The evolution of the narrative metaphor when chemical dependency is the dominant plot

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The evolution of the narrative metaphor when chemical dependency is the dominant plot

Justice, Melody M., Ph.D.
Iowa State University, 1993
The evolution of the narrative metaphor
when chemical dependency is the dominant plot

by

Melody M. Justice

A Dissertation Submitted to the
Graduate Faculty in Partial Fulfillment of the
Requirements for the Degree of
DOCTOR OF PHILOSOPHY

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For the Graduate College

Iowa State University
Ames, Iowa
1993

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Introduction and Overview</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Dissertation Format</td>
<td>4</td>
</tr>
<tr>
<td>Literature Review</td>
<td>6</td>
</tr>
<tr>
<td>Foundationalist Perspective</td>
<td>6</td>
</tr>
<tr>
<td>Social Constructionist Perspective</td>
<td>8</td>
</tr>
<tr>
<td>Summary</td>
<td>11</td>
</tr>
<tr>
<td>Disease Model</td>
<td>11</td>
</tr>
<tr>
<td>Systems Theory</td>
<td>14</td>
</tr>
<tr>
<td>Summary</td>
<td>18</td>
</tr>
<tr>
<td>Linguistic Systems</td>
<td>19</td>
</tr>
<tr>
<td>The Narrative Metaphor</td>
<td>23</td>
</tr>
<tr>
<td>The Structure of the Narrative</td>
<td>25</td>
</tr>
<tr>
<td>Dominant plot</td>
<td>25</td>
</tr>
<tr>
<td>Externalizing conversations</td>
<td>26</td>
</tr>
<tr>
<td>Unique outcomes</td>
<td>29</td>
</tr>
<tr>
<td>Landscapes</td>
<td>32</td>
</tr>
<tr>
<td>Landscape of action</td>
<td>32</td>
</tr>
<tr>
<td>Landscape of consciousness</td>
<td>33</td>
</tr>
<tr>
<td>Discourse</td>
<td>34</td>
</tr>
<tr>
<td>Summary</td>
<td>35</td>
</tr>
<tr>
<td>Methodology</td>
<td>36</td>
</tr>
<tr>
<td>Qualitative Methodology</td>
<td>36</td>
</tr>
</tbody>
</table>
iii

Page

Participants 38

Subject criterion 39

Subject characteristics 39

Sample size 40

Setting 41

Therapist 41

Procedure 42

Data Collection 47

Trustworthiness 49

Credibility 50

Transferability 53

Dependability 53

Confirmability 54

Data Analysis 54

Domain analysis 55

Steps of domain analysis 56

PAPER I. THE NARRATIVE METAPHOR: A DIFFERENT STORY FOR CHEMICAL DEPENDENCY

ABSTRACT 59

NARRATIVE METAPHOR 61

DISEASE MODEL 63

Comparison with the Narrative Metaphor 64

SYSTEMS THEORY 73

Comparison with the Narrative Metaphor 74

DISEASE MODEL AND SYSTEMS THEORY INTEGRATED 81
INTRODUCTION AND OVERVIEW

General Introduction

Over the past 30 years many approaches have been developed to work with chemically dependent individuals. Of those approaches the disease model (12 step) is the most prevalent.

However, research has indicated that the 12 step model has limited effectiveness. Evaluations of treatment programs show that a large number of patients drop out before completion and many that complete treatment continue to use (Moos & Finney, 1983; Selekman & Todd, 1991). Other research indicates that relapse rates after the first year of treatment range anywhere from 60% to 90% (Selekman & Todd, 1991). Another phenomenon that clinicians in the field are familiar with is the "revolving door"--patients who enter treatment two, three and four times.

As treatment centers looked for ways to increase their effectiveness with the problem of chemical dependency, interest turned toward the family's influence with the problem. Consequently, systems therapist started working with the chemically dependent population and their families.

Studies indicate that family therapy is no more or no less effective than the disease treatment approach. Although all the studies fall under the general heading of family therapy, the techniques, (i.e., structural, strategic,
Bowenian, brief, etc.), applied were quite different (Zweban & Pearlman, 1983). Consequently, no model of family therapy appears dominant at this time.

Both the 12 step model and family systems therapy tend to de-emphasize the individual's story about the experience with chemicals. This often leads to a struggle between the individual's worldview and the therapist's theoretical orientation. When this happens the individual does not feel understood or that the therapist has a predetermined agenda. As such, there is a growing interest in goodness-of-fit models for understanding the interplay between individuals, family and environment (Steinglass, 1981).

This dissertation takes the alternative format of an introduction plus two separate articles intended for publication. The articles present and develop a model of therapy, (narrative metaphor), that has not been used with the chemically dependent population.

The narrative metaphor of therapy is a model based upon social constructionism and the pioneering work of Anderson and Goolishian (1991). White took the theoretical approaches and developed a "how to" clinical model (White & Epston, 1990). White has used the narrative metaphor with varying presenting problems. However, the narrative metaphor has not been used with the chemically dependent population. Consequently, no research applies White's narrative metaphor with individuals presenting chemical dependency as their dominate plot.
The model uses ethnographic information from each individual in the therapeutic process. The information from the individual allows the individual and therapist to co-create a narrative about chemical dependency that is unique and non-problematic for the person. The narrative metaphor, will move beyond the current tug-of-war between systems theory and the disease model and the struggle between individual and therapist.

In this research, article one argues how the narrative metaphor provides a better therapeutic fit for individuals presenting chemical dependency as their concern. Article two is interested in how individuals experience the narrative metaphor when chemical dependency is the presenting problem. By developing a narrative about the individual's experience of the therapeutic process the research was able to further develop the model so it is useful with the chemically dependent population.

The articles are based on a qualitative study using the narrative metaphor with clinical cases presenting chemical dependency as their dominant plot. Qualitative research was chosen because of its focus on process, meaning given to lived experiences, multiple perspectives and attention to context (Marshall & Rossman, 1989). In addition, by directly interacting with the individual, the researcher had the ability to clarify information that would have otherwise escaped the standard paper-pencil questionnaire.
Dissertation Format

The dissertation consists of an introduction and literature review, methodology section, two articles and a general summary. The literature review provides an overview of the differences between the disease model and systems theory. From this review a social constructionist informed narrative metaphor for conversing with individuals presenting chemical abuse as their dominant narrative will evolve. This is followed by a methodology section that outlines the qualitative procedures followed in the research.

The first article critiques the disease model and systems theory in order to demonstrate how the narrative metaphor fills the gaps left by both models. It takes family systems theory and the disease model past their current position of antagonists. The narrative metaphor allows families to co-create a narrative that is a better fit for their experiences without forcing them to adopt either the disease model or systems theory. The narrative metaphor also eliminates the need for the therapist to persuade the family to give up their old views and see things his or her way. The therapist taking this perspective no longer takes an expert stance. This article was written for the Journal of Strategic and Systemic Therapies.

The second paper illustrates how the narrative metaphor looks and sounds in the therapeutic context. Ethnographic interviews were used to obtain individual's perceptions of the
therapeutic process and domain analysis was used to analyze the data. From the analysis of the data, questions were developed that were helpful when chemical abuse was the dominant plot.

The questions move the individual past a problematic position with chemical dependency and start to generate a new narrative. In addition, the questions generate new information that allows the therapist to move past his or her conceptualization of chemical dependency. This article was written for the *Journal of Marital and Family Therapy*.

Following the two articles is a general summary. The reference list includes material for the general introduction, literature review and general summary.
LITERATURE REVIEW

Foundationalist Perspective

Historically the mental health field has adhered to a foundationalist perspective. A foundationalist perspective follows the ideal of a formal mathematical system of description and explanation and is interested in scientifically verifiable objective knowledge. According to Bruner, (1986) application of the paradigmatic or foundationalist perspective leads to sound theory, tight analysis, logical proof, sound argument and empirical discovery guided by reasoned hypothesis.

On a large scale, the foundationalist perspective deals in general causes and in their establishment, and makes use of procedures to assure verifiable empirical truths (Bruner, 1986). Consequently, this perspective believes that there is an absolute reality and therefore, absolute truths.

Foundationalism, is based upon three general premises; objectivity, essentialism and representationalism. These combine to draw a picture of the world that has a correctness and is knowable.

The first premise, objectivity, alludes to the belief that there is a "truth" without bias and that some place "out there" an absolute truth exists. The "truth" domain is defined by observable facts and by the set of possible worlds that can be logically generated and tested against observable
"truths" (Bruner, 1986). The universe, in regard to "absolute truths" is static, and the bias of the observer can be minimized or eliminated. In this way, an observer has no affect on the truth because what is known as the "truth" is independent of the person.

Consequently, a therapist working from a belief in objectivity assumes that the clinician remains apart from the therapeutic process and objectively observes the patient. The clinician is in possession of an unbiased truth about how patients or families should function. Ultimately, the therapist's job or goal is to instruct these patients in order for them to see "reality" or the "truth."

Essentialism is the belief that there are universal basic elements of human behavior. Understanding of behavior comes from breaking behavior down into these universal elements and then putting it back together again. Essentialism makes the assumption that there is an underlying structure that determines if the individual will behave and interact in a "normal" or a pathological fashion.

The clinician would attempt to explain the meaning of the patient's story with regard to a normative structure concerning what makes individuals or families work (Parry, 1991). The therapist possesses superior knowledge and does something to the patient, to make the patient "normal" or better. In other words, the clinician has the ability, knowledge, and power to fix the patient.
The foundationalist perspective is also based on the premise of representationalism. This means that the descriptions of experiences are only a reflection of life and have no affect on the individual. It is the underlying structure of the system that affects how the individual or family will behave, think and feel.

The clinician looks for underlying pathology that affects the patient and makes "normal" behavior or thought difficult. Problems for individuals surface when the individual no longer is in touch with reality, or fails to see the "truth."

Therefore, a person's story is categorized according to the degree to which it exemplifies an inconsistency from the norm. Pathology is seen when the discrepancy is outside of the "normal" range.

Essentially, the desire of the foundationalist to be under the mantle of science established a two-tiered approach. The patient's story is on one level and the scientific explanation of what the story "really" exemplified, is on a higher level (Parry, 1991).

Social Constructionist Perspective

Another view of the world is from the social constructionist perspective. This perspective does not postulate about ultimate "truths" and one "reality." The perspective is not interested in developing well formed arguments to convince one of the "truth." Social
constructionism contends that realities about relationships exist in the eyes of the observer and are brought forth through languaging about them.

The social constructionist perspective believes that human behaviors and interactions fit better within a narrative conceptualization because language has the capacity to create and stipulate realities. The social constructionist perspective is interested in the effects of the individual's narrative, not searching for the "truth." From this perspective it is more important to convince one of the likeliness versus the "truth." As Bruner (1986) stated, the narrative mode leads instead to good stories, gripping drama and believable (though not necessarily "true") historical accounts.

Thus, it is our narratives that determine how we view the world, how we talk about the world in general, how we talk about our specific experiences, the way we ask questions, give meaning to events, how effects are experienced and how we construct our reality. In a sense, the picture we have of our self is co-authored during the process of conversing with others (Fine & Turner, 1991).

In order for individuals to make sense of the world in general and of themselves, they must somehow find a way to arrange experiences in a sequence that is coherent and plausible. These events must be arranged in a sequence that connects experiences in the past, present and allows for
prediction of future events. Bruner (1986) reminds us that every telling of a narrative is an arbitrary imposition of meaning on the flow of memory. Individuals highlight some events while others are discounted. Thus, every telling is interpretive and this connection of events is the individual's attempt to make sense of the world.

Even though individuals have narratives that give meaning to and shape their lives, these narratives are rarely just made up internally. Narratives are not created in a vacuum, they are influenced by a larger dominant plot that is told by the culture we are a part of. Learning how to use language involves both learning the culture and how to express intentions in congruence with the culture (Bruner, 1986). Nevertheless, each person gives unique meaning to his or her lived experiences and thus tells a unique narrative.

Social constructionism, then, is founded on the premise that descriptions shape life. The perspective argues that in order to make sense of our lives and express ourselves, experiences must be storied. It is through the telling of stories that meaning is ascribed to experiences (White & Epston, 1991). The stories or descriptions go beyond mere representation because they have very real affects and consequences.

In addition, all stories or descriptions are not equal or as good as another due to their real effects. For example, a story of Hitler is not equivalent to a story of
Mother Teresa. The effects and consequences of each story are dramatically different.

Summary

Bruner (1986) summed up the basic differences between the two perspectives as a contrast between two epistemological questions. The foundationalist perspective would be interested in the question, How to know truth? The social constructionist perspective would be interested in the broader question of, How do we come to endow experience with meaning?

The foundationalist perspective and the social constructionist perspective differ on various assumptions and beliefs (see Table 1). These differences lead to epistemological differences and then to different therapeutic models. The following section will describe the different therapeutic models that emerged from the two different perspectives.

Disease Model

The most pervasive conceptual viewpoint of chemical dependency is the disease model. This model is based on the foundationalist perspective. The disease model was first developed to work with the alcoholic population. However, as the use of drugs became a problem in society, the disease model was adapted to work with all chemicals.
In this model an alcoholic is a person who defines him or herself as alcoholic, has lost the ability to control drinking so that one drink sets off a chain of drinking, and has an inability to abstain from drinking for any continuous period. This model views the addictive process as a distinct entity and a treatable illness. Chemical dependency is a chronic, progressive disease.
For example, chemical dependency is a disease of time. Chemicals distort the feeling of time, it speeds it up then slows down. Chemical dependency is also a disease of relationships. The chemically dependent individual manipulates the spouse, teaches the spouse how to be an enabler, and ultimately the spouse develops an enabling identity.

Since chemical dependency is viewed as a disease, phases of the disease have been identified (Davis, 1980). The first stage is Prealcoholic. In this stage the alcoholic associates drinking with relief from stress. The second stage, Prodomal, is when the drinker begins to experience blackouts and loss of control over drinking. The third stage or Crucial stage finds the alcoholic frequently losing control and unable to go for long periods of time without drinking. In the final or Chronic stage the alcoholic begins morning drinking and needs to drink every four or five hours.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) hold a preeminent position in the overall effort to treat chemical dependency. It is a society of preexisting chemically dependent individuals organized around the principles of recovery contained in the texts of AA. The primary principle asks the individual to make a leap of faith and come to believe in a power greater than him or herself. Followers strongly believe that abstinence is the only way to recover. The 12 step model of AA or NA is based on the
disease theory of alcoholism and can be summarized as follows (Davis, 1980):

1) Chemical dependency is a threefold illness involving emotional illness, physical deterioration, physical addiction as well as moral and spiritual emptiness on the part of the person.

2) Chemically dependent individuals have an obsessive craving for chemicals that produces an allergic reaction in their bodies.

3) Chemically dependent individuals have lost the ability to control their using or to stop using by themselves.

4) Self-pride, self-delusion and denial are central to the disease.

5) Recovery requires abstinence. No dependent individual can ever return to controlled social use.

6) Recovery requires an admission of powerlessness over chemicals and a willingness to admit a power greater than oneself into one's life.

7) A destruction of the dependent ego is required if recovery is to occur.

8) Surrender will eventually be accomplished by a conversion to a spiritual way of life.

Unless patients stop using they will pass through the stages of the disease outlined above. If the patient never stops using, it might be fatal.

**Systems Theory**

Systems theory views complex human behavior from the perspective of interactive processes rather than identifying a specific cause for behavior located within an individual. Numerous factors in an individual's environment in interaction with the biological reality will ultimately
affect whether chemicals are used problematically (Bepko, 1985). Family systems focuses on the relationships among family members and the function chemical abuse plays in maintaining behavior patterns in the family system. Chemical use is not incidental to interactional issues, but rather, is of central importance in maintaining interactional equilibrium (Davis & Klagsbrun, 1977).

Kaufman (1985) maintains that chemical abuse might not be just an individual, marital or family systems problem, but might reflect a chemical abusing generating family system. That is, chemical dependency patterns that are maintained in one generation are passed down intergenerationally.

Since family survival (family homeostasis) is paramount to the family, maladaptive behaviors might be enlisted to maintain the balance. The slightest change calls for a reaction that maintains overall stability within the family's internal environment (Steinglass, Bennett, Wolin & Reiss, 1987). In many families emphasis is placed on short-term stability of family life. Families often misinterpret normative developmental changes, assuming that they are unacceptable threats to the overall homeostasis (Steinglass, Bennett, Wolin & Reiss, 1987).

The behavior of the chemically dependent individual serves an important protective function to help maintain the homeostatic balance of the family system (Stanton & Todd,
1982; Treadway, 1989). In this way, the using behavior becomes integrated into the family system and becomes part of the family's life and stability. Systems theory focuses on the identification of the adaptive and stabilizing functions that chemical dependency plays in the family system as well as the disruptive functions (Vannicelli, Gingerich & Ryback, 1983).

In the system organized around chemical use, all members of the family are affected. The family's self-corrective behaviors are generated by patterns of feedback that originate in relationship with the chemicals (Bepko, 1985). During the adaptation to the presence of the chemicals and in the efforts to understand the using behavior, the behavior of the family becomes more limited (Borwick, 1991).

Unfortunately, these maladaptive patterns solidify and become part of the everyday pattern of family life. As the chemically dependent person becomes more ritualized in chemical use, the family members also become more ritualized in behavior supposedly intended to control the using behavior (Borwick, 1991). The using problem appears to take on a life of its own, and family members appear to be unaware of the ways in which they participate in the accommodation of the using.

Since the major perpetuation of using patterns is the overriding need for the maintenance of the status quo, the addiction cycle becomes part of a family pattern. The
pattern involves a complex system of interlocking feedback mechanisms that serve to maintain the addiction and consequently, the overall family stability (Stanton & Todd, 1982). As such the presence or absence of chemicals becomes the single most important variable determining the interactional pattern between members of the family.

Chemically dependent families exhibit different patterns of behavior depending upon whether the individual is intoxicated or sober. Until sobriety, a stable drinking family could choose either using or non-using behavior patterns in a stressful situation. However, during sobriety the family members becomes restricted to only non-using behaviors.

Thus, the struggle toward sobriety creates change and upsets the family system causing dysphoric effects for the identified user as well as the entire family (Steinglass, Bennett, Wolin & Reiss, 1987; Usher, Jay & Glass, 1982; Vannicelli, Gingerich & Ryback, 1983). This means that the family's survival is threatened since previous family survival was based on the using interaction. The family system is unable to self-correct until the next using episode. Unfortunately, this might mean that the family will overtly or covertly encourage the user to begin using again.

In general, families adjust to chemical dependency by adapting interactional behaviors to minimize the impact upon family life. In doing so, chemical dependency becomes more
and more a part of everyday life. Marital and family conflicts may evoke, support and maintain chemical dependency as a symptom of family system dysfunction, or as a coping mechanism to deal with family dysfunction. On the other hand, conflicts may be a consequence of dysfunctional family styles, rules and patterns of alcohol use (Kaufman, 1985; Kaufman & Pattison, 1981). Therefore, chemical use is both the cause and the effect of family dysfunction.

**Summary**

Although there has been an increasing interest in the affect of family therapy with chemically dependent families, consistent research is still lacking. Never-the-less, the few studies that have included the family or significant other support the notion that the family has a significant role in treatment outcome, maintaining chemically dependent behavior, encouraging relapse and in cross-generational transmission of chemical dependency. However, most research indicates that current family therapy is no more or no less effective than the disease treatment approach (Zweben & Pearlman, 1980).

On the other hand, studies have also failed to show that the traditional disease model completely explains or eliminates chemical dependency. Studies have not been able to demonstrate that chemical dependency follows any identifiable path in its development or that it is a unitary entity. Studies have also found a lack of empirically demonstrated internal mechanisms that would account for the chemically
dependent person’s loss of control (Selekman & Todd, 1991).

There needs to be a consideration for the links between biological, psychological and environmental factors in assessing an individual (Moos & Finney, 1983). In this way, the individual’s total context is considered in order to plan an intervention. Research has shown that a genetic factor or psychological mechanism is insufficient to account for the reinforcement of continued chemical abuse (Davis & Klagsbrun, 1977). As such, the focus of treatment should be much more than simply eliminating the drinking.

These studies provide support for broadening the provisions of treatment. However, there are differences in how the disease model and systems theory conceptualizes chemical dependency and each is spending energy trying to persuade the opposing conceptualization of its usefulness (see Table 2). Consequently, interest is turning toward models that move beyond the stalemate of disease theory versus systems theory.

Linguistic Systems

Goolishian and Anderson (1992) were two of the first family therapists to move beyond viewing the problem as serving a function for the system. They began to understand human behavior from the domain of language. Since that time, other theorists have added to the body of knowledge.
Table 2. Comparison of Disease Theory and Systems Theory

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Disease</th>
<th>Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Origin of *CD</td>
<td>Single entity</td>
<td>CD generating systems</td>
</tr>
<tr>
<td>Maintenance of *CD</td>
<td>Underlying pathology</td>
<td>Serving function</td>
</tr>
<tr>
<td>Course of *CD</td>
<td>Predictable process</td>
<td>Circular pattern</td>
</tr>
<tr>
<td>Therapist</td>
<td>Expert</td>
<td>Observer in system</td>
</tr>
<tr>
<td>Solutions</td>
<td>Identify pathology correct diagnosis treatment</td>
<td>Interrupt interactional patterns</td>
</tr>
</tbody>
</table>

*CD - chemical dependency

The language domain draws upon the theories of social constructionism and the interpretive sciences as one way of talking with and understanding human systems and the problems they present (Anderson & Goolishian, 1991). This theoretical stance represents a post-modern shift. The theme of which is an interpretation of an experience. This means, that one cannot have direct knowledge of the world.

The interpretation is not independent of the individual nor is it constructed internally. Knowledge or the meaning given to the world and oneself is created through interaction between individuals (Anderson & Goolishian, 1991).

It is through dialogue that human systems mutually evolve their own language and confirm its meaning. It is in
language that humans are able to maintain meaningful contact with each other and through which realities are shared (Goolishian & Anderson, 1988). Thus, human action takes place in a reality that is created through social construction and dialogue. Consequently, language is a dynamic, social operation. This means that there is not an ultimate or correct reality, but multiple stories that describe multiple realities of shared experiences.

It is through story telling that individuals describe their past, present and future experiences. This means that in order to make sense of a situation or experience, a story must be told.

It is through this telling and retelling of the story that experience is given meaning. Hence, meaning is created through language and through language problems change (Coale, 1992). Anderson and Goolishian (1991) contend that problems are no more than socially created realities sustained by behavior coordinated in language. That is, through conversation problems are created and maintained.

Therapy is seen as a linguistic event that takes place in a therapeutic conversation. The therapeutic conversation is a mutual search and exploration through dialogue evolving toward the dissolving of problems and the dissolving of the therapy system. The role of the therapist is that of a master conversationalist. The therapist creates space for and facilitate a therapeutic conversation in which new
meanings emerge. In this way, the therapist and the client co-create new meaning in order to move beyond an old problem.

In this view, change is understood to require communicative action, dialogue and discourse. It is through the exploration of the problem that new descriptions and meanings emerge that are no longer labelled a problem. This is seen as the process of change.

A therapist working in this framework believes that the therapist and client jointly participate in creating the problem definition. This does not mean that there must be a consensus between all involved. On the contrary, consensus regarding the problem is rarely achieved. There are as many definitions of the problem, as many realities about it, as there are members of the language system (Anderson & Goolishian, 1991). Consequently, there is more value in talking about the problem from a multiple reality perspective rather than talking about a problem as a single reality.

Therefore, the therapist wants to know what each member of the system thinks about the problem. In this way the therapist and each member are in the process of creating the problem that is worked on in therapy. By engaging in the therapeutic conversation the therapist becomes a member of the problem system. The therapist becomes as equally and actively responsible for the co-creation of the problem definition and the remedies as the client (Goolishian & Anderson, 1992). This happens when, the therapist and the
client come together in dialogue in which neither maintains an independent meaning structure and each is seen as mutually effecting the other. In short, all of therapy is a dialogue and it is through the co-creation of narratives that a therapeutic reality is created and subsequently changed.

The Narrative Metaphor

White took the theoretical approaches of social constructionism and linguistic systems and developed a clinical "how to" model (White & Epston, 1990). The model is based upon the individual and therapist co-creating a narrative.

In order to create some sort of structure for our experiences a narrative is created. It is through the narrative that meaning is ascribed to past experiences, present experiences and an interpretation of future experiences. White and Epston (1991) contend, that since all stories have a past, present and future, then the interpretation of current events is as much future shaped as it is past determined.

The structuring of the narrative requires the use of a selective process in which we eliminate from our experience events that do not fit with the dominant evolving stories that we and others have about us (White & Epston, 1991). Consequently, only those experiences that confirm the evolving story are acknowledged. Those experiences that
contradict the evolving story are ignored.

Consequently, some experiences are selected to be attended to and others are ignored. Bateson (1972) argued that events that cannot fit into the dominant plot are not selected for survival. Such events will not exist for us as facts. It is in the stories that we have about ourselves that this selection process takes place. Only the experiences that get selected, are the experiences that get expressed.

As this selection process continues to take place, the narrative about an individual's life is created. Through the plotting of experiences into a narrative, meaning is derived and given to the individual's life. Since the stories that individuals have about their lives determine the ascription of meaning to experiences and the selection of those experiences that are to be given expression, these stories shape individual's lives (White & Epston, 1991). That is, the narrative is not just a description of life, the narrative actually shapes life and relationships.

Bruner (1986) contends that it is in the performance of an expression that we re-create, re-tell and re-construct our culture. It is not that the performance releases some pre-existing meaning that lies dormant in the narrative, but rather the performance itself is constitutive. With each performance people are re-authoring their narrative and with each telling the narrative becomes more than what it was previously.
The Structure of the Narrative

The process of therapy is co-creating a new narrative. In order to create a narrative, White has developed a structured model that incorporates all the elements of a narrative (White & Epston, 1990). In other words, the conversation is not free floating. There is structure and components that must be included in order to develop a narrative.

Dominant plot

In therapy, the dominant plot is the theme or connection between events that is causing the individual or family a concern. This plot tends to be so dominating it oppresses alternative memories or experiences, and in so doing, it oppresses alternative ways of being. Consequently, the individual or family starts talking in terms of always and never with regard to the problem.

In addition, when the dominant plot starts to be experienced as problematic, individuals tend to get into internalizing conversations. That is, the individuals or family tends to view the "problem" as something internal to an individual. When this internalizing of conversations starts to take place, it tends to perpetuate the problem. Therefore, the first step in the narrative process is to externalize the problem through what White and Epston (1991) call externalizing conversations.
Externalizing conversations

The goal or purpose of externalizing conversations is to converse with the individual in such a way that the "problem" can be seen as external from the individual. It is almost as if the problem becomes an object that is external to the individual and is described in a like manner. This objectification of the problem, begins the deconstruction of the problem-saturated dominant plot (White & Epston, 1991).

In this way, the individual is engaged in a conversation that describes the problem as separating from his or her relationships and life in general. The externalization of the problem allows for a less rigid or fixed viewpoint; it allows for the possibility of change in a situation that was before perceived as an internal, fixed problem.

Even though the problem was defined as internal to one individual, it affects each family member. Family members define their relationships according to the problem, attempt to find solutions for the problem or even blame themselves for the existence of the problem.

In order to externalize the problem or concern, the therapeutic conversation begins by mapping the affect. This is done through a general interviewing process referred to as "relative influence questioning" (White & Epston, 1991). That is, the conversation revolves around how and in what ways the problem has affected each individual. This helps the individual to identify the range of influences the problem has
The therapist asks questions such as, "In what ways has the drinking affected you, how has it affected your relationship with your wife, relationships with peers and other important communities? The conversation also includes how or in what ways the problem has affected the way an individual thinks about him or herself as an individual and as a family. This description is usually much broader than just the description of the problem as internal to the person. Rather than restrict the investigation of the effects of the problem to the relationship between the problem and the person who has the problem, externalizing questions identify the effects of the problem between the problem and various persons and between the problem and various relationships (White & Epston, 1990).

After the narrative starts to include ways in which the problem has affected each family member, the conversation turns to an evaluation of the affect. In other words, the therapist asks the individual to take a stance on the effect, positive or negative. Many times other family members have evaluated the effect and taken a position but the individual has not. This also ensures that the therapist is always working from the position of not knowing rather than knowing. All too often, the therapist makes assumptions that all the effects of the problem are negative since the individual came with concerns about the issue.
After the individual has talked about all the effects the problem has had on his or her life, and evaluated each effect, the therapist then begins to converse in such a way as to have the individual justify this evaluation. The therapist is interested to know in what ways the effect was positive or negative. Once again it prevents the therapist from making assumptions and invites the individuals to expound on their narrative.

By entering into a conversation with the individual that centers on what affects the problem has had on the individual, evaluating each effect and then justifying the evaluation, the conversation starts to externalize the problem. The individual has now entered into and joined a narrative that is starting to talk about and give new meaning to an old plot. Once a problem becomes external, it is easier to find solutions.

A second set of questions that the therapist uses to help externalize the problem are questions geared toward mapping the influence of the person. These questions invite persons to map their influence, and the influence of their relationships in the life of the problem (White & Epston, 1991). The questions help individuals and families to identify strengths, and resources that they have successfully used in the past. This information helps to contradict the narrative that has a problem-saturated oppressive dominant plot. Thus, the narrative starts to encompass a broader scope
of memories and allows unique outcomes to be appreciated.

In a narrative conversation the individual and therapist participate in a conversation that storys about the problem in a unique way. It is through the process of externalization that individuals gain a new perspective on their lives. New options become available in challenging the "truths" that previously had defined the individual and his or her relationships (White & Epston, 1991). Individuals are then able to start defining themselves and their relationships in new and nonproblematic ways.

The externalizing of the problem allows individuals to separate from the dominant story. In the space established by the separation individuals are freed from problem-saturated descriptions of their lives and relationships, encouraged to generate alternative and more rewarding stories of lives and relationships and assisted to identify and develop a new relationship with the problem (White & Epston, 1991).

Unique outcomes

As can be seen, externalizing the problem allows the person to separate from the dominant plot that has given meaning to his or her experiences. Ordinarily this is very difficult to do. However, once the person has separated from the dominant plot, previously neglected aspects of his or her experience is identified (White & Epston, 1991). These neglected aspects are what White and Epston have called unique outcomes.
Unique outcomes are those experiences that go unnoticed because they either do not fit within the dominant plot or they contradict the dominant plot. The outcomes are the entry points that can be used to stimulate alternative narratives.

Unique outcomes can be identified in the past, present and future. They are identified by encouraging the person to remember past events or times that contradict the dominant plot. These past outcomes facilitate performances of new meanings in the present; new meanings that enable persons to reach back and re-vision their personal and relationship histories (White & Epston, 1990).

Current unique outcomes are identified during the course of an individual therapy session when an individual behaves in a manner that contradicts the dominant plot. The therapist comments on this unique behavior and asks that the individual or family make sense of this unique event. Since these unique outcomes occur during the therapy session, they are directly available to persons for the performance of new meaning (White & Epston, 1990).

White and Epston (1990) also talk about unique outcomes that can be identified in the future. These are identified through a conversation about future plans, intentions and hopes of escaping the problem.

The therapist asks questions that move the conversation back and forth between past, present and future. An outcome in the past is framed as a precedence for the present unique
outcome. A unique outcome in the future is framed as a present act of defiance against the oppression of the "problem." A unique outcome in the present is an indication that the person has done something in the past to get ready for the future.

The moving back and forth between the past, present and future helps persons to identify outcomes throughout their life. By moving back and forth between time frames, the individual is assisted in identifying a pattern of events over time. This pattern over time can then be provided with meaning, rather than just being a random event. With the performance of new meaning around these unique outcomes, persons are able to identify their resistance to the problem across time (White & Epston, 1991).

The therapist enters into a conversation that opens up space and allows the individual to identify these unique outcomes. These outcomes must be significant to the individual or they will not contradict the dominant plot. The individual and therapist converse in such a way that they begin to be plotted into an alternative story or counter plot. In this way, the individual is an active, not passive, participant. The counter plot must develop a narrative that allows the individual to make sense of the unique outcomes and is in sharp contrast against the dominant plot. In response to the invitation to attend to unique outcomes, family members begin to entertain new descriptions of self, others and their
relationships (White & Epston, 1990).

**Landscapes**

In order to facilitate unique outcomes and create an alternative narrative, the therapist converses in a manner to structure a narrative. This is done by borrowing from Bruner (1986) what he considered to be the two simultaneous landscapes of a story.

**Landscape of action** The landscape of action contains the intention or goal, the situation and something corresponding to a "story grammar." It is in the landscape of action that there are four essential ingredients to the story. If any one is removed, the story or narrative ceases to exist. Landscape of action contains events that occur in a sequence over time with a common plot connecting them. When the individual has a problem the plot of the story contains a plight into which characters have fallen as a result of intentions that have gone awry, either because of circumstances, interaction or a combination of the two (Bruner, 1986).

The therapist's goal is to start conversing about events that occur in a sequence over time with a common plot connecting them. Only this time, the events are unique outcomes and the plot is a counter plot to the dominant oppressive plot. Questions are aimed at bringing forth the recent history and distant history of unique outcomes that relate to the problem.
When unique outcomes are found they are given a new name, one that differs from the name of the old dominant plot. The name of the alternative plot is important. It contributes to a sense of life going forward in preferred ways, gives meaning to experiences that would otherwise be neglected, helps sort and link events that take place between sessions and provides a sense of knowing what might be the next stop in the preferred direction in life (White & Epston, 1991).

**Landscape of consciousness** This landscape gives information about what those in the action landscape know or do not know, feel or do not feel, think or do not think. The landscape of consciousness comments about such things as desires, qualities, characteristics, purposes, motives, values, beliefs, and commitments. The landscape of consciousness has to do with the interpretation or meaning given to relationships and self derived from reflecting on past events.

Both the landscape of action and landscape of consciousness occur simultaneously in any narrative. At one level there is some sort of action that takes place and on another level there is meaning given to self and relationship derived from the action. Consequently, the narrative or story cannot be understood from just one level, both landscapes must be understood in order to hear the complete narrative.
Discourse

Within these two landscapes of a narrative, Bruner (1986), also talks about three features of discourse that happen simultaneously. These also must be understood in order to use the narrative mode to re-author individuals' and families' lives.

The first feature of discourse is presupposition; the creation of implicit rather than explicit meaning. Presupposition is what is taken for granted, what is expected to be the case (Bruner, 1986). In every narrative or story there is meaning that is conveyed through unexpressed ideas or assumptions made without clarification. This allows for the freedom to interpret or give meaning in various ways. This also leads to mistaken assumptions or interpretations when there is a lack of clarification.

The second feature or element of discourse is subjectification. The view of reality that is depicted through the filter of the consciousness of the individuals in the narrative. In this way, "reality" sounds different from each individual's view, but is connected by common themes. In addition, the depiction of "reality" probably changes over time. The subjunctive mode, then, is to be trafficking in human possibilities rather than in settled certainties (Bruner, 1986). This is in sharp contrast to the view that depicts "reality" as being seen through a lens of timeless universal truth and complete knowledge.
The last element of discourse that Bruner (1986) discusses is that of multiple perspectives. He describes this as the ability to behold the world not univocally but simultaneously through a set of prisms which each catch a different and distinct part of the world. This is what happens when families come in the therapy office and start the telling of their story. Each member is like a prism that catches a different part of the world and is describing what he or she has caught to the therapist. The therapist must have the ability to look through these prisms simultaneously and make no judgement about "truth" or correctness.

Summary

Stories or narratives that people live through determine their interaction and organization. As such, the evolution of lives and relationships occurs through the performance of narratives (Coale, 1992; White & Epston, 1990). The narrative metaphor conceptualizes chemical dependency differently than either the disease model or systems theory. It is language, not some underlying pathological structure or function that determines meaning and constructs relationships.

Consequently, the change that occurs in therapy is the change of meaning derived through dialogue and conversation. The change of meaning then, changes the person's interaction and organization.
Qualitative Methodology

Family therapy researchers have argued for the need to adopt an "observer in the system" perspective in regard to research and therapy (Joanning, Newfield & Quinn, 1989). This is in contrast to the perspective that therapy is seen as something an outsider does to the client in order to produce change or fix the client. Consequently, there has been a call for a research paradigm that is a better fit for the kinds of questions that family therapy researchers are asking.

Moreover, the research paradigm needs to be consistent with the belief about the nature of knowledge that many therapists have in the field of family therapy. Many family therapists assume that there are multiple ways to describe a given event. As more data are collected, more realities will emerge.

The inquiry or observation of a phenomenon, will have an influence on that phenomenon and, thereby change the observed event. Most importantly, it is not possible for any observer to have privileged access to what really happens in the world by uniformly applying a specific method of observation (Atkinson, Heath & Chenail, 1991).

Drawing on traditions rooted in anthropology and sociology, the qualitative research paradigm provides an
alternative to the quantitative research paradigm for exploring social science phenomena (Lincoln & Guba, 1985; Moon, Dillon, & Sprenkle, 1990)

Moon, Dillon and Sprenkle (1990) wrote that qualitative research:

in some ways reflects a phenomenological perspective, attempting to understand the meaning of naturally occurring complex events, actions, and interactions in context, from the point of view of the participants involved. (p. 358)

In short, qualitative research is interested in individuals' experiences, the meaning given to these experiences, and multiple perspectives occurring in the social context. By going directly to the phenomenon under study and observing it as completely as possible, a deep and full understanding is developed. The researcher can probe, ask questions at the appropriate time and be sensitive to nuances of meanings (Allen & Gilgun, 1987). As such, the researcher can gather an abundance of information and then check out interpretations to insure a clear meaning. In this way the participants become co-researchers, not just objects to be observed.

Even though there has been a call for a research paradigm that will be a better fit, most investigations still follow the traditional model of an observer making assumptions based on his or her expert stance. These traditional methods are derived from a linear, reductionist paradigm that assumes there is a "true" social world that
exists independent of each of us.

The narrative metaphor is based on interpretive, constructionist paradigms. The perspective assumes that events will affect individuals differently and how these events are given meaning will shape the individual's life. To this end, qualitative research provides a research method that is at least partially congruent with the epistemology of the narrative metaphor. In addition, qualitative methods tend to be more relevant to the clinician by asking similar kinds of questions that clinicians are asking and to explore these questions in ways that are clinically meaningful (Moon, Dillon & Sprenkle, 1990).

**Participants**

Individuals were selected according to criterion-based or purposive sampling. This method of sampling is one of the most common in qualitative research (Moon, Dillon & Sprenkle, 1990). It provides a broad scope of information with the fewest number of participants. In qualitative research subjects are included according to relevant criteria determined by the researcher based on the data being collected and the emerging research questions (Stainback & Stainback, 1984).

In this research participants were chosen who represent the range of possible individuals seeking treatment in order to insure the usefulness of the therapy model. It is not necessary to gather a random sample because the purpose of
the study is to develop the narrative metaphor with the chemically dependent population. The study was conducted with the permission of the Human Subjects Review Committee of Iowa State University.

**Subject criterion**  The criterion for the sample consisted of individuals who have problematic involvement with chemicals and have completed a traditional chemical dependency treatment program. Problematic involvement included positive drug test at work, operating while intoxicated (OWI), self referral, spousal force and being court mandated. All treatment programs followed the traditional 12 step model with referrals to AA, NA, Alanon, growth groups, co-dependency classes or adult children of alcoholics. Some individuals were involved with numerous "helpers" at the same time.

Individuals were sought who had been in traditional treatment in order to investigate the flexibility of the narrative metaphor with individuals who already had a disease model worldview. In addition, the field is interested in combining the traditional disease model with a therapy that could include the entire family.

**Subject characteristics**  The ages of the adult participants ranged from 22 to 55 years old. Males, females, adults, adolescents and children were included. Including partners and children, 36 Caucasian, two Afro-Americans and one Hispanic individual were involved in the investigation.
In terms of family composition, eight individuals were in their first marriage, one individual was single never married, four individuals were cohabitating, six individuals were in a second marriage, two individuals were divorced and one individual was in the process of a divorce but still lived with his wife. Two families consisted of biological parents and children, three families were blended, one married couple had no children, two married couples had no children living at home, one male had visitations with his children, one male was involved in a custody battle, one female had custody of her children and one female had no children. The number of children that the families had ranged from zero to three and the children's ages ranged from three to twenty two years of age.

In ten cases the male was identified as the chemically dependent person, and in three cases the identified abuser was the female. Participants did not need a significant other involved in therapy, but were invited to include others. Ten of the thirteen participants chose to bring at least one significant other to the sessions.

Sample size Qualitative investigations using ethnomethodology employ small samples, unlike quantitative research that utilizes large samples. A justification for a small sample size is that ethnomethodology requires the investigator to intensively explore the individual's phenomenological experience of chemical dependency and how
the narrative metaphor is helpful. The emphasis is on gaining a thorough description and understanding of the individual's narrative about chemical dependency and the therapeutic process.

Consequently, a sample size was needed that would give the investigator a picture of the range of experiences individuals were likely to report when chemical dependency was their dominant plot. Studies indicate that ten to twelve respondents tend to be sufficient to reach a saturation point (Joanning, Quinn, Thomas & Mullen, 1992). In the study, a total of 13 client units was sufficient to reach saturation.

Setting

The setting has been chosen because it is representative of a clinical therapy office. It is in an office complex containing other businesses. The office suite contains a waiting room and two therapy offices. The majority of therapy takes place with a therapist and client. There were no one way mirrors or recording devices. No other therapists were listening on speakers or calling in on telephones.

Therapist

The therapist involved in the study is a female doctoral student at Iowa State University in the Marriage and Family Therapy specialization. The program has been accredited by the Commission on Accreditation for Marriage and Family Therapy Education. In addition, the therapist is a Clinical Member of AAMFT and is employed full time as a clinical
therapist. She has 4.5 years of experience working with families, of which two years have been working with a chemically dependent population.

All therapy sessions were conducted by the same therapist applying the narrative metaphor. In this investigation, the role of the researcher was that of participant observer. It is quite common in qualitative research for the investigator to assume the role of the participant observer, interacting with the participants over an extended period of time (Moon, Dillon & Sprenkle, 1990).

Procedure

Each participant scheduled an appointment with the clinician at the earliest convenient time. The appointment times ranged from morning into the evening. The appointments were scheduled for approximately fifty minutes on a weekly or bi-weekly schedule, depending on the needs of the individual. The individual attended therapy sessions until both the individual and the therapist felt therapy was completed.

Previous research suggested that the number of sessions would range between six and fourteen with an average of ten (Joanning, Quinn, Thomas & Mullen, 1992). However, the number of sessions depended entirely on the client's needs and were not predetermined.

Each individual met in the same office with the same therapist. When the individual telephoned to set up the appointment an invitation was made to bring along anyone who
might be of help or support.

When the individual arrived, the therapist greeted the individual and escorted them from the waiting room to the office. Once inside, the therapist first asked if the individual had any questions or concerns before starting. Once this was done the therapist asked permission to take notes during the session in order to better help the individual. Once verbal permission was given, the therapist asked the individual what brought them to her office.

The therapist then followed the general format of the narrative metaphor as laid out by Michael White (White & Epston, 1991). However, language and questions were unique to each individual.

The therapist kept a rough outline of the narrative metaphor and recorded individual responses on the form (see Figure 1). This insured that the general format of the narrative metaphor was followed. Throughout the session, the therapist clarified meaning and repeated statements in order to validate her understanding of the individual's meaning.

These open ended questions were asked in order to construct an initial description of the individual's experience of chemical dependency. The therapist kept expanding upon a particular section until the individual had nothing new to add. For example, the therapist might ask, "How is the chemical dependency affecting you?" The individual's answer might further be elaborated on by the
Introduction

What brings you to my office?
You stated on the phone that _____, could you tell me more about that?

Externalize

How is _____ effecting you?
How is _____ effecting your relationship?
In what ways is _____ interfering with your life?
What is _____ having you do against your better judgement?

Evaluate Effect

Is _____ a good or bad effect?

Justify evaluation

In what way is _____ negative?
What makes _____ positive?

Unique outcomes

What could you do to help get your life back from _____?
How has that worked in the past?

Landscape of Action

Can you think of a time recently when _____ was not a problem?
Can you think of a time recently when you were not as _____ you could have been?
How did your past experience help you achieve that?
These events don't sound like they fit with _____, what would you call it?
Who would be least surprised to see you _____?
What do they know about you that would let them predict this?
What specific things have then seen?
Given what you've told me today, what can you say bout the next time something like this happens?

Landscape of Consciousness

What do you think _____ has to say about what you want from a relationship?
What does this tell you about what he values?
What do you think this tells me?
If you were to keep your commitment close to you, what can you tell me about the next event?
How has this changed your belief about self?

Figure 1. Narrative Metaphor Outline
therapist stating, "You mentioned it is affecting your relationship with your husband, in what ways?" The cycle of questions and answers begin to develop a narrative about the chemical dependency experience.

In addition, the therapist took the basic structure of the narrative model and developed questions about the individual's experience of the therapeutic process. She asked questions such as, how is therapy affecting your life? How is therapy affecting your relationship? What has been helpful about therapy? These questions were asked during therapy so that they became part of the process. Questions were developed that explored the individual's understanding of the therapeutic process (see Figure 2). These questions included exploring the effects of therapy, evaluating the effects, justifying the evaluation, exploring landscape of consciousness, describing what was most helpful, describing what was significant and asking for clarification. These questions were asked throughout the entire therapeutic experience in order to keep the total process recursive. In this way, the immediate feedback continually evolved the therapeutic process and kept the therapist out of the expert role.
Externalize

How is therapy effecting you?
How is therapy effecting your relationship?

Evaluate Effect
Is ___ a good or bad effect?

Justify evaluation
In what way is ___ negative?
What makes ___ positive?

Landscape of Consciousness
How has therapy changed your belief about self?
How has therapy changed your belief about spouse?
How has therapy changed your belief about your children?
If this belief stays with you, how will it change your future outlook?

Helpful
What was the most helpful aspect of therapy?
What have we talked about that was the most help?
What made ___ helpful?

Significant
seemed really important when we talked about it, was it? How so?
Other clients have told me that ___ was a turning point, How was it for you?
Looking over my notes you repeated ____, how is that significant?

Clarification
you stated that____ was helpful. What would you call that?
To me that sounds like respect, what would you call it?
If you had to give that a name, what would it be?
These two things seemed to belong together, what do you think?
When you said ____ yesterday, is this what you meant?
Data Collection

The data collection included interviewing and participant observation. In qualitative research interviewing is a good way to learn about the reality of the subjects.

Consequently, the data were collected through moderately structured ethnographic interviews. The central aim of ethnography is to understand the way of life from the native point of view, his or her relation to life, and to realize the native's vision of the world (Spradley, 1980).

In contrast to traditional methods that study people and make interpretations based on the researchers view, ethnographies learn from people. In this way, the ethnographer is the student learning as much as possible from the interaction. In this way, relevant questions are seen to emerge from the interaction process between the individual and the therapist.

The essential core of ethnography is the concern with the meaning given to actions and events by the people we are interested in understanding. The complex meaning system organizes their behavior, helps them to understand themselves and others, and makes sense out of the world in which they live (Spradley, 1980).

The narrative metaphor of therapy relies heavily on the ethnographic interview as the way to gather information and help understand the individual's worldview. Moreover, it
strives to use the interactive process to help the individual create change in life.

In this study the ethnographic interview was conducted by the therapist in order to have immediate feedback within the session. The goals were to understand how individuals experienced chemical dependency and the therapeutic process. With this understanding, the researcher was better able to develop questions that moved the individual past his or her current concern with chemical dependency.

The recursive nature of ethnographies allowed the therapist to obtain information that assisted her in developing questions that would expand and deepen the knowledge about the individual. In this research project, the investigator continually used the individual's language, asked for clarification and examples in order to build a complete narrative.

The researcher also used participant observation to expand the knowledge about the individual. When the researcher observed unique behavior, she commented on it and asked for an explanation. The research did not rely on others observing and making interpretations of the individual's behavior. The investigation was only interested in how the individual constructed reality and how that affected life and relationships. The clinician also asked if what was observed was typical when they were alone, or if having a third party participate had an influence.
Handwritten field notes were used to record the information obtained from the interview. According to Stainback & Stainback (1981) field notes are still the primary way qualitative researchers record the data they collect. Due to the sensitivity of the subject (legal and illegal chemical use) audio or video tapes were not available. Field notes were made in the session, and then notes were made after the individual(s) left the room. In this way, the researcher was the primary research tool.

The field notes were divided into two parts: descriptive and reflective. The descriptive section attempted to record what was said by each participant, paying close attention to the specific words used, and also how words were linked together.

The reflective section was about speculations, ideas or impressions of the researcher. These were speculations about the impact of certain questions, not speculations about what is "really" going on with the individual, or what function the chemical dependency is playing in the individual's life. **Trustworthiness**

Naturalistic or qualitative inquiry has its own set of criteria for adequacy. The criterion are utilized in order to test the trustworthiness of a naturalistic inquiry. The naturalistic paradigm and the scientific paradigm each have corresponding terms that deal with trustworthiness. The naturalistic terms are credibility, transferability,
dependability and confirmability which correspond with the scientific terms of internal validity, external validity/generalizability, reliability and objectivity (see Table 3).

Table 3. Aspects of trustworthiness

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Scientific Term</th>
<th>Naturalistic Term</th>
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<tbody>
<tr>
<td>Truth Value</td>
<td>Internal Validity</td>
<td>Credibility</td>
</tr>
<tr>
<td>Applicability</td>
<td>External Validity</td>
<td>Transferability</td>
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<td></td>
<td>Generalizability</td>
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<tr>
<td>Consistency</td>
<td>Reliability</td>
<td>Dependability</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Objectivity</td>
<td>Confirmability</td>
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(Guba, 1981)

Credibility Naturalistic inquirers are most concerned with testing the credibility of their findings and interpretations with the sources from which data were gathered (Guba, 1981). It is therefore important that there is some type of credibility criterion in order to assess the information that is obtained. In qualitative research there are several ways to assess credibility. In this investigation peer debriefing, triangulation and member check were utilized.
For this study there were two peer debriefing teams. One team consisted of the members of the dissertation committee and the other consisted of a faculty member who works with the chemically dependent population. The debriefing with members of the dissertation committee occurred at irregular time intervals during the study. The second debriefing team met at a regularly scheduled weekly meeting.

Peer debriefing allowed the investigator a chance to discuss her insights and growing questions with other professionals. During the debriefing the researcher would respond to any questions or concerns that the professionals posed.

Triangulation refers to the use of multiple data sources, multiple data collection and analysis methods and/or multiple investigators in order to increase the credibility of findings (Lincoln & Guba, 1985).

For the investigation, data were collected from multiple sources. Multiple participants were used to gather information about their experience with chemical dependency and what questions they found most helpful. This allowed the researcher to look for patterns of similarities in the data. The similarities helped evolve the narrative metaphor with the chemically dependent population.

A second form of triangulation took place with data collection. The data were collected through moderately
structured ethnographic interviews and through participant observation. Both types of data collection aided a thorough understanding of the individual's narrative and immediate clarification. This also allowed the researcher to look for similarities and differences between data collected through different methods.

The last form of triangulation used in the research was investigator triangulation (Stainback & Stainback, 1981). A second researcher read the field notes and a comparison was made between the two investigators conclusions regarding domains. There was a 90% agreement rate between the two researchers. When there was a disagreement a discussion ensued until agreement was achieved.

In order to stay consistent with the narrative metaphor, and be useful to clinical therapists, member check was chosen as another form of corroboration (Stainback & Stainback, 1981). This was the single most important action that the investigator took.

This type of corroboration used the subjects to confirm the accuracy of the researcher's field notes of a session and the material collected over time. It was the individual, not the researcher who ultimately made the decision on the meaning of the data.

The researcher asked questions such as, what did you mean when you said...; is this what you meant when you said...; what would you call...; in order to have the
individual categorize meaning, rather than the researcher imposing her meaning on the individual. This kept the whole process recursive. In this way, it was consistent with the narrative metaphor in continually staying in the position of not knowing and making no assumptions. This also allows the clinician that does not have access to a team to utilize the process.

**Transferability** Naturalistic inquiry is interested in statements that are descriptive or interpretive of a given context; idiographic or context relevant (Guba, 1981). The investigation was not interested in generalizing to the entire population. Rather, the inquiry was interested in transferability to a similar population, specifically a chemically dependent population.

In order to do this a purposeful or criterion based sample was collected (a description of the criteria was discussed under participants). In addition, data were collected that was "thick" in description in order to permit a comparison of this context with other possible contexts to which transfer might be contemplated (Guba, 1981). In other words, a complete story was developed with each individual.

**Dependability** Dependability is the concern with the stability of data, but making allowances for instability due to different realities. One way to increase dependability is to use multiple data collection. As previously described, data were collected through moderately structured
ethnographic interviews and participant observation. The researcher sought consistent patterns and reasonable explanations for differences across data collected from different sources.

In addition, the researcher made an audit trail to make it possible to examine the process whereby data were collected and analyzed. The audit trail includes the field notes from the ethnographic interviews, the interpretations from the sessions and the domain analysis (see Appendices A,B,C,D).

**Confirmability**  
Confirmability is the desire to corroborate the meaning the researcher has derived. In this research, this was done through triangulation, whereby a variety of data sources, multiple investigators and different data collections and methods were used to cross-check data and interpretations.

The most important test for confirmability was once again the member check, checking with individuals to confirm the researcher's perceptions. This continual effort to clarify and test meanings with the subject lead to clearly articulated concepts that fit the meaning individuals gave to their experience of the narrative process.

**Data Analysis**

Data analysis in qualitative research is a continually ongoing activity that occurs throughout the research project.
It involves organization, classification, categorization, a search for patterns and the determination of what further information is required to achieve an in depth, understanding about the topic of concern.

**Domain analysis**

Domain Analysis is a discovery oriented, qualitative method that is context sensitive and focuses on patterns of interaction (Gale & Newfield, 1992). The goal of domain analysis is to understand an individual's experiences through the categories of meaning used to talk about his or her life story. These categories of description evolve during the process of analyzing the data, rather than being hypothesized about a priori.

This perspective is consistent with the narrative metaphor in its belief about the understanding of meaning. Meanings are created through conversation between the participants rather than being "out there" in the world to be discovered by an expert. Consequently, the data were analyzed according the Developmental Research Sequence (DRS) developed by Spradley (1979).

The conversations between the individual and therapist were analyzed by establishing domains of meaning. Domain analysis is a search for characteristic phrases which are included in larger categories by virtue of some similarity.

In order to establish a domain of meaning, three elements need to be identified. One element in the structure
of a domain is a cover term. Cover terms are names for a category of knowledge (Spradley, 1979). For example, fruit is a term for a larger category of knowledge, the various types of fruits, such as apple, orange and banana.

The second element of a domain is two or more included terms. These are terms that belong to the category of knowledge named by the cover term (Spradley, 1979). In the previous example, apple, orange and banana all belong to the category of fruit.

The third feature of a domain is a semantic relationship. The semantic relationship links a cover term to all the included terms. For example, an apple is a kind of fruit. The semantic relationship is, "is a kind of."

**Steps of domain analysis** After the sessions, the handwritten field notes were entered into a personal computer in preparation for analysis. The researcher then went back and underlined characteristic phrases. These were areas of meaning that appeared important to the individual. They were phrases or terms that the individual verbally expressed as important, verbally punctuated or stressed or repeated over and over during the course of a session. The investigator noted characteristic terms such as "understand" and "hopeful" and phrases such as "feel like part of a team" and "you didn't try to intimidate me."

These phrases and key terms were then clustered as similar themes or topics emerged across participants. As the
terms were clustered, cover terms naturally evolved from the included terms. The cover terms defined domains of meaning that depicted a common narrative about the therapeutic process. For example, a cover term was empathy and the statements made during sessions were, easy to talk to, seemed to understand, felt like you cared. In this example, empathy was the cover term, and the three statements were included terms.

The information was continually fed back to the individual in order to verify the researcher's understanding. The individual confirmed or corrected the understanding. In this way, individuals were always in control of their narrative.

Feeding back the information to an individual also allowed the therapist to compare beliefs held by one individual with another individual. For example, "Several other individuals have stated that talking about positive and negative effects was unique for them, how is that for you?"

The common domains began to form the overall ethnography about how the narrative metaphor had affected the individual. In this way, the feedback helped to develop the narrative metaphor by alerting the therapist to common questions or themes that were most helpful.

Even though commonalties were looked for in order to further develop this therapeutic model, the core of the narrative metaphor is the belief in individual narratives.
That is, there might be some similar effects or similar questions that are beneficial, but how the individuals is affected is unique. Therefore, a very unique yet theoretically consistent model of therapy was developed for use with the chemically dependent population.
PAPER I. THE NARRATIVE METAPHOR:

A DIFFERENT STORY FOR CHEMICAL DEPENDENCY
THE NARRATIVE METAPHOR: A DIFFERENT STORY FOR CHEMICAL DEPENDENCY

by

Melody M. Justice

ABSTRACT

This paper describes how the narrative metaphor can create a better fit than the disease or systems model for individuals presenting chemical dependency as their dominant plot. Through the narrative metaphor, therapists and individuals can co-create a unique narrative that allows the individual to tell a story without struggling to fit the disease model or the family systems model. Case material is used to illustrate the effectiveness of the narrative metaphor.
The problem of chemical dependency has received much attention from the family therapy field. Since family therapists use a systemic epistemology to guide their clinical work with chemical dependency, an uncomfortable stance between the traditional disease model and the family systems model can develop. When a family gets caught between the two models, it is like trying to fit into two opposing cultures. In contrast, the narrative metaphor allows the family to tell their story without struggling to fit with either the disease model or family systems theory.

This paper will critique the disease theory and systems theory from the narrative metaphor perspective when the presenting problem is chemical dependency. The article will articulate how the narrative metaphor moves beyond the disease model versus family systems model controversy. The narrative metaphor creates a context that constructs a story driven by the individual's meaning rather than the therapist's values, regardless of the individual's worldview.
NARRATIVE METAPHOR

The narrative metaphor of therapy is based upon social constructionism and the interpretive sciences. In addition, the narrative metaphor can be referred to as a deconstructive method.

According to White's (1991) definition, deconstruction has to do with subverting taken for granted realities and those practices that are subjugating of persons' lives. Deconstruction then, has to do with undermining a person's old, unquestioned and oftentimes problematic ways of giving meaning to experiences.

The narrative a person tells guides the meaning given to an event. Individuals give meaning to their experiences in order to stay consistent with the dominant plot of the narrative. Experiences that do not fit the dominant plot are ignored. Consequently, it is through the narrative that people make sense of their lived experiences.

The narrative metaphor views the therapeutic process as a re-authoring of narratives. In the process of therapy space is opened up so that families and individuals have the flexibility to find new ways of being.

By the re-authoring of the narrative, deconstruction of the dominant plot occurs. Therapists contribute to the deconstruction of the dominant plot by co-authoring an alternative narrative, rather than taking an expert stance.
The narrative metaphor accepts the premise that chemical dependency is a multilevel phenomena. As such, the controversy over the definition of chemical dependency relates to a specific treatment defining one level of the problem as more correct than the other, internal disease versus a problem generating system. Furthermore, it relates to the ability to use language in a way that invests certain words with political and psychological power (Bepko, 1985). For example, the word enabling has changed from a positive adjective meaning to make possible, into a negative word meaning making it easier for the chemically dependent person to continue using. This word carries so many negative connotations related to the chemical dependency field that it has all but been eliminated from everyday language.

The narrative metaphor offers alternatives to the either/or choice of disease or systems theory. The narrative therapist creates a context in which the individual's definitions and meanings of chemical dependency drive the narrative, not the therapist's beliefs.
DISEASE MODEL

The disease model is the most pervasive conceptual viewpoint of chemical dependency. The disease model is based upon the belief that chemical dependency is a chronic, progressive disease. The 12 steps of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are based upon the disease model and are vital components of treatment centers.

However, research has indicated that the 12 step model has limited effectiveness (Selekman & Todd, 1991). Evaluations of treatment programs show that a large number of patients drop out before completion and many that complete treatment continue to use (Moos & Finney, 1983; Todd & Selekman, 1991). Other research indicates that relapse rates after the first year of treatment range anywhere from 60% to 90% (Selekman & Todd, 1991).

The disease model maintains that chemical dependency is a psychiatric diagnosis. This conceptualization contends that the addictive process is a distinct entity and a treatable illness. As such, chemical dependency is thought of as a chronic, progressive disease.

The disease model views chemical dependency as being the same process for every patient. This model assumes it has mapped out all the effects of chemical dependency. If a patient has not experienced a certain effect it is because he or she has not gotten there yet, but given time it will occur.
Patients who relapse frequently are viewed as unmotivated, resistant or not having "hit bottom." In other words, patients are not regarded as suitable for treatment if they display evidence of their diagnosis, namely loss of control (Selekman & Todd, 1991). Patients end up being punished for displaying the symptoms that got them the diagnosis of chemical dependency in the first place.

The disease model maps out the course that chemical dependency will follow, leaving very little room for uniqueness or deviation from the course. The traditional disease model counselor will take an "expert" stance and tell the patient what to expect from the disease, what will happen if abstinence is not maintained and what needs to be done to have a correct outcome.

**Comparison with the Narrative Metaphor**

The disease model has created one generic narrative that is intended to accurately describe every chemically dependent patient's life experiences. The story is viewed as merely a description; it has no affect on the patient's life. The disease model views the narrative as reflecting the underlying pathological structure of the chemical dependency. Therefore, conceptualization of chemical dependency as a disease is a dominant story.

Since the disease model views chemical dependency as the same process for each individual the patient must follow the dictates of the disease model or continue down the course of
chemical dependency. This implies that something has to be done by the counselor to the patient in order to effect a cure. It is an objective, hierarchical, linear cause-effect model.

If for some reason the traditional story does not fit for the patient, then the patient is viewed as failing, not treatment failing the patient. If the patient attempts to view him or herself as different, the patient is told he or she is in denial, is resistant or has not "hit rock bottom."

The narrative metaphor understands that the story an individual tells is not just a reflection or description of life, the narrative actually forms or shapes life and relationships. The story that an individual tells is also unique to that individual and it is impossible to create one narrative to fit an entire population.

The narrative therapist, co-creates a unique narrative to fit the individual. For example, one individual in therapy stated "this therapy is more personal, not the generic this is what chemicals do to families routine." Thus it becomes possible to use the narrative to rewrite or revise the meaning given to the individual's past, present and future experiences.

The narrative metaphor emphasizes that understanding or meaning ascribed to any situation is determined by the premises and presuppositions that a person has about the world (White & Epston, 1990). Accordingly, individuals select
information in regard to purpose. That is, information is selected and interpreted in a way that is in keeping with the individual's or family's taken for granted beliefs about chemical dependency (Parry, 1991). This can be damaging because an individual's belief system will become partially self-validating regardless of its ultimate truth or falsity (Efran & Heffner, 1991).

Consequently, an individual's behavior gets further defined and prescribed by the disease story of chemical dependency. Such beliefs tend to define the limits of what is possible and what is desirable for those who are a part of the story (Parry, 1991). The more accustomed the individual or family members are to the disease model presuppositions, the more restrained they are in seeing alternatives.

Taking a narrative conceptualization of chemical dependency allows for limitless explanations for using behavior. Individuals can talk about common concerns, but the specific affects that chemical dependency has or how the individual experienced it, are very specific to each individual. Since the narrative therapist enters into the conversation with the belief that an individual has a unique story to discuss, he or she is not an expert but rather, a participant in co-authoring a new story. It would be an indication of disrespect by the therapist to make assumptions about the effects of the chemical dependency. As one individual commented, "I've never been asked if the effects
are positive or negative, other therapists just assumed they were all negative." Except in very general terms, it is not possible to predict or know the effects of the chemical dependency in advance of the conversation (White & Epston, 1990).

A narrative therapist is cognizant of the fact that our culture and professional fields are full of labels. Chemical dependency or alcoholism has become one of the most widely used labels in our society. This label is used by the scientific community as well as the general community.

In most instances labels are used in place of the phenomena they seek to explain. It is often forgotten that these labels are a "short-hand" way to converse about the phenomena. When this happens, the labels are talked about as if they are the phenomena, not the label or diagnoses of the phenomena trying to be explained or given meaning. In other words, the label or diagnosis is the name, not the "thing" named.

A narrative therapist is very aware that the diagnoses of chemical dependency is the name of the phenomena and not the actual phenomena. The therapist conceptualizes chemical dependency as a socially constructed story in which there are multiple experiences and multiple realities of the same socially constructed story. The narrative therapist is also aware that the behaviors, effects, and how these are experienced vary from individual to individual.
The narrative metaphor does not make assumptions about labels or diagnoses. When an individual states that he or she is chemically dependent or an alcoholic, the narrative therapist does not jump to any conclusions. In this way, a unique narrative is co-created between individual and therapist. An individual illustrates this with the statement, "... by telling what made it negative it was my story, not the general AA story."

In addition, the terms alcoholism, chemical dependency and substance abuse are diagnoses or labels that have been reified (Effran & Heffner, 1991). When this happens the chemical dependency, appears to have a life of its own. It guides not only the individual's life, but the therapist's beliefs as well. Chemical dependency then becomes more powerful over time, and individuals and families appear to be oblivious to the progressive nature of their co-evolution around the problem definition (White & Epston, 1991). Consequently, the individual or family develops a chemical dependency saturated description of life.

In addition, according to Bateson (1972) alcoholism or chemical dependency could be called a dormative principle, a form of circular description. This occurs when the cause of a simple action is said to be an abstract word derived from the name for the action (Keeney, 1983). For example, a person drinks numerous alcoholic beverages on many occasions, experiences increased tolerance to alcohol and
wakes up in the morning wanting a drink. These behaviors are classified as the diagnostic category of chemical dependency. Then the claim to explain these behaviors as a result of chemical dependency is to invoke a dormative principle. This circular use of the term, chemical dependency is not an explanation for the phenomena. It is another confusion between the phenomena and the name of the phenomena.

This retranscription of the individual's problems into scientific classifications serves to decontextualize problems and thus detract from the available alternative stories the individual might use in order to create new meaning (White & Epston, 1990). These diagnoses or classifications provide definitions that prohibit individuals from examining their relationship with chemical dependency or allowing unique outcomes to be identified. In fact, individuals are discouraged from identifying unique outcomes. Exceptions to the use are viewed as excuses or denial about the chemical dependency. Any attempt in the past to stop using is seen as a failure. It is viewed as just further proof of the existence of chemical dependency.

The narrative conceptualization encourages the therapist to listen to and show respect for the various realities and experiences of each family member. Several individuals have stated that, "we all felt like we had a chance to give input; everyone played a part in the process; each one of us was listened to." The narrative therapist works from a stance of
cooperative co-authoring and mutual respect instead of from a stance of expert knowledge and privileged positions and ideas (Anderson & Goolishian, 1991).

The narrative therapist recognizes that labels or diagnoses only serve to cut off possible alternate stories when trying to create a context in which new meaning can emerge. Using a label means that one is participating in the creation of a problem in such a way that change or new meaning might be made more difficult (Frank & Bland, 1992).

The narrative therapist is continually looking for unique outcomes. A past attempt to stop "using" would be viewed as a unique outcome, rather than talked about as a failure. It is an attempt by the individual to reclaim his or her life from the chemical dependency. For example, some individuals have stated, "it helped us to see we had successes in the past so we can have them in the future; scales aren't all tipped to the problem side of our lives, realized we have positive things; we are more complete people, we still have failures but we also have successes."

The disease model has been successful in developing language and techniques that appear as if the disease model has access to or knowledge about the "true reality" of chemical dependency. The disease model has convinced society that this view is objective and unbiased in its account of the "truth" about chemical dependency.
As such, the disease model of chemical dependency has been assigned a "truth" status in our society. It is assumed to have certain knowledges that construct truths, and can bring about correct outcomes.

The disease model perpetuates the notion of the family having a problem saturated description of life. According to Foucault (1980) any time there is a dominant truth, as with chemical dependency, these truths are actually specifying correct outcomes or particular ways of being. In this way chemical dependency dictates an individual's life and relationships. The designated dependent patient will always talk in terms of the relationship to chemicals; currently using, relapsed, in recovery, an adult child of an alcoholic, a co-dependent, an enabler.

The narrative metaphor views the chemical dependency story not as an individual's complete life story, but only a selection of events that are influenced by the individual's belief about chemical dependency. The narrative metaphor helps the individual to deconstruct the problem saturated description of life. The therapist and individual together create a narrative that is no longer dominated by chemical dependency. Instead, the narrative is dominated by the individual's strengths and a non-problematic dominant plot. Individuals made statements such as "it's nice to stop defining family in terms of alcoholism; it came to me that I'm more than just an addict; I can be more than an alcoholic."
The narrative therapist works from a stance that the diagnosis of chemical dependency that the individual puts forth in therapy has many different realities and affects each individual differently. Through the plotting of experiences into a narrative, meanings are derived and given to the individual's life. The stories that individuals have about their lives determine the meaning given to experiences and which experiences are given expression. The goal of therapy is to open up space to co-create a new reality that allows new experiences and meanings to emerge. In this way each individual can create a new narrative that gives chemical dependency new meaning.
SYSTEMS THEORY

Systemic therapists started working with the chemical dependency population and their families to see if systems theory would be a more effective treatment model than the disease model. Although many therapists consider themselves systemic, the models or techniques applied were quite different, and appear no more or less effective than the disease model (Zweben & Pearlman, 1983). Consequently, no model of family therapy appears dominant at this time.

Family systems focuses on the interpersonal relationships among family members, rather than solely focusing on the individual labeled as chemically dependent. Numerous factors in an individual's environment in interaction with their biological reality will ultimately effect whether chemicals are used problematically (Bepko, 1985).

According to systems theory as the dependency progresses and stress increases, family members adjust their lives into patterns to survive the stress. The addiction cycle becomes part of a family pattern involving a complex system of interlocking feedback mechanisms that serve to maintain the addiction and consequently, the overall family stability (Stanton & Todd, 1982). Chemical dependency has then become an adaptive behavior in the ongoing life of the family (Ablon, 1984).
Systems theory assumes that the major perpetuation of using patterns in families that stay together is the overriding need for the maintenance of the status quo (family homeostasis) that has developed within the family system. As such the presence or absence of chemicals becomes the single most important variable determining the interactional pattern between members of the family.

Since behaviors serve a function for the family, the systemic therapist considers chemical dependency as a maladaptive behavior enlisted to maintain the family homeostasis. In this way, the chemical dependency becomes part of the structure in the family that determines behavior and family interaction patterns.

**Comparison with the Narrative Metaphor**

The systemic therapist talks about the family as having interlocking feedback and homeostatic mechanisms. The implication is that behavior is dictated by the system's structure or the function of the symptom.

When a therapist starts proposing that the client's behavior is serving some function, the therapist has just transcribed the client's story into a more abstract level. This implies that the real significance of what the client is saying means something other than what the client thought it did.

It also implies that the family contains an entity that is a feedback mechanism or homeostatic balance, rather than
the family behaves as if it has feedback mechanisms. The assumption is that the therapist has some expert knowledge about the client and his or her life. The therapist can then prescribe an intervention that has been created.

The narrative viewpoint contends that omitting the as if has a large impact on how the family is viewed. As time passes the omission is forgotten and feedback mechanisms are talked about as an "entity" that the family system possesses. Therapists are encouraged to remember that there is not an "entity" that is family stability. The label is a name for a set of interrelated behaviors.

The narrative conceptualization of chemical dependency understands that the meaning individuals attribute to events determine their behavior, not the symptom's function or the structure of the system. During adaptation to the chemical dependency family members are limited in behavioral choices, through gradual seemingly unconscious adaptation to the premises and suppositions about chemical dependency (Borwick, 1991).

By operating within the narrative paradigm, the therapist works on the same level as the individual, telling and re-telling a narrative. The therapist does not translate the individual's narrative into a more abstract level and thereby change the individual's meaning. The therapist and individual together, change meaning by co-creating a new narrative. Individuals have responded that, "we're in this
together; before I was always told; you became part of our life."

Rather than looking for the function that chemical dependency plays in the family, the narrative metaphor focuses on what chemical dependency needs in order to survive in the family. The family members' cooperative but inadvertent responses to the requirements constitute the chemical dependency's life support system.

The narrative metaphor changes the conceptualization of the location of the chemical dependency. When chemical dependency is viewed as part of a structure or serving a function, it is internal to the system. When chemical dependency is conceptualized as having requirements for survival and affecting individuals and relationships, then chemical dependency is external to the system.

Problems that are considered to be internal are thought of as relatively fixed qualities that are restricting and hard to change. It is difficult for individuals to make changes in a problem viewed as internal. This is particularly the case when they have suffered a longstanding and intractable problem that has eclipsed their life and relationship, like chemical dependency (White & Epston, 1990).

The narrative metaphor works at helping individuals to externalize the problem. White (1990) wrote that
externalizing the problem:

frees persons from problem saturated descriptions of their lives and relationships, encourages the generation of alternatives and more rewarding stories of lives and relationships and assists persons to identify and develop a new relationship with the problem. (p.22)

Individuals then become less transfixed by the chemical dependency and less constrained in their perception of events surrounding chemical dependency. This then opens up new possibilities and allows individuals to be released from the narrow focus of the dominant plot of chemical dependency. As one individual stated, "I feel like I have been freed." When individuals can separate themselves from the problem a new nonproblematic saturated perspective can be developed (White & Epston, 1990).

Systems theory views the struggle toward sobriety as creating change and upsetting the family system causing dysphoric effects for the identified user as well as the entire family (Steinglass, Bennett, Wolin & Reiss, 1987; Usher, Jay & Glass, 1982; Vannicelli, Gingerich & Ryback, 1983). This means that the family's survival is threatened since previous family survival was based on the presence of chemicals. The family system is unable to self-correct until the next using episode.

From the narrative vantage point, sobriety does not threaten family survival, sobriety is viewed as threatening the survival of the chemical dependency. Consequently, the chemical dependency is talked about as trying to encourage
individuals to do things against their better judgement to ensure the survival of the chemical dependency.

Systems theory's time focus is on the here and now. It is interested in what is currently maintaining the chemical dependency, not how it got to be a problem. Within this conceptualization, very little value is placed on history.

In the narrative metaphor, history has value. Only by reviewing history can the therapist and individual find a precedence for preferred ways of being. This allows for the opening of space for unique outcomes. Only by connecting the past, present and future can the therapist and individual co-create a narrative. Otherwise it is only a snapshot of time and a unique outcome can be dismissed as a one time occurrence. Individuals stated that, "it's a relief to see my whole life wasn't a mess; I suddenly realized I'd been an ok person from time to time; we do have a good marriage, we're just in a rough spot."

The systemic therapist's goal is to identify maladaptive behavior patterns that appear to be maintaining the chemical dependency. Systems theory does not usually take into account the effect of altering behavior in other individuals' lives. Systems theory tends to overlook what affects the chemical dependency has on each client. There are negative as well as positive effects. Many therapists make the assumption that the effects are negative because the client is coming in with a concern about chemical dependency.
This can leave the family feeling misunderstood, that the therapist had an agenda, or it might explain the phenomena of the symptom moving to another family member.

The narrative therapist does not make the assumption that all effects are negative. Instead, he or she maps the positive or negative effects of chemical dependency on each individual, and investigates what makes them positive or negative.

Systems theory states that the behavioral interactions create and maintain the problem of chemical dependency. This view tends to encase problems or behaviors in a rigid language structure. In the quest to be precise in describing behavior patterns, people are labeled and flexibility is lost, either in the client's view, the therapist's view or both (Efran, Lukens & Lukens, 1990). The moment behavior gets put into a category, much of it is no longer available for an alternate explanation.

The narrative metaphor contends that languaging about the problem creates and maintains the chemical dependency. With repetition, stories harden into realities, sometimes trapping the storyteller within the boundaries that he or she has helped to create (Efran, Lukens & Lukens, 1990).

Chances of success are increased when a therapist is not too quick to approach chemical dependency as an "entity"; for example, as a family symptom, a function of a symptom or a family typology that a therapist has already created a
solution for (Anderson & Goolishian, 1991). Instead, valuing chemical dependency as a socially created narrative that has multiple experiences and interpretations of the same story, allows the therapist to show respect for the various views, experiences and expertises of each individual (Anderson & Goolishian, 1991; White & Epston, 1990).
DISEASE MODEL AND SYSTEMS THEORY INTEGRATED

There is a push for the 12 step model and systems therapies to merge. Researchers argue that by combining the two, a more effective treatment model will be developed (Steinglass, 1981; Todd & Selekman, 1991). However, there are important differences between the two that makes the integration difficult for therapists as well as the clients.

In systems thinking the chemically dependent client is seen as the labeled victim who carries the symptom for the family. At the same time, family members are protected from their own difficulties in coping with one another and the world around them by the chemically dependent behavior (Steinglass, Bennett, Wolin & Reiss, 1987; Vannicelli, Gingerich & Ryback, 1983). Thus, it is the interaction that is of importance not the individual behavior.

Since systems theory contends that change occurs at the family level the definition of the chemical dependency population changes. Non-using family members must also be involved in the therapy. This is thought to successfully reduce using while at the same time maintaining the family structure.

The traditional disease model conceptualizes change at the individual level. Family members are involved with treatment for limited or educational purposes only. In AA the support agent is peers, rather than the family. In Al-Anon a spouse or mate learns to become detached from the
drinking partner as there is no direct work with relationships. The different focus between the two models can lead to contradictory messages for the client.

For example, a patient goes through a 12 step treatment program and is taught to detach from a partner and work his or her own program. Then the same client goes to a systemic therapist who speculates that it is the distancing from others that is causing problems; that the more the client distances the more the others will pursue. Obviously the client has just received two opposite but supposedly therapeutic interventions. The client might leave confused, angry, dissatisfied or discount either one or both therapists.

In either case the treatment center is dictating who needs to come to the therapy sessions. The professionals are taking an "expert" stance and making assumptions prior to the conversation. The narrative metaphor allows the individual to decide who needs to be involved in the process of therapy. This allows the therapist to be respectful of the individual, stay out of the "expert" stance and make no assumptions prior to the conversation.

The narrative metaphor believes that individual and therapist co-create a narrative. In order to do this, the effects of chemical dependency and how these influence the way the individual views him or herself must be explored. In this instance the narrative therapist might ask how detaching
from others has affected him or her, was the experience positive or negative and what made it positive or negative. Then the therapist might ask the individual how detaching has changed the view of him or herself. From this, the therapist makes no assumptions, but lets the individual state whether detaching is helpful or not and what makes it helpful or not.

The disease model defines treatment success as abstinence. From a systemic perspective the range of outcome variables to judge success must be expanded. Abstinence is no longer appropriate as an isolated goal. Instead, the therapeutic goals must be expanded to include improved functioning of the family as a whole and specific improvement in each family member (Steinglass, Bennett, Wolin & Reiss, 1987; Vannicelli, Gingerich & Ryback, 1983).

With either the disease or systems model, treatment success is predetermined before the conversation. The narrative metaphor contends that successful outcome cannot be determined in advance of the conversation, but evolves during the course of the co-creation of the narrative. The narrative therapist co-creates with the individual what is a successful outcome.

Both the 12 step and systems model view the locus of chemical dependency as internal. The 12 step model views chemical dependency as being located internally within the patient, while systems theory conceptualizes chemical dependency as being internal to the system. This also means
that change is perceived as occurring internally, either within the patient or within the system.

The narrative metaphor understands that viewing chemical dependency as internal makes it more difficult for individuals to make change. The narrative therapist views chemical dependency as being located externally, not something that an individual or a system possesses. Consequently, the narrative metaphor views change as occurring when space has been opened for the co-creation of an alternative narrative.

The 12 step model has developed a language of its own. In order for a patient to be successful in this model he or she must believe in the disease conceptualization and learn the 12 step language. If the patient fails treatment it is because the patient has not truly come to believe in the philosophy of the 12 step model.

Since a large portion of the chemically dependent population receives the traditional 12 step treatment, many systemic therapists are finding themselves working with clients after they have received treatment. The systems therapist contends that part of what is keeping the client stuck is the belief in the disease model and the use of the language. Some systemic therapists practically cringe when a new client states, "I've been in recovery for "x" amount of time; I'm a co-dependent, I'm an adult child of an alcoholic, She is an enabler." For many of these therapists their first
task is to rid the client of the chemical dependency language. The client has not asked for this exorcism, but the therapist contends that it is the client's belief in the disease model that is keeping him or her stuck. The systems therapist tries to help the client "move beyond" this stuck belief. This leads to a struggle between the therapist's beliefs and the client's worldview.

Both the 12 step model and family systems therapy tend to de-emphasize the individual's story about experiences. With the narrative metaphor an individual does not have to learn a new language or give up an old language. The therapist learns the individual's language and how the chemical dependency is affecting him or her. In this way, the individual's story is emphasized, rather than the therapist's.

This moves beyond opposition and concentrates on the individual's conceptualization or meaning of the narrative. In this way, individuals can begin to reauthor the narrative about their life and minimize the part that chemical dependency plays in their future. Table 1 provides a summary comparison of the three models (see Table 1).
<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Disease</th>
<th>Systems</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Origin of *CD</td>
<td>Single entity</td>
<td>CD generating systems</td>
<td>Socially constructed story</td>
</tr>
<tr>
<td>Locus of *CD</td>
<td>Internal to individual</td>
<td>Internal to system</td>
<td>External to either</td>
</tr>
<tr>
<td>Maintenance of *CD</td>
<td>Underlying pathology</td>
<td>Serving function</td>
<td>Linguaging about problem</td>
</tr>
<tr>
<td>Course of *CD</td>
<td>Predictable process</td>
<td>Circular pattern</td>
<td>Can not predict in advance of conversation</td>
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<td>Chemically dependent patient</td>
<td>Entire family</td>
<td>Conversation defines population</td>
</tr>
<tr>
<td>Participant's Label</td>
<td>Patient</td>
<td>Client</td>
<td>Individual</td>
</tr>
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<td>Therapist</td>
<td>Expert</td>
<td>Observer in system</td>
<td>Co-author</td>
</tr>
<tr>
<td>Solutions</td>
<td>Identify pathology</td>
<td>Interrupt interactional patterns</td>
<td>Create alternative narrative</td>
</tr>
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<td>Treatment</td>
<td>Abstinence</td>
<td>Family functioning variable</td>
<td>Participants define</td>
</tr>
<tr>
<td>Success</td>
<td></td>
<td></td>
<td></td>
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*CD - chemical dependency
DISCUSSION

Currently, the chemical dependency story consists of a struggle between the traditional disease model and family systems model. This article proposes a new therapeutic story for chemical dependency.

The narrative metaphor emphasizes the individual's narrative and how the narrative affects an individual's life. When a therapist emphasizes the narrative, he or she is removed from the struggle between viewing chemical dependency as a disease or as a behavior that is helping to maintain family stability. The therapist no longer has to fight opposing conceptualizations or more importantly, the individual's worldview. As an individual stated, "it is nice not to be ridiculed about my belief in AA or to have it shoved down my throat." The narrative metaphor, then, changes how a therapist conceptualizes chemical dependency and the therapeutic process as a whole.

The narrative metaphor encourages therapists to view chemical dependency as a socially constructed narrative with multiple meanings. This implies that the effects of and meaning given to chemical dependency will be unique for each individual. As the therapist using the narrative metaphor makes no assumptions prior to the conversation.

In order for the therapist to create a context for change and co-create new description, the therapist must listen to what the individual says and how the individual
tells the story. The questions the therapist asks are aimed at helping the therapist clarify understanding of the individual's experience. New meaning can only derive from finding differences in the old story. The therapist does not impose therapeutic language or labels onto the individual that must be learned. Nor does the therapist contradict the individual's story and tell the individual that he or she is resistant because meaning was not found in the therapist's narrative.

The narrative metaphor removes the therapist from the "expert" stance and promotes collaboration in the therapeutic process. This is demonstrated by individual comments such as, "I feel like we are in this together; we had a chance to make it fit for us; we worked together instead of you just telling us." The individual is the one who gives meaning to the chemical dependency, not the therapist. The therapist does not transcribe the individual's meaning into a more abstract disease theory, or hunt for the function that chemical dependency plays in the family.

In other words, the outcome of therapy is the generation or co-creation of alternative stories that incorporate vital and previously neglected aspects of the individual's lived experience (White & Epston, 1990). If the therapist tries to create a story that is too different from the individual's original chemical dependency story, it is rejected because it is not co-created nor does it seem relevant to the
individual's situation. The co-creating must take place in the individual's frame of meaning or reality so that the meaning is plausible. New stories must evolve from and yet contain elements of the old, familiar story (Sluzki, 1992). If individuals are so thoroughly entrenched in a story and are unable to converse about alternate stories they become stuck within a story that revolves around chemical dependency.

Above all, the narrative metaphor encourages a sense of authorship and re-authorship of one's life and relationships in the telling and retelling of one's narrative (White, 1990). Individuals can therefore move beyond the oppressive dominate plot of chemical dependency.

The goal of integrating the disease model and systems theory is to provide the individual with a more effective treatment mode. However, current opposition between the traditional disease model and systems theory is keeping the individual stuck in the middle.

The narrative metaphor moves both the individual and therapist beyond the struggle by emphasizing the individual's narrative. The narrative metaphor creates a context that preserves the positive aspects of AA while constructing a narrative driven by the individual's or family's meaning rather than the therapist's values (Borwick, 1991).
REFERENCES


PAPER II. NARRATIVE METAPHOR:

CHALLENGING THE DOMINANT STORY OF CHEMICAL DEPENDENCY
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ABSTRACT

The purpose of this research was to develop the narrative metaphor with chemical dependency as the dominant plot. Domain Analysis was used in order to understand how individuals give meaning to their experience of the therapeutic process. The information obtained assisted the therapist in determining what further questions might help the alternative narrative. Case material is used to illustrate the usefulness of this model.
INTRODUCTION

In our society chemical dependency has become a dominant oppressive story. Millions of dollars are spent each year in the effort to treat chemically dependant individuals. The traditional disease model views chemical dependency as an illness that a patient has, while systemic therapists focus on interactional behavior that helps maintain the chemically dependent behavior.

Currently, there is a struggle between the traditional disease treatment model and therapists using a systemic model. These differences define how therapists identify who to work with, issues to be worked on and what is considered successful completion of treatment. This struggle deteriorates into a dichotomy that becomes unproductive. When this struggle continues into the therapy setting, the individual can end up as the casualty.

As a clinician working with a chemically dependent population, the concern is how to move beyond the struggle. It is clear that a new way to understand chemical dependency is needed.

The narrative metaphor conceptualizes the process of therapy in such a way that the controversy over orientation, disease versus systemic, is a moot issue. The conceptualization of therapy as "co-creating a narrative" is informed by the underlying belief that families and
individuals can change during the therapeutic process if that process is one of co-creation rather than coercion. Therapists are not expert change agents, but instead are consulting co-authors. Their role is to collaboratively assist individuals with rewriting their stories so the story no longer is a story of problems (Selekman, 1991).

The therapist's task is to create a context for change; to open up space in which there will be a possibility for new meanings to emerge. The possibilities of new meaning are brought forth by combining the individual's meaning and the therapist's redescription of the individual's meaning. The new meaning challenges the individual's old problematic meaning context. The process of co-evolution is one in which family members and therapist together, develop new descriptions and draw distinctions. Consequently, therapy is the process of creating space for the co-authoring of alternative stories that were blocked out by the dominant oppressive story of chemical dependency.

With narrative therapy, it is unnecessary to confront the individual concerning denial about chemical dependency. Neither is it necessary to persuade the individual that believing in the disease model is the real problem. Rather, the therapist and the individual engage in a mutual conversation that continually evolves everyone's story about chemical dependency. In this way, the individual does not have to defend his or her beliefs nor does the therapist have
to take on the "expert" role. The result is a different meaning than that of the individual or the therapist (de Shazer & Berg, 1991).

The narrative metaphor has been used successfully with a variety of presenting problems. However, the use of the model with a chemically dependent population is absent. Consequently, the purpose of this article is to evolve the narrative metaphor when chemical dependency is the presenting concern.

This therapeutic model conceptualizes chemical dependency in such a way that the dichotomy between the disease model and the systemic model is obsolete. The narrative metaphor helps create a story that is different than the individual's old chemical dependency narrative. A narrative that is less problematic and allows the individual to move beyond the problematic "dominant plot" of chemical dependency.
METHODS

Study Design

The research is based on a qualitative study with clinical cases presenting chemical dependency as their dominant plot. Individuals are involved in therapy with a therapist that follows the general format of the narrative metaphor (White & Epston, 1991). However, language and questions are unique to each individual. Readers wanting more detailed information are referred to Narrative Means to Therapeutic Ends, White & Epston, 1991.

Appointments were scheduled weekly or bi-weekly, depending on the needs of the individual. The individual(s) attended sessions until the individual and the therapist felt therapy was completed.

Sample

Individuals were selected according to criterion-based sampling. Participants were chosen who represented the range of possible individuals seeking treatment in order to ensure the usefulness of the narrative metaphor with these individuals.

The criterion for the sample consisted of individuals who have problematic involvement with chemicals and have completed a traditional chemical dependency treatment program. Individuals were sought who had been in traditional treatment in order to investigate the flexibility of the narrative metaphor with individuals who already have a
disease model worldview. In addition, the field of chemical dependency is interested in combining the traditional disease model with a therapy that could include the entire family.

The ages of the adult participants ranged from 22 to 55 years of age. Males, females, adults, adolescents and children were included. Including partners and children, there were a total of 36 Caucasians, two Afro-Americans and one Hispanic individual were involved in the project.

In terms of family composition, eight individuals were in their first marriage, one individual was single never married, and four individuals were cohabitating. Six individuals were in a second marriage, two individuals were divorced and one individual was in the process of a divorce but still lived with his wife.

Two families consisted of biological parents and their children, three families were blended, one married couple had no children, two married couples had no children living at home, one male had visitations with his children, one male was involved in a custody battle, one female had custody of her children and one female had not children. The number of children that the families had ranged from zero to three. The children's ages ranged from three to twenty two years of age. In ten cases the male was identified as the chemically dependent person, and in three cases the identified abuser was the female.
Participants did not need a significant other involved in therapy, but were invited to include others. Ten of the thirteen individuals chose to bring at least one significant other to the sessions.

Qualitative investigations using ethnomethodology employ small samples. A justification for a small sample is that ethnomethodology requires the investigator to intensively explore the individual's phenomenological experience of chemical dependency and how the narrative metaphor is helpful. The emphasis is on gaining a thorough description and understanding of the individual's narrative.

A sample size was needed that would give the investigator a picture of the range of experiences individuals were likely to report when chemical dependency was their dominant plot. Studies indicate that ten to twelve respondents are generally sufficient to reach a saturation point (Joanning, Quinn, Thomas & Mullen, 1992). In the study, a total of 13 client units was sufficient to reach saturation.

**Therapist**

All therapy sessions were conducted by the same therapist applying the narrative metaphor. The therapist is a female doctoral student at Iowa State University in the Marriage and Family Therapy specialization. The program has been accredited by the Commission on Accreditation for Marriage and Family Therapy Education. In addition, the
A therapist is a Clinical Member of AAMFT and is employed full time as a clinical therapist. She has 4.5 years of experience working with families, of which two years have been working with a chemically dependent population.

**Procedure**

The therapist followed the general format of the narrative metaphor in order to understand the individual's experience of chemical dependency (White & Epston, 1991). Questions were asked in order to externalize the problem, evaluate the positive and negative effects, justify the evaluation, explore unique outcomes, explore landscape of action and landscape of consciousness (see Figure 1).

In addition, the therapist took the basic structure of the narrative model and developed questions about the individual's experience of the therapeutic process. These questions were asked during therapy so that they became part of the process (see Figure 2). Questions were developed that explored the individual's understanding of the therapeutic process. These questions included exploring the effects of therapy, evaluating the effects, justifying the evaluation, exploring landscape of consciousness, describing what was most helpful, describing what was significant and asking for clarification. These questions were dispersed throughout therapy in order to keep the total process recursive.
Introduction
You stated on the phone that ___ , could you tell me more about that?

Externalize
How is ___ effecting you?
How is ___ effecting your relationship?

Evaluate Effect
Is ___ a good or bad effect?

Justify evaluation
In what way is ___ negative?
What makes ___ positive?

Unique outcomes
What could you do to help get your life back from ___?

Landscape of Action
Can you think of a time recently when ___ was not a problem?

Landscape of Consciousness
How has this changed your belief about self?

Figure 1. Structure of narrative metaphor

Data Collection
The narrative metaphor relies heavily on the ethnographic interview as the way to gather information and come to some understanding of the individual's worldview. The overall goal was to understand how the individual views his or her experience with the therapeutic process. The recursive nature of ethnographies allowed the therapist to obtain information that assisted her in developing questions that would open up space and expand the knowledge about the individual.
Externalize

How is therapy effecting you?
How is therapy effecting your relationship?

Evaluate Effect
Is ____ a good or bad effect?

Justify evaluation
In what way is ____ negative?
What makes ____ positive?

Landscape of Consciousness
How has therapy changed your belief about self?
If this belief stays with you, how will it change your future outlook?

Helpful
What was the most helpful aspect of therapy?
What made ____ helpful?

Significant
____ seemed really important when we talked about it, was it? How so?
Looking over my notes you repeated ____ , how is that significant?

Clarification
you stated that_____ was helpful. What would you call that?
If you had to give that a name, what would it be?
When you said ____ yesterday, is this what you meant?

Figure 2. Therapist generated questions

Credibility
In this investigation credibility was insured by peer debriefing, triangulation and member check.
During the debriefing the investigator was able to discuss her insights and growing questions with other peers.

Three forms of triangulation were used in this investigation, multiple sources, multiple data collections methods and investigator triangulation. Data were collected from multiple sources in order to look for patterns of
similarities in the data. Data were also collected through moderately structured ethnographic interviews and through participant observation. This allowed the researcher to look for similarities and differences between data collected through different methods.

During investigator triangulation a second researcher read the field notes and a comparison was made between the two investigators' conclusions regarding domains. If there was disagreement a discussion ensued until agreement was achieved.

In order to stay consistent with the narrative metaphor, member check was chosen as another form of corroboration. The subjects confirmed both the accuracy of the researcher's field notes of a session and the material collected over time.

Transferability In this qualitative research interest was in the ability to transfer to a similar population, rather than the entire population. In order to do this, a criterion based sample was collected and a complete story was developed with each individual.

Dependability The use of multiple data collection methods were used to insure dependability. Data were collected through moderately structured ethnographic interviews and participant observation. The researcher looked for patterns and reasonable explanations for differences across data collected from different sources.
In addition, the researcher made an audit trail. This included the field notes from the ethnographic interviews, the interpretations from the sessions, and the domain analysis.

**Confirmability** In order to confirm the meaning derived, a variety of data sources, multiple investigators and different data collections and methods were pitted against one another.

The most important of these, was checking with the individuals to confirm the researcher's perceptions. This continual effort to clarify meanings with the subjects lead to an understanding of how the individuals gave meaning to their experiences of the narrative process.

**Data Analysis**

The data were analyzed according to the Developmental Research Sequence (DRS) developed by Spradley, (1979). The investigator searched for categories or areas of meaning that were important to the individual. These might be areas that the individual verbally expressed as important, verbally punctuated or stressed with tone of voice or repeated during the course of therapy.

Categories were then grouped together as similar themes started to emerge during the session. Clusters were continually fed back to the individual in order to verify the therapist's understanding. This enabled the individual to confirm that a cluster was representative of the narrative,
or correct any misunderstandings. In this way, the individual was always in control of the narrative.

Feeding back clusters to an individual also allowed the therapist to compare beliefs held by one individual with another individual. For example the therapist might make a statement such as, "Several other individuals have stated that chemical dependency affected their finances, How is that for you?" These common views began to form the overall ethnography or narrative for using the narrative metaphor with this population. In this way, the feedback helped to develop the narrative metaphor by alerting the therapist to common questions or themes that were most helpful.

Even though commonalities are looked for in order to further develop this therapeutic model, the core of the narrative metaphor is the belief in individual narratives. While, there were some similar effects or questions that were helpful, exactly how the individual was affected or what made a particular question helpful were unique to each individual. Therefore, a very unique yet theoretically consistent model of therapy was developed for use with the chemically dependent population.
RESULTS

The qualitative study described in this article described client-based perceptions of the narrative metaphor when chemical dependency was the dominant plot. The data gathered through moderately structured ethnographic interviews were analyzed according to the Developmental Research Sequence (DRS) developed by Spradley (1979).

Emergent Domains

The domains of meaning emerged as the conversation between individual and therapist unfolded. These domains emerged from the conversation that developed when the individual and therapist were discussing what was helpful about therapy.

The recursive process had two results. First, the therapist and individual co-created a narrative about the individual's experience with chemical dependency. Second, a story about the individual's experience of the narrative process was also generated. The domains that emerged through the conversation about the narrative process included: co-creation, empathy, respect, hope, responsibility, different view and significant times.
DISCUSSION

The emergent domains can be separated into two main themes. Theme one included the perceptions the individuals had about the therapist, theme two contained the perceptions of the therapeutic process in general.

The Therapist

Co-creation was the most pronounced therapist characteristic identified. This domain included the individual's description of the therapist's ability to be part of the therapeutic process. Many individuals felt that the therapist was part of the therapeutic process, rather than holding herself aloof from the process. Individuals made remarks such as, "we felt like a team that was working together to solve a common problem; we feel like part of a team; we were all in this together." Other individuals stated that, "previous counselors had separated themselves and that had not been helpful; their aloofness only served to heighten my awareness that something was wrong with me."

Several individuals remarked that it was more comfortable to work together rather than being told what to do and think. For example some individuals said that, "past counseling felt like an us-them situation with the counselor actually working against our family."

For these individuals it appears that the perception of jointly working together is important and helpful. This reflects the post-modern realization that there is no
privileged position or neutral vantage point from which to observe or practice, nor an objective reality being described by individuals or accessible to therapists (Parry, 1991). Both the individual and therapist are engaging in a mutual conversation that co-creates ideas and assigns meaning to past, present and predicted future experiences.

By reflecting meanings back and forth, new meanings are built upon by all participants, such that multiple "truths" can exist (Inger & Inger, 1990). As Joyce and Taylor (1990) describe, therapy is a co-creative process in which both parties change in tandem in a "dance" of mutual dialogue.

Therapists who operate from the narrative perspective view the therapeutic process as a mutually created narrative. Therapy is based on cooperation and close collaboration with the individual, rather than coercion (Selekman, 1991).

Empathy was the second domain to emerge. This domain included a description of the therapist's ability to show concern and caring for each individual. Individuals remarked that, "it was important that the therapist could empathize and understand where we were coming from; I felt like the therapist cared; I felt understood for the first time."

An individual stated that, "past counseling experiences left us feeling like just another number or one more insurance claim to file, the therapist's attitude did not help me want to change."
Using the narrative metaphor, the therapist inquires about the individual's concerns using cooperative rather than coercive language (Joyce & Taylor, 1990). The questions are asked in order to understand the individual's life experience. While the understanding comes slowly, it facilitates understanding from the individual's perspective and helps to eliminate invalid assumptions.

It is the primary task of the narrative therapist to discover the meaning of the individual's language and how those meanings operate within his or her life experience (Inger & Inger, 1990). The therapist then strives to use the individual's language and avoid therapeutic jargon. How many of us have become frustrated when we had to ask a doctor to "say that again" in plain English. The belief that individuals bring with them a unique and truly interesting life story creates an atmosphere of empathy.

Respect was the third domain to emerge. This includes individuals' descriptions of the therapist's ability to be respectful and take a nonjudgemental stance. Individuals said, "it was helpful not to be judged during therapy; I never got the impression you were judging us; I didn't have to defend myself." In fact many had felt that their perceptions and feelings were validated.

Other individuals had been concerned that they or family members would be criticized or ridiculed. Individuals experienced a sense of relief when this did not occur.
Therapists using the narrative metaphor maintain respect for all of the individual's ideas. They acknowledge that in a world in which there is not a privileged or absolute vantage point, all anyone has is a point of view (Parry, 1991). To have that point of view ridiculed, judged or discounted is a lack of respect for the individual. Instead the therapist questions and challenges within an attitude of validating the individual's point of view. This is a logical response to the realization that there is no single truth, only different perspectives and each one is a "true" or valid perception from that vantage point (Parry, 1991).

The Therapeutic Process

A different view was the most significant domain to emerge concerning the therapeutic process. In general individuals described the therapeutic process as having helped change their view of themselves and of their lives.

Several individuals stated that they felt free or a sense of relief by perceiving their experiences in a different way. Other individuals said, "I felt therapy changed my view of the future; I realized I've been an ok person from time to time; I can't think about it in the same way anymore."

If an individual continues to tell the same story, it is impossible for the individual to behave differently (Efran, Lukens & Lukens, 1990). The therapist's job is to co-create with the individual new ways of understanding the
chemical dependency. As this occurs previously ignored experiences begin to emerge. This enables the individual to view their life experiences from a different vantage point. When this happens a different narrative is told, and it is impossible for the individual to behave in the same manner.

A narrative therapist seeks to create a context in which alternate narratives are co-created that interpret the individual's experiences in a new way (Coale, 1992). This challenges the old dominant narrative and creates a different view of the chemical dependency.

**Hope** is the second domain to emerge. By engaging in the therapeutic process, individuals developed a sense of hope or positive outlook for their life.

Individuals made statements such as, "I now have hope; we can be hopeful about the future; therapy gave me renewed hope that our marriage can work." Several individuals commented that they no longer felt doomed and could lead some sort of normal life. Many individuals said, they had a feeling they could be successful and did not have to blindly follow the path of chemical dependency.

Individuals who define their lives in terms of chemical dependency have a sense of failure. Individuals get stuck in a "problem saturated" description of their life and experience a sense of hopelessness. The narrative metaphor challenges the tendency of the chemical dependency story to become taken for granted as the entire meaning of an
individual's life.

By embracing the belief that the ability to change is in the narrative, the inventive capacity inherent in stories can be released (Parry, 1991). This ability to co-create alternate views inspires hope and a positive outlook for the individual's future.

Responsibility was the third domain to emerge when describing the process of therapy. This included the individual's description of the therapeutic process as encouraging responsibility for his or her own thoughts and actions, and for therapy.

Individuals described taking a stance for the first time and feeling responsible for their lives. Several individuals stated that, "since it is my stance I'm responsible; I'm responsible because they are my opinions."

The narrative therapist views the individual as a consultant, rather than a client. Instead of creating a dependency upon expert knowledge, narrative therapy enables individuals to arrive at a point where they create alternative and special knowledge during therapy (White & Epston, 1991). This helps individuals to become aware of and describe their relationship with the problem, enabling them to assume responsibility for the problem, something they could not do beforehand (White & Epston, 1991).

Significant times was the fourth domain describing the process of therapy. Most individuals describe one of two
conversations as the most significant. The first critical conversation centered on talking about the negative and positive effects of the chemical dependency.

Individuals said that, "we have never been asked if the effects were positive or negative; other therapists made assumptions that all the effects were negative; by asking if an effect was positive or negative helped me get in touch with something I never thought about before."

The second significant conversation focused on situations when the individual influenced chemical dependency (unique outcomes). Individuals talked about how this was an unusual conversation. They stated that, "previous counseling didn't discuss times that this wasn't a problem; if I mention there were times this wasn't a problem, I was viewed as making excuses; I can see that I can beat this but before I couldn't."

A great deal of an individual's lived experiences fall outside of the dominant story of chemical dependency. However, individuals do not see these "unique outcomes" as long as they continue to tell the same story of chemical dependency. Unique outcomes are thoughts, feelings, and experiences that have a past, present and future location but cannot be accommodated by the current dominant plot of chemical dependency (White & Epston, 1991).

When unique outcomes are identified, individuals are encouraged to ascribe meaning to them. The ascription of
meaning to new and unique outcomes facilitates a different view of an individual's life experiences. With the different view of life experiences, comes new and different performances. In the process of performing new meanings, individuals revise their relationship with chemical dependency (White & Epston, 1991).
CLINICAL IMPLICATIONS

This research supports the narrative metaphor as helpful when chemical dependency is the dominant plot. Moreover, the results indicate that this therapeutic model can be used with individuals who have a disease model conceptualization of their chemical dependency.

The narrative metaphor moves the conceptualization of chemical dependency beyond the disease model versus systems model controversy. It places the focus back onto the individual's concern rather than on which view of chemical dependency is more correct.

These findings have implications for therapists working in a clinical setting in terms of how a therapist views the therapeutic process and the individual's presenting concern. In addition, the narrative metaphor has specific implications for those therapists conversing with a chemically dependent population.

Individuals' responses concerning attributes of the therapist are not surprising. The narrative therapist believes that characteristics such as warmth, empathy, caring and respect are important aspects of the therapeutic process. These finding support past research indicating that therapist characteristics are important in creating a positive therapeutic experience (Egan, 1986; Figley & Nelson, 1989; Gurman, Kniskern & Pinsof, 1986).
When a therapist fully embraces the narrative metaphor, he or she works with people at the level they describe their experiences, that is telling stories. The narrative therapist takes a stance that there are only different perspectives and each one is valid from that individual's vantage point. In this way, the therapist undermines the idea that a therapist has privileged access to the truth.

The therapist continually encourages the individual to assist the therapist in understanding the experience with the problem. This avoids classifying the individual's story according to its deviation from a norm (Parry, 1991).

The narrative therapist believes that each individual is an active participant in therapy. This is grounded in the realization that reality is not an objective given "out there", but is a narrative that is co-created through mutual dialogue, not a monologue.

As such, the individual's experiences of therapy are essential to the guidance of therapy. Asking individuals about therapy helps the therapist learn how the therapeutic process is effecting the individual. This avoids the false perception that the therapist is an expert with access to privileged truth.

Some models utilize a third person to inquire about the individual's experience of therapy. The person makes it clear that he or she is not a therapist and this is not part of therapy. However, the person is wanting information about
the client's experience of therapy.

From the narrative perspective, each time a different individual enters the conversation it is the creation of a new narrative. A third person co-creates a new narrative, rather than a continuation of the original conversation. With the removal of the therapist clarification or feedback cannot be asked for. A third person asking about therapy removes the conversation from the therapeutic context. In this way, the information does not become part of the new narrative, but rather a side discussion that is not part of the therapeutic process.

The inquiries into the effects of therapy should remain recursive so that the individual's experience of therapy becomes part of the co-created narrative between individual and therapist. In order to keep the conversation in the therapeutic context, a sole clinician can implement the narrative metaphor.

Narrative therapists inquire what made certain ideas more interesting, what part of therapy was most significant, or proved to be a turning point, as a way to encourage the co-creation of the narrative. This also challenges the idea that the therapist has an expert view by encouraging individuals to evaluate the effects of therapy in their lives and relationships (White & Epston, 1991).

Generally it is assumed that the effects of chemical dependency are negative. However, individuals indicated that
asking if the effects of chemical dependency were positive or negative was a significant turning point in the therapeutic process. By asking this question the therapist stays in the position of asking from the unknown rather than the known (Anderson & Goolishian, 1991). In this way the therapist opens up space for new information to emerge rather than closing it down by making assumptions.

In addition, the therapist wanted to know what made the effect positive or negative. By justifying their position, individuals became more aware of the ways in which chemical dependency was affecting their life. Taking a stance also facilitated a sense of responsibility.

The narrative metaphor challenges the tendency of the chemical dependency story to become the entire life experience. The therapist encourages talking about unique outcomes and then developing alternative stories.

Individuals responded that this part of therapy encouraged different perceptions of self and their life. It freed individuals from the problem saturated chemically dependent description of their life and relationships. From this difference individuals were able to give new meaning to past, present and predicted future events. This enabled individuals to develop a new and nonproblematic relationship with chemical dependency.

When the individual is able to give new meaning to events, the dominate story of chemical dependency is
challenged. The individual is able to move beyond the current problem story of chemical dependency and generate new and more rewarding stories about their lives and relationships.
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GENERAL SUMMARY

Chemical dependency has received much attention from the mental health field. Over the past 30 years various approaches have been developed to work with the chemically dependent population. Of the models, the disease and family systems model are the most widely used. However, research has indicated that the current models have limited effectiveness (Selekman & Todd, 1991).

As a therapist working with a chemically dependent population, it became clear that a new way to understand chemical dependency was needed. A conceptualization that was not only a better fit for clients but for therapists.

The narrative metaphor provided a new understanding of the chemical dependency phenomena. Since the narrative metaphor had not been used with the chemically dependent population, this research, 1) critiqued the disease model and family systems model from the narrative perspective, 2) developed an understanding of how individuals experienced the narrative metaphor and 3) provided support for the usefulness of the model when chemical dependency was the dominant plot.

The general introduction provided a historical review of the disease model, family systems theory and the narrative metaphor. From this review it can be seen that the narrative metaphor is a clinical "how to" model that has evolved from social constructionism and linguistic systems.
White (1990) hypothesized that if it was the narrative that created meaning and originally shaped an individual's life, then creating a new narrative would create change. Therefore, it is language, not some underlying pathology or function that determines meaning and constructs relationship. The change that occurs in therapy is the change of meaning derived through dialogue and conversation. The clinical model, then, is based upon structuring a co-created narrative during the therapy sessions.

The methodology section provided a detailed description of the research methods utilized in the study. Qualitative research was chosen because of the interest in individual's experiences, meaning given to those experiences and multiple perspectives occurring in the social context.

The data were analyzed according to the Developmental Research Sequence developed by Spradley (1979). This analysis enabled the researcher to establish domains of meaning based upon the individual's experience of the therapeutic process.

Paper number one discussed the gaps left by the disease model and family systems theory from the narrative metaphor perspective. This paper also described how the narrative metaphor provided a better fit than the disease or systems model for individuals presenting chemical dependency as their dominant plot.
Basically, the disease model has developed one generic narrative that is intended to describe every chemically dependent patient's life experiences. The disease model narrative perpetuates the idea of the patient or family having a chemically dependent saturated description of their life.

Instead of creating a narrative and trying to get people to fit the narrative, the narrative therapist co-creates a unique narrative to fit the individual. Thus the narrative metaphor helps the individual deconstruct the chemically dependent saturated description of his or her life. It then becomes possible to use the narrative to revise the meaning of past, present and predicted future experiences.

Systems theory views the chemical dependency as a behavior enlisted to maintain the family's status quo. In this way, the chemical dependency serves a function for the family.

The narrative conceptualization of chemical dependency understands that the meaning individuals attribute to chemical dependency determine their behavior, not that chemical dependency serves a function. In this way, the therapist avoids translating the individual's narrative into a more abstract level and thereby change the individual's meaning. The therapist and individual change meaning by co-creating a new narrative.
With the thrust to combine the traditional 12 steps model and systems therapy, clients work with therapists who have different conceptualizations of chemical dependency. A client experiences one therapist emphasizing behavior and the other therapist emphasizing the interaction patterns with significant others.

The narrative therapist emphasizes the co-creation of a narrative. In this way, the individual determines what is emphasized, not the therapist.

This article provided case material that illustrated the gaps left by the disease model and family systems model. Through the narrative metaphor, these gaps are filled. Therapists and individuals can co-create a unique narrative that allows the individual to tell his or her story without struggling with the therapist's worldview of chemical dependency.

The second paper used domain analysis to understand how individuals gave meaning to their experience of therapy. From the analysis seven domains emerged, co-creation, empathy, respect, hope, responsibility, different view and significant times.

The research supported the narrative metaphor as beneficial when chemical dependency was the dominant plot. Moreover, the results indicated that the model is useful with individuals who have a disease model conceptualization of chemical dependency.
The paper also discussed clinical implications for therapists embracing the narrative metaphor. The narrative metaphor influences how a therapist views the therapeutic process and the individual's presenting concern. In addition, the model has specific implications for those therapist conversing with a chemically dependent population.

The narrative therapist believes that the individual's experience of therapy is essential to the guidance of therapy. Therefore, the therapist must learn how the therapeutic process is affecting the individual. In this way, the individual's experience of therapy becomes part of the co-created narrative between individual and therapist.

The narrative metaphor challenges the tendency of the chemical dependency story to become the entire life experience. The therapist encourages talking about unique outcomes and then co-creating alternative stories. This enables individuals to have a nonproblematic relationship with chemical dependency.

The research indicated that the narrative metaphor is effective with the chemical dependency population. This method subverts taken for granted meanings and encourages individuals to view their life from a different vantage point. As this occurs, individuals are able to free themselves from the oppressive dominant plot of chemical dependency and generate more rewarding stories about their lives and relationships.
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Forever,

Mel
APPENDIX A. SUMMARY OF DOMAIN ANALYSIS

The following is a summary of client comments. Not all comments were included after the saturation point was reached. The comments started to repeat and no new information was obtained.

CO-CREATION
you asked, you don't tell me
feel like we are in this together
you are not against us
nice to do this together
feel like all part of a team
working together to solve the problem
we're working together
didn't tell me what to do, but explored together
we all felt like we were really part of a team
liked the way you were part of our life, other counselors were so aloof
not afraid to get down in the dirt with us
we're working together
didn't just tell me what to do
nice to talk not confront, confront
in here we talked, not lectured
we're a team
before I was always told
it's more personal, not the generic "this is what chemicals do to families" routine
we all felt like we had a chance to give impute
the kids even got a chance to talk
everyone played a part in this process
learned to be my own therapist
felt that we got a chance to make it fit for us

**EMPATHY**

gave a feeling of openness
you seemed to validate my decisions
easy to talk to
others acted like we were just a number, they could have cared less
you're very friendly
didn't feel like insurance claim to fill quota
think you are easy to talk to
you are a really good listener
comfortable talking with you
you're so understanding
felt like you really cared
really listened to what both of us were saying
felt understood for the first time
seemed to understand our experience
you really are concerned about us
felt your concern for me
able to empathize with our situation
you weren't sympathetic, but empathetic
have the ability to relate to us and the kids
it was ok to talk about anything because you understood
kids felt like you understood them and that is important to us
seemed to know just what we were talking about
not phony, but genuine caring
very concerned
seem like a very warm person

RESPECT

didn't look down your nose at me because I'm a mom with a drinking problem
created an atmosphere of trust
made us feel special, not like the same old son and dance
made us feel like we had something important to say
always included the kids
feeling that others experience same problems
really wanted to know what we meant
seemed to know what we were talking about
you're not judgemental
I didn't have to defend myself
I never got the impression that you were judging us
felt like you respected me
first time had counseling and not felt blamed for everything because of my drinking
even though used drugs in the past, you didn't look down your nose at me
never felt like I had to defend myself in here
it was nice that you didn't ridicule my belief in AA
I was skeptical about therapy because I did not want to get criticized
it helped that you never assumed or made judgements
during treatment I was always being judged, this is refreshing
its great not to be the bad guy for a change
its like you are on everyone's side at the same time
after the first few sessions I realized that you were not going to be jumping down my throat and pointing out all my flaws
did not try to intimidate me
didn't get into the struggle of who had worse experience with drugs, you gave me my due
maybe its because I'm Italian, but feeling respect is very important to me

HOPE
now we've moved beyond the problem
I think we'll make it now, had doubts before
Gives me hope to see that I don't have to follow in my father's footsteps
we can be more hopeful; do not feel like doomed to failure
we can succeed
we can make it
gave me renewed hope that our marriage could work
kids are not doomed to life like ours
I'm encouraged that son doesn't have to be addict like me
have small glimmer that we can have some sort of a normal life

its given the kids hope for the future

I always thought we deserved better, but never believed we could, before now

I think that the kids will be fine

we have a chance at a future

RESPONSIBILITY

This is my responsibility

now I'm responsible

It's the first time I've felt responsible for my life

I'm responsible because nobody is telling me what to do, its my decision

he seems more willing to do something because its his decision

I'm not sure how, but talking in here has helped me take a stance

first time I've had to take a stance, before I was always told

I'm responsible because they were my opinions, before it was always someone else's

the way we talked allowed each of us to own our opinions helped make my own decisions, not cram it down my throat

for the first time I can work my program, because it is mine, and not one you forced on me

not sure when it happened, but I've bought into the fact that part of this is my responsibility
DIFFERENT VIEW

I suddenly realized that I have been an ok person from time to time.

I can be more than an alcoholic.

Realized he isn't going to protect me anymore.

Never realized how well we do fit together.

I've never seen it from the kids point of view before.

I feel like I am free.

Relief to see that my whole life wasn't a mess.

We do have a good marriage, we are just in a rough spot.

Realized that I'm not like my alcoholic father, I don't have to continue down his life style.

It came to me that I didn't have to stop being the kind of parent that I wanted.

I didn't have to let this thing get the better of me, I can be a good parent.

I realized that she was committed to this relationship, she was just doing things against her better judgement.

This has changed our perspective.

We've come to see humor is the stuff the kids do-not everything is symptom of child of alcoholic.

This has put things in a different light.

Started to change the way I viewed myself.

I can't think about it the same way anymore.

I've changed my view, I can be the kind of wife I want to be.

It helped me see that I had successes in the past so I can have them in the future.

It's nice to stop defining family in terms of alcoholism.

It's more like you are a complete person, you still have the negative things, but now you also have the positives.
we've become more well rounded
scales aren't all tipped to the problem side of our life, realized we have positive things
it came to me that I am more than just an addict, I have other parts to me
I agree, now when I look at him, I see more than just an addict
when I look at our daughter, I don't see similarities to her anymore, I see our daughter

SIGNIFICANT TIMES
I've never been asked if effects are positive or negative, others have just assumed they were all negative
I thought something was wrong with me because there were some positive things and nobody asked about those before
I was afraid to admit there were some positive things about drinking
it sounds awful to say that there were some positive things about his using steroids
in the program I would get trounced for saying his using was partly positive
it feels good to get this out, there were some positive things about drinking
surprised to hear myself say there were some positives
asking me that made me get in touch with something I never thought about before
asking what made them positive or negative was quite helpful
by telling what made it negative it was my story, not the general AA story
when kids talked about what was negative in their terms - not AA's it really hit me
before it was always someone else's opinion, I could disregard what other people said
before I could always make excuses for how it didn't fit for me, now I can't do that.

realized why it was hard to quite, some of it was positive

talking about times that drinking was not a problem was a significant time

AA never wants to hear about times when drugs weren't a problem, this was a change

Talking about successful times gave us a different perspective

When you asked about times it wasn't a problem, I had to really think

Things seemed to change when we started talking about times we had control

when you asked about past times when coke wasn't a problem, it got me thinking differently, not sure how, it just did

it opened our eyes about the kids when talked about times they didn't act like kids of alcoholic

the turning point was when I realized I had some influence in my life

was significant for us when we started talking about not be passengers in life, but actually in the driver's seat

two times stick out in my mind, when we talked about positive effects of steroids, and when talked about how there were times when I had chosen not to use

at first I was really angry at him when I realized he had times when he didn't use, it was like he chose coke over me, then thought realized if he did it once can do it again. This was a real turning point for me

not sure why but the realization that I had some control was really important

sine I have some control I'm a different person and that was a pretty significant insight

My sponsor would kill me for saying this, but it was important for me to see that I had some influence over my life
APPENDIX B. SUMMARY OF NARRATIVE METAPHOR QUESTIONS

Introduction

What brings you to my office?
You stated on the phone that ____, could you tell me more about that?

Externalize

How is ____ effecting you?
How is ____ effecting your relationship?
In what ways is ____ interfering with your life?
What is ____ having you do against your better judgement?

Evaluate Effect

Is ____ a good or bad effect?

Justify evaluation

In what way is ____ negative?
What makes ____ positive?

Unique outcomes

What could you do to help get your life back from ____?
How has that worked in the past?

Landscape of Action

Can you think of a time recently when ____ was not a problem?
Can you think of a time recently when you were not as ____ you could have been?
How did your past experience help you achieve that?
These events don't sound like they fit with ____, what would you call it?
Who would be least surprised to see you ____?
What do they know about you that would let them predict this?
Given what you've told me today, what can you say bout the next time something like this happens?

Landscape of Consciousness

What do you think ____ has to say about what you want from a relationship?
What does this tell you about what he values?
What do you think this tells me, that is important to know?
If you were to keep your commitment close to you, what can you tell me about the next event?
How has this changed your belief about self?
APPENDIX C. SUMMARY OF ETHNOGRAPHIC QUESTIONS

Externalize

How is therapy effecting you?
How is therapy effecting your relationship?

Evaluate Effect

Is ___ a good or bad effect?

Justify evaluation

In what way is ___ negative?
What makes ___ positive?

Landscape of Consciousness

How has therapy changed your belief about self?
How has therapy changed your belief about spouse?
How has therapy changed your belief about your children?
If this belief stays with you, how will it change your future outlook?

Helpful

What was the most helpful aspect of therapy?
What have we talked about that was the most help?
What made ___ helpful?

Significant

_____ seemed really important when we talked about it, was it? How so?
Other clients have told me that _____ was a turning point, How was it for you?
Looking over my notes you repeated _____, how is that significant?

Clarification

you stated that_____ was helpful. What would you call that?
To me that sounds like respect, what would you call it?
If you had to give that a name, what would it be?
These two things seemed to belong together, what do you think?
When you said ____ yesterday, is this what you meant?
APPENDIX D. SUMMARY OF FIELD NOTES

The following is a summary of the investigator's field notes. The notes consist of examples of data collected from the beginning, middle and ending sessions.
CASE 93-013 Beginning Session
Externalize problem

Husband: Since test came back positive my boss knows and so do my co-workers. It's supposed to be private, but the company has a great grape vine.

Have to take time off work - not sure what I'll do - It's not like this is a vacation.

Kids know something is going on cause of the fighting and me being home and not sick.

Got caught using on the job

Financially we should be a lot better of than we are

To keep using and not get caught for as long as I did - get to be a good liar - able to figure out angles to everything

Sometimes I would lie when it wasn't necessary just to see if I could still get away with it.

Get myself convinced - when she would accuse me - I cold go on defense and believe it myself

Wife: I'm concerned that this will get out and our families will find out. I worry about that a lot

I've become pretty good detective - He thinks he's slick but, I usually know when he's scamming and that's most of the time

At first I thought I was going crazy when I'd confront him. Now I know it's the coke.

I'd wait by the phone when he's gone waiting for his call that he's been busted and he needs me to get him out of jail

Husband: coke is destroying our marriage it's pathetic

Wife: Not sure if there's any chance we can save it
AFFECTS OF COKE

Husband
    Boss knows
    Co-workers know
    Kids know
    Got caught
    Financial
    Lie
    Self convinced

Wife
    Families find out
    Worry
    Going crazy
    Wait

Both
    Coke destroying marriage
CASE 92-037 Beginning Session
Externalize problem

Male: My drug test came back positive, so I had to go to that _____ powell.

I had to spend every night listening to them people tell me what was wrong with me. They don't even know me

I don't have a problem. I just miscalculated I had just been tested three weeks ago. They usually only test every three months.

Don't think company should dictate my free time

The pot relaxes me- helps me to unwined

Guess have to find another way cause if come up positive again, I'll lose my job. Love my job. Its all I know.

Had a girlfriend, but she always nagging me about pot. We split about 2 1/2 months ago.

Thought that one would have worked. She was real nice and responsible- too much sometimes and then she would nag. All my girlfriends have been nags.

My folks worry about me. Had to borrow money from them and they don't understand what I do with money -I've got a good job.

Stopped going over there as much - always questioning me about money and when I'm going to settle down
REFLECTIVE

AFFECTS OF POT
  Went to Powell III
  Had to listen
  Miscalculated
  Relaxes him
  Possibility of lost job
  End of relationship
  Girlfriend's nag
  Parent worry
  Stopped seeing parents

Impression of co-workers and boss seem important
Job seems important
Husband: It's negative that my boss and co-worker know. They are going to think that I'm some sort of a drug addict. My boss will probably watch me like a hawk. Some of the guys will be leery about riding with me. That might think that I'm unsafe.

Kids knowing is negative. They learn all over the place that doing drugs is bad. You want your kids to think that you are perfect. It will be hard to tell them not to do drugs.

Getting caught on the job is really negative. It really makes me look like a "druggie" and I'm not.

Being a good liar - sometimes positive and sometimes negative. It can help me out in a pinch. I can also figure out short cuts to things and that can save time. But for the most part it makes it so that ____ never believes anything I say.

Wife:

Families finding out would be negative. I'm a private person and I wouldn't want them to know. Everybody would tell me to leave him in my family and ask why I put up with it. They know there is problems but nothing like this.

Its positive that I know for sure its coke. Know I know that I'm not crazy.

Financially we are in trouble we are behind in house payments and there isn't much left to juggle.

Waiting by the phone is negative. I can't sleep and the doctor told me I have an ulcer.

Husband: The coke is destroying our marriage.

Wife: Not sure if there's any change we can save it.
Husband does not want to be thought of as drug addict
Wife does not want others to know
Both agree *killing marriage*
Unsure if can *save marriage*
Male:

I've never been asked what's positive or negative.

Going to Powell was negative. I don't have a drug problem. I had to sit there and listen to all that crap. I don't want to do that again.

Miscalculating got me into trouble. I guess they must have some new policy since the merger. Won't be able to rely on old system anymore.

Company dictating my free time upsets me. As long as I can do my job that is all that should concern them. Since they can do this I'll have to give it up.

Loosing my job would be negative and it is all I have. I'll do whatever it takes to keep it. I went to that other place didn't I.

Girlfriends nagging me is negative. I don't know if it was just because I used pot sometimes or because they were just nags. If it was the pot, I won't have to worry about it anymore.

Folks worrying about me drives me crazy. I stopped going over there as much and I know it bothers them we used to be really close.

REFLECTIVE

Pot caused a lot of negative things.

Job is important.

Family seems important.

Already talking in terms of "giving it up."

* Positive and Negative seem important.
CASE 93-005 Middle Session
Unique outcomes

Male:

I could get rid of my stash. I always keep some on hand just to test myself. When I have it I usually end up using or selling it to a friend.

I could go to a different gym. Stay away from the other guys that are using. There are other gyms that the guys are clean. They would be more supportive.

Get more involved with the family. When I think more like a family person I stay away from the stuff. When I start to think like a jock, I'm in trouble.

Wife:

Lay down boundaries of what I'll accept. If that is not how he wants to live, then I have to leave the relationship.

As long as I felt like I didn't have a choice I was stuck. I have a choice and I can leave.

I'm going to do things that will get my life moving forward. He can be a part of it or he can stay behind. It's his choice. I'm not going to beg or nag anymore.

REFLECTIVE

Husband had times in past when he wasn't using
got rid of stash
different gym
part of family

Wife had times when wasn't problem
she did things on own
willing to leave him for first time

What would they call this?
CASE 93-025 Middle Session
Landscape of Action

Male:
I came home early two weeks ago, didn't go to ___ house.
I think it was the week before that, I told him I wasn't going to be coming around as much. I was trying to get my life in order

It's positive. one less time I was tempted to use. Came home and spent time with ___ she was happy and I enjoyed it.

Female:
When he came home I didn't question about how come or ___ must not have been home. Told him that I was glad to see him.

It was positive. Made me feel good and released tension. Think he was ready to defend himself.

REFLECTIVE

Didn't go to friends house
Came home
Didn't use
She didn't question
felt good
released tension

 Doesn't sound like loosing relationship
What would call it
Female: Last week I was offered some, but I refused. 3 months ago I was hardly using. Nobody ever talks about that. I was busy with work and we were involved with volleyball and going to the gym to exercise. I wouldn't be surprised to see me stop drinking. He knows how stubborn I can be when I want something.

REFLECTIVE

Seemed important that nobody talked about 3 months ago treatment didn't acknowledge that she had done some things in past that were helpful

* Unique outcomes seem important
Husband: I want a close relationship one in which I'm not sneaking around.

Want to be close and share things. I would like for her to be supportive and not always tell me that it's my problem.

Wife: Sounds like he does want a regular home and family. I thought he wanted me to leave him alone and let him work his own program.

Next time I start to feel like walking out, I'll think about what we've said - can't do the same thing when I feel different.

Husband: I realized that I'm not like my father. I don't have to continue down his path. All my life I've been told you're just like your father. Now I know that I'm not. I can have a family.

I'm going to work at this relationship instead of throwing in the towel cause I'm like dad.

REFLECTIVE

Can't do same thing now that she feels differently
He can be different cause not like dad

* Talking about changing belief seemed important
* Change belief cannot behave same
CASE 92-043 Middle Session
Externalize therapy process

Husband:

Therapy has helped me realize that I'm not just like my alcoholic father. Ever since I can remember people always told me you're just like your dad - especially mom.

When ______ and I got engaged she told me that it wouldn't last - look at all your other failed relationships - just like dad.

Wife:

When I compared her to dad it was like pushing her farther away. I'm learning how to tell her what I need instead of criticizing her.

REFLECTIVE

* Realized (Different view)
* Learning (Different view)
* Talking about changing belief
CASE 99-001 Middle Session
Externalize therapy process

Male: It's weird, but it's the first time I've felt responsible for my life. When I went through the program I sat there and thought what has this got to do with me. There talking about things that mean nothing to me

When you aren't talking about me, I can just blow it off. But now, this is me and I've got to get into gear.

Female: I finally figured out that he was just giving me a bunch of lip service. He was talking about all this stuff that I didn't have a clue about. When you started talking about positive and negative affects, it hit me he really likes doing this - he's getting something out of it - and he better change cause it will only get worse if we get married.

Since then, I think I have left him more on his own and he is doing something. Seems more willing to do something because it's his decision.

REFLECTIVE

* Responsible (Responsibility)

* Finally figured out (Different View)

* it hit me (Different View)

* positive and negative was significant (Significant time)

* He's more willing, it's his decision (Responsibility)
CASE 93-011 Middle Session  
Landscape of consciousness (therapy)

Wife: I went home one night after our session and I suddenly realized that I have been an ok person from time to time. Before I had myself convinced that I was lousy, something must be wrong with me why else would ____ treat me the way he does.

Talking in here helped me to see that I was ok and didn't deserve all the things he did.

Husband: it made me look in the mirror and I didn't like what I saw. When ___ talked about how she felt something was wrong with her. It dawned on me. It made me ill - I'm acting just like Dad and I hated the way he treated mom.

REFLECTIVE

* suddenly realized  (different view)

* helped me to see   (different view)

* dawned on me      (different view)
Female:

I feel more confident in my ability to make decisions. Before the program I felt like I couldn't make any decisions unless they were bad.

then in the program I couldn't make decision because someone made them for you. It was like you didn't have a choice. I'm an alcoholic so this is what I do.

Then I got to point, where I wanted to make decisions, but that was trying to take control

I started to think that I might as well give up. Just give myself over

In here I have discovered that I can make decisions. This therapy has helped me make my own decisions, not cram it down my throat

I even feel that I will be able to make better decisions about future relationships. I will be able to state my opinion and feel ok with that

REFLECTIVE

* have discovered (different view)
* helped make own decisions, not cram (responsibility)
* make better decisions about future (hope)
Female: This will sound pretty corny, but I really liked feeling like we were in this together.

My other counselor was so cold. It was always this is your problem, you know what to do, just work your program, I've told you before, I made it, now just do it. She was a cross between my mother and the Nike commercial - Just Do it.

If you had been like that, I'd have gone right back to drinking.

Working together made me have hope. It was like- if she's willing to work she must see something worth working for. It gave me a booster shot in my self confidence.

made me feel like you wanted to help me solve this problem because you cared, not just trying to save me from myself.

REFLECTIVE

* in this together (co-creation)
* gave me hope (hope)
* you cared (empathy)
CASE 93-025 Ending Session
Most helpful times in therapy

Male: we both talked about how easy you are to talk to. I was kinda worried that you being a woman, would side with ____.

I felt really comfortable and you do have a way of validating what I say.

Sometimes when we left we ended up laughing about how you seemed to take both our sides.

I also liked not having to defend myself in here. That other woman at ____ was always on my back - always making me defend myself.

Female: I agree with ____ you always listened to what both of us were saying. Our other counselor seemed to take sides. ____ felt like she was always on my side because he had the drinking problem.

At the time I felt like that was great. Let's gang up on him and give it to him. Only when we got home the arguing was worse than what it was before.

He needed someone who could understand his view - not condone his drinking.

REFLECTIVE

* easy to talk to (empathy)

* way of validating (empathy)

* not defend self (respect)

* listened (empathy)
CASE 91-027 Ending Session
Significant times in therapy

Husband: I told ___ that listening to the kids in here it struck me that I've never seen it from their point of view

When they talked about what was negative about my drinking in their terms - not AA it really hit me

I went home that night and felt physically ill. I couldn't believe what the drinking was doing to them. I thought I had kept them innocent

Wife: It was the first time I'd seen him cry. I thinking all his defenses - things he built around him so that he didn't have to see, just crumbled

At that point I knew we would make it

REFLECTIVE

* struck me (different view)

* significant when talked about negative in their terms (significant time)

* first time (different view)
CASE 93-006 Ending Session
Significant times in therapy

Wife:
Toward the beginning when we were first talking about if the using was good or bad I'm not sure what terms you used, but that really sticks out for me.

I was surprised to hear myself say there were some positive things about his using.

In the program I would have been trounced for saying that. Just another example of my codependent behavior.

But I did like being in total charge. I made all the decisions, just how I wanted.

Husband:
The time that sticks out for me was talking about times when I hadn't let my using control me.

I went home that night and felt pretty good for the first time in a long time.

there are times that I can beat this thing

This has put things in a different light

I'm not going to be so quick to feel like the bad guy all the time.

REFLECTIVE
* if using was good or bad sticks out (significant time)
* surprised to hear say (different view)
* times hadn't let control me sticks out (significant time)
* felt pretty good for first time (different view)
* I can beat this (hope) * different light (different view)
* I'm not going to be so quick to feel (different view)
Female:

not looking down your nose at me cause I drink and have kids. It's giving me my due - you know respect

I was afraid you would be real critical and get on your high horse about what a terrible person I am

I've heard that all before - it didn't work

This counseling was different I felt you did respect me. It does something to a person when you feel respected - feel like a human again.

REFLECTIVE

* giving me my due  (respect)
* respect  (respect)
* afraid you'd be critical  (respect)
* feel like human again  (different view)
Male:

when talked about son not being addict like me
It gave me something to look forward to. It's encouraging.

He can grow up and be ok. So it means I better get my act together as father - I can't blame it on my being an addict anymore. I can be a good parent.

Yea, I'd call it hope- hope for the future.

REFLECTIVE

* talked about son not being like me (significant time-unique outcome)
* look forward (hope)
* encouraging (hope)
* I can be good parent (different view)
* hope for the future (hope)