THE EXPLICATION OF CRAVING IN ALCOHOLISM:

A GROUNDED THEORY STUDY

by

Rochelle Renee Storm

Copyright © Rochelle Renee Storm 2005

A Dissertation Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

THE UNIVERSITY OF ARIZONA

2005
FINAL EXAMINING COMMITTEE APPROVAL FORM
STATEMENT BY AUTHOR

This dissertation has been submitted in partial fulfillment of requirements for an advanced degree at The University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this dissertation are allowable without special permission, provided that accurate acknowledgement of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: _________________________________________
ACKNOWLEDGMENTS

The completion of this dissertation required the assistance and support of many individuals. I wish to thank those whose efforts allowed me to move forward with this work. First and foremost, I wish to express my sincere appreciation to the fourteen men who shared their experience with me.

I wish to extend my appreciation and gratitude to my dissertation committee for their guidance and support throughout the doctoral program, as well as through the completion of this project: Dr. Terry Badger, Dr. Ida Moore, Dr. Elaine Jones (major committee members); Dr. Sandra Cromwell (minor committee). I wish to acknowledge Dr. Julie Erickson and Dr. Mary Koithan who were members of the original minor committee for their support and encouragement during the early stages of this project. Each member of the committee made a contribution to the expression of my creativity and encouraged “thinking outside the box”, without which this research would not have been possible. Dr. Badger facilitated the recognition of the process of craving which was prerequisite to the development of the theory. Dr. Moore and Dr. Erickson planted the original seed and encouraged the exploration of the craving construct as an area worthy of research. As the initial chairman of my minor committee, Dr. Jones provided the gentle prodding and guidance necessary to move forward with my comprehensive exams. She was also instrumental in the application of the chronic disease framework to the disease of alcoholism. Dr. Cromwell was there for the painful process of extrapolating vulnerability from alcoholism in relation to craving. Dr. Koithan urged me on in my quest to understand craving from a different perspective through the use of a different lens, true to the spirit of qualitative research.

Dr. Badger has a unique gift for knowing exactly what is called for in any situation. She intuitively knew when rest was critical for renewed strength before embarking on the next challenge, but she also knew when to gently prod in order to reach the next milestone. Balancing the thin line between conventionality and creativity, she encouraged the exploration of my ideas and innovation. She demonstrated genuine caring and commitment to my development as an individual as well as the scholar, and remained sensitive to my roles as a single mother and practicing clinician as well as doctoral student. My progression through the doctoral program and my development as a scholar and scientist are a credit to her extensive expertise and skill. I am forever indebted to her.

I wish to thank my colleagues Anita Goss and Sue Pennington for their steadfast support and encouragement throughout this journey. I am indebted to the innumerable staff of the Southern Arizona Health Care System who committed the time, energy, and their heart to the success of this endeavor.
DEDICATION

To all of those who have suffered from the disease of alcoholism and have died, that it might be different for those that follow.

To my daughters, Megan Marie Soles and Kathryn Louise Soles, who empowered me from the beginning of this journey to the end, through their unwavering belief in me and their steadfast love.
# TABLE OF CONTENTS

LIST OF ILLUSTRATIONS..................................................................................................................10

LIST OF TABLES................................................................................................................................11

ABSTRACT............................................................................................................................................12

CHAPTER ONE: INTRODUCTION........................................................................................................14
  Background of Problem ..........................................................................................................................15
  Alcoholism...........................................................................................................................................15
    Problems in Definition and Diagnosis ..............................................................................................16
    Current Definition.............................................................................................................................16
  Craving................................................................................................................................................17
  Purpose of the Study ............................................................................................................................18
  Research Questions............................................................................................................................19
  Metatheoretical Perspective................................................................................................................19
    Traditional Paradigms ......................................................................................................................20
    Objectivist/Constructionist Perspectives .........................................................................................23
  Symbolic Interactionism .....................................................................................................................24
  Perspectives on Chronic Illness .........................................................................................................26
    Disease and Illness ...........................................................................................................................26
    Health..............................................................................................................................................27
    Definitions of Chronic Disease and Illness .......................................................................................29
    Alcoholism as a Chronic Disease ....................................................................................................30
    Craving as Vulnerability ..................................................................................................................32
  Significance for Nursing ...................................................................................................................35
    Symptom Management in Chronic Disease ....................................................................................36
  Summary of Chapter One ...................................................................................................................38

CHAPTER TWO: REVIEW OF THE LITERATURE ..................................................................................39
  Craving.................................................................................................................................................39
    Conditioning Models..........................................................................................................................41
    Cognitive Models .............................................................................................................................45
    Transdisciplinary/Integrative Models ...............................................................................................48
    Phenomenological Models ...............................................................................................................50
  Current Gaps ......................................................................................................................................52
    Current Conceptual Status of Craving .............................................................................................54
  Summary of Chapter Two ...................................................................................................................58

CHAPTER THREE: METHODOLOGY ....................................................................................................60
  Qualitative Research ...........................................................................................................................60
  Symbolic Interactionism ......................................................................................................................63
  Grounded Theory Methodology .........................................................................................................65
# TABLE OF CONTENTS – Continued

- *Glaserian Grounded Theory* ............................................................................................................. 68
- Data Collection Procedures .................................................................................................................. 70
  - Sampling ............................................................................................................................................. 70
  - Participant Recruitment ...................................................................................................................... 71
  - Assessment of Alcoholism .................................................................................................................. 72
  - Assessment of Craving: The Interview ............................................................................................... 73
  - Interview Procedure ............................................................................................................................ 74
- Audiotapes of the Interview .................................................................................................................... 75
- Human Subjects ....................................................................................................................................... 75
- Data Analysis .......................................................................................................................................... 76
- Trustworthiness in Qualitative Research ............................................................................................... 76
  - Scientific Rigor ...................................................................................................................................... 76
  - Credibility .............................................................................................................................................. 79
  - Dependability and Confirmability ......................................................................................................... 79
  - Transferability ....................................................................................................................................... 80
- Summary of Chapter Three .................................................................................................................... 80

## CHAPTER FOUR: RESULTS .................................................................................................................. 81

- Portrait of the Participants .................................................................................................................... 81
  - Interview 1 - Lempie .......................................................................................................................... 81
  - Interview 2 - Lobo ............................................................................................................................... 82
  - Interview 3 - Arthur ............................................................................................................................. 82
  - Interview 4 – Diego ............................................................................................................................. 83
  - Interview 5 – Big Mac ......................................................................................................................... 84
  - Interview 6 - Teach ............................................................................................................................. 84
  - Interview 7 - Steve .............................................................................................................................. 85
  - Interview 8 - Wayne ............................................................................................................................ 85
  - Interview 9 - Buster ............................................................................................................................. 86
  - Interview 10 - Poncho ......................................................................................................................... 86
  - Interview 11 – Recovery ...................................................................................................................... 87
  - Interview 12 - Keef ............................................................................................................................. 87
  - Interview 13 - Sunshine ...................................................................................................................... 88
  - Interview 14 – Wolf Dancer ................................................................................................................ 88
- Explanation of the Grounded Theory ....................................................................................................... 90
- Four Stages of Craving ........................................................................................................................... 91
  - Stage One: Craving in the Background ............................................................................................... 91
  - Stage Two: Craving in the Foreground ............................................................................................... 93
  - Stage Three: Management of Craving ............................................................................................... 94
  - Stage Four: Craving Unsatisfied ......................................................................................................... 95
- Progression of Paths ............................................................................................................................... 96
  - Winning the Battle: Successful Suppression of Craving .................................................................... 98
  - Gaining Ground: Partial Suppression of Craving .............................................................................. 100
TABLE OF CONTENTS – Continued

Overcoming Craving: Successful Suppression of Craving ................................................................. 101
Losing the Battle: Unsuccessful Suppression of Craving ................................................................. 102
Surrendering to Craving: Choosing Alcohol .................................................................................. 103
Drinking: Craving Unsatisfied ........................................................................................................ 104
Summary ....................................................................................................................................... 105

Stage One: Craving in the Background ....................................................................................... 106
Omnipresent Craving ....................................................................................................................... 106
Desire for Alcohol .......................................................................................................................... 109
  Experience with Alcohol: The Pleasure ....................................................................................... 110
  Effect of Alcohol: The Function .................................................................................................. 114
    Euphoria ..................................................................................................................................... 114
    Transformation of Self ............................................................................................................. 116
    Enhanced Problem-Solving Ability ......................................................................................... 117
  Numbing and Escape ................................................................................................................. 120
    Anxiety Reduction .................................................................................................................... 120
Summary ....................................................................................................................................... 120

Stage Two: Craving in the Foreground .......................................................................................... 122
Craving Prodome .......................................................................................................................... 123
Characteristics of Craving .............................................................................................................. 124
  Mental Process ............................................................................................................................ 124
  Memory and Mental Representation ............................................................................................ 125
Conversations with Craving: Struggle ............................................................................................. 126
  Craving as Urge: Being Driven .................................................................................................... 132
Summary ....................................................................................................................................... 134

Stage Three: Management of Craving .......................................................................................... 135
Suppression of Craving as an Active Process ................................................................................ 135
Strategies for Management of Craving ........................................................................................... 138
  Reminders ................................................................................................................................... 139
    Memorabilia .............................................................................................................................. 139
    Hitting Bottom .......................................................................................................................... 139
    Sponsors .................................................................................................................................... 140
  Distraction .................................................................................................................................... 140
    Physical Activity ......................................................................................................................... 141
    Artificial Stimulation .................................................................................................................. 141
    Reaching Out ............................................................................................................................. 142
    Recovery Support ......................................................................................................................... 143
Prerequisites to Choice: State of Mind ........................................................................................... 145
  Desire for Sobriety ......................................................................................................................... 145
Choice of Alcohol: Drinking ........................................................................................................... 149
Craving as Need: Desire for Normalcy ............................................................................................ 150
Craving as Thirst: Insatiable Desire for Drink ............................................................................... 155
Summary ....................................................................................................................................... 156
# TABLE OF CONTENTS – Continued

Summary of Chapter Four .................................................................................................................. 160

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS ............................................................... 162
Interpretations of the Study.............................................................................................................. 162
Integration with the Literature ......................................................................................................... 163
  Congruence with the Literature .................................................................................................... 163
  Incongruence with the Literature ................................................................................................. 166
Congruence with the Theoretical Framework .................................................................................. 167
  Symbolic Interactionism ................................................................................................................. 167
  Chronicity ...................................................................................................................................... 169
  Vulnerability .................................................................................................................................. 169
Implications for Nursing Theory ...................................................................................................... 170
Implications for Nursing Research .................................................................................................. 171
Implications for Nursing Practice .................................................................................................... 173
Summary ........................................................................................................................................... 174
Limitations of the Study ................................................................................................................... 174
Recommendations ............................................................................................................................ 175
Summary of Chapter Five .................................................................................................................. 175

APPENDIX A: PARTICIPANT SCREEN .................................................................................................. 177

APPENDIX B: CONSENT TO PARTICIPATE ....................................................................................... 179

APPENDIX C: INITIAL INTERVIEW SCREEN ...................................................................................... 183

APPENDIX D: INTERVIEW QUESTION GUIDE .................................................................................... 185

APPENDIX E: DEBRIEFING SCRIPT .................................................................................................... 187

APPENDIX F: SUBSTANCE ABUSE RESOURCE LIST .......................................................................... 189

APPENDIX G: HUMAN SUBJECTS APPROVAL .................................................................................. 191

REFERENCES ...................................................................................................................................... 193
LIST OF ILLUSTRATIONS

FIGURE 4.1: Four Stage Theory of Craving for Alcohol ......................................................97
FIGURE 4.2: Winning the Battle: Successful Suppression of Cravings ...............................99
FIGURE 4.3: Gaining Ground: Partial Suppression of Craving ........................................100
FIGURE 4.4: Overcoming Craving: Successful Suppression .............................................101
FIGURE 4.5: Losing the Battle: Unsuccessful Suppression of Craving ................................102
FIGURE 4.6: Surrendering to Craving: Choosing Alcohol ..................................................102
FIGURE 4.7: Drinking: Craving Unsatisfied ........................................................................104
LIST OF TABLES

TABLE 1: Conditioning Models of Craving .................................................................44
TABLE 2: Cognitive Theories of Craving ....................................................................47
TABLE 3: Transdisciplinary/Integrative Models of Craving and Phenomenological Models of Craving .................................................................49
TABLE 4.1: Grounded Theory: Four Stages of Craving for Alcohol .........................90
TABLE 4.2: Stage One: Craving in the Background ...................................................91
TABLE 4.3: Stage Two: Craving in the Foreground .................................................93
TABLE 4.4: Stage Three: Management of Craving .................................................94
TABLE 4.5: Stage Four: Craving Unsatisfied .........................................................95
ABSTRACT

Alcoholism has been defined as a chronic progressive disease, the essence of which is manifest in the individual’s attachment to alcohol and the importance that alcohol assumes in his or her life. Craving is one of four phenomenon commonly reported by alcoholics as a significant source of discomfort. As a central feature of the medical model of alcoholism, craving could be viewed as a symptom of alcoholism. Because of its association with both relapse and loss of control, craving has quality of life implications, potential diagnostic value as a window into disease, and may be a prognostic indicator of treatment outcome.

The purpose of this study was to explicate the process of craving during the early recovery period. The research questions guiding this study are: What is the process of craving within the context of alcoholism? What is the relationship between craving and drinking behavior?

Grounded theory methodology facilitated the discovery process. The sample consisted of 14 informants, recruited from individual’s seeking medical care at the Southern Arizona VA Health Care System. Inclusion criteria include: age 18 or older; English-speaking; self-identification of alcoholism; self-report of craving; and sufficient memory of events for adequate recall and description. Following participant screening, data collection consisted of: written informed consent; elicitation of demographic data for background information; and assessment of craving through an hour-long audiotaped interview. Debriefing followed each interview, and informants were provided with information regarding community resources that could be contacted for additional
support. Audiotapes were transcribed by a skilled transcriptionist, with accuracy verified by both the researcher and the Dissertation Chairman. Participant pseudonyms provided the protection of privacy. Data analysis consisted of open coding, category formation, identification of core variables, and theoretical coding.

As an initial phase in a program of research, the outcome of this research was the development of a formal theory of craving, in recognition of potential applicability to other conditions in which craving is inherent, such as other addictive behaviors (gambling), addictive diseases (cocaine, heroin, nicotine), and medical conditions (obesity, eating disorders). The eventual goal is the investigation of interventions within a chronic disease framework.
CHAPTER ONE
INTRODUCTION

Despite recent advances in neuroscientific knowledge regarding addictive disease (Anton, 1996; Erickson, 1995; Meyer, 1994; O’Neill, 1996; Verheul, Van Den Brink, & Geerlings, 1999), our current understanding of alcoholism and efficacious treatment still lags far behind that of other diseases (Edwards & Grant, 1980; Milam & Ketchum, 1981; Miller, Gold, & Smith, 1997). Alcoholism is often identified late in its course, with the appearance of the consequences of and complications associated with alcohol abuse (Miller, Gold, & Smith, 1997; Lowinson, Ruiz, Millman, & Langrod, 1997). Loss of control and craving have been two key constructs of the medical model of alcoholism (Edwards & Grant, 1980; Jellinek et al., 1955; Ludwig & Wikler, 1974; Pattison, Sobell, & Sobell, 1977) while craving is one of four distinct perceptions commonly expressed by alcoholics in folk statements (Hore, 1974; Ludwig, 1986; Merikle, 1999; O’Neill, 1996).

The purpose of this research is to explore the process of craving within the condition of alcoholism. The outcome of this research is the development of a formal theory of craving, in recognition of potential applicability to other conditions in which craving is inherent, such as other addictive behaviors (gambling disorders), addictive diseases (cocaine, heroin, and nicotine dependence), and medical conditions (obesity, eating disorders). In the following sections, the background and significance of the problem, purpose of this research, research questions, significance to nursing, and theoretical perspective will be presented.
Background of the Problem

The importance of alcoholism in terms of costs to the individual and society will be addressed in this section. The significance of craving and its relationship to alcoholism will be examined, including definition of terms.

Alcoholism

The magnitude of alcohol problems is reflected in prevalence as well as individual and societal costs. The U.S. prevalence rate for alcoholism in the general population is 16% (28% in males, 8% in females) (Miller, Gold, & Smith, 1997). Translated to the 100,000 annual deaths directly or indirectly attributable to alcohol, abuse of alcohol vies with stroke and accidents as the third most important cause of death (Vaillant, 1996). In terms of resultant societal economic costs, the 1992 estimate of $148 billion is borne out as: 45.1% by the alcohol abuser and/or household, 38.6% by the government, 10.2% by private insurance, and 6.0% by alcohol-related trauma victims (Harwood, Fountain, & Livermore, 1998). Untreated alcoholics occupy an estimated 10-50% of hospital and emergency room beds for treatment of secondary health effects (McGrady & Langenbucher, 1996) and 25-50% of patients seeing a physician for a medical problem have an alcohol and/or drug diagnosis (Miller, Gold, & Smith, 1997). Yet only about 10% of alcoholism’s total cost to society is direct expenditure for clinically relevant costs: one-third (34%) are mortality costs (i.e., the 100,000 lives reduced an average of 28 years annually), and slightly more than one-third (39%) are morbidity costs. The resulting impairments in health, reduction in functional capacity, and treatment of
surrogate diagnoses accounts for almost 75% of the total annual cost of alcohol abuse (McGrady & Langenbucher, 1996).

**Problems in Definition and Diagnosis**

Research in alcohol dependence is lagging in comparison to other diseases, despite its high economic and societal costs (Pattison, Sobell, & Sobell, 1977; Vaillant, 1996). This is evident in the number of definitions, the lack of definitional clarity, the failure of definitions to capture the essence of the disease, and the proliferation of diffuse and nonspecific treatment which often results when disease causes and processes are poorly understood (Pattison, Sobell, & Sobell, 1997). Alcoholism has been described as an insidious disorder that is “cunning, baffling, and powerful” (Miller, Gold, & Smith, 1997, p. 29), and identification of the disease is often obscure, detected late in its course when the consequences of and complications from alcohol use become apparent. Similar to syphilis, “the great masquerader” which mimicked many other diseases in the pre-penicillin era, the many and varied expressions of medical and psychiatric consequences, as well as the moral implications of alcoholism often obscures its early diagnosis and treatment (Miller, Gold, and Smith, 1997).

**Current Definition**

Alcoholism in this study is synonymous with alcohol dependence. The concepts of the behaviors which underlie and generate alcoholism are embodied in the concept of addiction, defined by preoccupation, compulsivity, and relapse, giving rise to loss of control (Miller, Gold and Smith, 1997). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for alcoholism reflect these characteristics as a basis for
clinical diagnosis; however the essence of the disease is manifest in the individual’s attachment to alcohol and the distorted importance it assumes in his/her life (Miller, Gold, and Smith; Milam & Ketcham, 1981; O’Neill, 1996). The true disease hallmark is loss of control, as alcohol seems to react in the alcoholic’s brain to induce a kind of chemical slavery (O’Neill, 1996). This requires the distinction between two forms of problematic drinking: (1) alcohol abuse, a behavioral problem that implies choice (volition) in the use of alcohol, and (2) alcohol dependence, a medical disorder characterized by the loss of control (nonvolition) over alcohol use (Erickson, 1996; O’Neill, 1996; Milam and Ketcham, 1981). It is also apparent that the alcoholic’s claim that a very different and pathological relationship with alcohol is often experienced from the very first drink has been unsubstantiated by scientific study, and would be addressed by this proposed research.

Craving

The importance of craving in alcoholism is evident in its recognition as a central feature of the disease as well as its association with relapse. The strong urge to use a drug during periods of abstinence is a central feature of addiction. This has contributed to the resilience of craving as an important construct, despite attempts at abandonment of the use of the term craving in substance abuse research due to difficulties in both definition and measurement. The finding that craving is clearly a phenomenon experienced by most alcoholics, and not experienced by non-alcoholics, further underscores the importance of research into the clinical significance of the craving construct (Modell, Glaser, Cyr, & Mountz, 1992). Psychological and social treatment approaches to alcoholism have
resulted in only moderate success, with estimates that 28-80% of alcoholics drop out of the first month of treatment. Many of those who complete treatment are unable to remain abstinent or to avoid relapse (Froehlich & Li, 1993). Clearly, relapse represents the “sine qua non” of alcoholism (Gold & Miller, 1997, p. 27) with 7 out of 10 alcoholics relapsing during the first 6 months after treatment (Denzin, 1987) and 40%-60% abstinence rates estimated at one year following treatment (McLellan, Lewis, O’Brien, Kleber, 2000; Miller, Gold, & Smith, 1997). Consistent with the trend toward outpatient services and cost containment, the identification of craving (as a clinical feature) has been more recently linked to success (or failure) of outpatient detoxification (O’Connor, Gottlieb, Kraus, Segal, & Horwitz, 1991) as well as the basis for therapeutic decisions regarding treatment intensity and initiation of pharmacological agents as adjunct therapy (Anton & Drobes, 1998). Since craving is often implicated as one of those factors antecedent or at least contributory to relapse, an enhanced understanding of those elements influential in that process underscores more effective disease management. In short, the construct of craving has clinical as well as research implications.

Purpose of the Study

The purpose of this study was to explicate the process of craving within alcoholism. The focus of this study is craving during the early recovery period (initial abstinence from alcohol). The outcome of this initial phase in a program of research is the development of a formal theory of craving. The eventual goal is the investigation of interventions within a chronic disease framework. Grounded theory methodology was used to facilitate the discovery process.
Research Questions

This study was guided by the following two research questions:

(1) What is the process of craving within the context of alcoholism?

(2) What is the relationship between craving and drinking behavior?

Additional heuristic questions that provide the framework for understanding these two questions are: (1) What are your experiences with craving?

(2) How is craving defined?

(3) What is it like for you when drinking?

(4) What is it like for you when not drinking?

Metatheoretical Perspective

Nursing scholarship requires a critique of the assumptions that underlie the processes of inquiry as well as the knowledge that results (Bent, 1999). DeGroot (1998) describes a systems/process model for scientific inquiry in which four intrapersonal factors (world view, cognitive style, experience, methodological knowledge and skill) and two extrapersonal factors (influential others, sociohistorical context) influence each phase of the research process through their constant and mutual interaction with each other. World view is defined as the general philosophical orientation of the researcher, regarding the nature of human beings, knowledge and truth, and of nursing science. The underlying ontological and epistemological assumptions of a discipline’s world view drive its methodologies and function to: (1) provide a general orientation to phenomena of interest, (2) offer a way for organizing perceptions, (3) provide criteria for problem selection, (4) offer guidelines for investigation and methods, and (5) limit possible
solutions (Monti & Tingen, 1999). The purpose of this section is to describe the metatheoretical perspective that has influenced the development of the research question and proposed method of inquiry.

Traditional paradigms

Lincoln and Guba (2000) offer a comparison of the ontological, epistemological, and methodological bases for the five traditional paradigms: (a) positivism, (b) post positivism, (c) critical theory, (d) constructivism, and (e) participatory as the most recent addition. These five classic paradigms have been summarized into two predominant paradigms that characterize nursing science: empiricism and interpretative (Monti & Tingen, 1999). The ontological assumption of empiricism is that one reality exists for the purpose of verification and justification. Postpositivism (positivism influenced by historicism) represents a more recent variant in which the positivist emphasis on objectivity and the senses is moderated by sociological and historical context. The result is the recognition that reality can only be approximated, and an acceptance of qualitative methods of inquiry. Given its’ strength for hypothesis testing, the empiricism has demonstrated utility in the investigation of disease from the biomedical perspective, and is necessary for theory testing and validation of nursing practice.

However, empiricism has limited applicability in nursing. The discipline of nursing is both scientific and humanistic (Kritek, 1997) and as a profession, nursing has never focused solely on the physical body or on disease entities. Acknowledging the holistic nature of humans, nursing is concerned with the client’s experience of the condition, environmental influences that facilitate recovery, and social and spiritual supports that
enhance well-being (Frisch, 2003). The emphasis on an objective reality discovered only through the senses offers an inadequate means for exploring the array of human phenomena that are often the focus of nursing, especially the subjective experiences related to living, dying, and health. This paradigm is also less congruent with a nursing focus on holism, understanding of the human experience in health and disease, and other forms of knowing not verifiable by the senses.

The interpretative paradigm acknowledges the multiple meanings of reality and the derivation of knowledge from sources other than the senses. This paradigm’s ontological assumption of reality is that of complexity, holism, and dependence on context. Since the focus of investigation is on human experience, the emphasis is on subjectivity rather than objectivity. Because of the variability in reality and human experience, multiple ways of knowing are valued as a means to uncover knowledge within human experience. While the goal is to understand and derive meaning from human experience, instrumentation and conceptualization are also possible. Nursing knowledge originates within human relationship; multiple ways of knowing, including aesthetic, metaphysical, and sociopolitical may be more relevant for eliciting the relational phenomena of health, healing, and caring that is paramount to nursing (Bent, 1999). The nature and diversity of clients and settings in which nurses practice, and the predominance of females in nursing may reflect ways of knowing distinct from other disciplines or a different approach to knowledge development (Meleis, 1989). Carper’s (1987) four fundamental patterns of knowing (empirics, aesthetics, personal, and ethics) afford nursing its particular perspective and significance, making possible an increased awareness of the complexity
and diversity of nursing knowledge. Silva (1997) has suggested that it is time to value the truths arrived at by intuition and introspection to the same degree as those derived from scientific experimentation, since the scientist has no greater claim to truth than the philosopher. The adoption of an interpretative paradigm and the implementation of qualitative method of inquiry not only reflects a holistic view of health, but provides the means for the establishment of clarity regarding the phenomena that influence health, as a prerequisite for substantive grounding for practice.

The purpose of knowledge generation in nursing is to understand and care for individuals in relation to their health and their environment. A critical premise for the development of such an epistemology is that persons can only be adequately understood if studied holistically (Schultz, 1987). Holistic nursing care originates from the view that an integrated whole possesses a reality that is independent of and greater than the sum of its parts. The goal of holistic nursing is the enhancement of the healing of the whole person from birth to death (Dossey, Keegan, & Guzzeta, 2003). Such an approach requires an understanding of the interrelationships between the biologic, psychologic, sociocultural, and spiritual dimensions of the person who is also in interaction with the internal and external aspects of the environment (Engebretson & Littleton, 2001). Despite the recent nursing focus on holism and articulated theoretical position of holism as a central construct of nursing theories, nursing praxis has remained entrenched within the biomedical paradigms.

While the interpretative paradigm emphasizes humanistic approaches, it ignores the reality of physiological problems that are an integral part of a discipline such as nursing
that deals with health and disease, and embodiment. Nursing is not a social science, and must acknowledge those physiological and psychosocial phenomena that are at its core (Monti & Tingen, 1999). As summarized by Shalala “Nurses have one foot high on the crystal tower of knowledge and theory and one foot in the dust and grit of human need” (p. 7, as cited in Jacobs, DiMatto, Bishop, & Fields, 1998, p. 231). Nursing science must therefore address complex clinical problems dealt with daily in practice; research traditions that rely solely on interpretation are not amenable to the required theory testing. While qualitative methodologies such as grounded theory can offer theories that describe the knowledge embedded in practice, testing requires empirical methods. Kritek (1997) further suggests that the confusion regarding the multivariate nature of our practice and research and the complexity that our holistic perspective lends to this is one of the most troublesome aspects of our professional struggle. The goal however, is to “integrate the human spirit with physiological interventions” (Bartol & Courts, 2003, p. 86).

Objectivist/Constructionist Perspectives

Crotty’s (1998) framework which differentiates between objectivist research and constructionist research offers a means for resolution of the tension in nursing regarding the physiological and social realms. Objectivism, that truth and meaning reside in objects independent of consciousness, has been the epistemological foundation of western science. Constructionism holds that all knowledge, and thus all meaningful reality, is contingent upon human practice; constructed in and out of interaction between humans and their world, and developed and transmitted within a basic context. Meaning is not created, but constructed. From this perspective, the social world and the natural world are
not distinct worlds existing side by side, but are one human world in which our knowledge of the natural world is as socially constructed as our knowledge of the social world. Humans do not create the natural world but have to make sense of a world already in existence. The natural scientist studies nature as it is, from the outside and then invents concepts to describe and explain. Since the very existence of social phenomena originates from human action, the process of bringing these social realities into being requires the process of interpreting and reinterpreting them. Social realities are therefore meaningful by virtue of the very act that brings them into existence, in contrast to natural realities which are not. Crotty further illuminates the role of culture in the social world through the distinction between constructivism, as the individual’s experience of making meaning, and social constructionism, or the collective generation and transmission of meaning. Despite the confusion between realism (ontological notion that realities exist outside the mind) and objectivism (an epistemological notion that meaning exists inherently in objects), constructionism in epistemology is compatible with realism in ontology and this researcher’s beliefs.

**Symbolic Interactionism**

The theoretical perspective of symbolic interactionism is a sociological theory about human behavior in which people are believed to behave and interact on the basis of how specific symbols are interpreted and given meaning in their lives (Chenitz & Swanson, 1986). It is concerned with those basic social interactions by which we enter into a community’s perceptions, attitudes, and value, and become persons in the process (Crotty, 1998). Originating within social psychology and elaborated by George Mead
(1934) and Herbert Blumer (1969), symbolic interactionism is based upon the following interactionist assumptions (Benzies, 2001; Crotty, 1998). First, people (individually and collectively) act according to meanings that are ascribed to things. An underlying presupposition is that while the world exists separate from the individual, interpretation of the world using symbols (language) occurs during the process of interaction. Second, meaning arises through the process of interaction between individuals. The presupposition is that individuals have the ability to act on the basis of agreed upon meanings of things. Third, because meanings are assigned, they are subject to modification through the ever-changing process of interpretation. Reflecting a nondeterministic view of the individual, freedom of behavioral choice exists within the constraints of societal and cultural norms. Because of the inherent human cognitive capacity for abstract thought which precedes the symbolic use of language and gestures, a kind of thinking results in which objects and events can be placed in time, imaginary phenomena created, and learning transpire without directly encountering that which is required for learning. It is through this process of interpretation (of meaning) that people actively shape their future; selecting and interpreting stimuli to derive new meaning and arrive at new ways of responding.

Within the theoretical perspective of symbolic interactionism which informs the grounded theory methodology that will be used in this study, the individual and the context in which they exist are inseparable. The ontological assumption is that multiple realities exist; truth is tentative rather than absolute, since meaning changes with context. Address of theoretical questions about the nature of being occur through individual
interpretation of reality within a social context. The social world is a creation of human interactions; coming to know involves the search for ways to understand the meaning of a situation from an individual and group perspective (Benzies, 2001). Within this perspective, the individual and the context in which they exist are inseparable.

Perspectives on Chronic Illness

*Disease and Illness*

While the focus of medicine is disease, or biological malfunctioning, patients are concerned with the illness problems, or the way in which the individual within their social network experiences sickness (Kleinman, 1978; Tripp-Reimer, 1984). From this perspective, illness is a subjective phenomenon that represents personal, interpersonal, and cultural reactions to disease. Drew (1997) also suggests that a more accurate view of illness and healing is that of a social experience, since illness and healing are highly subjective realities that are dependent on cultural values and beliefs. Culture is that learned and shared system of symbolic meanings that share not only social reality but also personal experiences. Due to different cultures and cognitive systems of knowledge, clients and health professionals often view health, illness, and healing from different perspectives. The cognitive systems that have dominated our educational systems and defined our provider cultures have also contributed to the elusiveness of the illness and healing constructs. Effective intervention on the part of nursing therefore requires understanding of both physician (disease) and patient (illness) perceptions, likened by several authors to a process of culture brokering as a means for conflict resolution (Jezewski, 1995) and cultural negotiation as a model for nursing practice (Engebretson &
Littleton, 2001). Drawing upon the original work of Kleinman (1978), Tripp-Reimer (1984) suggests in her reconceptualization of the construct of health that it is within the domain of nursing to mediate between the etic perspectives of the biomedical model (focus on disease as biological and psychological malfunction) and the emic perspective of the patient (focus on illness as the subjective experience encompassing personal, interpersonal and cultural responses to disease) since each perspective in isolation is insufficient.

**Health**

In the Theory of Expanding Consciousness, Newman also asserts that disease and non-disease are not separate entities, but reflect the larger whole and represent a pattern of the whole (1994, 1995, 1997, 1999). Health, as an expansion of consciousness, is the process of living as fully as possibly rather than the achievement of a state to be maintained. Disease, reflecting the pattern of human-environment interaction, can serve as an integrating factor by providing the tension necessary for the expansion of consciousness. The nature of nursing is found in the nurse-client relationship, a partnership facilitative of the individual’s expanding consciousness, in which the task of the nurse is two-fold: (1) pattern recognition from which insight and action originate, and (2) mutual transformation (Newman, 1994). When health is viewed as the totality of life process and disease a meaningful aspect, the goal of nursing “is not to make people well, or to prevent their getting sick, but to assist people to utilize the power that is within them” in their evolution toward higher levels of consciousness (Newman, 1995, p. 115). This requires an acquisition of tolerance for the ambiguity and uncertainty prerequisite
for change and expansion, and a willingness to give up old agendas of fixing things and predetermined standards and definitions of health.

The “health within illness” concept (Moch, 1990) also suggests that the event of illness can facilitate the expansion of human potential through an acceleration of personal growth that results from increased awareness and transformational change. Consideration of illness as an opportunity for awareness shifts the current health care focus from fighting the enemy of illness to learning about oneself through the illness experience (Moch, 1990). Focusing on an illness experience leads to a problem orientation and deficit perspective in which a large part of the person’s whole experience is missing. Because people experience their body as a whole, the focus needs to shift to the health experience of chronic conditions to reflect the sense of wholeness in which the experiences of illness and health co-exist.

Consistent with this emphasis on holism and expansion is the more recent “insider view” of chronic illness that is concerned with understanding the meaning of illness (Thorne, 1999). This perspective of chronic illness employs a more qualitative approach to understanding illness through exploration of the inner meaning of the experience to the individual (Lewis & Lubkin, 2002). This is possible since the process of defining oneself as ill is a social process that involves not only the subjective experiences of physical and emotional changes, but the confirmation of those changes by others as well. Since an individual responds to his or her own definition of a situation (including symptoms and signs which are culturally influenced), an understanding of their perspective is
prerequisite for understanding the behavior and legitimizes a role for the patient as an authority regarding their chronic illness and craving.

**Definitions of Chronic Disease and Illness**

Definition of chronic disease requires the distinction between disease and illness, acute and chronic. Several authors have differentiated disease, the problem the practitioner views from the biomedical model, from illness, or the “human experience of symptoms and suffering” (Lubkin & Larsen, 2002). Acute disease is circumscribed, and characterized by the following: (a) sudden onset, (b) signs and symptoms related to the underlying disease process, (c) short duration, and (d) resolution with either full recovery (and resumption of prior activities), or death. The definition of chronic illness is more complex due to the following characteristics: (a) sudden or insidious onset, (b) difficulty identifying origination due to the contribution of multiple factors, (c) variable course, reflected by periods of exacerbation (episodic flare-ups) and remission (absence of symptoms), (d) indefinite duration, and (e) incorporation into an individual’s identity (Lubkin & Larsen, 2002). These characteristics of chronicity lend themselves well to a nursing definition of chronic illness as the “irreversible presence, accumulation, or latency of disease states or impairments that involve the total human environment for supportive care and self-care, maintenance of function, and prevention of further disability” (Lubkin and Larsen, 1995, p. 6-7). Similarly, the illness trajectory defined as the course of the illness over time as well as actions taken to influence that course is a useful framework for
understanding where an individual is in terms of both disease (symptomology and treatment) and illness experience (control of symptoms and day-to-day management of the condition) (Glaser & Strauss, 1967).

Alcoholism as a Chronic Disease

Alcoholism has traditionally been defined as a “chronic, progressive and potentially fatal disease characterized by tolerance, physical dependence, and/or pathological organ changes, all of which are the consequence of the drug ingestion” (Kerson & Kerson, 1985, p. 239) and characterized by exacerbation and remission during disease progression (Miller, Gold, & Smith, 1997; O’Brien, 1994). While alcoholism shares the characteristics of chronicity characteristics, there are several important differences.

First, the natural history of alcoholism is different in that much of what happens to an individual’s health is dependent upon continued use of alcohol and the degree of irreversible damage that has occurred (Kerson & Kerson, 1985). Alcoholism differs from other disease categories not in the kind or amount of physical damage caused, or its social or psychological impact, but in the terms of the societal view of the illness and its victims (Kerson & Kerson, 1985; McLellan, Lewis, O’Brien, & Kleber, 2000; O’Neill, 1996). Issues regarding societal definitions of acceptable behavior and responsibility which make it difficult for alcoholism to take its place alongside other chronic illnesses include: (a) confusion regarding alcohol use, misuse, and abuse, (b) failure to distinguish between physical and psychological dependence, (c) definition as a disease,
deviation, or criminal act, (d) legal issues concerning abuse of alcohol, and (e) definition of responsibility (Kerson & Kerson, 1985). In fact, the moralistic belief that alcohol use, abuse, and dependency lie on a continuum underpin the societal view that alcoholism is a self-inflicted disease in which alcoholics choose to go beyond harmless use and willfully drink to the point of dependence (Milam & Ketcham, 1981; O’Neill, 1996). It is for this reason that most people, including health professionals, believe that legitimization of alcoholism as a chronic disease removes the responsibility that society feels alcoholics should assume for their behavior (Lewis & Lubkin, 2002). When denied the legitimacy that allows the assumption of the sick role, clients are placed in problematic relationships in which they must arrive at solutions alone, leaving symptomatic persons to question the truth of their own perceptions. The importance of the resulting stigma in shaping disease definition and management is even more apparent in the recent observation that there are many illnesses (obesity, hypertension, chronic obstructive lung disease) in which voluntary behavior (volition) affects disease initiation and maintenance, especially when interacting with genetic and cultural factors. Risk factors such as obesity, stress level, and inactivity are the product of genetics, culture, and personal choice (McLellan, Lewis, O’Brien, & Kleber, 2000).

Second, the expensive effects of drugs on social systems (annual cost of 67 billion due to crime, lost work productivity, foster care, and other social problems) has been important in shaping the societal view of drug dependence as
a social problem in need of interdiction and law enforcement rather than a health problem that requires prevention and treatment (McLellan, Lewis, O’Brien, & Kleber, 2000). As a result, the definition and treatment of alcoholism as a chronic disease has been influenced by these factors in several important ways. Alcohol treatment has failed to borrow the study of medical response to chronic-relapsing disease, the first principle of which is to discover the natural history of the disease (Vaillant, 1981). Second, the failure to differentiate between voluntary initiation of behavior that leads to dependence and involuntary components (loss of control resulting from a changed brain) that are embedded within seemingly volitional choices has shaped current treatment strategies and outcome expectations in which alcoholism is viewed as an acute, curable condition (McLellan, Lewis, O’Brien, & Kleber, 2000; O’Neill, 1996). In the application of a chronic disease model to the disease of alcoholism, practitioners must adapt the care and medical monitoring strategies currently used in the treatment of other chronic illnesses to that of drug dependence (McLellan, Lewis, O’Brien, & Kleber, 2000; O’Brien, 1994; O’Neill, 1996). If current treatment does not seem to be more effective than the natural healing processes, it is imperative that health care professionals gain an understanding of those healing processes and the special role that they play in the facilitation of those processes (Vaillant, 1981).

**Craving as Vulnerability**

Vulnerability has been defined as the likelihood of experiencing poor health, within physical, psychological, and/or social parameters (Shi, 2001).
Vulnerable populations are those groups who demonstrate an increased relative risk or susceptibility to adverse health outcomes as evidenced by increased comparative morbidity, premature mortality, and quality of life (Flaskerud, 1998). Rogers (1997) further differentiates between vulnerability as that originating within the individual from risk which arises from the environment. However, vulnerability as normative deficit alone is inadequate for the predictions of individual health outcomes; strength and capacity are critical to the balance, but less accessible to understanding from an etic perspective in which phenomena are viewed by those outside the experience and expert view is valued (Spiers, 2000). Similarly, the etic perspective fails to explain phenomena of interest to nursing, such as addiction, that do not fit into the deficit/capacity balance.

The relationship of the metatheoretical perspective to the study of a vulnerable population requires an exploration of the craving construct within the construct of vulnerability. Within a phenomenological model (Jellinek, 1960; Anton, 2000; Lowman, Hunt, Litten, & Drummond, 2000; Meyer, 2000), craving is a symptom of the underlying disease of alcoholism, analogous to chest pain in cardiac disease and anhedonia in depression. When viewed as a prominent feature of addictive disease described as the “psychic pain of addiction” (Tiffany, 1997, S103), craving represents a vulnerability of chronic disease. From the perspective of researcher and clinicians, the pain of craving is the “most persistent, troublesome and intractable obstacle confronted by addicts attempting to remain abstinent” (Tiffany, S 103). For active substance users, moderate levels of drug
craving are acknowledged; abstinent addicts experience craving’s disruptive
effects on daily functioning, characterized by wrenching accounts of battles with
craving (O’Neill, 1996; Ludwig, 1986; Tiffany, 1997). In short, craving for
alcohol is significant for study as a central construct of addictive disease because
of its: (a) prevalence among addicts; (b) depiction as a significant source of
discomfort among alcoholics; and (c) association with both the loss of control and
relapse, important sources of significant morbidity and mortality among
alcoholics.

While the subjective nature of craving may best represent the heart of the
definitional problem, the difference in individual responses to craving at different
times reflects the crux of the issue for the individual (Ludwig, 1986). An emic
perspective of vulnerability is useful for understanding the experience of craving.
In this framework, vulnerability is a fundamental aspect of how individual’s view
their health and is recognizable as a quality of experience that is capable of
evoking different responses (Spiers, 2000). The primary assumption of emic
vulnerability is its existence as a lived experience, defined by the individual’s
perceptions of self, challenges to self, and resources available to withstand such
challenges. A second assumption is that people have a sense of themselves, with
the cognitive capacity to imagine their selves and their subjective experience. The
third assumption is that vulnerability is universal because of the potential for
danger from challenge as an existential human condition rather than aggregate
risk reflected in individual risk. And fourth, vulnerability is determined from the
perspective of the individual experiencing it. Spiers (2000) further identifies the following six attributes of emic vulnerability: (a) integrity, or soundness of various life dimensions; (b) presence of challenge calling for response; (c) capacity for action or ability to respond; (d) multidimensionality as variability among individuals and experiences; (e) power, or the extent to which a challenge influences action; and (f) mutuality through interpersonal interactions. There is no assumption that vulnerability has a direct impact on health and illness from the emic perspective, since vulnerability pertains to the whole experience, rather than risk factors, and represents a dimension of quality of life. This provides a framework for understanding how multiple challenges in individual’s daily experience are integrated and managed, and how choices related to prioritizing and selectively attending to challenges are manifested in quality of life. In summary, people experience the “troubles and turmoil of life in ways that cannot be captured simply by biomedical comparison to normative standards of risk. By reducing vulnerability to an epidemiological term, we reduce our vision of the world” (Spiers, 2000, p. 715).

Significance for Nursing

Nursing’s social sanction to assist those who are suffering is predicated on helping clients with the articulation of their own perceptions and realities rather than the imposition of externally defined conditions of health and illness. Exploration of the experience of vulnerability in relation to how the challenge is perceived has significant implications for interventions (Spiers, 2000).
**Symptom management in chronic disease**

Nurses have a primary responsibility for assisting individual’s in the management of their chronic illnesses. Consistent with the definition and characterization of chronic disease in which the goal is control rather than cure, symptoms often remain a major component that characterize the illness experience (Corbin & Strauss, 1992; Kleinman, 1978; Lubkin & Larsen, 2002). Often a source of significant distress and the most common reason for seeking medical care, symptom management is critical to effective disease management as well as quality of life (McDaniel & Rhodes, 1995; Rhodes & Watson, 1987).

When viewed from the same perspective as symptom management in other chronic diseases, craving is a source of significant distress, most troubling during early recovery when additional energy is required to resist it (Burman, 1997). Likened to the “psychic pain of addiction” (Tiffany, 1997), craving has significance with regards to quality of life. Despite the absence of an established causal relationship between craving and relapse, craving may well have inherent diagnostic value as has been the case for other symptoms such as chest pain in CAD, representing a “window to disease” (Haworth & Dulhy, 2001). In fact, symptoms inform the diagnosis of numerous other diseases, and in this case, craving would be an important indicator of the underlying process of addiction. A few authors have begun to explore symptom reduction and sobriety (Denney & Baugh, 1992), the measurement of quality of life in relapse and remission (Foster, Marshall, & Peters, 2000), symptom-triggered detoxification of alcoholics
(Wartenberg et al., 1990; Wiseman, Henderson, and Briggs, 1998), and alcohol craving as a predictor of outcome during outpatient detoxification (O’Connor, Gottlieb, Kraus, Segal, & Horwitz, 1991), and during treatment with a behavioral intervention and adjunct pharmacotherapy (Flannery, Poole, Gallop, & Volpicelli, 2003). However, little exists in the nursing literature specifically related to the management of craving as a symptom, or even its recognition as a symptom, despite the definition of alcoholism as a chronic disease. Within this framework, nurses would have the same responsibility for assisting individuals with symptom management, the ultimate goal of which is to avert negative outcomes and improve the quality of life, especially in those instances in which symptoms cannot be ameliorated (Corbin & Strauss, 1992).

The current models and theories of craving are consistent with the biomedical model and reductionist perspective in which the whole is reduced to its parts. A holistic perspective is necessary to facilitate the integration of the various dimensions in which craving is expressed into a comprehensive whole that is capable of more adequate explanation of the construct. While quantitative approaches have attempted to quantify craving, the reduction of experience to numbers (reflected in the current instruments that purport to measure of craving) (Singleton & Gorelick, 1998; Tiffany, 1992) has failed to move us closer to an adequate understanding of the construct or arrive at a more accurate definition of craving. An adequate definition of craving is required to guide research, theory and practice in nursing as well as related disciplines. A theory of craving derived
from an adequate and accurate definition of craving which integrates the various
dimensions of craving into a comprehensive whole is a prerequisite for testing of
various interventions and assisting individuals in finding meaning in their
experiences. Once nurses gain an understanding of what craving is and the effect
of various interventions, they can be instrumental in more effective management
of craving as a symptom of the chronic disease of alcoholism.

Summary of Chapter One

The first chapter provides an introduction to the importance of craving
within the context of alcoholism. The background and significance of the
problem, the purpose of the study, and the research question were presented. The
theoretical perspective for the study and influence of symbolic interactionism was
discussed. The significance of the study for the profession of nursing was
addressed. Chapter one concluded with an exploration of alcoholism within a
framework of chronic disease, and examination of craving within the perspective
of vulnerability. The following chapter presents the review of related literature.
CHAPTER TWO
REVIEW OF THE LITERATURE

The theoretical background, explicated in Chapter One, provides an initial orientation for the literature review. The literature review presented in Chapter Two is the result of an extensive search of the theoretical and empirical data to enhance the perspective of the substantive area of inquiry. The chapter includes a table of current models of craving synthesized from the literature. The chapter concludes with a summary of gaps in our current knowledge which would be addressed by this research.

Craving

Within the alcoholism literature, the influence of context is evident in: (a) the observation that individual’s respond differently to craving at different times, and (b) in the analogy of craving to other subjective states (hunger, sexual desire, and emotion) that are also influenced by contextual factors, such as motivation, learning, states of arousal, and environmental opportunities (Ludwig and Stark, 1974; Ludwig, 1986). Ludwig (1986) summarizes the current scientific thinking in the observation that it is easier to demonstrate the importance of craving in understanding alcoholic behavior than to define the role of craving in drinking behavior. The identification of conditions associated with craving, such as the onset of excessive alcohol use, binge drinking, relapse after a period of abstinence, and loss of control over drinking, as a substitute for adequate definition of craving reflects this difficulty. The term craving has also been used
to explain drinking that arises from needs that are psychological, physical (to relieve withdrawal symptoms), and/or (c) metabolic. Because the meaning of craving remains confusing and the term warrants more precise definition, several authors have suggested that it would be most helpful to find out what alcoholics mean by the term. From their study of 60 alcoholic veterans, Ludwig and Stark (1974) found that the majority experienced craving as an urge or need for alcohol or its desired effect, both when abstinent as well as after taking a drink. In conclusion, Ludwig suggests that while it is understandable that behaviorally oriented scientists would discount the importance of craving in order to avoid intangible urges and passion, the difficulty experienced in the observation and measurement of the phenomenon of craving does not make it any less real. “There are times, in fact, when craving is almost as palpable as any material object. The urge to drink may be intangible and unquantifiable, but for many alcoholics, it can be the most dominant force in their lives” (Ludwig, 1986, p. 15).

Traditionally, loss of control and craving have been two key interrelated constructs of the medical model of alcoholism (Jellinek, 1960; Ludwig, Wikler, & Stark, 1974; Miller, Gold, & Smith, 1997), while subjective craving is often incorporated into models of relapse as an appetitive aspect of physiological and psychological withdrawal (Isbell, 1955; Li, 2000; el-Guebaly & Hodgins, 1998). Craving has been associated with the transition of controlled drinking to alcoholism, the process of relapse, alcoholism treatment (Verheul, Van Den Brink, & Geerlings, 1999), and as a subjective marker of alcohol disorders.
(Singleton & Gorelick, 1998). Despite the voluminous literature on craving, its incorporation into many conceptualizations of addiction, and its prominence as a feature of alcoholism, craving remains a poorly understood clinical phenomenon that lacks definition and adequate theoretical conceptualization (Anton, 1999; Drobes & Thomas, 1999; Halikas, 1997; Tiffany, 1992). The table display of craving models (Anton, 1999; Drummond, 2001; el-Guebaly & Hodgins, 1998; Lowman, Hunt, Litten, & Drummond, 2000; Rohsenow & Monti, 1999; Singleton & Gorelick, 1998) and the following discussion of diverse craving perspectives is an attempt to integrate seemingly unrelated views into a more comprehensive whole.

**Conditioning Models**

The Withdrawal/Tolerance (Ludwig, Wikler, & Stark, 1974), Conditioned Incentive & Appetitive (Lewis, 1996), Neurobehavioral (Anton, 1996), and Incentive-Sensitization Models (Robinson & Berridge, 1993) are categorized as conditioning models because of the core characteristic of conditioning (or sensitization) that they share. Table 1 provides a summary of the conditioning models of craving. *Conditioned Withdrawal Models* are among the earliest explanations of craving, originating from the initial observations of drug opposite effects (*negative reinforcement*) that occur with alcohol cessation after chronic exposure (Isbell, 1955). While ample anecdotal, clinical, and experimental evidence exists to support priming or “first drink relapse phenomenon” (Ludwig, Wikler & Stark), these models fail to explain craving that occurs in the absence of
withdrawal symptoms. *Conditioned Incentive and Appetitive Models* posit that alcohol-related cues become conditioned stimuli (positive reinforcers) capable of eliciting the same craving or drug-like response as alcohol, serving as the catalyst for relapse or continued drinking through production of a subjective feeling of euphoria that is strongly reinforcing to the user. With support from both animal and pharmacological studies, these models offer an explanation of craving attributable to the associated euphoric effect or high. The failure to explain drinking in the absence of conscious craving, in the presence of negative consequences, or in relation to the observed inverse relationship between drug craving and the derived pleasure (Robinson & Berridge, 1993) represent their main limitation. The *Neurobehavioral Model* of alcohol dependence originates from a number of animal studies regarding the neurochemical effects of alcohol, and posits the anatomic structures and pathways involved in reward sensation and stress reduction, both believed to be mediators of alcohol-seeking behavior via sensitization. While support for this model is demonstrated through instrumentation (Anton, 2000) and the recent pharmacological development of anticraving medications (Swift, 1999), this model addresses only one dimension of craving. The *Incentive-Sensitization Theory of Addiction* suggests that craving and relapse, as the defining characteristics of addiction, are due to drug induced changes in the functions normally subserved by a neural system that has undergone sensitization-related neuroadaptations. Offering one of the best explanations of compulsive drug use in the face of diminished pleasure, aversive
withdrawal properties, and strong disincentive, and with pharmacological support
demonstrated as targeted neuroadaptations underlying sensitization, this model is
limited by its development and use primarily with drug addicts.
### Definition of Craving

Craving due to desire to experience positive or reinforcing effects associated with alcohol consumption. Alcohol-related cues become conditioned stimuli capable of eliciting craving or drug-like responses similar to alcohol.

### Tenets

<table>
<thead>
<tr>
<th>Model</th>
<th>Tenets</th>
<th>Assumption</th>
<th>Critique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conditioned Incentive &amp; Appetitive (Lewis, 1996)</td>
<td>Stimuli paired with drug administration become conditioned incentives that activate a central motivational state (or craving), which manifests as self-report, drug use, and autonomic responses. (Tiffany, 1997)</td>
<td>Craving causes drug use</td>
<td>Derived from empirical data. Fails to account for drinking in the absence of craving, or in the presence of negative consequences. (Robinson &amp; Berridge, 1993; Singleton &amp; Gorelick, 1998)</td>
</tr>
<tr>
<td>Tolerance Withdrawal Models (Ludwig et al. 1974)</td>
<td>Stimuli paired with drug administration become conditioned stimuli capable of eliciting conditioned withdrawal effects, which mimic autonomic &amp; affective aspects of withdrawal and which trigger craving. (Tiffany, 1997)</td>
<td>Craving causes drug use</td>
<td>Strong empiric support for stronger recurrence of craving during withdrawal phase (Lowman, 2000)</td>
</tr>
<tr>
<td>Neurobehavioral Model (Anton, 1996)</td>
<td>Posits hypothetical links between neurochemical systems (dopamine, glutamate, GABA, endogenous opioids), the stress reducing and reward enhancing effects of alcohol, and processes of sensitization and craving that result in compulsive drinking.</td>
<td>Craving causes drug use</td>
<td>Evidence from animal models and pharmacologic studies</td>
</tr>
<tr>
<td>Incentive – Sensitization (Robinson &amp; Berridge, 1993)</td>
<td>Sensitive brain system mediate a subcomponent of reward described as “incentive salience or wanting” rather than “liking” (or craving).</td>
<td>When sensitized, process of incentive salience produces compulsive drug-seeking.</td>
<td>Does offer explanation for: (a) Incongruence between craving self-reports and drinking, (b) Dissociation between craving self-report, euphoria, and dysphoria, (c) Increase in craving after substance use. Limited by development with animal models and use with stimulants (Drummond, 2001)</td>
</tr>
</tbody>
</table>

#### TABLE 1: Conditioning Models of Craving
Cognitive Models

Originating from social learning theory, these models posit that cognitive factors mediate the interaction between the individual, situational demands, and coping efforts. Table 2 provides a summary of the cognitive models of craving. Experimental evidence suggests only limited support for Marlatt and Gordon’s (1985) classic and well-known Relapse Prevention Model, suggesting the need for model respecification due to only moderate inter-rater reliability and predictive validity (Larimer, Palmer, & Marlatt, 1999). Failure to demonstrate support for the main tenets of this model (self-efficacy and expectations) is significant because of the influence of this model on alcoholism treatment and the clinical practice to date. Tiffany and Carter (1998) have challenged the underlying assumption that craving causes drinking. The Cognitive Processing Model (Tiffany, 2000) instead characterizes compulsive drug use as automatized behavior which operates independently of craving (Tiffany, 1997). While the demonstration of slower reaction times for task completion in the presence of alcohol-related cues supports the hypothesis that craving is cognitively demanding, the model is limited by its use primarily with smokers.

Rather than a theoretical model of craving, the extensive cue-reactivity literature suggests a Cue-Reactivity Paradigm for assessing (subjective) craving, physiological (autonomic), and behavioral (drug-use) responses to drug cues (Drummond, 1995; Tiffany & Carter, 1998). Developed within experimental conditions, the applicability of this model to natural settings and the real world
has been questioned. However, an extensive literature exists regarding cue reactivity in relation to cocaine and heroin, as well as alcohol.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of Craving</td>
<td>Craving in relapse is mediated by expectancies (anticipated effect of drug), conditioned stimuli, and self-efficacy (Drummond, 2001)</td>
<td>Craving as a constellation of verbal (subjective), somatovisceral, and behavioral responses that occurs with denial of drug access.</td>
<td>Subjective craving or cognitive symbolic manifestations of responsivity to drug cues.</td>
</tr>
<tr>
<td>Tenets</td>
<td>A theory of relapse, rather than craving. Craving experienced as the expectation of positive benefits of drinking especially in high-risk situations characterized by low self-efficacy (Singleton &amp; Gorelick, 1998)</td>
<td>Drug use is an automatic process, carried out without conscious awareness of effort, (similar to driving a car). Comprised of two components: (a) automatic functioning (drug use); and (b) non-automatic functioning (drug use denied) in which craving is experienced.</td>
<td>Represents a paradigm in which in exposure of individual’s to drug relevant cues under experimental conditions facilitates the study of craving and its relevance to drug-seeking behavior.</td>
</tr>
<tr>
<td>Assumption</td>
<td>Craving results in drinking</td>
<td>Craving does not cause drinking</td>
<td>Craving results in drinking; Altered cue reactivity reduces relapse liability</td>
</tr>
<tr>
<td>Critique</td>
<td>Has been widely adapted by the treatment community, despite limited research support. Supported by decreased confidence in the ability to abstain following cue-exposure.</td>
<td>Offers an explanation for drinking that occurs in the absence of craving.</td>
<td>Does not assume any theoretical model of craving.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Offers an explanation for drinking that occurs in the absence of craving.</td>
<td>An empirical treatment approach to test craving theories.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires further empiric testing in clinical addict populations, since developed with smokers.</td>
<td>Limited generalizability from experimental to natural setting.</td>
</tr>
</tbody>
</table>
Transdisciplinary/Integrative Models

These models differ from the earlier models in the provision of a more comprehensive explanation of craving through address of several dimensions or domains, and specificity for the construct of craving rather than craving within the construct of drinking or relapse. Table 3 depicts a summary of the Integrative Models of Craving. The Three-Pathway Psychobiological Model of Craving for Alcohol (Verheul, Van Den Brink, & Geerlings, 1999) is unique in its incorporation of individual differences into each of the three craving pathways. The strength of the model in synthesizing the best evidence from several disciplines (psychological, neurobiological, and psychopharmacological) is limited by failure to incorporate the subjective dimension. The Transdisciplinary Conceptualization of Craving (Abrams, 2000) addresses biological, psychological, and socio-cultural dimensions of craving in a biopsychosocial model that requires further development and testing by multiple disciplines. Despite its blueprint for transdisciplinary development and testing, this model also suffers from failure to address the subjective dimension of craving.
TABLE 3. Transdisciplinary/Integrative and Phenomenological Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Definition of Craving</th>
<th>Tenets</th>
<th>Critique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three-Pathway Psychobiological Model of Carving for Alcohol (Verheul et al. 1999)</td>
<td>Craving differentiated into three manifestations due to different underlying mechanisms and individual differences.</td>
<td>Reward craving (the desire for rewarding or enhancing effects of alcohol) results from dopaminergic/opioidergic dysregulation, reward seeking personality type, or both.</td>
<td>Strength derivation from numerous lines of evidence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relief craving (the desire for tension reduction) due to Gabaergic/glutamatergic dysregulation, stress reactive personality type, or both.</td>
<td>Fails to incorporate subjective aspect of craving.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obsessive craving (as a lack of control over intrusive thoughts of drinking) related to serotonin deficiency, disinhibited personality type, or both.</td>
<td></td>
</tr>
<tr>
<td>Transdisciplinary Conceptualization of Craving (Abrams, 2000)</td>
<td>Craving as a subjective experience within awareness, reflecting the retrieval of a strong learned desire (from memory) to satisfy a need</td>
<td>Three major parameters of craving (biological, psychological, and contextual or social-cultural) which may independent, additive, or interactive.</td>
<td>New Model conducive to further testing of various domains of craving.</td>
</tr>
<tr>
<td>Clinical Perspectives; Anecdotal Accounts (Drummond, 2001; Lowman, 2000).</td>
<td>Craving viewed as a symptom of an underlying addictive disorder.</td>
<td></td>
<td>Strengths include attention to human experience (Drummond) and derivation from empirical evidence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lack of clear specification of conditions under which craving is elicited is more useful for hypothesis generation.</td>
</tr>
</tbody>
</table>

Differentiation between “non-symbolic” or physical craving (as a manifestation of withdrawal), and “symbolic” craving (after prolonged abstinence) (Isbell, 1955). |

Craving as a manifestation of alcohol dependence (analogous to chest pain in heart disease) (Jellinek, 1957; Anton, 2000; Meyer, 2000; Edwards & Gross, 1976).
Phenomenological Models

Derived from clinical observation, these models posit a perspective in which craving is viewed as a symptom of an underlying addictive disorder (Anton, 2000; Drummond, 2001; Meyer, 2000), analogous to chest pain in heart disease and anhedonia in depression. Table 3 displays the Phenomenological Models of Craving. Subjective craving is also included in this category, as a holistic experience rather than another dimension of craving. While the strength of this aspect of craving is the derivation from anecdotal information and empirical data, the lack of clear specification of the conditions under which craving is elicited has utility in hypothesis generation rather than testing.

Denzin (1987) offers a phenomenological analysis of the alcoholic experience of men and women through a combination of life histories, ethnographic description, and phenomenological interpretation. Rather than investigation of craving from the same lived experience perspective, this author explores craving from three groups of scientific theories of alcoholism. Smith (1998) undertook a hermeneutic-phenomenological study to explore the problem drinker’s lived experience of suffering which highlighted the distress experienced by six problem drinkers. Banonis (1989) undertook a phenomenological approach to explore the phenomenon of recovery from addiction. While the lived experience of recovery for three nurses was characterized as the struggle to move from darkness to light, craving is not addressed. Both Smith and Banonis failed to address craving. From listening to recovering alcoholics tell their stories, O’Neill
(1996) identifies craving as one of four distinct perceptions commonly expressed by alcoholics in folk statements. Despite the past reluctance of society to accept alcoholic’s insights, he questions whether alcoholics and researchers are speaking with one voice but failing to hear each other, in view of the parallel between these anecdotal reports and the recent directions pursued by neuroscientist. Similarly, Milam & Ketcham (1981) provide one of the few depictions of alcoholism from both an etic (non-alcoholic perspective) and emic (alcoholic perspective). Their definition of craving reflects its evolution that corresponds with disease progression. Despite the value of anecdotal descriptions in unraveling the mystery of craving, the absence of systematic investigation and scientific rigor limits their validity and reliability.

In a rare exploratory study with 60 alcoholic men, Ludwig (1974) found that the proportion of the sample that acknowledged craving increased from 78% to 98.4% when open-ended questions replaced completion of a structured instrument that limited responses and restricted descriptions. In a similar descriptive study of 116 alcoholics asked to describe craving and the situations in which it occurred, Hore (1974) reported that 33% had experienced craving the preceding week which was perceived as either an emotional state similar to anxiety or as a mental experience in which thoughts were dominated by one idea. While these early attempts acknowledge the subjective aspect of craving through modification of structured questionnaires, limited description is provided.
More recently, Westerberg (2000) in an exploration of craving descriptors in 213 treatment seeking alcoholics found that the experience of craving was associated with more dysphoric states, physical feelings associated with thoughts of alcohol, more thoughts of alcohol, and desire for alcohol in response to environmental cues. While these findings validate physiologic and psychologic components of craving, little information is gained regarding the subjective experience of craving.

In the best and only study to date exploring the subjective experience of craving, Merikle (1999) in a sample of 23 substance abusers examined the descriptions of craving and situations that gave rise to it for common themes. The subjective experience of craving was characterized by the following eight dimensions: specificity, strength, positive outcomes, behavioral intention, thoughts, physical symptoms, affect, and cues. Despite the small sample size limiting generalizability of the results and the heterogeneity of the sample, this study is an important first step toward the development of an understanding of the subjective experience of craving.

Current Gaps

It is evident that a lack of conceptual clarity has implications for both the definition and measurement of craving which are attributable to several factors. First, the construct of craving is intertwined with several other theories and constructs (such as loss of control) that also lack clarity. Craving has been viewed as antecedent to, equivalent with, and a consequence of the loss of control
(Drobes & Thomas, 1999; Verheul, Van Den Brink, & Geerlings, 1999). This failure to differentiate the core components or dimensions of craving (such as irresistible urges) from both antecedents as well as consequences of craving (such as drinking) contributes to inadequate definition. These authors suggest that adequate definition requires restriction to strong urges or desires to drink that are subjectively experienced, with exclusion of potential precipitating and consequential factors for the sake of conceptual clarity. They further caution against a priori predictions about the nature of craving (supposed anticipatory/expectant qualities or conditioned status) which have the potential to influence the recognition of the importance of individual differences with respect to aetiological pathways (Verheul, Van Den Brink, & Geerlings).

Second, despite the conceptualization of craving as a central state (similar to fear or anxiety) representing a multi-dimensional response system comprised of subjective, behavioral, physiological, and biochemical correlates and the interrelationships (Geerlings & Lesch, 1999; Rankin, Hodgson, & Stockwell, 1979), disagreement exists whether craving represents a physiological, psychological, or behavioral state. Simple, single-factor models that focus on only one dimension of craving have developed that are consistent with the biomedical model and reductionist perspective in which the whole is reduced to its parts. However, while these models may afford an accurate representation of one dimension of craving, they are more indicative of a particular field of study than a scientific approach to craving. This inadequacy is related to: (a)
description of a multidimensional construct through a one-dimensional perspective; and (b) failure to recognize that differences in craving may reflect the placement of different explanatory labels on similar underlying states (during the cognitive labeling process) rather than the expression of different kinds of craving (Kozlowski & Wilkinson, 1987). While dimensions of a multidimensional construct may fall within the domain of various scientific disciplines, the failure to integrate the various perspectives and synthesize the isolated dimensions of craving into a comprehensive whole severely limits conceptual clarity, and thus utility, or the craving construct.

Third, and most important, the heart of the problem of definition is in understanding the subjective nature of the phenomenon of craving (Halikas, 1997; Hore, 1974; Koob, Weiss, Tiffany, Zieglgansberger, & Spanagel, 1999; Kozlowski & Wilkinson, 1987; Merikle, 1999; Pickens & Johanson, 1992). Despite the consensus as to the subjective nature of craving, there is little exploration of craving using qualitative methods. For the few attempts at portrayal of craving from the perspective of the alcoholic, the evidence of scientific rigor is often lacking.

Current conceptual status of craving

Craving represents a unique research challenge in that we continue to develop techniques for its measurement, yet are still unable to offer a precise definition of what is being measured (Flannery et al., 2001). There are several reasons however, for careful description of the subjective state (Kozlowski &
Wilkinson, 1987). First, drug users have an appreciation of the term as reflected in the common jargon (DeWitt, 2000; Ludwig & Wikler, 1974; Merikle, 1999). Second, past measures of craving have consisted of single and multi-item questionnaires in clinical settings, and behavioral measures (cognitive test performance, alcohol consumption) and psychophysiological measures (salivation, heart rate changes) in the research arena (Drobes & Thomas, 1999). Despite the recent development of several multi-item instruments, it is still unclear whether they are accurately measuring craving or some other related phenomenon (Flannery et al., 2001). Since ordinal scales rely on the patient’s interpretation of craving and the more specific questionnaires rely upon judgments regarding craving severity, some authors have emphasized the importance of understanding the meaning of the word craving to patients (Potgieter, Deckers, & Geerlings, 1999). Third, recent challenges to the traditional assumptions warrant the development of a comprehensive etiological model that differentiates core components of craving, such as irresistible urges, from both the antecedents (and precipitants) as well as the consequences of craving, such as drinking (Verheul, Van Den Brink, & Geerlings, 1999). For example, several authors have challenged the assumption that craving causes drinking (Flannery et al., 2001; Miller & Gold, 1994; Tiffany, 1997) or that there is consistency in the meaning ascribed to the term craving among professional and addicts (Sithartan & McCarth, 1992).
The current models and theories of craving are consistent with the biomedical model and reductionist perspective in which the whole is reduced to its parts. A holistic perspective is necessary to facilitate the integration of the various dimensions in which craving is expressed into a comprehensive whole that is capable of more adequate explanation of the construct. While quantitative approaches have attempted to quantify craving, the reduction of experience to numbers (reflected in the current instruments that purport to measure of craving) (Singleton & Gorelick, 1998; Tiffany, 1992) has failed to move us closer to an adequate understanding of the construct or arrive at a more accurate definition of craving.

Probably the most critical gap is the failure to explain craving as a subjective experience. Despite the repetition of certain anecdotal phenomena reported by recovering alcoholics and acknowledgement of the subjective nature of craving, there is a dearth of information on the subjective experience. The majority of scientific investigation to date has focused on single dimensions and empirical aspects of craving rather than the actual experience of craving from the vantage of those experiencing it. O’Neill (1996) has identified the reluctance of the public and the scientific community to listen to the “voice of the victims” and highlights the parallel between neuroscience and anecdotal accounts. He suggests that researcher and those afflicted have been speaking the same language, but not listening to each other in their descriptions and investigations of commonly reported phenomena such as craving (serotonin), euphoria (dopamine), and
normalization (endorphins). While craving is not usually identified by alcoholics as the reason for relapse (Tiffany, 1992/2000), there appears to be an explicit theory of craving that is evident among addicts (Hore, 1974; Merikle, 1999; O’Neill, 1996; Tiffany, 2000). Despite the difficulty of behavioral scientists in measuring other similar subjective phenomena, such as fear, when there is no objective yardstick, the exploration of craving as a subjective experience (Anton, 1999; Halikas, 1997) through a qualitative approach with its emphasis on the individual and on the meaning of the lived experience (Charmaz, 2000) would allow a closer approximation to the construct of craving, in a manner consistent with other problems of interest to nursing for which quantitative approaches are inadequate. When craving is explored through qualitative methods as a subjective experience expressed through physiological, psychological, behavioral, and emotional domains, the resulting conceptual clarity facilitates the generation of middle range theory (Jezewski, 1995). Through description and characterization of this subjective experience of craving, my research addresses these critical gaps. The clarification of this construct could further inform model development from a variety of perspectives and disciplines.

In summary, the current models of craving are limited in their conceptualization of craving which highlights the existence of several major gaps in the literature. First, the conceptualization of craving from a single cognitive, neurophysiological, physiological, or behavioral perspective has resulted in an array of one-dimensional craving models that address only one dimension of the multidimensional craving construct. The inadequacy
of these models are related to: (a) description of a multidimensional construct through a one-dimensional perspective; and (b) failure to recognize that differences in craving reflect the placement of different explanatory labels on similar underlying states (during the cognitive labeling process) rather than the expression of different kinds of craving. Second, the failure to integrate the various perspectives and synthesize the isolated dimensions of craving into a comprehensive whole represents a major gap.

In conclusion, current theories of craving have focused on etiologic mechanisms or the response to interventions without exploration of the subjective experience. The conceptualization of craving from single cognitive, neurophysiological, physiological, or behavioral perspectives has resulted in an array of one-dimensional craving models that address only one dimension of this multidimensional construct. This failure to explore craving as a subjective phenomenon and the failure to integrate the physiological, psychological, emotional, and behavioral dimensions into a comprehensive theory of craving are the two major gaps that have contributed to the failure to adequately conceptualize, define, and measure craving and has provided fertile soil for different interpretations of the term by clinicians, researchers, and addicts.

Summary of Chapter Two

This chapter provided a review of the literature in which the current knowledge of craving has been synthesized into the following categories: Conditioning Models, Cognitive Models, Transdisciplinary/Integrative Models, and Phenomenological Models. The Table of Craving Models depicts this
organization. Knowledge of craving as a subjective experience is addressed from within the Phenomenological Model. The current gaps in our knowledge are addressed through description of contributing factors. The chapter concludes with a review of the current conceptual status of the construct. In Chapter Three the methodology is presented.
CHAPTER THREE

METHODOLOGY

This chapter describes the methodology that was used in this study. It is organized into three sections: background of grounded theory; description of the procedures; and data quality. The background section includes a discussion of the usefulness of the grounded theory method for elucidating nursing phenomena from a qualitative research framework. This section includes a description of the symbolic interactionism theoretical perspective and the grounded theory process. The procedures section includes theoretical sampling, data collection procedures, and data analysis. The section on data quality addresses the issue of trustworthiness in this grounded theory study.

Qualitative Research

Qualitative research involves broad questions about human experience in which research strategies are employed during sustained contact with individuals in a naturalistic setting to obtain rich, descriptive data that enhances our understanding of individual experience (Boyd, 2001). Because the socially constructed nature of reality, the intimate relationship of the researcher with those studied (value-laden framework), and situational constraints shaping inquiry characterize qualitative research, answers are sought that emphasize how social experience is created and given meaning (Denzin & Lincoln, 2000). With a goal of theory construction rather than theory testing (Gallo, 1996; Morse & Field, 1995), qualitative research allows one to make sense of reality, explain and describe the social world, and develop explanatory models and theories.
Since the research question should guide the selection of the most appropriate approach (Morse & Field, 1995; Streubert & Carpenter, 1999), qualitative methods are appropriate when: (a) little information is known about a phenomenon, (b) there exists the suspicion that current theories or knowledge may be biased (Morse & Field, 1995), and (c) answers are sought for clinical questions in nursing in which human subjectivity and interpretation are inherent (Streubert & Carpenter, 1999).

Qualitative research offers alternative strategies for the development of knowledge about how persons make meaning in illness, and allows nurses to construct alternative and clinically applicable understandings for puzzling phenomena that are commonly encountered in clinical practice (Thorne, 1999). Consideration of the experiences of nurses and patients in the development of nursing theories enhances the descriptive and explanatory power as well as scope and utility of such theories (Jezewski, 1995). Qualitative findings often augment the meaningfulness of quantitative results, enhancing a real-world understanding of those results even when findings are statistically insignificant (Guzzetta, 2003). Thorne further describes the following outcomes of qualitative research regarding illness experience: (a) construction of a base upon which clinical wisdom can be based, (b) generation of additional research questions, which in combination with quantitative approaches can provided future direction for nursing; (c) promotion of skills of individual nurses to include empathy, advocacy, better system and service organization, and enhanced decision making capacity regarding when to intervene versus step back in order to prevent and minimize crises. Through an enhanced understanding of patients and the embedded complexities of the illness experience, nurses
are better able to fulfill the profession’s mandate to society. As summarized by Vassiliki (1981) “it seems…nothing less than tragic if nurses, in their concern for a kind of upward mobility, pride themselves on becoming increasingly scientific and analytic, and doctor-like in their relations to patients and far less human and far less compassionate as they relate themselves to the problems of their patients. Someone has to provide nourishment to the human spirit for those who are sick, and if nurses fail to do this, then we shall have to invent a new profession” (p. 15, cited in Bulger, 1996, p. 338).

With regards to craving, a qualitative approach is appropriate for several reasons. First, the concept of craving remains a poorly understood clinical phenomenon despite its incorporation into the many conceptualizations of addictive behavior. Despite the voluminous literature on craving, there is no adequate definition of craving. While instruments such as the Obsessive-Compulsive Drinking Scale (Anton, 2000) can provide general claims about a population group through transformation of the experience of craving into a numerical form, such instruments are unable to assist with interpretation of scores or facilitate understanding of their meaning (Thorne, 1999). Thorne suggests that the attachment of selected theoretical concepts to certain disease conditions followed by the assumption that this represents the way individuals feel about their situation has resulted in the current standardized or textbook way of understanding the meaning within illnesses. However, uncovering meaning embedded in illness phenomena through qualitative research affords nurses with a wider angle of vision regarding what clients are actually experiencing and what nursing care should involve. What also follows is an appreciation that the apparently illogical and irrational responses of clients are the
product of predictable clashes between client values and professional socialization (Thorne, 1999). The construct of craving within the context of alcoholism is a case in point, in which an implicit and unchallenged assumption is that craving causes or results in drinking behavior. Because the construct of craving has been characterized from this traditional textbook approach to understanding meaning rather than qualitative exploration, the behavior of those experiencing craving is often viewed as illogical and irrational. Through the use of a qualitative approach to the question of meaning, alternative and clinically applicable explanations for such puzzling clinical phenomena can be achieved and the process facilitated in which nurses begin to think differently about human health and illness as well as the potential role of nursing (Thorne, 1999).

Symbolic Interactionism

Symbolic interactionism, as discussed in Chapter One, is a theoretical perspective for the grounded theory methodology. Symbolic interactionism which will guide this proposed study is based upon the meaning that situations or events hold for the individual. Within this theoretical perspective, the individual and the context in which they exist are inseparable. The ontological assumption is the multiple realities exist; truth is tentative rather than absolute, since meaning changes with context. Address of theoretical questions about the nature of being occur through individual interpretation of reality within a social context. The social world is a creation of human interactions; coming to know involves the search for way to understand the meaning of a situation from an individual and group perspective (Benzies, 2001). This is consistent with the assumption that the insider’s perspective (the person with the disease) regarding daily
self-care decisions is best revealed through interpretative methods (Paterson, 2001; Thorne, 1999; Lubkin & Larsen, 2002). The etic perspective of vulnerability, which reflects functional incapacity according to normative social expectations, is therefore inadequate for the explanation of phenomena such as addiction that do not fit a deficit/capacity balance (Spiers, 2000). For these reasons, contemporary nursing theorists have advocated that clients be assisted with the articulation of their own realities and perceptions, rather than have external definitions of health or illness imposed upon them (Spiers, 2000).

From a symbolic interactionist perspective, nursing research is situated within the natural world of human behavior and social life. It is therefore imperative to understand not only what the individual knows about their world, but also what they believe to be important. Research questions focus on how individuals interpret meaning and how they act in particular contexts, since context constrains behavior. Because both the individual and society are dynamic, research questions also explore the attribution of meaning. Since interaction is the critical link between an individual and society, it becomes a focal point for nursing research (Benzies, 2001).

Within the alcoholism literature, the influence of context is evident in: (a) the observation that individual’s respond differently to craving at different times, and (b) in the analogy of craving to other subjective states (hunger, sexual desire, and emotion) that are also influenced by contextual factors, such as motivation, learning, states of arousal, and environmental opportunities (Ludwig, Wikler, & Stark, 1974; Ludwig, 1986). Similar to other constructs such as fear and anxiety, craving may be viewed as a multi-
dimensional response comprised of subjective, behavioral, physiological, and biochemical correlates. The relationship among these correlates warrants further exploration in order to arrive at a more adequate understanding of this general state, since overt behavior (drinking) is just one means of getting data representative of such a state (Rankin, Hodgson, & Stockwell, 1979). The identification of conditions associated with craving, such as the onset of excessive alcohol use, binge drinking, relapse after a period of abstinence, and loss of control over drinking, as a substitute for adequate definition of craving is indicative of the difficulty in defining the role of craving in drinking behavior.

Grounded Theory Methodology

Symbolic interactionism describes both a theory about human behavior as well as a method of inquiry (Annels, 1996), and embraces both qualitative and quantitative methodologies. However, the development of the grounded theory method from the symbolic interaction tradition of social psychology represented a response to the limitations of symbolic interactionism as a research method. Developed by Barney Glaser and Anselm Strauss (1967), grounded theory combines inductive and deductive research methods in order to explain a given social situation through the identification of core and subsidiary processes occurring within it (Baker, Wuest, & Stern, 1999). Through a combination of inductive and deductive research methods, social processes within human interactions are explored in order to discover theoretically complete explanations about phenomenon, and thus develop theory (Glaser & Strauss, 1967; Glaser, 1978). Being grounded in data that are systematically gathered and analyzed entails looking at how variables are given meaning in subjects lives (Charmaz, 2000) and the development of
increasingly richer concepts and models that explain how the phenomenon being studied really works (Glaser, 1978).

Grounded theory is unique in its origination from empirical data, openness to refinement, and emphasis on the analysis of a basic social process (Stern, 1980). Grounded theory is distinguishable from other methodologies by the following: generation of the conceptual framework from the data rather than the literature; (b) emphasis on the discovery of dominant processes in the social scene rather than description of the unit under study; (c) comparison of all data with all other data (qualitative comparative analysis or continuous comparative analysis); (d) modification of the data collection process according to the emerging theory; and (e) simultaneous data collection and analysis (Glaser, 1978; Glaser & Strauss, 1967; Stern, 1980/1994). Grounded theory strategies include: (a) simultaneous data collection (rich data from multiple sources) and data analysis (initial or open coding, generation of action codes, selective or focused coding, categorization); (b) category refinement and development; (c) data reduction and theoretical sampling; and (d) theory construction. Additional processes that are interwoven with these strategies throughout the process include memo writing (initial coding and later theoretical coding) and constant comparison.

The actual grounded theory approach includes: (a) theoretical sampling, the process in which data are collected, coded, and analyzed while simultaneously deciding the future direction of data collection; (b) substantive coding, through open coding and selective coding to explain what is happening in the data; (c) theoretical coding by the process of memoing in order to identify the core; and (d) theoretical sorting as the
process of organizing the memo’s into an outline for writing (Glaser & Strauss, 1967).

The relationship between data and theory is the conceptual code, or the conceptualization of the underlying pattern of a set of empirical indicators found within the data. By developing the hypothetical relationships between conceptual codes (categories and their properties) that have been generated as indicators from the data, “we discover a grounded theory” (Glaser, 1978, p. 55).

Glaser & Strauss (1967) further describe the following four stages of the constant comparative method. First, incidents applicable to each category are compared, based on the rule that comparisons are made with the previous incidents in the same and different groups while coding an incident for a category. Second, categories and their processes are integrated as the unit changes from comparison of incident with incident to comparison of incident with properties of the category. Third, delimiting of the theory occurs at the level of both theory and the categories through the processes of reduction and theoretical saturation. Reduction involves (a) the discovery of underlying uniformities in the original set of categories or properties that can be formulated into the theory as a smaller set of higher level concepts; and (b) reduction in the original list of categories for coding. Fourth, writing the theory results from collation of the memos written about the categories, or major themes of the theory. Since grounded theory is grounded in the data (relevant variables) rather than existing theory: (a) it offers the potential for transcending preexisting theories by means of a constant comparative method, and (b) it yields a more readily applicable theory (Glaser, 1978). Glaser (1978) summarizes the relevancy of grounded theory as dealing with “what is actually going on, not what ought to go on. It
gives traction over action; it makes sense, but making theoretical sense of common sense” (p. 14). Because craving for alcohol among alcoholics is a subjective experience as well as a process that has been associated with (and thus influenced by) acute withdrawal, protracted abstinence, stress, cues in the environment, (Koob, Weiss, Tiffany, Ziegglansberger, & Spanagel, 1999), alcohol ingestion (Ludwig, Wikler, & Stark, 1974), emotions, and internal states (Larimer, Palmer, & Marlatt, 1999), grounded theory methodology will be employed to account for a pattern of behavior that is relevant and problematic for those involved (Glaser, 1978).

Glaserian Grounded Theory

As a general methodology designed to explore social processes for the purpose of theory development from data that has been systematically gathered and analyzed (Streubert & Carpenter, 1999; Strauss & Corbin, 1994), grounded theory methods move the process of analysis toward the development, refinement, and interrelation of concepts. Regardless of version, strategies common to grounded theory include: (a) simultaneous collection and analysis of data, (b) a two-step process for coding data, (c) comparative methods, (d) memo writing aimed at the construct of conceptual analyses, (e) theoretical sampling to refine the emerging theory, and (f) integration of the theory (Charmaz, 2000). The following five steps of the grounded theory research process form this method’s fundamental components: (a) data collection, (b) formation of concepts, (c) development of concepts, (d) modification and integration of concepts, and (e) production of the research report (Stern, 1980 cited in Streubert & Carpenter, 1999). Qualities inherent in a well-drawn grounded theory, which are common to all interpretative methods, include
readability, personal voice, and connectedness with the reader (Stern, 1994). Glaser (1978) further specifies that the criteria for evaluating a grounded theory in his description of a good grounded theory as one that that fits (categories must explain the data), works (provides a useful conceptualization that explains the phenomena), has relevance, and is modifiable (durable in its ability to account for variation, but flexible to changes in conditions (Charmaz, 2000; Glaser, 1978). Glaser maintains an emphasis on the emergence of theory from the data through constant comparative analysis in which categories emerge with comparison, and properties emerge from more comparison. The research focus emerges out of open coding, collection by theoretical sampling, and analysis by constant comparison. Answers to three neutral questions posed by Glaser during examination of data allow the theory to emerge: (a) What is this data a study of? (b) What category or what property of what category does this incident indicate? (c) What is the basic social psychological process (or social structural process) that processes the main problem, in which life is made viable in the action sense?

Because grounded theorists search for social processes present in human interaction, grounded theory may be best viewed as “half art and half science” (Schatzman, 1980 cited in Stern, 1994) or more art than science (Sandelowksi, 1994). As such, the description of the magic or mysterious process of analysis during discovery has got to be somewhat elusive. By selecting Glaser’s (1978) original version of grounded theory to explore the process of craving, the developed theory would be immediately applicable to those who share the problem under study given the emergence of the theory from the data rather than the experience of the analyst (Stern, 1984). It is the creativity in
the act (interpretative steps involved in the process of analysis) that brings the real truth of a social situation into being and the Glaserian grounded theory approach is one way to approach this creative process, as data will come willingly to artful expression if one is dedicated to working with it rather than against it, as one lets the theory emerge (Glaser, 1992). Through the process of artful integration, the described theory would be as true to the studied social scene as could be made by the artful scientist, having originated as an informant-identified problem, relate ways in which informants solve the problem, and involve informants as study participants through the processes of checking back and revealing the theory as it developed (Stern, 1994). By remaining true to the data, theory respects and reveals the perspective of subjects (Stern, 1984; Charmaz, 2000). In addition, grounded theory represents a safeguard against inherited scientific dogma, since the explanation of key social structures or processes are derived from or grounded in the empirical data themselves (Stern, 1994). In short, the Glaserian form of grounded theory with its focus on empirical world grounding and emergence of theory as a creative process would therefore be expected to yield a theory that is readily applicable and that gives voice to those that experience the process of craving within the context of alcoholism.

Data Collection Procedures

Sampling

Sampling for this study was guided by the qualitative principles of appropriateness (purposeful sampling and a good informant who is articulate, reflective, and knowledgeable) and relevance (Charmaz, 2000; Sandelowski, 1994). While six
participants and 30 interviews has been suggested as the minimum required studies where the goal is to understand an experience (Ryan & Bernard, 2000), the actual sample size was 14 informants to explicate the process of craving. Actual sample size was determined by saturation or the point when no new conceptual information was forthcoming (Carpenter, 1999; Glaser, 1978; Glaser & Strauss, 1967). As the main concepts were identified, the more selective theoretical sampling guided data collection and advanced the theory (Carpenter, 1999; Glaser, 1978; Glaser & Strauss, 1967; Stern, 1980).

Participants were selected from individuals seeking medical care at the Southern Arizona VA Health Care System (SAVAHCS). Problematic drinking was identified by the individual as the criterion for referral.

**Participant Recruitment**

Health care professionals employed in both the inpatient and outpatient setting served as the primary source of referral. Identification of participants by health care providers was based upon self-diagnosis of alcoholism or the self-identification of problematic drinking and craving. Recruitment followed review of a script by the health care provider in which the researcher was granted permission to contact the participant (Appendix A). Following staff referral, participants were then screened for eligibility by the researcher. Data collection occurred in two phases during the same meeting between the researcher and the participant: (a) an initial interview screen, and (b) the interview. Meetings were arranged for a mutually convenient time at the medical center. One interview was scheduled with each informant; however, member checks were completed with two of the participants for verification of the emerging theory. The length of each
interview was approximately one hour. Each interview was tape recorded and transcribed verbatim by a professional transcriptionist. Participants were asked to select a pseudonym to replace their actual name.

Assessment of Alcoholism

The initial contact to potential participants was made by telephone or in person. To explicate craving in this study, all participants were self-identified as alcoholic (or acknowledge a problem with alcohol) in which craving for alcohol and impaired control after one or two drinks is prominent (Miller, Gold, & Smith, 1997). Qualifying questions included some demographic and detailed characteristics related to the purpose of the research. The qualifying questions determined that the participant: (1) was age 18 or older, (2) was able to speak English, (3) identified self as alcoholic, and (4) exhibited memory of an incident of craving that was sufficiently intact to recall specifics of the incident and associated details. Prospective participants were given the time, place, and format of the individual interview. The starting and ending times of the interview were emphasized. Once the participant agreed to the interview, participants were informed of the actual time and place of the interview.

The researcher described the study and the informant’s rights, and obtained written consent at the beginning of the meeting (Appendix B). A brief demographic questionnaire was used to obtain background information, and to establish the rapport that is paramount to gaining the understanding that is the goal of unstructured interviewing (Chamaz, 2000). Demographic questions included: (a) age, (b) marital
status, (c) children, (e) medical conditions, (f) psychiatric conditions, (g) medications, and (h) drinking history (Appendix C).

Since the researcher was employed at the Southern Arizona VA Health Care System (SAVAHCS), it was emphasized to each potential participant that his/her decision whether or not to participate would have no bearing on the health care received. In order to minimize blurring between the roles of clinician and researcher, the investigator conducted the interviews during times when not employed and in designated areas separated from the inpatient unit. While the potential for conflict of interest is acknowledged in settings in which the researcher is also employed, the utilization of safeguards to minimize such role confusion afforded an opportunity to explore this rich and relatively untapped data source.

Assessment of Craving: The Interview

Following completion of the demographic data, the second phase of the data collection was initiated with the interview. In order to discover processes associated with the experience of craving, broad data-generating questions were incorporated into an interview guide (Appendix D) in order to elicit the informant’s story (Chamaz, 2000). Generally, data generating questions asked in informal language: Tell me about your experiences with craving? How do you define craving? What has been your experience with craving? What is it like for you when you are drinking? What is it like for you when you are not drinking? The questions, derived from the research questions, were reflective of what the researcher was attempting to discover and were ordered from the more general to the more specific. The more specific questions were placed near the end of the
interview as clarifiers and probes. Since the informant is considered the expert in grounded theory, informants in this study were considered to be the experts regarding craving within the context of alcoholism, being permitted to tell their story with prompting only as necessary. Additional probes and clarifiers were used to elicit the most complete story, since each story added to the data bits collected. Ongoing clarification was sought from informants to ensure accurate interpretation of their words and to minimize investigator bias. The entire process was guided by the emerging theory as informed through ongoing data collection, theoretical coding, and analysis.

**Interview Procedure**

The interviews were conducted in a private office at a mutually agreed upon time for both the participant and the researcher. Two audiotape recorders were placed on a desktop midway between the participant and the researcher to maximize voice recording. The researcher faced the participant and the audio taped interviews captured in their entirety without any technical malfunctions. The technique of memoing was used to note nonverbal communication (body language) and impressions during the interview as rich data are constructed by attention to pertinent details (Chamaz, 2000).

In recognition of the potential risk of relapse associated with participation in a discussion regarding craving as suggested by the cue reactivity literature (Carter & Tiffany, 1999), the researcher engaged the informant in a process of debriefing immediately after the interview (Appendix E). The researcher inquired into his emotional state and feelings and ascertained his mental state. The researcher also made available information regarding resources (recovery support groups) which could be sought for
continued support following the interview if deemed necessary by the informant (Appendix F).

Audiotapes of the Interviews

All interviews were audio taped in their entirety. Within four hours of the interviews, the researcher reviewed each audiotape to note any significant impressions of the interview. This was done to capture any nonverbal behaviors and meaningful pauses that might be pertinent to the study. Any data that was missed due to noise, machine failure, or lack of audibility was captured as the notes would be useful for information recall.

The audiotapes were transcribed by a skilled transcriptionist. The researcher listened to each audiotape and simultaneously reviewed each transcript to correct any errors and ensure accuracy. Additionally, the researcher’s Dissertation Chairman randomly reviewed 10% of the transcripts for accuracy. After this verification of the accuracy of the transcriptions, data analysis was conducted.

During the interviews, participants used a pseudonym. Pseudonym names provided protection of privacy while still contributing to the building of rapport. Participants selected their own pseudonym to be used during the interview and reflected in the transcripts.

Human Subjects

Approval from the Committee for the Protection of Human Subjects at the University of Arizona was obtained prior to recruitment of participants (Appendix E). Detailed information about the study was provided to all participants. Participants were
asked to sign a consent form that explained the benefits and risks, and included assurances of confidentiality and anonymity. Pseudonym names were used during the process. Consent forms were maintained in a locked cabinet in the College of Nursing.

Data Analysis

Through the process of open coding, data were examined line by line to identify process and categories (Glaser, 1978; Glaser & Strauss, 1967; Ryan & Bernard, 2000). Substantive codes assigned to data bits to codified the substance, and categories were formed from clusters of coded data based on fit. Through the technique of constant comparative analysis, categories were compared for linkages, collapsed into more general and broader core categories, and ultimately, formed into a core variable. Theoretical coding conceptualized how the substantive codes relate to each other, similar to integration of hypotheses into a theory (Glaser, 1978; Glaser & Strauss, 1967). In summary, the data was fractured through open coding (substantive codes) and woven back together through the process of theoretical coding (theoretical sorting and integration of memos).

Trustworthiness in Qualitative Research

Scientific Rigor

The techniques of credibility, dependability, confirmability, and transferability were employed in this study to ensure trustworthiness (Lincoln & Guba, 1985).

Lincoln and Guba (1985), in response to the charge that rigor is not a hallmark of naturalism, suggest that the central issue regarding trustworthiness is the persuasion that the findings of an inquiry are worthy of attention. Rigor in qualitative research is
demonstrated through attention to and confirmation of information discovery, the goal of which is an accurate representation of study participant’s experience (Streubert & Carpenter, 1999). Criteria that have evolved within the conventional or traditional paradigm (internal validity, external validity, reliability, objectivity) to address the four basic questions of trustworthiness (“truth value”, “applicability”, “consistency”, “neutrality”) are dependent upon conventional axioms, such as naïve realism and linear causality (Lincoln & Guba, 1985, p. 253). Because of the different axioms that underlie the naturalistic paradigm, it has been argued that criteria defined from one perspective are inappropriate for evaluation of actions within another perspective. This is consistent with Crotty’s (1998) framework which suggests that the great divide does not occur at the level of methods (quantitative versus qualitative), but instead at the level of theoretical perspective (way of looking at the world and making sense of it) as it is informed by both epistemology (“what it means to know”) and ontology (“what is”) (Crotty, p. 10). What is required at this level is a distinction between the contradictory objectivist (existence of meaning apart from consciousness) and constructionist (existence of constructed rather than discovered meaning) epistemologies. Because the ontological notion of realism (realities exist outside the mind) is often mistaken for the epistemological idea of objectivism (meaning is independent of consciousness), Crotty (1998) concedes that realism in ontology and constructionism in epistemology are compatible since one can conceive of a world without a mind, but not meaning without a mind. Clarity at the level of theoretical perspective is therefore critical in the search for and application of
alternative criteria that are more congruent with the naturalistic axioms (Lincoln & Guba) and constructionism (Crotty) epistemology that commonly inform qualitative research.

Lincoln and Guba (1985) suggest that the same four questions are applicable to the establishment of trustworthiness in both the traditional and naturalistic paradigm, but that the difference exists in the means through which the questions are addressed. For example, the question of **truth value** which has been traditionally defined by internal validity (extent to which variations in dependent variables can be attributed to controlled variation of independent variables) is based upon naïve realism of a single tangible reality which is inconsistent with naturalistic axioms. These authors suggest replacement with the **credibility criterion** in which multiple constructions are addressed through both adequate representation and credible construction. Since the question of **applicability** has traditionally been approached through the external validity criterion which has also been informed by naïve realism (through the axiom of generalizability with its underpinning of representativeness), the criterion of **transferability** (dependent upon the degree of similarity between contexts under comparison) is more congruent with the naturalistic paradigm. Similarly, the question of **consistency** addressed traditionally by means of replication is replaced within the naturalistic paradigm with the **dependability** criterion which takes into account two types of factors: (a) instability, and (b) phenomenal or design induced changes. Finally, the question of **neutrality**, or objectivity as met through the traditional criterion of intersubjective agreement, is consistent with the notion of **confirmability** within the naturalistic paradigm.
Credibility

Credibility was demonstrated in this study through the use of three techniques. First, the researcher’s employment in the substance abuse field for the past several years enhanced the production of credible findings through the provision of opportunities for prolonged engagement and observation (to learn the culture, test for misinformation, and build trust). Second, the process of peer debriefing helped the researcher to stay on track through the provision of opportunities for: (a) discussion of relevant questions, (b) testing of working hypotheses as they emerge and thinking through the next steps of the methodological design, and (c) ongoing catharsis necessary for the maintenance of clear judgment. The researcher’s sponsors assisted with the process of peer debriefing, facilitated by this researcher’s initiation of a reflexive journal that serves as both a personal diary (“reflexive”) and methodological log (Lincoln & Guba, 1985, p. 327). Third, as the most crucial technique for the establishment of credibility, two participants were provided with an opportunity to critique the emerging theory to check the accuracy of the researcher’s reconstruction.

Dependability and Confirmability

The criteria of dependability and confirmability are both addressed through the audit trail (Lincoln & Guba, 1985). The inquiry audit entailed an examination of both the process (acceptability of the inquiry) as well as the product (findings, interpretations, and recommendations) of the inquiry, establishing dependability through support of the data and confirmability through internal coherence. The committee chairman served as a
process and product auditor, reviewing the researcher’s theoretical notes and memos which form the basis of the audit trail.

Transferability

Finally, transferability was demonstrated through the provision of thick or in-depth descriptions of the informant’s backgrounds, context of inquiry, and procedures followed in this study, in order to facilitate the comparisons made by other researchers. While the burden for determining whether elements of the work are transferrable to other people and circumstances resides with the reader, the burden for providing adequate information to make this possible resides with the writer (Lincoln & Guba, 1985; Sandelowski, 1994). Purposeful sampling also enhanced transferability of these findings to other groups. As Sandelowski (1994) summarizes: “The proof for you is in the things I have made—how they look to your mind’s eye, whether they satisfy your sense of style and craftsmanship, whether you believe in them, and whether they appeal to your heart” (p. 61).

Summary of Chapter Three

This chapter described the methodology used in the study. It provided the rationale for using the grounded theory methodology and described procedures that directed the research process. The procedures included a description of the Strausian version of grounded theory, sampling, data collection, and data management. The criteria for evaluation of grounded theory research was identified as the establishment of trustworthiness in qualitative research, and included credibility, transferability, dependability, and confirmability.
CHAPTER FOUR

RESULTS

This chapter presents the results of the data from the fourteen male alcoholics describing the process of craving for alcohol. The first section of this chapter presents a portrait of the participants through description of participant characteristics. The second section of Chapter Four provides an explanation of the grounded theory, including a model of the theory of craving (Figure 4.1). A summary of Chapter Four concludes this chapter.

Portrait of the Participants

Fourteen self-identified alcoholic male veterans participated in this study. The typical participant was a Caucasian male veteran who began his drinking career in high school, with an increase in drinking during his period of military enlistment. Each participant disclosed a diagnosis of alcoholism, and acknowledged craving for alcohol.

The next section portrays characteristics of each participant as well as a synopsis of their experiences with alcohol and craving for alcohol. Particular excerpts from each interview highlight the individuality of each participant.

Interview 1 - Lempie

Lempie was a 62 year old male who first drank alcohol at the age of 17 upon entry into the Air Force. Divorced for the third time with three children, he only has contact with his son. He is retired and lives alone in an apartment. His main medical problems are cirrhosis and hypertension for which he takes prescribed medication. Drinking was excessive and continuous from 1955 to 1991, and summarized as “pleasurable” except at
the end of a binge. His longest period of sobriety was 9 months following substance abuse treatment and he had been sober for 2 months at the time of this interview. For Lempie, craving only occurred during periods of sobriety “when you remember the good times that you had”. He offered several analogies to illustrate the pleasure inherent in craving, such as burning himself on a hot stove as a child (absence of craving) and sex.

Interview 2 - Lobo

Lobo was a 37 year old male who drank for the first time at age 16. He was currently enlisted in the Air Force and had been sober for the past six days, just completing an inpatient detoxification prior to the start of substance abuse treatment. He has no medical problems. Widowed for the past 9 years, he has no children. Two different 9-month periods of sobriety had been achieved in the past: at age 20 when he was a caregiver for his terminally ill wife, and at 36 when stationed overseas in a region of military conflict. His sobriety was predicated in both instances on needing “to be able to think clearly just in case something bad happened” in order to fulfill his role as caregiver and later soldier. Lobo acknowledged a different type of craving when sober than when drinking, and used the analogy of Christmas to illustrate the sense of anticipation associated with craving.

Interview 3 - Arthur

Arthur was a 45 year old male who took his first drink at age 9 when provided to him by his brother. Divorced for the past 10 years with no children, he has resided at a halfway house during this interim that he has been participating in substance abuse treatment. The main medical problems for which several medications are prescribed
consist of a chronic pain syndrome from numerous musculoskeletal injuries in the past, and depression. His current period of sobriety consists of 22 days, though he was able to remain sober for 18 months in 2001 upon completion of substance abuse treatment. Two different periods of his life are described to illustrate his alcohol use. Excessive drinking while married and in the military culminated in an incident of unlawful entry into an apartment that resulted in incarceration, military discipline, and divorce. Drinking in moderation allowed him to continue to function effectively as a caregiver for his elderly parents more recently. Arthur described two different forms of craving (of the mind as well as the body) as well as two different types of craving (during sobriety as well as drinking) that he has experienced.

Interview 4 - Diego

Diego was a 41 year old Hispanic male whose first drink occurred at age 17. Separated from his second wife for the past 5 months, he has two children with whom he attempts to have contact. Since his participation in the substance abuse treatment program, he has been residing at one of the halfway houses. There are no medical problems for which he is under medical supervision. His longest period of sobriety consisted of 7 years between the ages of 28 to 35, which he attributes to his active involvement in Alcoholics Anonymous. His current five-week period of sobriety was preceded by “hitting bottom” in which he was assaulted during his last “drunk”. Diego acknowledged a difference between the craving experienced during abstinence and the craving experienced while drinking, and he provided further illustration through analogy with smoking. He was also able to describe the mental as well as physical manifestations
of craving, with an emphasis on the struggle experienced during both abstinence (drinking versus not drinking) and drinking (controlled versus uncontrolled alcohol consumption).

Interview 5 – Big Mac

Big Mac was a 40 year old male who started drinking at the age of 17. He had returned to his home where he resides with his second wife and two children after completion of an inpatient detoxification the week preceding this interview. There are no medical conditions that require medical care. The longest period of sobriety has been ten months in 1985 which he attributes to an intensification of craving around the fourth month “as time wears on and I lose that thought (that you can’t do it) and I let my guard down and it’s like ‘You know what? You can do a couple. It’s not going to hurt you?’ And there we go again” (p. 15). He distinguishes between two different forms of craving: as a mental struggle when sober, and as a loss of control while drinking. Big Mac emphasizes the struggle between drinking and not drinking, with craving as the louder voice of “Gimme, gimme, gimme. You know we want it” (p. 12).

Interview 6 - Teach

Teach was a 44 year old male who first drank at age 16. Divorced for the past year with one young son whom he sees on a regular basis, he has been residing at a halfway house since the completion of his first substance abuse treatment program several months ago. Sober for the past four months, he was able to maintain 2 years of sobriety from 1989 to 1991. He takes prescribed medications for both diabetes and hypertension. Teach was able to describe the initial manifestation of craving while sober as hand tremors and
sweaty palms, which was immediately followed by thoughts of drinking. The absence of struggle and the characterization as an unquenchable thirst identified a different type of craving that was experienced while drinking. An emphasis for Teach was the management of craving, predicated by the clear-headedness of early sobriety that served to bolster his resistance.

*Interview 7 - Steve*

Steve’s first drink of dandelion wine at age 12 initiated his drinking career that spanned 33 years with little break. He has never married and has no children. There are no medical conditions. This 27-month period of sobriety followed “looking for job number 143” (p. 12) at the age of 42 and the realization that “I could not stop drinking” (p. 13), which led to completion of his only substance abuse treatment program. Steve differentiates between craving experienced when sober from that experienced when drinking, and compares the alcoholic’s need for alcohol with a vampire’s need for blood as depicted in an Anne Rice novel. He also describes physical as well as the mental expressions of craving, and compares the craving for cocaine to the craving for alcohol.

*Interview 8 - Wayne*

Wayne was a 47 year old male who experienced his first taste of alcohol at age 6 from his alcoholic grandfather and his first drink at age 12. Divorced five years ago from his third wife, he has two children with whom he has infrequent contact. Chronic right knee pain is his only significant medical condition that requires intermittent medication. His current seven-day period of sobriety was preceded by an inpatient detoxification, and he planned to arrange for temporary housing in a shelter until a bed was available in the
substance abuse treatment program. Despite his employment as a bartender, he was able to achieve a 9 month period of sobriety in 1984 which he attributes to active involvement in Alcoholics Anonymous. For Wayne, craving “comes when I’m sober and I don’t have it” (p. 18),

*Interview 9 - Buster*

Buster was a 63 year old male who began to drink at the age of 15. He was able to sustain a five year and later ten year period of sobriety (ending in 1992) without involvement in substance abuse treatment or Alcoholics Anonymous. Since his divorce from his second wife 13 years ago, he has had infrequent contact with his only daughter. His main medical condition is clinical depression for which he takes several medications. This current six month period of sobriety followed the realization that living out of his car in the mountains was not the answer, at which time he sought help at the VA. Buster was able to differentiate between “frustrating” craving experienced during sobriety and “craving out of necessity” while drinking.

*Interview 10 - Poncho*

Poncho was a 62 year old male who began his drinking career in high school and “just drank and drank and drank. And it’s just been the story all throughout my life” (p. 3). After 20-25 inpatient detoxifications, he was able to sustain an 8 year period of sobriety between the ages of 40-48 and achieve this 9 month period of sobriety after substance abuse treatment. Despite his divorce from his wife of 32 years this past year, he remains close to her and his two children. He receives medical care for diabetes and hypothyroidism, which includes a variety of medication, including insulin. Poncho was
able to differentiate between craving that is experienced as “fear” and shaking all over during periods of sobriety from that of having to “keep filling myself up with booze” to avoid getting sick when drinking.

Interview 11 - Recovery

Recovery was a 52 year old male who started drinking at the age of 15, with his longest period of sobriety consisting of 3 years (1985-1987) that he attributes to being “married and in church”. Divorced since 1992, he has no children. His current medical problems consist of lupus and hypertension for which he is under medical care and takes several medications. This current six-week period of sobriety followed the realization that drinking a case a day was too much and that he needed help which has consisted of substance abuse treatment and residence in a halfway house. He was approached for participation in this study when he recounted to his counselor several days prior to this interview an incident of “real bad craving” which subsided when he was distracted “throwing horseshoes”. Recovery described craving as a thought process that was lessened by distraction during periods of sobriety and temporarily alleviated by drinking a beer during periods of active drinking.

Interview 12 - Keef

Keef was a 58 year old male who began to drink at age 16 when “the best part of the week was the week-end” (p. 1). He remained functional until the age of 40, at which time he describes himself as a “full-blown alcoholic” due to his inability “to function without drinking”. Divorced for the past 10 years with no children, he remains close to his only brother. He receives medical care for several medical conditions, including renal
cell carcinoma, severe anemia secondary to gastrointestinal bleeding, and clinical depression. Keef only experiences craving when he is actively drinking “to medicate the pain of withdrawal” which he illustrates with the description of an incident where he broke into a Circle K for a can of beer to relieve his symptoms.

Interview 13 - Sunshine

Sunshine was a 36 year old male who first drank at age 13. He is single with no children, and had just ended a 10-year relationship with his significant other when he recognized the need for help and presented for detoxification several months ago. He has been diagnosed with depression and acid reflux. His longest period of sobriety was a two-year period (1996-1998) following an incident in which hostility was directed toward him while he was in a blackout. The ensuing sense of vulnerability prompted that commitment to sobriety. He distinguishes between craving experienced while sober and craving experienced while drinking, and describes the three stages of a drinking binge.

Interview 14 – Wolf Dancer

Wolf Dancer began his 45 year drinking career at age 17, though he had managed to sustain a five year period of sobriety (1995-2000) through active involvement in Alcoholics Anonymous. Divorced for the past 11 years with two sons with whom he has some contact, he remains close to his father who recently entered a nursing home. He suffers from a variety of significant medical conditions for which he takes several prescribed medications, including a chronic pain syndrome secondary to degenerative joint disease (DJD) and musculoskeletal injuries, a seizure disorder, and posttraumatic stress disorder (PTSD). Wolf Dancer was able to describe craving as a three-stage
process using an analogy of conversation between the drinking self, sober self, and craving, and the need to extinguish craving in order to avoid relapse.
Explanation of the Grounded Theory

The basic social process identified in the grounded theory was the process of craving alcohol. Table 4.1 Grounded Theory: Craving for Alcohol displays the four stage process of Craving for Alcohol: Stage One, Craving in the Background; Stage Two, Craving in the Foreground; Stage Three, Management of Craving; and Stage Four, Craving Unsatisfied. The model is presented in relation to these four stages in the process of craving for alcohol.

<table>
<thead>
<tr>
<th>Stage One: Craving in the Background</th>
<th>Stage Two: Craving in the Foreground</th>
<th>Stage Three: Management of Craving</th>
<th>Stage Four: Craving Unsatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire for Alcohol</td>
<td>Craving as Conversation</td>
<td>Management Strategies</td>
<td>Craving as Thirst</td>
</tr>
<tr>
<td>Craving as a Thought</td>
<td>Craving as Urge</td>
<td>Choice of Alcohol</td>
<td>Craving as Need</td>
</tr>
</tbody>
</table>
Four Stages of Craving

Stage One: Craving in the Background

In Stage One, Craving in the Background, craving is omnipresent though dormant, existing in the background. Craving is either absent from consciousness, or makes an appearance as a fleeting thought devoid of emotion. Craving is set against a backdrop of Desire for Alcohol. The category Desire for Alcohol is defined by two indicators that reflect the culmination of an individual’s previous drinking history: (1) Past Experience with Alcohol: Memory of Pleasure, and (2) Role of Alcohol: Desired Effect. Table 4.2 Craving in the Background depicts the category Desire for Alcohol and the two indicators: Past Experience with Alcohol, and Role of Alcohol.

TABLE 4.2. Stage One: Craving in the Background

<table>
<thead>
<tr>
<th>Desire for Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Experience with Alcohol</td>
</tr>
<tr>
<td>Role of Alcohol – Desired Effect</td>
</tr>
<tr>
<td>Transformation of Self</td>
</tr>
<tr>
<td>Numbing and Escape</td>
</tr>
</tbody>
</table>
Despite the identification of negative consequences associated with drinking in the past, an individual’s previous experience with alcohol remains etched in memory as a pleasurable experience. In addition, alcohol plays a specific role for an individual through the ability to perform one or more of the following functions: (1) Euphoria, (2) Transformation of Self, (3) Improved Problem-Solvability, (4) Numbing and Escape, and (5) Anxiety Reduction. In short, pleasurable past drinking experiences and beneficial effects derived from alcohol culminate in the overall evaluation of drinking as a positive experience. The perception of alcohol as pleasurable is retained as an omnipresent desire to drink, or *Desire for Alcohol*, that comprises the experience of craving in Stage One and underlies the process of craving in Stage Two.
Stage Two: Craving in the Foreground

In Stage Two, Craving in the Foreground, craving moves forward into conscious awareness and may be experienced in two different forms: (1) Craving as Conversation, and (2) Craving as Urge. Craving as Conversation refers to the talk in an individual’s head between the sober self and the drinking self, which is characterized by Struggle. Craving as Urge refers to a thought with movement toward action, as if Being Driven. Transformation of craving from a non-troublesome thought in Stage One to either a struggle or an urge in Stage Two eventually requires action. Stymieing may occur in Stage Two (craving exists in the foreground) for an indefinite period of time, during which time an individual is either struggling with dilemma or experiencing urges to drink. However, the resulting tension eventually requires resolution through some form of action, or Management of Craving through Choice (Stage Three). Table 4.3 Craving in the Foreground depicts the two categories of Stage Two with the corresponding indicator: Craving as Conversation, Struggle, and Craving as Urge, Being Driven.

TABLE 4.3. Stage Two: Craving in the Foreground

<table>
<thead>
<tr>
<th>Craving for Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craving as Conversation</td>
</tr>
<tr>
<td>Struggle</td>
</tr>
<tr>
<td>Craving as Urge</td>
</tr>
<tr>
<td>Being Driven</td>
</tr>
</tbody>
</table>
Stage Three: Management of Craving

The state of tension preceding this action in Stage Three, Management of Craving represents a period of Vulnerability during which an individual is struggling with craving or experiencing urges to drink, since an individual is susceptible to acting on the urge to drink if craving is not successfully managed. *Fork in the Road* reflects the juncture in Stage Three, Management of Craving of two opposing choices for resolution of the tension that originated with the movement of craving into the forefront of conscious awareness. First, an individual may choose to employ strategies to abolish craving, which if successful, will result in the suppression of craving and return to Stage One in which craving exists in the background. Second, an individual may select the alternate option, Choice of Alcohol and initiate drinking. Table 4.4 Management of Craving presents the Stage Three category *Fork in the Road* with the two indicators: Management Strategies and Choice of Alcohol.

<table>
<thead>
<tr>
<th>Fork in the Road</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Strategies</td>
</tr>
<tr>
<td>Reminders</td>
</tr>
<tr>
<td>Distraction</td>
</tr>
<tr>
<td>Choice of Alcohol</td>
</tr>
<tr>
<td>Drinking</td>
</tr>
</tbody>
</table>
Stage Four: Craving Unsatisfied

Once an individual elects to drink and enters Stage Four, Craving Unsatisfied, a different type of craving is experienced which is expressed in two forms: (1) Craving as Thirst, and (2) Craving as Need. Craving as Thirst refers to the Insatiable Desire for Drink regardless of the quantity of alcohol consumed. Craving as Need refers to the desire for the temporary state of Desire for Normalcy provided by alcohol’s suppression of withdrawal symptoms. Table 4.5 Craving Unsatisfied depicts the Stage Four category Drinking with the two indicators: Craving as Thirst, and Craving as Need. Consistent with the overall Theory of Craving which is cyclic, cycling continues between drinking and one or both forms of craving until drinking is terminated.

TABLE 4.5. Stage Four: Craving Unsatisfied

<table>
<thead>
<tr>
<th>Endless Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craving as Thirst</td>
</tr>
<tr>
<td>Insatiable Desire for Drink</td>
</tr>
<tr>
<td>Craving as Need</td>
</tr>
<tr>
<td>Desire for Normalcy</td>
</tr>
</tbody>
</table>
Progression of Paths

The basic social process, Craving for Alcohol, is depicted in the model as an active and ongoing process in which: (1) omnipresent craving which lies dormant in the subconscious (Stage One, Craving in the Background), (2) pops up into conscious awareness (Stage Two, Craving in the Foreground) and (3) must be pushed back down into the subconscious (Stage One, Craving in the Background) if drinking is to be avoided. Figure 4.1 Theory of Craving for Alcohol presents the four stage Theory of Craving and the two different types of craving experienced: (1) during sobriety (Craving as Conversation, Craving as Urge), and (2) while drinking (Craving as Unquenchable Thirst, Craving as Need). Since the management of craving does not exist only as an all-or-nothing situation once craving is experienced in Stage Two as either struggle or an urge, several outcomes are possible following progression through various paths. The ability to subdue craving through an active process that relies upon strategies for suppression, rather than the mere presence of craving, is a determinant in an individual’s choice of alcohol in Stage Three.
Figure 4.1. Four Stage Theory of Craving for Alcohol

Stage 1: Craving as a Thought
Stage 2: Aura (Prodrome)
Stage 3: Losing the Battle (B2)
Stage 4: Management Strategies

Choice of Alcohol

Craving as a Thought
Craving as Conversation
Craving as Urge

Management Strategies

Craving as a Thought
Craving as Conversation
Craving as Urge

Losing the Battle (B2)

Choice of Alcohol

Craving as a Thought
Craving as Conversation
Craving as Urge

Stage 1: Craving in the Background
Stage 2: Craving in the Foreground
Stage 3: Management of Craving
Stage 4: Craving Unsatisfied
Winning the Battle: Successful Suppression of Craving

Upon arrival at the point of choice, Fork in the Road in Stage Three, an individual may elect to employ active strategies for managing craving. Successful management of craving involves two categories of strategies: (1) Reminders that emphasize the negative consequences of drinking, such as memorabilia, Hitting Bottom, and Alcoholic Anonymous Sponsors; and (2) Distraction, such as physical activity or talking, which prevent the embellishment of the positive aspects of drinking. Figure 4.2 Winning the Battle: Successful Suppression of Craving depicts the success of managing strategies employed in Stage Three, Management of Craving. The result is the suppression of craving back into the subconscious, and return of the individual back to Stage One in which craving exists in the background. An individual may cycle repeatedly along this path throughout the day, depending upon the situation.
Figure 4.2. Winning the Battle: Successful Suppression of Cravings

Stage 1: Craving as a Thought
Stage 2: Aura (Prodrome)
Stage 3: Management Strategies

Stage 1: Craving in the Background
Stage 2: Craving in the Foreground
Stage 3: Management of Craving

A2 (Success)
A3 (Partial Success)
Fork in the Road
Vulnerability
**Gaining Ground: Partial Suppression of Craving**

Since the elimination of craving is not always accomplished with the initial attempt at suppression, the intensity of craving may be altered with several possible outcomes. Figure 4.3 **Gaining Ground: Partial Suppression of Craving** depicts the A3 Path which results when craving is only partially suppressed or subdued for a period of time during this cycling. An individual may cycle between the use of strategies to manage craving, and the experience of craving that results from an unsuccessful attempt at suppression. Craving in this primary path is experienced in two forms: *Craving as Conversation*, and *Craving as Urge*. *Craving as Conversation* depicts the conversation that occurs within the individual’s head as the struggle to drink or not to drink. *Craving as Urge* reflects a state of being driven to drink.
Overcoming Craving: Successful Suppression

An individual will continue to cycle along the A3 path until either: (1) an intensification of the effort to suppress craving is successful, or (2) the attempt to manage craving is abandoned in favor of drinking. Factors that influence the intensity of craving and the direction of this path include: (1) triggers that enhance craving, and (2) repertoire of strategies that de-emphasize craving. Figure 4.4 Overcoming Craving: Successful Suppression portrays the successful suppression of craving following a period of cycling along the A3 Path, and return of the individual back to Stage One where craving returns to the background.
**Losing the Battle: Unsuccessful Suppression of Craving**

With the unsuccessful suppression (and often intensification) of craving, the individual may choose to abandon the management strategies (*losing the battle*) and drink. Figure 4.5 *Losing the Battle: Unsuccessful Suppression of Craving* depicts the abandonment of the efforts to manage craving in Stage Three in favor of alcohol through the B2 Path.
Surrendering to Craving: Choosing Alcohol

An individual may also bypass strategies in Stage Three and elect to manage craving through drinking. Figure 4.6 Surrender to Craving: Choosing Alcohol depicts the choice of alcohol through the B1 Path without any attempt to suppress craving through strategies.

![Diagram of the process of surrendering to craving and choosing alcohol](image-url)
Drinking: Craving Unsatisfied

With the choice of alcohol in Stage Three, a different type of craving is experienced once drinking is initiated from that which exists along the primary path in Stage Two. Table 4.5 Craving Unsatisfied displays the category Drinking, with the two indicators: Craving as Thirst, and Craving as Need. Craving within this pathway also exists in two forms: (1) Craving as Thirst, and (2) Craving as Need. Craving as Thirst refers to an Insatiable Desire for Drink regardless of quantity of alcohol consumed. Craving as Need refers to the Desire for Normalcy that occurs when withdrawal symptoms are temporarily suppressed by alcohol. One or both forms of craving are experienced as an individual cycles along the B3 Pathway between drinking and craving. Figure 4.7 Craving Unsatisfied: Drinking depicts the B3 Path in which an individual continues to cycle between drinking and craving, until the sequence is interrupted with the cessation of drinking.
Summary

The preceding section has provided an overview of the four stage Theory of Craving for Alcohol. The first section provided a description of each of the four stages: (1) Stage One, Craving in the Background, (2) Stage Two, Craving in the Foreground, (3) Stage Three, Management of Craving, and (4) Stage Four, Craving Unsatisfied. The second section provided a summary of the progression of the following paths: (1) Winning the Battle: Successful Suppression of Craving, (2) Gaining Ground: Partial Suppression of Craving, (3) Overcoming Craving: Successful Suppression, (4) Losing the Battle: Unsuccessful Suppression of Craving, (5) Surrender to Craving: Choosing Alcohol, and (6) Craving Unsatisfied: Drinking.

The theory posits two distinct categories of craving, each distinguished by two different indicators. An ever-present desire for alcohol underpins the existence of craving in the background (Stage One) as well as the foreground (Stage Two) and constantly informs the two options available to an individual: (1) to manage craving, or (2) to drink. The basic social process is a four stage process of craving for alcohol characterized by an ongoing process in which craving moves forward into the foreground of conscious awareness, and must be suppressed through active involvement on the part of the individual if drinking is to be avoided.

Each of the four stages of the Theory of Craving will be described in detail in the following sections. The categories and their indicators as well as paths that define each stage will be described in the order of stage progression. Excerpts from participant interviews will be incorporated for purposes of illustration.
Stage One: Craving in the Background

Craving for alcohol in Stage One is defined as the state of dormancy in which: (1) thoughts of alcohol are absent, or (2) the thought of alcohol presented as the fleeting thought; “a cold beer would sure taste good”. Even without conscious recognition of craving, participants felt that craving was ever present and could be called forth into conscious awareness at any time. The experience of craving did not always require a trigger for prompting into consciousness, as reflected in descriptions in which craving appeared out of the “clear blue”. Most participants related the need for constant vigilance given this unpredictability of craving. The following excerpts illustrate the omnipresence that characterizes craving as it exists in the Background in Stage One.

Omnipresent Craving

In the first stage of this model when craving is in the background, participants either denied a consciousness of craving or were aware of the presence of craving as fleeting thoughts that were not a source of discomfort. For example, Poncho relates that if you’re doing what you’re supposed to be doing, you know, and, and, you’re concentrating on your program, you know, you don’t think about it as often (p. 14, line 15-19). And, you know, like today. The thought never even crossed my mind (p. 14, line 23-24).

Due to the pervasiveness of craving and the unpredictability of its appearance, participants were of the opinion that a constant state of vigilance was required. This constant state of “being on guard” extended throughout the period of sobriety, irregardless of the length of the time that an individual did not drink. For example,
Poncho relates that craving was present throughout the eight years. And it’s still a struggle today. Every day I get up, you know. I know I have to, it’s just something that, it just doesn’t go away, you know (p.12, line 4-7). It’s in your body, you know. I guess they say that, you know, it’s something in your brain that triggers it (p. 12, line 11-13). Stays the same. Some people say they lose the, lose their cravings. I (p. 12, line 43-44) hear, hear people say that but I don’t believe it. I mean, it does diminish. But still, you have to be on guard, like I told you about that woman that had 24 years. And, all of a sudden she was sitting there at the table and she, her whole body started shaking. And she had to get on her knees and pray that she got through that and she did. It can hit you any time” (p. 13, line 1-9). So, I got two years in. But then, all of a sudden out of the clear blue, I got a craving (p. 16, line 12-14).

Always patient and ready for the opportune moment to take the initiative, Wolf Dancer recounts his sponsor’s description of craving in the following analogy.

He said it’s a sleeping giant just waiting for you to make a mistake. A mistake in your program. A mistake in your thinking. Just, it never goes away. It’s always there. And, how you handle it depends on your axis. He said that’s why you have people who twenty years of sobriety and all of a sudden boom (p. 23, line 4-11).

The need for vigilance is also captured in Big Mac’s description of craving as a forgotten memory tape. I mean I don’t, like I won’t get to shaking and salivate like you know, thinking about (p. 10, line 44-46) drinking. It’s just I’ll think that I have a, a handle on it. That it, it’d be different this time. You know, I can handle it this time. And so, I would let my guard down and say, ‘Okay, yeah. I’ll, I’ll get it’” (p. 11, line 1-4).

The issue for most participants was not the presence or absence of craving, but rather the individual’s response to the craving since craving was never eliminated.

Craving never goes away. It’s how you handle it. What you do about it. To where, which one’s strongest basically is what it is. Until you get to that point where the sober guy wins out all the time. And the craving loses. And the guy you, you used to be, that guy who could drink and control. And the problem is, some people never make it all the way. They just continue to have long periods of sobriety sometimes. Sometimes short ones. Depending on what’s going on in their lives (Wolf Dancer, p. 10, line 32-41).
In a similar manner, Lobo acknowledges that

I feel the cravings. Well, I don’t think them cravings will ever go away. They may, like I said, subside, but I don’t think they’ll ever go away (p. 15, line 659-661). Well I have learned, the cravings, like I said, will always be there. It’s just how we, how we react on them, mentally and physically (Lobo, p. 15, line 685-687).

Participants were also able to describe situations that illustrated the specificity of triggers that were unique to the individual. Several excerpts illustrate a logical connection between trigger and craving in which craving was stimulated by an expected trigger.

The cravings was, be, it was really situational. Like in Alaska, we’d go fishing. And you know pole in one hand and a beer in the other (p. 10, line 4-6). Or like camping. ‘But man you know, a beer’d be real nice like now. Or a couple of shots’ (p. 10, line 9-11). I would almost say past activities that I, that I did. I mean, I wouldn’t, don’t get, I wouldn’t wake up in the morning and go, ‘Man, I’d, I’d love a shot of whiskey.’ It never started out like that, for me. It would always be, like we’d go to dinner (line 28-32). But while we were having appetizers I would have a beer. I’d have two beers. And then, and that, you know it. I’d find myself going you know, ‘A beer or two for appetizers and then I won’t drink tomorrow’. That’s how it would start out (Big Mac, p. 10, line 35-40).

Participants also described puzzling instances of situations in which exposure to alcohol failed to stimulate craving as would have been anticipated. Several participants were able to provide examples of situations that involved exposure to alcohol without an awareness of craving with the associated discomfort. Wolf Dancer described filming

a wedding inside a bar for my little sister, for her son. And I saw everybody drinking and it didn’t bother me. Didn’t have any cravings. Because up here (p. 4, line 44-46) there was no want or need. In fact, I even bought the groom and best man drinks. And I drank Coke. But, uhm, stress or doubt or a situation can bring on a craving in you. More like when I used to go visit my Dad down at the nursing home. I always used to stop and get a couple, three miniatures of, uh, whiskey or sometimes a pint of Schnapps in order to handle facing my father. His illness. How he’s going downhill (p. 5, line 1-9).
Poncho described a similar situation in which he was able to remain sober for 2 years while working with co-workers:

As soon as we left work and got home, they’d pop open the bottle and they would start drinking. And you know, it didn’t bother me (p. 16, line 24-28). I prayed and you know, I was going to meetings. And, and you know, I thought, ‘Oh, these guys. Look what they’re doing to themselves, you know. When I wake up in the morning, I’m going to feel good. These guys are going to feel like crap, you know’. And that’s what kept me going (p. 16, line 37-44).

Buster summarizes the paradox in the following example involving his brother, which he also uses to illustrate the common misconception, surrounding the alcoholic’s ability to resist with any exposure to alcohol.

And I was going to the Circle K and he said, ‘Would you pick me up a bottle?’ My brother drinks but he doesn’t get into trouble. And then he said to me, he qualified it by saying, uhm, ‘Are you going to be okay bringing that bottle back? Are you sure you can get that bottle and bring it back or, or will you have problems with it?’ Well, that’s uh, what I think what most people, what most people, and I could be mistaken, consider cravings. Like, ‘Oh, my God. There’s a bottle. I, I’ve got to have a drink out of it’. I, I don’t experience that. Uh, I told him, I laughed at him and I said, ‘No problem. I’ll bring it back’. I said, ‘I don’t like that stuff anyway. (Laugh) I didn’t like it when I drank. I don’t like it now’. So, uhm, that’s I think, I think what a lot of people consider a craving in the true sense of the word. That’s craving. When you can not even handle alcohol or smell it, uh, or be around a person who’s drinking without doing it yourself. I’ve been fortunate I think that I’ve been able to, to, to, that I don’t suffer from that form of craving. Uh, that my craving is, is directed in other ways. Even though I have to con-concede that, what’s the difference? Still I went back to alcohol anyway (p. 12, line 3-27).

Desire for Alcohol

A synthesis of the information provided in the interviews resulted in the category

Desire for Alcohol that characterizes the first stage of this theory in which craving exists in the background. Consistent with the concept-indicator model of grounded theory (Glaser, 1978), two indicators define this category: Experience with Alcohol: The
Pleasure, and Effect of Alcohol: The Function. Participants were able to describe their past experiences with alcohol, often their first exposure to drinking, which became etched into memory as pleasurable. This often provided the context within which triggers were embedded. Participants were also able to describe the effect of alcohol in terms of the perceived benefit, or what they felt that it did for them.

While the participants were able to consistently identify the negative effects aspects of drinking (failed marriages, DUI, withdrawal symptoms) and were able to identify the linkage with the loss of control, the pleasurable effects of alcohol remain prominent. Each participant expressed the desire to drink if it existed as a viable option.

If you ask me…if you ask me, ‘would you like to drink?’ Yes, I would like to. I would like to be a normal drinker. I would like to just go casually and have a glass of wine for dinner, (p. 8, line 363-366) or have a couple of beers with a friends, or drink one pitcher with two friends and that’s it. I would like to do that. It’s just that I know that I can’t. I know that I’ll never be able to control it. That is one of the things I’ve always struggled with. Is the controlling the drinking. It’s a battle (Diego, p. 9, line 367-372).

The following sections provide a description of each indicator that comprises the category Desire for Alcohol that underpin craving.

Experience with Alcohol: The Pleasure

The participants began to drink in early and middle adolescence, and alcohol use escalated during their military experience. The earliest experience with alcohol was evaluated as a positive experience, and usually accompanied by the desire to drink again at the earliest opportunity.

And I started drinking when I was 17 years old, when I went in the Air Force with older people who were my co-workers…And we would go down to Mexico. And it was a pleasurable, meaningful experience to sit with people to drink, talk about the bosses, talk about work, the airplanes…And that was my first experience with
drinking (Lempie, p. 1, lines 26-37). an, good times times wasn’t just in the Air Force. Good times was when I worked for a living. In the old days drinking was very popular. We would come out of work. We would go for happy hour (Lempie, p. 2, lines 17-20).

Diego recounts his earliest experiences with alcohol, and summarizes his drinking history in the following excerpt.

I started drinking when I was 14. I remember, ah…I didn’t like the taste, but I liked the effect. So I started with a couple of beers with friends and stuff and then after that (Diego, p. 1, lines 9-12). At the age of 17 and just, I thought it was pretty cool so I was in the military for about 4 years and it was just one big party, that’s where it really kind of progressed to ah…you know pretty much drinking almost every day, the ah….10, 12 beers a day. And then I did suffer my first black out when I was in the military. I thought it was cool to drink martini’s and I used this line from uh MASH, from the, like a Hawkeye Pierce and stuff, he would say, ah…he would say something like ‘I'm searching for the perfect drink, I’m looking for a drink that’s dying of thirst’ (laugh). ‘Make me a martini, a painful martini. A martini painfully dry’. I drank like 10 or 12 of them and blacked out. That was my first black out. And of course I got into all sorts of trouble of course from drinking (Diego, p. 1, lines 30-41).

For many of the participants, drinking during the adolescent and early adult years was often heavy, compressed into the week-end, and evaluated as a positive experience.

Okay, I guess I started drinking constantly probably about 16, you know, after …when I was in high school we would drink every weekend, go to keg parties at the river and/or party at somebody’s house. During the week wasn’t so bad but like I said the weekend was pretty constant. When I graduated high school I went into ah…civilian tech school and then I started drinking pretty regularly and few times while I was in tech school it became a problem so I would make a promise not to drink during the school week, that never worked (Big Mac, p. 1, lines 8-19).

Common among participants during these early years was a sense of excitement for and anticipation of the week-end, because of the heavy drinking that had come to be associated with it.

Uh, I started drinking when I was in high school. That was like the best part of the week was the weekend. Like, oh wow, my friends would go to parties and
drink. And I went in the Service for a couple years. Then I came out and I didn’t drink much for about five years. Then, uh, about the age of uh 28, I started drinking and just got gradually worse every year. ‘Til I went out, by the time I was 40 years old I was a full blown al-, alcoholic. I couldn’t function without drinking. I was, I was a f-, functional drunk for quite a while. But then that ended. I couldn’t function any longer (Keef, p. 1, lines 11-22).

Lobo describes a similar experience with alcohol in the following description.

Probably around 19. I used to look forward to Friday’s. I guess …I planned on Fri…on the weekends. Because I was always looking forward to, because I knew me and a few friends would get together on the weekends and what we were going to do. We’d set out to go to a bar to get drunk. So I… (Lobo, p. 4, line 179-184) …I don’t know if that would be considered a craving or not. I guess it…I guess it would be, in a way, because I’d be craving…craving for the weekend I guess you could say (p.5, line 185-188).

Alcohol also facilitated having a good time through lubrication of those awkward social situations common in adolescence.

I went from just drinking beer, uh, starting on the weekends and getting drunk on the weekends. My dad noticed it a lot. But I’d only do it like on certain weekend nights. Saturday, sometimes Sundays. Uhm, when I was in sports definitely after a game to loosen up. And girls. I started using alcohol as a way to meet young ladies. And then, uhm, when I was 18 and I joined the Navy, uhm, 1978 after I graduated high school, that’s when I really took up drinking because I wasn’t at my family’s house, my dad’s house anymore. The Navy didn’t care if I drank. So, I cut loose (Teach, p. 1, line 21-33).

My first time that I got actually drunk I was either 12 or 13. It was in 1971, ‘70 or ‘71 or somewhere around there. I don’t remember exactly. And, uhm, I actually recall the reason that I got drunk. We were at a, uh, uhm, a junior high school dance on a Friday night and there was one guy, uh, he was a 9th grader. Uh, I was a 7th grader. And he had been drinking, and, you know, you could tell and everybody knew it. And all the girls were around him. It was like something special and this kind of hit me like, “Well, I’m very shy and I don’t have a girl. I’m afraid to ask one to dance”. Perhaps, if I had some of what this guy’s… this stuff had…what this guy had, perhaps I would be able to do that. And I honestly think that was what clicked me initially at my ear-, at that teenage, school age, to start, uh, using alcohol strictly on the weekends (Wayne, p. 1, lines 15-35).
Many of the participants were able to describe a significant drinking experience early in their drinking career that stood out in their mind. The following description provided by Steve serves to illustrate the extent of the drinking that was common among the participants as they recounted their drinking history.

And they had an enlisted club there, as they have in most of them. And I went in to there like very early on. Like second or third night there. And got into a drinking contest with a Navajo Indian because the idiot gringo that I am, I, I had seen in the movies that Indians can’t drink, can’t hold their firewater. So, I thought I could win this drinking contest. And we drank, Percy and I each drank, it’s kind of hazy now, but at least one pitcher of beer each. And, uh, then we decided that wasn’t going to prove anything and decided to walk into town, which is only a mile or so away, and do some serious drinking. And, uh, that’s when my first real genuine black out occurred. I recall we got past the guard shack on the way off. There was like five or six of us walking out. And right about that time, we all had to evacuate our bladders. It was time for, uh, to take a leak. And, uh…as I was, I have…I can distinctly recall this, and it happened in 1978. As I was facing out, from the street, you know, face the roadway and there would be a proper row, we were lined up facing out from the road, taking a leak, and I could feel my bladder draining. It was so full. I had had a gallon of beer. I could feel my bladder draining but at the same time it was like my brain was draining out of my head. This curtain was coming down. And, uh, I have very dim memories of the rest of that night. One of them involved throwing up in a bathroom in some horrible dive bar. My glasses were in the toilet, so I rinsed them by flushing them in the toilet and swishing them out. And there are one or two other things that I remember from that night and woke up the next morning on the concrete floor in the barracks next to my bunk minus my wallet and my pocket that the wallet had been in. I had been pick pocketed and (p. 3, line 10-46). they took my pocket, too. And I don’t remember anything about that. And I had an absolutely astonishing hangover. I could not keep water down for two days. And on the third day I could keep water and crackers down. And the fourth day I was able to eat breakfast and I got drunk again. And, uh, I proceeded to drink an awful lot in the Marine Corps. I did a lot of drinking. I drank a lot of hard liquor. I drank a lot of beer. I didn’t waste much time on wine, except when we were in Spain. I got some Sangria. But I pretty much went directly to shots and beers and then skipped the shots and just started drinking out of the bottle. The people I hung around with, we would get a bottle of booze and take the bot-, the cap off it and throw it away. ‘We’re not going to need that. We’re not putting the, we’re going to empty this bottle.’ And we did (Steve, p. 4 line 1-17).
Effect of Alcohol: The Function

Participants evaluated the overall experience of drinking as pleasurable, and described “a point” that was desirable while drinking which became more elusive as they progressed in their drinking career. Diego explains that “it was typical kind of drinking for the effect” (p. 3, line 120-121) which he further summarizes in the following description.

That’s the whole thing where you, where I want to control it, all right. So I decide I’m only going to have two beers. I’m going to have two beers and I’m going to have one of those little shooters of Jim Beam just to kinda put it over there. So then I finish that and ah, I want more and so I’ve got the effect and I know that I’m there. And I say to myself, ‘This is it. I know that I’m there’. And I say to myself, ‘This is good. I’m done. I’m good. This is all I need’. But then after let’s say, you know, an hour or two passes by, the effect wears off. The effect. The sense of ease and comfort. The relaxed, the little high. The effect of alcohol. So it wears off and so, then I want, I want that back. I go back to the store and while I’m at the store I say, ‘Why am I going to get two more beers? I don’t want to be coming back and forth kind of thing’. So I just go for the quantity (Diego, p. 10, line 433-450).

Steve summarizes the general consensus of the participants in his response to his Mother’s expressed concern over his drinking.

She asked me, ‘Can I please stop? And why do I drink alone?’ And I said, ‘I like the way it feels in my blood stream. I don’t feel that I have to have a social situation. I like the feeling of booze. I like the way alcohol affects me’ (p. 8, line 7-12).

Euphoria. The experience of euphoria, often experienced with the first drink, was often described by participants as transformational or a life-changing experience. Steve offers one of the best illustrations of the euphoria commonly experienced in his description of his first experience with alcohol in the form of dandelion wine.

It tasted like grass clippings steeped in dirt. It was awful. And it felt wonderful. It changed the way I felt about everything. About myself. My, I never felt very
comfortable or secure or good about myself prior to that (p. 1, line 25-28). And it tasted terrible but before the awful taste was out of my mouth, was such a warmth, well being and wholeness. Just oozed all over my pores and I started to feel just fine. The way I thought I should feel (p. 1, line 35-39).

Steve’s second exposure to alcohol resulted in a similar, even more intense experience.

And I topped it off with gin. And stirred it up and I drank it down. And that also tasted absolutely terrible. But it felt even better than the dandelion wine. It, it felt so good and I felt so good and bulletproof and marvelous and full of myself and on top of the world and great that I wanted…weaved up to the top of the hill, out in front of our house which is, there’s a road there. And I actually walked up the road and laid down in the middle of the road and rolled down the hill in the middle of the road on the pavement and rolled into the yard and threw up and, uh, I had a horrible pounding hangover and still thought it was wonderful and I couldn’t wait to do it again (p. 2, line 13-26).

Teach clearly remembers the experience of his first drink and the effect he obtained from the alcohol. “I liked it. I liked it a lot. Uhm, first time the beer ta-, I tasted it, uhm, it make me feel warm inside. Made me feel real good. Made me feel good about myself” (p. 1, line 11-14).

The pleasure of drinking was also an antidote for boredom as Diego relates in the following example.

When the boredom sets in and I get restless and I don’t have anything to do, then you think, ‘Well, a couple of drinks would really make time go by’ (p. 6, line 235-238) and “When I don’t… don’t have things to do, the fun of drinking kind of elevated the boredom and things became more humorous, ah…watching a sporting event seemed a little better (Diego, p. 13, line 127-130).

Lempie summarizes the consensus of the participants regarding the pleasure derived from alcohol in the following excerpt. “I always like drinking. I liked the taste. I liked the feel. The way the body feels. I enjoy drinking. Drinking to me has been pleasurable” (Lempie, p. 12, line 12-14).
Transformation of Self: This was evident in several participants’ description of two different selves: a drinking self and a sober self. The following excerpts illustrate the influence of alcohol in the transformation of a less than adequate self.

At first it was still fun, you know. There were still parts of times when I felt, there was the period of that warm glow and the wholeness and ‘I, I am somebody’. And, uh, but then it rapidly turned into ‘I, I am…I’m going to be somebody else ’cause I don’t like who I am. I’m going to be somebody else. And I don’t know who. But I’m going to be somebody else’. And, uh, and then, uh, that, that feeling would become illusive and it would take more and more booze and, uh, then it got to where the desire for that feeling led me to drink so much that I would black out every single time. And if I didn’t black out, I was very, very cranky. And, uh, that’s about the only times I was not a happy drunk, is if I didn’t have enough to black out, which wasn’t often. ‘Cause I wouldn’t start if, if I, if I only had a couple of beers I wouldn’t even start. ‘Cause that would just make me angry and, uh, and frustrated and disappointed in myself (Steve, p. 12, line 21-40).

Alcohol also provided the means for meeting societal expectations. Participants found it possible with alcohol to overcome shyness, especially during adolescence, and gain a sense of ease during expected social interaction.

For Wayne, “the alcohol had the effect eventually of giving me the confidence that I lacked for some reason or another…it gave me a feeling of, uh, ten foot tall and bullet proof. It gave me confidence around girls” (Wayne, p. 3, line 11-15, 19-20).

Lobo offers the following example regarding the ability to overcome the shortcomings of the sober self through alcohol.

Compared to trying to hide who I am or trying to, not really hide who I am, trying to be somebody I’m not. Somebody that everybody expects me to be. I’m like two different people. It just helps me. I guess in a way it helps me feel like sometimes I fit in and other times it just makes me get to where I don’t even worry. I don’t thing about anything or worry about anything (Lobo, p. 13, line 565-579).

Big Mac liked the ability to be more open when he drank, “cause predominately I
am somewhat of a shy person. So, it wouldn’t make, actually, what it would do is, uhm, create a new Big Mac” (p. 13, line 15-18). Big Mac further describes the difference between the sober and the drinking self as kind of weird because it’s, you know, two people living in the one skin. And that wasn’t a Jekyll and Hyde. Like I wouldn’t get in my car try to run school age kids over. He would, he was who I wanted to be. He was like I am now. I’m caring, I feel compassion. I think about other people. But when Little Mac, I guess what I’d call him, was he was, he was mean (p. 13, line 23-26, 32-36).

For Poncho, the effect of alcohol was one in which he would “feel important. I was an only child. And I kind of lived a secluded life. And uh, once I started drinking, it made me feel something that I should have been that I wasn’t” (p. 10, line 14-15, 19-23).

*Enhanced Problem-Solving Ability.* This relates to the perception of participants that there was an improvement in their ability to solve problems after the initiation of drinking. This was also differentiated from mental clarity that was achieved through sobriety, through two observations. First, several participants acknowledged the need for mental clarity that was possible only through sobriety, in order to perform adequate role functions that were deemed important (as a soldier, as a caregiver) or managing urges to drink through resistance. Second, even with enhanced problem-solving ability while drinking came recognition of the influence of alcohol on mental clarity.

Wayne offers a helpful analogy in order to illustrate the enhanced problem-solving ability (problem-solvability) experienced while under the influence of alcohol. It’s almost like, you’ve seen a maze that they put a rat in-- and watch how he goes around to get to the center of the maze. Well, to me life is like when I’m sober, it’s like a maze. OK? For me to reach the center it’s going to take awhile. It’s going to take some wrong turns. But eventually I can get there. But it seems like when I drink alcohol, all the mazes have a door so it’s just a-- straight way to the center. And I’m averting all the…what I should be doing and what’s reality is,
you have to work your way through. But with alcohol it’s like I enter here, the maze is here. I should be going this way, this way. Uhm. Open the door here and another door here and another door here and there (Wayne, p. 7, line 39-44; p. 8 line 1-25).

This enhanced state of problem-solving was lost with the cessation of drinking and regained again with the resumption of drinking, as Buster illustrates.

I would think more clearly. I would c-, I would have an answer, even though when I sobered up again I wouldn’t. I’d think, ‘Oh, God. That wouldn’t work.’ But the, the, the alcohol the next day would give me the false impression that getting drunk, or when I started drinking again the next day, ideas would come to me that didn’t come to me the day before. (p. 15, line 12-19) And, uh, it would give me ideas. But it was a vicious cycle ‘cause when I’d come to or sober up, those ideas didn’t make any sense. And, uh, then I would drink again, uh, the same day and it would make sense (p. 15, line 24-28). The, those same ideas would come back to me and, and inevitably I think I’d wind up doing some of those ideas. I could think more clearly -- drunk than I could sober (p. 15, line 36-38, 42). ‘Cause my brain in my, under the influence it…it seems to me while I’m under the… I’m, I’m thinking while I’m under the influence that what comes to me makes sense at that particular time. And then when I sober up again, it doesn’t make any sense. It’s a vicious cycle (Buster, p. 16, line 25-30).

Several other participants suggest other effects of alcohol that contribute to the enhanced problem solving ability. For example, Wolf Dancer identifies mental clarity and increased energy as underlying an enhanced ability for task orientation. “When I first start drinking, it’s almost like my head clears up… And then I get a lot of energy and I really take a hard focus on what I want to get done. But then I take it beyond that point” (p. 2, line 33-34, 38-40).

However, an additional effect of alcohol that contributed to this enhanced problem-solving ability was a downplaying of the importance of problems. Poncho concedes that “sometimes I, I would say that. Yeah, that I could think a little more clearly. Don’t get rattled right away” (p. 20, line 31-33).
Keef further suggests that for him, “it’s not, it’s not clarity. It’s that all doesn’t matter… It’s not that big of a deal. It’s like, you know, whatever. You know, once I’m on, it doesn’t matter what happens” (p. 11, line 38-39, 43-45).

Numbing or Escape. The ability to escape of be numbed by alcohol was also identified as a desired effect of alcohol among participants. Lobo provides the following example to illustrate this effect.

It just make me forget, or, yeah, basically it made me forget everything that I didn’t want to care about…didn’t want to feel or remember for the day or…before. Or if I was angry it would mellow me out” (p. 17, line 768-772). He further elaborates that “other times it just makes me get to where I don’t even wor…I don’t even think about anything or worry about anything (p. 13, line 577-579).

Several participants identified a relationship between stress and craving, with alcohol representing a source of relief.

What set me off too was stress (Diego, p. 13, line 581). If my wife and I were get into a fight or some kind of stressful situation, I would say ‘I don’t want to feel like this, I want to feel like this. I want to feel the buzz’. So stress definitely is a trigger too…that sets me off. ‘Why, why stay sober and miserable? Every time I walk into a liquor store I want to drink. Every time I see a beer ad, I want to have a beer. Here I am 30 days, she doesn’t appreciate me, we do all this fighting, and the heck with it’, you know. And you know, I figure once I have four beers in me she can say whatever she wants and I don’t really care, you know, ‘what the hell. As long as I can just (p. 13, line 585-596) have the beer (laughs) (p. 14, line 597).

Wayne describes his current situation involving discharge from the detoxification unit without a place to stay to illustrate the effect of stress and desire for alcohol.

The trigger begins up here thinking of what circumstance I’m in (p. 22, line 34-36). It’s episodic and then it builds to the point where you get in the right circumstance, uh, and you say, ‘Oh, f-- it. So what?’ Like me, I’m in a prime, prime condition for that this evening. And I realize this. This homeless bull shit is not for me. I’m four and a half hours away from a bed. Ok? And I’m pr-, in prime condition to the, to, to, uh, say f-it, you know” (Wayne, p. 18, line 17-26). He further elaborates that “It’s, it’s a craving to whatever situation I may, might be in
It’s craving when you sit somewhere by yourself and you think, ‘Boy, this stinks. Uh, what am I doing here?’ Uhm, I really don’t want to think about tonight. You know, I’m going to sit on this bench or under this tree. I’m not going to freeze to death. I’m not going to starve to death. But then what do I want for comfort. I don’t want a teddy bear. I don’t want a woman. I don’t want a, uh, a radio. Then what is there? Well, a pint of vodka sure would make the night go easier. Those are the thoughts that go through the head (Wayne, p. 19, line 31-43).

Anxiety-Reduction. The reduction in anxiety was akin to euphoria, but seemed to be a distinct effect of alcohol that was commonly reported by participants. This desire to experience the reduction in anxiety from alcohol was often associated with a sense of anticipation and/or urgency.

I never wanted to like buy a six pack and bring it home and drink in my apartment. I just wanted to go over there and … and drink right away, as soon as I got it. Get that sense of urgency and the sense or relief that I needed, that my brain told me I needed and my body… felt good. The more I felt good, the more I drank (Arthur, p. 13, line 538-544).

Buster provides the following description of the short-lived reduction in anxiety.

It might put me at ease somewhat. Relax me somewhat. The first few drinks. Even, uh, after maybe three beers I feel relatively good. And then I put it away and say to myself, ‘Ah, you can handle it’. But that’s only, that’s short lived” (p. 13, line 8-12). “That’s another thing that alcohol does for me. Uh, it makes the worry go away which has haunted me pretty much all my life (p. 19, line 41-43).

Poncho further elaborates on the experience of the first drink. “I feel the calmness after I get the first—the first one in. It just goes in so nice. It feels good going down” (p. 6, line 34-35, 39-40).

Summary

In Stage One, Craving in the Background, craving is either not granted access to conscious awareness, or announces its presence in the form of fleeting thoughts that are seemingly unimportant. Craving is characterized as omnipresent, since the emergence of
craving into conscious awareness could occur at any time, often out of the “clear blue” without obvious provocation. Craving remained dormant yet watchful in the background which required a constant state of vigilance on the part of the individual. Participants describe keeping their “guard up” in order to prevent craving from gaining a foothold in this stage.

Craving for alcohol in Stage One, *Craving in the Background*, provides a backdrop of desire for alcohol. Despite the identification of the adverse outcomes consequential to drinking, individuals’ previous experience with drinking and the perceived benefits derived from alcohol color the memory such that pleasure remains prominent. The category *Desire for Alcohol* is therefore defined by the two indicators: (1) *Past Experience with Alcohol: Memory of Pleasure*, and (2) *Desired Effect of Alcohol: The Function*. Despite the recognition of negative consequences from alcohol, an individual perceived the experience of alcohol as pleasurable and retained the desire to drink. In any given individual, alcohol performed one or more of the following five functions: (1) Euphoria, (2) Transformation of Self (3) Improved Problem-Solving Ability, (4) Numbing and Escape, and (5) Anxiety Reduction.

The following section provides a description of Stage Two, Craving in the Foreground.
Stage Two: Craving in the Foreground

In Stage Two, *Craving in the Foreground*, craving moves into conscious awareness and the Desire for Alcohol continues to exert influence in two ways. First, an underlying *Desire for Alcohol* forms the background or context within which the alcoholic exists. Second, *Desire for Alcohol* informs the two forms of craving that characterize Stage Two: (1) *Craving as Conversation* and (2) *Craving as Urge*. *Craving as Conversation* is descriptive of the ensuing struggle within the individual between the voices that support and oppose drinking. *Craving as Urge* reflects an overwhelming *drive* to drink.

During Stage Two, craving undergoes transformation from a thought to an urge as it moves from the individual’s subconscious (existence of craving in the background) to the conscious (craving exists in the foreground). For some individuals, the experience of craving was preceded by a physical manifestation, or prodome similar to an aura preceding a migraine. The majority of the participants did however describe the ensuing struggle between drinking and not drinking as a “battle”, evident as self-talk or an ongoing conversation in their head. While participants might struggle with arriving at a definition and description of what craving was, they were clearly able to delineate what craving was not. With either the amplification of the struggle, or the insistence of thought as urge comes the recognition of a tension and resultant vulnerability, since drinking represents one option for resolution of the tension. Steve summarizes that

There are still times when I know a drink would solve the problem. There are feelings I get when I know I would feel better. The problem would and I don’t even care if the problem’s solved or not. I know I would feel better if I had a drink (p. 17, line 31-36).
Eventually action is required for resolution of the tension; in Stage Three, *Choice* an individual chooses to manage craving either through suppression or through drinking.

The following section provides a description of the craving prodome and the two categories of craving that comprise Stage Two, *Craving in the Foreground: Craving as Conversation*, and *Craving as Urge*.

**Craving Prodome**

Several of the participants described the occurrence of physical symptoms that immediately preceded the experience of craving. Steve illustrates the prodome with the following example.

That feeling, the physical sensation -- I felt was exactly the way I felt, the level of excitement that I felt if I’d been a day or two or three, if I’d been two or three, I, if I had been three days without drinking and I had some booze, that’s exactly the same way I felt (p. 18, line 18-19, 23-27). That same rush of giddiness and almost tingly and lightheaded… Oh, it was a physical sensation. That’s correct. Yes. And I’ve had that from, uh…I was bicycling. And I had only gotten from here, it was a seven, seven mile bike ride and I had only gotten about three miles into it, two and half miles into it, and fatigue…and this happened two different times. Fatigue came over me and it felt…at that time the craving was actually more for crack, but it was initially a physical sensation. I felt just like I had been up for two or three days drinking and smoking (p. 18, line 31-32, 37-46) crack. And it was the, the physical fatigue kicked in. It was exactly the same level of fatigue that you get from drinking and smoking crack for two or three days. And it was instantaneous that as soon as I felt this and I…it just took a split second to think ‘I’m a… what the?’ I didn’t have to think. I felt the sensation of the fatigue and then the craving kicked in (p. 19, line 1-8). The physical craving and then the mental craving came. Yes. Almost instantaneous. But initially it was the physical. As I started to feel uncomfortable and…and, it was like ‘What is wrong’? And then I knew the, the drink and a hit of crack would feel just fine (Steve, p. 19, line 17-22).

Teach was also able to describe a prodome of physical sensations that preceded the mental struggle through the following example.
To me a craving is, uh, when my body starts to - you know, when I start to shake. When I start to, to get nervous that’s when I, my, my first instinct for, ‘cause that’s what starts (p. 10, line 16-17, 21-23). I’ll sit there watching TV. Even if I’m not watching, uh, anything to do with alcohol my hands’ll start to shake and, and my palms get real sweaty and I’m like, ‘Oh oh. Here we go.’ And that’s to me is the first indication of a craving. That a craving’s come on. And I’ve, I’ve started to learn that (p. 10, line 27-32).

Poncho described a similar physical reaction that preceded craving, which differed through the prominence of fear.

Before I took that, that last drink, I, uh, you know, I had cravings. I, I guess what happens when I get cravings is, is I, I get fear (p. 5, line 5-8). what they call self-centered fear. Which is the fear of losing something that you’ve al-, you now have or want to get. And, you know, I wanted to hold on to my house. I wanted to hold on to my job and I got this fear. And, this fear would lead to resentments against people. When I got these resentments, my whole body would shake. I would just shake all over and the only way that I could settle down would be take a drink. And, I would go out and have that drink and then from then on I was off on, uh, drinking every day (p. 5, line 12-24).

**Characteristics of Craving**

**Mental Process.** Despite a physical manifestation that either preceded the expression of craving (prodome) or accompanied the experience of craving, participants for the most part felt that craving was a mental process in Stage Two. Lempie offers the following definition of craving.

A thinking process. Me telling you about that is not a thinking process. It’s just so-its’a different thought wave…It’s not relishing in the, in, in the alcohol. It’s just telling you something. So there’s a different thought wave” (p. 7, lines 37-42)”. However, he acknowledges the physical component of craving: “I can talk about it right now and not, and not feel like I want a drink. Because my body isn’t psyched up for drinking. In other words, I’m just talking. I’m not feeling those feelings (p. 6, line 3-6).

Big Mac also defines craving as a mental experience and illustrates the physical component associated with craving in the following excerpt.
I mean, I, I wouldn’t, it wouldn’t consume my time (p. 11, line 22-27). I would go, you know, ‘Yeah, I’d love to have a beer now’. But it’s not like I would stop fishing just to go, ‘Man, I wish I had a beer’ (p. 11, line 28-30). I know my body would want it because I remembered how it made me feel, so even my body was, ‘Yeah man, good old couple of Budweisers’d be real good right now (p. 11, line 40-44). Actually, that’s, I know why they call it a craving because it is. It was, it was almost like you’re subconscious or something’s going ‘Gimmie, gimmie, gimmie. You know, we want it, you know. And we’d like to have it’. (p. 12, line 3-7). And it’s, I’d almost say more of a psychological than a physical. I mean I wouldn’t get the shakes, you know, in anticipation of a drink…It’s funny, ‘cause you think of the good time of when you are drinking and you forget all about the stupid shit that you did (p. 12, line 11-17, 18). So you would glorify, going ‘Man, don’t you remember that time?’ You know, you forget about waking up in the bathroom floor. You know, you forget about the stupid stuff that you’ve done. So it’s selective memory (Big Mac, p. 12, line 25-29).

Arthur differentiates craving of the mind from craving of the body in that craving is not necessarily the body, but the mind…when I think about, it I had to time to think about drinking then my mind would say, would already say, ‘Okay’. For some reason it would say, ‘Okay, I want it, and I won’t I’ll just go to any length to get it’ (p. 11, line 475-476, line 478-482).

Memory and Mental Representation. For most of the participants, craving was associated with memories of alcohol which were specific to the individual. Lempie summarizes many of the participants’ experience of craving as a memory of the good times. The cravings of alcohol is, I remember the good times I had (p.1, line 24-26). Well, when I went to the hospital, El Rio here, and I quit drinking, after two months of medication and feeling better, I had these cravings. And the cravings is when you remember the good times that you had. The fun that you had. You don’t remember the bad times. And I really didn’t have many bad times (p. 2, line 36-42).

The perception that drinking had made things “seem better” in the past was also associated with craving.

There are still times when I know a drink would solve the problem. There are feelings I get when I know I would feel better. The problem would and I don’t even care if the problem’s solved or not. I know I would feel better if I had a
drink” (p. 17, line 32-36). “I felt like a drink would be just a wonderful thing. I felt it would be terrific. I knew I would feel better if I had a drink. It did not occur to me to actually take a drink. But I knew I would feel better (Steve, p. 17, line 14-18).

In his differentiation between two different kinds of craving, Buster provides a further elaboration of this one type of craving as

basically, uh, a frustration. Uhm, when you, when anyone has a bad day, they look for an escape somehow. Different people do it different ways (p. 10, line 29-32). But I was exhausted at the end of the day. And frustrated after going to the store fifteen times ‘cause I didn’t get the thing the I was supposed to get. And, uh, that’s the frustration, uh, craving. Like, ‘Oh, God. I need a beer. Just to get over that miserable day’. That’s one. Uhm, that one I can control, uh, relatively easy. That’s the one I described earlier I think. When I, you know, I give it a few minutes. Sit (p. 10, line 38-46) down, relax, drink some water or something. And uhm, that goes away. That frustration, that anger. That, whatever you want to call it. That, that craving. I don’t really refer to that as a craving but I guess you could say it is (Buster, p. 11, line 1-5).

Conversations with Craving: Struggle

Craving was often referred to as a voice that spoke to the individual, particularly through the drinking self which embodied the underlying desire for alcohol which was ever-present. Lempie provides several examples of the voice of craving always in waiting.

But once you start slipping into this, ‘Damn, I remember sitting at the bar. We’re playing pool. I remember that keoke with that lady. Boy that was great. Oh, you know, maybe I can drink it intelligently. You know, go have a cou-’ And I know I can’t, you know. I know I can’t. But once you start slipping into that mode (Lempie, p. 5, line 40-46).

Lempie relates another example of the permission to drink that craving appears to provide and the ensuing struggle.

You’ve been sober a year and two months. You know, things are pretty cool. You know, you’re working. You’re volunteering at Armory Park. Things are really cool, you know. Don’t screw it up by drinking. ‘Aw, but I like to drink you know.
Man, I’ve been sober for so long’. See that craving? There’s your cravings (Lempie, p. 9, line 1-7).

Lempie also illustrates the wearing nature of the struggle after craving has caught or captured the attention of the drinking self.

Before I do it, I get like, and I don’t get like shaky or anything. I just feel something inside that goes like ‘Oh, yeah, sure. Man, things would be cool. This is great’. And, but it wasn’t great the day before cause the day before I put it off. You see I didn’t buy no booze at the liquor store. I went for a ride. That’s how I do it. But little things at a time eat at you and eat at you and eat at you. And finally you just give up and surrender. ‘I surrender. I surrender’ (p. 26-35). It builds. It’s like a crescendo. It’s a, like if one little thing, if one little thing triggered in my mind the pleasure of drinking. See I could talk about it because nothing’s triggering my mind (p. 22, line 22-25).

Diego and Big Mac describe the influence of triggers in both the emergence of craving as well as strength of craving at different points in the first few months of early sobriety. Their descriptions present a scenario in which: (1) the memory of “remember what it was like” stimulated by a specific trigger that is unique to the individual is immediately followed by, (2) the voice of craving that gives the drinking self permission to drink. The duration as well as the outcome of the resultant struggle is influenced by the degree of resistance the individual is able to muster against craving, or the strength of the sober self to resist the drinking self once empowered by craving.

I would, I would ah, go into a convenience store to get something, walk by the beer section and remember what the Michelob tasted like (p.7, line 317-320). Or the Corona, and something you know, the taste of the beer. But that would only last for just like 30 seconds and get it out of my mind (p. 8, line 324-326). Because I wanted alcohol. Now I remember when it was, ah, like those little spots of short term sobriety when you are struggling and it’s be like 30 days. That was a lot harder because I would I would walk by the beer section and get that, ‘remember what it was like’ you know. And just say ‘the heck with it’ and go grab a couple of beers. ‘I’m not going to do this to myself (p.8, line 330-337). You know, struggling with staying sober. Not drinking, being miserable (p. 8, line 341-342). In fighting it, fighting not drinking (line 346). That’s like ah,
convincing yourself. It’s a mental yes or no thing going on. ‘Should I drink? Should I not drink?’ you know. ‘Ah, a couple of beers won’t hurt, you know’. It’s a struggle. It’s a struggle when you are not (Diego, p. 8, line 350-354).

Big Mac further describes the influence of vigilance on the strength of craving.

And it never really bothers me the first few months. Never really does. And it doesn’t bother me, uh, if someone drinks around me. I mean, that doesn’t bother me. But I’ll look at them drinking going, ‘Man, I’d love to have that beer’. You know. Or especially if I see somebody doing a shot it, “Yeah, I remember those days.” And in the beginning I know to tell myself that you can’t do it. But as time wears on and I lose that thought and I let my guard down (p. 15, line 26-37). It’s like, ‘You know what? You can do a couple. It’s not going to hurt you. You’re a big boy’. You know, you know, ‘You just do a couple and then you go home’. And there we go again. We’re right back on it (p. 15, line 41-45).

Big Mac also characterizes the struggle between the sober and the drinking self, as the resistance afforded by the sober self is overcome by the louder voice of craving that speaks to the drinking self.

Actually, I, I do have a conscious thought that I shouldn’t be doing it. Every time. Every time. I have a conscious thought that, you know, ‘where this is going to lead?’ And I always come back, ‘Naw. Not, not this time’. And it’s a lie as soon as I say, ‘no, this time’... I know that I’m lying to myself (p. 17, line 22-28). And I won’t say it’s a physical need. It, it may very well be. But it’s more psychological. You know. I, ‘cause then I fool myself where, ‘You’ve earned this beer. You know, you’re, you’re doing OK. You know, a few beers’s not going to hurt you’. And it’s the same song over and over again (Big Mac, p. 17, line 39-45).

Big Mac further elaborates on the influence of craving in the following example.

I guess it would make me lower my guards, you know, ‘cause I would, I start telling myself that, ‘you know, it’s not as bad as you’, as this small voice is reminding you. So, it just kind of drowns it out (p. 20, line 2-6). And I have chosen many a thing beneath it. I will go to alcohol or... (p. 20, line 18-19). And it, it messes with your, your sense of import-, you know, what’s important to you. I mean, you, not only, I mean, you’re already resigned to losing yourself. ‘Cause you know it. I mean, it, it’s a conscious thing that you’re thinking of all that time. I mean, there’s no way you can’t. But then you also find yourself, as I said, you’ll miss appointments with our family. You’ll miss, I mean, God, just anything (Big Mac, p. 20, line 31-39).
Teach summarizes several important characteristics of craving in the following excerpt. For example, he differentiates between the urge to drink and the ensuing struggle between the drinking and the sober self when there is failure to immediately satisfy the urge to drink. The excerpt also provides a description of the prodome that signals the appearance of craving, as well as a sense of urgency (perception of “going crazy”) in the initial response to an urge.

It feels like, uhm, if I don’t get a drink right that minute, I’m going to go crazy (p. 8, line 22-23). What I mean “go crazy” in, I, I feel like I’m going to go, I don’t know what I mean by crazy. What I mean by that is if I don’t go out and get a drink right then and there I think I’m going to explode inside. But then I stop. I step back and I go ‘What are you, nuts? You’re going to blow sobriety?’ And then I’ll call my sponsor. See, once I, ‘cause now I’m clearheaded. Before, even though I was not drunk or, at the time, when I had a craving I’d go out and drink. There was no thinking about it. I just did it (p. 8, line 31-41). Because I was satisfying my craving. But now that I’m clean and sober I, I step back (p. 8, line 45-46). And I’m like, “No. I’m not going to give in to you.” I, I have a battle in my head. My mind is saying, ‘Yeah, you want it’. And then the other half of my mind is saying, ‘No. You don’t need this, Jim. You’re clean, you’re sober’. So, it’s like I got a little war [Laugh] going on in my head (p. 9, line 1-6). And it, that’s what I mean by going crazy. ‘Cause my, two sides of my brain start talking to each other” (p. 9, line 10-12). In addition, “I mean, I can’t use an excuse anymore, ‘Well, you know, I, I can’t see you.’ Naw, that’s crap. That’s start, that’s my mind saying, ‘Now, you, you ought to drink.’ I had that constant battle all the time. My mind was telling me, ‘Yeah, go out and have a drink, man. It’s OK’ (p. 10, line 7-12). I think, well, for me it’s actually when my hands start to shake and get all sweaty that’s the beginning of it. Then it, then my mind starts to think about it (p. 11, line 1-5). And then the clear side is telling the not-so-clear side, the wan-, I-want side as I like to call it. When the clear side says, ‘No’, the I-want’s like, ‘But I want it, I want it.’ So, there’s that struggle. And then once that, see, it starts with the shaking, then the sweaty palms and then I start thinking about it. But if I don’t think about it, or if, if my hands don’t start to shake or my palms get wet, I don’t get a craving. But I’m starting to recognize that that’s the craving for me now. Before it was just go out and do it (Teach, p. 9-19).
Poncho provides another example of craving after the discovery of three small bottles of vodka under his mattress. He again makes reference to the physical prodome that precedes the process of craving and the unpredictability of the appearance of craving. “And sometimes I get that thought, ‘Oh, you could have that one. It ain’t going to bother you’. So when I go home tonight, I’m throwing the darn thing out” (p. 14, line 40-43). He further elaborates that when I’m not drinking and get my craving, I have those, those fears and those shakes (p. 8, line 2-4). It comes and goes (line 9). I can even go for a period of time. It won’t even, it won’t even bother me. But then it just hits me, ‘Oh, wouldn’t a drink be nice about now’. And I could taste it in my mouth, you know (p. 8, line 13-17).

Wolf Dancer provides the most complete definition and description of craving in his eloquent illustration of the internal conversation that occurs between the drinking self, the sober self, and craving.

If I really concentrate on craving, well, eventually, I’ll go drink (p. 4, line 24-25). Well, really think hard about taking a drink. The craving brings on, well, like they used to say, ‘stinkin’ thinkin’. You start to talk to yourself and the other inner person that’s in you starts saying, ‘Well, hell. You ought to be able to control your booze. You used to. What’s the matter with now?’ (p.4, line 30-36). But like with me I have an argument. And, I mean a literal two-sided conversation. Out loud (p. 5, line 42-44). The craving’s right in the middle (p. 6, line 41). It’s like a third person. It is a, it’s an emotion really (p. 6, line 45-46). It’s part of your emotional make up. Uh, you have that person who’s sober, his emotion. He wants to stay sober. You got this guy over here that’s still convinced he can drink. And you got the guy in the middle. And he’s talking to both of them (p. 7, line 4-9). He’s telling the guy who wants to drink, ‘Hey, we can get away with this. Let me talk to this jerk.’ That craving is a third person that talks to both sides of your drinking (p. 7, line 13-16). Your sober side and your – (line 20). ‘You used to drink. Never had a problem with it. What makes you so different now?’ And those thoughts keep going over in your head. And, that’s that craving. ‘Hey, why can’t I?’ It’s a battle of I guess denial. You would, you could put it in the category of denial. ‘Cause the guy in the middle and the guy on the other side both deny the fact that you got a problem with alcohol. When it’s two against one, you usually lose (p. 7, line 28-36). He, he works both
sides of the fence to get what he wants (p. 7, line 41-42). It’s a thought and an emotion. Combination. It’s the need. Because you’ve got that one guy that you can normally handle in your sobriety that wants to drink. You got the guy over here that knows you can’t. And up here comes that craving guy. He wants a drink. Period. He don’t give a shit about the other two. So, he works both ends against the middle. He ke-, keeps convincing the guy that wants to go drinking that it’ll, it’ll work, it’ll work. And then he goes to work on the guy who’s sober. That sober emotion part of you and starts picking the things that he knows will trigger. That’s why sometimes you have to end up taking a drink and not even realizing it. You’ll, because you’ll go to that one place to get a cup of coffee. But that one place is where you used to get the pint of booze. You go get your coffee. When you get up to the counter all of a sudden the next thing you know, you’re ordering a half pint of whiskey. And you go out in the car and take a drink out of it and you say, ‘What the shit am I doing?’ (p. 8, line 1-21). I think because the sober part of me just all of a sudden, I don’t know, takes a holiday. Gets tired of fighting. Doesn’t think it’s worth it anymore. And, that’s what the craving’s been waiting for. For him and his buddies that likes to drink. The craving also works in, “Well, how much fun can you have sober? Look at all the times you used to drink and have fun.” In other words, a craving is kind of a prior emotion of when you could control your drinking where you could walk away and say no. Or, maybe that’s all I want. And that third person is that guy that he don’t give a shit. He wants a drink. Period. And, he’s going to try to talk you into it. And, when you got that craving in the middle, you got two people, two emotions working on that (p. 8, line 25-40). Trying to stay sober. Yeah. Sometimes you will, but in the cases of relapse, relapse is when you lose. When you lose that argument. And you (p. 8, line 44-46) let the craving take over. Because the craving and the guy who wants to party and drink, they win (p. 9, line 1-2). It’s with me constantly. Never goes away. It’s a constant battle between the person who used to be and the person who is (p. 9, line 8-10). In other words, where you crossed that fine line between normal drinker and alcoholic. Because there is a fine line. It’s like wa-, walking a human hair. And a lot of people could drink and do all this all their lives and never lose the control (p. 9, line 14-16). And that craving is right there in the middle. Kind of, that little voice in the back of your head. Sooner or later it convinces you can take a drink and walk away” (Wolf Dancer, p. 10, line 3-6).

Consistent with the description of a prodrome that signaled the onset of craving, several participants described a period of irritability that corresponded with the struggle.

A lot of times I’d get aggravated (p. 7, line 314). Yeah, and it’d make me easily...I’d get real irritable a lot of the times because I knew I couldn’t take that drink. It made me real agitated (p. 7, line 318-320). That was a constant battle (p.
8, line 337). For you know, a few months (p. 8, line 341). I finally, I guess, finally, mentally blocked it (Lobo, p. 8, line 366).

I would, I would get mad. I would get angry, frustrated. Uhm, because I had put limitations on myself, but I was sticking with it (p. 23, line 42-44). I act, I had urges to drink” (p. 24, line 2). Sometimes I really, really, really wanted a drink, but I held my own for that two year period (p. 31, line 5-7). I wanted to drink. I wanted to be, at that point, at that point I just wanted to drink to be a part of the group (Sunshine, p. 31, line 13-15).

_Craving as an Urge: Being Driven_

_Craving as Urge_ represents the second form of craving that may be experienced during Stage Two, _Craving in the Foreground_. This form of craving portrays a sense of urgency and _Being Driven_.

Lempie illustrates the transformation of craving from a thought to an urge state through his description of the ability of craving to stimulate the “arousement zone”.

But once you start slipping into that mode… Slipping into that mode. You are going to slip. Once I get the thought of the pleasure that I had” (p. 5, line 45-46, p. 6, line 1-3). I’m talking about it but I don’t have any desire to drink. I don’t have any, I’m not saying, this is not, this is not getting to my arousement zone (p. 23, line 39-42). There is an arousement zone with me as far as drinking. And it’s not seeing other people drink and it’s not walking through the liquor store or going into Fry’s and seeing the booze over there. I just see it. I don’t bother with it. It’s, it’s not my arousement zone. My arousement zone is when I consider the enjoyment of going to the racetrack (p. 24, line 1-8). It’s just a place, it’s a, it’s a thought process in your mind that arouses your ambitions (p. 28, line 43-45). You know, its, you see, it, it gets into your mind someplace to do something (p. 29, line 10-11). And then that, that craving, and we just called it an arousement zone. We don’t know it’s an arousement zone, right? But they’ll call it a craving zone. That craving for that is there (p. 29, line 15-18). ‘Man, that’s not a bad idea’. It’s got your, your zone. See. Now …it’s started. It’s, it’s got a foot in there (Lempie, p. 29, line 27-29; line 33).

Arthur further differentiates between a thought and an urge in the following example.
I had thoughts about drinking. I wanted to drink. Ah. It’s like, it’s like, ah. It’s not, more than. It wasn’t that gut feeling anymore. It was more of a … Like my taste buds were salivating when I think about it. And, ah, the urge. The anxious feeling would come back, and the, ah, it was just, Ah, it was just like I had already decided to go drink. I wanted to drink something. I wanted to drink some alcohol. And I did (p. 10, line 454-466).

The intensity and sense of urgency that characterizes urge as well as the suggestion of action is illustrated in the following example provided by Recovery.

“I’ve always had an urge to drink ever since I’ve started drinking. I started getting old and everything and I just, the craving got worse and worse all the time. I’d wake up in the morning and I’d want a beer like I’d want a cup of coffee, you know” (p. 1, line 11-16).

While participating in a substance abuse treatment program, Recovery described an incident of craving that surprised him.

It’s a Friday afternoon, you know. It’s, I’m just standing outside smoking a cigarette, and just a, a real bad craving hit me all of a sudden. ‘Man, a good cold beer’d go good right now’ (p. 1, line 11-16, line 19-23). If you’d been in my mind, you, you’d, you know it. It’s hard to explain really (p. 1, line 45-46). You know, just, I just wanted a beer so bad. You know, I can’t really explain it. I just, I just had a taste for it (p. 2, line 1-3).

He further elaborates that

Just, just the thought come to my head, you know. ‘But it, you know, it sure would, a beer sure would taste good and everything’. And you know, if I’d been at some place where there’s beer in the refrigerator, I would have got a beer, you know, without even thinking about it. Just walked over and got a beer, you know (p. 15, line 32-38). It would have been automatic to me (p. 15, line 42).

While most of the participants were able to relate their experience with craving in the form of struggle, Keef denied the existence of this type of craving. Rather, craving was experienced during sobriety as an urge that was acted upon, or as a response to withdrawal symptoms once drinking was initiated.

It’s, I never, you know, I never walk around like three days thinking ‘I got to have a drink. I got to have a drink’ (p. 36, line 18-20). Yeah, I never walk around sober thinking about drinking, you know (p. 13, line 1-2). Either I drink or I don’t (line
6). It’s like, uh, if I want a drink, I drink. If I don’t, I don’t. I don’t plan you know. That’s, the only craving is when I, is when I start coming down. And I come down really hard. So, I got to keep jacking myself up. ‘Cause see, I jack myself right into, uh, the emergency room (p. 13, line 11-16).

**Summary**

Craving moves into conscious awareness in Stage Two, *Craving in the Foreground*. *A Desire for Alcohol* underpins the expression of two different forms of craving: (1) *Craving as Conversation or Struggle* and (2) *Craving as Urge or Being Driven*. Craving that is experienced as conversation is descriptive of the struggle that ensues between the sober and the drinking self. Craving as an urge carries the suggestion of urgency and action characteristic of a drive state. Once craving moves into the foreground of conscious awareness, some form of action is required for resolution of the resultant tension. The following section describes the requirement for action with entry into Stage Three, *Management of Craving*. 
Stage Three: Management of Craving

Once an individual becomes aware of craving as it moves from the background to the foreground, action is required. The conscious awareness of craving as a struggle or an urge results in a state of tension that represents a period of vulnerability, since an individual is susceptible to acting on the urge to drink if craving is not successfully managed. The requirement for resolution of this tension through action is inherent in Stage Three, Management of Craving. *Fork in the Road* represents this juncture in which an individual is faced with the following two choices: (1) *Manage Craving* through implementation of strategies aimed at suppression of craving, and (2) *Drink*.

*Suppression of Craving as an Active Process*

Participants were aware of an active process for suppressing craving, or pushing it back down after it had emerged into consciousness. This represents the basic social process of the theory of craving, since craving for alcohol appears to be an active and ongoing process in which craving pops up into an individual’s awareness (craving in the foreground) and must be pushed back down into the subconscious (craving in the background) if drinking is to avoided. It was during the period in which an individual was involved with the process of suppressing craving that feelings of vulnerability were most intense. This vulnerability reflected a recognition that the unsuccessful suppression of craving would result in drinking.

That the suppression of craving is an active and ongoing process is illustrated by the following description provided by Lobo:

I haven’t really thought about it, but I know it’s still there. I keep thinking what are, I keep thinking about the responsibilities that I have. What’s more important.
And it keeps trying to push. I keep trying to push it back (Lobo, p. 10, line 440-444).

Lobo provides further elaboration of the process of blocking out craving.

When I quit, it was, I, I mean I knew I could get it, but I didn’t want it. So I just try to push the craving, cravings away. They were, I, I would say they were both physical and mental because I knew the consequences of what would happen, or what I would do if I did drink, mentally and physically (p. 6, line 271-276). Sometimes it could be kind of hard to get because I would have to sneak out somewhere, you know, so I knew the consequences of that also, which wouldn’t have been hard to do. I’d just have to make some, some night, night maneuvers to go get it when I was overseas. But with my wife, that was different. The cravings. I just started drinking a lot, a whole lot more coffee, and ate a whole lot more candy (p. 7, line 277-286). It’s kind of subsided, you know kind of eased it a whole lot. And then finally until, I got, I didn’t, I pushed it far enough back behind in my mind, or back in my mind, where she was more important, you know, what I was, actually why I was doing this, you know. So the cravings just, I just finally blocked them out after awhile (p. 7, line 290-296). It’s kind of subsided, you know kind of eased it a whole lot. And then finally until, I got, I didn’t, I pushed it far enough back behind in my mind, or back in my mind, where she was more important, you know, what I was, actually why I was doing this, you know. So the cravings just, I just finally blocked them out after awhile (p. 7, line 290-296). I’d say that was probably a couple months. Took me a couple of months to finally get to where I had pushed it away (Lobo, p. 7, line 300-302).

However, varying degrees of success with the process of suppression is also evident in this process as “I guess you would say the cravings would come back because (p. 14, line 631-632) it’s just like (line 636) I can’t always block them out (p. 14, line 640) when they come up” (Lobo, p. 14, line 644).

Lempie provides another illustration of the process involved in the active suppression of craving in relation to the “arousement zone”.

I think what happened last time is I let the arousement zone grow too, too big for me. And I shouldn’t, should have snuffed that in the bud the minute, the minute that started hitting me I should have stopped it (p. 28, line 5-9). By not thinking about it. In other words, when it first comes up-- (p. 28, line 14-15). Like when I first started thinking about it, ‘You know, maybe I ought to go to New Orleans. Boy, you could handle that’. Right away I thought that. ‘No! No! Forget it, dude. Forget it. You ain’t going. Is, no. Don’t even look at the r-, at the computer. Don’t even get the hotel prices. Don’t even see that the bar you’re going to go has changed its name’. You see that’s, that’s tickling the arousement zone. Right? (p. 28, line 20-27). You know, that’s how it all works. It all works. So,
what I should have done immediately when I was thinking about that. ‘Nope. Don’t think about it. Forget it. It’s out of the picture. You ain’t doing it’ (p. 28, line 33-37). You know, it’s, you see, it, it gets into your mind someplace to do something (p. 29, line 10-11). And then that, that craving, and we just called it an arousement zone. We don’t know it’s an arousement zone, right? But they’ll call it a call it a craving zone. That craving for that is there. Like if you were watching, that’s what this TV advertisement is about. You see a, a Hummer on TV. Right? ‘Man, that’d be neat for me and my kids. We’d go to Africa and [laughs] go on a ride’. You know what I’m saying? ‘Hey, that’d really be neat, you know. Yeah, you know it’. Or, or, or some advertisement for a product on TV. Like, you don’t need a weight loss, but they got this stuff on TV for weight loss, you know. ‘Man, that’s not a bad idea’. [clicks tongue] It’s got your, your zone. See? Now, -- (p. 29, line 15-29). It’s started. It’s, it’s got a foot in there. But if you’re, if you’re a diet conscious person who’s constantly on a diet -- (p. 29, line 33-35). That’s the way you keep it out (line 40). Is not letting it in there (p. 29, line 44). Not thinking about it. So, that, that would happen like, uh, if you’re, if you’re, whatever, whatever gets in there, if you’ve got a craving for, once it gets in there you build on that craving. You build on that craving. At least I do. I build on craving. That’s, that’s the best example I could use (Lempie, p. 30, line 6-12).

Wolf Dancer also acknowledges the process of suppressing craving by “putting cravings to the side” in the following example.

And, I went straight to a meeting. And I passed a whole bunch of bars that I used to stop in to have a quickie or Circle K where I used to stop in and get a pint. And, I just concentrated on getting to that meeting. That’s just to put the cravings to the side (p. 6, line 7-12). ‘Cause drinking was a way of dealing. That’s when you start stuffing feelings and, and you, that could happen when you’re sober for any length of time (Wolf Dancer, p. 6, line 16-19).

Wolf Dancer further elaborates on what it means to “not entertain the thought of drinking” through a process of pushing the thoughts out of your mind and focusing on something else. He also provides an eloquent description of the progression that occurs when craving in not completely extinguished.

In other words, if you just, if you don’t put the thought completely out of you mind, if you leave a little piece of it even (p. 23, line 42-44). Well, if you leave a little piece of it, the next time you have a craving, there’s that little piece left over that you left last time. And, pretty soon you’ve got a whole (p. 24, line 3-6) -- A
lot of pieces of craving. Until that craving becomes the drink (p. 24, line 10-11). Well, just getting up and doing something. You know, something. Anything to take your mind off of it. To totally get rid of the craving. Even with the mirror. If ten minutes later you’re still thinking about it, you better get your ass some place and call somebody or do something. Because if you think, ‘Well, I’ve got it under control, it’s OK. I’ve thought about it but I’ve changed my mind’, you’ve left a little piece of it there (p. 24, line 17-26). You have to get, it’s kind of like a cancer. You got to get rid of it all. You can’t leave any of it behind. Because the longer you let those little pieces, pretty soon they’ve grown into a giant craving. And, that’s when you wake up all of a sudden and you’ve drank and you didn’t know why. Because all of those pieces finally put themselves together and said, ‘Let’s have a drink’ (Wolf Dancer, p. 24, line 30-37).

In short, the choice of alcohol appears related to the ability of the individual to successfully suppress craving shortly after its recognition as craving. The following sections describe progression through Stage Three, Management of Craving in which the choice to manage craving or to drink are discussed. From the juncture Fork in the Road in Stage Three, two choices are possible for the individual: (1) to manage craving through the use of strategies designed to suppress craving, or (2) to choose alcohol and drink. A description of the specific strategies used to suppress craving is followed by discussion of the various path progressions.

**Strategies for Management of Craving**

Since the emphasis on the positive versus the negative aspects of drinking appears to shift in relation to time of last drink, successful management of craving appears to involve a simultaneous process in which the: (1) negative aspects of drinking are moved to the forefront, and (2) positive aspects of drinking are relegated to the background. The following strategies function to deemphasize the positive outcomes associated with alcohol: (1) **Reminders** that emphasize adverse outcomes from past drinking, and (2) **Distraction** through physical activity, talking, and artificial stimulation. Examples of
reminders include memorabilia or Alcoholic Anonymous sponsors, both of which are able to keep the negative memory of the “last drunk” or “hitting bottom” on the forefront. Strategies such as physical activity and talking appear to prevent the positive aspects of drinking from taking a stronghold in an individual’s consciousness, comparable to “nipping it in the bud”. Participants were able to describe a variety of specific strategies that were employed in an attempt to manage craving.

Reminders

Memorabilia. Reminders came in the form of memorabilia of some symbolic significance for the individual or another individual who was able to keep reminders of the reason for getting sober in the forefront.

Like I have this leather jacket and I still haven’t cleaned it because there is blood on it. And I still haven’t cleaned it because there is blood on it, and I keep it there to remind me that you know, I got clobbered upside the head because I was in a blackout (Diego, p. 19, line 857-860).

Hitting Bottom. Diego offers the following definition of “hitting bottom” as a form of memorabilia and illustrates its use as a strategy for managing craving.

I’ve been to meetings too, like I told you earlier, where they start talking about the drinking and you…you do get that thing, whatever it is, the craving, I guess. ‘Oh yeah, I remember’. And you smile, ‘yeah, yeah, yeah’, sitting in the bar, joking and everything like that. But then you know, you’ve got to remind yourself what (p. 21, line 957-963) it’s like. With me it’s the last blackout. You know, they always tell you, ‘you remember your last drunk, what that was like, because that’s usually your bottom’. Your last drunk, I think, at least for me. It usually is for me, the last drunk. When I’ve experienced some good sobriety, you know some good recovery, it’s that last drunk that I was going to remember, ‘Man, it was awful. It was awful being totally out of control, totally blacked out, not being able to defend myself, getting hit over the head. Somebody could have just killed me there and left me there and nobody would have known. Nobody would have cared’ (Diego, p. 22, line 964-976).
Sponsors. An Alcoholic Anonymous sponsor performed a similar function for several of the participants, by keeping the reason for getting sober in the forefront of awareness. Big Mac illustrates the shift that occurs in the priority of sobriety through “selective memory” and the role of the sponsor.

I mean, that would be a lie saying I forgot about it. It’s selective memory. I still know all the rules. It’s just they lose their importance. Because I forget having the shakes, you know, in the beginning where, you know, I couldn’t eat a bowl of soup if my life depended on it. You know, I mean, I, I forget. Like I said passing out in the bathroom. You know, I forget throwing up all over myself. Tho-, those things you, you don’t remember until you have to. Which is, as bad as I hate to say it, it’s getting a sponsor and he makes you remember that stuff. But because he, (p. 16, line 35-46) he keeps it in your face. Which is good. Because I know I can’t depend on myself. Because I forget that stuff (p. 17, line 1-3).

Distraction

Distraction consisted of those strategies that allowed the individual to direct the focus away from craving. This served to prevent the positive aspects of drinking from remaining in the forefront and taking a foothold. Just as participants were able to relate situations that did not appear to be troublesome for them, most participants were able to describe situations or conditions in which craving would become prominent and require immediate action. For example, Wolf Dancer illustrates the interaction of internal and external stimuli in the creation of craving.

I got that attitude that I could handle it. But if I didn’t have that drink I couldn’t. Now when I’m sober and I go visit my dad, we go past that 7/11 or Circle K where I used to and I get a tinge of, ‘Hey, we should stop there and buy a drink’. But your old habits any time, if your old habits are still a part of your life, now, how am I trying to put this. Situations in which you drank, uh, like a lot of guys. I wasn’t a big bar drinker. I did most of my drinking at home. And so, when I did start on my relapse road with the cravings, any situation that wherever I bought a bottle to drink with or to get through the day, I’d get that craving. The tinge. If I was sober. So, you have to get past that craving because everything in my particular life can trigger craving. So, a movie (p. 5, line 13-28) a sound (line 32).
Try to think of something else. Try to, well, I try to bring up the memory of, ‘Hey, remember what happened last time’ (p.5, line 36-38).

Physical Activity. Several participants identified some form of physical activity as a means of distraction. Diego describes the use of “some type of activity, physical activity (p. 17, line 778). Doing something, or riding a bike” (Diego, p.18, line 782).

Lobo suggested a relationship between the strength of craving and the need for relief through strenuous physical activity in order to avert drinking.

It depends on how strong the cravings are and if I can catch them before they get to that, that strength. ‘Cause they get, sometimes very intense where I have to go do something strenuous so I don’t have to. So I can push them away. Go run. Go to the weight room or something, or just go. If they happen at work, sometimes I’ll just go off by myself (Lobo, p. 13, line 583-590).

Artificial Stimulation. Several participants acknowledged an increase in their consumption of sweets, caffeine, and sometimes tobacco during the early period of recovery. This was in contrast to minimal consumption of sweets while drinking. Several participants reported a reduction in craving when consuming sweets.

I just started drinking a lot, a whole lot more coffee, and ate a whole lot more candy. Hard candies, sucking on a lollipop at lunch, you know (p. 6, line 284-286). It’s kind of subsided, you know, kind of eased it a whole lot (p. 6, line 290-291). Yeah, it didn’t actually make it go away completely, it just helped ease it, you know, because…And I smoked a whole lot more (Lobo, p. 8, line 349-351).

Several participants identified a special affinity for the regular consumption of ice cream in particular. Sunshine illustrates the intensity of the need for sweets that seemed to replace the want of alcohol in the following description.

I pass up sweets all the time. I’m not a sweet eater as a rule. You can put any kind of sweets in my face. Cake, beautiful pastries and I’ll pass them up ‘cause I don’t have a craving naturally for sweets. But for the last two years anyway, I’ll wake up in the middle of the night and have to have sugar. I crave sugar. I have to have
a sugar fix. Something sweet. And then, go right back to bed (p. 26, line 2-9). The
night before last night, I was having bad dreams and I woke up and I was, I’m
living at sister’s house, and I’m not familiar where anything is. So, it was almost
like I was looking for a drink (p.26, 15-18). ‘Cause I was running around in the
middle of the night, looking through all the cupboards and looking through the
refrigerator for that craving. You know, it was like a mad man looking for
alcohol. It was like I was looking for a drink, but it was sugar. [Laughter] (p. 26,
line 22-27). And, my sister had bought, she, she works at, uh, a[n] Italian
restaurant. She, she brought some canola’s home and I had never had those
before. And, I ate those suckers so fast. And then, I felt like, it felt so much
better (p. 26, line 31-35). I felt, I felt, uhm, just relieved (p. 26, line 43). I felt
relieved and, and my craving was, and I felt kind of, I don’t know. I, I’ve been
doing this for the last two years. I’ll wake up at like 5 o’clock in the morning you
have a bowl of ice cream (p. 27, line 1-5). Yeah, like during the day (p. 27, line
14) -- I don’t crave sweet-, it’s in the middle of the night – (p. 27, line 18-19)
when I crave. It’s consistently in the middle of the night when I wake up craving
sugar. But any other time I can pass it up like nothing (p. 27, line 23-25). Even
beautiful, you know, sweets and chocolates and stuff like that. Like, less is more
has always been my theme with sugar (p 27, line 29-31). It, it, well, that was a
binge I was going on for a while. An ice cream binge (p. 27, line 36-37). And, or,
or I’d wake up and I’d eat, uhm, a handful of chocolates because they were in the
house (p. 27, line 41-43).

Reaching Out. Several of the participants identified reaching out to others as
another strategy that was found to be helpful in the reduction of craving.

For me it’s, ah, talking to people (Diego, p. 20, line 912). The, why the AA
meetings help, ah, I get to see people who have been you know sober a long time
(p. 20, line 916-917) and I know their stories and I know they’re really a few of
these folks are like gutter and you know, street level kind of drunks and they have
managed to piece it all together and live a real nice life (Diego, p. 21, line 918-
921).

I’ve learned how to I guess repress them, or learned other things to do that will
take my mind off of the cravings, instead of dwelling on them, you know.
Because I know what it can do to my body (Lobo, p. 11, line 485-489). The
cravings are there and I’ve known they cause irritability or made me easily
aggravated, so I try to keep those, or like I said, actually I try to push them to the
side and keep ‘em away. And actually, I’ve found a few people I can talk to about
it if I need to, so that helps too” (p. 11 line 495-500). You know I blamed it on
everything, but it was just, I tried to do it by myself for too many times and it
didn’t work (Lobo, p. 13, line 552-554).
Steve contrasts the craving associated with cocaine and the craving associated with alcohol in the following example. He also illustrates the value of reaching out to others and talking through a period of acute craving, and describes the process for the establishment of a support network as a prerequisite for the utility of this strategy.

At one point in particular I was smoking cigarettes and I went to light my cigarette and the lighter didn’t work the first two times and the… I had to click the lighter three times to get it to light and that triggered an amazing intense craving for crack – (p. 20, line 1-6) because there’s a lot of lighter clicking when you’re smoking crack (line 10-11). And I called my friend Dave right away. And thankfully he was there and he answered and he said, ‘Hang on. We’ll stay on the phone. In about two minutes it’s going to start to taper off’ (p. 20, line 15-19). And it did. And it was the same, now of the alcohol craving. It was a, being a different sort of a buzz, it took a little longer to taper off. But it did pass. And being aware that it’s going to pass and that eventually they’ll be fewer and farther between and less intense. I found that to be helpful. To know that. And to use the telephone. That would be the single biggest piece of advice. Get some phone numbers and call people. And don’t wait for the craving to, to make some, make some calls, establish some contacts, and have some people that you can call. And just call them a few times when you’re not having a craving just to say (p. 20, line 23-35) ‘This is just a dry run. I got the right number. You know who I am. I got your number at this meeting. I got your number from so-and-so. I got your number however’ (p. 20, line 43-46). You know, establish the contact and then talk about football or, you know, politics or whatever. The weather. Just talk, whatever for, just to establish a contact so that when you do have a craving you can have somebody that you can call and feel reasonably comfortable (p. 21, line 1-6). Make the call before it’s you know, before it seems catastrophic (Steve p. 21, line 22-24).

Recovery Support. Recovery support was another means through which participants reached out, through either recovery support groups such as Alcoholics Anonymous, substance abuse treatment programs, or religious affiliations. With the exception of two participants, each of the participants described a reliance on Alcoholics Anonymous as an integral component of their recovery. Participants received support
through the Twelve Steps and Alcoholic Anonymous adages which served to reinforce the commitment to sobriety.

And then there is the steps, so I go to meetings to try to find somebody to get to be my sponsor. I worked the steps before, so I have a working knowledge of them, so I go to the meetings and just kind of...kind of, to get a feel for the AA program again (Diego, p. 21, line 921-926). And there is always somebody that says something you know, like ‘Just don’t drink today. Come back tomorrow. Anybody can not drink for you know 24 hours, and if you can’t do this, then go 5 minutes to 5 minutes’. I always hear something that kind of helps (Diego, p. 21, line 943-948).

While two individuals felt that Alcoholics Anonymous had not been helpful, they both acknowledged support through their participation in the substance abuse treatment program.

I think the treatment helps a lot you know. If you’re staying with a group of people too, sort of like a halfway house like what they got us in, because of, well, not all of them, but the majority of them are trying, they want to get sober. They don’t want to (Diego, p. 22, line 977-982). So we start talking and somebody will start glorifying it you know and I’ll say ‘Well, don’t you remember your last drunk, what happened’? Or somebody else will say ‘Yeah it was good, but remember how it was, how awful it was’. Somebody always, and that’s what meetings do too. Somebody will talk about how good it was but then. Yeah, but then they’ll talk. Well, it’s, they call experience register, how it was, what it was like, and what we are like now. And yeah we’ll talk about ‘Yeah, it started out real good but then I lost everything. And then you know, I hit bottom’… to remind you. That’s why the meetings are so good, because yeah, you’ll hear that story and it’s your story. It’s similar. The similarities are remarkable when it comes to the stories of how we, we go down. The levels are different... somebody takes a lot more, winds up in prison where I didn’t have to go to prison, but it’s the same story. I try to control my drinking, I couldn’t control it. Things started happening, and I hit bottom and then I came to AA and now I have haven’t drank since... There is hope in the meetings. There is hope. That’s what it is (p. 22, line 986-1009). You go to the meeting, you’ve got, you’re like if this person can do it, then I can do it. It’s not like it’s out of my reach, you know what I mean. Yeah, I’ve struggled with it. I haven’t been able to stop in the past, but you know I see these folks and they been able to do it. They aren’t any smarter or less smarter or more smarter or better looking or rich. It’s nothing, there is just simple steps that they follow and if they can do it, well I pretty much can do it. It gives me hope (Diego, p. 23, line 1010-1019).
Support for the management of craving is also available through recovery support. Steve suggests that knowledge of the characteristics of craving can be of benefit in the successful management of craving.

But whatever it was, it will pass. It will taper off. It’ll go away. So, I think if, if people can be made aware of that and somehow come, come to believe that it will pass. That the craving is going to go away, and right that minute when you’re feeling that craving, it’s probably not going to get any worse (p. 19, line 27-33). It’s, I have not experienced that the craving intensifies. Once I feel a craving for a coup…in-, initially once I become aware of it, then it’s going to seem very all encompassing. But then I realize that it’s really not getting any stronger. The craving is not intensifying once I become aware of it. And then it’s going to calm and it’ll taper off and it’ll pass. And everything will be OK. So, I would, I find that to be something helpful (p. 19, line 37-45). So that’d be…it’ll…things move. Each individual one will pass and become farther apart and fewer of them and less intense (p. 21, line 28-30). But in the short term, actual, the craving is happening. What helps is knowing that it’s going to pass and picking up the phone (Steve, p. 21, line 34-36).

Prerequisites to Choice: State of Mind

Desire for Sobriety. Most of the participants acknowledged the importance of state of mind in the successful management of craving. Without a commitment to sobriety and an “acceptance” of the inability to drink, an individual was unlikely to even chose to implement strategies to manage craving much less be successful in the effort. Poncho provides an illustration of the underlying commitment to sobriety.

I’m really committed. I don’t care what alcoholic thinking I get. I just have to fight it off, you know. Just call my sponsor, you know. I don’t always. When I got to that fork in the road, I wanted, you know. I could either drink or call my sponsor. And I always took the path of drinking, instead of calling my sponsor and walking through it (p. 24, line 16-24). Because I wanted to drink more than I wanted to be sober (Poncho, p. 24, line 28-29).

Diego summarizes the influence of acceptance on the process of craving and the attempt to manage craving through various strategies.
If I haven’t like fully given myself over to the fact that I can’t drink, it’s a struggle. That I’m always in the store and I see a bottle of liquor, you know. And it’s a struggle and (p. 11, line 501-504) like, ‘No. No, I have to remember what happened’. And so what keeps me away from the drinking is the fear of losing contro, but ineve-inevitably, I forget about that and then I just say, ‘The heck with it, I want, I want to drink a beer tonight’. Because I want the effect (p. 11, line 505-510). Yeah. The sense of ease and comfort that comes with those first couple of drinks (Diego, p 12, line 518-519).

Diego further elaborates on an active strategy of pushing thoughts of drinking from his mind with two examples.

If you asked me if, if, if I wanted to drink today I would say ‘yes, if I could control it’. But I know that I can’t so you know, I just push that out of my mind. I know that I can’t control the drinking. Yes, I would like to be just a normal drinker (p. 14, line 601-606). And now when, now what, what I’ve noticed it that when people start talking about it, I think about you know, the effect. The effect of alcohol, that it had on me. It made me relax. It made me relax. It made me jovial. You know, that’s what I think about. And I have to quickly replace that with, ‘And oh yeah, and you blacked out too and you got beat up pretty bad. They could have killed you that night and nobody would have known. Nobody would have even cared’. I have to remember that, keep that fresh in my memory (p. 14, line 614-623).

Keef was the only participant that did not experience Craving as Conversation with the inherent struggle. However, Craving as Urge did appear to precede the initiation of drinking, and there is an acknowledgement of the influence of mental state on the decision to drink or to not drink.

I never walk around sober thinking about drinking, you know…either I drink or I don’t (p. 13, line 1-2, 6). If I want a drink, I drink. If I don’t, I don’t. I don’t plan, you know. That’s the only craving, is when I, is when I start coming down. And I come down really hard. So I got to keep jacking myself up. Cause see, I jack myself right into, uh, an emergency room (p. 13, line 11-16). I never craved it. I didn’t miss it. It just came to a point where I just didn’t do it again. And I, I have no idea why. But then about six, seven years, I just, I wanted, I wanted to go buy some vodka (p. 7, line 4-8). It wasn’t a craving. It’s just something I knew. I know alcohol. I, I’ve know it since I was 16 (p. 7, line 34-35, line 39-40).
However, Keef was the only participant without lifetime sobriety as a goal. While he acknowledges “a lot of help (p. 8, line 17), I’ve never said I’m going to drink again. I’ve never done that. I just didn’t start up again. I didn’t start” (p. 8, line 5-7).

I have never told anyone I was going to stop drinking. ‘Cause I knew I never would, you know. It’s not like, ‘Okay. I’m not going to drink anymore’. I never said that. I never said it to myself. I always knew I would drink again because I like to drink. Always did (p. 8, line 41-46).

Arthur further illustrates the influence of the mind and the relationship of various strategies on the process of craving.

It’s not necessarily the body, but the mind. What I understand from the phenomenon, in the mind is real strong for me, ah…in my case. Ah…when I think about, if I had the time to think about drinking then my mind would say, would already say, ‘Okay’. For some reason it would say, ‘Okay, I want it, and I won’t. I’ll just go to any length to get it’. And ah, that occurs only when I’m not working a program or recovery on a daily basis. Once I stop, thinking I’m well enough to stop, and not deal with AA or ah, writing down my fears or my resentments, anything working on that aspect of my recovery, I have time to think about using. And when I think about it and I’m not working my program, my mind is already made up that I’m going to use. I’m going to drink, and that’s really scary (Arthur, p. 11, line 475-491).

Several of the participants also made reference to the influence of state of mind in their decision to even implement strategies to suppress craving.

They say you have to hit bottom. You have to really convince yourself, you know. The book talks about it. The AA book says you have to concede to our innermost self that we are alcoholic. We have to get rid of the illusion, the delusion that we could control our drinking, you know. And I know when I’ve done that. You know. And I know that like now, I know that I’m done. There’s no way I can control my drinking (Diego, p. 8, line 354-362). It’s all about wanting it. If you don’t want it and you are trying to stay sober for other reasons and just to get sober, it’s not going to work. It’s a fight, it’s really the misery thing and miserable, irritable, you’re restless; trying to fill time with stuff, and nothing seems to work” (p. 23, line 1040-1046). When I haven’t surrendered (p. 14, line 634). When I’m not serious about stopping, about recovery and going to meetings, when I’m not serious about that, I find that I’m really like on edge, I’m irritable (p. 14, line 638-641).
Despite the constant struggle during early recovery, Lobo describes the relationship between “wanting alcohol” and choosing not to drink.

It just, I didn’t, I didn’t want it (p. 9, line 382). I could get it, but it would have been harder for me to get. Instead of just going to the corner store and buying it actually, you know. So, and plus, it was a stressful situation. But I knew somebody depended on me because I could be called up at anytime, day or night to go out on a mission. So that, I guess mentally, I just blocked it out. (p. 9, line 393-399). I felt that, you know, any time my life could have been in jeopardy (line 409-410). So, I didn’t want to take that chance (p. 9, line 414).

Lempie describes a process in which craving is able to gain a foothold, as the memory of the “good times” encroach upon “feelings of sobriety”.

The feelings of sobriety. Because I want to be sober. So, I do-, I can sit here and talk about drinking. I can go to the bar, have a coke. But I can’t do that too long (p. 6, line 11-14). But if you don’t remember the good times, if you, if you stay focused on your sobriety, you can stay sober. But once you start slipping into this, ‘Damn, I remember sitting at the bar’ (p. 5, line 37-41).

Poncho summarizes the underlying commitment to sobriety in the following description of acceptance.

When you read that first, uh, that First Step, ‘We admitted we were powerless over alcohol. That our life had become unmanageable.’ It’s something you don’t say. You have to feel it in your heart (p. 18, line 39-44). I want to stay sober and I’m going to do what I have to do. ‘Cause so many people were pulling for me and I don’t want to let anybody down, especially myself. And I feel it in my heart that ‘Hey, you can’t drink’. And I do. I get that feeling in there (p. 27, line 37-44).

Several of the participants described the process of “alcoholic thinking” or “stinkin thinking”, eloquently summarized by Poncho in the following excerpt.

If I’m not doing what I’m supposed to be doing to stay sober, you know. Uh, the last time I stopped praying. I said, ‘Well, I don’t need it.’ And then I stopped going to AA. And my mind went wild. You know, it just said, ‘Oh, you could have a drink, and this and that.’ And, you know, I don’t think the relapse occurs when you take that first drink. The relapse occurs when you start to get that
stinkin’ thinkin’ in your mind. That, ‘Oh, maybe a (Poncho, p. 13, line 34-44) drink would be OK,’ or ‘I don’t need a meeting,’ or ‘I don’t need this, and I don’t need that.’ And then, boom, you’re in the stew (p. 14, line 1-4). If you’re doing what you’re supposed to be doing, you know, and, and you’re concentrating on your program, you know, you don’t think about it as much (p. 14, line 15-19). When I get thoughts of drinking, and you know, I just have them. I mean, that’s my alcoholic thinking. I mean, I got an alcoholic mind. And the only way to put it out of there is to maybe say the Serenity Prayer or do something spiritual that I have a Higher Power that’s saying, ‘Hey, don’t take that drink’. Even when I go for a job interview, it’s funny. I have the, you know, I have my Higher Power next to me. I say ‘C’mon in with me, you know. [laughs] (p. 17, line 28-39). But it works. I talk to Him, you know. Some people say, ‘Well, you know, Let, if you feel like drinking, have you Higher Power take the drink’ (Poncho, p. 18, line 1-4).

Choice of Alcohol: Drinking

The Choice of Alcohol represents the second option in Stage Three, Management of Craving as an alternative to Management Strategies. The selection of alcohol could follow: (1) Management Strategies when the effort to suppress craving is abandoned in favor of drinking, or (2) Craving as Urge directly as an initial response to craving. Figure 4.5 Losing the Battle: Unsuccessful Suppression of Craving depicts the B.2 Path in which the individual abandons the effort to suppress craving through implementation of management strategies, loses the battle, and chooses alcohol. With the initiation of drinking, the individual cycles along the B2 Path between drinking and craving. Figure 4.6 Surrender to Craving: Choosing Alcohol depicts an alternate pathway, Path B1, in which an individual chooses alcohol as an initial response to craving and then continues to cycle along the B2 Path between drinking and the experience of craving.

Two different forms of craving are experienced with the initiation of drinking: (1) Craving as Thirst, and (2) Craving as Need. Craving as Thirst refers to the Insatiable Desire for Drink or the unquenchable thirst for alcohol regardless of quantity of alcohol.
consumed. *Craving as Need* relates to the ability of alcohol to restore a temporary state of *Normalcy* through suppression of withdrawal symptoms. However, variability exists within the same individual as well as between individuals in relation to: (1) the degree to which one or both forms of craving are experienced during sobriety and while drinking, and (2) the point at which the different forms of craving are expressed.

Most often the decision to drink was described as *losing the battle*. Wolf Dancer uses the following analogy to illustrate the choice of drinking.

> Your choice between drinking and not drinking’s the same thing as standing in front of an oncoming locomotive. You know what’s going to happen. And if you win the battle, you get off the railroad track and you don’t get hit (Wolf Dancer, p. 11, line 2-6).

The plight of the participants in their return to alcohol is summarized in the following excerpts. For example, Poncho relates that “I’ve gone for years, you know, or a year at a time without drinking, but always go back to the bottle because I get that stinkin’ thinking about, ‘You can have one’” (Poncho, p. 18, line 35-38). Buster further elaborates that

> During those fifteen year periods when I didn’t drink, I didn’t crave alcohol in that sense. The times that I went back to drinking again were times that I mistakenly convinced myself, ‘Oh, well, you can handle it’. And, uhm, obviously, I couldn’t (Buster, p. 11, line 31-36).

*Craving as Need: Desire for Normalcy*

The majority of the participants were able to differentiate between craving that they experienced while sober and craving that was experienced while drinking. And most participants were able to make a distinction between two forms of craving while drinking: *Craving as Need*, and *Craving as Insatiable Thirst*. For two of the participants,
the main expression of craving was related to withdrawal symptoms. For example, Buster relates in the following description that during the time I didn’t drink, uhm, I didn’t, to my recollection, experience cravings in the sense that I think most people would consider cravings. Uh, I didn’t have a, a white knuckle approach to it, uh, abstaining from consuming alcohol. I think my craving was more in the, all my life, has been more in the, the way of, uh, drinking more alcohol to, to, uh, offset a hangover or the, the withdrawal symptoms to the night before or, for long periods of time I just kept doing it so I didn’t have to sober up. Uhm, sometimes during that or during that span of years, uh, I’ve been in the hospital a few times where I had assistance in, in withdrawing from alcohol which made it much easier. Uh, but I don’t drive by a bar and say, ‘I got to look the other way because if I don’t I will stop and go in there’, at least not for now” (p. 1, line 25-41).

While the participants were all familiar with craving associated with alcohol withdrawal, only Keef experienced this form of craving as the only form of craving. However, his description of the craving associated with alcohol withdrawal illustrates the intensity of this form of craving and its ability to drive behavior.

The craving is only to medicate myself (p. 18, line 14-15). I don’t, I don’t crave alcohol (line 19) for any reason other than, than not being sick (p. 18, line 23-24). I never really crave, if I’m sober. I never really crave alcohol. I just kind of want to get away for a while (p. 29, line 12-15).

Keef offers the following example to illustrate the intensity of the craving, which is also descriptive of the alcohol withdrawal syndrome.

I get very, very, I mean, it’s like, I don’t know how to explain it except I get so sick that I feel like I’m dying. I have to medicate myself. That’s the way I, I look at it. ‘Cause I got to fix myself. Because, you know, ‘cause it would get the, the, it would get so bad, the shaking inside and the, the brain’s going crazy. It feels like, you know, to me it felt, this, I figured if this is what people must feel when they have radiation poisoning or something. It just, it just, completely crazy. It just makes me nuts. So, I’ll do almost anything to get something to drink to medicate myself. I’ve done incredible things just to medicate myself. And, I’ve done things to get my, myself in trouble from medicating myself (p. 3, line 8-22). Well, I, I ended up in my sister’s house one morning and, like 3 o’clock in the morning when I was coming down. And there’s, no, nothing to drink. So, I went
up to Circle K and threw a big rock through the window. Walked in and grabbed a tall pack, walked out. I medicated myself. But that’s called burglary. But, to me, it was medicating myself. That’s, I mean, I’m not, I’m not, I’m not, I don’t have a criminal mind. You know, I’m not a criminal. But, and I wasn’t sane all year I, I was medicating myself. It’s, that, put it, that strong. That I would do just about anything to get something to drink if I need it. And I have... It’s the worst craving, yeah, that’s craving (p. 3, line 26-38, line 42-43). Once I start I’ll drink and then I’ll pass out or go to sleep. Then I’ll wake up and the craving’ll be right there. The first thing. And, a-, and, it gets worse everyday (p. 4, line 5-8) to where I just end up in the hospital. That’s how it’s been the last ten years or so. Once I start, I don’t stop until I end up in the hospital or jail. ‘Cause I can’t stop drinking myself. It hurts too much (p. 4, line 12-16).

Keef further describes craving as both “physical and mental. I mean, my brain’s, my brain feels like it’s scrambled and I’m shaking and I got this terrible feeling like my chest is going to blow out” (p. 4, line 29-32). Keef relates craving to withdrawal symptoms in which there is the need to drink more.

I need to, I need, I need more to drink to calm myself down. I can make the pain go away with more alcohol (p. 5, line 1-3). Once I start, forget it. Just forget it, you know. I mean, it’s, there’s nothing can stop me. You know. And, it’s, uh, you know, I get desperate sometimes (p. 5, line 11-14). To medicate myself, to make my pa-, pains go away (p. 5, line 19, 23). Because it really hurts. I mean, not so much physical pain, mentally, too. It’s like something, I mean, you know, my, my head’s going to blow up, you know. It’s, just, you know. It, it’s insane. It’s nothing I can really explain to somebody. It’s like the worst thing you can imagine. I’ve done it a lot of times. I know what it is (p. 5, line 27-34) I feel like I’m going insane (p. 29, line 24). Well, my brain, it’s not functioning properly, you know. Stupid things, like my teeth hurt, you know. Everything hurts. And I’m usually ashamed ‘cause I usually mess something up or feel bad about something once I start drinking” (p. 29, line 28-32).

Keef further summarizes the association between craving and withdrawal symptoms as

I crave something. I crave alcohol to medicate the, the, the -- the pain (p. 6, line 3-4, 8). That’s the craving. That stopped the pain (p. 16, line 17-18). I craved the alcohol cause (line 22) it’s going to make me feel better, you know. I didn’t have a craving to get drunk because someone’s bothering me, you know, or I had problems, or you know, whatever” (Keef, p. 16, line 26-29).
Several participants were able to describe changes in craving with the progression of a binge. Sunshine provides the following example of stages in a binge.

I’ll get shak y for it (p. 14, line 41). However, during the middle of a binge it’s less motivated. Well, it’s, uhm, it’s, I’m sick at that point (p. 16, line 27-28). Because I’ve been abusing my body for a long period of time. So, I’m sick at that point. And the craving is different (p. 16, line 32-34). At that point it becomes more like a need (line 38-39). To keep me from, it, it, it, it makes me feel better physically. It’s, it’s, I know part of it’s psychological, but part of it is just from doing it so much that, uhm, it, it makes me feel better to get (p. 16, line 43-46) the alcohol back in my system. It settles my stomach and, uhm, and it settles my nerves. So, that’s, so, that’s why it’s an ongoing thing. That’s why it’s such a horrible demon” (p. 17, line 1-4). Toward the end of the binge, “my body’s worn out (p. 18, line 26-27). And I can’t drink anymore (line 31). And, I made a conscious decision to sleep it off (line 35-36). I would say it’s different. I might pick one or two up just to keep me in the sleep mode (p. 19, line 22-23). But it’s less. It lessens. It definitely lessens. And, at that point, I’m just sick and tired (p. 19, line 27-28).

Lobo also speaks to the strength of this form of craving as a driver of continued drinking, and uses the analogy of Christmas to portray the anticipation of the next drink.

Because physically I really didn’t touch on, but they’re kind of, it’s like an anxious when they come up. You’re anxious, you know, ’cause you’re anxious to get off work so you can go get that drink. Sometimes when those cravings get that strong, that’s some of the, some of the times that’s the first place I went, straight to the store. No going home or change or anything, just bar, straight to the bar. That’s how strong the cravings got sometimes. It depends on what kind of day it was. The more stressful the day I had, the more stronger the cravings grew (p. 687-698). It’s kind of like, like Christmas time, sometimes in a way, as an example. Like you know when you’re a kid growing up, you know it’s Christmas eve so you know Santa Claus is coming the next day. So you know what to expect the next morning when you get up. So the cravings are kinda like that, and (p. 16, line 730-735) the anticipation. Like your stomach not queasy but, you know, jittery so. ‘Cause you know what, what’s, what’s gonna, what you set out to get from that. That you know you’re going to get, say from the fix from alcohol. So the, I think, then when you get to the store and you’re standing in line, it’s like the cravings kinda subside a little bit because you’ve got that bottle in your hand. See, so it’s both physical and mental, I think (Lobo, p. 17, line 736-744).
Steve uses the analogy of a vampire’s need for blood to illustrate the alcoholic’s need for alcohol when experiencing Craving as Need. He also uses the term vehement: “vehe” for vehicle and “ment” for mind, to reflect being “driven out of one’s mind” by this form of craving.

And, uh, I recall a couple of times, ‘I’m just going to get a pint. That’s all I’m going to do. I’m only going to have a pint.’ Many times, ‘I’m just going to have a pint’. And I would get a pint. I would go home and I would drink it in about 90 minutes. And that wasn’t doing it. I could hardly feel it. And I would go back and get another one and then that would do the trick. And, uh, ‘cause I would start, ‘cause there was two different things that played into my, my need for, my craving for it. The trying to do without was just horrible. Trying to do completely without, uhm, life just did not seem remotely live able. I would feel, I recall thinking at the time I was reading. I had read one of those Ann Rice “Interview with the Vampire” novels. She’s done like four or five or seven of them. And in one of them she did, had written a really good description of how the vampire felt this incredible need for the blood of the living human and how they would fight that. And I had read many vampire stories before and several written by her. And I thought they were pretty good, but I thought ‘I know exactly how the, this vampire feels. I have got to do this. And I can’t do it and I have to do it. And I could feel it in my bones. This absolute need’. And it was not any longer a desire to feel whole and good and fun and life of the party. It was just a by, I need it to feel right. And when that thought occurred to me I said, ‘That’s what junkies say. Junkies say I need to feel right, that I need to get right’. And that scared the hell out of me. And I tried very, very, very hard to stop drinking. But still, well, the only time I actually succeeded in not drinking when I really longed to was one day I was on my bicycle and I had the $3.11 in my pocket to get a pint of whatever was on sale that day. And I was on my way to the Circle K and I got about half way and I stopped. And it was, ‘By God, I’m not going to do it. I’m not going to drink’. And I turned back around and I went home and I had an absolutely horrible, miserable, twitchy night. I wanted to drink. I had this insane, insatiable need to drink. And it was…I had no intention of socializing with anyone. I didn’t want to talk to anybody. I just absolutely had to drink. And it was not like I was going to get drunk. I didn’t even want to get drunk. I just had to drink. I would feel (p. 14, line 31-46) okay if I could have at least, I mean, I knew even a half a pint would not do it. A half a pint would just not even quite take the edge off. So, I went back home and had a very miserable night. Sleepless. I tossed and turned and miserable. And, uh, the next day I went and got a pint. And, uh, I felt just fine. I don’t recall feeling drunk. But I felt calm. The, that incredible need. That, that craving. That desire was ab— it had abated and had gone away for a little while. And I felt okay for a
few hours. And I actually, I felt relief. Not remotely drunk. I didn’t go through any sort of the enjoyment phases. I just was, it was immense relief. And I felt calm. And, uh, then I was able to for awhile get by on just a pint a day. But I would have to virtually chug that pint. I couldn’t stretch it out over the course of a day because it didn’t work. It had to be that wallop” (p. 15, line 1-23). He was summarized that “if I had no alcohol in my system, I felt awful and I knew that I had to have some” (Steve, p. 17, line 15-17).

Several participants drew a comparison between alcohol and heroin withdrawal.

For example, Buster’s use of alcohol was
to alleviate the cravings. They were like not just cravings. They were like, uh, uh, when a heroin addict, I would, I would think when a heroin addict withdraws from heroin. Uhm, he, only this is like the same day you got drunk. Uhm, or the next morning. You will drink to feel better. That, so your body will physically feel better. Now that, that is what I will describe as craving out of necessity. So you know, so that you, well, at first you’re afraid you, you’re going to die. And then you’re afraid you’re not going to die because you feel so bad. So what to do to avoid that is to have some more alcohol (Buster, p. 11, line 17-29).

Recovery describes the following recognition of craving, as “it’s just a craving, you know. It’s going…it’s just going to be there until you satisfy that craving, you know” (p. 14, line 16-18).

*Craving as Thirst: Insatiable Desire for Drink*

Several of the participants were able to differentiate between the craving they experienced at different points in sobriety as well as while drinking. For example, Wolf Dancer describes the following three stages of craving.

The initial craving which I, is could be triggered by, like I say, anything. A song. A sound or a movie (p. 17, line 22-23). And then that middle craving, which is the argument that you’re having when you’re going to go drink or not. And then the craving you get once you’ve started drinking. You get to that craving point where that’s all you want (p. 17, line 28-32). Anything can trigger the craving. What you do about it depends on that battle you’ve got going on (p. 17, line 37-39).
Craving while drinking was experienced either as a loss of control, or the inability to moderate the alcohol consumption in order to “maintain”, or as an inability to consume enough alcohol for satiety. For example, Sunshine offers the following definition for this type of craving as a “lack of control. When I have a craving, I, I, I’m out of control. I, I can’t think for myself. I let the craving take over” (p. 8, line 33-34, 37-39).

Several participants referred to this form of craving as the sensation that they could not consume enough alcohol to be satisfied.

While I was drinking? Yeah, because I always wanted more (Lobo, p. 5, line 224-225). It was like there was never going to be enough (line 229). So it was always there. So if we ran out, like I said, we could always go get some more, and it was like…I, I couldn’t get enough, as it was the feeling, until I passed out or blacked out (Lobo, p. 6, line 241-245).

Wolf Dancer summarizes the experience that many of the participants shared with regards to craving after they start drinking.

Not until I get to that point where alcohol is all I want. (p. 15, line 41-42). In other words, you don’t want food (p. 15, line 46). Uh, you don’t want sex. You don’t want anything. You just want to keep on drinking. It’s kind of like a switch goes off in your head – (p. 16, line 1-3) and you’ve decided, ‘Hey. The hell with the world. I’m just going to sit here and drink. Don’t need anybody’ (p. 16, line 7-9). It’s, it’s a craving that just turns into the only thing you want to have. Period (p. 16, line 15-16).

Summary

Management of craving does not appear to be an all or nothing proposition however, since several outcomes are possible once craving has moved into conscious awareness as a struggle or an urge. For example, an individual may win the battle and return to Stage One in which craving exists in the foreground, following the implementation of strategies that successfully suppress craving. However, the initial
attempt to suppress craving may be unsuccessful. In this instance, an individual may gain ground through an intensification of his initial efforts to manage craving, with eventual successful suppression of craving and return to Stage One. Or an individual may lose ground when efforts to manage craving are abandoned rather than intensified, and drinking is initiated. And finally, an individual may lose the battle and choose alcohol as an initial response, without any attempt to manage craving.

The tension resulting from the failure to suppress craving represents a period of continuing vulnerability as the individual remains susceptible to loss of the battle and the choice of alcohol. This period of vulnerability can result from: (1) postponement of some form of action in response to the conscious recognition of craving in Stage Two, Craving in the Foreground; and (2) unsuccessful attempt at suppression of craving in which the individual cycles between the implementation of management strategies and the experience of craving.

Resolution of the resulting tension follows two possible alternative pathways. First, the individual may increase his effort to suppress craving through increased management strategies, which successfully suppress craving and allow the return to Stage One in which craving exists in the background. Second, the individual abandons the effort to suppress craving through implementation of management strategies, loses the battle, and chooses alcohol in Stage Three, Management of Craving. With the initiation of drinking in Stage Four, Craving Unsatisfied, the individual experiences a different type of craving which exists in two different forms: Craving as Thirst, and Craving as Need. An individual may experience only one form of craving or both forms of craving.
in either the: (1) A Pathway with *Craving as Conversation, Craving as Urge*, or (2) B Pathway (after initiation of drinking) *Craving as Thirst, Craving as Need*.

The theory of craving reflects a recurring, cycling process with several alternate pathways that culminate in either the suppression of craving (Path A2) or the initiation of drinking (Path B1). Stymieing in Stage Two in which craving was prominent in the foreground without some form of action represented a period of heightened vulnerability for the individual, since the failure to suppress craving through a concerted effort increased the likelihood of drinking. It was this situation in which the individual was most susceptible to triggers influencing the decision to drink. However, each of these paths may also be accessed indirectly following an initial implementation of management strategies. With intensification of management strategies (Path A3), craving is suppressed and the individual returns to Stage One through Path A2. With abandonment of management strategies that have been unsuccessful in the suppression of craving, drinking is initiated through Path B2. Drinking can be accessed through two pathways: (1) Directly in Path B1 as an initial choice, and (2) Indirectly in Path B2 following an unsuccessful attempt to manage craving through Path A3.

Just as craving appears to shift back and forth between the background and foreground of conscious awareness, the emphasis on the positive versus the negative consequences of drinking appear to shift between the background and the foreground at different points in time. Successful management of craving therefore appears to involve a simultaneous process in which the: (1) negative aspects of drinking are moved to the forefront, and (2) positive aspects of drinking are relegated to the background. The
following strategies function to deemphasize the positive outcomes associated with alcohol: (1) Reminders that emphasize the negative consequences of drinking, and (2) Distraction which prevents the emergence of a focus on the positive aspects of drinking. Examples of Reminders capable of keeping the negative memory of the “last drunk” or “hitting bottom” in the foreground include an Alcoholic Anonymous sponsor as well as memorabilia. Strategies that prevent the positive aspects of drinking from taking a stronghold in an individual’s consciousness and enable an individual to “nip it in the bud” include physical activity, talking, and artificial stimulation.

In summary, this grounded theory exploration of craving within the context of alcohol discovered a four stage process that highlights the active management of craving to avert drinking. Stage One, *Craving in the Background*, is represented by omnipresent craving that lies dormant in the subconscious. Craving exists as (1) an absence of conscious awareness of craving or (2) a fleeting thought. Craving is set against a backdrop of *Desire for Alcohol*, determined by two indicators: *Past Experience: Memory of Alcohol*, and *Desired Effect: Function of Alcohol*. Stage Two, *Craving in the Foreground*, follows the movement of craving into conscious awareness. Two forms of craving are represented by the following indicators: (1) *Craving as Conversation*, characterized by Struggle between drinking and not drinking, and (2) *Craving as Urge*, or *Being Driven to Drink*. Conscious awareness of craving in Stage Two represents a period of vulnerability as the individual is required to take some form of action to avert drinking. Stage Three, *Management of Craving* is determined by two indicators: (1) *Management Strategies*, or (2) *Choice of Alcohol*. Strategies for management of craving include: (1)
Reminders, or (2) Distraction. Successful management results in the suppression of craving and return of an individual to Stage One in which craving exists in the background. The failure to suppress craving results in the choice of alcohol and with the initiation of drinking in Stage Four, *Craving Unsatisfied*, a different type of craving is experienced. Two forms of craving in Stage Four are represented by the following indicators: (1) *Craving as Thirst*, or the *Unquenchable Desire for Alcohol*, and (2) *Craving as Need*, in which a temporary *Return to Normalcy* follows suppression of withdrawal symptoms. This concludes the description and summary of the four stage process of *Craving for Alcohol*.

**Summary of Chapter Four**

Results for this qualitative grounded theory study were presented in this chapter. The core concept, *Craving for Alcohol*, was a three stage process. Characteristics of the participants are presented in the first section as a Portrait of the Participants. The second section summarized the grounded theory.

Stage One, *Craving in the Background*, is represented by omnipresent craving. In this stage, craving exists (1) in the subconscious as an absence of conscious awareness of craving or (2) as a fleeting thought. Craving is set against a backdrop of desire for alcohol, determined by two indicators: Past Experience with Craving: Memory, and Drinking for the Effect: Function of Alcohol.

Stage Two, *Craving in the Foreground*, follows the movement of craving into conscious awareness. Two forms of craving are represented by the following indicators: (1) *Craving as Conversation*, characterized by *Struggle* between drinking and not...
drinking, and (2) Craving as Urge, or Being Driven. Recognition of craving into conscious awareness requires some form of action and signals movement into Stage Three, Management of Craving. The successful management of craving results in suppression of craving and return to Stage One in which craving exists in the background. Failure to suppress craving results in the choice of alcohol and with the initiation of drinking, the expression of a different type of craving in Stage Four, Craving Unsatisfied. Two forms of craving in Stage Four are represented by the following categories and indicators: (1) Craving as Thirst, or the Insatiable Desire for Drink, and (2) Craving as Need, or Desire for Normalcy.

In the next chapter, discussion and recommendations of the study will be presented. Chapter Five will also include implications for nursing theory, implications for nursing research, and implications for nursing practice.
CHAPTER FIVE
DISCUSSION AND RECOMMENDATIONS

This final chapter presents the interpretations of the study and the integration of findings with the literature. The implications for nursing theory, nursing research, and nursing practice will also be addressed. Recommendations and a summary conclude Chapter Five

Interpretations of the Study

The core concept, Craving for Alcohol, is a four-stage process. Stage One, Craving in the Background, is represented by omnipresent craving. Craving exists as: (1) an absence of conscious awareness of craving, or (2) fleeting thoughts. Stage Two, Craving in the Foreground, follows the movement of craving into conscious awareness. Two categories and a corresponding indicator represent this form of craving: (1) Craving as Conversation, or Struggle, and (2) Craving as Urge, or Being Driven. Recognition of craving into consciousness requires some form of action on the part of the individual, signaling movement into Stage Three, Management of Craving. The successful management of craving through the use of strategies results in suppression of craving and return to Stage One in which craving returns to the background of awareness. Failure to suppress craving in Stage Three results in the Choice of Alcohol and progression to Stage Four, Craving Unsatisfied. With the initiation of drinking is the expression of a different type of craving, also represented by two categories and corresponding indicator: (1) Craving as Thirst, or Insatiable Desire for Drink, and (2) Craving as Need indicated by a desire for Normalcy.
The following section provides an integration of the study results with the review of the literature. The original literature review provided a comprehensive review of the eclectic literature of craving in an effort to discern an organizing framework. A return to the literature revealed: (1) congruence between study results and craving models based on positive and negative conditioning, and conditioning/sensitization, and (2) incongruence with the assumption underlying much of the literature that craving causes drinking. These study data suggest that it is the management of craving rather than the mere presence of craving that determines outcome in relation to drinking.

Integration with the Literature

The review of the literature at the onset of the grounded theory study was useful to discern the breadth and depth of the problem across the disciplines, which allowed the investigator to narrow the focus to nursing. While the literature review initially spanned a period of several years prior to data collection and analysis in the course of the investigator’s role as a clinician, the actual synthesis of the voluminous literature of craving immediately preceded this study. The discussion of the findings of this study will be presented in the same order as the categories synthesized from the literature review to highlight concurrence or dissimilarities.

Congruence With The Literature

The earliest work of Isbell (1955) differentiated between two forms of craving: (1) Symbolic, during periods of abstinence, and (2) Non-symbolic, related to alcohol withdrawal. Despite the array of craving models elaborated since that time, the influence of this earliest distinction regarding craving is evident in the perspectives of positive
reinforcement, negative reinforcement, and conditioning and/or sensitization. The findings of this study are congruent with each of these perspectives.

Models based upon positive reinforcement, such as Incentive and Appetitive Models (Lewis, 1996) that emphasize euphoria as the source of craving, find support from the study data that euphoria was a desired and sought after effect of alcohol. The initial experience of euphoria, often profound and associated with the first drink, later became a sought after intention of alcohol. This euphoria was: (1) anticipated prior to the start of drinking in Stage Three, Management of Craving; (2) represented a state to be achieved while drinking in Stage Four, Craving Unsatisfied; and (3) formed the memory trace underlying craving during abstinence in Stage Two, Craving in the Foreground. Euphoria was described by participants as the memory of “that sense of comfort and ease” in Stage Two, Craving in the Foreground, which became associated with alcohol.

Models based upon negative reinforcement, such as Withdrawal/Tolerance Models (Ludwig, Wikler, & Stark, 1974) and Phenomenological models (Drummond, 2001; Lowman, Hunt, Litten, & Drummond, 2000) are derived from the drug opposite effects that follow alcohol cessation in Stage Four, Craving Unsatisfied. Craving related to withdrawal symptoms was identified by participants in this study as a distinct form of craving, though variation existed in terms of the presence of and severity of withdrawal symptoms. Since alcohol resulted in the creation as well as the temporary suppression of withdrawal symptoms, an endless cycle of drinking follows as an attempt at “self-medication” or achievement of some state of feeling normal.
Models based upon conditioning and/or sensitization, such as the Neurobehavioral Model (Anton, 1996), Incentive-Sensitization Model (Robinson & Berridge, 1993), and Cue Reactivity Paradigm (Tiffany & Carter, 1998) which posit craving as a conditioned or sensitized response also find support from these data, especially in the form of triggers. Participants felt the influence of triggers during the struggle when craving was experienced as conversation between the drinking and sober self in Stage Two, *Craving in the Foreground*. The subtle influence of a trigger was also felt to be involved when craving made an appearance out of the clear blue, as in movement from Stage One when craving was in the background to Stage Two when craving moved into the forefront of conscious awareness.

The data also support two other characteristics of these models. First, the failure to totally suppress craving after its initial appearance resulted in a sort of primed situation. Often not even consciously aware of this enhanced state of susceptibility to the suggestion of alcohol, the individual was susceptible to whatever their particular prompt might be. This would appear to offer one explanation for those seemingly puzzling situations in which an individual begins to drink without apparent provocation after a period of abstinence. Wolf Dancer eloquently summarizes the importance of complete suppression of craving if drinking is to be avoided.

If you don’t put the thought completely out of your mind, if you leave a little piece of it even (p. 23, line 42-44). Well, if you leave a little piece of it, the next time you have a craving, there’s that little piece left over that you left last time. And, pretty soon you’ve got a whole – (p. 24, line 3-6) a lot of pieces of craving. Until that craving becomes the drink (p. 24, line 10-11).
A second way in which these data offer support for the conditioning models (Robinson & Berridge, 1993; Tiffany & Carter, 1998) relates to the specificity of triggers and cues that were specific to the individual. The data lend support to the influence of conditioning, sensitization (Anton, 1996; Robinson & Berridge, 1993), and cue reactivity (Tiffany, 1990; Tiffany & Carter, 1998) in the finding that situations that were often associated with craving failed to elicit craving in some individuals. Further support for the influence of conditioning and sensitization on the specificity of triggers is found in individuals: (1) specific knowledge of those situations which were known to stimulate craving, and (2) accounts of those situations in which exposure to alcohol failed to stimulate craving as would have been expected. This puzzling paradox underlies one of the most common misconceptions regarding craving, so succinctly summarized by Buster when asked to pick up a bottle of alcohol for his brother.

‘Are, are you going to be OK bringing that bottle back? Are you sure you can get that bottle and bring it back or, or will you have problems with it?’ Well, that’s, uh, what I think what most people, what most people, and I could be mistaken, consider cravings. Like, ‘Oh, my God. There’s a bottle. I, I’ve got to have a drink out of it.’ I, I don’t experience that. Uh, I told him, I laughed at him and I said, ‘No problem. I’ll bring it back.’ I said, ‘I don’t like that stuff anyway.’ [Laugh] I didn’t like it when I drank. I don’t like it now. So, uh, that’s, I think, I think what a lot of people consider a craving in the true sense of the word. That’s craving. When you can not even handle alcohol or smell it, uh, or be around a person who’s drinking without doing it yourself (p. 12, line 4-22).

*Incongruence With The Literature*

While these study data are congruent with models that posit positive reinforcement, negative reinforcement, and conditioning/sensitization as an explanation for craving, these study data challenge the assumption the craving causes drinking which underpins the predominance of literature. The observation that alcoholics: (1) often drink when
unaware of craving, and (2) commonly refrain from drinking even when experiencing craving lend support to Tiffany’s (1992, 1998, 2000) challenge of the extant literature that craving causes drinking. These data suggest that it is the management of craving rather than the mere presence of craving that determine outcome in terms of drinking.

Congruence with Theoretical Framework

*Symbolic Interactionism*

The theoretical perspective of symbolic interactionism (Mead, 1934; Blumer 1969; Crotty, 1998) informed the grounded theory methodology that was used in this study. Elements from chronic disease and vulnerability also provided an orienting theoretical perspective for this study. It was therefore not surprising that research findings were congruent with the theoretical perspectives. The research also demonstrated the appropriateness of using symbolic interactionism as the theoretical perspective with the integrated perspectives of chronic disease and vulnerability. This section highlights the key linkages between study findings and the perspectives of symbolic interactionism, chronic disease, and vulnerability.

The theoretical perspective of symbolic interactionism is a theory of human behavior in which people behave and interact on the basis of how specific symbols are interpreted and given meaning in their lives (Chenitz & Swanson, 1986). The following three tenets define this perspective: (1) people act according to meanings ascribed to things, (2) meanings are derived through social interaction, and (3) meanings are subject to modification through an interpretative process (Benzies, 2001; Crotty, 1998).
Results of this study reveal that alcoholics act toward alcohol according to the meaning of alcohol was specific to the individual. An underlying desire for alcohol in both Stage One when craving was in the background and Stage Two when craving was in the foreground was the result of an individual’s past experience with alcohol as well as the desired effect from alcohol. Craving was entwined with memories of alcohol.

The meaning ascribed to alcohol was also evident in the positioning of the negative and positive consequences of drinking. For example, the negative consequences of drinking were prominent during the early recovery period while the positive outcomes were in the background. With a longer duration of sobriety or length of time since the last drunk, the positive aspects of drinking gained prominence and were emphasized as the negative consequences of drinking became blurred in the background. In a manner similar to the movement of craving back and forth between the background and foreground, the positive and negative consequences of drinking seemed to shift between the background and foreground in importance. The success of managing craving appears related to an individual’s ability to use strategies which maintain the negative consequences of drinking in the forefront and the positive consequences of drinking relegated to the background.

Meaning was also evident in an individual’s commitment to sobriety. The willingness to remain sober or avoid alcohol was captured in the phrases such as “feelings of sobriety” or “acceptance” of the inability to drink. It was in this way that state of mind was influential in whether an individual would even attempt to employ strategies to manage craving rather than just act upon the urge to drink.
Chronicity

Lubkin and Larsen (2002) describe the following characteristics of chronic disease: (1) sudden or insidious onset, (2) origination due to multiple factors, (3) variable course, characterized by periods of exacerbation (episodic flare-ups) and remission (symptoms absent), (4) indefinite duration, and (5) incorporation into individual identity. Glaser and Strauss (1967) further define an illness trajectory as the course of an illness over time and the actions taken to influence that course in terms of disease management and the illness experience.

Results of this study support the supposition that craving represents a symptom of the chronic disease of alcoholism. The following characteristics of craving suggest definition as a symptom: (1) specificity, (2) intensity, and (3) duration. The omnipresent characterization of craving, as well as appearance and disappearance into the foreground and background of consciousness is consistent with the exacerbation and remission of chronicity. The grounded theory discovery of an active process of managing craving through the implementation of strategies is also consistent with a model of symptom management, since the participants actively employed strategies to manage craving in an effort to avoid drinking.

Vulnerability

In contrast to the view of vulnerability within the framework of relative risk or susceptibility to adverse health outcomes (Flaskerud, 1998; Rogers, 1997), Spiers (2000) posits an emic view of vulnerability as a quality of experience with four attributes: (1) integrity, (2) challenge, (3) capacity for action, and (4) multidimensionality. This study
data are consistent with this emic view in which craving is a factor that influences the individual’s quality of life, and represents a challenge to be managed rather than a deficit state.

In summary, the four-stage Theory of Craving for Alcohol supports the theoretical framework of symbolic interactionism that underpinned this study. Further support is also demonstrated for models of chronicity and symptom management, and an emic perspective of vulnerability. The following sections address the implications for nursing theory, research, and practice.

Implications for Nursing Theory

The purpose of knowledge generation in nursing is to understand and care for individuals in relation to their health and environment. Alcohol treatment has failed to borrow from the study of medical response to chronic-relapsing disease (Vaillant, 1981). The failure to discover the natural history of alcoholism through the same scientific rigor afforded other chronic diseases and relegation of the management of the illness to the lay community has resulted in a “folk science model” (Pattison, Sobell, and Sobell, 1977; Edwards and Grant, 1980) in which craving has remained shrouded in mystery and myth. Current theories of craving are consistent with a biomedical model in the depiction of isolated aspects or dimensions of craving. The four stage Theory of Craving offers a definition of craving as a process rather than a product from which to begin to understand the experience of craving.

The potential of the grounded theory, Craving for Alcohol, may serve to enhance the nursing profession’s perspective on symptom management in addictive disease from a
chronic disease framework. Grounded theory, as a qualitative research methodology, has promise for explicating basic social process and the development of middle-range theory. Through generation of theory that is abstract enough to extend beyond this data but specific enough for further testing in other populations and situations in which craving is inherent, this theory represents a beginning theory that not only contributes to the science of disease management, but the accumulating body of knowledge regarding symptom management. Since an effective theory base should underpin nursing intervention, the four stage theory *Craving for Alcohol* represents an explanation of craving as a basic social process from which to frame intervention. The development of this model represents taking the lead in the development of a generic symptom management model with utility for directing care and research across a variety of conditions in which craving is inherent. In addition to the elaboration of craving as a basic social process, the four stage theory of Craving for Alcohol incorporates three important components of symptom management: (1) symptom experience, (2) symptom management, and (3) symptom outcome (University of California, School of Nursing Symptom Management Faculty Group). The distinct knowledge base derived from the Theory of Craving has the potential to guide further research and provide direction for practice interventions that contribute to the health of individuals from the unique perspective of nursing.

**Implications for Nursing Research**

This study serves as an example of the value of using grounded theory as a qualitative method to enhance the development of nursing knowledge through theory construction in nursing. The finding that several participants made reference to craving
under different conditions and in relation to substances other than alcohol, such as tobacco, heroin, and cocaine, suggests a common thread that warrants further exploration. The finding that craving varied in intensity and responsiveness to strategies further support the utility of a symptom management perspective for further investigation. The Theory of Craving offers a beginning framework from which to further elaborate characteristics of craving under various conditions and with different populations. This qualitative study provides a springboard for further exploration of characteristics of craving, similar to the elaboration of the following dimensions in symptom mapping: (1) intensity, as strength or intensity, (2) timing, or duration and frequency, (3) level of distress, and (4) quality (Lenz, Pugh, Milligan, Gift, & Suppe, 1997).

The finding that stress was associated with increased craving and sweets resulted in a temporary reduction in craving underscores the need for further investigation and isolation of the following: (1) physiologic factors, (2) psychologic factors, and (3) situational factors (Lenz, Suppe, Gift, Pugh, and Milligan, 1995). The isolation of factors that influence the process of craving is prerequisite for development of theory related to symptom prevention and management since these study data do indeed suggest that: (1) individuals actively employ strategies that affect craving, (2) craving is a cyclic and recurring process that varies within the same individual as well as between individuals, and (3) the ability to avert the choice of alcohol is related to the successful management (suppression) of craving. And finally, the exploration of the experience of vulnerability from an emic perspective (Spiers, 2000) in relation to quality of life and ability to meet challenge has significant implications for interventions.
Implications for Nursing Practice

The discipline of nursing is both scientific and humanistic (Kritek, 1997) and as a profession, nursing has never focused solely on the physical body or on disease entities. Acknowledging the holistic nature of humans, nursing is concerned with the client’s experience of the condition, environmental influences that facilitate recovery, and social and spiritual supports that enhance well-being (Frisch, 2003). Since symptoms are the most common reason that individuals seek healthcare, and the traditional role of nurses has emphasized symptom management (University of California, School of Nursing Symptom Management Faculty Group), the finding that craving is a process that is actively managed by individuals underscores the importance of adoption of a symptom management perspective to practice. Knowledge of craving as a four stage process provides a beginning framework for guiding practice through which nurses are able to assist individuals in the active management of craving. Use of strategies which facilitate movement of craving into the background can promote empowerment, more effective disease management, and an enhanced quality of life. Nurses can be instrumental in the identification of those factors specific to the individual that influence craving, as well as the efficacy of various management strategies.

Finally, knowledge of the Theory of Craving can be useful in offering individuals and the public a more realistic view of craving from an emic perspective of vulnerability (Spiers, 2000) in which the process of craving represents the interplay between challenge and response to that challenge. With an emphasis on growth and resilience rather than failure, the Theory of Craving offers an alternate explanation for behavior that often
appears to be contradictory and puzzling. When Nursing’s social sanction to assist those who are suffering is predicated on helping client’s with the articulation of their own perceptions and realities rather than the imposition of externally defined conditions of health and illness, care that is humane and compassionate as well as effective is an anticipated outcome.

Summary

These sections summarized the implications of this grounded theory for nursing theory, nursing research, and nursing practice. The Theory of Craving offers an alternate perspective of a middle range theory capable of adding to the science of nursing, and guiding both research and practice.

Limitations of the Study

The study was based upon the analysis of 14 in-depth interviews from 14 self-identified alcoholics who acknowledged the experience of craving for alcohol. The limitations of this study originate within data gathering techniques.

Although my role as a researcher was made clear, my role as an adult nurse practitioner with addiction expertise was also known to participants through employment in detoxification. While participants were encouraged to tell their own story, the questions asked during the interviews shaped the participant responses and ultimately, the study findings. Improvement of my interviewing techniques and skill in moving participants through their stories was demonstrated with progression of data collection. Since the interviews were the primary data source however, influences on the interviews
such as my use of probes and familiarity with participants from prior professional relationship, pose potential limitations of the study.

Recommendations

This grounded theory study represents an initial stage in a program of research which addressed craving for alcohol. Through the elaboration of a four stage process of craving which initially is a useful perspective, it is anticipated that the theory will undergo modification and revision over time and following further testing. This study has resulted in the identification of the following questions for further study:

1. What is the process of craving within the context of heroin, cocaine, and nicotine dependence? What are the similarities and differences with craving for alcohol?

2. What is the process of craving in women? What are the similarities and differences between women and men?

3. What is the relationship between craving and stress?

4. What is the relationship between craving for alcohol and carbohydrate craving?

Summary of Chapter Five

This chapter presented a summary of the four stage process of craving in which individuals were involved in the active management of craving. Study findings were integrated with the extant literature. The review of the literature included theories of craving, chronic disease, and vulnerability. Congruence with perspectives of craving originating from positive and negative reinforcement, as well as conditioning and sensitization models was noted. Incongruence with the common assumption underlying much of the literature that craving causes drinking was demonstrated with the study data,
suggesting that the management of craving rather than the mere presence of craving
determine the outcome of the process of craving.

The Theory of Craving is consistent with the theoretical framework of symbolic
interactionism that underpinned this study. The study findings lend further support to the
framework of chronicity, nursing models of symptom management, and an emic
perspective of vulnerability, with implications for effective disease management and
quality of life. Implications for nursing theory, nursing research, and nursing practice
concluded this chapter.
APPENDIX A: PARTICIPANT SCREEN
PARTICIPANT SCREEN

You are being offered the opportunity to participate in a research study that is designed to explore the experience of craving in relation to problematic drinking. The purpose of the study is to gain an understanding of a phenomenon that is commonly reported by individual’s who experience problems with drinking. As a potential source of discomfort and possible contributor to relapse, an enhanced understanding of craving may lead to more effective management of a variety of conditions in which craving is found.

If you are willing to participate in this study, you will be contacted by the principal investigator Rochelle Storm, RN. She will describe the study and further screen your eligibility. Participation in this study will involve a one-hour interview at a mutually convenient time here at the medical center. A second interview may be requested to gain additional information if necessary during the course of the study. There is no cost to participate in the study. There is no compensation for your participation in the study.

Your willingness to consider participation in this study is appreciated. However, any decision to not participate in this study will have no effect on the medical care you are seeking at this medical center.
APPENDIX B: CONSENT TO PARTICIPATE
SUBJECT'S CONSENT FORM

Project Title: Grounded Theory Explication of Craving within Alcoholism

You are being asked to read the following material to ensure that you are informed of the nature of this research study and of how you will participate in it, if you consent to do so. Signing this form will indicate that you have been so informed and that you give you consent. Federal regulations require written informed consent prior to participation in this research study so that you can know the nature and risks of your participation and can decide to participate or not participate in a free and informed manner.

PURPOSE
You are being invited to participate voluntarily in the above-titled research project. The purpose of this project is to explore the process of craving within alcoholism, or problematic drinking.

SELECTION CRITERIA
You are being invited to participate because craving is a phenomenon that is commonly reported by individual's experiencing problematic drinking. Criteria for inclusion in this study include: minimum age of 21; ability to speak English; self-identification as alcoholic; self-report of craving; and self-evaluated intact memory for adequate recall and description of events. Approximately (8-12) subjects will be enrolled in this study.

PROCEDURE(S)
If you agree to participate, you will be asked to consent to the following: participate in an interview with the primary investigator concerning your experience with craving. The interview will be conducted in private in a mutually agreed upon time here at the medical center and will last an hour. A second or third interview may be requested at a later date during the course of the study if more information is deemed necessary. The interview will consist of two phases. The first phase is designed to provide general background information, such as age and marital status. The second phase will allow you to describe your experience with craving. While the investigator will ask some questions and guide the interview, you will have the opportunity to tell your story. The interview will be tape-recorded and later transcribed for review by the investigator. The investigator will take a few notes during the interview to supplement the information from the taped interview.

RISKS
Risks are considered minimal, though it is acknowledged that some discomfort may be encountered during a discussion of events associated with craving. Upon completion of the interview, the investigator will inquire into your thoughts and feelings as part of a process of debriefing and to facilitate adequate closure. The researcher will also provide
information regarding community resources, such as recovery support groups, that could be sought for continued support if felt necessary later.

**BENEFITS**
Informants often report the sharing of their story as a positive experience. A typed copy of the interview will be made available for your review in order to clarify the accuracy of the investigator’s impressions. An anticipated outcome of this research is the development of a theory of craving, with potential applicability to other conditions in which craving is inherent, such as other addictive behaviors (gambling), addictive diseases (nicotine, heroin, cocaine), and medical conditions (obesity, eating disorders).

**CONFIDENTIALITY**
You will be asked to select a pseudonym to be used during the interview and reflected in the transcribed transcripts to protect anonymity. The results will be submitted for publication after data analysis, and anonymity will be maintained at that time as well.

**PARTICIPATION COSTS AND SUBJECT COMPENSATION**
There is no cost to participate in this study. There is no monetary compensation.

**CONTACTS**
You can obtain further information from the principal investigator Rochelle Storm, R.N., Ph.D. Candidate at (520) 792-1450, extension 6392. If you have questions concerning your rights as a research subject, you may call the Human Subjects Committee office at (520) 626-6721.

**AUTHORIZATION**
Before giving my consent by signing this form, the methods, inconveniences, risks, and benefits have been explained to me and my questions have been answered. I may ask questions at any time and I am free to withdraw from the project at any time without causing bad feelings or affecting my medical care. My participation in this project may be ended by the investigator or by the sponsor for reasons that would be explained. New information developed during the course of this study which may affect my willingness to continue in this research project will be given to me as it becomes available. This consent form will be filed in an area designated by the Human Subjects Committee with access restricted to the principal investigator, Rochelle Storm, Ph.D. Candidate or authorized representative of the Nursing Department. I do not give up any of my legal rights by signing this form. A copy of this signed consent form will be given to me.

____________________  __________________
Subject's Signature       Date

INVESTIGATOR'S AFFIDAVIT
I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

_________________________________ __________________
Signature of Investigator      Date
1/2000
APPENDIX C: INITIAL INTERVIEW SCREEN
Initial Interview Screen

1. What is your age?

2. What is your marital status?

3. Do you have children?

4. Do you have any medical conditions?

5. Do you have any psychiatric conditions?

6. Do you take any prescribed medications?

7. Please provide a description of your drinking history?
APPENDIX D: INTERVIEW QUESTION GUIDE
Interview Question Guide

1. Tell me about your experiences with craving?

2. Describe characteristics of craving (intensity, quality)?

3. What is craving associated with?

4. What is it like for you when you are drinking?

5. What is it like for you when you are not drinking?
APPENDIX E: DEBRIEFING SCRIPT
Debriefing Script

Based upon what we have talked about today, do you have any concerns or questions?

It is possible that this conversation could have triggered some urges. Has this conversation triggered any urges for you?

If you experience such urges, it might be helpful to remind yourself that most urges last only 10-15 minutes.

If you experience any difficulty following this conversation, there are organizations in the community that you might find helpful.
APPENDIX F: SUBSTANCE ABUSE RESOURCE LIST
### Substance Abuse Resource List

#### Outpatient Counseling Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carondelet Behavioral Health</td>
<td>721-3833</td>
</tr>
<tr>
<td>CODAC</td>
<td>825-0009</td>
</tr>
<tr>
<td>Compass Health Care</td>
<td>620-6615</td>
</tr>
<tr>
<td>Inter-Tribal Health Center</td>
<td>882-0555</td>
</tr>
<tr>
<td>Jewish Family Services</td>
<td>795-0300</td>
</tr>
<tr>
<td>La Frontera</td>
<td>884-9920</td>
</tr>
<tr>
<td>New Hope Behavioral Health</td>
<td>297-3329</td>
</tr>
<tr>
<td>Pascua Yaqui Tribal Services</td>
<td>883-6087</td>
</tr>
<tr>
<td>Pathway Drug Abuse Program</td>
<td>751-8918</td>
</tr>
<tr>
<td>Project P.P.E.P.</td>
<td>792-5705</td>
</tr>
<tr>
<td>Renewal Counseling</td>
<td>791-9974</td>
</tr>
<tr>
<td>Serenidad Counseling Services</td>
<td>884-0290</td>
</tr>
<tr>
<td>Teen Challenge</td>
<td>792-1790</td>
</tr>
<tr>
<td>The Fountain Counseling Center</td>
<td>797-7950</td>
</tr>
<tr>
<td>Tohono O’Odham Services</td>
<td>383-6000</td>
</tr>
</tbody>
</table>

#### Self Help Groups

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Children of Alcoholics</td>
<td>323-2229</td>
</tr>
<tr>
<td>Al-Anon/Alateen</td>
<td>323-2229</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>624-4183</td>
</tr>
<tr>
<td>Cocaine Anonymous</td>
<td>326-2211</td>
</tr>
<tr>
<td>Codependents Anonymous</td>
<td>882-5705</td>
</tr>
<tr>
<td>Divorce Recovery</td>
<td>323-3952</td>
</tr>
<tr>
<td>Nicotine Anonymous</td>
<td>326-6165</td>
</tr>
<tr>
<td>Narcotics Anonymous</td>
<td>881-8381</td>
</tr>
<tr>
<td>Rational Recovery</td>
<td>212-4587</td>
</tr>
</tbody>
</table>
APPENDIX G: HUMAN SUBJECTS APPROVAL
REFERENCES


Shi, L. (2001). The convergence of vulnerable characteristics and health insurance in the U.S. Social Science & Medicine, 53, 519-529.


