By using this approach, the researcher was able to build on information obtained from earlier interviews in later data analysis. Following the first interview, data collection and analysis took place simultaneously.

Data was coded into categories and then into higher-order themes which included the categories. Sorting and grouping of codes facilitated this process. Open, axial, and selective coding were used to identify concepts, formulate categories, relate categories to one another, and develop a storyline based on a core category (Strauss & Corbin, 1990).

Open coding was used to identify concepts and higher level categories. During axial coding connections between categories and subcategories were made, and codes and categories were assigned designations such as antecedent conditions, intervening conditions, actions/strategies, and phenomena, where applicable. Selective coding was used to clarify the overall storyline of the recovery process, which was emanating from participants' stories. Present data and

data collected earlier were compared throughout this process. Analyses and codes were then applied to later sets of data.

A system of coding, entering codes on cards, and sorting cards into categories was used for the first three interviews. By the fourth interview, assigned codes were subsumable under higher level categories arising from the first three interviews. For all interviews, multiple codes were assigned to meaning units. By using multiple codes, the various levels of meaning within a phrase, story or incident could be accommodated and were not lost. For example, the specific content and context of a meaning unit could be coded, as well as its greater meaning or time position within the overall recovery process.

Techniques to enhance theoretical sensitivity during data analysis were employed (Strauss & Corbin, 1990). These questioning techniques allowed the researcher to broaden thinking about the data and to view it critically, with analytic depth (Strauss & Corbin, 1990).

Memoing was also utilized. This involved recording all ideas and hypotheses about the phenomenon as they occurred to the researcher. Memos, or records of insights, understandings, and emerging patterns, contributed to the density of the emerging model.

Immediately following each interview, field notes were recorded and memoing began. Transcripts were then checked

for accuracy and coded according to categories, as described above. Timelines of each individual's recovery process were produced, as were integrative diagrams mapping steps and factors in the entry process and overall stages of the recovery process. Memoing was used at all stages, before and while coding, while diagramming, and while sorting codes and perusing categories. Such memos were grounded in the data, as they were ultimately tied to specific comments and quotes of the participants.

Extensive use of memoing, in addition to coding, was made, so as not to lose the process aspect of recovery. Initial coding broke the interviews down into discrete pieces; patterns emerged while doing the coding. Therefore, memoing and diagramming facilitated higher level forms of coding, ie. axial and selective coding, which put the data back together in new ways at higher levels of understanding. Memoing and diagramming helped capture patterns emanating from the distillation process of coding. Thus, like data collection and analysis, and like open, axial, and selective coding, coding, memoing and diagramming were integrated, interactive processes which stimulated and complemented one another. The researcher moved back and forth between them.

Throughout data analysis, emerging concepts and hypotheses were checked against and modified to accommodate new data. As collection and analysis proceeded, the researcher returned to the literature and to participants

for clarification and verification, as needed. By the fifth participant interview, it was found that patterns, themes, and ideas described by earlier participants were being repeated and summarized. Broad stages, categories, and themes that emerged from analysis of previous participants' interviews were also found in the sixth participant's interview. At this point, as no new information related to general themes and stages was forthcoming from analyses, saturation was determined to have been reached, and data collection ceased.

A final validation process was then completed, at which time participants read the descriptions of themes and stages which had emerged. Participants validated the themes and stages found. Specific editorial changes suggested by the participants, such as those related to editing and inclusion of quotes, were then incorporated into the thesis.

The Instrument

The researcher is the instrument in qualitative research. For this reason, the researcher must thoroughly prepare to engage in qualitative research, as well as be aware of the influence of personal experience, beliefs, values, and emotional reactions. Personal experience and training informs the direction of research and the researcher's view of the data. Bracketing, or analysis of the researcher's personal preconceptions and experiences, prior to and during data collection and analyses, is

necessary. The following section, which outlines my personal experience and views in relation to the research topic, provides a bracketing for this study.

To more competently complete this qualitative research project, I read numerous books and articles on qualitative research methods. I also audited a course in qualitative research methods. A portion of a course in quantitative research methods in which I was enrolled encompassed qualitative research approaches. A group project and an individual miniproject completed during that course involved qualitative analyses.

The above mentioned miniproject involved interviewing twc individuals from the general population who were recovering from chemical dependency. This experience provided some indication of effective questions; for example, general questions about positive change were too vague, while a question asking what helped bring about recovery was productive. Although previous to the collection of this data I realized relationships with others influenced the recovery process and were important considerations in intervention, I was surprised at the strength of this theme in the emerging data. In the addictions field there has been debate about the extent to which others can influence the practicing substance abuser to enter treatment and to what extent an individual must "hit bottom" themselves. Thus, the interviewees emphasis on the influence of their

relationships with others, both in early and later recovery, was intriguing.

Because of my training and previous work as an addictions counselor, I was sensitized to the content area of chemical dependency. In addition to professional experience, I had personal familiarity with individuals, both Native and non-Native, who had undergone recovery and therapeutic change processes. I had listened to many unsolicited stories of recovery. The powerful transformative nature of and hope inherent in this process was overwhelming.

I had also received counselor training at a Native training centre which focuses on chemical dependency recovery. I was greatly influenced and empowered by this experience and share a common vision with this organization and its members. This vision views chemical dependency as a serious problem to be overcome in Native communities, while at the same time envisions a major psychological healing process to be occurring among Native people. The stories and recovery of my co-trainees gave evidence of the great trauma Native people have experienced, as well as the great healing and cultural resurgence that is taking place. I believe it is important to enlighten others and to share this message of hope and, as well, for those in recovery to serve as teachers and role models for others. I believe the recovery process is a phenomenon too important to ignore or take for

granted.

Having lived and worked as a counselor in Native Canadian communities, and having a degree in cultural anthropology, I had some sensitization to the content areas of Native culture and counseling in Native communities. I had also lived in a once self-sufficient, traditional Indian community which was being ravaged by the onslaught of resource development, and observed first-hand the accompanying disruption and malaise which resulted in the community from this encroachment. The effects included increased substance abuse. This experience engendered strong feelings of anger, sadness and desire for redress of injustices. I believe the current movement toward psychological healing and cultural revitalization will strengthen the chances of redress and improvement of social conditions in Native communities.

Such a background informed and influenced the direction of data collection and analysis. In addition, it must be remembered that, despite my lived experience in Native communities, I am not Native and have not had the experience of growing up as a Native person. Therefore, I needed to validate my analyses with the views of the participants during the research process.

My formal training in counseling psychology, through workshops and study in a Master of Education program, and my experience in various counseling-related positions was an

asset in conducting interviews which encouraged participants to discuss the topic of recovery comfortably. Again, this background influenced the direction of data collection and analysis, in a way that was particularly sensitive to therapeutic processes. Both my background in counseling and anthropology meant that I tended to be more interested in data and storyline than in theory. My indirect connection to the extended social network of participants certainly aided in ensuring rapport and comfort during interviewing. It may also have influenced the direction of data analysis and produced some blind spots. For example, it may have engendered difficulty in recognizing negative instances in the recovery process, or a taking for granted of certain aspects of the phenomenon.

My personal and professional experience evidently influenced topic selection and research design. I chose to interview Native individuals who had gone through a therapeutic healing process because I wanted to compare my informal observations of this process with formal, solicited, and more carefully analyzed data. I also wanted to provide a forum for these stories to be heard.

I also desired to see solutions and recovery processes documented. I believe that the psychological literature generally, and the literature on Native people specifically, is too problem-focused, while much important information about positive change is being lost. This research study was

partially an attempt to document and make others aware of the healing process occurring among Native people. It is believed great insight can be gained from these individuals' stories, both for those who are attempting to heal, as well as for helpers who attempt to assist in the process.

Credibility, Auditability, and Fittingness

Guba and Lincoln (1981) have utilized the terms credibility, auditability, and fittingness to address concerns related to reliability and validity in qualitative research. Attention to these three criteria, it is believed, increases the trustworthiness of qualitative research.

Credibility is similar to the concept of internal validity found in quantitative research. It implies valid and accurate recording and depiction of the phenomena under study. The following approaches were used to enhance credibility: (a) effective interview techniques, such as empathic listening, appropriate nonverbal behaviours, and clarifying questions were utilized; (b) verbatim transcriptions of interviews were made; and c) transcriptions were compared with audiotapes to ensure accuracy.

Member checks are another crucial way to ensure validity (Lincoln & Guba, 1985). Member checks involve returning to the participants to validate descriptions and interpretations. In this research project, participants were asked to provide clarifications of interview material when

necessary, and to review findings, themes and categories for acceptability, and suggest modifications if required.

Triangulation is another method by which credibility is enhanced (Lincoln & Guba, 1985). Triangulation may be achieved by combining information from varied data sources, methods, investigators, or theoretical perspectives. Theoretical triangulation was achieved in this study by integrating preliminary and final results with extant literature. Source triangulation was achieved by interviewing numerous participants, varied in age, sex and tribal affiliation.

Auditability indicates that another researcher could follow the original researcher's research path and understand the logic of the findings, given the emerging data. Therefore, it is similar to the concept of reliability and consistency of findings in the quantitative paradigm. To achieve auditability, an audit trail was kept which outlined research decisions, dates, and influential events. Field notes, memos, and reflexive journal entries were also a part of the process. The final report documents and explains the development of the research question, sample selection, data collection, and analysis.

Fittingness is similar to the quantitative concept of external validity and indicates the representativeness and generalizability of the findings. Transferability (Lincoln & Guba, 1985) is another term used to describe fittingness. In

qualitative research, the burden of deciding transferability of findings lies with the individual trying to apply the findings to other situations. However, it is the original researcher's responsibility to provide a data base and the thick description necessary to allow others to judge transferability (Lincoln & Guba, 1985). Therefore, data presentation in this research project features quotations and descriptions of context and background sufficient to ensure the required data base. Also, the richness of the data and effectiveness of its presentation may allow for what some term empathic generalization. That is, the power of the data and findings may resonate with the experience of others in somewhat different but similar contexts.

Ethical Considerations

The research proposal and appropriate ethical forms were submitted to the Ethics Review Committee of the Department of Educational Psychology and ethics approval was received. Written informed consent was obtained from all participants. The general purpose of the study and the participant's role was explained. Participants were told that interviews were being tape recorded and transcribed. They were also informed that their participation was voluntary and they were free to withdraw from the study at any time. They were informed that they had the right to refuse to answer any questions.

Confidentiality guidelines were explained to

participants. They were informed that information shared in the interview would not be shared with others, except for the purposes of the study, and that anonymity would be maintained by use of code numbers and fictitious names. The transcriber of audio recordings was asked to sign an oath of confidentiality.

A potential risk of this study for participants was the reexperiencing of negative emotions related to traumatic events, especially while recalling early stages of recovery or emotional issues pertinent to the healing process. However, the focus of this study was on positive change and all participants were individuals who had undergone treatment and a successful change process. Therefore, they had extensive coping skills and support networks at their disposal.

The researcher monitored participant reactions during the interview for signs of distress and fatigue. Appropriateness of continuing the interview was assessed throughout. The researcher utilized basic counseling skills when required for distress, and options for receiving further help were discussed, when necessary. Telephone check-ins were utilized in cases where distressing topics emerged during the interview.

Research Considerations

There were a number of important issues to be considered in this study. This was an initial, exploratory

study. Enough data was gathered to suggest a framework for the development of a definitive formal theoretical model (Strauss & Corbin, 1990) of chemical dependency recovery among Native Canadians and the factors which influence it. A beginning point for comparison with the general recovery process was provided, and common themes, stages, conditions, processes, and shared meanings were extracted. This provided a substantive model of recovery, which could potentially guide practice for people working with similar populations. Further research would be helpful in delineating a definite formal model.

Secondly, all participants were indirectly connected through a broad social network of Native people in recovery. Therefore, some of their experiences or therapeutic paths may be similar to one another, yet differ from the experiences of other Native Canadians recovering from chemical dependency who are not part of this network. For example, the experience of "self-changers" who have not undergone treatment may be different. As well, the experience of Canadians of Native ancestry who have overcome substance abuse, but who do not identify themselves as Native or do not identify with Native culture may be different. Core processes, stages, and essences of the experience may be similar for Native chemical dependency recoverers generally, but variations in details related to context, contingencies, and intervening conditions may vary

for these groups. The goal of this research project was not to specify those variations within the general population of Native chemical dependency recoverers, but to delineate a set of general conditions under which the phenomenon does take place. As Strauss and Corbin (1990) state, the specifying of conditions, not generalization per se, is the goal of grounded theory.

A third consideration of this study was its retrospective nature and the varied lengths of time since initial recovery for participants. Some participants had begun their initial sobriety many years ago, while others' recovery was more recent. Therefore, the individual's perspective of the change process differed somewhat, depending on the time period since initial sobriety and the present stage of recovery. Time may have diminished some memories and caused others to take on new meaning and significance. However, certain important points in recovery were remembered vividly by all participants, despite length of sobriety. Also, due to the varied ages, length of time spent abusing substances, and time since initial treatment, a variety of perspectives and historical periods were sampled. Therefore, differences related to stage of recovery, in addition to similarities across cases, were assessed.

Description of Participants

Demographics of the Group

The participants ranged in age from 22 to 51 years. Three were male and three were female. Four were Status Indians, one was a non-Status Metis, and the sixth had attained Indian status through Bill C-31. Three had grown up on Indian reserves, one had grown up in a small town, and two had been raised in a combination of reserves, cities, and towns. One rated the family raised in as very traditional Native, two rated their family as somewhat assimilated, one rated family as fairly assimilated, and two rated family raised in as very assimilated. Participants grew up in three different provinces of Canada and tribal backgrounds included Cree, Ojibway, and Chipewyan.

Five of the six had children, one did not. One was living in a common-law relationship, one was involved in a committed long-term relationship, and four were currently single. Of the latter four, three had previously been married or lived in a common-law relationship. Three participants currently had children living at home. Four had been single parents. Lengths of solid sobriety ranged from 3 to 18 years. Three participants had experienced relapses previous to this period of sobriety. Lengths of alcohol and drug use ranged from 4 to 20 years. Two participants had used alcohol exclusively, one had used mostly alcohol with some use of other drugs, and three had used both alcohol and

other drugs. Three participants had attended Native treatment programs and three had not.

All of the participants were either involved in upgrading their education or were involved in a successful career. Since entering recovery, two had completed numerous training programs and gone on to work in the field of human services. One of these was still working in this field, while the other had returned to university. A third participant had a successful career in the performing arts. Of the other three participants, two were currently attending education programs, while the third was about to begin one. Two of these participants had successfully completed training programs related to human services.

Individual Profiles

John

John is in his early 50s. His children live with their mother, but he visits them frequently. At the time of the interview, he had a girlfriend, but was not involved in a committed long-term relationship.

John had grown up in a family that for the first ten years of his life was very traditional . His father worked the trapline and the Native language was spoken at home. Following this time, John began to attend Indian residential school and alcohol abuse entered the family.

John did not begin active use of alcohol until he was 25 years old. His use lasted approximately 17 years;

following this time, he began his first attempts to quit drinking. He had a period of five years of mixed sobriety and relapse, followed by six years of solid sobriety. He first attended treatment after using alcohol for eight years. He attended treatment twice more, once before solid sobriety, once after.

Beverly

Beverly is a woman in her mid-30s who has raised her children as a single parent, but was living in a common-law relationship at the time of the interview. She had grown up in a small northern town as a non-Status Indian, but had recently acquired Indian Status under Bill C-31. When she was a child, her father drank; her mother did not. Her father attended residential school when young. She is uncertain whether her mother ever attended residential school.

Beverly began using alcohol and other drugs at age 12; she considers most of her use to be abuse. Her alcohol and drug use lasted about 20 years. She began recovery four years ago, relapsed, and now has three years of solid sobriety.

Elizabeth

Elizabeth is a divorced woman in her late 40s. A number of her children are grown; those that are teenagers currently live with their father. Elizabeth was married for over 20 years and had also raised her children as a single

parent for a period of time. She currently lives alone, but is involved in a committed long-term relationship.

Elizabeth had been raised as a non-Status Indian on a reserve, in a somewhat assimilated, somewhat traditional family, in which the Native language was spoken. Neither of her parents drank and her grandfather lived with the family. However, both of her parents had attended residential school and she experienced verbal, physical, and sexual abuse as a child. At age 16 she moved to the city.

Elizabeth did not begin to drink until age 17. She identified her first ten years of drinking as nonabusive, the last seven as abusive. Her marriage had been physically abusive. She has 15 years of sobriety.

Henry

Henry is a single man in his mid-40s. He grew up on a reserve and attended high school in a small town. His family was somewhat assimilated, but the Native language was spoken at home. His parents were devout Catholics. Henry began to drink at age 16 and was incarcerated from age 16 to 20. Upon release he began to drink again, and used alcohol and drugs for seven more years. He has been sober for 18 years.

Cheryl

Cheryl is a single mother in her early 20s. While growing up, she lived on a reserve, in a small town and in a city. She described her family as very assimilated. Both of her parents attended Indian residential school and the

Native language was not spoken at home. Both of her parents drank when she was young, but her mother quit when she was in her mid-teens.

Cheryl began to use alcohol at age 12. She drank heavily from age 14 to 16. Following the birth of her son, she drank less, but still used alcohol and other drugs. She has three and a half years of sobriety.

Don

Don is in his early 20s. He is separated from his common-law wife and is raising at least one of his children on his own.

Don was raised on the reserve, with some time also spent living in the city. He rated the family he grew up in as very assimilated. English was the main language spoken in the home. Both of his parents attended Indian residential school and both of his parents drank when he was a child.

Don began using alcohol and drugs at age 16 and quit at age 20. He has four years of sobriety.

CHAPTER FOUR
RESULTS

I. Overview of Themes and Stages

Introduction

Four major themes emerged from analysis of the participants' stories. These themes represented elements essential in the participants' recovery. Three of these themes were important throughout the entire recovery process, at all stages of recovery. The fourth became an important theme for all participants by the stage of Middle Recovery. The four themes were:

Utilizing Resources and Doing the Work

The Importance of Others

Psychospiritual Changes

The Importance of Native Spirituality and Culture

Four stages were identified. They were:

Entering Recovery - Recognition, Acceptance and Receiving Help

Early Recovery - Building a Sober Lifestyle

Middle Recovery - Working on Deeper Issues

Late Recovery - Reaching Balance and Continuing Growth

The four themes will be overviewed in this section. In the following section, the four stages will be described in detail. Important aspects of the themes will become apparent within the descriptions of the stages. In a third section overall patterns and changes across stages will be summarized for each theme. Finally, models emerging from

analysis will be presented.

Theme #1: Utilizing Resources and Doing the Work

One theme found throughout the recovery process was the participants' use of available and varied resources, whether in the form of treatment programs for chemical dependency, Twelve Step recovery groups (Appendix D), therapists, Native elders, or a network of supportive sober people. At some point early in the recovery process the participants became willing to receive help. They became increasingly open to a variety of resources, and began to choose helping resources appropriate to the type of recovery work they were doing at that point in the recovery process.

Participants also "did the work" of recovery. That is, they became involved in and did what was necessary for recovery: They attended treatment, attended Twelve Step group meetings, used the tools of recovery by working the steps of Twelve Step groups, built a support network, and engaged in therapy, despite the emotional pain involved. The participants did not just talk or think about doing what was required, they actually did it and followed through with and completed it once begun. Although thinking and talking were sometimes part of the work, making changes in behaviour was also necessary. Actually doing something to deal with an issue or problem was important.

The required work varied with the stage or place the participant had reached in recovery. At different stages,

different types of work were necessary. Each individual also had recovery or therapeutic work to do unique to their own life experiences. Being committed to and actively involved in recovery and the work required for recovery was common to all six participants.

Theme #2: The Importance of Others

All of the participants described how important other people had been in their recovery. Relationships with people played a role in their entry into recovery, as well as maintenance of sobriety and emotional and spiritual growth later in recovery. Other people and their relationships with other people functioned as motivators, role models, supports, advisors, and confronters. In some cases, a relationship with another person served as an obstacle to be overcome.

Rebuilding damaged relationships and establishing positive relationships with others was on-going once the individual entered recovery. Once sobriety was stabilized, helping others also became an important part of the recovery process.

Theme #3: Psychospiritual Changes

All six recovery stories demonstrated that recovery was a psychospiritual change process. As the term psychospiritual indicates, changes in the individual took place on a psychological, or cognitive and emotional level, and on a spiritual level. Changes occurred in the

individual's feeling states, in the way the individual thought, and how he or she perceived the world. With these changes, the individual's view of himself and others, as well as his view about himself in relation to the world and the natural environment were modified. Through the recovery process, spiritual awareness and involvement in spiritual activities and reflection were enhanced. The changes affected the participant's view of and relationship with a Higher Power or creative life force, alternately called the Creator, Great Spirit, or God. The culmination of these changes can be seen in the behaviour and emotional, mental and spiritual state of participants in Late Recovery.

As described by the participants, perceivable turning points highlighted the series of psychospiritual changes. Turning points occurred when the individual shifted into a different way of thinking and perceiving self, the world, or the situation at hand. He or she began to "see" things differently and to feel differently. Following a turning point, the individual had a different sense of him or herself or the situation. He or she was no longer the same internally or psychologically and would never view things quite the same way again. Feelings, as well as thoughts, were implicated in this process and behavioural changes were made as a result.

Psychospiritual change occurred throughout the recovery process. It began with the turning point of recognition in

Early Recovery and culminated in the profound changes seen in individuals who reached Late Recovery. Doing the work of recovery and the input and influence of others were factors that moved the psychospiritual change process forward. For the six Native participants in this study, Native spirituality and cultural identity played an increasingly important role in psychospiritual change as recovery progressed.

Theme #4: The Importance of Native Spirituality and Culture

A fourth theme - The Importance of Native Spirituality and Culture - emerged from the stories of the participants. It entailed involvement in Native spiritual practices, an awareness of Native traditions and spiritual philosophy, an awareness of Native culture and history, a search for cultural identity as a Native person, and a healing of the traumas associated with a history of oppression, subjugation, and cultural loss. For all participants, it became an important theme by the Middle Stage of recovery. This element then became interwoven throughout their relationships with others, in their use of resources, recovery work done, and psychospiritual changes made. Native Spirituality and Culture was the theme which appeared to distinguish this group of chemical dependency recoverers from the general population of people in recovery. Aspects of this theme will be detailed under the section entitled Middle Recovery, and to a lesser degree in Late Recovery.

Overall patterns in the theme will then be summarized in the section Summary of Themes.

II. In-Depth Description of Stages and Themes

A. Stages of Recovery

Stage 1: Entering Recovery - Recognition, Acceptance, and Receiving Help

All of the participants described an initial process, often a distinct event, which propelled them into recovery. This event or process was remembered vividly, retold in great detail and almost relived within the interview, even by those with long periods of sobriety. It was evident that this event or change in the participant's life held great meaning and was of utmost importance. Without it, recovery would not have taken place.

Most of the participants framed this critical event, or at least a piece of this entry process, as a "turning point" in their lives. It involved a shift in the individual's perspective and feelings about their drinking and drug abuse. It was comprised of an internal shift within the individual, as well as an accompanying external shift in his or her actions. It resulted in a shift from an alcohol and drug dependent lifestyle to a lifestyle committed to living free of alcohol and drugs.

Three broad elements seemed to come together to produce the initial movement or shift into recovery: external events and crises; a shift in the individual's

internal psychological state, which included recognition of the problem; and relationships with and the involvement of other people in the process.

External crises.

Participants described an accumulating number of crises and a worsening of their substance use as their addiction progressed, just prior to their decision to quit or seek help. This was especially so for older participants and those who had used psychoactive substances longer, particularly beyond their early twenties. Most importantly, a particular set of crises or a particular crisis immediately preceding the shift into recovery was described in detail by all of the individuals interviewed. For five of the participants, these external events were strongly linked with interpersonal crises. For the sixth, the interpersonal nature of external crises was less pronounced, although present.

For Elizabeth, the triggering event was the apprehension of her children:

> My kids, they were apprehended one weekend by Social Services. I had left them.

Previous to this, with increasing depression, alcohol use, and the repeated beatings of her spouse, Elizabeth had become overwhelmed by her inability to look after her children and her feelings of inadequacy. She had temporarily given her children up to Social Services. She fought "hard to get them back", but lost them again to Social Services,

when depressed and suicidal, she again went drinking. To regain custody of her children, she agreed to attend a residential treatment centre. As Elizabeth stated, "I didn't want to be there, but I knew that I had to do something in order to get my kids." While in treatment, Elizabeth was confronted with her alcoholism and made the decision to quit drinking:

> By the time I came out of [the treatment centre], I had accepted the fact that I was an alcoholic. I surrendered. I knew that I did have a problem with alcohol.

For Beverly, as well, the precipitating crises involved her children:

> I started drinking real heavy. I just started drinking and drinking and drinking. More than I had. I wasn't looking after my kids.

The final crisis occurred when her daughter almost missed school because of her drinking.

> It wasn't until my daughter started grade one. I was so happy, me and my friend went out and celebrated after their first day of school. We celebrated them going to school. We just got so drunk ... Then that next morning I woke up and the kids wanted to go to school. I said "No, you don't have to go to school today, you can stay home." It was the second day of school and they really wanted to go. We were over at our friend's. We weren't even at home. I don't know, something just snapped in me.

Following this, Beverly, still hungover from drinking the evening before, drove her children to school and contacted her friend, who called Alcoholics Anonymous. That evening she attended her first AA meeting.

Like Elizabeth and Beverly, Cheryl's movement into

recovery was triggered by an event involving her child:

> One night I went drinking with my cousins and I was just sloshed. I couldn't stand. My son - I always kept my drinking away from him; he never saw me drinking or anything like that. I would come home and he would be sleeping. That night I came home and he woke up. He came running to me, you know how little kids do. But this time he backed away from me - like he didn't know who I was. That's when I realized I was becoming who I didn't want to be. I didn't let myself make excuses, I just tried to find people who could get me into treatment right away.

Don's turning point and crises also involved children, but in a different way. Numerous crises took place in Don's life immediately preceding and during his final drinking episode. Just previous to his last binge, his common-law wife decided to leave him, taking their child with her:

> What brought me into recovery ... I was staying common-law with my ex and I was staying in an apartment right behind a hotel and it was more convenient for me to pick up alcohol and drugs. It was just before Christmas. My ex decided to leave, so she packed up her clothes and the baby's clothes and she left.

Don began drinking with relatives that night. During the evening a series of traumatic, negative events took place. Don and his relatives were involved in assaulting and stealing alcohol from an individual with whom they were drinking. Later, Don was accused of making passes at a female relative and an argument with her boyfriend ensued. The final event of the evening was the one Don thought of the next day before making the decision to quit drinking:

> I still stayed up. My nephew was just a little over one year old. I was giving him little sips of some whisky. He was getting a little hyper and I

> thought it was pretty funny. It wasn't until the next day you know when I thought about it ...I was just worried about my little nephew. I thought about the little guy and about giving him little sips. That more or less freaked me out ... My old man was working at [a Native treatment centre]. Christmas Day I told him that I was going to quit. He got me into [the treatment centre].

For John, loss of his family was the crisis implicated in his final movement into long-term recovery. Unlike the others, John had attempted to maintain his sobriety for five years previous to his following six years of solid sobriety. During those first five years, he would maintain sobriety for fairly long periods of time, sometimes for almost a year, then relapse with a brief drinking binge. During this time, he attended some AA meetings and began to think about his drinking. He reached a point where he became "sick and tired" of his drinking and recognized that his behaviour was self-destructive. However, he stated that before he was fully in recovery, "... there was a number of things that had to happen like my ex-wife leaving me. It opened a whole new door."

John saw this as the point where he finally "hit bottom":

> That hit bottom. I was left in the desert now, it's time to survive. It's time to live now. To me that was impossible. It seemed impossible at the time.

His "routine of life was no longer the same" due to the separation from his wife and family. This crisis found him "teetering on the edge" and "near death". He was "self-

destructive". At this point, he sought help from others and began to rebuild his life:

> When I hit bottom, I went to a meeting and came into AA. I reached out.

After a period of difficulty and relapse, he began his solid recovery.

Henry's initial entry into recovery was less motivated by a significant relationship than in the case of the other five participants, but as with the others, external crises played an important role. He stated:

> I'd been drinking all summer quite a bit and doing a lot of drugs ... I remember one time drinking and then waking up at the Salvation Army and having a few crumpled dollars in my pocket. I went to this tavern - it was Sunday afternoon and I tried drinking. I couldn't drink any more ... I ended up going to a movie that afternoon. ... I remember weeping lightly because I had no place to go. Couldn't go home because my Mom and Dad kicked me out and I ran out of friends' places to go and stay. My nights were over at the Salvation Army.

Henry was homeless. The physical effects of withdrawal following his drinking binge led to a detoxification unit:

> I remember getting on the bus. I went to the hospital and I said, "Look I don't know what's going on with me - my hands are shaking and I'm starting to see things." So the doctor sent me to the detox. I stayed there for ten days, just drying out. Then I went to [the treatment centre] and stayed there for a month.

Following treatment, Henry stayed in a halfway house for nine months. By this time Henry was clearly in recovery. Physical crises, such as no place to live and physical withdrawal symptoms were important factors in his initial entry to recovery.

Internal psychological states - recognition and acceptance.

Along with external crises, a corresponding internal state of emotional pain and a resulting cognitive recognition of the reality of their substance abuse and the problems caused by it was essential. Without this recognition or realization, the participants would most likely have remained in denial, experiencing crises and emotional pain, heedless to the difficulty their substance abuse was creating. Following recognition, a further solidifying or acceptance of their addiction and a commitment to recovery took place.

All six participants described an internal event within themselves of emotional and cognitive dimensions. It involved strong, painful feelings accompanied by mental deliberations and a cognitive realization of their problem - a sort of mental-emotional shift in their being. Most described it as a turning point. For some, this event occurred before entering treatment, for one it took place in treatment as did the acceptance phase, and for others, entry to recovery occurred in a number of stages, with the original internal event of recognition causing them to seek help and the following shifts producing acceptance and commitment, following treatment.

For Elizabeth, the emotional pain just previous to entering treatment was intense:

> I just cried because I was so in pain. And my kids - it felt like my kids had died. Because I didn't even know where they were.

Elizabeth was also scared:

> I had to do something, but I didn't want to go to [treatment]. It was the suggestion of my social worker. I was scared to death when I went there. But I covered it all by being angry, you know. But deep down I was scared to death.

Anger was first displayed when Elizabeth arrived at the treatment centre:

> So I went to [the treatment centre] but I was very arrogant when I got there because I had had a little bit of time to stay sober. I was mad at Social Services. I hated the judges. My ex-husband was to blame. Everybody. I had a lot of anger because it was their fault not mine. You see, at that point I hadn't realized that this was all my doing ... I remember walking in and I saw some people and I thought, "these jerks - I don't belong with these jerks in here."

Elizabeth's anger, however, was punctured by the confrontation of a counselor who was a recovering alcoholic:

> All of a sudden he said to me "If you have so damn much control over your alcohol, why are your kids with Social Services?" He just bellered out this truth and my tears just came ... I was bawling like crazy because the truth was laid in front of my face for the first time in my life.

Following this confrontation, that important "something" happened to Elizabeth. Fifteen years later, Elizabeth identified it as the turning point from which she never turned back:

> I walked out of there and I hated him. I went crying to my room and I stayed there. But something during that time clicked. I didn't know what, but something did. ... It was definitely a turning point for me because I had, at that point, come from denial to reality. I had been made aware

> of what was happening there and something in here - innerly - happened. I recognized - "Yes, I do have a problem."

At that point Elizabeth had recognized her addiction. A further solidifying of this recognition was necessary before she completely entered recovery:

> Then what needed to happen was I had to accept the fact ... I had to surrender to the fact that I had a problem with alcohol.

This happened before Elizabeth left treatment:

> I was a little bit less hostile. He took me to his office and started talking to me. I didn't cry again and I didn't scream ... I listened. Then from there on, by the time I came out of [the treatment centre], I had accepted the fact that I was an alcoholic and I recognized the fact that I was an alcoholic. I surrendered. I knew that I did have a problem with alcohol... There was no more denial. I knew.

Cheryl's initial recognition of her problem took place before treatment and propelled her to seek help. Again emotional pain and negative internal feeling states preceded and accompanied this recognition:

> I guess what really got me into recovery was I became ashamed of who I was.

Shame was what she felt when she came home drunk and her son, from whom she had previously hidden her alcohol use, saw her drunk and reacted by backing away from her.

> I was ashamed. It was an eye opener. I tried to fool myself that I wasn't the one who was going to drink. I wasn't alcoholic. I didn't do drugs as bad as everybody else did. I guess I hid it good for awhile. That time - the way he looked at me was like I was a total stranger. That really made me realize that I was becoming who I didn't want to become. That I was becoming my parents.

Her son's response, and Cheryl's observation of this response, coupled with the shame she felt, led to recognition of what she "was becoming" and her need to seek help "right away". This intense moment of realization was crucial in Cheryl's decision to enter treatment. However, like Elizabeth, a further realigning or movement into total acceptance and admittance of the problem was necessary. For Cheryl, this happened in the treatment centre:

> I went in there thinking I was an ACOA [Adult Child of an Alcoholic]. It was my parent's fault I did all those things. It was all their fault I have so many problems. I remember my first meeting we had. I didn't say I was an alcoholic or a drug addict ... I said I was an ACOA. And my counselor gave me the form, the questionnaire. I took that questionnaire and every answer was a "yes" answer. I ended up being an alcoholic and a drug addict when I walked out of there.

Like the confrontive question of Elizabeth's counselor, the questions of the chemical dependency assessment helped move Cheryl forward into the next phase required for certain entry into recovery. Cheryl left treatment having reached acceptance of her chemical dependency. As she said, before she entered treatment she "knew" she had a problem, but when she left treatment she was able to accept and admit this problem fully:

> Like I knew. Like you can know something. But it's whether you want to say it.

Cheryl saw her entry into treatment as her first turning point, the beginning of her recovery. "The time I went into treatment was one [a turning point] because that's where I

originally started from."

Similar to Cheryl, Henry experienced a psychological change event, or turning point, within himself previous to entering treatment for his chemical dependency. This event, in part a response to his physical predicament and internal crises, and in part a response to his emotional and spiritual pain, was the beginning of his journey into the chemical dependency treatment network:

> I figured I better do something because I wasn't getting anywhere at all. You know I was living in too much pain. When I thought of drinking I thought, "There must be better ways."

Henry detailed the thoughts and events of the day when he reached his turning point:

> I remember that time, the feeling ... not the feeling ... but the questions that came out, like you know, "you don't have to do this". It was as if something was talking to me. I didn't understand it then. "You don't have to do this any more. You can leave it."

This inner voice, presenting the hope of change and another way of life, again manifested itself later in the day when Henry was sitting alone in the darkened movie theatre:

> Again something came to me. I guess the questions that were really outstanding for me then were: "Where have you been? Where are you going? Where are your friends? What are you going to do? What is your purpose in life?" I remember these questions coming up and I didn't have any answers for them.

Henry began to weep in the theatre. For him, these questions were "painful".

> The questions were painful you know. They weren't painful at a physical level. They were questions

> that were touching my spirituality and it moved me. I didn't have answers to them so that left me in a place where I didn't have any place to go.

At this point Henry had no place to go both physically and spiritually:

> That was the turning point in my life. These questions that were coming up from somewhere I didn't have answers to.

These searching questions helped Henry recognize that something was wrong and needed to be changed in his life. The ensuing comments of his friends about his unhealthy appearance and the physical effects of alcohol withdrawal, which both resulted in fear, led to the hospital and the doctor who placed him in a detoxification centre.

Henry identified a second turning point in his entry into recovery which occurred at the detoxification centre. Something again shifted in him when an attendant showed him compassion by wiping his face and talking to him about her own life. This and a visit from an "old drinking buddy" in recovery, who talked to him about sobriety while Henry was in detox, helped solidify his entry into recovery. At this point, Henry had begun to accept and trust the process of recovery.

Beverly's moment of recognition came when Beverly observed and <u>felt</u> her daughter's sad response to the fact that she would miss school because of Beverly's drinking. This instant of realization was accompanied by searching questions to herself and emotional pain:

> I don't know, something just snapped in me and I got up and I thought "What are you doing? What are you doing to your kids - and yourself?" And I got them ready and I drove them to school. And my daughter's look, like the way they looked at me, like it was so pathetic, not pathetic, but sad. I went home and I just started crying. And I was just shaking. I was so hungover and sick. I phoned my friend and said "You know we've gotta do something about our drinking." I was just crying and I went over there. She called AA and we went to a meeting that night. An AA meeting. Our first meeting. I was so shaky. I was so hungover. And I just started crying in the meeting.

Beverly identified her reaction to her daughter as the first turning point in the recovery process:

> It was like I actually woke up ... It was really strange that morning. It was like I went back to sleep. I was gonna go back to sleep because she came and shook me. I said "No, go back to sleep. You don't have to go to school today." She left me and she was crying. It was just like something snapped inside of me. I lifted up my head, right up high. And I got up and I thought "What am I doing?" That was it right there, in that instant.

Two weeks later, Beverly attended day treatment for one month. Following this she entered a residential treatment program and met people from Narcotics Anonymous (NA), a Twelve Step recovery program for addicts. She began to attend NA meetings and then began to live with a man who was an NA member. Unfortunately, he was not honest about being drug-free:

> He started smoking drugs and I started smoking drugs. And then when people would come around we'd lie. And God, then I went back out drinking after that. And this one guy in AA I knew, he owned a bunch of houses and I rented a house from him. He was just a slum landlord and he was ripping people off. And he was ripping me off. So I got real drunk and I wrecked his place.

With this return to alcohol and drug use, Beverly began t experience the same crises and emotional pain that she had in her previous alcohol and drug-using days:

> After that all the same things started to happen again ... We had no place to live and I stayed at my friend's place.

However, Beverly reentered recovery with what she identified as her second turning point. It was when,

> I came to terms with that relapse or when I realized. That afternoon, I remember I phoned up my friend to bring me some booze and she did. I phoned another friend to bring me some hash and he did. I sat there with that. I went to the neighbors and I drank. I felt like I was in a fog. I felt like I was outside of my body watching me do all these things. Then again I thought "What am I doing?" ... I can't remember what I did with that hash, but I didn't keep it. I think I threw it in the garbage. That's when I picked up the phone [to contact an NA member] I thought "I don't want to live like this." Like I got all those same ugly feelings back again. And I thought, "No, no. I can't do this."

Beverly's relapse resulted in a partial replay of her original entry into recovery, including crises, emotional pain, contemplation, and recognition of her problem. However, with her reentry, Beverly had reached a deeper level of acceptance and commitment to recovery.

Don, too, experienced an initial recognition of the effects of his drinking, followed by a relapse, which in his case was brief. His entry into recovery can be seen as a number of small, graduated shifts. At the time of his decision to enter treatment, he recognized the effect of giving alcohol to his nephew. He "thought about it" and "was

worried about his nephew". It "freaked him out". Worry, concern and uncertainty were the predominant emotional states at the time of recognition. Don was also worried about his common-law wife and daughter, who had just left him. Somewhat like Elizabeth, he went into treatment to get his family back:

> When I went to treatment I was really moody. That's all I wanted to do was work on the relationship. I think half my treatment was just wondering what was going on outside. ... Wondering what she was doing and where was my baby.

During the second half of his treatment program, Don recognized that his recovery could not be dependent on his common-law wife, who was still drinking:

> I decided, I'm going to do it for myself. If she doesn't want to be part of my recovery, then I'll have to do it, be there for myself. And I made the best of what time was left at the treatment centre. I made up my mind that it was going to be for me and not for her. I thought anyways ...

But as Don's words connote, the process was not yet finished. One to two months following completion of his treatment program he had a brief relapse:

> My brother handed the joint to me and I took a drag of it. I handed it back to him and started shaking my head. Right from there I went into a little grievance period. Before that I had so much anger in me. What brought it up was that I was really in a pity trip thinking "Why me, why this, why that? Can't see my kids" ... and all this. I went home and waddled around the house the whole afternoon and when the evening came I went to another meeting. I just didn't really want to hang onto that -that guilt. I didn't want to knock myself down any more. I wanted to get on with life.

Through his relapse, Don was able to recognize the anger he

had been storing and the further guilt he would feel if he did not deal with his relapse or change his behaviours. He also went through a period of introspection at this time, that featured soul-searching questions:

> Well I decided that "Am I really doing this for myself? Have I got it set in my mind that if I'm sober for one year - is my ex, is she going to come back? Or are some things going to be happening to me? Start working or what, what's really going on here?" I had to make some choices for myself. No one was going to help me make these choices. Not a sponsor. Not an AA member. Not my student counselor. No one was going to make the decision for me. It had to be with myself and whether I really wanted to make something out of this program I had just started.

Don had now reached a deeper level of commitment and acceptance of his chemical dependency.

John's entry into long-term recovery was a longer drawn-out process, with fairly long periods of sobriety and periodic relapses. He became exposed to Alcoholics Anonymous and listened to people tell their stories at meetings. This process helped him reflect on his alcoholism and behaviour:

> There were people who were coming up there and sometimes they were really telling my story and it made me think.

A period of questioning and recognition took place:

> I began to go to AA meetings and discover that I don't have to continue the way I live. I discovered that wasn't me ... It's like a guy finally discovering that he keeps ramming his head on the wall and keeps doing that. And "why am I doing this? Why am I hitting myself? Why am I being self-destructive?"

However, he identified his separation from his ex-wife as the turning point which "opened the door" to his long-term

recovery. With her leaving he was in extreme emotional pain:

> That was the most traumatic thing. Because I was separated from my family. My routine of life was no longer the same. It was a whole new ball game. I didn't know what to do. I was very self-destructive. It's a miracle that I was not successful in totally destroying myself. ... The only way I can describe that is near death.

He was eventually able to recognize the bottom he had hit. He reached out, by attending AA and becoming a committed AA member. His bottom resulted in a greater commitment to a recovery program and acceptance of his alcoholism.

As can be seen from the stories of the participants, entry into recovery required both external events or crises and an internal shift within the individual. Crises needed to be accompanied by an internal awareness and processing of the effects of crises related to alcohol and drug abuse. There was both an emotional and mental component involved in this recognition, which included extreme emotional pain and soul-searching questions or reflections. In effect, the individual's internal "self" had to process and recognize what was actually happening outside himself. During the process of recognition, the external and internal spheres needed to be "in sync". As Henry observed, at his initial turning point:

> It seemed when I look back on it now, my inside and my outside were matching. They were congruent.

A third final ingredient, in addition to external events and internal processes, however, was needed to facilitate entry into recovery. This was the additional ingredient of other

people.

Involvement of and relationships with other people.

Other people played a significant role in participants' entry into recovery. In some cases, the individual's close relationship with another person was a motivating factor or a catalyst for their emotional pain and eventual recognition. In these cases, the presence of or responses of others or strong feelings for another helped connect the external events of alcohol and drug abuse with internal feeling states, thoughts, and recognition. The chemically dependent person's connection to or interaction with another person added the final ingredient and stimulated the recognition process. In other cases, recognition was a critical event that needed to be followed up by the active involvement of others. This involvement or action on the part of others facilitated the chemically dependent person's movement into recovery.

Relationships with others played a key role in the participants' initial entry into recovery, particularly for five of the individuals. For the three women interviewed, their relationship with their children was a strong motivating factor in entry. As Elizabeth observed, she entered treatment because of her strong love for her children and her desire to regain custody of them:

> Every time I sobered up, the reality of it all would hit, because I loved my kids so much. I loved them then too, you know.

She "did not want to be" at treatment, but attended treatment because she loved her children and wanted to get them back. The pivotal question with which the counselor in treatment confronted her involved her relationship with her children. Even though she accepted her alcoholism by the end of treatment, the influence of her children as a motivating factor remained:

> At [the treatment centre], that was a very difficult thing for me, you know. I more or less said, "Yeah, I'm here for me", but I didn't mean it inside. I was there for my children.

For Elizabeth, the importance of her children in her sobriety continued into the early years of her recovery. Their presence was the mainstay of her sober survival in the two years following treatment, when she had no other supports and was living with an actively alcoholic husband:

> I loved my kids so much, you know, that when I would look at them I knew why I quit drinking. It was for my kids. They say, "you don't quit drinking for your kids." Well, I have a hard time with that.

For Cheryl, as well, her child was a pivotal factor in her entry into recovery. She stated: "What got me into recovery was my son." His reaction to her drunken state was the key that activated recognition of her problem. With this recognition, Cheryl realized she was beginning to repeat the alcoholism of her parents and that her addiction would affect her son in the same way her parents' alcohol abuse had affected her:

> I was becoming my parents. That's the worst thing

> of all. ... Because my most important priority was my son. I wasn't going to let him grow up the way I did.

She also was not willing to lose her son to drinking:

> I was 16 when I had him, so there was no way anyone was going to take him from me. He was the most important thing to me.

As Cheryl stated unequivocably, "Without my son I wouldn't have been in recovery. I would still be drinking."

Beverly's children also played an important part in her decision to cease alcohol and drug use and seek help. Her daughter's tears at the possibility of missing school because of Beverly's drinking triggered recognition of the havoc she was creating in her children's lives. Her daughter and son's response activated Beverly's concern for her children.

These three women's connection to their children and, in two cases, the reactions of their children, were instrumental in bringing external events into contact with internal processes. In Elizabeth's case, her connection to and love of her children brought her to treatment. The confrontation of her counselor brought her [illegible]on. In Cheryl and Beverly's case, their children's response supplied the spark that ignited initial recognition.

Don, too, experienced a spark of recognition of the effects of his alcohol and drug use because of his concern for his nephew. Following this, he decided to quit drinking and entered treatment. However, an even greater motivator in

his decision to enter treatment was his connection to his common-law wife and child:

> What helped me make that decision [to enter treatment] was that I wanted my family back together. I was willing to go to any lengths to try and get it back together.

His relationship with both his wife and his child and his desire to reunite his family were important motivators. He hoped for a family reunited in sobriety. Not only did he drink, but so did his wife. He hoped, "that eventually she would go for treatment, too. After I was done my 28 days and I could look after the baby." Like Cheryl, Don had seen "a lot of things when" he "was growing up" and he didn't "want that life any more" for himself or his children.

For John, as well, the action of a spouse helped bring about his movement into long-term sobriety. When his wife left him he "hit bottom". John identified this as a turning point in his recovery:

> My ex-wife leaving me. It opened a whole new door. ... She was very important and she was part of my recovery. She opened the door by leaving.

His children also played an important role in his surviving so that he could recover. Their presence and his connection to them helped get him through his suicidal days:

> Many days and nights I almost wanted to end it all. But what made me hang in there was my two daughters. They pulled me through.

For Henry, his relationships with others did not play as pivotal a role in his initial turning point or his recognition that he must do something about his drinking.

Close relationships were not key motivators. However, actions of others and interpersonal relationships did influence his situation and movement toward recognition and recovery. His "parents had kicked" him out and he had "ran out of friends' places to go". The action of his parents and potential reactions of his friends meant he was homeless.

The critical event of recognition was also followed up by the involvement of others. His friends' reaction to his physical and psychological state hastened his movement to detox:

> I ran into two friends. They said to me, "You look as if you're dead." That really scared me.

Because of their comments and the physical withdrawal symptoms he was experiencing, Henry admitted himself to hospital. There a knowledgeable doctor referred him to a detoxification unit. The input of the doctor, carrying out his responsibilities, moved Henry further along into recovery.

Recognition was a critical event that needed to be followed up by the involvement of others. Once in the detoxification centre, the compassionate actions of an attendant there initiated a second turning point, moving Henry further into recovery:

> At the detox, when you're coming out, or at least when I was coming out of a drunk, I'm really in pain. .. For about three or four days when I was at the detox centre, I didn't know what was going on. I was lost. But there was something I remember so clearly, that I'll treasure this ... I was just shivering. I was shaking. So empty inside and

> lost. A lady came down and sat beside me ... She started talking a bit about her life. I remember her having this wet face cloth. Wiping my brow. The sweat you know. I thought "Gosh, I can't remember when - nobody ever treated me like this before." Because as I remember it now, it was done so lovingly and so compassionately and so accepting. That was another turning point. Because when you're on the streets from sixteen to twenty-seven, there's nobody out there that's treating you with love and understanding and compassion. You're out there surviving really - just like animals. So that's what I remember, even to this day ... how important that was for me, because I didn't trust people then.

In the detox attendant's actions, Henry sensed something different, a different way of life, and the beginning of trust in others and in the recovery process.

Also, while in detoxification, an old drinking friend who had become an AA member and who had gone through the recovery process himself, helped further Henry's movement into recovery. This friend's actions perhaps further predisposed Henry to receiving help in the upcoming treatment program. When Henry was in detox, his friend came to visit him and talked to him about sobriety and the compassionate group of people "that he hung out with". The change Henry saw in this man had a powerful influence on him. As Henry stated: "He was instrumental in me getting into recovery."

The final influence solidifying Henry's entry into recovery was his treatment counselor. Henry portrayed him as effective and able to work well with Native men:

> He joined me in my world. And I thought, "This guy knows what it's all about" ... He was the guy that

> really coached me into doing my Step Four, taking a look at my drinking history and all the harmful consequences and the people I'd harmed.

For other participants, as well, the involvement and input of friends and helpers was important in moving the entry process along to completion. In some cases their role was supportive and in others it was confrontive.

As was the case for Henry, for Beverly a drinking friend played a role in her getting help. Her drinking partner called AA and together they attended AA.

In Elizabeth's case a friend started the process which led her to treatment:

> Sunday, when I went to get my kids they weren't there. This friend of mine ... saved my life by reporting me, so that my kids were at Social Services.

Following this social worker, with persistence and compassion, ensured that Elizabeth entered treatment:

> The reason I ended up in [the treatment centre] was that a social worker from the drop-in centre referred me there. ... I couldn't stay sober. It was just too painful to stay sober. But this beautiful social worker kept on working with me. ... I went there one day and I just cried because I was so in pain. The pain was so horrible. That's when she made the referral to the treatment centre.

The social worker's caring, persistence and responsible performance of her duties, including concrete forms of help, were key:

> She was there, doing the professional work. The referrals and everything. Yet she was so nurturing and patient. She came to pick me up and drove me over there. Because I wouldn't have went if I had to get there myself.

Her counselor in treatment facilitated the next, necessary stage of Elizabeth's recovery. This time confrontation was what was needed:

> All of a sudden that one time in his office he just laid the truth in front of my face because I guess I was doing this song and dance ... Inside I was petrified because this person had guts enough to tell me the truth.

This confrontation sparked essential recognition of her alcoholism.

For the other participants, the input of friends and relatives played a role in nudging the entry process ahead. In some cases, relatives even took on the role of helpers, similar to Elizabeth's social worker. Often, these friends and relatives were themselves people in recovery. Twelve-Step program members, who were not relatives or former friends, also began to play a role.

John had a relative who was in a recovery program:

> I had a cousin who was going to AA meetings. He always wanted to drag me along. I remembered him. When I hit a bottom, I went to a meeting and came into AA. I reached out.

Having a relative in a recovery program may have acted as a predisposing factor in reaching out to recovery. Two participants had parents who were in recovery programs. These participants entered treatment at the ages of 19 and 20. The young age at which they entered recovery may have been influenced by their parents' example and support.

Don's father had been in recovery for a number of years and was part of a network of [illegible] people in recovery. His

father "got" him "into" a Native treatment centre soon after Don told him he wanted to quit drinking.

Cheryl's mother also had been in a recovery program for numerous years when Cheryl decided to enter treatment. Previous to Cheryl's decision, her mother had spoken to Cheryl about treatment centres. She also encouraged Cheryl to seek help for her personal problems. Like Don's father, Cheryl's mother, was part of a network of Native people who were in recovery or concerned about chemical dependency. Once Cheryl entered recovery, her mother was "the most important person". She served as a role model and mentor.

Although Beverly's entry into recovery was not influenced by a recovering family member, a Native elder did plant the seeds of change. Previous to her entry, he presented her with a positive vision of her future and options related to recovery:

> About a year before I quit, I ran into this elder. He was telling me about [the treatment centre which she later attended]. And all this stuff about recovery. I said, "Well, I didn't need it. Hey it wasn't for me." But he told me. He came around for awhile. Then I never saw him again. He said, "There's gonna be a lot of changes soon. I know that." And he left.

The elder also told her "Your life is gonna start coming together. The pieces will start fitting." Later, in recovery, Beverly found out that "a lot of the pieces are starting to be put together. I can actually see it."

Program members became helpful supports once participants became actively involved in Twelve Step groups.

Program members began to "provide a lot of support and help" to Beverly after she started to attend AA and NA. When she relapsed they did not desert her. After she began drinking and using drugs again, she "realized too" that she was in trouble because "people from the program started calling" her. When she decided to quit she "picked up the phone" to seek help from NA members and returned to NA meetings. She thought, "I'd better go. I was scared to go back. But I went anyway. From then on I stayed in the program."

Another participant who experienced relapses was also assisted in continuing the recovery process by recovery program members. When he almost gave up, John kept hearing people say, "It's not impossible. Everything's on your side today ... The only thing you lose is all the problems that you've created, that you live in."

AA members also had been important in his realization process. When he went to AA meetings and heard others speak, he discovered he did not have to continue in his drinking life style. There was another way of life without drinking. Listening to AA members talk and the process of identifying with their stories had been helpful:

> And just by listening to other people talk. I went to meetings and I started to hear these people saying things that I identify with. Then all of a sudden, you know, I'm not the only one.

John and a number of other participants discussed the effect of groups and group members in therapy during residential treatment. Group therapy and fellow group

members in the treatment program played a significant role in the treatment process. For John, there were "a lot of integral parts to the recovery centre". "Group members" and "good counselors" were two important parts. In the group there were,

> People who sit by you and listen to you and not say a word. And there are people who can suggest ways or tell their stories. Hearing about others' stories. To give you an idea, to give you a direction.

For Cheryl the "constant therapy" and concentrated time away from the outside world to focus on oneself in treatment was helpful. This was made easier by the group process:

> It was easier because if there was something I was dealing with, well, we had groups every day. Certain people are always there for some reason. If I'm in a group and I'm dealing with somebody. There's a reason I can't stand them. That's what brings up things. And that's what I deal with. Even when we weren't in groups, we were sitting around a table drinking coffee, having a smoke and talking about everything we had done in our past.

The treatment group provided a mirror and a support. For Cheryl, the group aspect was one of the two "most important parts" of treatment. For Beverly, as well, "group therapy really helped" in treatment.

As can be seen, the process of moving into recovery or "entry", was an interplay between crises, an internal processing of those crises and their effects, and an involvement of and a connection to other people. Through this interplay recognition took place. Upon receiving help, a further solidifying of this recognition resulted in

acceptance and a willingness to do the work required for long-term sobriety and personal growth. As Beverly stated a "combination of things" were crucial for recovery to take place.

Stage #2: Early Recovery - Building a Sober Lifestyle

All the participants identified a period of time in their recovery, following entry, where they needed to adjust to a new and sober lifestyle. Part of this process entailed a movement away from friends and acquaintances who used alcohol and drugs, and an immersion in groups and settings which supported their sobriety. An important piece of work in this stage was building a supportive network of sober acquaintances.

Most of the participants utilized Twelve Step groups and meetings intensely during this period. Attitudes and behaviours also had to be adjusted to maintain sobriety. For this, they relied on the steps and methods of Twelve Step programs and other chemical dependency recovery programs. In this stage they also began working on establishing positive interpersonal relationships with others, and confronting and repairing the damage to relationships that occurred during their addiction.

For the majority of the participants, these first one-to-two years of recovery were difficult. Three experienced relapses, while five of the six specifically stated the great difficulty of their first one or two years.

Creating distance from substance-abusing people and environments.

A period of isolation away or distance from drinking and drug-using companions was important for most. A sober network helped fill the gap left by this movement away from substance-abusing companions. Beverly stated:

> I totally cut off all my friends, who I used to hang around with in my drinking days. I made a whole new load of friends. I stuck close to the program. Too scared to go out into the real world actually. Because it wasn't safe. I wasn't scared of using or drinking, it was just I couldn't handle what people were doing to themselves. I was so vulnerable. If I saw it happen, I would feel bad because there was nothing I could do.

As had Beverly, Cheryl "found new friends" and changed her relationships with old friends who still drank and used drugs. She described the process she went through handling the peer pressures from other young people she knew who drank and used drugs:

> That was one hard thing. Everybody was still going out partying ... I had to stay away from them - that's what I had to do. I had to not necessarily forget who they are and leave them be, but I wasn't as close to them any more as I used to be. They still all talked to me, but they understood where I stood ... When you first sober up of course they phone you and tell you to come out. That's when you've got to say "no" and not allow them to step on you ... Then I guess, too, when you sober up they feel uncomfortable after that to be around you. So they in a way stay away too.

For Henry, a period away from alcohol and drug-using acquaintances and environments was also necessary. For him, the halfway house provided his "haven" away from alcohol and drugs:

> Staying in the halfway house was important for me. Because if I had gone back to the reserve, surely I would have gone back drinking ... Being at the halfway house ... it was a haven, it was a harbor. It gave me the opportunity to rest and take a look at my life and work. I really didn't know what I wanted yet.

For other participants as well, sober environments seemed to function as havens which helped create distance from substance-abusing environments. Cheryl worked at a Native treatment centre the first year of her sobriety. Don also worked in places where his co-workers were in recovery, including a Native treatment centre.

Beverly described her use of Twelve Step programs as a haven and stabilizing influence which kept her away from substance abusing situations, even after she ventured back out into the "real world":

> When I was 9 months clean coming back, I started getting involved in theatre again. That was actually my first time out into the real world. But right after that I came right back into NA. There were a lot of points on the road where I could have drank and didn't. I didn't want to. Every stop we made I went to a detox, NA or AA meeting.

Like the others, Elizabeth took the initial step of isolating herself from drinking friends. However, she did not form a network of sober supports and "didn't have anybody" to talk to during the first two years of sobriety. Her relationship with her children and God were her only forms of sanctuary at this time.

Building a supportive network.

Building a strong network of sober supports was an

important step that made early recovery easier and more likely to be successful. It was complementary and simultaneous to creating distance from unhealthy substance-abusing environments and people. Five of the six participants actively immersed themselves in an extensive network of recovering people during Early Recovery. The sixth participant, Elizabeth, did not do so until later in recovery.

Cheryl said about her first year of recovery, "I stayed around people who were sober. That's what I guess kept me sober." Because of her job in a Native treatment centre, she was surrounded by people in recovery and people who understood the recovery process. She said, "When I started recovery I could not talk to somebody who had no clue of what I was going through, who hadn't experienced it themselves." Being around others who understood was important for her.

Utilizing AA and attending meetings was also an important part of building a supportive sober network. Cheryl stated:

> I attended meetings. I went to a lot of meetings actually in my first year. Being around people who were sober - during work hours too, I could talk to somebody. Getting to meet a lot of people, it made it easier for me to go to any meeting that I wanted to go to because I knew somebody and that's what got me through the first year. Plus my biggest support was my Mom because she's in the program and she was like my sponsor - the first two years.

Don identified going to AA meetings and involvement in

AA as important tools in early recovery and in helping him deal with friends and relatives who still drank and used drugs. In early recovery:

> It was being a good AA person. Going to meetings, talking at meetings. That's about it.

He sometimes went to three to four meetings a day during this period of time.

Henry also identified AA meetings as the main tool he utilized in early recovery:

> Mostly it was just going to AA meetings. That's all I knew then. I didn't know anything else, so that's what I stuck with.

After completing her treatment program, Beverly started going to NA:

> After treatment they say "Go to 90 meetings in 90 days." So I went to about 130 in 90 days. .. I just basically, for the first year and a half, went to a lot of meetings.

She surrounded herself with Twelve Step program members. However, picking the "right" program members was important for Beverly. In her initial entry into recovery she became involved with dishonest program members. When this happened, relationships with program people became a negative influence on her recovery. Being around the wrong people and anger about these relationships figured strongly in her relapse.

Observing program members carefully and choosing trustworthy people with positive recovery as role models and supports strengthened her second entry into recovery:

> When I came back, I really sat back and observed this time. I watched people. I saw who were the "winners" and I saw the people who were just using the program as a crutch. Just because they were out of jail and using it in all kinds of ways ... So I sat back and observed.

Previously, she had "trusted anybody" because she "didn't know what trust was". But following her relapse, she looked for people she "could trust".

For Don, too, some mistakes previous to his relapse were in his relationships with program members:

> I didn't have a sponsor. I didn't have a home group. I wasn't making new friends. I think that's what was going on. I was just running to meetings. Not talking to anybody. Not getting phone numbers. Just being really antisocial. Walking in and walking out.

John, too, began to utilize AA more seriously following a number of relapses. When he "hit bottom", he "went to a meeting and came into AA". Previous to this he had been exposed to AA, but not used it intensively. AA meetings and members helped him not give up when he "hit bottom". He continued to seek their assistance and was able to establish long-term sobriety.

The three participants with shortest periods of recovery discussed the importance of establishing relationships with sponsors, more experienced Twelve Step program members chosen by less experienced members to guide and advise them. Cheryl mentioned the importance of her mother, who took on a role similar to a sponsor in the first two years. Beverly detailed her search for an appropriate

sponsor, a process in which she "fired" the first two before finding a third who was supportive. Don also recounted in detail his selection of a sponsor and the process of establishing this relationship. Evidently, the significance and memory of such mentors was still strong for participants who were at earlier stages of recovery.

Unlike the other five participants, Elizabeth did not form a network of sober individuals to support her during the first two years of her sobriety. This made her early recovery very difficult:

> I didn't have the tools at that time ... I was awfully lonely ... For two years I just about died. I wondered "why-why do I bother? Why was it I felt so alone?" I didn't have anybody, didn't have any sober friends ... I didn't have any support systems when I came out of treatment. I didn't know how to make friends without alcohol. I didn't know how to risk myself. I was very scared, so I never did anything. I didn't go to AA meetings. I didn't get a sponsor. I didn't get any of those things.

Elizabeth identified fear as the reason she did not attend AA meetings, even though told to do so upon leaving treatment. The effect of sobriety without supports was "crazy" behaviour. She stayed in a marriage with a practicing alcoholic:

> The alcohol is cunning and baffling. Even if you're sober, you still do crazy things, that you don't do when you're healing and have support systems. You become a dry drunk because of the fact that you don't have support systems or you're not in a program.

Lack of active involvement in a recovery program and lack of sober support systems kept Elizabeth from dealing with

deeper issues. It was not until five years after treatment, following self-therapy, in the form of books and workshops, that Elizabeth was able to confront emotional issues.

It was at ten years of sobriety, after she "began to feel discontented" and "scared", and began to experience "the same symptoms" of "irritability and depression" as when she used to drink, that Elizabeth completed the step she had missed ten years earlier; she joined AA.

Utilizing the tools of recovery programs.

In early recovery the participants also began to "work the steps" or utilize the steps and recovery methods of Twelve Step programs such as AA and NA. They also began making use of other resources like workshops, training courses, and books which would help them reestablish appropriate social and communication skills and begin to repair the damage of addiction. From these, they learned how to successfully live alcohol and drug-free. Attendance at assertiveness, life-skills, and addictions training courses were common during this period.

All of the participants discussed utilizing the "steps" of AA or NA at some point in their recovery. For five of the six this utilization began in Early Recovery. Five out of the six specifically highlighted the importance of completing Step Four which involved taking a searching inventory of oneself and one's behaviours. At the beginning of recovery, this inventory was often focused on the

individual's previous substance use.

Starting to build positive relationships.

Besides building a supportive network and utilizing resources and tools to ensure sobriety and adjustment to a sober life, a further task begun in Early Recovery was working on building or reestablishing positive relationships with friends and family. Most participants were confronted with the challenge of reentering the family and social circle as a sober person. In some cases, this meant handling relationships with drinking family members and those still mired in emotional problems. It often involved individuals who had been harmed by addiction in some way, but who did not understand the recovery process. In other cases, it meant confronting or accepting changes in relationships that had occurred due to the participant's addiction or recovery. It often meant rebuilding damaged relationships or learning how to have positive relationships and friendships with others. This work would eventually complement the support network. In addition, recovery tools were used to facilitate the process.

Building positive relationships often entailed confronting feelings underlying difficult relationships with others. Henry described how his anger kept him from being close to others in early recovery:

> A friend of mine asked me one time - "Henry, do you have any friends?" I was about a year into recovery. I said, "Yeah, I think I do." "Well, who are they?" he asked me. "Do you really?" "I don't

> think so." I said. He said, "Do you want to know why?" "I don't know if I want to know why, but okay tell me." He said, "Henry people are afraid of you. I think the reason why they're afraid of you is you're an angry man, you're bitter, you're hostile. You're indifferent and aloof to people." I remember those words so clearly. I mean that's how I was when I was drinking.

At this point, Henry was confronted with an area in which he needed to make changes. As he progressed in recovery, his anger began to "dissipate" and he began to build a large network of friends. Seventeen years later, his interview was filled with references to friends who lived in many places.

In Early Recovery, John was confronted with his anger at his ex-wife and the loss of this relationship and the family unit:

> I think there was one big turning point. I was still dwelling in my separation with my ex-wife. Dwelling in the hurt and pain. I had a lot of anger and a lot of pain and a lot of resentments. I kept living in that pain. Finally I got sick and tired of it. I was crying out for help and I was saying, "Gee, when is this going to end?" An old lady said, "It will only end when you want to end it, you want to do something about it." That's why she got angry with me. Because I kept talking about my hurt and pain. All these things were happening to me and everything else. She got angry with me. She said, "I'm sick and tired of hearing you say the same thing over and over. You're like a broken record that repeats itself. You come home with me and I'll show you something." I couldn't dare pick on this little old lady. I had to be nice to her. She took me home and she took out her Big Book [the basic text of Alcoholics Anonymous] and turned to a page. In there it tells me if I have a resentment against some person, place or thing, pray for them. And anything you want for yourself to be given to them. The last damn thing I wanted was for something I wanted for myself to be given to my ex-wife and her boyfriend. The last damn thing. That's what it tells you to do. It took two days to listen. Then one day I decided

> "The heck with this I'm gonna do it." It was more like I was daring - let's see it work. And I stuck to it. Prayed every night for them. Everything I wanted for myself. I even prayed for other people I had resentments against. Fourteen days. One particular day I was at work and my phone rang and my ex-wife phoned and said my girls wanted to see me. I hadn't seen them for 14 days. So we rendezvoused in the parking lot. I saw these two beautiful girls. And I looked up and I saw this blonde woman and I thought, "Who the hell is she?" It was like a shock. To finally realize that all the anger that I'd felt was no longer there.

This event was the beginning of a new relationship with his ex-wife, one based on friendship and recovery. It was also a turning point for John which gave him "a whole different perspective", a sense of freedom and a sense that he could accomplish many things. He felt his life was wide open and no longer restricted. He felt he was "onto something big", "onto a life". He could "do anything" he wanted, "be anything".

John's story of letting go of resentments is a good example of changes made in relationships during recovery. It also shows the interaction of the three themes - relationships with others, taking action or doing the work, and psychospiritual change.

The change and sense of resolution from this event seemed to allow John to pass into another stage of recovery. In his next intimate relationship, he soon recognized its unhealthiness and left it, utilizing a Native treatment centre as a haven in which to reassess his priorities. This time he understood his partner's anger. He did not rage at

her, even though she was vengeful toward him.

In Early Recovery, Cheryl's anger and previous hatred toward her mother began to abate. She began to have a closer connection with her mother. It was during this period that they began to rebuild the relationship between them:

> We hated each other. Going into recovery was what brought us together.

As recovery progressed this close relationship continued and deepened.

Don, too, was able to begin a new relationship with his father. His father assisted him in entering treatment. As Don continued in recovery, they became closer, eventually being able to discuss the hurts of the past.

Relationships with friends and family members who were still drinking were more difficult. Don listed his relationship with his ex-wife and lack of access to his children as one of the two main obstacles he confronted in recovery. In Early Recovery, he had to accept the fact that his wife was not going to attend treatment and that he "was on his own". Following his relapse, Don recognized the true depth of his anger at his ex-wife and committed himself to his own recovery without her input.

Reentering an actively alcoholic family as a sober person was extremely difficult. Following treatment, Elizabeth returned to a household with a drinking spouse and children who had been affected by years of parental alcoholism and family violence. No other family members had

received help and none understood her sobriety. She identified her return to an alcoholic marriage and an untreated family as her greatest obstacle in recovery:

> My husband was still practicing. He would be sober three weeks and then would practice. My kids, the older ones were already bigger ... Even though I wasn't drinking, it seemed like my whole family was going crazy. I didn't understand that I was in that family boundary. I was the only one trying to change. I was trying to get out of that and I was screwing up the family. They didn't want that. So they reacted in every which way. Because there was my spouse still practicing. My kids were sniffing glue. Getting in and out of trouble, especially the scapegoat in our family. It seemed like there was no one there to support me. The more I tried to do those things, the more my ex-husband condemned. The kids they started getting bigger. I would get names. And "Don't give me that fucking psychology, that counseling. Just 'cause you're taking a course." I would get things like that and I would start crying sometimes because I felt so alone and you need the family. You need somebody to support you. I think that's when sometimes people go back and use.

Despite these difficulties, Elizabeth managed to stay sober. She began to reestablish her role as a responsible mother. By immersing herself in this role she avoided relapse:

> I would take a look at them. They're such beautiful kids and I love them so much. Sometimes I would just be literally bawling I was so depressed. They would be on the floor playing. Five kids, three little babies. They were so beautiful and I loved them so much. Many times I remember sitting on the couch feeling so alone and the kids would be on the floor and I'd think "Yeah. ... I don't want to lose these kids. I don't want them to be with Social Services again." You know, that's what kept me going.

<u>Stage #3: Middle Recovery - Working on Deeper Issues</u>

Following adjustment to a sober lifestyle, the

participants entered another period of recovery which involved deeper emotional and therapeutic work. This usually centered on dealing with and healing traumatic losses and childhood issues. Losses and trauma experienced in adulthood, such as miscarriage, abortion, and spousal abuse were confronted and grieved, as was abuse and trauma experienced in childhood. Childhood issues included sexual abuse and family violence, family alcoholism, and the trauma of residential school. Individual and group psychotherapy, as well as ACOA (Adult Children of Alcoholics) and co-dependency workshops, support groups and books were common resources used at this time.

Native identity issues were also confronted during this stage. For most of the participants, Native identity struggles had begun in childhood with the advent of prejudice, residential school, or loss of culture.

All the participants became involved in Native spirituality and Native cultural and spiritual activities by this period of their recovery. Five identified specific points after Early Recovery when they became involved in or when this influence became a major focus. Three framed involvement in Native spirituality as a new or different phase of their recovery.

Building positive relationships continued to be of importance in this phase and for most, relationships with others continued to be reevaluated and modified. Building

and healing interpersonal relationships at a deeper level was described by the majority.

Career changes and preparations for engaging in a useful career, as well as occupational struggles, also took place during this stage.

Confronting and working through traumatic losses and childhood issues.

After two years of solid sobriety, John felt he was at a "stuck point" in his recovery:

> I came to Step 4 where I take my own inventory. I felt really bad for what I'd done to others while drinking. I remembered doing my Step 4. I worked hard at it for months. And then Step 5. I was supposed to feel all this joy. Trumpets blaring and all this. But nothing happened. I realized there was a nagging feeling there. I went to elders and I went to churches and I went back to AA. Still -like I was stuck in the program. Not as happy as I should be, so I kept on my search.

His "search" led to ACOA (Adult Children of Alcoholics) and the discovery of childhood issues which needed to be confronted:

> One day a friend of mine suggested ACOA. When I went to my first meeting I was really nervous. There were pamphlets and all that. The lady was reading and she came to Step 3. And it just hit me right between the eyes. Then all of a sudden I just burst. I just cried. I cried for it hit me so hard, that I realized I was onto something big. It was then that I discovered my child. And ACOA. I worked at it almost two years, with the help of psychologists, hypnotherapy, reading books. Going all out, to recover. To get rid of that nagging I wanted to answer. So I did. I went back to AA and I no longer felt that I was stuck in the program.

John observed that "AA had taken care of what he did to others" when he was drinking, but had not "taken care of

what had been done to him" in his childhood. He had to go beyond AA into other programs in order to continue his recovery at a deeper level. ACOA work helped him deal with what had happened to him as a child. In his case childhood trauma resulted from the changes he and his family underwent when he was sent to residential school and his father lost his trapline due to the actions of the government.

In her second year of recovery, Cheryl too began to confront losses that had taken place in her first year of sobriety and in her childhood. She had returned to school, but quit "because there were still a lot of things [she] had to deal with before [she] went back to school". She then attended a ten day follow-up program at the treatment centre where she had first completed treatment. This initiated a new phase of recovery:

> That was the first time I dealt with my abortion. It was what I needed. In the program you reach a spiritual awakening ... For me it was more of a spiritual awakening in that program. I knew then that's when I had to get all that load off. When you carry something around for how long, your shoulders become heavy. There were a lot of things going on in my ten day follow-up. I got more out of that than I did my treatment because treatment is just learning about what and how to beat what drugs and alcohol does to you. The ten day follow-up is more dealing with emotions and feelings and that's when I really started my recovery at that point.

During this period, Cheryl had also moved to a new location with her mother and was attending many workshops, including ACOA workshops. With the help of her mother, she began to confront childhood issues, including her anger at her father

who had been abusive to the family. She considered this the "most important part of her recovery ... bringing all the past back so that [she] could deal with it".

During this time period, as well, Cheryl confronted the individual who had sexually abused her as a child. She also attended group counseling sessions and utilized the services of a psychologist whose work using family sculpturing in dealing with childhood losses was helpful.

After a year and a half to two years of sobriety, Don also began to explore childhood issues. He credited the Native treatment centre where he worked as influential in this. Attendance at ACOA workshops was mandatory for staff. He stated that this attendance at ACOA workshops "really contributed" to his recovery program and he "did a lot of healing". There was "a lot of pain" connected to childhood issues which ACOA workshops helped him work through and let go of. He stated, following workshops, "you feel like someone took a thousand pound weight off your back." Don also attended ACOA group meetings at this time.

Currently, he was beginning to confront sexual abuse issues. During his fourth year of sobriety, the memory of the abuse had come back to him:

> About ten months ago I went through a life skills course. I was sitting in group and "bang". I had a really wicked flash inside my body. I closed my eyes and I remembered what happened with myself being abused.

In his recovery, Don had begun to "touch on those feelings"

related to sexual abuse "a little bit", but had not "really" done in-depth "work on that yet". He had, however, begun to discuss childhood issues and other aspects of recovery he had in common with his father:

> My father you know has shared a lot of his experience with me, especially when he was abused. It opened some doors ...

Discussions involved "father and son issues", "woman" and relationships issues, and "mother and son issues". As with Cheryl, part of his healing work involved sharing, with his parent who was in recovery, thoughts and feelings about family difficulties.

Beverly also began to face the effects of painful childhood events during this stage of recovery. Following her first year of solid sobriety and two years after first entering a recovery program, Beverly began to attend psychotherapy sessions to help her resolve difficulties emanating from childhood abuse and family alcoholism:

> It's hard. It's really hard. I've been in therapy for two years now. Working on sexual abuse issues and I'm starting to make contact with those in therapy ... There's so much emotional and physical abuse. Mental, spiritual abuse. I actually am just finding out now that I lived in a fantasy world since I was real little. That was my escape ... My dad was an alcoholic. My mother never drank. My dad used to beat up my mom all the time. I remember that. There was a lot of sex happening within the brothers and sisters. That's all come clear to me now.

Beverly also began a Native training program, which focused on chemical dependency, a few months after beginning therapy; this program was "intense" and complemented her

work in therapy. She also attended useful workshops, including one on co-dependency.

Confronting childhood sexual abuse was helpful to Beverly. Beverly also stated that one especially useful piece of therapy was "working on anger. I've got lots of anger and still have lots of it." As well, learning about her "own boundaries" and her "own limits was important".

Like Cheryl and Don, Beverly was still "in process", in the middle stages of recovery, dealing with childhood issues. There was "lots of anger" and pain. It was a painful, but necessary period, fraught with emotional turmoil, with periods of calm followed by psychological upheaval.

For Beverly, one of the main obstacles in her recovery was the "spiralling down into depressions when I don't know what's happening. Especially with this sexual abuse." At these times she had to phone a supportive friend or utilize the services of her therapist.

The participants with longer periods of recovery, appeared to have passed through this stage, and had less disruption currently in their lives. However, they had done similar therapeutic work and experienced similar ups and downs and turning points in their recovery.

Henry began to confront childhood issues and become involved in ACOA work when he had been in recovery for almost ten years. His later beginning of this work compared

to John, Cheryl, Don, and Beverly may be due to the fact that ACOA work and resources became more popular and widespread during the 1980s, when Henry had already been in recovery for some time. Henry stated:

> The summer of '84 I began to sense another vacuum in my life - that needed to be dealt with. I didn't know what, so I started phoning around. You know the AA central office and I said, "Is there an ACOA group there?" "No, there's nothing." ... I heard of an ACOA workshop that was coming up. I was there for the four days and the stuff that the facilitator was talking about was literally hitting home. Every time she said something. So I knew then that "Okay, there are some issues around my childhood, my family that needed to be taken care of, dealt with."

Following this, Henry attended workshops and training sessions related to childhood and ACOA issues. He eventually began to deliver ACOA and co-dependency workshops. After four to five years of personal and professional work in this area, Henry had a sense of resolution about these issues.

One year after attending his first ACOA workshop, Henry also began to utilize psychotherapy to help him deal with deeper issues. A colleague "suggested [he] go to therapy" because Henry "couldn't make any connection between [his] head and [his] feelings". He eventually felt a greater sense of intrapersonal "congruence" from this psychotherapeutic work.

Elizabeth's middle stage of recovery was a series of "ups and downs", periods of therapeutic work and spiritual awakenings, with periods of difficulty and discontent. This period stretched from about two years to ten years of

sobriety. Following her first two years of isolation and depression, Elizabeth began a process of "self-therapy", through the use of books and workshops. She "went on a real high" after she "got over that hump" of her first two years of sobriety:

> I was into self-help books. I was taking workshops. I was doing anything in my power to educate myself and to get well ... I took workshops on self-esteem. Once I got over that hump I really went on this wagon about "getting well, getting well". I did everything in my power to get well.

After a period of self-therapy and working on wellness, Elizabeth found, at five years of sobriety, that she began to "deal with deeper issues". She began to confront issues like the loss of her baby through miscarriage when she was drinking, the family violence that had taken place in her marriage, and the sexual abuse of her childhood. She also began to read ACOA literature and books about dysfunctional family dynamics. Elizabeth also described this time as a period of spiritual awakening.

An intensive additions counselor training course at eight years of sobriety resulted in "a turning point", a greater acceptance and liking for herself and a greater willingness to take risks to help others:

> After I took that addictions course, I began to literally have a lot of faith in me. That's when I think it started, when I really started taking the risks, the bigger risks in my life. Ever since that time I've been taking more and bigger risks. Like doing workshops, developing programs.

However, the way was not yet clear. A series of

disappointments in Elizabeth's employment situation awaited her. She overcame these disappointments and entered a certificated training program in the human services. At this point, Elizabeth reached a down or "stuck point" in her recovery:

> I was no longer on this high. I was beginning to get disillusioned by life. I started getting down ... Pretty soon I was not interested in too much and I was getting sort of panicky.

Around this time, Elizabeth left her husband. Soon afterwards, she sent her children to live with their father because of the hours required for her coursework and her lack of money as a student:

> I really started getting depressed. I was beginning to go down ... nothing made me happy.

She began to experience the same symptoms of irritability and depression she had in her drinking days and felt like she "was drowning".

Fortunately, by chance, she met a woman who was an AA member. She began to attend meetings and "joined AA as a desperate route". She wanted to regain the contentment she once had. She later realized that part of her problem was her separation from her children. She felt as though something was missing from her life. However, for her, this period and the fear she experienced was a positive learning experience for she learned not to take her sobriety for granted. She had reached a deeper appreciation and respect for her sobriety.

Leaving inappropriate intimate relationships.

Elizabeth's middle stage of recovery seemed to end with a final piece of work. She had earlier left her abusive husband. She now decided to begin an intimate relationship. However, this time, compared to earlier in her life, she chose a partner carefully. She ended a relationship with a man she had just met, that was not healthy for her. She felt "proud" that her sobriety had made her "strong enough to assess" a relationship and end an inappropriate one. She instead chose a relationship with a fellow AA member with whom she shared similar values.

Other participants, too, ended inappropriate intimate relationships during this stage. Don, after a number of attempts to reestablish a relationship with his still-drinking common-law wife, finally left the relationship. He also gained access to his children. Beverly observed that she "was coming to another turning point" and was soon to leave her common-law spouse, who was a fellow NA member, but who had values very different from hers. Cheryl reached a major turning point during this period and left an abusive mate who drank. As was the case for Elizabeth and Don, a relationship with a drinking partner became an obstacle in Cheryl's recovery. Both Cheryl and Beverly decided at this point they were not ready for an intimate relationship and needed time alone.

Healing relationships at a deeper level.

Just as some relationships were ended, others were strengthened and healed during this time. Cheryl's relationship with her mother became increasingly stronger. Together they were able to discuss the hurts of the past:

> Going into recovery ... helped us to deal together with certain things because a lot of things that I was feeling are the same as what she was feeling. So she understands. It's easier for me to deal with a lot of things that I didn't when we were growing up ... Even if there were certain things that I had to deal with about her, I could go to her because she was in the program ... One of my biggest problems was my dad because he was so abusive to all of us. Even though they're divorced, she helps me to see his side, understand. That makes it easier so that I can deal with it and it would make it easier for me to forgive.

Cheryl relocated when her mother did and eventually began to live with her mother. She spent time with her mother, who was an on-going source of support and information:

> My mom works in places where there's sobriety. Certain functions that go on. She's got better access to workshops than anyone who is just coming off the street. I hang around with her a lot and she shows me different ways of getting resources and that's what I use.

Don, too, grew closer to his father at this stage and began to rebuild this relationship at a deeper level:

> I've gotten to know my dad a lot more ... It wasn't until about a year ago that we started talking. There were some things that I went through and he started opening up his life with me. It made some sense. I've lived with him for the past year already. The year that I stayed with him we did a lot of talking, a lot of growing, a lot of sharing."

John's relationship with his ex-wife, who was also in a recovery program, continued to evolve during this phase. Earlier, he had let go of his resentments toward her. Now she became a support when he was dealing with childhood issues:

> There were people with me - even my ex-wife. Friends and relatives who understood.

It seemed that, for John, Cheryl and Don, having a recovery program in common with a family member facilitated healing.

For others, family relationships were not so easy to heal and the support not available in the natural family was found outside of the family. For a time, it was necessary to recreate or adopt an outside "family" of supports. For Elizabeth, living within an actively alcoholic and dysfunctional family system was difficult:

> That was very, very hard. Until I started learning that I go alone on this until I adopted a system along the way. I adopted a family outside my family.

In her middle phase of recovery, Elizabeth ended her isolation and began to recreate a family of supports outside the unhealthy family system.

For Beverly, it was her family of origin that she replaced with a network of Native people involved in Native spirituality and culture:

> It's like I've got a whole new family again. It's really sad though to know that my own family, I can't turn to in that way. That's been kind of bothering me too. But when I go back to them, they

> haven't really changed. So I'm not putting myself in that position again to go back to my family.

Spiritual awakening and involvement in Native spirituality.

Involvement in Native spirituality and traditional Native ceremonies was important for all participants during this stage. A number identified this period of recovery as being intensely spiritual in nature and as a time of spiritual awakenings and spiritual depth. Cheryl had a "spiritual awakening" during this period while attending follow-up.

Elizabeth also identified this as a period of spiritual awakening. After five years of sobriety she found she "was having all types of spiritual awakenings and noticing spiritual shifts in" herself. She remembered all of a sudden one day "seeing the sunset as beautiful instead of depressing" as she would have in the past. She began to notice and appreciate the beauty of flowers. She found she was no longer resentful of people or their successes and "it felt good". Elizabeth also started to work at a Native treatment centre. Here she began to attend traditional Native sweats spiritual cleansing and prayer ceremonies.

Like Elizabeth, Henry had a spiritual awakening and a turning point, following a number of years in early recovery:

> I'd been sober three or four years ... My boss was a traditional cultural woman. She said to me "There's a three day workshop, do you want to

> come?" I said, "Yeah, okay, let's go." ... We got to the workshop and a friend of mine was presenting stuff. Trust and brainstorming stuff, talking in small groups and such. I remember him doing flip chart work and I was watching. We were all sitting around in a circle. And on the right hand side of me, just at the end of my peripheral vision, I saw my Grandfather standing there. I continued to listen and then my Grandfather came into view again. He was looking and listening to what was being said. He was smiling, he was nodding. He was agreeing and every once in awhile he would look at me and smile.

This vision of his grandfather helped Henry recognize and begin to experience the spiritual side of life and of his recovery:

> In the Native world we're always saying that we do have visitors that come from the other side and pay us a visit. So when that happens to me now, I know that they're there and I acknowledge them ... That kind of awareness that goes beyond the physical realities is a big part of my recovery.

The setting of this event also foreshadowed and gave spiritual support to Henry's eventual work in presenting workshops and training others.

Sometime after returning from the workshop, Henry was invited to take part in a traditional fast. As part of the preparation, he entered his first sweat lodge. Here he experienced intense visions and another spiritual shift, or turning point.

> I think at this point something inside of me shifted. From knowing this life. That's when my belief began to develop in a spiritual world outside this world ... I don't know how you would label this kind of turning point - the spiritual shifting or psychic shifting.

At this point Henry had shifted from simply "going to AA

meetings" to stay sober to experiencing a spiritual form of recovery. He had begun a new phase of his recovery which incorporated extensive use of traditional Native ceremonies and Native spiritual practices.

Beverly also began to utilize Native spirituality during this stage of recovery. She attended traditional sweats, pipe ceremonies, traditional circles such as family and women's gatherings, and as well, took part in fasting. She identified her involvement in Native spirituality and culture as a new chapter in recovery. It was when she began a Native training program that she met an elder and started to take part in traditional ceremonies:

> That's when I got involved, that's when I started learning about my culture. I seem to learn more from my own culture. NA, AA they were stepping stones for me. I still go back to the circles of AA, NA. I'll never leave that. But my culture is the strongest right now.

Don, too, distinguished his later use of traditional Native spirituality from his earlier period of simply attending AA meetings:

> Now how do I deal with it? I look on the cultural aspect. More of a spiritual thing. After I finish this interview, I'll be leaving for a sweat right away.

He had first become familiar with traditional spiritual practices in his treatment program, but became involved in and committed to this lifestyle during Middle Recovery.

Cheryl was also introduced to Native spiritual practices in the treatment centre. She began utilizing these

more extensively during her second year of recovery when she had also started to confront traumatic losses:

> I've been learning more about my culture - using sweetgrass, going to sweats, sometimes even going into a library and reading. Talking to different people, to elders.

She stated that "talking to elders, being aware of spirituality in Native culture" helped keep her in recovery. It was important in helping her overcome her sense of inadequacy and the prejudice she had experienced.

John mentioned involvement in Native spiritual activities as one of the most helpful aspects of treatment, along with "good counselors" and the input of group members. He often sought the wisdom of Native elders and was involved in traditional activities:

> I go to a lot of sweats. Do a lot of meditating in sweat lodges. To me, I've become awake. I'm awaking my spirit.

Confronting and embracing one's Native identity.

Accompanying an involvement in traditional Native spirituality and culture was a search for one's Native identity and an understanding and healing of traumas experienced as a Native Canadian. This exploration and healing resulted in a strong cultural identity and pride.

John came to recognize the traumatic effect of Indian residential school on himself as a child. He realized that this was part of childhood wounds from which he had to heal. In fact he identified this as the major trauma of his childhood:

> I think my journey began long before I was introduced or even experimented with alcohol. Because a lot of my traumatic experiences were based on my experience in residential school. I had some kind of traumatic experience that I hadn't dealt with. I think it's called "chronic shock", which I had not dealt with. As I grew older, I lived in a fantasy for a long time - a form of forgetting.

Emotional suppression and a negative self-concept were developed in residential schools designed to assimilate Indian children:

> I discovered that a lot of things stem from when I was growing up in residential school. All of my character defects were from there. Because I learned in residential school - you don't feel. You were taught not to feel. That you were bad. You would sin and go to Hell. God is unforgiving. God is all-punishing. ... I had a lot of anger. It was in residential school that I learned how to suppress my feelings. The only way you could show that you were human was "when the going got tough, the tough got going". It was all the military fashion and that's what they taught. And to care for another human being was "That's ridiculous - don't do that." I grew in military mentality and I learned how to suppress my feelings. I'd constantly be telling myself that "I don't feel no pain. Men don't cry." Tough guys. When the going got tough, the tough got going.

Also traumatic was the movement back and forth between residential school and home. John found, when he returned home, he no longer fit in, and he became confused. He had changed due to residential school; he had become quieter, more subdued and less active. His parents did not understand the changes in John and his father acted resentful.

To add to this disruption, when John was ten years old, his father lost his trapline. In an effort to make the Native people of the area farmers, the government took away

trapline rights. At this point John's parents began to drink. They had never drank before but had previously lived a traditional lifestyle. This led to the breakdown and dysfunction of his family. These changes took place while John was away at school for ten months. When he came home for two months in the summer he found his once predictable home chaotic. He became extremely confused, as his home was different from residential school and different from early childhood. In healing childhood issues, an understanding of the effects of cultural trauma was essential for John.

John identified confusion over his cultural identity and where he fit in relation to Native and non-Native culture as one of the obstacles in his sobriety and recovery. When he married a White woman and began driving a new car, he was called an "apple" by some on the reserve. When he became strongly involved in Native culture, his White friends in the city made comments about him being a "radical Indian". He turned to the elders in his confusion. They suggested he take the best of both worlds and in his recovery he followed their advice.

In her recovery, Elizabeth too experienced struggles related to her Native identity. Like John, she had been confused. Raised on a reserve as a non-Status Indian, she experienced discrimination from other Native people because she was not a "Treaty Indian". When she moved to the city in her mid-teens, she was considered an Indian because she was

not White.

Because of her negative experiences and the abuse she suffered in childhood, a sense of Native cultural identity was hard to attain. Elizabeth experienced confusion for some time between Metis, traditional Native, and White identities and cultures. At five years of recovery, Elizabeth began to confront this issue seriously. She began to learn about Metis culture. She found it was necessary to be aware of and accept both traditional Native and Metis cultures. She had to learn to balance these. Listening to others tell their stories about struggles similar to hers was helpful. Spirituality was also important in this process.

For Cheryl, too, Native identity was one of the issues she had to confront and begin to work on in Middle Recovery. As a child she had experienced prejudice from non-Native people:

> I grew up with every other nationality. People were prejudiced against me and my brother especially because he looks Native.

She was keenly aware of prejudice because of reactions towards her brother and the division of children along ethnic lines in small-town schools. However, because she did not look as Native as her brother, she could sometimes pass as White and was sometimes not identified as Native. At times this bothered her:

> I guess I was always fighting to say, to tell them, "I am Native, I am Native, I'm Native." They wouldn't believe me. I remember bringing kids home just to show them my parents.

Confusion around her identity, at points wanting to proclaim it, at other times trying to hide it, was common. Before entering recovery she "even dyed [her] hair blonde":

> Because women, especially Native women are always looked down on more, treated less. By acting White, I looked White, and stuff like that, nobody would treat me like that.

However, with these attempts at hiding her identity, her shame increased:

> I guess what really got me into recovery was I became ashamed of who I was. I started going out with a White guy and he didn't like Natives. Because I didn't look like one. That's why he went out with me. So I "tried to be White", as they say and I guess it got to me after awhile because I tried so hard to please him and yet it didn't work anyway.

Currently, Cheryl was learning about her culture in the same way Elizabeth had in the middle stage of her recovery. It was part of a process of self-acceptance and rediscovery of who she was. Previous to recovery she had "acted White" to avoid prejudice, but said, "When I started recovery is when I started to like who I was." At this point she was immersing herself in her culture, learning about it and trying to learn her Native language. She stated she was now more involved in her culture than when she was younger. She reflected that right now, "being around my own people is what helps me the most."

Beverly, also still in Middle Recovery, was as well immersing herself in and learning about Native culture. Her "whole support system" was in the network of people involved in traditional Native spirituality.

Beverly saw the family she was raised in as "very assimilated" to White society. Having grown up in a small town, traditional Native culture was not taught and there was minimum exposure to traditional values. For Beverly, the trauma she had experienced was a loss of culture. In this stage of recovery, she was attempting to discover her culture and fill the void her childhood had left. About her involvement in Native spirituality and culture she observed:

> That has helped me mostly. Learning about my identity. Because I never learned about my culture. Never in my whole life.

Something beyond mainstream recovery programs was required to fill this cultural void:

> When I was in NA, it was fine. A lot of these people were great, going to dances, doing all these things. But there was still a part of me that was missing. A really big part of me that was missing. And I was really lonely. When I started going out to [the Native training centre], I started seeing all these things that were me. It was all the Native people. The pipes and the sweetgrass.

Of her involvement in Native spirituality and culture, Beverly emphasized "it's helping me learn, understand who I am."

During the middle stage of recovery, Henry found a stronger sense of his Native identity. However, this was partially found by being immersed in an all-White training institution. At the beginning of Middle Recovery, he had become involved in traditional Native ceremonies and spirituality. But five years later, at eight and nine years

of sobriety, he found himself to be the only Native person in his training program. He described the main effect of this training:

> When I look back on it now I think my sense of being a Native person became much deeper and richer, although I was in an institution where it was all White. It got me in touch with my Nativeness, being Canadian more than ever. Because when I was there I was kind of a hit. Because I was a Native and I was Canadian.

Like Elizabeth and John, Henry had reached a deep appreciation and acceptance of his Nativeness and went on to reach a sense of balance and acceptance in and of both the Native and non-Native worlds.

Don did not discuss Native identity issues specifically, although sexual abuse events were tied to issues of belonging and lack of acceptance when moving back to the reserve from the city. Don did talk about the difficult struggles he experienced in becoming part of a spiritual circle and committing himself to Native spirituality. The discipline and his reactions to the discipline required brought back childhood memories of sundances and his Grandmother's responses to his behaviour. Now in the middle stage of recovery and involved in traditional ceremonies, Don was beginning to remember and reconnect with traditional memories and influences from childhood:

> I remember walking to sundances ... It's starting to come back. Each time as I try and remember about it, it gets stronger and stronger.

Similarly, in recovery Cheryl began to "like who [she] was", remembering her grandparents' words and actions which reflected a cultural pride and stability:

> When I started recovery is when I started to like who I was. I remembered what my grandparents used to tell us. My grandparents used to sing to us in Cree ... My grandparents were more into the culture. My one grandmother was more into the culture. She died when I was about nine years old. She was teaching us Cree. She would sing to us in Cree and tell us things like "Always be proud of who you are. Never be ashamed." Telling us about the Medicine Wheel, all the four colours. And how one day we'll all be together and they'll be joined ... Remembering the way my grandparents were, sewing, doing beadwork, stuff like that.

In his recovery John had also reconnected with family elders and memories of their words and actions:

> I realize all the things that I have heard from my father and grandparents have all come back. One of the greatest gifts my late grandmother gave to me. It's something I try to cherish and I try to use every day. ... I try to use as much as I can. The gift of kindness.

Memories of her grandfather's use of sweetgrass had an influence on Elizabeth. "Early in life something was instilled" in her, "to be connected to" sweetgrass. She felt "really good" when she smelled it now and used it in her work. Her reconnection with traditional Native practices, such as smudging with sweetgrass had begun in Middle Recovery.

As well, a reconnecting with his grandfather at the beginning of Middle Recovery can be seen in Henry's vision of his grandfather during the workshop which heralded a turning point and spiritual awakening for him.

Making career changes and enduring occupational struggles.

By Middle Recovery, participants began to experience career changes or engage in preparations for career change. All three participants currently in Middle Recovery had returned to or were returning to school, to prepare for upcoming or eventual attendance at university.

Don was looking forward to upgrading his education. Cheryl saw "starting school again" as a turning point. Both had unsuccessfully attempted to attend school earlier in recovery. Beverly observed that her current coursework was teaching her new skills in forming and asserting her opinion. Her success in school was also forcing her to reassess her previous negative view of herself as a student and to confront associated childhood memories. After a period of trying their hand at paid and voluntary jobs helping others and, in the case of Beverly, the eldest of the three, after involvement in work related to a previous career in the performing arts, the three were upgrading their education and training in order to undertake viable careers.

Elizabeth and Henry, now in Late Recovery, had also returned to school and training programs during Middle Recovery to increase their skills in their chosen professions. Career preparations and struggles seemed to be a common element of this period. Although later successful

at his career, John recounted at this time, "I was still having a rough time in life. Trying to get a job." Elizabeth, too, had experienced career disappointments during this period. Henry changed jobs frequently and was still searching for a satisfying position during Middle Recovery. Don saw his recent decision to assert his rights at work and quit his job, after a period of struggle, as an important turning point.

Stage #4: Late Recovery - Reaching Balance and Continuing Growth

Three participants seemed to have reached a later stage of recovery. These were the individuals with longer periods of sobriety. For these three, John, Henry and Elizabeth, there appeared to be a "settling in" and stability to their lives, as well as a spiritual attitude of acceptance and purpose. The "ups and downs" and emotional turmoil of Early and Middle Recovery were no longer found or so extreme. They had reached an acceptance of themselves and of others. They were comfortable with their cultural identity and seemed to have found a bicultural balance, being comfortable, accepting and able to function in both the Native and non-Native worlds. All three were successful in their careers. They all were involved in being role models to and helping others. They utilized their own difficulties and experiences of the past to assist others. This was important to all three and was related to their sense of purpose. All had a

strong belief in and connection to a Higher Power. Issues from childhood and Native identity struggles had been confronted and a certain level of resolution reached in these.

Although a balance had been achieved in their lives, this did not mean that emotional or spiritual growth was finished or that there were no issues to be addressed and worked on. Two of the participants had personal recovery work remaining in the area of intimate relationships. The third identified unfinished recovery work involving her children that needed to be done.

Emotional balance.

For John, a trip made as part of his career became the setting for a spiritual shift in his recovery. He stood on the mountain where a famous Indian chief had stood:

> I saw the very spot where he spoke to the Indian nation. I went up to the top and I spent a whole night. Fasting and praying. Because when I came down, strange as it may seem, I know I left everything up there. All the problems.

He described his current emotional state since that time:

> All of a sudden I'm living in the middle. I have my ups and downs. It's not way up there. You know the highs and lows we have. There are little dips. They're not as bad, I can live with them. I can see, not with my eyes, but with my heart. That's what I realized, why I went to that place.

John's journey and the spiritual shift he experienced there, helped him solidify and recognize an emotional balance he had been working toward.

Over time, John had developed a different attitude

toward emotions and events, a different way of handling feelings. He was simultaneously more in touch with feelings and accepting of them. This change reflected a kind of serenity:

> Things that happen I can observe and let them. And really feel. Feel pain to it's total and not shy away from it. And feel total joy. ... It's like when I would feel total pain, I would push it away or try to push it away. Or when I'd feel real joy, I would try to keep it. I just let it flow now. Through me. Just allow it to flow through. It will always be part of me.

Elizabeth, too, had had a series of ups and downs during Middle Recovery. However, following a particularly frightening and depressing low point where alcoholic symptoms returned, Elizabeth joined AA and began a healthy intimate relationship. Following these changes she seemed to begin a new stage in her recovery. She identified the beginning of her relationship as a turning point and a necessary step in her recovery:

> That was a big turning point for me. ... I went all that time without any relationship and you can't do that. Sobriety is you're sober for a good period of time and you begin to get well. You have to learn to move from A to B.

After this turning point, Elizabeth began a period of contentment, in which she was busy with her endeavors and enjoyed life:

> I do relaxation. I do crafts, go for a walk. Just enjoying, being thankful for beauty ... There are so many things. Nobody can say they're bored. So much to read, so many things to see. What I'm doing in my job really gives me a lot of pleasure.

She was now able to discuss painful events from the past,

remembering the pain in order to help others but no longer overcome by it. The pain was no longer "hurt that was going to wipe [her] away."

Like John, Henry, in the later stage of recovery, was no longer an "angry and bitter man" and handled emotions differently than in the past:

> Somehow over the years my anger has dissipated. It has diminished to a degree where even my facial expression has changed. I have a picture at home that was taken around August or April'75. I showed it to my therapist and her first reaction, her first words were "seething". And I was like that ... Over time somehow that anger has diminished. Now I know why I'm angry. Before I used to inflict my anger on people. Nowadays I just inflict it on myself and lately "Alright, you're angry. Okay. That's okay."

Fear was another obstacle in Henry's recovery which had diminished over time. He now dealt with fear and emotional pain differently and as a result was more trusting of others:

> Living in the institution, that whole scene is based on anger and fear. I brought that defensive posture into my recovery and AA meetings. And not being able to trust people because of the fear of being humiliated and rejected. I guess underneath that is the pain of it all. Once a guy gets in touch with that, letting it go - I means it's okay to be afraid and be rejected. I still have problems with rejection, some problems with trust, but not so much. I think those things diminish with time.

John, too, spoke of the process of accepting and putting fear, which was once an obstacle for him, in perspective:

> I'm not afraid any more. The block for me was fear. Fear was a giant. I was watching a movie one

> day. A little old Chinaman was teaching this guy about 50 floors up. This little Oriental was running across the wall, on the edge of the building. And he told his student, "Now run across." The guy stood on the edge and looked. The old Oriental gentleman said, "Go ahead you have fear. But remember it's okay, it's only feelings. Fear can't physically push you over, unless you allow it." So I don't. I understand what fear is doing to overcome the fear ... By understanding that it's okay to feel it. Accepting the feeling. Knowing that it's okay.

Putting fear and other diff ulties in perspective was important in his life:

> If it's huge and big, according to who? It's always me. Because the elders have taught me that. When I once went to an elder about my big problem, he listened for hours. Then he picked up a stone and said, "When I was a little boy, I went hunting. I saw these great big moose. I had no weapon. I ran away. But then when I thought about it ... " He said his grandfather had told him to pick up a stone and he did. He had told him, "Put it next to your eye and close the other." So he did. It was big. "Then he told me to hold it at arm's length and I did. And he walked away from me." And with that the old gentleman quit talking to me. And then I thought about it, "What's that got to do with it?" And it's so simple to understand. See, I made that stone really big. A boulder. Great big. When I know that out here it's that small. But it's only me that's making all the problems.

Both John and Henry also discussed the importance of being aware of and coordinating feelings, thoughts, and actions. In his later recovery, Henry saw himself as more "congruent" that is, his thoughts, feelings, and behaviours were synchronized with one another:

> Now, ever since, there's much more congruence in what I think, feel and how I behave. Before it was think one thing, feel another and act out differently.

Similarly, John observed that one of the helpful things he had begun to do in recovery was to "take responsibility in following" both "feelings and logical thinking" in his actions.

Increased self-acceptance and awareness.

All three participants also displayed an increased self-acceptance and self-love. Elizabeth stated:

> I'm a lot healthier when I accept myself as I am and appreciate who I am. Because I love me today. I like me today. I don't hate me any more. I'm a lot stronger.

Henry reflected:

> I think in my years of recovery I have learned how to follow my own experience and acknowledge it and then embrace it and not try to find the "why" of all ... It's more an attitude of acceptance of how I really am and how I experienced my life, how I relate to people. I guess I'm more comfortable in the posture of acceptance rather than the asking of "why?".

Henry also stated:

> I'm really looking forward to old age because I think I will be such a grand guy ... I know I'm growing old gracefully.

John echoed Elizabeth and Henry's reflections on self:

> The spirit of John is living again and I like who he is today ... I don't mind what I am, I am me.

Self-acceptance required an understanding of the positive and negatives of oneself:

> Finding your balance is understanding the good, the bad in you. And if you have too much of anything it's no good for you. Then you will find your balance sooner. Knowing that down the middle, I'm black and white in character. I'm bad and I'm good, as long as I understand that.

Recovery became a process of self-discovery. As John said, "I had been searching for me. I think I found John. I know what he's like."

Recovery was also a process of "chiselling away" that which was not truly oneself. Positive growth and the releasing of one's potential was similar to Michelangelo's creation of the sculpture of David. It involved a keen awareness and knowledge of the "marble", of both its beauty and its faults. John told the story of the creation of David to illustrate his point and ended it saying:

> Michelangelo replied, "All I did was chisel away everything that wasn't David" ... It's a similar process. I just chisel everything away that is not John. It's a masterpiece, your gifts.

Self-awareness was an important tool in this process. As John sai "I've always got to be constantly aware, be aware of John."

Henry also stressed the importance of utilizing self-awareness and awareness as part of recovery:

> I think that's the biggest part of my own recovery in the last five years. I got this idea from an elder. Before we were going into another fast he said ... "I want you guys to pay attention. There are messages out there that you need to pay attention to ... You're gonna be in the bush by yourself four days, four nights. I want you to pay attention to what's happening to you on a physical level ... but also pay attention to what goes beyond that ... to what's happening to you on a mental level, your mental faculties. Your plans, your memories, your thoughts. But also pay attention at a deeper level ... Pay attention to your spiritual problem-solving. The other was the emotional. Pay attention to those four areas in the context of where you are. Also pay attention to your physical surroundings because there are

> messages out there and there will be visitors that will be coming to visit you" ... I think ever since then that's what I've been using as part of my recovery, paying attention to these four quadrants ... And to people around me and how I'm reacting to people. How do I feel with people? What is my mind doing while I'm talking to you? How is my spirituality? ... It's an awareness thing really. That's what it's about.

Helping, acceptance, and compassion for others.

With self-acceptance and self-awareness came a greater acceptance of and compassion for others. John stated:

> I accept who I am - by that I can accept others. Just the way they are ... I learned first to live with myself, then learned to live with others. Because whatever happens to me affects others. Whatever I do to me, affects others -those around me.

A greater awareness of others' feelings and situation was important. Because the participants in Late Recovery had accepted their own selves and experiences, they were attuned to and could relate to others. John observed:

> I'm very aware of other people's feelings and where they're at. Because I identify with them. Although I'm not in that situation doesn't mean I've forgotten.

Acceptance and compassion became the basis for helping others:

> I have friends who go through a lot of traumatic experiences, but I understand them. I know what they're feeling. I don't have to be dramatic or anything to help them. I understand what they're going through.

A commitment to compassionately help others was strong for John:

> I met a young lady who's going through some traumatic experiences. I'm there beside her. The

> other day she came up to me and said, "Thank you for being you, having patience and compassion through." To me, it was like somebody handing me a medal. I've done that for her. And I'll continue to do that for others.

Compassionate understanding also extended to people who still abused alcohol and drugs:

> I've learned to balance friends and relatives. You still have caring for people even though they drink. Because I understand they're sick, that I have to accept them just the way they are.

Elizabeth, too, was involved in, and committed to helping others. An acceptance and understanding of her own experiences formed the basis for her compassion:

> When I listen to moms, they talk about their kids and they've lost them. I can relate to that ... See I'm a helper now. I work in a field where I listen to these kinds of problems every day, every week. A person can talk about sexual abuse, verbal and physical abuse. I relate. I listen to moms - their children have been sexually molested. That's happened in my family. One of my kids was sexually molested. I can relate to that because that is second victimization. The loss of a child during your practice of alcohol. I know what that is like.

She now was also able to extend her help to family members, some who still used alcohol and drugs:

> I've been thinking a lot about nurturing my adult children of alcoholics. You see my work is not done as a mother. It's far from being done. I have my grandchildren now, too.

Like Cheryl's mother and Don's father, Elizabeth was beginning to focus energy into assisting her children in their healing process, now that the bulk of her own healing work was done.

Henry, too, had attempted to assist family members with

problems. He had taken in a nephew who had been living with a drinking parent and sought psychological help for him. He eventually had to confront his nephew in the same way Henry had been confronted about his behaviour when he was younger. Henry, as well, was involved in and committed to helping others. He considered compassion and understanding to be crucial ingredients in his helping.

Being helped to helping others - Henry's story.

All three participants in Late Recovery showed a clear transition from predominantly requiring help to being able to provide help to others.

In Henry's recovery there was an interesting interplay of getting help and helping others. His story illustrates well the change from predominantly receiving help to predominantly being of help to others. In it, there was a shift from being helped and wanting to help others, to a stronger ability and commitment to help others. Henry described his pretreatment days:

> I was working, walking around the streets as part of my job, picking up people - drunks, alcoholics, prostitutes from back alleys and taking them to hospitals. I remember when I was doing that work how good it felt to help people. But in the meantime I was still using and drinking, so I didn't know whether it was me helping the drunks or the drunks helping me.

Soon after this Henry himself was sent to the hospital for detoxification. Following treatment and aftercare, he began to work as an attendant "helping people out" in the detox where he had been a patient the previous year. His

commitment was not yet so strong:

> I got fired from there. I didn't care. "So what," you know.

Around this time he also worked his "way down" from university to a college course in addictions counseling. He stated, he "didn't have any sense of responsibility or discipline" at the time. However, at five to six years of sobriety, Henry started an AA group on his own reserve and worked there for two years helping alcoholics in treatment.

Henry eventually attended a major training centre in the field of chemical dependency and went on to present his own workshops, maintaining stable employment as a counselor and trainer for many years. The compassion shown to him by others who helped him was now important in his own work:

> When I do my own counseling, I try to be like them. Loving, compassionate, understanding, really getting into their pain with them. Helping them move with that. Because it's so important when people are relating to each other that they do it on a level where they're both at the same ... help each other to move. Sometimes when we get into therapy it's like both of us are psychologically and spiritually connected.

Utilizing role models to becoming a role model - John's story.

One of the ways of helping others was by being a role model to others. All three participants in Late Recovery functioned as role models and had utilized role models in their own recovery. In his recovery, John clearly demonstrated the process of utilizing and then becoming a positive role model. Previous to sobriety, negative,

depotentiating role models were copied:

> When I drank, the bitterness came out. I became very, very violent. I was very self-destructive. I hadn't recognized that at all because I thought that was what everybody did. That's what you're supposed to do. I lived that way for almost seventeen years.

In residential school, he had learned to suppress his feelings and to be a "tough guy":

> I grew in military mentality and I learned how to suppress my feelings ... And I lived that way and that's what I brought up into my adult life. That's what I lived with in the sixties and the seventies. I lived in fantasy for a long time. In the sixties, it was Elvis Presley. I wanted to be like him. Like I'm cool and I get to smoke, my cigarette dangling like Jimmy Dean. Jimmy Dean - I wanted to be like him. Because I could do a lot of things and not have to be me.I can be an actor. Don't have to show anybody what I really feel.

However, in AA he learned there was another way of living and gained hope and inspiration from the stories of others, with which he could identify:

> But as time went on, I began to go to AA meetings and to discover that I don't have to continue the way I live ... I started to hear these people saying things that I identify with.

A cousin in AA, one early role model was a factor in his introduction to AA. In recovery, John began to utilize the wisdom and example of AA members, as well as Native elders and role models. Native role models were important in both his recovery and career:

> I guess the people who influenced me was a man, the late Will Sampson, he's from the United States. The other gentleman is the late Chief Dan George. I thought, "If they can do it, in spite of all the problems they have or they had, I can do it too."

Standing on the spot where a famous Indian chief spoke to his people was an inspiration and the setting for a spiritual change. John also began to reconnect with and follow the examples of his grandparents.

One story he told demonstrated clearly the transition from following or utilizing a role model to becoming a role model:

> I think one of the things that really helped me is seeing examples of other people. I see a lot of people who got it made. They got it together. One particular incident that happened to me, I still remember, it stays with me. I noticed this little old gentleman, always happy. People liked him, just loved him. They were just all around him. I was at the point where I was feeling really bad and I wanted to get well. I looked at him and I thought "Gee, I'm going to ask him, I'm going to talk to him." ... So I bought him coffee and put it in a room alone and I sat down with him. He knew that I was feeling really bad and he knew what I was going through. It was then that I asked him "You know, I like the way you are. I like the things you do. I like the way you talk. Everything about you I like, I want." He looked at me calmly and said to me, "This, everything you see good about me, is mine. Get your own." That instant I became very defensive. I thought, "Gee I thought this program was about sharing and caring." And then he said this, "Yes, this is mine, but I'll show you how to get your own. ... I'll show you how to get it and you can get your own." And it took almost five years of hard work for me. Hard work. Sometimes I almost didn't make it. I'd fall off, then try again, fall off, be sick, for five years. And when I really got into the program, I began to do things for myself. It has only been recently that I discovered that, "Yeah, I do have it all together." I've got what a lot of people want. And I always tell them, "This is mine, you get your own. But I'll show you how to do it."

The passing on of help, the sense of being a link in the chain, was strong. John stated:

> Today a lot of young people come up to me ... and they shake my hand and say "I'm proud of you." ... They call that flying the Indian flag. I'm willing to do that. One day I will turn the flag over to the younger generations. "It's your turn." I feel I'm doing that. I'll do so. A young man or young lady will come along and I'll hand them the flag and say, "Now it's your turn, fly the flag for the people."

In the same way, Elizabeth said of the help she received and gave to others:

> This was given to me at one time from somebody. Now I have to give it back to somebody else. So I do those kinds of things to help and give it back to my community.

<u>A sense of purpose, gratitude, and connection to a Higher Power.</u>

The spiritual aspect of their healing and the related struggles they had worked through, was recognized and forefront for participants in Late Recovery. There was a sense of purpose about them in what they did and about what they had been through. There was also a connection to a Higher Power and a gratitude for their life and the helping role they could play in Native society. Elizabeth explained:

> There was a purpose. I know that our Creator has a vision for us, some of us had to go through sexual abuse, through violence you wouldn't believe, victimization somehow or other. We had to go through the alcoholism in order to experience and be able to understand another individual because we were going to be helpers somewhere along the line if we had healed ... So I am very, very grateful to the pain that I have gone through because He had a destiny for me. He meant for me to be a worker in the field I'm in. I'm very grateful for all of that because I can relate to the people when they talk. There's so much work to be done especially in the aboriginal community.

John also described his sense of purpose, its relation to the Native community, and his gratitude to his Higher Power:

> I know what I was like back then when I was 25 years old, before I drank. When I look back now, I think those 17 years or so were meant to happen because prior to that, people looked up to me to be an example and so forth. I had no knowledge of what alcoholism was. So the Great Spirit planned it for me to go through that road, to go through the skid rows, to go through the near-death situations. And to come out of it and finally to pick up where I left off. With new knowledge, experiences, that is necessary to be of some use to my Native people. To myself, to other people ... I feel very fortunate. And I'm not here by mistake and I've never been back there by mistake. For a reason, not by mistake. If it hadn't been for the Great Spirit, I wouldn't be where I am. I've been guided. And it's not by mistake I'm here ... Today I feel like I've made a contribution to Native society.

In later recovery, Henry was now aware of the role his Higher Power had played in his entry to recovery:

> When I look back on that one. When I talk at AA meetings. I think with all the confusion that I was living with and all the pain that I was living with in those days, that was when God provided me with a moment of clarity to ask myself these questions.

Like Elizabeth and John, Henry felt a sense of purpose and a commitment to help his Native people. Following his intensive training, he received job offers from various parts of the world:

> But there again, here is where this intuition comes up again. "Well, where does your heart belong?" And right away my heart says, "it belongs with the Native people up in Canada."

Bicultural balance.

All of the participants believed they had a role to play, a contribution to make in Native society. They, as well, felt they were part of society at large. In John's recovery, recognizing his role in society was important:

> And to know the world exists out there. And I'm part of that. Part of society. I'm part of that. And wherever I feel that I fit, okay.

Similarly, both Henry and Elizabeth had successfully completed non-Native training programs and, like John, had been involved in work respected by the non-Native community. All three mixed with pecple of various backgrounds, both Native and non-Native. All three also related to people both in and out of recovery programs.

John spoke of the necessity of achieving balance between being a recovering person who was a member of a Twelve Step program and being part of the non-AA world:

> He and other people told me, they kept saying "Always remember that it's not just AA. There's life outside there too. There are people out there, too."

A sense of "being part of the whole", recognizing one's role in connection with others, even in success was important. As John said:

> I didn't do it alone. But because I was part of it. In other words, I was part of the whole crew. I'm part of them and I represent them.

All three had reached a bicultural balance. They were comfortable in both Native and non-Native realms and appreciated the positive contributions of both. In fact,

they seemed multicultural. Henry was very involved in Native spiritual traditions and had learned much from Native elders. However, he also utilized non-Native psychotherapy and was now attending a non-Native educational institution. He was very interested in non-Native psychologists such as Carl Jung. A variety of individuals from around the world served as role models:

> I remember talking to one of my therapists about four years ago. Like "who are the important people in your life?" And I said "Who are they?" The ones that have affected my life now, at least currently, are Carl Jung, Jesus Christ, Ghandi, Mother Theresa. All those are role models. Those and others. There were a lot of them.

Henry, too, cited many Native and non-Native helpers - counselors, AA members, and colleagues - who were "instrumental" in his recovery.

Elizabeth also appreciated and enjoyed aspects of both Native and non-Native cultures:

> I'm going to see Les Miserables ... So not only aboriginal things. I mean that has nothing to do with Native people and I'm going to thoroughly enjoy it. I love ballet. I love opera ... I like those things because of my immersion that I have here in the city. And I can really get off on pow-wow music, the sweat lodge. All of those give me joy. Spanish music. I'm even thinking of Chinese. I like all kinds of music ... And I have a lot of nonaboriginal friends and I've met a lot of beautiful people. Now the Australian people seem closer to me too, from that conference.

Although native spirituality was "really big" for her "right now" and was an important resource in her recovery work, Elizabeth, like Henry and John, had a spiritual connection to people worldwide. She stated that she "followed" the

wisdom of many "wise people" from both the Native and non-Native cultures.

John, too, consulted and made great use of the wisdom of non-Native "elders", along with Native elders, for example in the lectures of Leo Buscaglia and the words and acts of non-Native AA members. He stated:

> I think the main thing is to find balance. Believe me I've been in this White man's world for a long time. At the same time I was in touch with the Native culture. And there's one thing I discovered along the way - in my journey. The elders kept talking about balance.

For John, although Native spirituality was a fundamental part of his recovery and kept him from becoming "stuck" in any one group or resource, "both non-Native and Native spirituality" had been "very important" in his recovery.

Appreciation and forgiveness of others.

A sense of appreciation for others and gratitude for the help participants had received from others was clearly evident in all three participants. A change in perspective, from the early days of recovery, where anger and resentments were still strong, to a forgiveness and thankfulness towards others had transpired.

John now saw his ex-wife leaving him as positive and was grateful to her for leaving:

> Today I believe that God places people in your life for a reason and I think that I'm one of the most fortunate men, that I met my ex-wife. Today I'm a million times thankful for that, for her.

He had forgiven his ex-wife and she had since become a

support to him. He was even grateful to his ex-girlfriend who had taken everything from their apartment at one time, because she was the person who introduced him to the idea of ACOA.

He also viewed with gratitude AA members who had once confronted him. Of those who had played a role in his recovery he said:

> I like a lot of time. Today I would say that. At one time I would say these guys are a bunch of assholes. But they gave me a lot along the way. People gave me tough love. I didn't understand that. Some people kicked my ass, when I needed it. Because I didn't know any better for myself.

John recognized the importance of others in his recovery and had a sense of humility about his own importance:

> I can't say I did it alone, because I alone can't do much. There were people with me ... people who understood. I am fortunate. I am a lucky man. ... I'm always aware that I don't know enough. I don't know everything.

A sense of humility and perspective about his success in recovery and in his career was necessary and an important tool in maintaining sobriety. He said of successes, "They can leave overnight. You can lose it." It was paramount he remember where he "came from" and how fragile his sobriety could be. He saw his life and the presence of others as gifts from the Creator:

> The life that you have is only a gift ... And so the people around me, they are all my gifts ... We are all gifts to one another.

Elizabeth, too, now viewed those who had confronted her in the past differently, with a sense of gratitude:

> This friend of mine - I used to say "my so-called friend" when I first sobered up - saved my life by reporting me ... I hated her for years for that.

She had "hated" her counselor in treatment when he confronted her, but years later recognized that he had been "vital" and "instrumental" in her recovery. She also recognized and was thankful for those who had helped her through their supportive, nonconfrontational role, ie. her social worker, her mother, and even her teacher from childhood:

> Because the sexual abuse was going on I was not a happy person at that time already. Then when I met my teacher she was so loving. She needed to be there in my life too because if she hadn't I don't know what might have happened to me. She believed in me and she always respected me and treated me like a human being. She treated me like I mattered. I will never forget her for that. I managed to say "Thank you" to her when she was about 88 years old.

Elizabeth had also forgiven others with whom she had once been angry. Of her husband's hurtful behaviour when she miscarried a child she said, "I don't care now. It doesn't bother me, but at the time, it just about killed me." She also had "dealt with" feelings toward and did not "resent" a supervisor, who in retaliation for a confrontation from Elizabeth, blocked her chances of resuming a job she enjoyed.

Henry, too, viewed others with gratitude and forgiveness. While doing his ACOA work, he had forgiven his mother and father for past hurts. He observed that "a lot of people played a role in my life and that's part of my

recovery. Oh lots of people." He recognized that his friend was "instrumental" in his recovery. He was also grateful to others like the detox attendant who showed him compassion and said:

> I remember it now ... Even to this day I don't think I ever told this woman about that incident. I'm going back there one of these days and, if I see her, I'll tell her.

B. Summary of the Themes

The Importance of Native Spirituality and Culture

One theme, the importance of Native spirituality and culture, was unique to the participants as Native people in recovery. Spirituality, often an important part of chemical dependency recovery, took on a distinctly Native form for the six participants. In addition, the need to forge or restore a Native cultural identity and heal the traumas suffered as Native Canadians, was vital and particular to their recovery.

The pre-eminence of Native spirituality and culture in the participants' recovery can be heard in their own words:

> Native culture was one of the instrumental parts of my recovery. [John] ... I now use a lot of my Native spirituality. That's <u>really</u> big for me right now [Elizabeth] ... That has helped me mostly. Learning about my identity. My culture is the strongest right now [Beverly] ... One [thing which helped keep me in recovery] was being aware of spirituality in the Native culture [Cheryl].

For three, Beverly, Don, and Henry, involvement in Native spirituality and culture was seen as a new phase of recovery. For all participants, it became an essential part

of their recovery and their life.

For most, an involvement in Native spiritual practices and a confrontation of Native identity issues began in earnest in Middle Recovery, following a period of stabilization and adjustment to an alcohol and drug-free life style. It included involvement in traditional ceremonies and rituals, such as sweats, fasts, and pipe ceremonies, the burning of sweetgrass, listening to elders, connecting with the memories of forbearers, utilizing Native role models, and learning about Native history.

Native spirituality and involvement in cultural activities took on an increasingly important role as recovery progressed. It began to function as a resource and important stabilizer. It provided a connection to other Native people, a sense of belonging, a reconnecting with one's culture and a means of discovering one's identity. It facilitated spiritual growth and psychospiritual change. Confronting and resolving Native identity issues was an important piece of therapeutic healing. Once this process had been undertaken, Native identity became a key resource.

Therefore, Native spirituality and culture functioned on all levels, as a part of the other three general themes of recovery - as a resource, as a piece of recovery work to be done, as an important connection to others and as a force in psychospiritual change. It was multilayered and multipurposed. Its presence in recovery was complex and

rich, and touched on many aspects of the participants' lives.

Most importantly, it provided that missing "something" in their lives, that piece of themselves and their identity that had been lost or confused. It filled the void. As Beverly stated, before her involvement in Native spirituality and culture, "There was a part of me that was missing. A really big part of me that was missing. I was really lonely." But she found that part at the Native training centre. As she said, "I started seeing all those things that were me. And it was all the Native people." With this connection a movement toward completion and wholeness was felt.

As well, Native spirituality and culture was something the participants could identify with deeply as Native people. Henry explained:

> Discovering my Native background or cultural or traditional things ... was really exciting for me because I felt those rituals and ceremonies and beliefs and values to be much closer to home to me at a spiritual level than the ideas and beliefs and values of the Roman Catholic Church. So different you know. In a way they're the same I guess in word. But being comfortable with these ideas and beliefs was much more to my liking.

Native spirituality and culture also had a balancing and broadening effect on their recovery. As John described it, it kept one from "getting stuck":

> People can get stuck in AA or ACOA. Keep spinning their wheels with the same issues. They need to get out and work on the next thing. Returning to Native culture helped keep me from getting stuck.

A rediscovery of or reinvolvement in Native spirituality and culture was intimately tied to the search for Native identity and the healing of traumas experienced as a Native person. These traumas included prejudice, lack of acceptance by others, loss of culture, destruction of community and family, and the myriad abuses and traumas associated with residential school. Family alcoholism and abuse began to be viewed and understood in the context of these historical traumas.

With the development of acceptance and pride in their Native identity, recovery itself became merged with the participants' identity as Native people. Recovery was part of their vision for Native people and was linked to their concern for future generations. Cheryl stated:

> That's what keeps me in recovery, too, is knowing who I am as a Native person. My son also, helps me too because he is almost full Indian. More than I am ... The future is what I think about. If I can start recovering, I can stop the chain reaction that's going on in each family in my family. And when my son gets older he won't have it that hard. I want to teach him that healing is the best way to live.

The three participants with the longest recovery periods linked their purpose in life and the ultimate purpose for their chemical dependency to their helping role in the Native community. Along with this commitment was an acceptance of their rightful place in society at large. They were now strong and secure enough in their own cultural identity to be fully confident in themselves vis-a-vis the

dominant society.

The evolution of this change can be seen in the differing words of Cheryl in Middle Recovery and Elizabeth in Late Recovery. Cheryl said that at this time she was "more comfortable in Native society". Although she could "still function well enough in other cultures", she needed a period of immersion and rediscovery of her Native roots after a time of "trying to be White".

In contrast, Elizabeth stated, "When I'm in the White community I feel just as comfortable as I am in the Native community." She had passed through a period of culture shock upon moving to the city, through a period of rediscovery of her Native and Metis roots, to a state of bicultural comfort.

Despite the differing stages of the participants, it was evident that, for all six, a rediscovery of Native cultural and spiritual traditions played an extremely important role in their recovery, once they had reached stability in sobriety. Embracing their Native identity, as well as coming to terms with the traumas they had experienced as Native people, was an important part of the healing process. For them, a connection to Native traditions and Native cultural identity led to a fuller, more complete recovery.

Three other themes were found throughout the recovery process. These themes are more likely common to recovery

from chemical dependency in general.

Utilizing Resources and Doing the Work

A wide variety of resources were utilized by participants at different stages of their recovery. One commonality of these participants as a group was that they made use of many and varied resources, and were open to a variety of resources that could be helpful. They did not grow dependent on a single resource. They recognized when something new was needed as they confronted different problems or stages of recovery. They utilized many types of resources: people, groups, programs, therapies, books, and workshops.

Elizabeth and John summarized this trait well. John observed, "I utilized everybody. So I would say in a good way, I am a user of people. In a positive way." Elizabeth stated, "I utilize my friends. I use people now but in a positive way." As Henry said in his recovery, "There's different answers at different phases of my life - for the questions I had in the theatre in 1974."

Cheryl discussed the need for varied resources at different times in the recovery process:

> When certain issues come up in my life, like men or relationships, I concentrate on that one area. That's where I look. That's when I go to counseling and get different ideas ... At times it wasn't good enough for me just to go to meetings ... And the more people I got to know ... They know what kinds of resources and whenever I need it - that's where I go and ask people.

As the stories of the participants attest, it was

necessary to be open to various resources and to the process of searching for resources which would be helpful to their recovery. There was an openness to receiving help and confronting issues. Cheryl observed:

> It's more or less learning to find help and that's what it's all about. Learning to get help and help and help. Not being afraid to ask somebody for it. That's the most important one. Because I never asked before. I always did everything on my own.

All of the participants described a process beginning in entry in which they began to "reach out" toward, accept, trust, or seek the help of others.

A willingness and commitment to doing the work required for recovery was also important. Action, or the actual doing and taking concrete steps was necessary. At the beginning of recovery this involved attending treatment, actively taking part in it and seeing it through to the end. This work helped participants complete the tasks of entry: recognition and acceptance of their chemical dependency. In Early Recovery, it meant attending meetings, getting a sponsor, and actually working through the steps of a Twelve Step program. Through this work, they were able to build a supportive network, detach from substance-abusing environments, and utilize the tools of recovery. Later, in Middle Recovery it meant dealing with deeper issues, such as childhood traumas, through therapy and workshops, or by doing self-therapy through reading and writing. It meant actually processing emotionally what was being learned.

Beverly highlighted the work aspect of recovery:

> If you really want something, you really have to work hard to get it. You have to do a lot of footwork. And it's worth it.

For Cheryl, doing the work of recovery was also important:

> Every time that I experience something that's hard, that is when I go through a shift ... It's not bad to be happy, but that's when you do less work. It's like going out to play and then coming back in to work.

John also described the necessity of "doing the work" of recovery:

> People have to do things for themselves. A lot of people don't believe that. We get lost in this idea that the Creator's gonna do it. But the Creator gave you gifts that you can use. ... I can sit here and dream about where I want to be, but if I don't do anything about it - then I won't get there.

As Henry said, "The answers weren't provided." One had to search for them.

Besides utilizing external resources, such as groups, therapists, and treatment programs, the development and utilization of internal resources or psychological tools, such as coping skills and awareness skills, were important. These could be learned or facilitated by outside resources, but one had to actually apply them in one's daily life for success.

One such skill often mentioned by participants was awareness of one's self - one's behaviours, thoughts, and emotions. Both Henry and John described this skill

extensively. Cheryl, too, described an important on-going tool in recovery as:

> Watching. The real big one is being conscious of what I'm doing all the time ... What I've learned now is the things that get me back into my old thinking and old ways before I started recovery. I'm always having to watch for those things.

Awareness of oneself, one's behaviour, thoughts, feelings and interactions with others, and watching for old patterns and changing old patterns to more positive ones was paramount. All of the participants described this process.

Sometimes awareness was utilized to learn from painful mistakes. Beverly stated:

> A lot of new changes are starting to come up. I can feel it. This time I have to do something. I have to go with it. A lot of times I went off track. I didn't wanna face a lot of things. But this time I know. I feel like I've been given another chance to do things over again. And I have to do it.

A commitment to recovery and doing the work required of recovery was necessary despite the difficulty or emotional pain involved. Beverly had a dream which symbolized her recent struggles in and commitment to recovery. She described her reaction to the upward climb she made in her dream:

> Here I am, in so much pain. Like I'm just barely hanging on. I just about woke up. I thought, "No, I gotta finish this." I was in <u>so much pain</u>. I could barely get over it. But I did. Like I didn't care how much it hurt. I got over.

Beverly described her willingness to recover and her on-going commitment to the recovery process:

> I just went for it and just kept going for it ... I wanted it and I still want it. I still want to continue going.

She continued on her path of recovery, despite the emotional pain and sometimes suicidal depressions she experienced related to her confrontation of past sexual abuse, knowing this was a necessary part of her healing. It was important she keep going and not give up.

Sticking with it and not giving up despite the difficulties was necessary for Don as well. He gave an example from his involvement in Native spirituality:

> Just get back in there again. That's about it. It's like riding a bike. You fall off a couple of times, but you don't give up. You just keep on going ... It's hard work. I find it hard. There's commitment you know.

Commitment can be seen in Elizabeth's comment, "I did everything in my power to get well" and John's description of "going all out to recover" during Middle Recovery. Elizabeth's and John's stories also showed instances of not giving up. Despite the pain and loneliness of her first two years of sobriety while living with an alcoholic husband and having no outside supports, Elizabeth stuck with her decision and held on to her sobriety. John's process of "letting go" of resentments toward his ex-wife showed a willingness to do the required work suggested despite anger at, skepticism of, and the painfulness of the process. He "stuck to it" for 14 days before "something happened". As Cheryl said, it was important you "don't give up" in

recovery.

Commitment to active involvement was crucial because recovery was an experiential process. Recovery could not be accomplished by simply thinking about it. It had to be experienced. It required the active involvement of the individual's feelings, thoughts, and actions. An individual had to fully experience and work through the stages. Cheryl observed:

> The only way that a person can really know about recovery is when they're in it. From my experience I could read on it and read on it and read on it, but I wouldn't be dealing with anything if I just read a book. I could take out how many books, learn everything about healing, but it's when I do the healing, that's what counts. It's mostly "action speaks louder than words." It's more doing, doing, doing.

For Elizabeth, the actual experiencing and working through difficulties allowed her to better help others. Earlier in recovery when she had neglected to do the work and was only thinking about things, she encountered problems:

> I was reading books like Future Shock. I was getting into books like that. I was beginning to get disillusioned by life. I started getting down. You see I wasn't doing anything other than just all that. I began to intellectualize everything and it got me into trouble.

For John, intellectualizing had also been an obstacle earlier in recovery:

> A lot of times prior to AA or therapy, I used to think I could fix anything. I could. From up here. From the head. But when it came to me, oh boy, that was different. It was a whole new ball game.

The Importance of Others

For all participants, the importance and input of other people in the recovery process was pervasive and found throughout the entire process. As Cheryl succinctly said about recovery, "It can't be done alone." John said, "I can't say I did it alone, because I alone can't do much." Although individual decisions and recovery work was necessary, recovery was not a solo flight. The additional input of others was required, as was a reconnecting with others on the part of the recovering person. Because this theme was so extensive in the data, it will be divided into three main areas and the patterns in each across the recovery process will be summarized.

Supports and change agents.

Other people and the participants' relationships with other people functioned as supportive and change-facilitating agents. In some cases, other individuals were consciously or actively attempting to provide support or elicit change; in other cases, the individual was influential simply through their presence and the participant's strong bond with them.

In earlier stages of recovery, and especially in the entry stage, a relationship with another person, or the presence of and important bond with another person influenced the movement toward recovery. For Elizabeth, Beverly, Cheryl, and Don their relationship with their

children was an important factor in their decision to seek [illegible] Their children did not purposefully or actively push them into treatment, but the participant's bond with, and love for, his or her children did. Elizabeth, Cheryl, and Don also spoke of their concern for and love of their children as being an on-going part of their recovery, either as a support or motivator.

For John, his relationship with his daughters was the bond which facilitated his survival and kept him from suicide, thus allowing him to survive to reach recovery. A positive relationship or close bond with another human being seemed to provide a consistency, a sense that one's life was of importance to someone.

People who were "there" or present for the individual in support were important for all participants. For Elizabeth, her mother provided a support during her crises and in her recovery by her mere presence and consistent faith in and concern for her daughter:

> My mother was the first one I contacted when I decided that ... "That is enough" ... She was there with her gentleness, she was there. She was the first one I phoned. I was so down and out. I was so depressed I phoned her and I said "Mom, I want to quit drinking. I feel awful." I just burst out crying. In Cree she started talking to me and she said "I know my daughter" ... She phoned the prayer line to ask them to pray for me ... That was the beginning. My mother, even though she doesn't have that counseling or that approach, she just is there ... She has a quiet strength about her even though she has been in a lot of pain. But she was always there. Even now I enjoy spending time with my mother. Sometimes I phone her up and say "Let's go to breakfast at MacDonald's."

Beverly, too, talked about the importance of people who "were there" for her, people who did not tell her what to do or rescue her, but who listened and stood by, never deserting her.

> I met my friend 13 years ago. I was drinking then, but she always supported me. She was always there for me. Nobody else in my whole life has been there like she has. I ran into her almost a year in recovery, coming back. We've been in contact since. She's been a really good friend. A really good role model ... She's been there. She's been like my mom.

The people at the Native training centre too "were there" and had "been a good support". Beverly also observed how her NA sponsor "was there" for her:

> My other sponsor talked to me about how she cared and "Phone me anytime." One night I was having a crisis and it was about midnight and I phoned her. She got mad at me and said, "Can't you phone at a better time?" Yeah, right, I don't need this either. Then I met my current sponsor and I've had her since. She's been there.

John, too, commented on the importance of others being there who understood. In dealing with emotionally painful childhood issues in recovery, he observed, "There were people with me, ... people who understood."

An important part of treatment had been group therapy members. "People who sit by you and listen to you and not say a word" were helpful. In his helping of others, John, too was "there beside" others. He said, "All I have to do is be with them - that's all. I don't have to play God." Compassion and empathy were part of the helpfulness found in others who listened and "were there" in support.

Compassion was also one of the two important qualities identified by participants in more active forms of helping and support, and in the behaviour of professional helpers. John, Elizabeth, and Henry all specifically pinpointed the helpfulness of compassion and caring in the helping relationship. They had all experienced this in numerous helpers and felt it to be an important part of their own helping of others. Related to this, was Henry's observation that "joining" the client in his or her own world had been important in his relationship with his treatment counselor, as had been the counselor's firm directives to complete required work. Both empathy and firm direction were helpful. Similarly, John commented that the effective counselor was one who could be at the client's level, who could empathize, yet not become reactive to or intimidated by an angry or manipulative client.

Don observed that his therapist helped him by "listening and encouraging" him. Encouraging words of others, such as program members, were also helpful to John. There appeared to be a kind of underlying faith in the client or the change process in these helpers. Elizabeth alluded to this in describing her social worker, who she said "kept working on" her.

The other important quality in helpers identified by the participants was that of confrontation. Elizabeth pinpointed this, and compassionate understanding, as key

helping elements instrumental in her sobriety:

> They were both instrumental in my sobriety. One with confrontation to tell me the truth and one referring person was so loving and so understanding ... They were so vital. They were so important.

Sometimes these qualities were found in one helper. Henry observed that his counselor in treatment could be "tough" as well as "join" him in his world. John spoke of the importance of "tough love" shown to him by a number of program members. Their confrontations had been extremely helpful. Timely confrontation appeared to be very effective.

Coaching and providing suggestions was another important helper role. Henry mentioned the importance of his treatment counselor coaching him through his Fourth Step. John saw the effective counselor's role as one of coaching or facilitating the client's process, helping him discover what was important and helping him move through the process. Part of this coaching took the form of giving suggestions. Cheryl commented on the usefulness of ideas gained in therapy and counseling sessions. All participants mentioned the importance of Native elders and listening to the words of elders. Often their advice and suggestions were given in the form of symbolic teaching stories.

Group therapy members and Twelve Step program members were also helpful in providing suggestions. John described this as one of the helpful roles of group therapy members. Program members also gave suggestions and helped coach

others through words or examples. Sometimes this was done directly or through the telling of their own story.

The helpfulness of other recovering individuals sharing or telling their own story or aspects of their recovery was highlighted by John, Cheryl, Henry, and Don. Elizabeth mentioned the importance of this in her struggle for cultural identity. Hearing others' stories and experiences provided a mirror, as well as a feeling of hope and a sense that one could change. About the things that kept her in recovery, Cheryl observed:

> Being with people who have been there is what the strongest part is ... Why I became attracted to AA meetings is because someone's talking and it seems like they're talking about you. It's easier to see - it's like you're standing out there and you can see yourself. It makes it easier for you to talk. You know they've been there, too.

Recovering individuals served as helpful role models, both in the telling of their story and their behaviour. Both Cheryl's mother and Don's father served as role models to their children to varying degrees. John described numerous role models in Twelve Step programs who were helpful, as well as Native role models. Don described his recruitment of a sponsor in the same way John had described his seeking of a program role model. Don chose his sponsor for the qualities he admired and hoped to emulate:

> I told him that I wanted a sponsor. "Basically I like what you've got. You're a family man and you like your kids. You're generous and you're [illegible]ing and you're humorous. I like that in you. [illegible] those qualities."

Don's sponsor became an important figure in his recovery for a number of years.

Similarly, Henry was positively influenced by the behaviour of individuals and friends in recovery and later by historical role models. Elizabeth was influenced by a friend's involvement in AA; her positive involvement with this friend influenced her to join AA herself. Beverly began to observe program members carefully following her relapse, to see who the "winners" were and how they behaved.

Role models gave the recovering person something to strive for and a sense of hope. There was the sense "if he or she can do it, so can I." Role models also presented a concrete idea of what to strive for and possible ways to accomplish it.

In contrast, a number of participants described what was not helpful in others who attempted to help - be they counselors or other recovering people. John stated that counselors who dictated to others were not helpful. Likewise, Beverly found her first sponsor unhelpful because of her attitude, that, "If you wanna be in our circle, then you gotta do what we do." Don had learned from negative therapy experiences to seek help from other therapists. He described therapy in which the therapist discussed the sexual behaviour of other clients as very unhelpful. As well, inappropriate suggestions regarding sobriety by a therapist who did not understand alcoholism were not

helpful. Cheryl found the therapy she attended before treatment was not helpful because she was in denial and not honest about her problems and situation. Beverly observed that people who "rescued" her from going through painful learning experiences were not helpful.

Receiving help to helping others.

As described in the stories of Henry and John, a movement took place from predominantly receiving help at the beginning of recovery to predominantly being of help to others in later recovery. Henry and Elizabeth's recovery demonstrated the shift to being active helpers, including roles as professional helpers. John's story clearly described the process of becoming a role model, following extensive use of other people as role models.

Despite the fact that their role in helping others was not specifically asked about in the interviews, but rather the focus was on what helped the participants in their own recovery, the importance of helping others emerged nonetheless. Elizabeth, Henry and John's stories show a more advanced place along the continuum to helping others, while Don and Cheryl's current recovery depicts a middle stage in this process.

Don described how he had earlier sought a sponsor who could function as a role model and the helpfulness of this process. Now in Middle Recovery, he expressed much concern about the future of young people and tried to be a role

model to them:

> They haven't seen me drink. That feels good ... They ask me how come I don't drink, how come I don't smoke up. I tell them why and what's going on with me. They understand that.

In the same way, Don attempted to be a positive role model to young people in his interactions with them. He made a conscious effort not to act negatively or say negative things around them. It was "worth it that they don't hear it". In his words and those of the other participants, there was a sense of responsibility to serve as a role model.

Cheryl, also in Middle Recovery, gave a transitional view of the process of becoming a helper in the same way Don demonstrated the transition to becoming a role model:

> I wanted to be helping people later on in my recovery, but being a younger person, nobody takes you seriously.

This created some difficulty in her move to help others, particularly those older than her. However, currently she had come to terms with this:

> I don't think much any more of what people think of me because I'm a young person.

Her career goal was to become a counseling psychologist.

The shift to becoming a helper or a role model did not mean participants no longer received help or were finished the change process. As Elizabeth said, "There's been so many people that have been instrumental in my growth and I continue to meet those people." John observed various people "all contributed to my recovery and they're still doing so".

As well, although a professional helper, Henry continued to attend psychotherapy.

Building healthy relationships.

Another process that all participants engaged in was the building of healthy relationships. As was described in earlier sections, this included healing and rebuilding previous relationships on a deeper level, leaving unhealthy relationships or letting go of old ones, and when possible building them on new healthier foundations. Part of this process involved changes in ways of assessing relationships and changes in the way one formed relationships and made decisions about them. Generally, participants progressed from a state of having difficult relationships with others at the beginning of recovery to a situation of improved, healthy relationships in Late Recovery.

For those in later recovery, a reconnecting and healing of family relationships whenever possible was seen. Healing was also the case for those in Middle Recovery with family members who were in recovery. Handling relationships with family members who abused alcohol and drugs, or who were still involved in the unhealthy patterns associated with abuse and chemical dependency, was more difficult. In Middle Recovery, this sometimes required a distancing from or cutting off of these ties for a period of time, with a concomitant establishment of a supportive "family" outside the natural family.

Forming healthy intimate or spousal relationships in recovery was one issue all participants discussed. By all it was framed as important, significant, and difficult. Each had taken different routes in navigating through this issue, but for all it seemed an enduring concern. Often one participant's story formed a counterpoint for another's on this topic or one's experience reflected another's words.

In John's recovery, he found it was important he "let go" of his spousal relationship with his ex-wife. This relationship was reestablished as a supportive friendship. John also began to assess intimate relationships differently. He ended one relationship with a recovering individual because of its unhealthiness. He was in the process of reassessing a current relationship with a woman who was in early recovery. For John, dealing with intimate relationships was still an on-going issue.

Henry was still confronting the issue of intimate relationships at 18 years of sobriety. In his later years of recovery he had refrained from establishing intimate relationships. This area seemed to be the next piece of work he was preparing himself for in therapy:

> I was noticing I've not mentioned any women in my life. I think the reason I'm having difficulty with relationships is because I'm just learning how now to be in a relationship with myself in terms of being a man in a world of men and women ... I could go out there and get into a relationship because everybody's in a relationship. But in my recovery I discovered what a relationship entails ... That's why I'm going into Jungian therapy to be in a better

relationship with myself.

Elizabeth, too, waited some time to establish what she considered to be a healthy intimate relationship. Her decision to enter a relationship with a fellow AA member who, like her, had many years of sobriety, was made carefully. She realized the importance of being emotionally ready for a relationship and the difficulty of relationships. Yet, she found it was time to confront this issue. For her, the beginning of this relationship was a turning point in her recovery and her partner became an important support:

> Relationships are very important. But you have no business to be in a relationship when you're first sobering up. Because it takes a long time to heal ... and if you are going to have a relationship it isn't easy. They are very, very difficult. Because there's two people holding two different values and two different up-bringings. Especially two recovering alcoholics. That is not an easy thing to do. You've got to be pretty damn strong and healthy to do that. But you have no business to go on and on for years and years to be sober and be alone. We were <u>meant</u> to have partners ... That needs to happen ... I allowed that to happen because I wanted to live ... I needed to have that happen ... Now I'm so glad I risked myself because I was scared to do that ... That was a big turning point for me.

Elizabeth's observation about the difficulty of two recovering individuals maintaining a healthy intimate relationship in early recovery was seen in Beverly's problems in her relationship. Although both in recovery, Beverly and her spouse were experiencing growth in different directions and their values were very different. Because

they had not yet reached a balanced point in their recovery and were still experiencing intense psychological changes, maintaining a relationship was hard.

Even more difficult was maintaining a relationship with a mate who was still abusing alcohol and other drugs. This was an especially trying situation in Early Recovery. Elizabeth experienced great emotional upheaval in Early Recovery due to her reentry into an actively alcoholic marriage. She eventually left this relationship. Beverly relapsed while living with an NA member who was using drugs. Don attempted repeated reconciliations with his common-law wife who was still drinking and eventually left this relationship. He was in the initial stages of forming a different association with his ex-common-law, in a process reminiscent of John's with his ex-wife:

> She's in a program too now ... Now we're seeing who is going to be whose friend here.

Earlier in her recovery Cheryl entered an intimate relationship with a partner who was abusing alcohol and who was physically abusive to her. As this relationship progressed she found it hard to pursue recovery at the same level as before. Upon leaving this relationship, she felt she was moving forward again. She said, "I broke up with him and again I'm into recovery."

Handling intimate relationships in the beginning years of recovery was pinpointed as a major obstacle by three participants. Elizabeth identified reentering the unhealed,

untreated family which included an alcohol-abusing husband as one of the two main obstacles in her recovery. Don also identified his relationship with his drinking common-law wife, and concerns around custody of his children who were living with a drinking mother, as one of his two main obstacles in recovery. Cheryl described her abusive intimate relationship as an obstacle to progress in recovery. She framed intimate relationships generally as obstacles in recovery. For her, handling intimate relationships was "one of the big issues" in recovery. Now in Middle Recovery she believed she needed to focus on her own growth before committing herself to a marital relationship. She said, at this point, "I can't be in a relationship where's it's people living together."

In Cheryl's case and others, turning points in one's recovery were associated with decisions about and changes in intimate relationships. Cheryl saw her decision to leave her relationship and the realizations she came to during this process as a turning point. She said, "I knew my life wasn't going to be with him. I had to make my own."

Like Cheryl, Beverly decided she needed to "go it alone" at this point in her life and "let go" of a relationship with someone moving in a different direction. She viewed the forthcoming change in her relationship as an emerging turning point.

Elizabeth, in Late Recovery, saw her establishment of a

healthy and fulfilling intimate relationship as a turning point. Likewise, the ending of John's intimate relationship with his ex-wife became the catalyst for a turning point in his recovery. It seemed that by confronting and working through issues related to intimate relationships, a turning point was experienced by these participants. A difficult obstacle became the crucible for positive change.

Psychospiritual Changes

The stories of the participants' demonstrate that recovery from chemical dependency was, in its fullest expression, a psychospiritual change process. Changes of an emotional, mental, and spiritual nature occurred within the individual and in the individual's relationships with the outside world. Through the recovery process, the individual came to view oneself, others, the world, and one's place in the world differently. Self and others were viewed more positively and with acceptance, and one's life and role was seen to have purpose. Accompanying this change in outlook were changes in how one acted in relation to self, others, and the outside world.

Related to these changes was the development of a spiritual view of life and an involvement in spiritual practices. There was a reassessing of one's values, a determining of what was important to the individual, and a discovery or rediscovery and adoption of positive values. There emerged a sense of connection to oneself, other

people, the social environment, the natural world and to a Higher Power or power greater than oneself. Therapeutic work in dealing with emotional issues and an increase in spirituality took place simultaneously. They were intertwined in a process in which psychological processes, of a cognitive and emotional nature, and spiritual processes led to changes in the individual.

The spiritual nature of recovery was evident in the stories of the participants. Four participants actually described the changes in the recovery process using spiritual terms. They discussed "spiritual awakenings", "psychic, spiritual shifts" and "awaking my spirit". They could feel or were aware of the shifts or changes in themselves emotionally, in their outlook, and in their subsequent behaviour.

The psychospiritual process began with entry into recovery and was often associated with an intense internal change event. Looking back on her recovery, Elizabeth observed that the day in treatment she decided to no longer drink was the initial spiritual event in her recovery. It was followed by other "spiritual awakenings". Now in Late Recovery she realized how spiritual and how important this event was. Henry, too, framed the process of entry into recovery as spiritual. The questions he asked himself before entering the detoxification centre "were touching his spirituality". All of his later turning points in recovery

were associated with spiritual or "psychic" shifts. Spiritual awareness was "a big part" of his recovery. For John, "spirituality played a great part" in his recovery. Recovery was a process of spiritual discovery.

The culmination of psychospiritual changes was seen in the descriptions of the three participants who had reached Late Recovery. The three participants with less years of sobriety, in Middle Recovery, were in process, moving toward these changes. The transitional position of participants in Middle Recovery can be seen in three examples related to the development of balance in their emotional and spiritual state.

A balance or integration between the mental, emotional, and spiritual aspects of oneself was evident and described by participants in Late Recovery. Henry described a sense of greater integration between his feelings, thoughts, and actions. John described being in touch with feelings once repressed, while at the same time following logical thinking. Don, however, in Middle Recovery, was still feeling a lack of integration. He stated he had recently experienced a "stuck" period, in which he felt his mental development trailing behind his emotional development. He had done much emotional work but felt "like an eight-year old" mentally. He looked forward to his attendance at school to help strengthen his mental faculties and to achieve balance.

A difference in emotional balance can also be seen between those in Middle and Late Recovery. Don, Beverly, and Cheryl were still experiencing the emotional upheaval of confronting traumatic issues, while the other three participants had completed much of this work and come to some sense of resolution. They had achieved greater emotional balance and were better able to handle crises and change. As John said, following work in both AA and on ACOA issues, he was "able to function".

The way emotions, such as anger and fear, were handled and the level of these emotions also changed as recovery progressed. John and Henry described a generalized anger and fear in Early Recovery, which dissipated over time and was dealt with now in various more appropriate ways.

Beverly was still struggling with anger; "anger work" had been extremely useful in therapy, but there was "still lots" of it. However, anger expression had changed radically for all participants since the days of alcohol and drug use. Five described the violence and "crazy behaviour" of that time, while all now led a nonviolent life style.

The developmental process of establishing a spiritually committed life style was also evident. Henry described earlier spiritual shifts and realizations, before reaching a spiritual balance. When he first was asked to attend a sweat, he responded with "oh sure" and "jumped in [his] big black Magnum and went thundering out west". He did not

realize at first with what he was becoming involved. He proceeded to discover the depth of the spiritual search and a balanced commitment and acceptance of it. Similarly, Elizabeth in the earlier days of recovery felt she "wasn't worthy enough to pray" to God. Now problems didn't "get [her] down like before" because she "knows there's my Creat ". She now used prayer when confronted with difficulties.

However, Don, in Middle Recovery, was still struggling with the nature of his spiritual experiences and the shape his commitment would take. It was "hard living that way" (the traditional spiritual way), at times. At one point, he "gave up at the ceremony", but continued on with his involvement in Native spirituality nonetheless. Also, as Henry had, Don was beginning to achieve a greater detachment from material things and the physical world. He no longer needed new clothes to feel good about himself. For him, this movement away from an emphasis on material things was a turning point and a movement toward a more spiritual life.

Postscript: Recovery as an On-going Process

All of the participants framed recovery as an on-going process, with new and different pieces of work to be done, issues to be faced, and changes in themselves occurring at different stages. For them, recovery was never a finished product, but a movement forward into greater emotional and spiritual growth. It began with healing from the addiction,

but continued on to deeper levels of healing.

The participants were constantly learning new things about themselves and life. They were open to this learning and change and accepted the fact that they would change positively, if only they were open to the change and the necessary work and emotional pain required. They had accepted that struggle would be part of the process.

They also recognized that there would be "stuck points" and plateaus in their recovery, points where they would not change or progress and would feel stuck or would simply maintain their life style, with little noticeable change for awhile. They all, too, were aware that, although sober, they could potentially return to active substance abuse at any time and needed to maintain habits, attitudes, and strategies learned in early recovery to stay alcohol and drug-free.

The images and descriptors with which the participants recounted their recovery demonstrated its evolving nature. Some used terms such as "journey" and "discovery" to describe their recovery. Others recounted metaphors and dreams which portrayed recovery as a process. To John, recovery was "like climbing a mountain". After six years of solid sobriety and 11 years of involvement in recovery programs, he stated, "I'm not totally recovered. I'm still recovering. I'm still in the process of getting well."

Beverly told of a dream which symbolized her recovery

process. In it she was walking up stairs. As she ascended, the climb became harder and more painful. At points she had to stop to rest, but she continued to climb. As she said of the hard work she had done in recovery, after three solid years of sobriety: "This is just a beginning and I've done so much. But there's a lot more and I know it." She pinpointed two turning points or shifts in her recovery and foresaw another about to occur. She said, "I think I'm coming to another turning point."

Like Beverly, Elizabeth presented her recovery as a series of stages and pieces of work, with accompanying turning points. After 15 years of sobriety she was not yet finished. She observed, "My work is not done." Henry, with 18 years of sobriety, was still in therapy working on personal growth issues. He stated, "At a spiritual and psychic level, my recovery is still moving."

Cheryl, too, saw her recovery as an on-going process with different stages of work, turning points, and therapeutic issues to be resolved. She observed she was "changing everyday" and that recovery was "a lifetime program". A sexual abuse survivor like Beverly, she had some difficult, painful struggles, yet at the same time had learned immensely from these:

> Every time that I experience something that's hard, that's when I go through a shift ... Most of my learning is when I go through a hard time.

The times of calm following these changes were rest stops

that allowed Cheryl to gather strength for the next piece of work she had to do:

> When I'm feeling good about myself, that is when I'm appreciating myself changing those old habits, all the tapes I had like "you're no good" ... So I'm stronger for the next mole hill or mountain.

Recovery needed to be a step-wise progression. Otherwise, it would be overwhelming. Cheryl stated: "Like I can't deal with it all at once. I've got to deal with it a little at a time. With as much as I can handle." Like the others, she was enthusiastic about the on-going nature and experiential learning of the recovery process:

> I guess I'm always trying to learn, learn, learn. That's what keeps me in recovery too. It's always keeping me learning.

Don, too, had to work through numerous psychological issues and phases following stabilization of his sobriety. Like Cheryl and the others, he had to do this in manageable stages. He had begun to remember instances of sexual abuse and to "touch on" the guilt feelings involved, but had not yet confronted the range of feelings involved and not "really done any work on that yet." Painful issues, such as sexual abuse, often required a repeated cycling back to work on the issue again at another, deeper level later in recovery.

Elizabeth's confrontation of childhood issues reflects such a cycling back to work at deeper levels. She had begun to confront childhood sexual abuse at five years of sobriety, then later began to explore dysfunctional family

dynamics. At 12 years of sobriety she again began to delve into family of origin issues, but "more heavily" this time around.

Henry discussed the increasingly deeper levels of work possible with longer periods of recovery:

> However you use these Steps, you can go as deep as you want with them. A lot of people in their early recovery do them to get their lives straightened out. Get a job, live a manageable life and quit drinking. But I think those of us who are in recovery say, ten, fifteen, twenty years, thirty-five years - find these Steps can go deeper. For instance, where I'm heading now is into deeper meditation and deeper spirituality.

Beverly described the increasingly deeper levels of work required in her recovery:

> It seems to me when I first came into recovery, I started from where I was five years ago and I'm kind of working my way down. It's getting more and more clear. Because I've never remembered my childhood. And now I'm starting to. That's where I'm at right now. Getting right into all that stuff.

The on-going nature of recovery was not only found in its progressive, developmental, ever-deepening aspect, but also in the on-going maintenance of earlier awarenesses and tools. Despite the many profound changes participants made in recovery, it was important that they not forget they could again suffer from alcohol and drug abuse if on-going recovery strategies were not utilized. Chemical dependency had a chronic quality that required constant vigilance. John said:

> I have to keep in focus where I'm headed and also at the same time keep in focus where I've been.

> Remember where I came from. At the drop of a hat, if I took a drink now, if I went back to drinking, I'd be right back to square one.

For Cheryl, "knowing where she came from" was one of the things which kept her in recovery. Going to AA meetings and meeting people who just started recovery, she would realize "Yeah, I was there before." It kept her aware of her chemical dependency and kept her from getting on her "high horse and galloping away".

That recovery was an evolving process rather than a lock-step procedure can be seen in the individuality of each participant's recovery. Each participant's recovery process was unique, despite the general similarities and patterns seen across recovery stories. No two recoveries were exactly alike. Each individual had their own issues and recovery work to face. Although others may have similar issues to confront, each person had their own unique combination of experiences, their individual timeline, and their own sequence and combination of approaches in dealing with these experiences. While general stages and issues were observable and could be envisioned, the actual twists and turns of each individual's recovery journey were not completely predictable.

Although others were crucial to recovery, and could help and could share their experiences and ideas, recovery was the participant's own process. They ultimately had to decide what would work for them at different points and what

they were going to do in their recovery. They had to be immersed in their own recovery, actually do the work and make it fit for them as individuals. As Beverly said, "I'm getting ... my answers all the time." Nobody else could tell her exactly how to do her recovery work and healing, or do it for her. Similarly, Don realized "no one was going to make the decisions" for him. Cheryl observed:

> Well, everybody's different. Nobody's recovery is the same as another person's. It's impossible because I would never tell somebody that "You should do your program like I'm doing." It would probably never keep them sober. It's your own unique

III. Emerging Models

A. The Integrated Change Model of Long-Term Recovery

A model of long-term recovery from chemical dependency was constructed which incorporates the themes and stages described. (Figures 1-2). Identified as the Integrated Change Model, this model integrates psychological and spiritual aspects of recovery, as well as incorporates the tasks and factors important in on-going recovery and psychospiritual change. It is integrated as well due to its inclusion of both internal and external aspects of recovery, ie. internal processes/states and external events and behaviour, as well as the interpersonal context of recovery. Additionally, it incorporates aspects unique to the experience of Native recoverers.

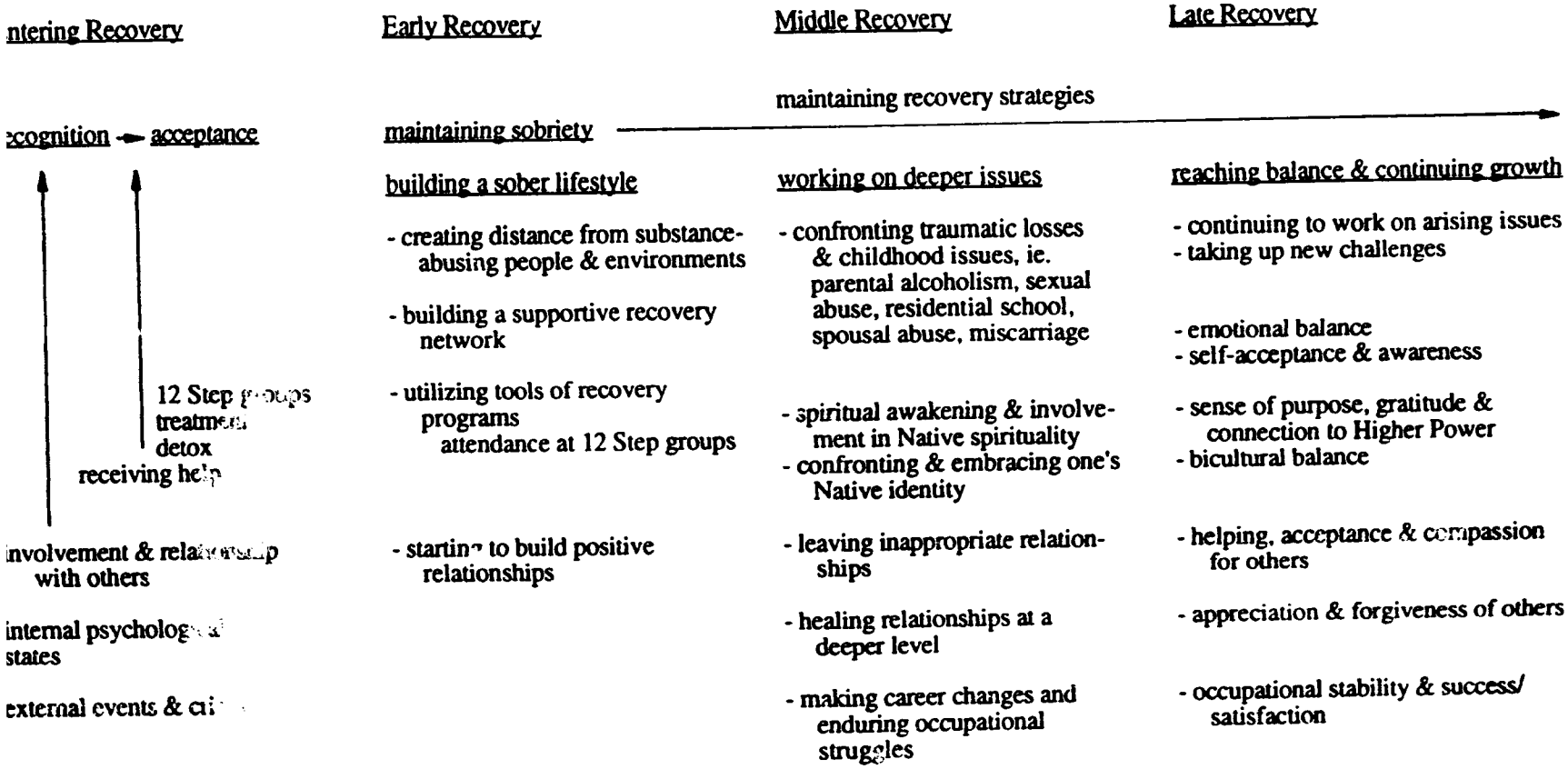


Figure 1. Integrated Change Model of Long-Term Recovery - General overview of stages, incorporating external, internal, behavioural, and interpersonal aspects

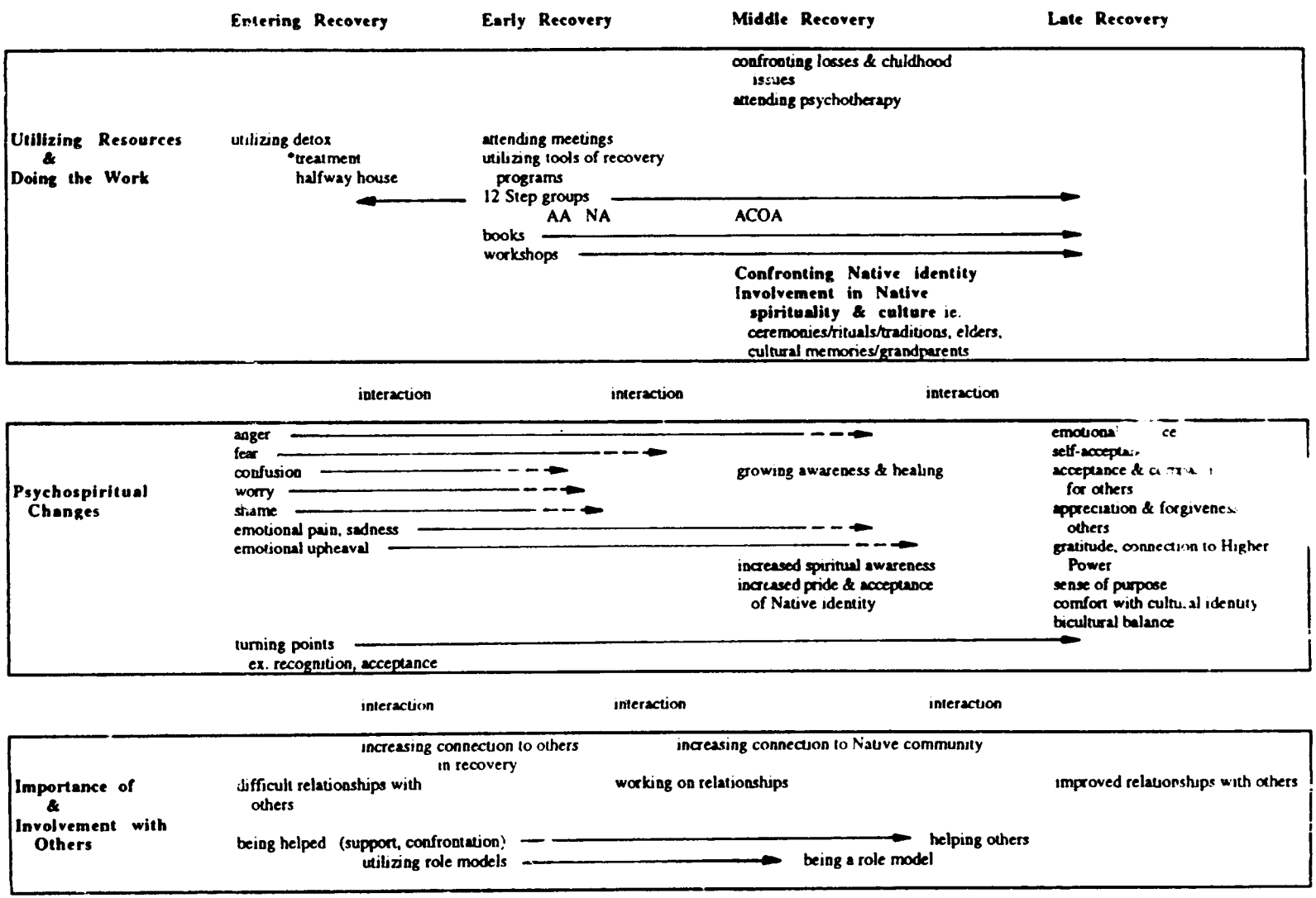
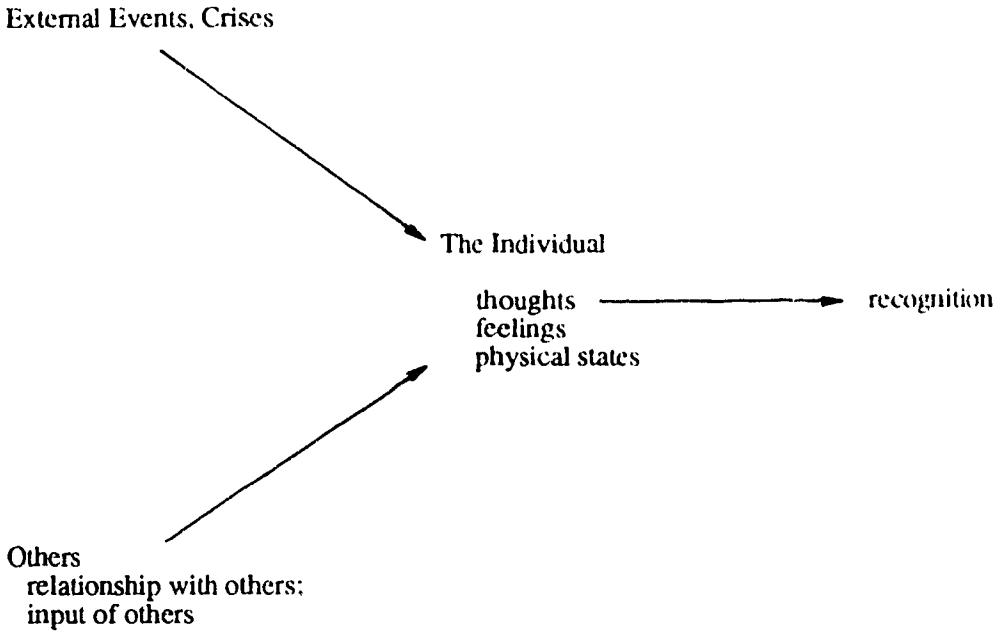


Figure 2. Integrated Change Model of Long-Term Recovery - Integrated elements, indicating key elements and interaction between elements across the stages

B. The Integrated Change Model of Entry

A schematic model indicating the basic elements required for initial entry into recovery has also been delineated (Figure 3). This model incorporates the external, internal and interpersonal factors which come together to begin recovery.



Interpersonal relationships help connect the crises, external events of substance abuse with the internal state and processes of the individual.

Figure 3. Entering recovery

CHAPTER FIVE
DISCUSSION AND SECONDARY LITERATURE REVIEW

Introduction

In this chapter results are discussed in relation to the extant literature. The discussion includes literature reviewed in the initial literature review found in Chapter Two, as well as additional sources researched during and following data collection and analysis.

The present findings will first be compared with studies and models pertaining to chemical dependency recovery in general. The findings will then be viewed in light of research specific to Native chemical dependency recovery, as well as counseling and therapeutic processes relevant to Native people. The role of Native spirituality, cultural identity, and incorporation of traditional healing practices into the recovery process, which were found in the current study, will be examined.

Comparison of the findings with existing literature serves as a form of theoretical triangulation (Patton, 1990), in that the literature is a further source of data with which to compare findings related to the phenomenon of long-term chemical dependency recovery of Native individuals.

Discussion

Comparison with General Chemical Dependency Recovery Models and Literature

Stages of Recovery

Analysis of the stories of participants indicated a number of developmental stages in and an evolving quality to the recovery process (Figure 1). That recovery is composed of different stages or phases and is an on-going evolving process is consistent with the work of several experts in the field of chemical dependency.

Larsen (1985), after 20 years of clinical experience in the area, has divided the recovery process into two stages, Stage I Recovery and Stage II Recovery. Stage I Recovery entails breaking the primary addiction. Stage I is the period during which the chemically dependent person becomes sober and achieves sustained abstinence.

Stage I Recovery corresponds to the stages of entry and, most particularly, Early Recovery, as described in the model found in this thesis. In his descriptions of Stage I Recovery, Larsen focuses more on sustained abstinence or the building of a sober life style than on the entry process.

Stage II Recovery follows Stage I Recovery and involves confronting the deeper fundamental issues that were present in the individual's life before the addiction (Larsen, 1987). Because these painful issues took place in the context of interpersonal relationships, Larsen sees the

building of healthy relationships and learning how to function capably in healthy relationships as the main work of Stage II Recovery (1985). Problems in Stage II revolve around intimacy and the ability to function in relationships. Dealing with one's self and changing self-defeating learned behaviours which become apparent in relationships is part of this work. The stages labelled Middle Recovery, most especially, and Late Recovery in the Integrated Change Model are synonymous with Larsen's Stage II Recovery. Nace (1987) also identifies this same period. He also views it as a separate treatment stage and labels it "integration".

Larsen (1985) places the beginning of Stage II Recovery at two to six years of sobriety, which again corresponds with the experiences of the participants. The stage labelled Middle Recovery began for most participants during the two to six year period. Three participants actually pinpointed the two year mark following entry as the time of an important shift to a new phase. For one of the younger participants with less years of substance abuse, this shift appeared to begin somewhat sooner, during the one to two year period.

Based on his clinical experience, Gorski (1989) has divided the recovery process into more numerous and discrete stages. He delineates six stages which he refers to as: transition, stabilization, early recovery, middle recovery,

late recovery, and maintenance. Much of Gorski's work is similar to the findings in the present study. Gorski's maintenance stage is undoubtedly the same as the Late Recovery stage described in the Integrated Change Model. Like the participants, Gorski describes this stage as a period of balanced living with continued growth and development, including spiritual growth. The individual meanwhile, maintains an awareness of his chemical dependency during this stage. Gorski's late recovery stage corresponds to part of the Middle Recovery stage in the Integrated Change Model, ie. the deeper healing of traumatic losses and childhood issues. Gorski describes periods of frustration preceding this stage, similar to the "stuck points" participants described, which propel the individual to confront family of origin issues.

Many of Gorski's middle recovery tasks correspond to the rest of the tasks in the Middle Recovery stage of the Integrated Change Model. These include making relationship and career changes, as well as repairing the damage caused in these areas by addiction. Learning to function well in family, work, intimate, and friendly relationships is a priority; the interpersonal network does not solely focus on program people as in Early Recovery.

In the current study, a time division between this work and later family of origin work which is found in Gorski's model was not generally found among the participants.

Gorski's late and middle recovery tasks seemed to be happening at the same time during the period labelled Middle Recovery in the present research. This may be because people in recovery are now dealing with childhood issues sooner than recovering people did in the past, due to the emergence of a strong ACOA movement and greater awareness of these issues. Henry's recovery, which chronologically began earlier than the others, more closely approximated Gorski's division into two stages.

Early recovery in Gorski's model is similar to Early Recovery in the current model. Like the participants, Gorski observes that at this time the recovering individual's social circle is primarily composed of other recovering people. Working the steps of Twelve Step programs are useful, as is listening to the stories of others and telling one's own story in meetings.

Gorski's transition and stabilization stages are found in the stage called Entering Recovery in the Integrated Change Model. His transition stage resembles the recognition process, in that it involves recognition that one has lost control over alcohol and drug use. Gorski's stabilization stage describes the time in treatment or the period of receiving help found in the current study. Hope and motivation as well as contact with a sober circle of people and role models begins at this time. Therefore, the acceptance process, described in the present study, is found

at the end of stabilization and the beginning of early recovery in Gorski's model. Gorski places acceptance of the addiction and the recovery process, as well as, the conscious awareness of the active work that needs to be done to stay in recovery at the beginning of his early recovery stage.

Gorski observes that it may take from 3 to 15 years to move from stabilization to maintenance. This time frame is consistent with the findings in the current study. As well, he states that after two years of sobriety, it is often necessary to begin to work on family of origin issues for comfortable sobriety. The first year of sobriety should be focused on chemical dependency issues. Gorski's framework is again consistent with the findings in the current research.

Although Gorski and Larsen label, and Gorski chunks stages in the recovery process differently than does the current study, the same processes and sequence of changes are involved. Thus, their work parallels the current findings and ties Native recovery to the same broader stages of change generally found in long-term chemical dependency recovery (Figure 4).

Prochaska and DiClemente's work (1986) in the area of addictive behaviour change also describes the movement from a focus on addictive behaviours in early recovery to deeper levels of therapeutic work in later recovery that is found in Larsen (1985) and Gorski's (1989) model, as well as the

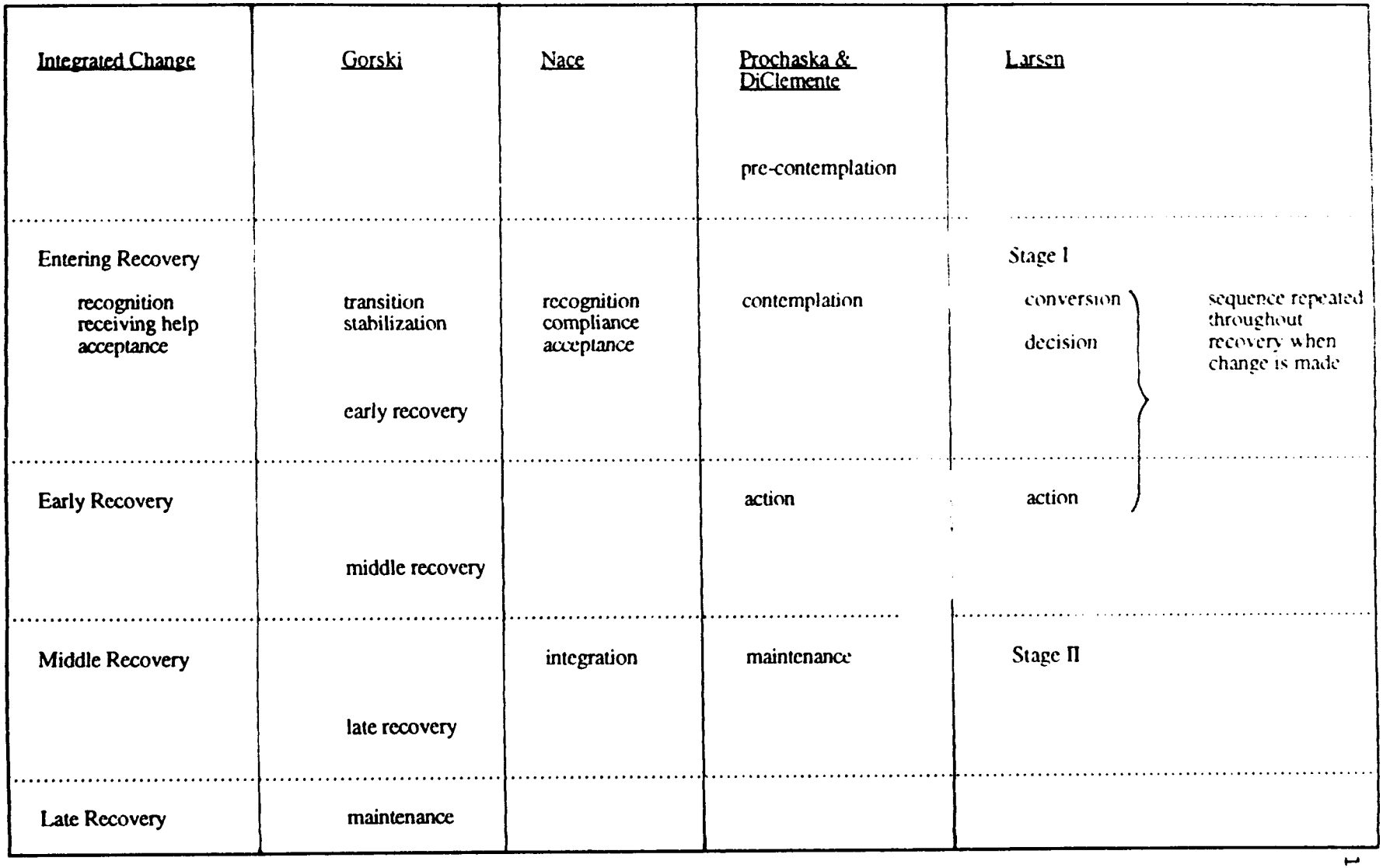


Figure 4. Comparison of stage models of addictive behaviour change and chemical dependency recovery

model in the present study.

The evolving, progressive nature of recovery and the characteristics which make it an on-going process, which were found in the stories of the six participants, are also described by Gorski (1989) and Larsen (1985). Gorski (1989, p. 8) states that "recovery means change". He sees it as a long-term, developmental process composed of steps or stages, in which the individual learns progressively more complex skills and increasingly experiences emotional and spiritual growth.

Larsen (1985) also views recovery as a process of on-going change. He describes the "corners" reached in the recovering individual's emotional, spiritual, and psychological life throughout the recovery process. When these "corners" are reached and the individual comes up against the next issue or stuck point, a conversion experience and resulting change takes place. Such changes take place throughout recovery. Larsen's "corners" and "conversions" are analogous to the "turning points" described by participants in the current study. In fact, Larsen identifies conversion experiences as turning points and, like the current analysis, observes that one's perceptions are altered by the conversion process. He also describes the on-going, constant nature of recovery and change. He emphasizes that in recovery one must act over and over to change self-defeating habits.

The "stuck" points frequently experienced before a change or a new piece of recovery work is started were described by the participants, and by Larsen and Gorski as well. As did a number of participants, both Larsen and Gorski highlight the common "stuck" point recovering people reach and must work through in the movement from addiction-based issues to deeper issues such as childhood trauma. Gorski (1989) observes that individuals who are successful in recovery are those who recognize when they are stuck and who utilize their consciousness in dealing with these stuck points.

Entering Recovery

Extensive description of the entry process was provided by the participants; therefore extensive analysis of this initial stage of recovery was possible. Important elements which emerged were the internal processes of recognition and acceptance, the presence of external events and crises, and the importance and involvement of others in this process (Figure 3).

Aspects of the entry process can be viewed according to Strauss and Corbin's (1990) analytic paradigm which separates aspects of human change processes into categories of antecedent conditions, intervening conditions, phenomena, and strategies (Figure 5). In the current study, crises functioned as initial causal or antecedent conditions. Internal events such as emotional pain, soul-searching

John

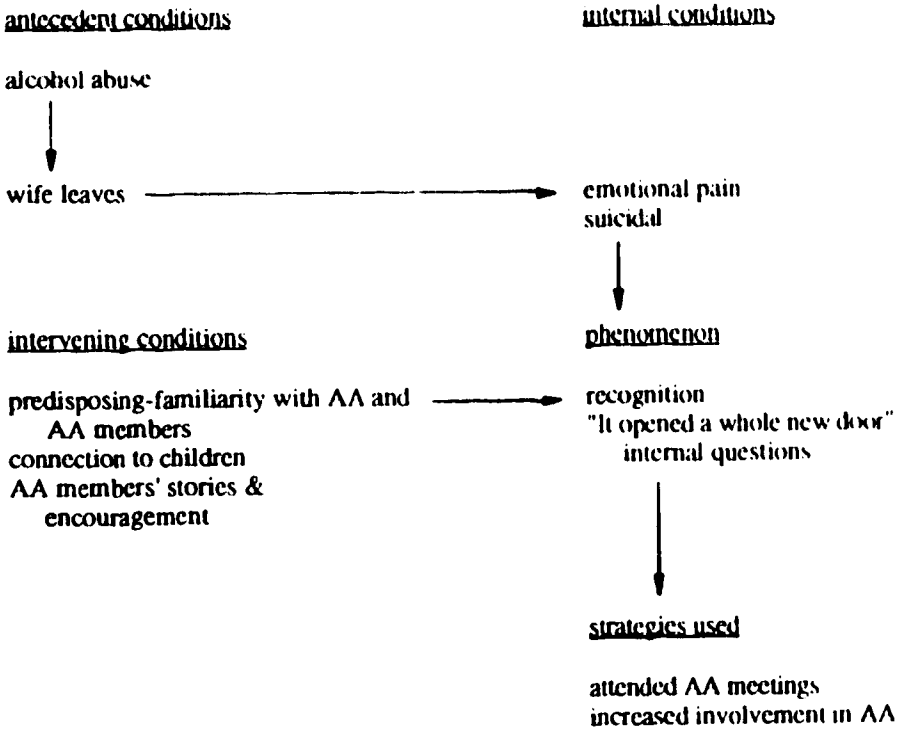


Figure 5. Conditions leading to recognition - John

questions, and the shift that occurred at recognition were the internal processes and phenomena which took place. Intervening conditions which helped move the entry process forward often involved the actions of other people or relationships with other people. Receiving help from others, through attendance at treatment or AA, was one of the strategies participants utilized in response to external events, emotional pain and recognition, which in turn became one of the intervening conditions moving recovery forward. Finally, a level of acceptance was reached internally. This interplay of external factors and actions, internal change processes, and the involvement of and with others began recovery and continued to be the combination which produced change throughout recovery.

In the current study, recognition and acceptance were the terms used to describe the internal processes or phenomena taking place as the individual entered recovery. It was later found that Nace (1987) utilizes the same terms to identify internal processes taking place during entry, although he does not term the process entry. He instead discusses "treatment phases" of recovery. His schemata are based on previous literature, as well as his own clinical experience. As does the current analysis, Nace's begins with the process of "recognition". Internal recognition and admitting that a problem exists define this phase. Nace also identifies the "acceptance" phase found in the current data,

in which the individual whole-heartedly accepts his alcoholism, ie., that he can no longer drink and what he must do to stay sober. Nace's descriptions clearly parallel the terms used and the processes described in the current research. As does the current study, his analysis validates the presence of a recognition and acceptance process at the beginning of recovery.

Nace also adds another phase that can occur between recognition and acceptance: compliance. In this phase, individuals have recognized their problem, but not reached total acceptance. They "go along' with treatment and involvement in Twelve Step programs, but do not take full responsibility for their recovery. This phase may possibly be found in the stories of participants who relapsed or may be seen briefly in the participants' descriptions of the treatment process, but compliance as a definitive stage or process was not clearly described by participants in this study.

Prochaska and DiClemente's (1986) model focuses specifically on the initial addictive change process and less on the total recovery process. Their "contemplation" stage, in which the individual reflects on and confronts the effects of his addiction, resembles the recognition process of the current model and may also subsume the acceptance aspect. Their "action" phase, in which the individual begins to change behaviours, may be comparable to Early Recovery,

but also includes the tail-end of entry when the individual first seeks help and attends treatment. Following this, changes are maintained and strengthened in what Prochaska and DiClemente have labelled the "maintenance" stage. This stage is comparable to the on-going process of maintaining sobriety described by participants following Early Recovery.

Prochaska and DiClemente see relapse as the point at which the individual moves out of the change process back into addictive behaviours and a precontemplative state. However, the individual can reenter the contemplation stage in order to begin the change process again. This appears to be precisely what participants did in this study following relapse (Figure 6). However, the current study takes into account the cycling back to recognition or contemplation in tandem with the effect of interpersonal relationships.

Larsen's general model (1985) of the steps needed for change can also be applied to the entry process. The first step is what he calls "conversion", or the awakening to the potential loss of something if he or she does not change, which the individual is not prepared to lose. This step is analogous to the "recognition" phase found in the stories of the participants. In fact, the potential loss of their children or spouse was identified by three participants as a motivating force.

According to Larsen, conversion must next be followed by a whole-hearted decision to do what is necessary for the

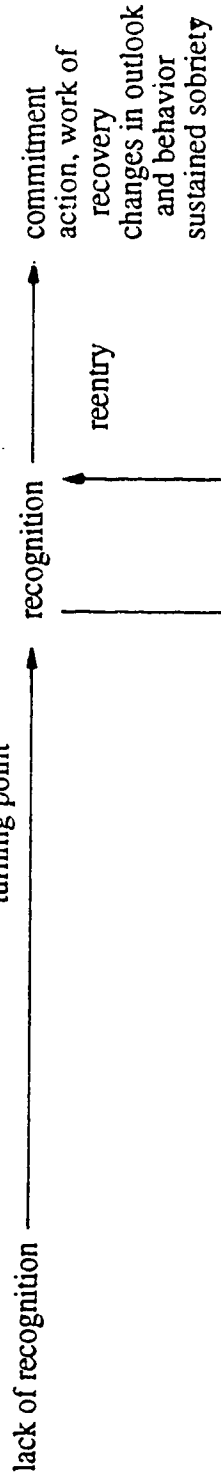


Figure 6. The relapse and reentry process

change to take place; it must be one's own decision. This step would appear to require the whole-hearted "acceptance" described in the current study. It also embodies the commitment described most clearly in the stories of participants who relapsed. Action is the final step in the change process according to Larsen. In entry, this step can be seen in the participants' requests for help and attendance at treatment and Twelve Step meetings.

Recognition, contemplation, and conversion all appear to be different descriptors for the same process. Gorski (1989) also includes recognition in his model, which he describes as recognition of loss of control during the transition stage, and recognition of the need for help in the stabilization period.

In total, recognition most likely encompasses recognition of a problem, of the negative effects of substance abuse, of loss of control, and of potential future losses. Acceptance may entail acceptance of one's addiction, of the extent of the problem, of acceptance of what one must do to deal with the problem and an acceptance of help from others.

In the current study, it was found that external cues and crises play a role in setting recognition in motion. These aspects are mentioned in the studies of Prochaska and DiClemente (1986), although they are described in less detail there. Prochaska and DiClemente observe that

environmental changes in the individual's life often instigate the movement from the precontemplative to the contemplative stage. Gorski (1989) also states that, during the transition stage, life problems force the individual to recognize the difficulties in which substance abuse has placed him. Similarly, a group of men in recovery reported that an awareness their lives were in crisis was the main cognitive set at the time of their decision to quit drinking (Amodeo & Kurtz, 1990). Hunt and Seeman (1990) found one commonality of women just entering recovery was the fact that they were living in a state of crisis. A group of self-changers cited humiliating events as instrumental in their decision to quit (Tuchfield, 1981). Lakota Indian self-changers described a "tiredness with an obnoxious situation" (Medicine, 1982, p. 204) as what led them to the decision to quit drinking.

It is evident that entry to recovery involves both external and internal events. As well, relationships with other people, as motivators or helpers, play an important role. Vaillant (cited in Hunt & Seeman, 1990, p. 235) has, likewise, commented on how a series of events need to come together for recovery to happen. The current model of entry takes into account the role of others and interpersonal relationships, as well as internal and external events in the entry process. The importance of other people in the recovery process will be examined in the next section.

The Importance of Others

The importance of other people in the recovery process was a theme which ran throughout all phases of recovery. A myriad of people, interpersonal relationships and types of help influenced the process - from babies to elders, from parents to recovery group members, and from close friends to professionals.

The participants often described their relationships with others as motivating factors bringing them into recovery, and the support and involvement of others as change agents moving the process along. People influenced their entry into recovery, assisted and provided support at various stages of the recovery process, and relationships with people comprised part of the work of recovery.

In a study of men in recovery (Amodeo & Kurtz, 1990), two of the motivators described by the participants as helpful in maintaining their sobriety were, fear of losing their family, and the support of others. In MacDonald's study (1983), the number of close, emotional supports was predictive of maintenance of sobriety. Self-changers identified the persistent support of others as key factors in abstinence (Tuchfield, 1981). In their extensive research, Prochaska and DiClemente (1986) found that helping relationships were one of the three highest ranked processes out of ten change processes used in addictive behaviour change.

The interpersonal nature of recovery is evident in both the clinical and research literature. Quantitative studies of treatment outcomes have generally indicated that existence of close stable relationships and involvement in a positive family setting are predictive of positive outcome (Bromet & Moos, 1977; Finney, Moos, & Mewborn, 1980). The current study, and other qualitative studies, show exactly how strong relationships with others positively affect recovery.

Helping relationships were vital in successful recovery and were heavily depended on in the early stages of recovery. Gorski's work (1989), as described in the section Stages of Recovery in this discussion, substantiates these findings. Gorski emphasizes the importance of utilizing role models or people who have already experienced the upcoming phase of recovery. Like the participants, he views listening to and observing sponsors, mentors, and models as vital in the process.

An interesting process also evolved as participants continued recovery. From a role of predominantly receiving help, the recovering individual became increasingly more capable of and involved in helping others. This shift was also found in Hunt and Seeman's study (1990) which compared women just entering recovery with those in recovery for five years or longer.

A third aspect involving interpersonal relationships

was also important in the recovery process. This was the centrality of working on and building healthy relationships. Much of the participants' focus and recovery work was centered around this issue. Like the participants in the current study, the recovering women with five or more years of sobriety in Hunt and Seeman's study (1990), were involved in an extensive process of reassessing old relationships and establishing new ones.

Building healthy relationships is so important following early recovery, that Larsen has made it the thrust of his writings on Stage II Recovery. He states that, "Nothing is more central to Stage II Recovery than increasing [the] ability to function in loving, rewarding relationships" (Larsen, 1985, p. 79). This includes the individual's relationship with self and a Higher Power as well. Problems in Stage II Recovery have to do with intimacy and the ability to function in relationships. The focus on building and learning to function in healthy, loving relationships can be seen in the subthemes of Middle and Late Recovery in the current study. Issues relating to intimacy were also apparent.

According to Larsen (1985), deeper problems from childhood are acted out in relationships. Often relationship problems lead the individual to realize the need for continued personal growth (Larsen, 1985). Such a realization process was found in the stories of participants. One clear

example was Henry's observations about the psychotherapeutic work he needed to do to prepare himself for intimate relationships.

According to Larsen (1985), in Stage II Recovery the individual must deal with the context in which emotional pain came to be, that is, the social context or the world of personal relationships. As Larsen observes, the chemically dependent person develops an addiction in and sometimes due to the company of other people. He, therefore, "must get well in the company of others" (Larsen, 1985, p. 15).

As the participants in this study clearly identified, changing self-defeating behaviours, learned earlier in life, which interfere with recovery and healthy relationships, is key (Larsen, 1985). This requires on-going work and recovery strategies, which are discussed next.

Doing the Work

All of the participants emphasized the importance of action or actually doing what was necessary for recovery. Along with internal awareness and recognition of problems, and the input of others, there needed to be an acting on the problem and a working toward a solution. As Larsen (1985) emphasizes, in order to change self-defeating behaviours (or habits) in recovery, one has to act over and over again.

In their models of change, both Larsen (1985) and Prochaska and DiClemente (1986) include an action phase as the third important step. Prochaska and DiClemente also

posit that skill acquisition is the third main ingredient important in effecting addictive behaviour change, in addition to therapeutic relationships and the understanding of events. Four of the ten processes they have delineated as important in addictive behaviour change are skill-related. These include reinforcement or contingency management, counter-conditioning, and stimulus control. The use of these processes peaks in the action phase of change, and although less intense in the following maintenance phase, they are still utilized to prevent relapse.

That action or the work of change is necessary in making real changes in recovery, and that action or doing, as well as an internal processing, must be present for effective changes to take place, is apparent from analyses of the participant's stories. Gorski (1989) outlines some of the actions which are necessary at different phases of the recovery process. His suggestions echo many of the tasks and approaches taken by participants in the current study. His work also indicates that different stages require different pieces of work. The major "pieces of work", tasks, or actions participants described at various stages are found in Gorski's stages and have been summarized in the section Stages of Recovery in this discussion. They entail the emphasis on Twelve Step work related to abstinence in the earlier phases of recovery, with the addition of psychotherapeutic work in later recovery.

Many of the on-going tools, skills, and processes utilized throughout recovery, which were described by participants are also highlighted by Gorski (1989). These include learning to function in relationships, learning to handle life's ups and downs, taking responsibility for one's own actions, controlling self-destructive or negative behaviour patterns, recognizing what one has control over and what one does not, attending to one's career, and becoming a productive member of society. One also must remain aware of oneself and one's behaviours, ie. pay attention to one's thoughts, feelings, actions and ways of relating to others, form positive relationships with a variety of people in and out of Twelve Step programs, and seek professional help when required. Participants in the current study described all of these actions mentioned by Gorski.

As well, the participants' openness to varied resources which might be useful at different stages and for different types of recovery work is similarly implied in the writings and suggestions of Gorski (1989) and Larsen (1985). By these authors,the use of Twelve Step recovery groups, ACOA work, and therapy are all accepted and seen as important.

Psychospiritual Change

Recovery from chemical dependency as a psychospiritual change process was one of the underlying themes found in the words of the participants. Change in recovery had a

spiritual as well as a psycho al quality to it. It involved changes in the way individuals related to and viewed themselves, others, a Higher Power and the world. Beliefs and values were modified and a spiritual perspective was gained.

Spirituality may be defined as "the life principle that pervades a person's entire being - one's volitional, emotional, moral-ethical, intellectual, and physical dimensions - and generates a capacity for transcendent values" (Burns, 1991, p. 50). Spirituality has been described by Ochberg (1991, p. 9) as "a transcendent feeling of harmony and communion with humanity or Nature or the unknown reaches of space". It "includes a sense of belonging and of having a place in the universe. A deep appreciation of the natural world, ... a gratefulness ... joy and wonderment are all part of spirituality" (Ochberg, 1991, p. 9). It also embodies the "state of being fully alive and open to the moment" (Merwin, cited in Ochberg, 1991, p. 9). Vaughan (1991, p. 105) states that "spirituality presupposes certain qualities of mind including compassion, gratitude, awareness of a transcendent dimension, and an appreciation for life which brings meaning and purpose to existence."

The spiritual aspect of recovery is frequently discussed in studies of recovering individuals and in the chemical dependency literature (Gorski, 1989; Larsen, 1985; Orford, 1986). Larsen views conversion experiences as

spiritual events, in the same way the participants saw and, some explicitly labelled, their turning points as "spiritual". Spiritually-loaded processes such as self-liberation, a new sense of life, commitment to change, and a greater awareness of self and others were all perceived to be important factors by individuals who had undergone a change in addictive behaviours (Orford, 1986). These same processes were described repeatedly by the participants. Phrases such as "my horizons opened up", "it opened a whole new door", "a whole different perspective", "a freedom from all this", "a whole new world", "I still want it", "making a commitment", "going all out to recover", "I will continue to do so", "constantly aware of myself", and "understanding others" were found throughout the interviews.

Seven of the 10 processes in addictive behaviour change described by Prochaska and DiClemente (1986) have a spiritual aspect; they either involve one's relationship with self, others, or the world. Self-liberation is one of the three highest ranked processes. The other two are consciousness-raising (or awareness) and helping relationships. The importance of awareness stressed by the participants, therefore, is found in other studies.

That a change in one's way of viewing self and the world, found among the participants, is a common aspect of recovery can be seen in Prochaska and DiClemente's processes as well. Self-reevaluation and environmental reevaluation

are two of the ten. Similarly, Hunt and Seeman (1990) observe that recovery involves a transformation of identity, a restructuring of self, a sense of hope, and the development of a new belief system.

Long-term changes observed in participants in later stages of recovery were reflected in both the external and internal worlds of the individuals. Like the participants in Late Recovery in this study, women with five years of sobriety and active involvement in recovery were found to have both stable lives and a clear sense of self (Hunt & Seeman, 1990). This is in sharp contrast to the internal and external state of women just entering recovery and of the participants in this study previous to entering recovery.

It is evident that change in recovery can be viewed as a process which entails both spiritual and psychological dimensions. It involves cognitive, and emotional changes which are coupled with changes of a spiritual nature. As Vaughan (1991, p. 105) states, "spiritual issues are inextricably interwoven with psychological health."

In the present study, the term psychospiritual was used to describe the combination of psychological and spiritual changes in recovery. A number of writers have also used the term "psychospiritual" to describe the intertwining of spiritual and psychological aspects in the change process (Brown & Peterson, 1989; Brown, Peterson, & Cunningham, 1988; Dubs, 1987; Genia, 1990). Brown et al. (1988)

specifically utilize the term psychospiritual to describe the type of change that occurs in recovery from chemical dependency. Brown and Peterson (1989) use the acronym, BASIC-ISs, to signify the interlocking parts important in their treatment model for chemical dependency. The letters stand for behaviours, affects, sensations, images, cognitions, interpersonal relationships, and spiritual actualization. Thus, all the components found in the present study - the emotional, cognitive, interpersonal and spiritual - are represented and combined in their model. As Brown et al. recognize, all contribute to and are part of the change process in recovery. Many, as well, would posit that most transformative change processes are psychospiritual in nature. As Genia (1990, p. 46) observes, psychological and spiritual aspects in combination "create a powerful therapeutic process".

The psychospiritual nature of changes that occur in recovery was especially apparent in its later stages. Gorski (1989) comments on the importance in later recovery of finding one's purpose in life, doing that which is meaningful, and discovering how one can contribute to the world. For him, this is the truly spiritual part of one's recovery. Gorski observes that, at this point in recovery, one finds joy and meaning by fulfilling one's purpose. This same joy, meaning, and purpose were found in the participants who had reached Late Recovery.

Not surprisingly, the characteristics of healthy spirituality are also characteristic of psychological maturity (Vaughan, 1991). Included in Vaughan's compilation of such characteristics are: letting go of the past; facing fears; love and compassion; a sense of community; awareness of both the inner and outer world; insight and forgiveness; making peace with oneself and others; living in harmony with nature and other people; and authenticity, or being responsible and true to one's self and beliefs, as well as being reasonably consistent in thoughts, words, feelings, and actions. These characteristics are clearly the thematic threads discussed by participants in Late Recovery. As Vaughan (1991, p. 105) observes, based on Mazlow's studies of self-actualized people, the "psychologically healthiest [individuals] are those with a well integrated, deep sense of spirituality".

Ingredients and Models of Change

A distillation of the themes indicates three broad ingredients essential in entry to recovery and in successful long-term recovery from chemical dependency. Stated simply, they are awareness (internal processes), work or action (behaviours as well as involvement in external events), and other people. Events and other people are factors in the change process outside the individual which impinge on the individual.

Prochaska and DiClemente (1986) implicitly recognize

these three main spheres in their listing of the three general ingredients important in effecting long-term change in addictive behaviours. They identify skill acquisition (action, behaviour), understanding (awareness), and therapeutic relationships (others).

The importance of awareness and action, two aspects residing in the individual, are built into Prochaska and DiClemente's (1986) basic model of addictive behaviour change. Contemplation, or awareness, is a necessary first step toward change in their model. Pre-contemplation, or lack of awareness, is the stage which precedes contemplation. Action is the third stage in their model. The fourth stage, Maintenance, involves continued action, as well as a modicum of continued awareness.

Although Prochaska and DiClemente are mostly delineating the initial change process in terminating addictive behaviours, these same stages are applicable to the various changes made throughout recovery. An analysis of the stories of participants in the present study indicated that awareness and action were crucial ingredients in change throughout recovery.

Larsen (1985) frames his conversion-decision-action model, which also incorporates both awareness and action, as a general sequence required in changes made throughout recovery. In his work, Larsen also clearly recognizes the third ingredient underscored as necessary for recovery in

the present study, ie., the interpersonal aspect.

The broad set of factors posited in the models found in the present study - external events, others, internal processing, and action are similar to these found in Bandura's (1977) theory of reciprocal determinism. In his theory, the reciprocal interaction of environment or situational variables, person variables within the individual such as information processing, and behaviour are all important in effecting human learning. His theory also recognizes the crucial importance of the social or interpersonal aspect within environmental or situational variables. The importance of role modeling is also emphasized in his work. Bandura's model includes affective aspects. However, the current analysis takes emotional aspects within internal processing into greater account than does his theory.

The stories of the participants may also lead one to add a further factor operating in the change processes of recovery. This factor is the unseeable, transcendent or spiritual force they describe. One may view it as separate from the other forces, or as I prefer to see it, within the nexus of the combined factors. That is, the presence of the factors coming together to potentiate change <u>is</u> the spiritual force.

<u>Summary</u>

Models, stages, and major themes found in the current

thesis are consistent with findings in the chemical dependency literature. The stages, and general tasks and characteristics of each stage, are similar to what others have found; the labels and exact divisions vary from model to model. Unlike most of the literature, the current study also analyzes the combination of forces that come together to facilitate recovery, most particularly in entry. External events, internal processing, action and interaction with other people are fundamental aspects producing the psychospiritual shifts or changes of recovery.

Because the recovery process is mostly known through clinical and personal experience, and little qualitative research has been completed, the current study adds to the legitimacy of the extant literature and adds some detail to less described aspects. Most literature focuses on what the recovering individual or helper can do to facilitate recovery. The current research also looks at less active factors in the process (ie., close interpersonal relationships) that impinge on the process.

This research also indicates that recovery for Native Canadians is similar to non-Native recovery in its broader patterns and themes. The elements specific to the participants as Native people will be discussed in the next section.

Comparison with Literature on Native Recovery, Native Counseling Approaches, and Ethnic Identity

Introduction

Despite commonalities in the recovery process, some issues that must be confronted are specific to each person's recovery. Other individuals may face the same issue, but it may not be a general or necessary issue for all.

Certain groups, such as minorities or women, may be more likely to confront struggles particular to their histories and situation. The six participants demonstrated such a pattern, in that one of the deeper issues which they had to face by Middle Recovery was their cultural identity. Numerous traumatic losses and childhood issues, tied to the oppression and colonization of Native North Americans, emerged and became "the work" of recovery. Spirituality, a common component of recovery, also took on a specifically Native shape. Native-based resources and approaches were increasingly utilized. Relationships with others also reflected this connection, as elders and networks of Native people involved in recovery and Native spirituality became important supports.

Entry and Early Recovery

As little qualitative work in the area of Native chemical dependency recovery is available, not much comparison can be made with the literature. Medicine (1982) however, did interpret the findings of others who spoke with

Lakota Indian self-changers, individuals who quit using alcohol on their own, without the help of treatment or recovery programs. The emphasis in her study was on abstinence, not full recovery. Therefore, later stages of recovery found in the current study which featured Native themes cannot be compared.

Medicine found that an initial period of introspection was important in making the change to abstinence. This is analogous to the "recognition" phase of entry identified in the current study and other writings, as well as Prochaska and DiClemente's (1990) contemplation phase. The internal soul-searching questions participants found themselves asking most definitely compose part of what Medicine termed "introspection".

Unlike the participants in the current study, the individuals in Medicine's study did not build a support or recovery network in early recovery. This was most likely due to lack of such support systems in the community and their lack of involvement in recovery groups or treatment, which would have facilitated or encouraged such a movement. They did, however, take the step of creating distance between themselves and alcohol-using acquaintances. This was similar to actions taken by the participants. However, in the case of the Lakota, they isolated themselves within the community. They maintained their time away from the alcohol-abusing environment by psychological withdrawal rather than

by leaving the environment or creating new networks. Thus, the step of moving away from the alcohol-abusing environment was undertaken, but the complementary move toward replacing the social network with a sober supportive one was not. Some may have gone on to utilize traditional indigenous healing approaches and other forms of community support, but this was not specifically documented. Medicine (1982) only discusses the use of traditional ceremonies generally, as a possible means to assist Native individuals in maintaining abstinence.

Medicine (1982) comments on the painfulness and extreme social isolation Lakota individuals experienced due to the process of isolating themselves without establishing alternate networks of support. Such painful isolation is reminiscent of Elizabeth's description of her first two years of sobriety without supports.

Henry's comments about the difficulty of maintaining sobriety in one's home community when first sober, and the need for havens away from a community where substance abuse is high in order to help one solidify early sobriety, are applicable to the situation described in Medicine's study. Interestingly, once Henry was confident in his own sobriety, he returned to his reserve to organize an AA group, thus providing a support network which had been previously lacking. Similarly, in their follow-up study of Indian alcoholics ten years after hospital treatment for

alcoholism, Westermeyer and Neider (1985) found those successful in maintaining sobriety had moved away from former ethnic affiliations during the first year or two of abstinence. Following this time, the majority increased their involvement in the Native community, which included helping relatives with alcohol problems.

The Importance of Others

As in the current study and the general chemical dependency literature, the importance of relationships with others in successful recovery is indicated in quantitative studies of treatment outcome among Native people. Although there is more quantitative than qualitative research in this area, the information is still sparse.

In their study of treatment outcome among American Indians who had been involved in a hospital detoxification-treatment program, Westermeyer and Peake (1983) found that those with two years of sobriety had stronger interpersonal relationships than those who had returned to drinking. They also were more likely to be married and have stable employment. These sober individuals also helped other alcoholics and were positive role models in their communities. These findings parallel the general patterns found in the current study. Also, although they all later left the relationship, four of the participants were in intimate live-in relationships at two years of sobriety.

Also similar to the patterns found among participants

in Late Recovery in the present study, Westermeyer and Neider (1985) found in their ten year follow-up that Native individuals successful in maintaining sobriety had increased their social contacts and activities of all kinds, both those in the Native and the non-Native community.

Whether interpersonal relationships play a greater role in Native peoples' recovery from chemical dependency cannot be ascertained from the current study. The importance of relational values, interpersonal networks, and interpersonal relationships in the Native community has been described (LaFromboise, 1988; Thomason, 1990). Some Native therapists have developed approaches which utilize these strong interpersonal networks (Attneave, 1969; Red Horse, 1982; Speck & Attneave, 1973). The present study certainly indicates the pervasive role interpersonal relationships played among the six Native individuals interviewed. For five of the six, an interpersonal crisis led to entry. None of the participants mentioned the influence of crises based in material losses, such as loss of a job.

Elizabeth actually discussed the influence of her relationships with her children in her recovery, in terms of its grounding in her Native ancestry:

> To me my children are part of me and I am part of them ... Being aboriginal - we're all interconnected. That's part of us ...I am sober for my children. My children make me who I am today. And vice versa.

This strong sense of interconnectedness and sense of

connection with the group found in Native communities (Murphy & DeBlassie, 1984), partially explains the difficulty of maintaining sobriety in communities where numerous friends and relatives are abusing substances and where there are few role models of abstinence or recovery. It also indicates the especial importance of an alternative Native reference group which can model sobriety and recovery, as well as the need to build recovery networks within communities.

Among the participants, the role of support groups such as AA and NA was crucial. McWhirter and Ryan (1991) believe support groups can ultimately be successful in Native communities, because their self-help and practical focus are in keeping with cultural patterns. Jilek-Aall's study indicates that AA groups which incorporated traditional Native philosophy were extremely successful among the Coast Salish (Jilek-Aall, 1981).

The current study indicates the important role of Native recovery networks, and the role of Native treatment centres and training programs in facilitating such networks. Native treatment and training programs provided a sober community which stood as an alternative to the drinking community. The healing-community aspect of effective Native substance abuse programs has been identified by Weibel-Orlando (1989) as one of their predominant qualities. The healing-community aspect is evident in Cohen, Walker, and

Stanley's (1981) description of a successful Native treatment centre in Seattle. The program provided services to the individual from referral, through detox and treatment, to aftercare. It also included outreach services to community youth and the criminal justice system.

Important aspects of the healing-community concept found in successful Native substance abuse programs include processes of: mutual group support in treatment, ie., being both helper and helpee simultaneously; those once in need helping others, or "passing on the help"; and the helping of one's community as healing for oneself (Weibel-Orlando, 1989). These same processes were described as very important by participants in the current study.

Weibel-Orlando (1989) highlights the importance of role models in the initiation and leadership of Native treatment programs. She views the presence of charismatic role models as one of the four common traits of successful Native substance abuse intervention programs, based on 50 programs she has observed. The effect of strong role models can be seen in Cohen, Walker and Stanley's (1981) description of the successful Native treatment program in Seattle. The program was initiated and staffed by recovering Native alcoholics. The importance of role modelling in Native cultures has been commented on (LaFromboise, Trimble & Mohatt, 1990). The current study substantiates the crucial influence of role modelling in the recovery process of the

six participants. Every participant discussed the positive effect of role models.

The Importance of Native Spirituality, Native Culture, and Traditional Healing Practices

The present study demonstrates the importance of Native spirituality and traditional healing practices in the long-term recovery of the participants. The power inherent in these approaches became accessible following initial recovery and abstinence. Numerous writers have suggested the usefulness of traditional Native approaches in therapeutic healing and in chemical dependency recovery (Attneave, 1985; Jilek, 1982; LaFromboise, 1988; Long, 1986; Thomason, 1990). A number of therapeutic programs have successfully utilized traditional approaches, including cultural teachings, culturally relevant activities, elders, and traditional healing ceremonies and rituals (Ashby, Gilchrist, & Miramonetz, 1987; French, 1990; Guillmet & Whited, 1987; Red Horse, 1982).

The successful Native alcoholism treatment program described by Cohen et al. (1981) utilized traditional elders and spiritual leaders, Native cultural activities, and cultural discussion groups. Most of the program was designed and implemented by Native individuals. Individual and group therapy was culturally sensitive and incorporated a Native orientation.

In the current study, traditional Native approaches

were successful in combination with chemical dependency treatment and chemical dependency recovery principles, as well as in combination with psychotherapy and therapeutic work. Abstinence and basic sobriety needed to be reached first, for the full power of Native spirituality and ritual to be accessed by these six individuals who had substance abuse problems. The inclusion of Native spirituality and culture in the treatment process was a positive force for the individuals who attended Native treatment programs. This force was later discovered or rediscovered by those who did not initially attend such a program.

Darou (1987) describes traditional healing practices being used successfully in combination with psychotherapy. The current study definitely validates the power of this combination following Early Recovery. Jilek-Aall (1981) found that the merging of Native philosophy with AA programs improved chemical dependency recovery among the Coast Salish. The successful treatment program described by Cohen et al. (1981) also featured the incorporation of Native philosophy with general recovery principles and programming, including AA. According to the participants in the present study, such incorporation was helpful during the treatment process as well as later.

Weibel-Orlando (1989) calls for more systematic investigation into the efficacy of indigenous healing strategies, as well as the need for collection of life

histories of Native individuals who have maintained sobriety following intervention. The current study indicates the efficacy of indigenous healing approaches in chemical dependency recovery, when combined with an understanding of chemical dependency, an attention to recovery principles, and therapeutic work. In addition, it provides an initial collection of "success" stories focusing on Native recovery.

Spiritual principles or processes known to be important in traditional Native spiritual philosophy were also found to be important for the participants in the current study. For example, the principle of balance, the finding of meaning and purpose, the process of spiritual vision, the use of symbolic metaphors (Heinrich, Corbine & Thomas, 1990), and the sense of connecting with a larger body of experience or something greater than oneself (Murphy & DeBlassie, 1984; Thomason, 1991) were reflected in the participants' stories. The Native belief that spirituality is a crucial aspect of healing and therapeutic process (Darou, 1987) was evident.

Cultural Identity Process

A process of discovering and defining one's cultural or ethnic identity as a Native person was important for the participants. Intensive work on this issue usually began during Middle Recovery and resulted in a strong sense of pride in being Native. Three areas of literature which address this process are examined.

Native chemical dependency literature.

The importance of cultural identity issues and treatment approaches sensitive to these issues in Native chemical dependency recovery and prevention is highlighted by a number of researchers and clinicians (Cohen et al., 1981; French, 1990; Jilek-Aall, 1981; Neale Query, 1985). Based on her research and that of others, Neale Query (1985) views the special cultural and identity needs of Native people to be crucial considerations in chemical dependency treatment. According to Neale Query, programming and interventions which do not take into consideration such needs, are doomed to fail. Jilek-Aall (1981) also stresses the importance of cultural identity in Native recovery from alcoholism.

From his work as a counselor with Cherokee youth, French views "the development of a sense of 'Indianism' to be the most significant step in both preventative and intervention models" (French, 1990, p. 70). Programming in which he was involved, included cultural awareness work and activities, and an exploration of Native history and contemporary society. The successful Seattle program described by Cohen et al. (1981) also incorporated cultural identity work into its treatment program, through the use of discussion groups focused on Native identity.

The participants who attended Native treatment programs with cultural and spiritual activities, found that these

activities introduced them to a greater awareness of Native identity and the possibility of future work on this issue. The others who did not attend culturally sensitive treatment programs, later gained exposure to cultural identity issues and Native culture in Native training programs and through employment at Native treatment programs. In either case, all participants expressed the strong critical influence of this aspect in their recovery.

Native counseling and mental health literature.

Participants in the present study confronted ethnic identity issues in-depth during Middle Recovery, the stage at which they were dealing with deeper therapeutic issues. Literature related to counseling Native people and Native mental health supports the potential need and importance of confronting Native identity in the therapeutic process (Guillmet & Whited, 1987; Heinrich, Corbine, & Thomas, 1990; Katz, 1981; Marchand, 1990). Ethnic identity issues and conflicts, arising from cultural trauma, oppression, and racism were significant for the majority of the participants. Darou's (1987) caution that the effects of racism and prejudice must not be overlooked when counseling Native people was strongly validated by the words and stories of two participants.

The need to consider the degree of assimilation to and type of identification with the dominant culture when working with Native people (Trimble & Fleming, 1989) can be

seen in the varied degrees of immersion in Native culture among participants. The degree of assimilation to the majority culture appeared to affect the participants' intensity of immersion in Native culture during later recovery. Beverly and Cheryl who were highly assimilated to the dominant culture, tended to more intensely immerse themselves in Native culture to the exclusion of non-Native culture during Middle Recovery. It was as if they needed to submerge themselves in what had been denied for so long.

In this regard, it must also be remembered that due to cultural diversity and varied degrees of assimilation, for some, attendance at a Native treatment centre featuring a strong cultural component may not be appropriate. For those of Native ancestry, who identify strongly with the dominant culture, such initial exposure may be contraindicated. The influence of Native ancestry may be a self-identity issue that needs to be confronted later in recovery.

Ethnic identity literature.

The combined stories of the participants indicate a series of stages in the development of a strong Native cultural identity. In Early to Middle Recovery, even sometimes in treatment, the participants became more aware of their Native identity and its importance. As they began to feel better about themselves due to their abstinence and positive change in life style in Early Recovery, they moved into a period of greater involvement in Native spirituality

and culture. There was an increasing sense of acceptance and pride in their Native identity. In the same way, that they became strong enough to confront other painful issues, in Middle Recovery, they were able to face personal traumas associated with the oppression and disruption of Native culture. Following immersion in Native culture and spirituality, and the healing of cultural traumas, participants entered a stage of bicultural balance, in which their Native pride, as well as a belief in their rightful place in society, and a connection to and appreciation of other cultures was secure. Three individuals, who were in Late Recovery, had reached this stage.

Thomas' model (Cross, 1980; Ford, 1987) of stages in the ethnic identity development of Black Americans parallels the current findings. The process described in his model is very similar the changes in ethnic identity apparent in the stories of the participants. Thomas identifies five stages in the ethnic identity process. The first stage is dominated by confusion, self-denial, lack of self-worth, and a dependence on White society for identity. This stage is evident in John's, Elizabeth's, and Cheryl's descriptions of their pre-recovery state. The next stage is marked by anger, resentment and rage related to the emotional pain suffered as a minority person. This stage was less discussed by participants, although in their drinking, rage was expressed through violence. In recovery, anger was handled in

healthier ways. Anger and bitterness was a predominant theme in a number of participants' life stories; some of this anger and bitterness was clearly tied to cultural trauma.

Thomas' third stage is one of information-seeking, where cultural heritage is explored, understanding is striven for, and pride is intense. The fourth stage entails commitment and activity related to the culture group. This enables the individual to forge a link within the ethnic community and to realize their identity through action. Thomas' third and fourth stages are identical to the cultural work done by participants during Middle Recovery. The intense immersion Thomas describes is particularly evident in the stories of Beverly and Cheryl.

Thomas' fifth stage is labelled "transcendental" and entails a sense of personal freedom from racial, ethnic, gender, and class labels, an acceptance of oneself as part of humanity, and a sense of multiculturalism. During this stage, the individual emerges from the earlier social isolation and immersion in a single cultural group, and reaches out to contact with other groups of people. According to Thomas, in the final stage, ethnic identity has been internalized and a new sense of self has been incorporated. The individual is less defensive and better able to withstand prejudice, due to a strong inner sense of self and set of internal standards. This final stage describes much of the dynamic found among participants in

Late Recovery, ie. their sense of connection to all humanity, their sense of personal freedom, loss of attachment to ethnic labels, and their multiculturalism. Their sense of purpose in relation to Native society is something which is not described by Thomas' model.

Cross' model (Cross, 1980) of the process of ethnic identity development among Black Americans, includes a fifth stage which incorporates the aspect of social commitment to one's cultural group found among the three participants in Late Recovery. The importance of translating one's personal ethnic identity into actions meaningful to the group and helpful to "the resolution of problems shared by the group" (Cross, 1980, p. 86) which was found among the participants is highlighted in his fifth stage, which he calls Internalization-Commitment. Generally, the other overall processes of Cross' developmental model are similar to Thomas'.

The relevance of the stages of ethnic identity development found in the present study, and in Thomas' and Cross' work, can be seen in its resonance with other minority groups. Downing and Roush (1985), for example, have applied Cross' model directly to the experiences of women.

Counseling and Native People

Although the current research is focused on chemical dependency recovery, the therapeutic work undertaken by the participants entailed more than chemical dependency issues.

In addition, many of the instrumental aspects identified in helpers, were found throughout the stages of "full recovery". Therefore, the findings of this study have some relevance to the area of counseling and Native people.

The findings in the present study are consistent with a number of points made in the literature on counseling Native people. One such finding was that empathy and compassion were crucial in the helping process. Trimble and Fleming's observations (1989) about the importance of basic counselor attributes of empathy, caring and warmth when counseling Native people, reinforce this finding. Conclusions by researchers in the area of counseling Native people, that Native people tend to value trust and understanding more than other counselor trait (LaFromboise & Dixon, 1981), is certainly apparent from the words of the participants.

Empathy is generally considered important in the counseling process. Whether these traits are more important for Native clients than for other groups cannot be determined from the present study. Nonetheless, it is clear that for this group of Native individuals, compassion and understanding were crucial.

Related to the elements of compassion and understanding, was the participants' emphasis on the helper's accepting and understanding of the client's world. Helpful individuals were those who knew of what the client spoke, who had either shared similar experiences or could

enter into his or her world. Terms such as "joined me my world", and "be on the same level" were used. At times, sensitive self-disclosure was helpful. In LaFromboise and Dixon's study (1981), acceptance and self-disclosure were two counselor traits found to be perceived very positively by Native clients.

The equalitarian nature of helping relationships was evident in the present study. LaFromboise and Dixon (1981) discuss the appropriateness of "confident humility" in the helper. Thomason (1991) highlights the importance, when working with Native people, of meeting the client as a person, not as a case.

Participants also spoke of the importance of counselors guiding, coaching, and encouraging, in other words, facilitating the process, rather than dictating. The importance of pacing, or allowing the counseling process to unfold, when working in the Native community, has been noted by Trimble and Fleming (1989).

While understanding, acceptance, and facilitating were highlighted by the participants, the importanc of timely and appropriate confrontation was also stressed. The literature on counseling Native people does not specifically address this issue. However, the chemical dependency literature deals extensively with the necessity of confrontation, as well as the importance of appropriate timing and type of confrontation at different stages of the

treatment and recovery process (Nace, 1987; Valle, 1976).

In counseling generally, a balance of compassionate support and timely confrontation, as described by the participants, is considered to be important. However, very much in keeping with the personal and experiential nature of helping in the Native community, helpful confrontation cited by the participants was tied to the confronter's knowledge of or familiarity with the situation at hand, and was often based in the helper's own experience and personal knowledge.

Related to the importance of the personal experience of the helper, is the evident usefulness of role modelling in the change process. In addition to nonprofessional helpers, a number of effective professional helpers described by the participants were engaged in the recovery process themselves and served as role models.

The above makes clear that basic therapeutic approaches and counselor traits found to be effective generally, such as empathy, acceptance, and facilitating the experiential process, were of utmost importance to the participants. Processes especially important in chemical dependency counseling, such as timely confrontation and role modelling, were also crucial to the Native participants.

Summary

The present study indicates the importance of cultural identity issues and utilization of Native spirituality and cultural practices in later stages of chemical dependency

recovery among six Native individuals. The literature on counseling and mental health among Native North Americans is consistent with these findings. The cultural identity process described by participants during recovery is congruent with models and findings in the ethnic identity literature.

Since there were no available studies which qualitatively researched the process of long-term recovery from chemical dependency among Native people, the findings cannot be compared on this basis. However, documented observations of successful Native intervention and treatment programs indicate the usefulness of incorporating traditional cultural and spiritual aspects, in addition to the need to address cultural identity issues.

Observations of successful Native treatment programs also indicate the importance of role models, as well as, strong interpersonal networks of support (ie., a healing community) in long-term recovery among Native people, which were found in the present study. Literature on counseling Native people also indicates the importance of role modelling and support networks in the Native community as well as the importance of compassion and empathy in helpers, which were found in the current study.

Quantitative studies of treatment outcome among American Indians demonstrate the importance of strong interpersonal relationships and networks in maintaining

sobriety which was found in the current study. The movement toward helping others and becoming role models in their community as recovery progresses, which was described by the participants, is also indicated in these quantitative studies.

CHAPTER SIX
CONCLUSIONS AND IMPLICATIONS

Conclusions

Many insights were gained from the process of listening to the participants share their stories. A greater appreciation and understanding of chemical dependency recovery in general was reached, as was a greater awareness of the experience of long-term recovery among six Native Canadians.

It was evident that a number of forces or factors needed to come together for recovery to happen. Initially, crises, recognition of these crises (or internal processing), and the involvement of others were required for the individual to enter recovery. In other words, the external, internal, and interpersonal needed to come together for recovery to begin. As well, a response or action which brought help and a later internal process of acceptance were necessary to solidify entry.

Generally, three broad ingredients were required to maintain sobriety, and to continue positive change once the individual had entered recovery. One of these ingredients was awareness, or the continued use of one's internal processes. The recovering individual needed to be in touch with the psychological and spiritual dimensions of self, including one's sensations, thoughts, and feelings. The second ingredient was doing the work of recovery, or taking action and using available resources. This was the behaviour

or action component which needed to be added to awareness. Actually doing or experientially completing recovery tasks, as well as an openness to receiving help and the various resources which could be helpful was necessary. There was an element of commitment in this. Finally, a connection to others and relationships with others were fundamental. Other people provided a support network and an impetus for change. Relationship with others was the context in which recovery was acted out.

The current study particularly demonstrated the strong influence of other people, as supports and change agents, as well as because of their relationship with the recovering individual. The influence of children and the chemically dependent individual's connection to his or her children was a specific influential relationship that emerged from this study. A shift towards helping others, after receiving help oneself, was also evident.

The themes found within the interviews - psychospiritual change, doing the work of recovery, and the importance of others in the recovery process - reflect these basic ingredients or building blocks of recovery, ie. the internal change processes, the external behavioural work, and the interpersonal. Doing the work of recovery and involvement with others were the ingredients that fueled psychospiritual change.

The current study clearly indicated that

psychospiritual change in recovery was holistic and transformative. It took place on all levels: emotionally; spiritually; physically; socially; and mentally, with changes in thoughts, beliefs and values. As well, the process forever altered the individual. There was a transformation of identity, and a new structuring and view of self, as well as a different relationship with the world.

Long-term recovery was also an on-going process. Healing began with the addiction, then proceeded to deeper levels. Individuals who continued the recovery process to deeper levels became self-actualized individuals, for whom the spiritual aspects of recovery were important. Recovery was also a continual process of daily awarenesses and routines. It required struggle and the daily application of recovery principles and strategies. Within this process, stuck points and relapses were possible.

The stages of recovery in the model presented in this study are similar to other models of recovery that have been developed. However, other models are not as encompassing. The present model incorporates the broad spectrum of factors - external, internal, behavioural, and interpersonal - which contribute to initiation and maintenance of recovery. It, as well, reflects the integration of psychological and spiritual aspects found in recovery. The particular uniqueness of the model is that it brings into focus those aspects of recovery specific to Native recoverers.

The present study demonstrated the importance of Native identity issues in later recovery, as well as the need to do healing work around these issues for the Native participants. It also revealed the devastating effects of cultural oppression on Native people. Their therapeutic work involved healing the traumas of racism, residential school, cultural disruption, and loss.

The study also indicated the profound role that Native spirituality and Native cultural traditions can play in the long-term chemical dependency recovery of Native people, once sobriety has been stabilized. Involvement in Native spirituality and cultural traditions allowed participants to heal traumas connected to their Native identity and brought recovery into a deeper realm. It broadened and balanced their recovery. For the individuals in this study, then, involvement in Native spirituality and culture led to a fuller, more complete recovery.

This study also indicated the importance of a Native network of sober, recovering individuals who can support, assist, and inspire others. It also revealed the powerful effect of healing communities within the larger Native community.

Implications

Implications for Practice

Numerous findings emanating from the present study have clear implications for helping professionals, for service

delivery to Native people, chemically dependant individuals and their families, for Native communities, and for the non-Native community, in terms of its response to and understanding of Native peoples. Results of the study suggest the following:

Relationships with other people play an important role in the initial process of recognition and seeking help for an addiction, as well as in the maintenance of sobriety. This finding indicates the importance of help being made available to, and programs being targeted at, the individual while he or she still has ties and strong interpersonal connections to others. The research implies the greater difficulty that may be involved in assisting the individual, once he or she has lost a connection to a circle of loved ones. It also confirms the potential power of intervention strategies which utilize the family's relationship with the substance abuser in order to facilitate movement into treatment. It demonstrates how and why these work, and the importance of pursuing approaches which educate the family about chemical dependency and about useful ways to respond to chemically dependent family members.

Services for families of chemically dependent individuals are essential. Findings show the difficulty of the recovering addict reentering an untreated family system. Reflections of the participants as parents and as children living in alcoholic homes indicate the devastating long-term

effects of parental substance abuse on children. Helping families to understand and learn new responses to chemical dependency, as well as heal from its negative effects, not only will facilitate the chemically dependent individual's entry into recovery and make his reentry into the family less traumatic and more positive, it will also have a preventative effect on children and facilitate healing and growth in other family members. It will help children break the cycle of chemical dependency.

There is a continued need for services and support groups which help move the individual into stable sobriety. Despite what sometimes appears to be a high rate of failure and relapse, services such as detoxification and treatment centres, and support groups, such as AA and NA, are extremely helpful and important in the recovery process.

A variety of resources to assist the chemically dependent person at various stages of recovery are necessary. Availability of multiple resources in the community is essential. Books, support groups, therapists, and treatment programs were all found to be helpful in long-term recovery. Different resources were required and used at different points, sometimes in ways unique to the individual. The individual requires a variety of resources from which to choose.

A supportive recovery network is crucial in maintaining sobriety in early recovery, and in facilitating one's

ability and motivation to confront deeper issues in later recovery. Helpers or professionals working with chemically dependent individuals need to recognize the importance of these networks, understand how these networks and related support groups work, and at times facilitate the individual's process of building these networks, if they are lacking. Therapists may need to coordinate therapeutic work with aspects of the individual's recovery program.

Professionals, such as a doctors or social workers, who understand chemical dependency and who provide appropriate referrals and assistance, can facilitate the recovery process. An understanding of addiction is fundamental for helpers, such as social workers, who assist practicing chemically dependent individual ho are experiencing crises. Agencies and workers apprehending children should be aware of increased substance abuse on the part of a parent as a response to the painful loss of children, and be cognizant of ways to facilitate the recovery process for parents.

Therapists generally need to assist clients who have substance abuse problems in achieving sobriety before proceeding to long-term, in-depth psychotherapy. Therapists evidently need to have some awareness of chemical dependency in helping these clients.

The study also reaffirms the importance of empathy, compassion, and caring, as well as timely confrontation, in

counseling the chemically dependent person, as well as in counseling generally. Despite the extent of knowledge and effort on the part of the helping professional, however, awareness and action on the part of the chemically dependent person is essential, as is an environment conducive to sobriety.

Resources and a forum for working on cultural identity issues and ways of reconnecting with one's Native identity, culture, and spirituality are important for Native people. This aspect may need to be integrated into treatment, counseling, and therapy for Native people. The therapist working with Native individuals should familiarize himself with Native culture, ethnic identity issues, and relevant Native history.

The study indicates that Native spirituality and traditional healing and cultural practices are extremely useful when combined with psychotherapy, and with chemical dependency treatment and recovery principles. The research supports the usefulness of indigenous healing approaches when combined with alcoholism treatment. This combination, as well as the combination of indigenous healing approaches with therapeutic approaches in later recovery, can be extremely effective and powerful in facilitating healing and change. The combination of chemical dependency knowledge and traditional knowledge is an important trend.

The traumatic effect of Indian residential school also

needs to be considered. There is a need for awareness about this issue among the general public, as well as a need for healing work around this issue for many Native people. In the current study, one participant spoke extensively about the negative effects of attending residential school. At least four of the other participants had parents who attended residential school, with clearly negative effects on resulting parenting skills, sense of ethnic pride, and related problems of abuse and chemical dependency. These effects have an intergenerational quality which needs to be addressed. There is a need for services to deal with the effects of residential school trauma, and helpers who are aware of this issue and who can provide appropriate services. Self-help support groups may be another useful option.

A number of Native treatment centres and training programs are providing assistance beyond initial treatment of clients and training of trainees. In the months and years following treatment and training, these centres and programs are utilized as havens, supports, and meeting places for recovering Native people, as well as healing centres and sources of inspiration for Native communities. They are multipurpose programs providing services to the Native community beyond the simple level for which they receive funding. The actual level of assistance they provide may not be readily apparent. Thus, funds allotted to these centres

and programs is money well spent. Such centres and programs should continue to receive financial support from the government.

Additionally, due to the interpersonal nature of substance abuse and recovery, as well as due to the strong relational nature of Native societies, there is a need for community approaches to problems of chemical dependency and abuse. Community-based strategies which help communities understand and find ways to overcome substance abuse need to be supported.

The need to continue work which focuses on eliminating chemical dependency and abuse in Native communities is evident at this time. Helpers, whether Native or non-Native, must be knowledgeable about these issues to be of assistance to the Native community.

Finally, as more individuals in the Native community enter recovery and undertake the healing process, there will be a positive effect on the next generation. This is apparent from the stories of participants who had parents in recovery. Their parents provided strong role models and healthy supports, and these individuals entered recovery at a young age. Thus, with parents in recovery, children's substance use and period of active addiction may be briefer. The present research indicates that children are affected by trauma and parental chemical dependency, but it also shows they are positively influenced by parents' active recovery.

Currently there are a number of Native individuals reversing the trend of addiction and abuse. The dominant society needs to be aware of this positive movement and lend support, emotionally and financially. The healing path needs to be continued and applauded.

Implications for Future Research

More qualitative research on and documentation of individuals' recovery from chemical dependency is needed. The factors and models presented in the current study require further validation and elucidation. This is especially the case for Native North Americans' recovery process. There is a lack of such documentation and research, while there is a great need for models of successful recovery.

It would be useful to gather more stories of Native individuals who followed a long-term recovery process, as well as those who did not continue the process into deeper levels of therapeutic work. Differences between these two sets of phenomena could then be understood. It would also be useful to research the recovery process of Native Canadians who did not utilize Native spirituality in their recovery, or those who had relapsed or had difficulty maintaining sobriety, to observe the differences. It would also be enlightening to interview Canadians of Native ancestry who do not identify with being Native or who do not identify with Native culture, in order to determine how their

recovery process differs and how they deal with cultural identity issues in recovery.

The current study also indicates the need for further research into the effects of Indian residential schools and documentation of people's experiences in residential schools, as well as their process of healing and recovery from this experience.

More qualitative study into the psychotherapeutic change process, in regards to emotional healing from abuses, such as physical and sexual abuse is also needed. Such study could inform therapeutic practice and service delivery. As well, general factors operating in these therapeutic change processes could be compared with other change processes, such as initial addictive behaviour change, to elucidate general principles of transformative change.

Finally, more research into the phenomenon of the healing community and its structure is required (Weibel-Orlando, 1989). This community appeared to play a significant role in the participants' recovery.

Usefulness of the Current Study

The results of this study are useful to those working in the addictions field, to therapists and counselors, and to Native and non-Native people concerned about substance abuse and recovery. By documenting individuals' stories and processes of positive change, models of recovery and hope are provided. From this, concepts leading to solutions can

be generated. A greater understanding of the change process can help engender proactive approaches and better intervention strategies. The present study also contributes to the sparse formal literature on an important and growing Canadian phenomenon - the emotional healing of Native people following 400 years of trauma.

Most importantly, the participants' stories in the present study serve as an inspiration to others and a vision of what is possible. They provide potent models and a sense of hope. They reveal that success and healing are possible, despite the current difficulties facing Native communities.

Personal Reflections

I was emotionally moved by the power of the participants' stories and the depth of their experiences. Their strength, and a sense of hope and vision predominated. Although I had previously listened to recovery stories, I was once again struck by the trials, effort and courage of individuals in recovery, as well as by the specialness of the recovery process. It was a great honor and opportunity to be allowed to share in the participants' experiences.

I was surprised at how clearly participants could remember and describe important turning points in their recovery. In my own personal experience, and while counseling others, I had seen and felt emotional decisional shifts in the change process. For this reason, I had included a question about turning points in the interviews.

However, I did not quite expect the response to be so strong or turning points to be so easy to access. Most identified with the experience of turning points and could describe specific turning points in their recovery. It appeared certain aspects of the recovery process were so intense, that the memory did not fade with time, but, in fact, took on enduring significance. Recognition was one such turning point. As well, the role of others and helpers in the initial entry process was well-remembered.

I was also very surprised at the role seemingly passive children played in recovery. This influence had been indicated in previous interviewing, but I did not expect the strength of the influence as it emerged. It reminded me of an elder's saying, that "our children are our counselors." That is, children can provide a mirror for ourselves; their behaviour and responses furnish cues and clues to aspects of ourselves and messages about what is happening in our lives.

I also found that the process used in researching the topic in some ways reflected the terrain being studied. In locating and accessing participants, I utilized my contacts within the Native and chemical dependency recovery communities; both of these communities have strong interpersonal networks. As often happens in the Native community, in the case of one of the participants, I discovered I knew her mother as I chatted with her before the interview. Thus, the strong interpersonal nature of

Native and chemical dependency recovery networks was used, as well as was observable in, the contact phase of the research process.

Because I had contact with these networks, I also often had external validation of comments and observations made by the participants. I sometimes heard the same assessment about a change in a relationship from others, or actually saw evidence of an aspect described, at work in the individual outside the interview context.

As well, because I was familiar with the area of chemical dependency recovery, I was familiar with terms such as, "the program", "Step Four", and "ACOA", which the participants used frequently. It also meant I sometimes had to ask them to clarify comments / terms, for the benefit of the interview, even though I understood what they meant. Knowing a few of the participants before the interview, I was able, in a few instances, to ask about important aspects of recovery that had been left out. On the other hand, I found my personal composure was more seriously affected following interviews of participants I knew the best.

On the whole, the research process had a number of personal effects. I could relate to some of the traumatic experiences and healing processes described by the participants. Because of this, I began to reflect back on my own experiences of living around chemical dependency, as well as my own growth process that resulted from that

experience. It helped me recapture the sense of vision and hope that I had lost sight of in graduate school. It also reconnected me with my previous work as an addictions and family support counselor, particularly when one of the participants spoke of the role her social worker had played. It reminded me of and reinforced the importance of the work I had done.

I also found that sharing in the stories of the participants connected me to my current experience as a student. Four of the six were or were about to be students. The impoverishment and stresses described by a fifth participant due to her previous dual role as a student and mother seemed very similar to my own. I felt less alone in my experience after hearing her story. It also gave me hope for the future that life would again feel more positive, satisfying and less stressful following my school experience.

Finally, I found that, from listening to the stories of the participants, I began to reflect on my own spirituality and what was important in my spirituality. Overall, then, through the experience of hearing the participants' stories, I reconnected with what was important in my spirituality, my personal growth, and my professional life. I also became aware of work I needed to do in these areas. From the experience I became more in touch with who I was and what I needed to work toward in my own healing.

The power of listening to others' stories, which was pointed out by the participants, is evident in my personal response to their stories. Again, the research process itself validated a phenomenon described by participants.

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Appendix A: Interview Guide

1. Please tell me about your experience of recovery from chemical dependency, what this journey has been like for you from the beginning until now.
2. Please tell me about the things (events, experiences, actions, therapeutic processes) which helped bring about your sobriety and recovery.
3. Were there turning points in the process? If so, what were they and what seemed to bring them about?
4. Please tell me about the things you did that seemed helpful to recovery and positive change.
5. Please tell me about the role that other people have played in your recovery. What did others do or what about others was helpful? What was not helpful?
6. What aspects of counseling or treatment were most helpful? What were not helpful?
7. What did the counselor(s) do or what about the counselor(s) was helpful? What was not helpful?
8. Please tell me about some of the obstacles you've experienced in maintaining sobriety. What were some of the obstacles to making positive changes?
9. What ongoing skills, processes or recovery work was necessary or is still being used to maintain sobriety and positive change?
10. Is there anything else we have not discussed that needs to be said?

Appendix B: Explanatory Letter

My name is Linda Massimo. I am a graduate student at the University of Alberta in the Department of Educational Psychology. For my master's thesis I am conducting research into chemical dependency recovery among Native Canadians. The purpose of the study is to better understand the process that allows Native Canadians to recover from substance abuse and the factors that influence this recovery. It is hoped that what is learned from this research can be used to assist others in the recovery process.

I would like to ask your permission to interview you about your experience of recovery from chemical dependency. The interview will take 1-2 hours and will be tape recorded. The tape recording will then be transcribed into typed manuscript, so that I can analyze the information given. Understandings gained from this will be combined with understandings gained from other interviews. This will provide general learnings about the chemical dependency process among Native Canadians. At a later point I may ask for clarification if I have questions about information contained in the interview. When general themes have been drawn from the data, I may also request your views on the accuracy of the themes I have identified.

Consent Form

I, _____, consent to being a participant in this study about my experience of recovery from chemical dependency. I understand that my participation in this research is completely voluntary, and that I may decide freely to withdraw, without prejudice, at any point in the research process.

I further understand that my participation will be confidential. Any identifying names will be changed in the transcript process. A number code will be substituted for my name. Audiotapes will be accessible only to the researcher and transcriber, and will be destroyed upon completion of the study. The transcriber will be required to sign an oath of confidentiality.

Signature:_____

Date: _____

Appendix C: Demographic Data Sheet

Age:

Sex:

Tribal affiliation:

Type of community raised in:

Would you say the family you were raised in was:

traditional Native _____

somewhat assimilated _____

very assimilated _____

bicultural _____

How would you describe yourself now in terms of the above categories?

Number of years of substance abuse:

Age at treatment:

Type of treatment:

Number of years since treatment:

Number of years of sobriety:

Appendix D: Description of Twelve Step Programs

Twelve Step programs are self-help support groups which assist individuals in overcoming addictions and difficulties related to addiction in the family. They include groups such as: Alcoholics Anonymous (AA), for recovering alcoholics; Narcotics Anonymous (NA), for individuals who have problems with other drugs in addition to alcohol; Gamblers Anonymous (GA); and Adult Children of Alcoholics (ACOA), for individuals attempting to overcome problems related to parental alcoholism. Many other forms of Twelve Step groups exist.

Twelve Step programs utilize twelve steps as guidelines to recovery, which are based on the twelve steps of Alcoholics Anonymous (Alcoholics Anonymous, 1976).

The twelve steps, as originally articulated by the founders of AA are:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people whenever possible except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.