MUTUAL AID & TWELVE STEP

Mutual Aid Societies and Twelve-Step Recovery

William L. White — Selected Papers, Volume IV

33 Papers

White's research on mutual aid societies — from the Washingtonians and pre-AA groups through Alcoholics Anonymous, Narcotics Anonymous, and the full spectrum of modern peer recovery support.

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Alcoholic Mutual Aid Groups (United States)

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Abstinence-based mutual aid societies organized by and for those experiencing severe alcohol-related problems have a long and rich history in the United States. The first of these societies rose in two cultural contexts: within Native American tribes in the eighteenth century and then within Euro-American communities in the mid-nineteenth century. The impetus for such societies was the rise of alcohol problems among Native peoples, and a three-fold rise in annual per-capita alcohol consumption and related personal and social problems within the new American republic.

Native leaders, including Papounhan, Wagomend, Neolin (the Delaware Prophet), Tenskwatawa (the Shawnee Prophet), Handsome Lake, and Kennekuk (the Kickapoo Prophet), introduced nativist religious and cultural revitalization movements that called for the rejection of alcohol and a return to Native traditions. The mid-eighteenth century recovery "circles" among the Delaware Indians constitute the earliest geographically de-centralized, sobriety-based support structures in the United States. Native religious and cultural revitalization movements, created by messianic leaders who themselves had suffered from alcoholism, emerged at a time when alcohol was being used as a tool of economic, political and sexual exploitation of Native peoples. These early movements were followed by "Indian Preachers" in recovery from alcoholism (Samson Occom, William Apess) who provided a Christian framework of recovery from alcoholism, and late nineteenth century abstinence movements that blended both Native and Christian beliefs and rituals (The Indian Shaker Church and the Native American Church).

Sobriety as a Cultural Phenomenon

By the 1830s, Americans suffering from what was about to be newly christened as "alcoholism" sought shelter within a rising temperance movement. It was within the local temperance societies that the drunkard would fine a mechanism to stop drinking (signing the pledge), a forum for public confession and commitment, sober fellowship, and support for keeping the pledge. Between 1840 and 1875, recently

sobered drunkards began to organize their own temperance societies that were focused more on personal reformation than public education and political reform. The first society founded exclusively for the purpose of such reformation was the Washingtonian Total Abstinence Society organized in April, 1840, in Baltimore, Maryland.

The Washingtonian Society emphasized the importance of public confession, pledge signing, mentorship of new members, continued sharing in the Washingtonian meetings, sober fellowship and service to other "hard cases." The Society experienced explosive growth, quickly rising to a membership of more than 500,000, and rapid geographical dispersion that was due, in part, to the leadership of men like John Hawkins and John Gough, two of the most effective and widely traveled temperance lecturers of the nineteenth century. In spite of this dramatic increase in membership and public visibility, most Washingtonian groups collapsed within a few years due to the loss of their closed ("drunkards only") meeting structure, internal dissension over political and religious issues, damaged public credibility, and co-optation by more powerful temperance organizations.

Following the collapse of the Washingtonians, fraternal temperance societies filled the void of mutual support for "reformed men" seeking to be shielded from the temptations of drink. Among the more prominent of such societies were the Sons of Temperance, Order of Good Templars, the Independent Order of Rechabites, the Order of the Friends of Temperance, and the Independent Order of Good Samaritans. The membership of some of these societies was made up almost exclusively of reformed men. The emphasis on sober fellowship and economic assistance eventually widened the doors of membership to include anyone willing to sign the pledge and meet other requirements for membership. Membership in these societies declined as conflict arose over whether their focus should be exclusively on the personal reformation of the drunkard, or the legal prohibition of alcohol.

Another genre of alcoholic mutual aid society, the Ribbon Reform Clubs, emerged in the 1870s under the leadership of men like J.K. Osgood, Dr. Henry Reynolds, and Francis Murphy. The Ribbon Clubs drew their name from the practice of members wearing a ribbon on their clothing to both publicly convey the hope of reform for the drunkard and to recognize one another as they traveled. The purple, blue and red ribbons became visible symbols of personal recovery in the closing decades of the nineteenth century. The Ribbon Reform Clubs emphasized pledge-signing, regular meetings for mutual support, rescue work with other drunkards, and a prohibition against political discussions at their sponsored events.

These early alcoholic mutual aid societies inspired calls for the creation of special institutions to care for the inebriate. Several hundred inebriate homes, medically-directed inebriate asylums, and proprietary addiction cure institutes opened in the last half of the nineteenth century. These institutions spawned patient-led organizations that provided mutual support both during and following treatment. Among the more prominent of these societies were the Ollapod Club (New York Inebriate Asylum), the Godwin Association (Franklin Reformatory Home for Inebriates), the Dashaway Association (The San Francisco Home for the Care of the Inebriate) and the Keeley Leagues (Keeley Institutes). The Keeley Leagues were the largest of these institutional aftercare groups with more than 370 chapters and 30,000 members during the mid-1890s.

Another type of alcoholic mutual aid society emerged from the work of Jerry McAuley. McAuley, an alcoholic ex-convict, achieved sobriety through religious conversion and went on to open the Water Street Mission in New York City in 1872. This marks the beginning of the urban mission movement in the U.S., out of which also grew the alcoholism programs of the Salvation Army and rural religious Inebriate colonies such as Keswick Colony of Mercy founded by William Raws in 1889. Mutual aid groups such as the Drunkard's Club,

founded by Orville “Awful” Gardner in New York City were the earliest precursors to religiously-oriented alcoholism recovery support groups such as the United Order of Ex-Boozers, Alcoholics Victorious, Alcoholics for Christ, Mountain Movers, Liontamers Anonymous, High Ground, and Overcomers Outreach. There is a more recent trend toward offering recovery support groups within the framework of a larger addiction ministry, such as the One Church—One Addict program founded by Father George Clements of Chicago.

Groups like the Business Men’s Moderation Society, founded in 1879, marked the beginning of mutual aid societies that were neither abstinence-based nor religiously oriented. The moderation societies pledged themselves to limit the frequency and volume of alcohol consumption and to avoid practices like “treating” that encouraged drunkenness.

Collapse and Rebirth

Most of the alcoholic mutual aid societies and alcoholism treatment institutions founded in the nineteenth century collapsed during the first two decades of the twentieth century. One attempt to rebirth such support was Boston’s Jacoby Club, founded in 1910 by Ernest Jacoby as a club for alcoholic men to “help themselves by helping others.” The Jacoby Club was created as an appendage to the Emmanuel Clinic, which was seeking to combine religion, psychology and medicine in the treatment of alcoholism.

This dearth of mutual aid resources changed in 1935 when the meeting of two alcoholics, Bill Wilson and Dr. Robert Smith, reaching out for mutual support, marked the founding of Alcoholics Anonymous (A.A.). A.A. grew slowly, extracting its Twelve Steps and Twelve Traditions from the experiences of its early members and groups. It stood alone as the dominant sobriety-based support structure from its founding into the mid 1970s. There were adaptations of A.A. to alcoholism (Alcoholics Victorious), Eleventh Step adaptations of A.A. for A.A. members of particular religious faiths (e.g., Calix Society for Catholic A.A. members), but virtually no major competing groups. A.A.’s survival as an organization and continuing growth mark it as the yardstick by which all other such societies are measured.

A.A.’s sole cultural ownership of alcoholism mutual aid was challenged in the mid-1970s and 1980s with the founding of new alcoholic mutual aid societies. This began with the founding of Women for Sobriety (W.F.S.) by Dr. Jean Kirkpatrick, which was later followed by another women-focused alternative to A.A., Charlotte Kasl’s sixteen step empowerment program. Also emerging were secular alternatives to A.A.: Secular Organization for Sobriety (S.O.S.), founded by James Christopher and Rational Recovery (R.R.), founded by Jack Trimpey. Schisms within S.O.S. and R.R. spawned other abstinence-based secular other organizations--LifeRing Secular Recovery and the Alcohol and Drug Abuse Self-Help Network, the latter evolving into Self Management and Recovery Training (S.M.A.R.T.). The 1980s also witnessed the rebirth of moderation-oriented mutual support groups like Moderation Management (M.M.), founded by Audrey Kishline. M.M. provides a nine-step framework that includes a brief, 30 day period of abstinence, a self-analysis of life priorities and drinking patterns, drinking within prescribed limits, and mutual support in face-to-face and online support groups.

The other modern trend was the adaptation of A.A.’s Twelve Step program for those experiencing problems with drugs other than alcohol. The most significant of these were Narcotics Anonymous, Cocaine Anonymous, Pills Anonymous, and Potsmokers Anonymous. While the support group movement has broadened far beyond A.A. to encompass an ever-widening circle of problems, nearly three fourths of all support meetings attended in the United States are meetings for the resolution of alcohol and/or other drug-related problems (Kessler, Mickelson, and Zhao, 1997).

The modern story of mutual aid groups is clearly one of expansion and specialization. In spite of their many differences, there are common threads

within all of the above mutual aid societies. Each provided or continues to provide a framework for acknowledging and defining the nature of an alcohol or other drug problem, and initiating and sustaining changes in alcohol and drug consumption. They also provide a means of reconstructing personal identity and interpersonal relationships and clarifying one's personal goals and values. What distinguishes them from professionally-directed addiction treatment is that such change occurs in the context of relationships that are non-hierarchical, non-commercialized, reciprocal, and often long-enduring.

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Side Bar

Addiction Mutual Aid Societies
A Chronology

Native Recovery "Circles" (1737-1750)
Handsome Lake Religion (1799)
Washingtonians (1840)
Fraternal Temperance Societies

- Sons of Temperance (1842)
- Independent Order of Good Samaritans
  & Daughters of Samaria (1847)
- Order of Good Templars (1851)

The Dashaway Association (1859)
Ribbon Reform Clubs (1870s)

- Royal Ribbon Reform Club (1871)
- Blue Ribbon Reform Club (1871)
- Red Ribbon Reform Club (1874)

The Ollapod Club (1868)
The Drunkard's Club (c.1871)
The Godwin Association (1872)
Peyotism (1870s) / The American Indian Church (1918)
Business Men's Moderation Society (1879)
The Indian Shaker Church (1882)
The Keeley Leagues (1891)
Jacoby Club (1910)
United Order of Ex-Boozers (1914)
Alcoholics Anonymous (AA) (1935)
Calix Society (1947)
Narcotics Anonymous (1947, 1953)
Alcoholics Victorious (AV) (1948)
Potsmokers Anonymous (1968)
Pills Anonymous (1975)
Women for Sobriety (WFS) (1975)
Overcomers Outreach (1977)
Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS) (1979)
Liontamers Anonymous (1980)
Cocaine Anonymous (1982)
Secular Organization for Sobriety (SOS) (1985)
Rational Recovery (RR) (1986)
Moderation Management (MM) (1994)
Self Management and Recovery Training (1994)
One Addict—One Church (1994)
LifeRing Secular Recovery (1999)
Teen-Anon (1999)



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A Photographic Essay
Addiction Recovery Mutual Aid Groups:
An Enduring International Phenomenon

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The fellowship of Alcoholics Anonymous, based on its membership growth, geographical dispersion, longevity, and integration with professional treatment has dominated modern discussion of the role of mutual aid in the resolution of alcohol- and drug-related problems. Such domination has obscured awareness of mutual aid societies that pre-date AA, the growing variations in AA practices around the globe, and the increase in mutual support adjuncts and alternatives to AA. This essay recounts and illustrates the rise of addiction recovery mutual aid societies around the world.

Native American recovery "circles" constitute the earliest abstinence-based mutual aid recovery societies. Between 1737 and 1840, messianic Native leaders (e.g., Papounhan, Wagomend, Neolin, Tenskwatawa, Handsome Lake, and Kennekuk) (Plate One) achieved sobriety through profound conversion-like experiences. They then launched new religious and cultural revitalization movements that called for personal and cultural redemption and the rejection of alcohol. Some of these movements (Longhouse Religion, Native American Church, Indian Shaker Church) continue to provide a culturally-nuanced medium of alcoholism recovery (White, 1998, 2001a).

By the 1830s, American alcoholics were seeking refuge in a growing network of local temperance societies. As the American temperance movement increased its rescue work with drunkards, the context was set for the rise of mutual aid societies organized by and for "hard cases" (as those with severe alcohol problems described themselves). America witnessed a succession of such groups: the Washingtonian movement of the 1840s (Plate Two), fraternal temperance societies organized explicitly for the mutual reclamation of drunkards, and the Ribbon Reform Clubs of the 1870s (Plates Three and Four). There were local mutual aid societies, from the Dashaways in San Francisco (1859) to the Drunkard's Club in New York City (1871). There were mutual aid societies created within the growing

network of inebriate homes, inebriate asylums and private addiction cure institutes, the more notable of which included the Ollapod Club (1864), Godwin Association (1872), Keeley Leagues (1891) (Plate Five), and the Brotherhood of St. Luke (1904). Also evident were mutual aid groups focusing on the needs of young inebriates (cadet societies), women (Martha Washington Society, 1842), and those who preferred moderation rather than abstinence (Businessmen's Moderation Society, 1879) (Cyclopaedia of Temperance, 1891; Cherrington, 1925-1926). Explicitly religious frameworks of mutual support for alcoholism recovery during this period date from Jerry McAuley's 1872 founding of the Water Street Mission in New York City (Plate Six).

The temperance movement in Europe also contained recovery mutual aid societies. Among the more prominent of these were American-born temperance societies such as the Order of Good Templars founded in 1851, the Blue Cross (Switzerland, 1877), the Kreuzbund (Germany, 1885), Croix d'Or (Gold Cross) (France, 1910). As in America, many of the early temperance societies (e.g., the German Order of Temperance, French Temperance Society, the Irish New Ross Temperance Society in Ireland) were organized around moderation rather than abstinence principles (Cherrington, 1925-1926). Special groups that provided mutual aid for recovering women rose in tandem with gender-specific alcoholism treatment facilities in both American and Europe (Plate Seven).

Many American mutual aid groups collapsed in tandem with the advent of alcohol prohibition and the demise of nineteenth-century treatment institutions. Other than a few local groups such as the Jacoby Club (1910) and the United Order of Ex-Boozers (1914), the opening decades of the twentieth century are noteworthy for their lack of American mutual recovery groups. In Europe during this period, the first alcoholic patient associations, such as Zukunft--the Abstinence Union in Austria (1926), were founded (Flemming, 1937; Eisenbach-Stangl, 1996).

The founding of Alcoholics Anonymous (AA) in 1935 brought a framework of recovery (AA's Twelve Steps) and a set of organizational principles (AA's Twelve Traditions) that exerted a profound influence on subsequent recovery mutual aid efforts and on the professional treatment of alcoholism (Plate Eight). The 1940s and 1950s witnessed an explosive growth of AA membership in America, the increased spread of AA outside the U.S. (Barath, 1991), the first adjunct (Calix Society, 1947) and alternative (Alcoholics Victorious, 1948) to AA, and the first adaptations of AA for problems other than alcoholism (e.g., Narcotics Anonymous/NA, 1953; Gamblers Anonymous/GA, 1957) (Plate Nine).

AA's growth outside the United States in the 1940s and 1950s was particularly evident in North and Central America, Australia, Europe, Africa and Asia. AA's reach eventually extended to 2.1 million members who today meet regularly within 100,766 registered groups in 134 countries (Kurtz & White, 2003). NA went through a similar period of international growth during the 1970s and 1980s, eventually expanding to 20,000 registered groups in more than 100 countries (Stone, 1997).

During the mid-twentieth century, mutual aid alternatives to AA also increased in Europe and Asia. Among the most significant of these were the Swedish Links (1945), the Danish Links, Vie Libre (Free Life Movement, 1953), the Polish Abstainers Club (1960), the Danshukai movement (All Nippon Abstinence Association, 1963; Danshu-Tomo-no-Kai; Zenkoku Danshu Renmei) in Japan, and the Pui Hong Self-Help Association (1967) in China (Kurube, 1992; Mäkelä, 1996; Đwiatkiewicz, 1992; Room, 1998; Humphreys, 2004; Cheung and Ch'ien, 2003). Earlier groups, such as the Good Templars, continued to serve a recovery mutual aid function in many European countries.

There were several significant mutual aid trends in the closing decades of the twentieth century. First, there were a growing list of adaptations of AA's Twelve Steps for people with drug problems other than alcohol: Potsmokers Anonymous

(1968), Pills Anonymous (1975), Cocaine Anonymous (1982), Nicotine Anonymous (1985), and Prescription Anonymous (1998), as well as special support structures for persons involved in medication-supported recovery (Methadone Anonymous, 1991) and those experiencing co-occurring disorders (Dual Recovery Anonymous, 1989; Double Trouble in Recovery, 1993). Second, there were a growing number of secular (Women for Sobriety, 1975; Secular Organization for Sobriety, 1986; Rational Recovery, 1986; SMART Recovery, 1994; and LifeRing Secular Recovery, 1999) (Plates Ten and Eleven), religious (Liontamers Anonymous, 1980; One AddictBOne Church, 1994), and cultural (Free N' One, 1987; the Native American Wellbriety movement) alternatives to AA. The late twentieth century also witnessed new adjuncts to AA (Jewish Alcoholics, Chemically Dependent People and Significant Others, 1979) and the first modern moderation-based mutual aid societies: Drinkwatchers (1970s), Methods of Moderation and Abstinence (1980s) and Moderation Management (1993) (Plate Twelve).

In Europe and Asia, AA and NA groups have continued to grow as have such alternatives as the Alcoholic Treatment Clubs (e.g., Italy, 1979). There is also a European trend toward the political organization of addicts as in the Junkie Bund (Germany, Junkie Union, 1970s) (Appel, 1996). In the United States, there has been a significant growth in grassroots recovery advocacy organizations (White, 2001b). These new organizations constitute a bridge from mutual aid into the arena of social policy advocacy (Plate Twelve). There are also trends toward the globalization of recovery mutual aid via the Internet, and the professionalization of the mutual aid movements via the rise of self-help clearinghouses and "consumer-run" service agencies (Oka & Borkman, 2000).

Particularly striking in this chronology are the long history, geographical range, and the growing varieties of addiction recovery mutual aid societies. The groups noted here differ markedly in their germinating conditions, missions (from a singular focus on mutual aid to broader political, cultural or religious agendas), core ideas, mechanisms of change, rituals of contact (from formal meetings to social clubs), gender representation, degree of family involvement, financing; level of inclusion/exclusion of professionals, degree of political advocacy, and responses to relapsed members. In spite of such diversity, there are universal themes within these groups, such as the dangers of mission diversion and professionalization, regardless of the cultural contexts in which they arise. As research increases on the role of mutual aid groups in long-term addiction recovery, so will interest in the history, practices and future of recovery mutual aid societies.

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Plate Six: Jerry McAuley, Founder, Water Street Mission (Courtesy Illinois Addiction Studies Archive)

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Plate Twelve: Moderation Management Booth at 2002 American Psychological Association Conference (Courtesy of MM)



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The temperance movement in Europe also contained recovery mutual aid societies. Among the more prominent of these were American-born temperance societies such as the Order of Good Templars founded in 1851, the Blue Cross (Switzerland, 1877), the Kreuzbund (Germany, 1885), Croix d'Or (Gold Cross) (France, 1910). As in America, many of the early temperance societies (e.g., the German Order of Temperance, French Temperance Society, the Irish New Ross Temperance Society in Ireland) were organized around moderation rather than abstinence principles (Cherrington, 1925-1926). Special groups that provided mutual aid for recovering women rose in tandem with gender-specific alcoholism treatment facilities in both American and Europe (Plate Seven).

Many American mutual aid groups collapsed in tandem with the advent of alcohol prohibition and the demise of nineteenth-century treatment institutions. Other than a few local groups such as the Jacoby Club (1910) and the United Order of Ex-Boozers (1914), the opening decades of the twentieth century are noteworthy for their lack of American mutual recovery groups. In Europe during this period, the first alcoholic patient associations, such as Zukunft--the Abstinence Union in Austria (1926), were founded (Flemming, 1937; Eisenbach-Stangl, 1996).

The founding of Alcoholics Anonymous (AA) in 1935 brought a framework of recovery (AA's Twelve Steps) and a set of organizational principles (AA's Twelve Traditions) that exerted a profound influence on subsequent recovery mutual aid efforts and on the professional treatment of alcoholism (Plate Eight). The 1940s and 1950s witnessed an explosive growth of AA membership in America, the increased spread of AA outside the U.S. (Barath, 1991), the first adjunct (Calix Society, 1947) and alternative (Alcoholics Victorious, 1948) to AA, and the first adaptations of AA for problems other than alcoholism (e.g., Narcotics Anonymous/NA, 1953; Gamblers Anonymous/GA, 1957) (Plate Nine).

AA's growth outside the United States in the 1940s and 1950s was particularly evident in North and Central America, Australia, Europe, Africa and Asia. AA's reach eventually extended to 2.1 million members who today meet regularly within 100,766 registered groups in 134 countries (Kurtz & White, 2003). NA went through a similar period of international growth during the 1970s and 1980s, eventually expanding to 20,000 registered groups in more than 100 countries (Stone, 1997).

During the mid-twentieth century, mutual aid alternatives to AA also increased in Europe and Asia. Among the most significant of these were the Swedish Links (1945), the Danish Links, Vie Libre (Free Life Movement, 1953), the Polish Abstainers Club (1960), the Danshukai movement (All Nippon Abstinence Association, 1963; Danshu-Tomo-no-Kai; Zenkoku Danshu Renmei) in Japan, and the Pui Hong Self-Help Association (1967) in China (Kurube, 1992; Mäkelä, 1996; Đwiatkiewicz, 1992; Room, 1998; Humphreys, 2004; Cheung and Ch'ien, 2003). Earlier groups, such as the Good Templars, continued to serve a recovery mutual aid function in many European countries.

There were several significant mutual aid trends in the closing decades of the twentieth century. First, there were a growing list of adaptations of AA's Twelve Steps for people with drug problems other than alcohol: Potsmokers Anonymous

(1968), Pills Anonymous (1975), Cocaine Anonymous (1982), Nicotine Anonymous (1985), and Prescription Anonymous (1998), as well as special support structures for persons involved in medication-supported recovery (Methadone Anonymous, 1991) and those experiencing co-occurring disorders (Dual Recovery Anonymous, 1989; Double Trouble in Recovery, 1993). Second, there were a growing number of secular (Women for Sobriety, 1975; Secular Organization for Sobriety, 1986; Rational Recovery, 1986; SMART Recovery, 1994; and LifeRing Secular Recovery, 1999) (Plates Ten and Eleven), religious (Liontamers Anonymous, 1980; One AddictBOne Church, 1994), and cultural (Free N' One, 1987; the Native American Wellbriety movement) alternatives to AA. The late twentieth century also witnessed new adjuncts to AA (Jewish Alcoholics, Chemically Dependent People and Significant Others, 1979) and the first modern moderation-based mutual aid societies: Drinkwatchers (1970s), Methods of Moderation and Abstinence (1980s) and Moderation Management (1993) (Plate Twelve).

In Europe and Asia, AA and NA groups have continued to grow as have such alternatives as the Alcoholic Treatment Clubs (e.g., Italy, 1979). There is also a European trend toward the political organization of addicts as in the Junkie Bund (Germany, Junkie Union, 1970s) (Appel, 1996). In the United States, there has been a significant growth in grassroots recovery advocacy organizations (White, 2001b). These new organizations constitute a bridge from mutual aid into the arena of social policy advocacy (Plate Twelve). There are also trends toward the globalization of recovery mutual aid via the Internet, and the professionalization of the mutual aid movements via the rise of self-help clearinghouses and "consumer-run" service agencies (Oka & Borkman, 2000).

Particularly striking in this chronology are the long history, geographical range, and the growing varieties of addiction recovery mutual aid societies. The groups noted here differ markedly in their germinating conditions, missions (from a singular focus on mutual aid to broader political, cultural or religious agendas), core ideas, mechanisms of change, rituals of contact (from formal meetings to social clubs), gender representation, degree of family involvement, financing; level of inclusion/exclusion of professionals, degree of political advocacy, and responses to relapsed members. In spite of such diversity, there are universal themes within these groups, such as the dangers of mission diversion and professionalization, regardless of the cultural contexts in which they arise. As research increases on the role of mutual aid groups in long-term addiction recovery, so will interest in the history, practices and future of recovery mutual aid societies.

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Photo Plates

Plate One: Tenskwatawa, The Shawnee Prophet (Courtesy McKenney-Hall Portrait Gallery of American Indians)

Plate Two: Founders, Washingtonian Temperance Society (Courtesy Illinois Addiction Studies Archive)

Plate Three: Dr. Henry Reynolds, Founder, Royal Ribbon Reform Club (Courtesy Illinois Addiction Studies Archive)

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Plate Five: Keeley League members petitioning Pennsylvania legislature to provide funds for treatment of indigents (Courtesy James Oughton, Jr.)

Plate Six: Jerry McAuley, Founder, Water Street Mission (Courtesy Illinois Addiction Studies Archive)

Plate Seven: Patients of the first Swiss alcoholism program for women, founded 1892 (Courtesy Dr. Harald Klingemann)

Plate Eight: Early AA Members practicing anonymity at the level of press (Courtesy Illinois Addiction Studies Archive)

Plate Nine: Earliest Narcotics Anonymous literature (Courtesy NA World Services, Inc.)

Plate Ten: Dr. Jean Kirkpatrick, Founder, Women for Sobriety (Courtesy of WFS)

Plate Eleven: Marty Nicholas speaks on recovery without higher powers at the 2002 LifeRing Secular Recovery Conference. (Courtesy of LifeRing, Inc., Photographer, William Carpenter)

Plate Twelve: Moderation Management Booth at 2002 American Psychological Association Conference (Courtesy of MM)



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An Exploratory Investigation of the Association between Clinicians' Attitudes toward Twelve-step Groups and Referral Rates

Alexandre B. Laudet, PhD, William L. White, M.A.

Abstract

Affiliation with 12-step groups has been consistently linked to the achievement of abstinence among persons experiencing alcohol and other drug problems. Clinicians play a critical role in fostering clients' engagement in 12-step, yet, little is known about clinicians' attitudes and beliefs about 12-step groups, or about the association between such beliefs and referral practices. This exploratory study investigates this association to gain a greater understanding of determinants of referral practices. Participants were 100 clinicians working within outpatient treatment programs in New York City. Participants held highly positive views of 12-step groups in terms of helpfulness to recovery, but a large percentage endorsed items describing potential points of resistance to 12-step groups, in particular the emphasis such groups place on spirituality and powerlessness. More positive attitudes were associated with greater rates of referral, while resistance to the concepts of spirituality/powerlessness was associated with lower rates of referral. Implications of findings for clinical settings are discussed as well as a research agenda designed to more fully elucidate determinants of clinicians' 12-step referrals.

Key words: 12-step, self-help, referrals, attitudes, beliefs, clinicians, staff.

Introduction

Affiliation with twelve-step groups such as Narcotics Anonymous, both during and after treatment has been identified as a cost-effective and useful approach to promoting abstinence among persons experiencing alcohol- and other drug-related problems (Fiorentine & Hillhouse, 2000, Humphreys & Moos, 2001; Miller et al., 1997; Montgomery et al., 1995; Morgenstern et al., 1997; Project MATCH Research Group, 1997a; for reviews: Kownacki & Shadish, 1999; Tonigan et al., 1996). As a result of such findings, professional helpers across many disciplines are being trained to understand and to collaborate with mutual aid groups (Kurtz, 1997). This trend is

likely to grow in the addiction treatment arena as severe and persistent substance problems are conceptualized as chronic disorders best managed with the time-extended disease management techniques used in the treatment of other chronic conditions, such as hypertension, diabetes, asthma and chronic pain (McLellan, Lewis, O'Brien, and Kleber, 2000; White, Boyle and Loveland, 2002).

Role of Clinicians in Fostering 12-step Participation

Clinicians have long been recognized as playing a key role in substance users' treatment outcome (Najavits, 2002). Findings from a number of empirical studies indicate that clinicians appear to have more impact on client outcome than either type of treatment or patient baseline characteristics (e.g., Luborsky, McLellan, Diguer, Woody & Seligman, 1997; McLellan, Woody, Luborsky & Goehl, 1988; Najavits, Crits-Christoph & Dierberger, 2000; Project MATCH Research Group 1998). As access to and duration of formal services are reduced due to fiscal austerity and aggressive managed care, clinical outcomes may be increasingly influenced by the degree to which treatment programs actively support clients' transition into the post-treatment phase of recovery, including affiliation with 12-step or alternative mutual aid structures (Humphreys et al., 1999; Mankowski et al., 2001). Substance users' ambivalence about abstinence is a normal part of the recovery process (Miller & Rollnick, 1991), and clients entering addiction treatment may dismiss or reluctantly comply with the suggestion they attend mutual support groups. Findings from a recent study of attitudes about 12-step groups among substance users enrolled in outpatient treatment suggest that a large percentage of clients have little experiential knowledge of 12-step groups. Twenty-five percent of the clients surveyed were not sure about the potential benefits of 12-step groups and half did not know whether 12-step groups had any limitations or drawbacks (Laudet, 2003). Clinicians can play an important role educating clients about recovery mutual aid groups, redress misconceptions and concerns about such groups, suggest particular group meetings (e.g., meetings for newcomers or specialized meetings for women, gays and lesbians or veterans to name only a few), review different 12-step fellowships (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) and alternative recovery support structures (e.g., Women for Sobriety, Secular Organization for Sobriety, church-based recovery ministries).

The importance of referring clients to 12-step groups has been acknowledged by government agencies and by several professional organizations in their practice guidelines for substance-related problems. In 1988, the organization of the Surgeon General's Workshop on Self-Help and Public Health was designed to stimulate recommendations for how the self-help movement and the formal public health system might be mutually enhanced. The American Psychiatric Association (1995) has recognized the role of 12-step groups as an adjunct to treatment and noted that "referral is appropriate at all stages in the treatment process, even for patients who may still be substance users" (p. 11). More recently, the Practice Directorate of the American Psychological Association (1999) has issued similar guidelines describing 12-step groups as "a crucial part of any recovery program" and "a life-long resource for recovery after treatment ends."

In spite of the critical role clinicians can play in facilitating clients' engagement in 12-step fellowships, little is known about referral practices or their determinants. What little evidence is available about referrals suggests that clinicians do refer most of their substance-using clients to 12-step groups. For example, a large survey of treatment programs in the Veterans' Administration system indicated that 79% of clients were referred to Alcoholics

Anonymous, 45% to Narcotics Anonymous and 24% to Cocaine Anonymous (Humphreys, 1997). Further evidence for the important role that clinicians play in fostering 12-step engagement comes from an AA membership survey where one-half of respondents reported being introduced to the fellowship by a treatment staff (Alcoholics Anonymous World Services, 1998). Finally, the importance of treatment professionals' role in fostering 12-step participation is also underlined by a recent study concluding that the early pattern of 12-step attendance predicted continued meeting attendance over the course of six months of treatment (Weiss, Griffin, Gallop, Luborsky, Siqueland, Frank, et al., 2000).

Clinicians' Attitudes and Beliefs about 12-step Groups

With little known about clinicians' 12-step referral practices, even less is known about the basis for referral. Among the key determinants of human behavior are attitudes and beliefs (e.g., Fishbein, 1979). In a study conducted among graduate clinical psychology and social work students, Meissen, Mason and Gleason (1991) reported that attitudes about self-help groups predicted intention to collaborate with such organizations. In the addiction services field, little is known about clinicians' views of 12-step programs. Available findings suggest that they are generally favorable to 12-step groups (Freimuth, 1996; Laudet 2003). For example, results from a recent survey assessing staff members' beliefs about addiction treatment was conducted in Delaware prior to implementing NIDA's Clinical Trials Network; 82% of staff surveyed agreed that "12-step groups should be used more" (82%) and 84% that "spirituality should be emphasized more" (Forman, Bovasso, and Woody, 2001). These findings are interesting but limited– only a few general items are used to assess attitudes about 12-step in the context of studies with a broader investigative focus.

It is especially critical to learn more about what addiction services clinicians think and feel about 12-step groups because in spite of being the most frequently used resource for substance use-related problems in the US (Kurtz, 1990; Room and Greenfield, 1993; Weisner, Greenfield, and Room 1995) these fellowships have been and remain the subject of controversy. Several aspects of the 12-step recovery program have been identified as potential stumbling blocks for both substance users and clinicians (Chappel and DuPont, 1999; Laudet, 2000a). This is due to a multiplicity of factors. The program's emphasis on spirituality, surrender and powerlessness contradicts contemporary dominant western cultural norms of self-reliance and widespread secularism (Davis and Jansen, 1998) and constitutes stumbling blocks for many (Connors and Dermen, 1996; Klaw and Humphreys, 2000). Other points of resistance toward the 12-step program among treatment professionals include their lack of professionalism, lack of empirical support for their effectiveness, the risk that members become overly dependent on the group, that members get bad advice from other group members, and that the usefulness of these groups is limited in time (i.e., only needed in early recovery) or in scope (i.e., deals with only one substance while clients have multiple issues – for a review, see Chapel and Dupont, 1999). Some treatment professionals may also be concerned about the "dangers" and limitations of 12-step groups (e.g., Kurtz, 1997). Although many of these concerns and beliefs may be inaccurate or unfounded (e.g., Chapel and Dupont, 1999), they are widely held, may influence clinicians' referral practices and thus deserve empirical investigation. The purpose of this study is to explore clinicians' beliefs and attitudes about 12-step groups, and the association between these beliefs and referral practices.

Materials and Methods

Sample Study participants (N = 100) were recruited at five large inner-city outpatient drug-free (i.e., non-methadone) community licensed addiction treatment programs in New York City. All programs contacted agreed to participate. As in Humphreys' study of clinicians' referral to self-help (1997), all staff members who have clinical contact with clients were recruited to participate in the study. The study was introduced to staff as "a survey among professionals in the substance abuse treatment field [designed] to learn of their views about treatment and about other recovery resources." Participation was voluntary based on informed consent and it was anonymous (participants' names were not collected). The study was approved by NDRI's Institutional Review Board and by the review processes of the participating agencies. A federal Certificate of Confidentiality was obtained to protect data from intrusion. Data were collected using personal interviews conducted at the programs and lasting some 40 minutes; participants received $20 for their time. Data collection was conducted between May 2001 and January 2002. Refusal rate was estimated at 12 percent.[1]

M*easures* As mentioned earlier, there has been little empirical work on clinicians' views of 12-step. As a result, no standardized measures have been developed. Where feasible, we used items adapted from previous studies in related fields (adaptation consisted of changing wording from 'self-help groups' to '12-step groups'). Where no such measure was available, we developed items for this study as described below. In addition to participants' sociodemographic and background information (e.g., gender, race, education and professional training, length of current job tenure), the domains and measures used for this study were:

Attitudes about 12-step groups: (1) H*elpfulness of 12-step groups* was assessed using an item from Salzer et al.'s (1994) study of mental health clinicians' attitudes toward self-help groups: "In your professional judgment, how helpful/harmful are 12-step groups?" Scale: 0= Very Harmful, 10 = Very Helpful. Two other items were used: (2) How important a role do you believe 12-step groups can play *in comprehensive treatment system*? Rating scale ranged from 0 = not at all important, to 10 = extremely important; (3)"How important a role do you believe 12-step groups can play *in the recovery process*?" Same rating scale as previous item.

Beliefs about the controversial aspects of 12-step groups. We used a scale developed for this study and described in greater details elsewhere (Laudet, 2003). Briefly stated, a pool of items was generated from reviews the extant literature as well as from pilot interviews with both clients and staff members (Laudet, 2000b) and from statements previously used by Meissen and colleagues (1991) in a study of future clinicians' attitudes and intentions toward mutual-help groups (mentioned in the Introduction – e.g. "12 step groups can be dangerous because the leaders are not professionally trained"). After deleting redundant items, the final list consisted of 9 items presented in the Results section (Chronbach Alpha = .66). Respondents were asked: "Please indicate the extent to which you agree or disagree with each statement". The response categories were 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree. Principal components factor analysis with Varimax rotation produced three interpretable factors accounting for a total of 57% of the variance in the item responses. Consistent with prior literature on possible points of resistance to 12-step groups, the factors were labeled "Risks of participation,"

[1] Exact refusal rate is unavailable as the study's field records for the period of May-August 2001 were lost in our World Trade Center offices.

"Religion and powerlessness" and "Untrained leadership." The individual items and factor loadings are presented later in this paper.

Referral rate: Participants were asked *whether* they refer any of their clients to 12-step groups; clinicians who answered positively were asked *the percentage of clients they refer* to these groups. This variable, labeled "referral rate," is what is used in the analyses.

Interest in additional information about 12-step Several researchers have put forth that clinicians' knowledge of 12-step is often limited and that more training is needed toward a better understanding of 12-step and greater insight into its meaning (e.g., Caldwell, 1999; Caldwell & Cutter, 1998; Davis & Jansen, 1998; Humphreys et al., 1999; Wollert, 1999). In 1987, Kurtz and Cambon identified lack of information and understanding as the "most important factor in social workers' reluctance to refer clients to 12-step." More recent reviews of both professional social work journals (Davis and Jansen, 1998) and graduate university curricula in social work (Wollert, 1999) point to the absence of information about 12-step. Therefore, we wanted to assess their level of interest in obtaining additional information about these organizations and their recovery programs. We asked each participant, "How interested would you be in obtaining further training or information about 12-step groups?" The item was answered on a Likert-type scale where a higher score indicates higher interest (response categories: not at all, a little, moderately, very much, extremely).

Results

Sample Background

Sample characteristics are presented in Table 1. The sample was an experienced group of clinicians with diverse levels of educational attainment. Participants were mostly non-white females. Job titles were: counselor (44%), social worker (20%), case manager (17%), clinical supervisor (13%), and paraprofessional social worker (e.g., case aide – 6%).

VIEW TABLE 1

Attitudes towards 12-step groups

Participants generally held highly positive attitudes toward 12-step groups (Table 2) in terms of their helpfulness and importance to treatment and to the recovery process.

Beliefs about controversial aspects of 12-step groups. Percentage of participants who agree or strongly agreed with each of the statement are presented in Table 2. With the exception of two of the three items in the 'Untrained leadership" subscale, all the items received agree/strongly agree ratings from at least one third of participants. The three items endorsed by the largest proportion of clinicians were: risk of becoming dependent on 12-step groups (69% agree/strongly agree), risk of getting retraumatized or triggered to relapse (67%) and intensity of 12-step groups (57%).

VIEW TABLE 2

Referral Rates

All clinicians reported referring at least *some* clients to 12-step groups; the percentage of clients referred as reported by participants (referral rate) ranged from 10% to 100% (mean = 76%, St. Dev. = 36.8%).

Interest in 12-step Information

Participants expressed very high interest in obtaining such information: 37% were "extremely" interested and 49% "very much"; 7% 'moderately, 6% a little and 1% "not at all").

Bivariate Association among 12-step attitudes, beliefs and referrals

The three attitudinal items were strongly correlated (r = .80 between importance of 12-step groups to treatment and to recovery, r = .49 between helpfulness rating and importance to treatment and r = .62 between helpfulness rating and importance to recovery, all p

values p < .001). Therefore, a summary measure was computed and was used in the following bivariate analyses (Chronbach Alpha reliability coefficient for this summary score =.76).

Participants who held more positive attitudes toward 12-steps (on the summary measure) reported significantly higher rates of referral (r = .35, p<.01). Stronger endorsement of the Religion and Powerlessness subscale of the Controversial Aspects of 12-step Scale was significantly associated with lower referral rates, indicating that participants who expressed greater concern about the emphasis on religion and powerlessness reported referring fewer clients to 12-step groups (r = -.36, p<.01). The other two controversial aspect factors, Risks of participation and Untrained leadership, were not significantly associated with referral rates.

Discussion

Participants held highly positive attitudes about the helpfulness of 12-step groups, about the importance of these groups to the treatment system and to the recovery process, consistent with findings reported in prior studies (Forman et al, 2001; Freimuth, 1996). Referral rates were positively correlated with attitudes whereby greater perceived helpfulness and importance of 12-step groups was significantly associated with higher referral rates. The study also assessed clinicians' views on aspects of the 12-step program previously identified as potential points of resistance for both clinicians and prospective members. Findings indicated that a large percentage of clinician participants strongly endorsed statements describing these concerns. This was particularly true for items concerning the emphasis on religion and on powerlessness. Moreover, stronger endorsement of these items - stronger concern about these aspects of 12-step programs - were associated with lower referral rates. This finding is consistent with and extends that of a previous large-scale study conducted to examine the influence of patients' religiosity on whether they were referred to and benefited from 12-step groups (Winzelberg and Humphreys, 1999). Results showed that clients who engaged in fewer religious behaviors in the past year were referred to 12-step groups less frequently by clinicians than were clients with greater levels of religious participation. However, referrals to 12-step groups were effective at increasing meeting attendance, irrespective of patients' religious background, and all patients experienced significantly better substance abuse outcomes when they participated in 12-step groups. The authors concluded that the viewpoint that less religious patients are unlikely to attend or benefit from 12-step groups might therefore be overstated. On the other hand, it must be recognized that the 12-step emphasis on spirituality and powerlessness may be among the reasons why some substance users choose to not participate in these organizations; for example, in a small study conducted among 19 (white, highly educated and employed) members of Moderation Management, participants consistently attributed their decision to drop out of AA after attending only a few meetings to an aversion to the spiritual focus of the program and to conflicts with AA's concepts of surrender and powerlessness (Klaw and Humphreys, 2000).[2] Overall, while some substance users may not want to affiliate with 12-step groups because of the spiritual emphasis, clinicians should not assume that clients who are less religious will not affiliate with or benefit from 12-step participation. Instead, referral should include

[2] Two other areas of conflict were cited in the study: Feeling out of place among AA members because one's drinking problem that was less severe, and being unable to relate to unemployed, homeless or otherwise "down and out" members; Klaw and Humphreys note that Moderation management members surveyed were predominantly an "elite" of highly educated, employed, Caucasian persons.

information about how powerlessness and spirituality are applied in the context of 12-step recovery –e.g., powerlessness over drugs of abuse, not powerlessness over all aspects of one's life; one's definition of a Higher Power need not be religious (AA Big Book, Chap. 4: "We agnostics", 1976). Where feasible, clinicians should also inform clients about addiction recovery mutual aid groups other than 12-step fellowships (see later discussion).

In addition to endorsing spirituality and powerlessness as potential points of resistance to 12-step programs, a large percentage of participants in the present study agreed that members can be triggered to relapse in 12-step groups and can become dependent on such groups. In a study conducted to identify obstacles to 12-step participation among substance users in outpatient treatment, few (5%) participants cited the risk of being triggered to relapse and none mentioned the risk of becoming dependent on the group when asked about potential obstacles to 12-step attendance in an open-ended format (Laudet, 2003). However when asked in a structured format using the Controversial Aspects of 12-step Groups Scale used in the present study, 35% of outpatient clients agreed/strongly agreed that 12-step participation can trigger relapse and 55%, that members can become dependent on these groups. Neither question has ever been addressed empirically so it is difficult to assess how well founded such beliefs are. However, because these beliefs seem quite prevalent (among both clients and clinicians), clinicians should address them and other beliefs clients may express to determine their source (e.g., personal experience or hearsay) and to provide strategies that would minimize the risk of negative outcomes such as relapse and over-dependence on 12-step fellowships.

Finally, level of interest in obtaining additional information/training about 12-step group was very high among study participants. This finding is consistent with previous reports from a number of different sources. For example, of the 16 recommendations that emerged from the Surgeon General's Workshop on Self-Help and Public Health (1988), the incorporation of information and experiential knowledge about the concepts and benefits of self-help in the training and practices of clinicians was given *number one priority.* The need for training on self-help was also expressed unanimously by a sample of graduate students in clinical psychology and social work who were surveyed about their understanding and attitudes toward self-help: 97% agreed or strongly agreed that they needed more training on that topic (Meissen et al., 1991). Reviews of both professional social work journals (Davis and Jansen, 1998) and graduate university curricula in social work (Wollert, 1999) point to the absence of information about self-help. Lack of information and understanding has been identified as the "most important factor in social workers' reluctance to refer clients to self-help groups" (Kurtz & Chambon, 1987). Training and information about 12-step principles is particular critical. Twelve-step concepts are ubiquitous in the addiction field: 12-step principles are often integrated in treatment orientation, some clinicians in recovery are vocal proponents of the approach and clients are often well versed in the use of 12-step slogans ("Let go and let God," "Easy does it"). As a result, clinicians may feel they know more about 12-step recovery than they actually do because they are often surrounded by 12-step "lore." Familiarity with 12-step slogans and with the individual 12-steps does not mean one understands them as put forth by the founders of AA and as practiced within and outside 12-step meetings. Misunderstandings and inaccurate beliefs about the 12-step program are not prevalent only among clinicians (Chappel and DuPont, 1999); they are widespread, even among long-time fellowship members. As discussed earlier, the 12-step approach has been viewed as controversial and often remains misunderstood and misinterpreted in spite

of its popularity. As a result, those working with persons experiencing substance use problems "may need more information about 12-steps to determine their own interpretation and meaning of the controversies surrounding the program" (Davis & Jansen, 1998, p. 170). Only with accurate information can clinicians educate clients effectively about various 12-step programs. Our findings indicate that clinicians express high interest in obtaining such information.

The present study has several limitations. First, referral rates were assessed by self-report; however, the rates reported here are similar to those documented by Humphreys (1997) in a large treatment survey, lending credence to their accuracy. Second, the sample size (N=100) is relatively small; further, participants (mostly women and ethnic minorities) although typical of outpatient treatment staff in New York City where the study was conducted, are not representative of the addiction treatment workforce nationwide. Third, the study relied primarily on non-standardized measures of attitudes and beliefs about 12-step groups since none have been developed to date.

In spite of these limitations, results from the present study have important implications. First, present results point to the need to take clinicians' beliefs and attitudes into consideration when seeking to understand (or modify) their practices. Prior studies have concluded that clinicians' practices are critical to client outcomes (e.g., Luborsky et al., 1997; McLellan et al., 1988; Najavits et al., 2000; Project MATCH Research Group 1998, Sisson and Mallam, 1981) and 12-step referral practices are likely to be particularly important for clients' post-treatment recovery. The present study indicates that clinicians' attitudes and beliefs may constitute an important determinant of their referral practices. Additional research is needed to elucidate what clinicians think and feel about 12-step groups as well as whether these beliefs are consistent with 12-step philosophy and with the growing body of empirical research bearing on the effectiveness of 12-step groups, types of individuals who may need additional support to affiliate and effectiveness of various referral strategies (e.g., Sisson and Mallam, 1981).

Second, there is strong evidence, both from the present study and from previous reports, that clinicians need and want additional information about 12-step groups. This critical knowledge gap must be addressed. This would ideally take several forms including the integration of education on 12-step in academic curricula, in-service trainings at the treatment agencies, and greater coverage of the topic in professional social work and clinical journals. In addition, both AA and NA provide educational literature for professionals in written form and on their Internet sites. Of particular importance is the need to disseminate and explain empirical findings about 12-step participation (e.g., effectiveness and cost-effectiveness studies) since one of the criticisms of 12-step organization is that their effectiveness lacks empirical support (Chappel & DuPont, 1999). In order to come to their own conclusions about the controversies surrounding the 12-step program, clinicians should also be informed of the criticisms of 12-step programs. Finally, information about addiction recovery support groups that are not based on the 12-step program (e.g., Secular Organization for Sobriety, Women for Sobriety, faith-based recovery groups) including increasingly available Internet resources and literature should be reviewed by clinicians.

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Table 1- Sample Description (Return to article)

Male	29%
African American	61%
Hispanic (Puerto Rico)	23%
Education	
HS/some college	24%
Bachelors' degree	41%
Graduate degree	35%
Professional experience	
In current program (mean yrs, SD)	5.6 (4.7)
In treatment field (mean yrs, SD)	7.5 (5.9)

Table 2 – Clinicians' Attitudes and Beliefs about 12-step Groups (Return to article)

Attitudes about 12-Step Groups

Helpfulness of 12-step groups [a]	9.6 (1.1)
Importance of 12-step in comprehensive treatment [b]	9.3 (1.4)
Importance of 12-step group in recovery [b]	9.6 (1.0)

Controversial Aspects of 12-step Groups Scale [c]

	Agree/ Strongly Agreee	Factor Loading
Factor 1 Religion and Powerlessness	%	
12SGs can be too intense for some people	57	.77
Religious aspect of 12SGs is an obstacle for many	29	.72
Emphasis on "powerlessness" can be dangerous	29	.64
Factor 2 Risks of Participation		
Can get retraumatized or triggered in a 12SG	67	.87
12SGs can lead to pick up or relapse	39	.74
Can become dependent on 12SGs	69	.60
Factor 3 Lack of professionally trained leadership		
12SG meeting leaders dominate the rest of the group	16	.73
12SG should seek professional guidance	35	.79
12SGs can be dangerous: leaders are not professionally trained	14	.56

[a]Mean, SD: 0 = Very Harmful to 10 =Very Helpful.
[b] Mean, SD: 0 = not at all, 10 = extremely
[c] 12SG = 12-step groups



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Confessions of an A.A. History Buff

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In my years researching the history of addiction treatment and recovery, I have met many wonderful people, including some truly “colorful characters." I have particular affection for A.A. historians whose unrelenting investigations have constituted major contributions to the history of recovery in America. This column introduces the world of these investigators with a candid interview with Merton, one of the most dedicated and tenacious of these historians.

Merton, how did you first become involved in investigating the history of A.A.?

I got involved with A.A. history around 1990 as a purely personal quest. I wanted to know how the miracle of A.A. came to be. Reading Pass It On: The Story of Bill Wilson and How the A.A. Message Reached the World (PIO), I was surprised to discover that the book Alcoholics Anonymous was written in Newark, NJ. Living close by, I drove there to find the building where the book was written. Most of Newark was dilapidated at that time from a legacy of corrupt politicians and the summer riots of 1967. The 17-19 William St. building was boarded up and in shambles. However, it still sported a sleek black marble art-deco entranceway crowned with brushed metal letters spelling the word "Calumet" in Miami Vice font. I entered and made my way through the artifacts of the homeless, then navigated up 6 flights, being careful to avoid holes in the floor and two open elevator shafts. I finally reached Office 601, which according to PIO was the earlier office of Honor Dealers, or more formally Henry G. Parkhurst Inc. according to City Records. My mind whorled with fantasies of finding yellow-pad chapter drafts, a multilith copy or a first printing of the Big Book. Down the hall, the much smaller later Office 604 was brightly lit by sunbeams piercing the fallen window boards. I vividly remember saying to myself, "Wow, this is where it happened!"

I find something special in the places where historical events occurred, as if an invisible energy is timelessly etched there. This is particularly true with A.A. places. There was a special quality to the Calumet Building that one really can't put into words. Standing in this decaying wonderland, I felt

the presence of Ruth and Bill, Hank and Fitz, and the guy off the street, me. I got the bug then and there and have been enthralled with A.A. history ever since.

Are there individuals who have guided you through the promises and pitfalls of your historical investigations?

There have been many. Frank M., then archivist at A.A.'s General Service Office in New York, was my first contact. His encouragement was decisive in my continuation to explore. He provided redirection and focus to my work when I was consumed with "who did it first". I wanted to know if the first A.A. meeting was between Bill and Bob, or Ebby and Bill, or Rowland and Ebby. Noting my disturbance Frank asked if I knew what the "F" word was among A.A. historians. I said "NO". He said, "It is First". This is a valuable A.A. Historian concept. Others who provided guidance include Ernie Kurtz, the foremost authority on the history of A.A..; Mel B., who coauthored PIO, and helped me locate and gain acceptance from Hank P.'s family; Paul Lang, who served as the curator at Stepping Stones; Charlie Bishop, who was helpful in locating books related to A.A. history; and other A.A. historians such as Mitch K., Ken and Howard of the North New Jersey A.A. Archives, and the late Earl H. of Tulsa.

Much of the historical work on A.A. has focused on the life and influence of Bill Wilson. What has most impressed you about Bill Wilson as you have studied his life?

My research deemphasized Bill precisely because of that emphasis. That aside, two of the most notable dimensions of Bill's multifaceted character were his commitment to helping alcoholics and his open mindedness. From reading the Stepping Stones and GSO archives, I was struck by the single motive behind so much of what Bill did. He had an unwavering commitment to help the drunk stop drinking.

When I say "Open-minded" I mean it in the extreme sense of the word! It's my belief that without this level of open-mindedness (and sales ability) there would probably be no A.A. today. Consider the package he was dealt. He had to sell a book that had not been written about a process that had not been organized coherently regarding recovery from a condition that was considered medically incurable to the richest and most inquisitive group in the world, the Rockefeller Foundation. Even more challenging, it had to be sold to A.A. earliest members.

Bill's involvement in researching alcoholism treatment with LSD and niacin are profound examples of his open-mindedness. The former has brought some criticism. However, it seems quite unfair to criticize someone on this issue armed with hindsight. The experiments were the first into the substance by the still very active Dr. Abram Hoffer and the recently deceased Dr. Humphrey Osmond. The doctors were interested in it because it appeared to mimic schizophrenia. Bill was a member of the same research group, but was interested in it as a treatment for Alcoholism. Dr. Hoffer last ear cited a 40% success rate in recovery by alcoholics in this study. Bill abandoned the research before it entered the counterculture. Bill's vitamin B-3 studies were conducted later in conjunction with the same two doctors.

I've formed a hypothesis regarding Bill's later life. It is this: after A.A. "Came of Age" in 1955 and the fellowship was formally turned over to the members, Bill spent the rest of his life trying to find a solution for the alcoholic who A.A. couldn't seem to reach, and to delve into areas precluded from A.A. by Traditions.

Who do you think is the least acknowledged figure in the early history of A.A?

From the Eastern Branch history of A.A., which has been my focus, Hank P. would unquestionably merit that distinction. The current account of Hank staggering into the office to redeem his shares for drinking money is incorrect based on the extensive correspondence between the two at the time

What is sad is that the account has not been corrected. Bill was careful to minimize Hank's contribution in his own renditions. This was largely due to his fear of potential litigation stemming from representations he made to Hank about how proceeds from the book would be applied after the complete redemption of all stock and transfer of the book to the Alcoholic Foundation. Hank's failure to return to A.A. and his family's failure to set the record straight reinforce the adage that history is written by the winners. Under other circumstances, Hank might be referred to as A.A.'s third co-founder. I am pleased to have had the opportunity to interview Hank's family about his unrecorded contribution to the early history of A.A. and what happened with him after he left.

Have your investigations given you any clues as to the origin of the Twelve Steps?

Many say that the roots of the Twelve Steps came from the Oxford Group. To an extent this may be true and evidenced by Frank Amos' seven step account in his survey of the Akron Oxford Group's alcoholic members dated 2-23-38. Perhaps the greatest neglect regarding step source research has been with respect to the Jerry McAuley's Water Street Mission materials which I'll speak of below. When I read McAuley's three early books, the Steps jumped off the page at me.

It seems that A.A History buffs are interested in tracing the roots of almost every idea and practice within A.A.

Yes, nothing is sacred. We've even attempted to track down the origin of concerns about what is today known as the "Thirteenth Step." The thirteenth step refers to the concern over the danger that romantic sexual relationships pose to one's potential for success in the first year of recovery. Its documentation even preceded Bill's final enumeration of the Twelve Steps. Hank was the first eastern branch alcoholic who took hold of the program after Bill returned from Akron in 1935. He provided Bill with a handwritten list of ideas for what became the "Big Book". It included the topic of "sexual relapse" (also one of the earliest uses of the term "relapse" in recovery circles). A review of the marriage difficulties and drinking relapses of early eastern members suggests that these two problems were enmeshed. The serious business of getting sober in early A.A. was often interrupted by scenes resembling a soap opera. The first edition of the Big Book states that sober A.A. members were not the arbiters of anyone's sex conduct. Then it cleverly offers the metaphor of un-spiced and over-spiced food.

Your investigations led to some questions about A.A.'s founding date. Could you describe what you discovered and people's reaction to this discovery?

Good historians have to follow the evidence even if we don't like where that takes us, and even if others have a lot of emotion about what we are investigating. For example, I was advised by an editor reviewing my manuscript on early A.A. history to look into the events surrounding the Atlantic City AMA Convention in Atlantic City that immediately preceded Dr. Bob's last drink. The dates from the detailed AMA records didn't line up and Dr. Bob was not indicated as signing in to any one seminar or the Convention as a whole. There was a second time misalignment with respect to Sue Smith's very specific accounting of an argument with her father on the date of his return. He refused to give permission for her to attend a dance at a named school. Wally P., another A.A. historian, was going to Akron he offered to check the Akron Beacon Journal for the date of the dance at that school. It occurred exactly one week later. So the date was actually June 17, 1939.

The Convention dates alone were enough to reasonably discount the possibility of the June 10th date. However two independent simultaneous events reduce the odds of mistake to an almost statistical impossibility. Keep in mind we're trying to track the exact location of people who are drunk at a time more than sixty years ago It may seem surprising to go into

such myopic detail over such minute triviality, but that's precisely how history is reconstructed. Of course it is hard to do this work and not get emotionally involved on some level. This happens to even seasoned A.A. Historians who are used to finding such inconsistencies.

Do you ever use your own experience to try to sort out historical truths?

Yes. As one example Bill Wilson is said to have read The Varieties of Religious Experience by William James just prior to his "white light" experience and permanent sobriety. The book contains only two pages and one footnote dealing with alcoholism. I can't imagine anyone who has read this book honestly saying that it is possible that any alcoholic a few days out of the bottle, could make any sense of it. It seems more likely that Bill only read the brief alcoholism references that dealt with Jerry McAuley's Water Street Mission and S.H. Hadley's religious experiences that permanently removed their desire to drink. The descriptions of both Bill's and the McAuley/Hadley experiences are very similar and would be an accurate description of my own experiences. I think it natural to filter an account through our own subjective experience in arriving at what was in the minds of the people we explore. One can then estimate whether any particular account seems experientially honest.

Let me use a more risky but equally factual example about which there are two highly polarized but mutually exclusive accounts. One account states that Bill's LSD experiments were being investigated for the purpose of triggering or deepening a positive spiritual experience in new A.A. members to facilitate a deeper and more rapid recovery. The other account, stated by Dr. Hoffer recently, is that LSD was being investigated as a potential trigger to induce negative delirium tremens. Documents written by Bill at the time of the experiments indicate the former purpose. Here we can use the historical evidence to arrive at a choice of which account is most accurate.

There seems to be a growing interest in the history of A.A. among A.A. members.

Do you think the study of this history can strengthen one's recovery?

It will certainly put someone in touch with a great group of people.

What do you think is the ideal approach of the recovery historian?

There is no ideal approach, as each person will approach their investigations from their own perspective. My beliefs about the history of A.A. continue to evolve, sometimes dramatically. All writings on the subject come from the author's perspective, but the key to this work is finding the original material-the best evidence we can access and then document those sources. This is why our Archives are so important.

There is much physical evidence regarding A.A. history to be discovered and there is much to confirm, expand or refute in the available histories of A.A., including my own. "Seek and you will find" and "Absence of proof is not proof of absence" have been my core mottoes. Few A.A. historians take offence when proved wrong. The goal is to confirm what really happened as clearly as available evidence will allow. Above all it is fun and can be enjoyed at any level. Local archives always need help such as builders, chemists, artists, framers, computer specialists, historians, financiers, audiophiles, typists, artists and photographers. Anyone can find a role in uncovering and preserving this history.



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Twelve Defining Moments in the History of Alcoholics Anonymous

William L. White and Ernest Kurtz

Abstract

Misconceptions about Alcoholics Anonymous (AA) abound in spite of (or because of) the thousands of theses, dissertations, books, professional and popular articles, and Internet commentaries that have been written about AA. One of the most pervasive characterizations of AA is that it is a "treatment" for alcoholism—a characterization that distorts the meaning of both mutual aid and alcoholism treatment. This article describes 12 character defining moments in the history of AA that highlight the differences between AA and alcoholism treatment.

Introduction

There is a long history of recovery mutual aid groups that pre-date the founding of Alcoholics Anonymous—Native American recovery "circles"; the Washingtonians; Fraternal Temperance Societies; Ribbon Reform Clubs; institutional support groups such as the Ollapod Club, the Godwin Association, and the Keeley Leagues; and early faith-based recovery fellowships such as the Drunkards Club and the United Order of Ex-Boozers (White, 2001). There is a similarly rich history of modern adaptations and alternatives to Alcoholics Anonymous that include an ever-growing list of Twelve Step fellowships, as well as explicitly religious (e.g., Alcoholics Victorious, Overcomers Outreach, Liontamers Anonymous, Celebrate Recovery and Ladies Victorious) and secular (e.g., Women for Sobriety, Moderation Management, Secular Organizations for Sobriety, Rational Recovery, LifeRing Secular Recovery) frameworks for addiction recovery (Kurtz & Kurtz, 2007).

Alcoholics Anonymous (AA) has earned its place as the benchmark by which all other mutual aid groups are compared (Kurtz & White, 2003). That distinction is the product of AA's:

- Historical survival and longevity (White, 1998)
- Growth (nearly 2 million members and more than 106,000 local groups)(Alcoholics Anonymous, 2007)
- Geographical dispersion and accessibility (150 countries) (Alcoholics Anonymous, 2007)

- Role in inspiring larger social reform movements (Johnson, 1973; Roizen, 1991)
- Influence on the modern treatment of alcoholism and other drug dependencies (White, 1998), and its
- Influence on the popular culture (Room, 1989, 1993).

Because of its emergence as an enduring, international movement, AA has been subjected to a level of scrutiny beyond that of any of its predecessors or current rivals. In 1994, Pittman and Bishop published a bibliography of AA literature that listed more than 2,900 books, dissertations, theses and articles written on AA. Such attention, particularly scientific attention, has since increased, as has the literature of an AA backlash movement whose books/articles have spawned their own mini-industry (See the writings of Peele, Bufe, Ragge and Trimpey as illustrative examples) and Internet websites (e.g., http://www.orange-papers.org/orange-not_good.html, http://www.aadeprogramming.org/index_frames.html). Often responding to such public criticisms of AA are recently sobered and grateful alcoholics--the least qualified persons to speak about what AA is and is not, for given the value that AA places on humility and tolerance and its traditions of anonymity and non-involvement in outside issues, the AA member who is the first to step into the limelight to defend AA is by definition the least qualified to do so.

The ever-growing definitions of AA have reached a point where they tell us more about each author than about AA as an organization or a framework of alcoholism recovery (Miller & Kurtz, 1994). AA has been variably depicted as a society (Wilson, 1949), social movement (Room, 1993), culture of recovery (White, 1996), system of beliefs and speech event (Makela, et al, 1996); spiritual program (Miller & Kurtz, 1994), and a religious cult (Bufe, 1991). One of the most pervasive characterizations of AA is that of a "treatment" for alcoholism (Bebbington, 1976; Tournier, 1979; Emrick, 1989; Najavits, Crits-Christoph, & Dierberger, 2000; McGovern & Carroll, 2003).

In 1994, psychologist William Miller and AA historian Ernest Kurtz, wrote a seminal article noting popular and professional misconceptions about AA. Using AA's own literature, Miller and Kurtz challenged these misconceptions.

> *AA writings do not assert that: (1) there is only one form of alcoholism or alcohol problems; (2) moderate drinking is impossible for everyone with alcohol problems; (3) alcoholics should be labeled, confronted aggressively or coerced into treatment; (4) alcoholics are riddled with denial and other defense mechanisms; (5) alcoholism is a purely physical disorder; (6) alcoholism is hereditary; (7) there is only one way to recover; or (8) alcoholics are not responsible for their condition or their actions* (Miller & Kurtz, 1994, p. 165)

This chapter extends the work of Miller and Kurtz by using AA's own history to elucidate the essential character of AA. That historical evidence confirms that AA is not a treatment for alcoholism and that such a characterization distorts the

nature of and diminishes the potential value of both AA and alcoholism treatment.

There are moments in the lives of individuals, families, organizations and countries that can profoundly and permanently shape character and identity. Each of the following seminal events in the history of Alcoholics Anonymous offers a window of insight into those dimensions of character that separate AA from other recovery mutual aid groups and from professionally directed alcoholism treatment. Unless otherwise noted, the historical incidents described are drawn from four AA publications which will be subsequently referenced using their acronyms, *Alcoholics Anonymous Comes of Age (AACA)*, *'Pass It On': The Story of Bill Wilson and How the AA Message Reached the World (PIO)*, *Dr. Bob and the Good Oldtimers (DBGO*) and *Twelve Steps and Twelve Traditions* (TSTT), and Ernest Kurtz's scholarly study, *Not-God: A History of Alcoholics Anonymous*.

1. Jung's Refusal

In 1926, Rowland Hazard, a Yale graduate and prominent Rhode Island businessman, was treated for alcoholism by the renowned psychoanalyst Carl Jung (Bluhm, 2006). Following a relapse in 1927, Hazard requested further treatment from Jung. Jung refused this request on the grounds that Hazard had received the best of what psychiatric and medical science had to offer and that hope for future recovery would have to be found elsewhere. In this communication with Hazard, Jung added that the rabid appetite for alcohol had been quelled in some alcoholics through the medium of a powerful spiritual or religious experience. He suggested Hazard seek such an experience. That recommendation led to Hazard's subsequent involvement with the Christian evangelical Oxford Group. Sobered within the Oxford Group, Rowland Hazard began carrying his message of hope to other alcoholics. In November1934, Hazard carried such a message of hope to Ebby Thacher. On the verge of being sentenced to Windsor Prison, Thacher was instead released to Hazard's custody. In late November 1934, the newly sobered Thacher carried that same message of hope to his long-time friend Bill Wilson. Thacher's visits created no instantaneous conversion, but they did start a new "internal dialogue" that triggered a crisis in Wilson's drinking and served as a catalyst for the subsequent events that marked the founding of Alcoholics Anonymous (PIO, 1984, p. 115).

The Jung-Hazard-Thacher-Wilson chain of interactions mark the earliest catalytic moments in the founding of Alcoholics Anonymous. Jung brought an affirmation of the limitations of professional assistance in recovery from alcoholism, and he added professional legitimacy to the transformative power of spiritual experience. The Hazard-Thacher-Wilson connections established the "kinship of common suffering" (one alcoholic sharing with another alcoholic) as the basic unit of interaction in the yet-to-be-born organization of AA (AACA, p. 59). Sociologist Frank Riesman (1965, 1990) later described the potential catalytic, self-healing effects of helping others as the "helper principle."

The legitimacy of the helper in the Hazard-Thacher and Thacher-Wilson relationships came not from the kind of external authority that Jung and other service professionals possessed, but from "experiential knowledge" and

"experiential expertise" (Borkman, 1976). Credential verification came not from a university registrar's office, but through a presentation and acceptance of one's own life story. Stanley Jackson (2001) recently noted of this "wounded healer" tradition: "They have established their credentials as persons who know first-hand about suffering, who have suffered and emerged from the experience stronger and wiser, and who have the capacity to serve others as healers of souls" (p. 6). The Hazard-Thacher-Wilson relationships were built on a foundation of moral equality, emotional authenticity and a profound level of mutual empathy and identification.

The Hazard-Thacher-Wilson chain also offers the first evidence we have of the coming importance of story construction and storytelling in AA. AA's unique storytelling style was described as follows in 1939, "Our stories disclose in a general way what we used to be like, what happened, and what we are like now" (Alcoholics Anonymous, 1939, p. 70). What one offers in interactions within AA is not "feedback," "counseling," "treatment" or even "advice", but one's own "experience, strength and hope" couched in the form of story. Within AA, this distinctive style of interaction evolved into what Borkman (1999) has described as the "sharing circle"—an egalitarian exchange of life stories detailing the experiences of alcoholism and alcoholism recovery. Such storytelling was institutionalized as a form of spiritual communion within the fellowship of AA.

As people in recovery assumed paid roles as alcoholism counselors and as this role became progressively professionalized, self-disclosure of their recovery status and their recovery stories became viewed as "unprofessional" and a sign of "poor boundary management" (White and Popovits, 2001). The differences in the relationship between counselor and the client in alcoholism treatment and the relationship between AA member and AA member, as well as the sponsor and sponsee relationship, was further widened when AA promulgated guidelines for AA members working in the alcoholism field (A.A. Guidelines…, ND). The attributes identified in these Guidelines that were seen as essential for working professionally in the alcoholism field were defined, not in terms of technical skill, but in terms of the ability to maintain clear role separation and in terms of such traits as faith, courage, self-discipline, humility, patience and tolerance.

2. A "Hot Flash" and Failed Evangelism

Following Ebby Thacher's visits, Bill Wilson's drinking reached another point of crisis and on December 11, 1934 he was re-hospitalized for detoxification at the Charles B. Towns Hospital in New York City. At age 39 and unbeknownst to him, Bill Wilson had taken the last drink of his life. A few days into this belladonna-facilitated detoxification, Wilson, a confirmed agnostic, underwent a profound spiritual experience in the aftermath of a deepening depression:

> *The last vestige of my proud obstinacy was crushed. All at once I found myself crying out, "If there is a God, let Him Show Himself! I am ready to do anything, anything!" Suddenly the room lit up with a great white light. I was caught up into an ecstasy which there are no*

> *words to describe.... And then it burst upon me that I was a free man.....All about me there was a wonderful feeling of Presence, and I thought to myself, "So this is the God of the Preachers!" (Alcoholics Anonymous, 1957).*

Later questioning whether he was losing his sanity, Wilson described the experience to his physician, Dr. William Silkworth. Silkworth, known in AA folklore as "the little doctor who loved drunks," framed the event as a potential conversion experience.

> *No. Bill, you are not hallucinating. Whatever you got, you had better hang on to; it is so much better than what you had only an hour ago. (AACA, 1957, p. 13)*

What easily could have been understood as an organic psychosis or a toxic side effect of medication was instead interpreted by Silkworth as a potentially life-transforming spiritual experience.

Bill Wilson's "Hot Flash" as it came to be known within AA—drawn from a popular phrase used in the mid-twentieth century to convey a sudden idea of great value or a life-changing event or experience--is important in several ways in the larger story of AA. It further validated that medical care for alcoholism was necessary but in itself insufficient (a fact confirmed by Wilson's prior hospitalizations), and that spiritual experience could open a pathway to long-term recovery. Wilson's experience at Towns' Hospital established early in AA history the potential for what psychologists today describe as "quantum" or "transformational" change—a sobering personal transformation in identity and character that is unplanned, vivid, positive and permanent (Miller & C'de Baca, 2001; White, 2004). Dr. Silkworth's response to Wilson's transformational change experience also underscored the limits of medical/psychiatric treatment and, like Jung's earlier response, set a precedent for professional humility and respect for the potential role of spirituality in alcoholism recovery.

In the months following his discharge, Bill Wilson tried to sober up the world, but the drunks at the Towns Hospital and Calvary mission to whom he described his Hot Flash were uniformly unimpressed and unmoved. Wilson eventually discovered that others would achieve successful recovery through a quite different process. This imbedded the idea of the varieties of recovery experience within AA's earliest history and led Wilson to later affirm that "the roads to recovery are many" (Wilson, 1944). The distinctions between and legitimacy of a climactic "spiritual experience" and a slower process of "spiritual awakening" were judged to be important enough to later discuss in a special appendix of the book *Alcoholics Anonymous*.

Bill Wilson himself soon discovered on a visit to Akron, Ohio that undergoing a profound spiritual experience does not automatically silence the siren call of the bottle.

3. Panic at the Mayflower Hotel

In May 1935, Bill Wilson, demoralized at the end of a failed business trip, found himself in the lobby of the Mayflower Hotel fearing that he might take a drink and destroy his hard-earned sobriety. His sense of what he needed to prevent his return to drinking

was not to reach out to a professional, but to find another alcoholic with whom he could talk. A series of phone calls led him to Dr. Robert Holbrook Smith who was at that time struggling with his own alcoholism. Their growing friendship, mutual support and vision of helping other alcoholics marked the formal ignition of AA as a social movement. The date of Dr. Bob Smith's last drink in June of 1935 is celebrated as AA's founding date.[1] Soon after that last drink, Bill Wilson and Dr. Bob Smith began the search for AA number three.

The mutual discovery that Bill Wilson and Dr. Bob Smith could achieve together what they had failed to achieve alone became the glue that held AA together. The discovery that the gift of sobriety could only be retained by giving it to others rose to consciousness in these earliest days of AA. The call from the Mayflower Hotel was the first incident in AA history in which an alcoholic picked up a telephone rather than a drink, affirming the potential of replacing dependence upon a drug with interdependence between members of a recovering community. This event also set the basic relationship within AA as one in which no member could claim moral superiority over another.

There are several aspects of this early encounter that distinguish it from other relationships intended to help the alcoholic. Facing the most severe test of his early sobriety, Wilson sensed that he needed, not professional counseling, but the communion that comes from shared experience and mutual vulnerability. The Wilson-Smith relationship was voluntary as opposed to coerced, reciprocal (service to others as service to self) as opposed to fiduciary (one party having obligation to care for the other), sustained as opposed to transient, personal as opposed to paid, and free of even a whisper of contempt. An event in New York soon threatened the future of these critical characteristics.

4. Professionalism: AA's First Temptation

By late 1936, fledgling groups of recovered alcoholics were meeting within the larger framework of the Oxford Group in Akron, Ohio and the New York City area. Bill Wilson was staying sober and laboring full time to spread what would become the AA movement, but a crisis was brewing in terms of the poverty in which he and his wife Lois were living. It was in this circumstance that Charles B. Towns, owner of the Towns Hospital where Wilson had repeatedly been treated and whose corridors he now roamed trolling for drunks who might be interested in his nascent program, offered Wilson paid employment at the hospital as a "lay alcoholism therapist." Wilson's first instinct was that this was the perfect solution to his financial straits and his desire to work full time to spread this new message of hope to alcoholics. There was after all a precedent for this lay alcoholism psychotherapy role. Towns' offer to Bill Wilson was preceded by a tradition of distinguished lay therapists in the alcoholism arena that included Courtenay Baylor, Francis Chambers, and, most importantly, Richard Peabody whose book, *The Common Sense of Drinking*, was currently popular. Bill Wilson could have easily become part of this growing network of lay therapists.

[1] That date has been celebrated on June 10, but recent historical research suggests the date of Dr. Bob Smith's last drink was probably June 17, 1935 (White & Merton M., 2006).

The response of his fellow recovering alcoholics to Bill Wilson's employment opportunity marked one of the first examples of what would come to be called "group conscience" in Alcoholics Anonymous. The group rejected the idea on the grounds that their emerging fellowship could be hurt by tying itself to a hospital and that Bill's accepting a paid position could destroy this fledgling community of recovered alcoholics. "Why should we do for nothing what you'd be getting paid for? We'd all be drunk in no time" (PIO, 1984, p. 177). Eventually convinced of the wisdom of what he was hearing, Wilson turned down the Towns' offer. In that act, even before the young fellowship had found its own name, Alcoholics Anonymous escaped its first temptations: professionalism and the potential use of AA by an AA member for personal financial gain. By defining itself as a spiritual program, the fellowship declared that its most essential elements were not for sale. In retrospect, one can only speculate on what might have happened had Bill Wilson accepted the proffered patronage of Charles Towns and his hospital.

By the end of 1937, the fellowship had 40 sober members. At this point, one man seeking entrance tested its character and indeed its very soul.

5. Who can be an AA member?

In 1937, a man approached the numerically larger Akron group to inquire about possible membership. He ended his appeal with the following words,

> *But will you let me join your group? Since I am the victim of another addiction even worse stigmatized than alcoholism, you may not want me among you. Or will you?* (TSTT, 1981, p. 142).

The question of inclusion was not whether this man was an alcoholic. It was that he was homosexual. In the social climate of the late 1930s, this question set the group conscience of to boiling. Initial concerns were raised about how this could bring disgrace to the fellowship and keep some people from seeking its help. There was precedent for such exclusion. Some nineteenth century recovery mutual aid societies developed membership criteria that excluded all but "reputable drunkards" (White, 1998). An emerging AA was on the verge of just such a decision. Bill Wilson later explained how the deadlock was broken.

> *And finally the day of resolution came. A bunch of us were sitting in Dr. Bob's living room, arguing. What to do? Where upon dear old Bob looked around, and blandly said, 'Isn't it time folks to ask ourselves, "What would the Master do in a situation like this?" Would he turn this man away? And that was the beginning of the AA tradition that any man who has a drinking problem is a member of AA if he says so, not whether we say so*. (Borden, 2007, p. 18).

When AA experienced rapid growth in early 1940s and before the Twelve Traditions had been created to govern its organizational life, it was not unusual for local groups to develop all manner of membership criteria and even to blackball some seeking membership (White, 1998; Wally P., 1995).

> *So beggars, tramps, asylum inmates, prisoners, queers, plain crackpots, and fallen women were definitely out. Yes sir, we'd cater only to pure and respectable alcoholics! Any others would surely destroy us….We built a fine mesh fence around A.A.* (TSATD, 1952, p. 140).

As groups began to communicate with each other, it became clear that, "If all those rules had been in effect everywhere, nobody could have possibly joined AA…" (TSTT, 1952, p. 140). The 1937 Akron principle prevailed and was later codified in AA's Third Tradition. The phrase "honest desire to stop drinking" in the original 1939 statement of AA's singular membership requirement was simplified in 1949 to "desire to stop drinking" to assure inclusiveness.

This milestone marks an important contrast between AA and alcoholism treatment organizations. Where the latter would evolve elaborate admission criteria that served as exclusion as well as inclusion criteria and the practice of administratively discharging clients who lacked sufficient motivation or drank following their admission, AA's threshold of engagement was simple but non-negotiable. No one within or outside AA had the authority to bar entrance to AA or throw someone out of AA as long as a single criteria was present: a desire to stop drinking.

6. A Rich Man's Warning about Money

Bill Wilson's decision not to accept the offer of employment at Towns Hospital did not quell his larger vision of AA missionaries and AA hospitals—a vision that continued to propel his search for philanthropic funds to support a growing AA. The quest for financial support led in February 1938 to a meeting with the staff of John D. Rockefeller, Jr. Rockefeller was widely known for his philanthropy and his support for other projects that had sought to address alcohol-related problems. After reviewing AA's past work and future plans and the recommendation of his staff to provide $50,000 in funding to AA, Rockefeller expressed his fear that money might harm this quite remarkable movement (Kurtz, 1991). Rockefeller's hesitance was his concern that material assets could corrupt the spiritual nature of the rising AA movement.

Rather than provide the requested $50,000, Rockefeller placed $5,000 in the treasury of Riverside Church to provide temporary financial support for Dr. Bob Smith and Bill Wilson. Today, one could only speculate how receipt of $50,000 in 1938 (the equivalent of over $600,000 today http://www.westegg.com/inflation) would have shaped the subsequent organization and core values of AA as well as its historical fate. AA might have easily morphed into just one more service agency if such funding would have necessitated a board of directors, a paid director, a paid service staff, the inimitable policy and procedures manuals and financial/service reporting systems and future licensing and accreditation processes. AA co-founders later reflected that Rockefeller's refusal had saved them from themselves. The fellowship's pledge of corporate poverty is in marked contrast to a multi-billion dollar addiction treatment industry and the pressure addiction treatment organizations experience to maintain and increase their revenues.

7. The Split from the Oxford Group

Between 1935 and 1937, the growing number of sobered alcoholics (the "alcoholic squadron") that constituted AA's first generation continued to meet within the larger framework of the Oxford Group (OG), but there was strain in the relationship between alcoholic and non-alcoholic OG members, particularly in New York City. Bill Wilson was criticized for his pre-occupation with alcoholics, and alcoholics at the OG-affiliated Calvary Mission were discouraged from attending meetings at Bill Wilson's Clinton Street home. Wilson would later say of this tension, "The Oxford group wanted to save the world, and I only wanted to save drunks" (Kurtz, 1991, p. 44). Differences in their central missions, core beliefs and meeting rituals eventually led to a split between the OG and AA. That split occurred in New York in 1937 and in Ohio in 1939, but a distinct AA identity did not gel until 1939. The first meeting independent of the OG that called itself Alcoholics Anonymous occurred in Cleveland on May 18, 1939.

The departure from the OG was another critical milestone in AA history for several reasons. First, the split affirmed that whatever this new group was, it was not a religion, nor did it have any religious affiliation: "We are not allied with any particular faith, sect or denomination, nor do we oppose anyone." (Alcoholics Anonymous, 1939, p. viii). This transition opened the doors of entry to AA to future generations of alcoholics of multiple faiths and of no faith. Second, in breaking with the OG, AA emancipated spirituality from its religious roots in a manner later self-characterized as "spiritual but not religious." AA forged what it was, in part by figuring out, via group conscience, what it was not.

The centrality of spirituality is a distinct feature of AA. Alcoholism treatment institutions and practitioners may talk about the role of spirituality in alcoholism recovery, but few would claim that spirituality is the core of their approach to treatment. AA unashamedly claims just that. That stance separated AA from alcoholism treatment and from later explicitly religious and explicitly secular recovery mutual aid societies.

8. "Here are the steps we took…"

Plans for a book describing their program of recovery proceeded in tandem with the growth of sober members. As AA separated from the OG, its members articulated six principles adapted from the OG that had guided their recoveries:

1. We admitted that we were licked, that we were powerless over alcohol.

2. We made a moral inventory of our defects or sins.

3. We confessed or shared our shortcomings with another person in confidence.

4. We made restitution to all those we had harmed by our drinking.

5. We tried to help other alcoholics, with no thought of reward in money or prestige.

*6. We prayed to whatever God we thought there was for power to practice these precepts.. (*AACA, 1957, p. 160)

In December 1938, Bill Wilson expanded these six principles to twelve steps that reflected the experience of AA's earliest members. These steps were included in the crucial fifth chapter of what came to

be known as AA's "Big Book." Refinements resulting from group discussions were made in the wording of the steps and a prologue was later added that stated, "Here are the steps we took, which are suggested as a program of recovery" (Alcoholics Anonymous, 1939, p. 71)

The codification of the AA program in book form was a central vehicle for the diffusion of AA and the crucial means of maintaining the integrity of the AA program as Alcoholics Anonymous experienced explosive growth in the years following the book's publication. The decision that the fellowship would publish its own materials also heightened its organizational autonomy and generated a substantial portion of the income that would support its central service structures. A critical examination of AA's Twelve Steps further underscores the differences between AA and the professional treatment of alcoholism.

Professional treatments for alcoholism purport to be theory-grounded, science-based, professionally delivered and supervised, and externally accountable (to a variety of regulatory and funding bodies). AA's Steps and the larger body of literature in which they are imbedded have little to say about alcoholism, its etiological roots or its treatment. The steps and all other AA literature focus instead on the experience of the alcoholic. What statements that can be found on the etiology of alcoholism and on alcoholism recovery depict alcoholism as a malady of spirit and character (e.g. "self-centeredness"; "self-will run riot") and its resolution as a spiritual rather than medical or psychological process (Kurtz, 2002). Alcoholics Anonymous makes no claim to scientific truth; it claims only the lessons of collective experience. AA's Steps are not intervention protocol performed by and supervised by professionals, but actions taken by members who are achieving the goals of sobriety and serenity. The "we" and "our" in AA's steps refer not to a relationship between a therapist and a client, but relationships within a community of recovering people. Where the centerpiece of treatment is made up of clinical protocol and the professionals who deliver it, the centerpiece of AA is the shared experiences of and interpersonal relationships between its members as they seek resources within and beyond themselves to quell the appetite for alcohol.

AA's steps focus not on treatment offered by others, but on the actions taken by alcoholics that have resulted in successful recoveries. Treatment, in the alcoholism context, is what a professional administers to an alcoholic. Recovery, in this same context, is what the alcoholic experiences on his or her way to health and wholeness. The relational context of the Steps is not one of professional therapy, but one of mutual support. The actions suggested in the Steps are ones taken not in the context of professional treatment, but in the context of membership in a community of shared experience.

9. Growing Pains

The speedy decline of the Washingtonians following their rapid growth to more than 400,000 members in the early 1840s confirmed the dangers posed by the sudden growth of recovery mutual aid societies (White, 1998). Alcoholics Anonymous experienced both local and national surges in membership

in the 1940s. This growth was generated in great part by early media coverage: a September 1939 article on AA in *Liberty Magazine,* a series of *Cleveland Plain Dealer* (in October and November) of that same year, and newspaper sports page coverage of the spring 1940 announcement that the Cleveland Indians star catcher had joined AA. This early visibility was followed by a *Saturday Evening Post* article in March 1941 that led AA's membership to grow from 2000 members to 8000 members in that year alone. AA learned several lessons during this first period of dramatic growth.

The calls coming into AA in Cleveland were so great that members with minimal sobriety time were asked to make Twelve Step calls. When both the newly sobered and their new recruits stayed sober, Alcoholics Anonymous learned that its message could be conveyed by very imperfect messengers. AA also learned that it could grow by expansion or by at times a more conflictual cell division. The inevitable personality tensions that emerged during the rapid induction of new members spawned new meetings and triggered the adage, "The only things required to start a new AA meeting are a resentment and a coffee pot."

Early AA members found creative ways to reach alcoholics in communities that did not yet have local meetings. Letter writing and visits by AA members who traveled as part of their jobs were particularly relied upon to reach those in need. The dissemination of the book, *Alcoholics Anonymous*, played a pivotal role in spreading AA's message. A unique approach to inducting new members (sponsorship) also emerged in Cleveland and was rapidly diffused throughout AA. By 1944, Alcoholics Anonymous had learned that as an organization it could survive rapid growth and in the process began to see itself as a movement that could spread throughout America and beyond. AA's self-awareness as a growing social movement heightened the difference between AA and professional treatment, but the question remained whether AA would need a paid professional class and special institutions to support this growing movement.

10. AA and the Business of Alcoholism Treatment

Alcoholics Anonymous faced a critical challenge in the late 1930s and early 1940s. Most alcoholics reaching out to it were in late stages of alcoholism. Alcoholics in such a state could and did die from alcohol withdrawal. Yet helping professionals generally eschewed work with alcoholics, and many hospitals had morality clauses that refused admission to alcoholics. These were the conditions that contributed to Bill Wilson's early vision of AA missionaries and AA hospitals. Rockefeller's refusal to provide $50,000 to AA tempered but did not eliminate this vision. AA members who were part of the medical profession (e.g., Dr. Bob Smith in Akron and Teddy R. in New York City) had helped open alcoholism treatment units in local hospitals, and AA committees were organizing alcoholism services in what has been described as the *Knickerbocker Paradox*. At the Knickerbocker Hospital in New York City, AA members remodeled a newly opened alcoholism unit. AA members had admitting privileges and visited patients daily in the unit. Patients were only discharged to AA sponsors. And yet local AA declared that

AA had no official role in Knickerbocker's alcoholism treatment unit—developing a clear distinction between what was done by AA as an institution and what was done by AA members either individually or collectively (White, 1998).

The closest AA itself came to owning and operating a hospital for the treatment of alcoholism was in Cleveland in the early 1940s. Several occurrences moved AA members to abort this effort, including the sudden illness of the individual raising funds for the project, but in the end it was the AA's group conscience that ended the vision of paid AA missionaries and AA hospitals. After the collapse of the Cleveland project, AA's position on such outside projects hardened. As one AA trustee declared, "Better do one thing supremely well than two things badly" (Quoted in White, 1998, p. 164). This position was soon expanded:

> *Neither A.A. as a whole nor any A.A. Group ought to enter any other activity than straight A.A. As groups, we cannot endorse, finance or form an alliance with any other cause, however good…. But, if these projects are constructive and non-controversial in character, A.A. members are free to engage in them without criticism if they act as individuals only, and are careful of the A.A. name (Dangers in Linking A.A…., 1947).*

What emerged within AA was an understanding that Alcoholics Anonymous was not a treatment for alcoholism and that treatment for alcoholism was an outside endeavor to which AA should not be formally linked. The view of the distinction between AA and treatment became most clear in a crisis at High Watch Farm.

As noted earlier, many AA members acting as individuals helped establish hospital-based alcoholism treatment units and volunteered or were employed in such units. AA members were also involved in non-hospital settings that provided post-detoxification rehabilitation—places referred to as "AA farms" or "AA retreats" until AA objected to such designation. High Watch Farm was a retreat in Kent, Connecticut where, beginning in 1940, AA members could initiate or strengthen their recovery from alcoholism. A small board of AA members, including Bill Wilson and Marty Mann, oversaw the management of High Watch. Daily operations were directed by Ray C., who provided a structured program of lectures, assigned reading, meditation and AA meetings. But Ray C. was a psychologist and the spiritually-grounded philosophy of the High Watch soon drifted from AA immersion to an increasingly psychological approach, leading to tension between the manager and the board (Harbaugh, 1995). This conflict eventually led to the resignation of Marty Mann from the board. Her resignation letter offers a window into the growing distinction between AA and treatment in the 1940s.

> *At Blythewood, a particular method of treatment, psychiatry, was used by one man, Dr. Tiebout, to help me get well. At the Farm, now, a particular method of treatment (the word is Ray's own: one might call it metaphysical psychology…) is being used by one man, Ray C_____, to help others get*

> *well. I repeat: I have nothing against either method of treatment. But they belong in one classification; and the Farm as it used to be, and A.A. as it is, belong in another....* **(**White, 1998, p. 174).

The boundary between treatment and AA again threatened to become blurred in the late 1940s and early 1950s with the development of the "Minnesota Model" of alcoholism treatment. This model incorporated AA principles and practices into treatment, hired AA members as alcoholism counselors and spawned a halfway house movement that also relied heavily on a Twelve Step philosophy. The 1950s mark the beginning of AA's profound and widespread influence on alcoholism treatment—an influence that grew as the Minnesota Model was replicated across the United States and indeed the world in the 1970s and 1980s. To avoid potential misunderstandings about the distinction between AA and professional alcoholism treatment, AA discouraged the use of names for institutions (e.g., "Twelve Step House") and roles (e.g., "AA Counselor" "Two-Hatter") that conveyed affiliation or sponsorship by AA. This experience also led AA's General Service Office to issue special guidelines for AA members who worked in the professional alcoholism field (Alcoholics Anonymous, ND).

As AA concepts and treatment concepts became increasingly blurred in the 1990s, there was growing concern within Alcoholics Anonymous about the effect treatment was having on the fellowship and even its program. (The percentage of people entering AA via referral from treatment increased from 19% in 1977 to 40% in 1989. Makela, et al, 1996). AA old-timers lamented the distortion of AA spirituality with what they perceived as the pop psychology of alcoholism treatment, complained that some AA meetings were turning into group therapy sessions filled with pained confessions and discussions of "codependency issues" and how to get in touch with one's "inner child," and expressed fears that the growth in treatment had weakened the service ethic within AA.

This infusion of treatment language and concepts into Alcoholics Anonymous prompted historian Ernest Kurtz (1999) to define "real A.A" as represented in the fellowship's own experience and literature. He suggested five criteria through which authentic AA meetings could be identified: 1) the use of a language of spirituality (as opposed to the vocabulary of therapy), 2) humor and appreciation of paradox, 3) the distinctive AA story style ("what we used to be like, what happened, what we are like now"), 4) respect for the Twelve Traditions, and 5) an experience of community (based on members' *need* to be there).

11. The NCEA Affair

In 1944, Mrs. Marty Mann, one of the first women to get sober in AA, developed a personal vision that would change America's perceptions of alcoholism and the alcoholic. To fulfill this vision, she created the National Committee for Education on Alcoholism (NCEA)—precursor to today's National Council on Alcoholism and Drug Dependence. Mann proposed five ideas as the centerpiece of her public education campaign:

1. Alcoholism is a disease.

2. The alcoholic, therefore, is a sick person.
3. The alcoholic can be helped.
4. The alcoholic is worth helping.
5. Alcoholism is our No. 4 public health problem, and our public responsibility (Mann, 1944, p. 357)

Mann and NCEA went on to establish local branches that 1) conducted public education campaign on alcoholism, 2) encouraged local hospitals to admit alcoholics for acute detoxification, 3) established alcohol information centers, 4) established clinics for the diagnosis and treatment of alcoholism, and 5) created "rest centers" for the long-term care of alcoholics (Mann, 1947, p. 255).

Several things for a time blurred the boundary between AA and NCEA. First, Mann started NCEA with the blessings of AA's co-founders, broke her AA anonymity in her NCEA role (initially with the permission of Bill Wilson), and talked extensively about AA in her non-stop lectures around the country. Second, the names of Bill Wilson and Dr. Bob Smith appeared on the NCEA letterhead, suggesting an affiliation between AA and NCEA. This blurring of boundaries reached a point of crisis in 1946 when NCEA sent out a solicitation of funds on the letterhead bearing the Wilson and Smith names. The storm of protest from local AA members prompted the conclusion that "total non-affiliation was the only solution" to AA's relationship with other organizations (PIO, 1984, p. 320).

The NCEA affair confirmed three things. First, it established that AA is not an organization whose focus includes public education and public policy advocacy. AA's mission is not one of social change: it is not a temperance movement or a movement to change alcohol-related social policies and programs. Second, it confirmed the need for complete organizational autonomy and separation of AA from all other organizational entities. Finally, it affirmed the need for a set of principles that could guide AA's organizational life.

12. "Bill's Damned Traditions"

The rapid growth and considerable internal conflict experienced within local AA groups in the early 1940s set the stage for the development of AA's Twelve Traditions (Wally P., 1995; Pearson, 1985). Bill Wilson, through his travels to AA groups across the country and through his prolific correspondence, spent a growing amount of time offering guidance and the lessons being learned from local groups experience on the many points of contention. It was Earl T., one of the original Chicago members, who first suggested the need for a set of principles of self-governance for AA. That suggestion assumed greater weight when Bill Wilson read a 1945 AA Grapevine article on the rise and fall of the Washingtonians in the 1840s from many of the very issues that were then plaguing AA (Wilson, 1945). The resulting principles of self-governance--AA's Twelve Traditions--linked personal recovery to AA unity; acknowledged God as the ultimate authority in AA as expressed through group conscience, posited a model of servant leadership; established a single membership criteria ("a desire to stop drinking"), affirmed local group autonomy, committed AA to a singular purpose ("to carry its message to the alcoholics who still suffers"), established the principles of non-affiliation and financial self-support,

eschewed professionalism and excessive organization, declared a position of silence on outside issues, confirmed a public relations policy based on attraction rather than promotion, and posited anonymity as the "spiritual foundation" of all of the traditions ("principles before personalities") (TSTT, 1981).

The Twelve Traditions were first formulated and disseminated in 1946. Early reviews were lukewarm, with groups occasionally referring to them as "Bill's damned traditions." Some groups during this period invited Bill to speak if he would agree NOT to talk about the traditions. But support for the traditions grew as they came to be seen as a synthesis of AA's hard-earned experience. They were formally adopted at AA's first International Convention in 1950. AA's Twelve Traditions allowed the fellowship to chart a path that avoided the pitfalls of centralization of organizational power, charismatic leadership, money and property, professionalism, and organizational growth and decay that had plagued earlier recovery mutual aid efforts (White, 1998; Room, 1993; Borkman, 2006). Few organizations have a mission, vision or values statement as visibly influential on the daily life of the organization as the Twelve Traditions are within the life of AA. That alone is a rearkable feat. Even more remarkable has been AA's ability to avoid the evolution from a mutual help movement into a formal, hierarchical organization with centralized leadership and a paid class of service professionals (Katz, 1981).

AA's Twelve Traditions make it clear that AA is not in the business of alcoholism treatment and that its members must forever reject any effort to professionalize AA service work:

> *"That we must, at all costs, avoid the professionalization of A.A.; that simple Twelve Step work is never to be paid for; that A.A.'s going into alcohol therapy should never trade on their A.A. connection; that there is not, and can never be, any such thing as an "A.A. therapist"* (Wilson, 1983, p. 27).

The Traditions freed AA members to work in paid and volunteer roles in alcoholism treatment or in alcoholism-related political advocacy, but to do so only as individuals who did not bring the AA name into such endeavors.

AA's commitment to singleness of purpose and its non-affiliation stance protects the fellowship from co-optation and colonization. When individuals and other groups concerned about other problems asked if they could join AA, they were politely told that they were welcome to adapt the AA program to those problems, but that they could not join Alcoholics Anonymous unless they met its single criterion for admission. This policy led to the wide adaptation of the Twelve Steps to nearly every conceivable problem while protecting the AA process of mutual identification—one alcoholic talking with another alcoholic. Even family members of AA members were excluded from AA's closed meetings, which led in 1951 to the adaptation of the AA program via the Al-Anon Family Groups.

A central test of all recovery mutual aid societies is whether that community of recovery can survive the

passing of its charismatic leader(s) and first generation. Three events mark AA's mastery of this test: 1) the death of co-founder Dr. Robert Smith on November 16, 1950, 2) the replacement of the Alcoholic Foundation with the General Service Board of Alcoholics Anonymous in 1954 and the subsequent transfer of responsibility for AA service from the co-founders and old-timers to AA membership, and 3) the death of co-founder Bill Wilson on January 24, 1971. These events successfully tested the ability of AA to self-sustain itself without centralized, charismatic leadership. Thirty-five years later that test has been met. AA's policy of elected and rotating leadership continues. AA's unique organizational structure guided in great part by the Twelve Traditions has withstood the test of time.

Alcoholics Anonymous and Alcoholism Treatment: Separate and Distinct

Seen as a whole, the twelve defining moments summarized in this paper shaped the character of Alcoholics Anonymous as an organization in ways that clearly distinguish AA from the process of alcoholism treatment and the institutions that provide such treatment. The intent of this review is not to portray one as superior to the other, but to suggest that they are distinct entities whose respective value requires separation and boundary protection. Alfred Katz (1981) articulates this principle of separation and respect when he notes that formal human service organizations and mutual aid groups have distinct qualities that should remain separate and be mutually respected. Ernest Kurtz argues a similar position regarding AA and therapy, noting that both have value, but that "it abuses both to present either as the other" (Kurtz, 1999, p. 164).

AA chose a minimalist approach to organizational infrastructure, whereas alcoholism treatment institutions are formal organizations with often elaborate hierarchies and levels of professional status. There are no CEOs, CFOs, or Directors in Alcoholics Anonymous. Where treatment institutions are subject to considerable governmental oversight and all the accompanying regulatory requirements (e.g., service documentation), AA is accountable only to its membership who act through each group's Group Service Representatives. There are no audits, no site visits, no records on individual members, and no monthly service reports. Treatment institutions rely on external funding and are heavily influenced by the dictates of funding agencies; Alcoholics Anonymous is supported only by the contributions of its members and the sale of its literature.

Service relationships in alcoholism treatment are hierarchical (inequality of power), fiduciary (one party having legal obligation for the care of the other), and commercialized (one party is being paid to be there); service relationships in AA are non-hierarchical, reciprocal (mutuality of support) and non-commercialized (no member is paid for his or her support of another member). Clinical staff in alcoholism treatment programs are expected to be credentialed (educated, certified and licensed) by external authorities; status within AA comes solely from one's history, character and conduct within the AA community. Where the former focuses on the importance of professional assessment and diagnosis and professionally directed treatment

planning, AA emphasizes self-diagnosis and following the steps that others have found successful. The emphasis on the knowledge and technique of the treatment professional and adherence to service protocol in alcoholism treatment is replaced in AA with an emphasis on what each AA member must do each day to sustain his or her recovery.

There are significant risks of potential harm resulting from alcoholism treatment, e.g., stigmatizing diagnoses; expensive and potentially prolonged sequestration; pressure for intimate self-disclosures; "therapeutic" confrontation; potential side-effects of medications, and significant consequences for failure to complete treatment and resuming alcohol and drug use. Such potential for harm is recognized and addressed, in part, through the mechanisms of informed consent, confidentiality procedures, clinical supervision and codes of professional conduct. The degree of personal invasiveness and harm in AA is minimized by the absence of treatment procedures, discouragement of taking others' "inventory", discouragement of cross-talk (feedback, advice, confrontation in response to another's disclosure) and through the protective mechanisms of AA's Twelve Traditions and group conscience.

The process of treatment and the process of AA are fundamentally different. Alcoholism treatment often involves getting into yourself by exploring painful aspects of one's personal history. In contrast, the AA experience is more one of getting out of oneself—connecting with resources and relationships beyond the self. Where alcoholism treatment often focuses on personal pain; Alcoholics Anonymous focuses on personal character, e.g., increasing capacity for honesty, forgiveness, gratitude and tolerance. Where alcoholism treatment often focuses on increasing self-esteem; AA focuses on ego-deflation, cultivation of humility and a shift in focus from "I" to "We."

AA is not a treatment for alcoholism, nor is AA a policy advocacy organization, a public information agency, or a religion. AA is a self-governed community of men and women who offer each other their "experience, strength and hope" toward the goals of 1) maintaining recovery from alcoholism, 2) enhancing quality of life of those recovering from alcoholism, and 3) carrying a message of hope to the still suffering alcoholic. As stated in its own literature, AA is "not a social service organization," "not a cure," nor does it "prescribe treatment for alcoholism." "The sole purpose of AA is to help the alcoholic who wants to stop drinking" (Typical misconceptions about A.A., 1951).

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The Future of AA, NA, and Other Recovery Mutual Aid Organizations

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Addiction recovery mutual aid societies have played a significant role in the resolution of severe alcohol and other drug problems throughout the world and have exerted a particularly profound influence on the professional treatment of addiction (Humphreys, 2004; White, 2004). The purpose of this article is to discuss five current contextual influences that will influence the future of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other addiction recovery mutual aid groups. First, we will place that future within its historical context.

Before AA

The story of peer-based recovery mutual aid societies in the United States begins with Native American religious and cultural revitalization movements (early, 1730-1830, recovery circles, prophet movements and sobriety-based Indian religions) and extends through the histories of the Washingtonians, numerous fraternal temperance societies, the ribbon reform clubs, the Drunkard's Club, the Businessmen's Moderation Society, institutional support groups like the Ollapod Club and the Keeley Leagues, and groups emerging from recovery-focused religious ministries, e.g., the United Order of Ex-Boozers and the Jacoby Club (Coyhis & White, 2006; White, 1998, 2001, 2004, 2009). Two foundational points from this history are critical to this article. First, a large number of recovery mutual aid societies existed before the birth of Alcoholics Anonymous in 1935. Second, while all of these societies provided a viable recovery mutual aid framework for their members for a period of time, none outside of Native America retained a recovery-focused mission or survived their founding generation.

The AA Standard

Addiction professionals and representatives of alternative recovery mutual aid groups ask, sometimes resentfully, why AA constitutes the standard by which all other recovery support groups are measured. That status at present is based on AA's size (measured by total membership and number of groups), the scope of its international dispersion, the range of its adaptation to address other

problems, its influence on the design professionally-directed addiction treatment, the quantity and increasing quality of AA-related scientific research, and AA's growing visibility as a cultural institution. But even more than these, AA has earned this benchmark status by its survival, raising the question of why AA survived and thrived when its predecessors collapsed or were diverted from their recovery-focused missions.

Threats to Early AA and Other Recovery Societies

AA faced many of the same threats that confronted and mortally wounded its predecessors—threats that today's other recovery mutual aid societies face in their own efforts to survive and grow. Such threats include:

- transitioning from charismatic leadership (and the character foibles of such leaders) to peer leadership development and leadership rotation;
- surviving the disengagement, fall from grace (most often from relapse), or death of founders/leaders;
- failing to define a program of recovery prior to the experience of rapid growth (with a resulting dilution/corruption of the program);
- defining the limits of membership too restrictively or too inclusively;
- professionalizing peer support (e.g., the crisis in AA provoked by Bill Wilson's offer of employment at Towns Hospital);
- money (too much, too little, ill-timed, tainted) and property (e.g., early vision of AA hospitals);
- managing critics, credibility challenges, and relationship with the media; and
- escaping the divisive power of religious, political and professional controversies.

Why AA Survived

The attributes of AA that gain the most attention among both supporters and critics of AA are the Twelve Steps, but I have long argued that the key to AA's vibrancy as an organization rests not with the Steps but with the Twelve Traditions. The Traditions were AA's response to the threats that fatally wounded AA's predecessors and that could have similarly destroyed AA.

AA survived because of 12 core ideas and principles that have remained unchanged and have governed AA's organizational life since the 1940s. These core ideas/principles:

- affirm the link between group unity and personal recovery;
- establish governance by group conscience and servant leadership;
- define a singular membership requirement ("desire to stop drinking");
- assure the autonomy of each AA group;
- proclaim a singularity of purpose ("carrying its message to the alcoholic who still suffers"), thus minimizing the risk of co-optation and providing a rationale for long-term affiliation and leadership development;
- commit AA to a relational strategy of cooperation without affiliation or endorsement of outside enterprises;
- pledge AA to a policy of financial self-sufficiency/corporate poverty (eschewing the accumulation of money and property that had long served as standards for measuring organizational success);
- promise that AA's mutual support will remain forever free and non-professional;
- dictate organizational minimalism ("the least possible organization") and a system of rotational leadership;
- assert that AA has "no views whatsoever" on outside issues, particularly those related to "politics, alcohol reform, or sectarian religion";
- assure a public relations strategy based on attraction rather than

promotion and extol personal anonymity at the media level; and
- posit anonymity ("principles before personalities") as the spiritual foundation of all of the Traditions (Alcoholics Anonymous, 1953/1989).

When the larger cultural influence of AA is written in the centuries to come, these radical principles of organizational management may well be celebrated as a contribution even greater than AA's framework of alcoholism recovery (Room, 1993). AA's Twelve Steps exist within a pre-existing tradition of alcoholism recovery movements, but the Twelve Traditions fueled a fundamentally new type of organization—one that broke all the prevailing rules about how organizations must be structured and managed.

The Importance of Context

The birth of each recovery mutual aid group is rooted in a particular historical context that shapes its character and culture. Recovery support groups must "work" at personal/family levels in order to provide sense-making metaphors that can serve as catalysts for change, but they must also work at broader cultural levels.

AA's birth in 1935 and many of its core ideas (e.g., powerlessness, unmanageability, hope, and service) were rooted in the economic/spiritual crash of the 1930s. AA historian Ernest Kurtz (1991) has suggested that AA and its unique program of recovery could only have sprung from the unique circumstances of the Depression era. AA also arrived in the wake of the repeal of Prohibition and a century-long, culturally divisive debate between Wet and Dry political opponents. AA provided an escape from this contentious debate by shifting the focus from the product (alcohol) to the unique vulnerabilities of a subpopulation of drinkers (alcoholics).

NA was birthed within the rising epidemic of heroin addiction emerging in the wake of World War II and the social response to that epidemic. Draconian federal and state anti-narcotics laws of the 1950s dramatically escalated criminal penalties for drug possession and sales, filling courts and prisons with an ever-growing legion of addicts. NA's birth (1947), rebirth (1953), near death (1959), and slow early growth until the 1980s unfolded in the context of subterranean drug subcultures, "loitering addict" ordinances that prohibited known addicts from associating with each other under penalty of arrest, and the need for "rabbit meetings" (meetings that shifted from home to home) to avoid police harassment.

AA and NA's existences as separate institutions and the distinctiveness of their separate cultures reflect the policy dichotomy of "good drugs" and "bad drugs." One implication of this understanding is that any cultural shift away from such dichotomous thinking would have potentially profound effects on the future of AA and NA.

The Future

The future growth or decay of AA, NA, and other recovery mutual aid organizations will be greatly influenced by the presence or absence of core values of organizational management, the nature of those values and principles, and the degree to which they can be refined and reinterpreted in the face of changing cultural contexts. Five emerging contexts will exert a profound influence on AA, NA, and other recovery mutual aid organizations:

1. The growing varieties of recovery experience.
2. The cultural and political awakening of American communities of recovery.
3. The commercialization of recovery support.
4. Technological innovation and recovery support.
5. An emerging science of recovery.

As we will see, each of these contexts will pose threats to and opportunities for recovery mutual aid societies.

The Growing Varieties of Recovery Experience

The most important trend in the modern history of recovery mutual aid societies is the growing varieties of recovery experience (White & Kurtz, 2006). The most significant threat to the future of these societies involves the unique interpersonal chemistry of mutual identification. Mutual identification stands as the critical precursor to mutual support, continued participation, and service to others within a mutual aid society. Such mutual identification combines the experiences of choosing and being chosen.

> *The "secret" of Alcoholics Anonymous, the thing that makes A.A. work, is identification. As Marty Mann is reputed to have said to her fellow sanitarium inmate on returning to Blythewood from her visit to the Wilson home in Brooklyn Heights for her first A.A. meeting: "Grennie, we aren't alone any more."* (Kurtz, 2002)

AA co-founder Bill Wilson was himself a student of this identification process. In a March 30, 1954 letter to Betty T., who represented the Habit Forming Drug Group—a pre-NA group that often met in tandem with AA meetings—Wilson posed the following question:

> *Do any of your recoveries who were strict addiction cases find difficulty in identifying themselves with other AA members? I have noticed in many alcoholics a marked aversion to dope addicts- and vice versa.*

Wilson understood that this process of identification profoundly influenced recovery outcomes as well as the fate of local mutual aid groups and the larger fellowship of which they were a part. Attempts to enhance this process of identification historically relied on the defining and enforcing membership criteria. Each recovery support group must wrestle with the twin risks of drawing that boundary of inclusion too narrowly—and shutting out many who are still suffering—or too broadly—and losing the chemistry of mutual identification critical to mutual support. It is a delicate balance. Currently, the changing characteristics of people in recovery and people seeking recovery are stretching and testing the capacity for such identification. When mutual identification weakens or is lost, groups shrink, dissipate, and die and/or spawn new groups.

Historically, weakened levels of mutual identification within AA and NA have produced new AA and NA groups based on all manner of member characteristics, experiences, and meeting format preferences and have spawned alternative or adjunctive anonymous groups (with founding dates noted below) based on:

- Drug choice: marijuana (1968, 1989), prescription drugs (1975, 1998), cocaine (1982), nicotine (1985), benzodiazepine (1989), methamphetamine (1995), heroin (2004), persons in recovery on methadone (1991), and generic groups, i.e., All Recoveries Anonymous (1955-1957), Recoveries Anonymous (1983), Chemical Dependent Anonymous (1988);
- Occupational identification: International Doctors in Alcoholics Anonymous (1949), Pilots (1975), Lawyers (1975), Anesthetists (1984), Nurses (1988), and Veterinarians (1990);
- Co-occurring problems: Dual Disorders Anonymous (1982), Dual Recovery Anonymous (1989), and Double Trouble in Recovery (1993);
- Religious affiliation: Calix Society (1947) and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS, 1979); and
- Family experience: Al-Anon (1951), Alateen (1957), Families Anonymous (1971), Recovering Couples Anonymous (1988), and Teen-Anon (1999).

To these groups have been added an increasingly diverse range of:

- spiritual adjuncts or alternatives: The Red Road to Wellbriety;
- religious frameworks of recovery: Alcoholics Victorious (1948), Alcoholics for Christ (1976), Liontamers Anonymous (1980), Free N' One (1985), Overcomers in Christ (1987), Millati Islami (1989), and Celebrate Recovery (1991); and
- Secular frameworks of recovery: Women for Sobriety (1975), Secular Organization for Sobriety/Save Our Selves (1985), Rational Recovery (1986), Men for Sobriety (1988), SmartRecovery® (1994), Moderation Management (1994), and LifeRing Secular Recovery (1999).

Even more stunning than the growth of these recovery support options is the many people who are simultaneously participating in two or more recovery support structures—suggesting people are using different groups to meet different recovery support needs.

So what does this growing proliferation of religious, spiritual, and secular recovery support groups and new patterns of co-attendance mean to the future of AA and NA? The clue to a potential looming crisis can be found by returning again to AA and NA's historical origins. AA and NA are historically rooted in two distinctive patterns of addiction: late-stage gamma species alcoholism among white middle-aged Protestant men and urban heroin addiction among young white ethnics and people of color. These patterns are diminishing through a process of aging out, with oldtimers lamenting the loss of "real" alcoholics/addicts. These earlier patterns are being replaced by a new generation of polydrug users whose patterns of alcohol and other drug (AOD) use render obsolete the concept of "primary drug." Indicative of this shift, the latest treatment admissions data in the United States reveal that only 18% of those entering addiction treatment report "alcohol use only" as a primary problem and only 36% report "drug use only" (usually a combination of drugs), with only 13.6% reporting heroin as a primary drug choice (SAMHSA, 2008).

What will happen to boundaries of identification within AA and NA when nearly all persons seeking recovery bring patterns of multiple AOD use and no clear "primary drug" of choice? Rituals of qualification (the "what it was like" part of one's story) have and will continue to evolve within AA and NA through these changing membership profiles. Looking decades ahead, one could anticipate the dilution or outright loss of distinctiveness between AA and NA, the potential collapse and merger of some local groups, significant changes in AA and NA culture, and the resulting search by some for "real AA" and "real NA" (see Kurtz, 1999 for an excellent discussion of "real AA").

The opportunities posed by these trends are that AA and NA could both expand in spite of their diminishing distinctiveness and that both fellowships could celebrate their growing diversity by reaffirming Bill Wilson's 1944 declaration: "The roads to recovery are many." For the history watchers among us, the key will be to closely monitor how AA and NA reinterpret their Twelve Traditions in light of changing addiction and recovery environments. Interestingly, this trend may pose less of a threat to NA with its focus on "addiction" rather than drug-specific identification.

Groups established as an alternative to AA and NA will be similarly challenged to maintain their unique identities and niches within the global recovery community in light of both the changing patterns of AOD problems and the growing varieties of recovery experience within AA and NA. These groups have often criticized the narrowness of approach of the Twelve Step fellowships, but it is actually the growing diversity within AA, NA, and other Twelve Step fellowships that most threatens the future growth of non-Twelve step recovery support groups.

The Cultural and Political Awakening of Communities of Recovery

An earlier article in this column (White, 2008) recounted the growing cultural

and political awakening of individuals and families in recovery. That awakening is being spawned by many factors, including:

- the growth and philosophical diversification of communities of recovery,
- the emergence of an identity (*person in recovery*) that unites members of diverse recovery support fellowships and those in recovery outside those fellowships,
- the rise of a new grassroots recovery advocacy movement (see www.facesandvoicesofrecovery),
- the international spread of the recovery advocacy movement, and
- the rise of new recovery community institutions (recovery homes/colonies), industries, schools, ministries/churches, community centers, cafes, recovery community service organizations, and sports teams, as well as new genres of recovery literature, art, music, dance, theatre, and comedy.

In 1976, 52 prominent Americans publicly announced their long-term recovery from alcoholism as part of the National Council of Alcoholism's Operation Understanding. Their "coming out" was a landmark in the modern history of alcoholism recovery. In September 2009, more than 70,000 people in recovery participated in public Rally for Recovery events in cities across the United States—an achievement that would have been unthinkable only a few years ago. So what does this cultural and political awakening mean for recovery mutual aid societies? Several trends are already clear:

- Continued efforts will need to be made to define if and how public recovery advocacy can be pursued within the framework of the anonymity tradition of Twelve Step fellowships. Conflict on this issue will increase and will likely create a nuanced distinction between anonymity related to one's identity as an AA/NA member and one's public advocacy as a person in recovery.
- Role confusion will develop for a time between recovery mutual aid societies, their linked institutions (e.g., clubhouses), and new recovery community institutions (e.g., recovery community service organizations, recovery community centers).
- There will be similar role ambiguity and conflict between the recovery mutual aid sponsor, the recovery coach (working in a volunteer or paid role in a recovery community organization), and the professional addictions counselor.

The threat posed by these developments is the potential division, distraction, and disruption that can flow from such institutional and role conflicts. The opportunities posed by these new recovery community building activities will be twofold. First, while recovery mutual aid members privately debate their relative merits and demerits, these new institutions will be assertively linking a growing number of people to these very mutual aid groups. Second, the broader menu of recovery supports being spawned by these new organizations will mean that some people who have struggled unsuccessfully to achieve stable recovery will now find and maintain that stability. Just as the resources of AA, NA, and other recovery mutual aid societies enhanced outcomes of professional treatment, these new recovery support institutions are enhancing the outcomes of both professional treatment and recovery support societies (see White, 2009 for a review of existing studies).

The history of recovery mutual aid societies, specialized addiction treatment and new recovery community organizations indicates a potential shift in focus from facilitating the intrapersonal recovery experience to creating supportive community environments in which such recoveries can flourish. This new understanding of the ecology of recovery will increase the transformative potency of

professional treatment institutions and peer recovery support groups at the same time it sharpens their understanding of the social contexts in which addiction and recovery are nested.

The Commercialization of Recovery Support

There is a growing network of peer-based recovery support organizations funded by (or modeled on) the Center for Substance Abuse Treatment's Recovery Community Services Program (RCSP) and Access to Recovery (ATR) program. These recovery support services have generated a new role (referred to variably as recovery coach/guide/mentor/specialist that offers a menu of support to people that spans pre-recovery identification/engagement (outreach), recovery initiation and stabilization, recovery maintenance (e.g., post-treatment recovery checkups), and enhancement of quality of personal/family life in long-term recovery. The most cursory online search of "recovery coach" also reveals the increased privatization of these services, e.g., recovery coaching offered for private fees. This seems to be a perceived zone of business growth by life coaches, those who previously provided intervention services for AOD problems and by addiction counselors disgruntled with treatment organizations they perceived as caring more about paper work than people work.

What is most significant for the future of recovery mutual aid fellowships is that this new role of recovery coach is being rapidly commodified, professionalized, and commercialized. As noted above, this could have the potential of heightening ambiguity and conflict between the roles of sponsor, recovery coach, and addiction counselor in the short run and, in the long run, potentially eroding the service ethic within communities of recovery. It will also stir heightened controversy about whether people are trying to "sell the program." Any trend that increases paid recovery support at the expense of volunteer service work in support of one's own recovery and as an expression of gratitude has the potential of injuring recovery mutual aid societies and the larger community.

The opportunities emerging from this trend are twofold. First, we may well see elevated long-term recovery outcomes for persons with high problem severity/complexity and low recovery capital. People are now achieving stable recovery whose needs have transcended the time and emotional resources of both sponsors and professional addiction counselors. This achievement magnified over time will result in aggregate membership growth of recovery mutual aid societies. The rise of new peer-based recovery support roles also promises, at personal and at systems levels, a reconnection of acute addiction treatment to the larger and more enduring process of long-term recovery.

Technological Innovation and Recovery Support

A quiet revolution is unfolding in the world of addiction recovery spawned by new media for interpersonal communication, e.g., cell phones, internet-based recovery support meetings and new social networking web sites. If there is a growth window shared by nearly all recovery mutual aid societies, it is in the arena of online recovery support. This new media has the potential to transcend many of the traditional barriers to face-to-face meeting participation: geographical inaccessibility, inconvenience, schedule conflicts, lack of transportation, lack of child care, social anxiety/phobia, fear regarding physical/psychological safety, and fear of stigma and discrimination. Today, peer recovery support is a mouse click away. Imagine a day in the future when more people participate in online (or other electronic media) recovery support groups than attend face-to-face meetings. That day has already arrived for many non-Twelve Step recovery support groups, and that day could also arrive for AA and NA far faster than might be imagined.

The growth of "virtual recovery" raises many questions about the future of recovery and the future of recovery mutual aid societies.

- How will the online recovery support meeting experience for different populations compare to their experience of face-to-face meetings?
- How quickly will a media that seems particularly well-suited to special populations (e.g., women, status-conscious professionals, adolescents, persons with limited mobility, persons living in remote locations) spread through the mainstream cultures of AA, NA, and other recovery support fellowships?
- Can key activities within recovery mutual aid societies be performed without or with only limited face-to-face contact? How will these activities be changed in this process?
- Will the internet create a milieu in which secular and religious alternatives to AA and NA can compete with AA and NA in terms of accessibility and effectiveness for particular groups of people?
- The internet provides opportunities for instant globalization of recovery support—allowing daily communication with individuals in recovery from all over the world. How will regular contact with recovering people from other countries/cultures influence the culture of recovery in the United States?
- Could text-based electronic communications emerge as an important alternative/adjunct to formal meetings for some recovery fellowship members?
- Are there areas of unforeseen harms that could befall particular individuals using electronic media for recovery support or harm that could occur to recovery mutual aid fellowships?

The threats posed by Internet and other electronic support media are at the moment overshadowed by the potential of this media to reach exceptionally large numbers of new people in need of recovery support. I suspect the effects of this new recovery support media will be far more profound than any of us can currently visualize.

An Emerging Science of Recovery

Addiction and addiction treatment research agendas are being extended by a growing interest in the scientific study of long-term recovery. This emerging recovery research agenda includes the application of methodologically sophisticated studies of recovery mutual aid fellowships. Most of what we know about these fellowships from the standpoint of science is at present based on studies of AA, but studies of other Twelve Step fellowships as well as religious and secular alternatives are increasing. The questions raised by this increased scientific focus include:

1. How will the sometimes harsh light of science affect the cultural status of recovery mutual aid groups?
2. How will emerging science affect how these groups are seen by their own members and by those in need of recovery support?

The growth in scientific studies of recovery mutual aid groups is doing two things. First, it is confirming a lot of recovery fellowship folklore. For example, studies of AA are confirming internal AA folklore about the effectiveness of AA and the potent ingredients of AA participation, e.g., dose/intensity effects of participation and the value of Step work, sponsorship (being sponsored and sponsoring others), reading AA literature, having a home group, etc. AA oldtimers read the findings of expensive scientific studies and smugly reflect, “I could have told them that for the price of a cup of coffee.” But one of the critical functions of science is to confirm or disconfirm tenets of experiential knowledge. Science is revealing such things as who responds and does not respond to AA, the most effective timing of AA participation, the best linkage procedures between addiction treatment and AA, and the value of matching individuals to particular fellowships and particular meetings.

Science will also spark controversies by challenging prevailing beliefs of recovery fellowship members. Research on the potential value of medication-assisted recovery is challenging and softening many AA members' views about medication. One of the most controversial issues within NA in the coming decade will be the science-driven push to re-evaluate local group policies on methadone and other medications, e.g., denial of the right of more than 265,000 persons in methadone maintenance in the United States to speak at NA meetings, chair a meeting, or head a service committee—even by individuals with prolonged stabilization, no secondary drug use, and achievement of global health and positive citizenship. Some will attempt to avoid this debate by declaring that scientific studies on methadone maintenance are an "outside issue," but the growing weight of science will exert enormous pressure on NA as an institution, as it will all recovery mutual aid fellowships.

All recovery mutual aid societies will be scientifically evaluated in the coming decades on such dimensions as accessibility, attraction, engagement (affiliation and retention rates), short- and long-term effects on the course of AOD problems, effects on global health and functioning, and the potential social cost offsets from such participation. Some groups will face this scrutiny and actually achieve heightened scientific credibility (as has happened with AA in the past decade); others will not withstand the effects of such scrutiny.

An issue most critical to the survival of recovery mutual aid groups is the question of how long members should continue to participate. Twelve Step fellowships have implicitly encouraged sustained if not lifelong participation whereas many of the alternatives to Twelve Step Fellowships do not expect sustained member participation. Among the latter, members are expected to avail themselves of sufficient support to initiate stable recovery and then leave and get on with their lives.

Science is actually revealing that this latter position may work at an individual level. Recent studies of AA reveal a population of positively disengaged individuals who initiated recovery within AA, then later ceased active participation but continued to sustain their sobriety and emotional health over time (Kaskutas, Ammon, Delucchi et al., 2005). An interesting outcome of this finding is that the actual societal impact of AA may have been grossly underestimated, as its contributions have generally been measured by its active membership numbers—a figure that ignores the existence of this larger community of people positively affected by but no longer actively participating in AA. The same is likely true for other recovery fellowships.

Interestingly, the "participate as long as and for only as long as you need to" policy may work at a personal level for many individuals but may doom a recovery mutual aid group's organizational viability. The future of any recovery mutual aid organization rests on its leadership development and long-term meeting maintenance capacity. The personal recovery outcomes of a recovery support group will not always distinguish those groups that will survive and thrive from those that will stagnate and die or regress to the status of a small ideological cult or commercial platform.

The threat science poses to recovery mutual aid groups lies in the intragroup controversies and schisms its findings can elicit, but science will add credence to much that has been learned within recovery mutual aid societies. It will also refine how such societies operate and, through that process, enhance the ability of these groups to support long-term recovery and to survive over time.

Summary

The birth and early survival of AA and NA were rooted within unique historical contexts, as were those recovery support fellowships that preceded and followed them. AA and NA (and all other addiction recovery mutual aid societies) are facing fundamentally new contexts in which they will have to reaffirm or redefine their identities. These new contexts include the

expanding varieties of recovery experience, increased institution-building within the culture of recovery, the growing professionalization and commercialization of peer recovery support, radically new media for interpersonal communication, and an emerging science of addiction recovery. These contexts present both threats and opportunities to the future of AA, NA, and other recovery mutual aid groups.

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Perceptions of 12-step Interventions among NHS Substance Misuse Patients attending Residential In-patient Treatment in a UK Treatment Setting.

Abstract

In spite of a considerable evidence base suggesting the benefits of participation in Alcoholics Anonymous and other 12-step fellowships, most studies have been conducted in the United States. Preliminary studies have suggested that clients in addiction treatment in the United Kingdom may be more ambivalent about 12-step groups, and the current article examines barriers and pathways to engagement in 12-step recovery support groups for 125 drug and alcohol users (84.5% of the total sample) attending an inpatient detoxification unit in Birmingham, England. Two-thirds (69.4%) reported prior attendance at 12-step meetings, but current levels of affiliation were low and significant barriers to 12-step meeting attendance were identified. Barriers to participation include the perceived religious components of 12-step meetings, prior negative experiences in 12-step meetings, failure to identify with group members, and difficulties simultaneously participating in both 12-step meetings and structured treatment.

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How Alcoholics Anonymous and Narcotics Anonymous Work: Cross-disciplinary Perspectives

Abstract

Evidence from multiple lines of research supports the effectiveness and practical importance of Alcoholics Anonymous and Narcotics Anonymous. Conference presenters discussed the relationship between 12-step participation and abstinence among various populations, including adolescents, women, and urban drug users. Insight from the arts and humanities placed empirical findings in a holistic context.

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NARCOTICS ANONYMOUS: ITS HISTORY AND CULTURE

Alcoholics Anonymous (AA) stands as the benchmark by which all other addiction recovery mutual aid societies are measured due to its longevity, national and international dispersion, size of its membership, adaptation of its program to other problems of living, influence on professionally-directed addiction treatment, cultural visibility, and the growing number of scientific studies on its active ingredients and their effects on long-term recovery. That said, other addiction recovery mutual aid societies are growing in number and in the diversity of their philosophies and methods. Although Narcotics Anonymous (NA) was one of the earliest adaptations of the AA program, NA remains less well-known among addiction professionals. The purpose of this paper, abridged from the forthcoming new edition of Slaying the Dragon: The History of Addiction Treatment and Recovery in America, is to provide an overview of the history and culture of NA and to distinguish the NA program from AA and other recovery mutual aid societies.

Introduction

Addiction recovery mutual aid societies rise within unique historical contexts that can exert profound and prolonged effects on their character. Just as the birth of Alcoholics Anonymous (AA) is best understood in the context of the repeal of Prohibition and the challenges of the Great Depression, the history of Narcotics Anonymous (NA) is best understood in the cultural context of the 1950s. It was in this decade that the notion of "good" drugs and "bad" drugs became fully crystallized. Alcohol, tobacco, and caffeine achieved the status of culturally celebrated drugs as an exploding pharmaceutical industry poured out millions of overthe-counter and prescription psychoactive drugs. Heroin and cannabis became increasingly demonized in the wake of a post-World War II opiate addiction epidemic. Social panic triggered harsh new anti-drug laws. Known addicts were arrested for "internal possession" and prohibited from associating via "loitering addict" laws. Any gathering of recovering addicts for mutual support was subjected to regular police surveillance. Mid-century treatments for addiction included electroconvulsive therapy ("shock treatment"), psychosurgery (prefrontal lobotomies), and prolonged institutionalization. This is the inhospitable soil in which NA grew.

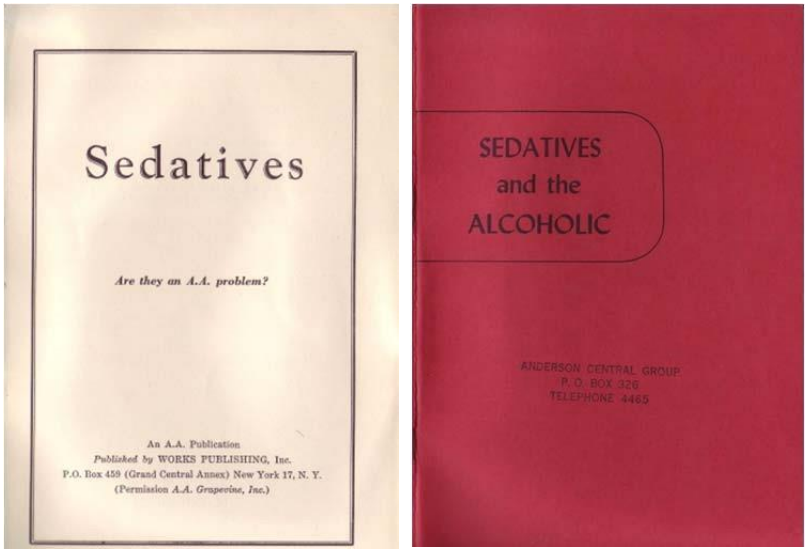
Two 1935 events were critical to the eventual rise of recovery mutual aid groups for drug addiction: the founding of Alcoholics Anonymous and its subsequent outreach to hospitals and prisons, and the opening of the first federal "Narcotics Farm" (prison hospital) in Lexington, Kentucky.[1] This article will explore the history of NA, but read carefully, because there was more than one NA, only one of which survived to carry its message of hope to addicts around the world.

Addiction Recovery in AA: Dr. Tom M.

Within four years of the founding of AA, individuals addicted to opiates and other drugs began exploring whether mutual support and practicing AA's 12 Steps might offer a means of recovery. Ground zero for transmission of the AA program to drug addicts was the U.S. Public Health Service Hospital in Lexington, Kentucky. Opened May 25, 1935, and widely known as the "Narcotics Farm" or "Narco," this prison/hospital treated people addicted to narcotics who had been sentenced for federal drug crimes and those who applied for voluntary treatment.[2] One enduring outcome of Narco was the discovery there that the program of Alcoholics Anonymous could be successfully applied to other drug addictions.

Dr. Tom, a physician who had been an alcoholic before developing a twelve-year addiction to morphine, entered the Narcotics Farm in 1939 to take "the cure" and while there, found a newly published book—*Alcoholics Anonymous*—that changed his life.[3] Upon returning to Shelby, North Carolina, in the fall of 1939, Dr. Tom M. and three other men held the first meeting of Alcoholics Anonymous in North Carolina.[4] Dr. Tom M. is the first known person to achieve sustained recovery from morphine addiction through Alcoholics Anonymous,[5] and the Shelby group became a resource for AA General Headquarters in New York to respond to inquiries about a solution for drug addiction.[6]

Early experiments in applying AA's Twelve Steps to the problem of opiate addiction span a period in which AA was becoming increasingly conscious of "other drugs." AA member "Doc N." wrote a letter to the *AA Grapevine* in 1944 suggesting a "hopheads corner" through which AA members who were also recovering from narcotic addiction could share their experience, strength, and hope.[7] This was followed by a long series of *Grapevine* articles about drugs (narcotics, sedatives, tranquilizers, and amphetamines), including a 1945 warning from AA co-founder Bill W. about the dangers of "goofballs" in which he acknowledged that he had once nearly killed himself with chloral hydrate. Early *Grapevine* articles became the basis for a series of AA pamphlets, beginning in 1948 with *Sedatives: Are they an A.A. Problem*?[8]



(L) Sedatives: Are they an A.A. problem? (1948)
(R) Sedatives and the Alcoholic (1952)
Courtesy Bruce C.

The key, sometimes contradictory, points in these early (1948, 1952) pamphlets were that:

- The alcoholic has a "special susceptibility to habit-forming drugs of all types" (1952, p. 18).
- Pills often lead to a resumption of drinking and loss of sobriety.

- A “pill jag” should be considered a slip.
- “The problems of the pill-taker are the same as those of the alcoholic” (1948, p. 8).
- Pill-takers are often psychopathic personalities, and AA members should only concern themselves with the “disease of alcoholism” (1948, p.9).
- AA members should refrain from administering sedatives as part of their 12-Step work— a not uncommon practice during this period.

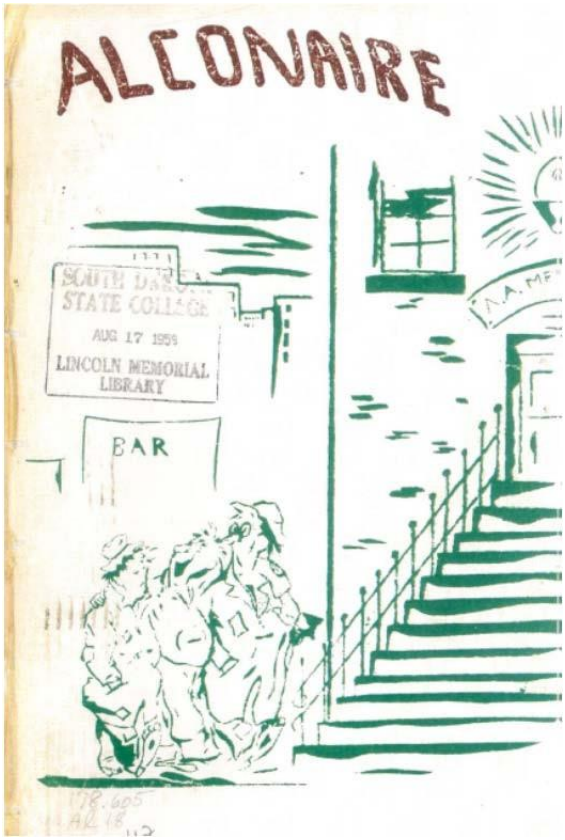
The creation of the *AA Grapevine* in 1944 created the conduit through which addicts in AA first recognized their mutual presence and reached out to one another. During these early *AA Grapevine* exchanges, Dr. Tom suggested the possibility of establishing an AA group for addicts at the U.S. Public Health Service Hospital in Lexington.[9] Two and a half years later, another AA member, Houston S., turned this idea into a reality.

Houston S. and Addicts Anonymous

AA outreach to prisons grew throughout the late 1940s and 1950s, as did prison-based AA groups. Current and former members of prisonbased AA groups communicated through newsletters bearing such names as *Alconaire* (South Dakota), *Alky Argot* (Wisconsin), *BAR-LESS* (Indiana), *The Corrector* (Illinois), *The Cloud Chaser* (Minnesota), *Cross Roads* (Quebec, Canada), *Eye Opener* (Ohio), *Folsomite* (California), *New View* (New Hampshire), *PenPointers* (Minnesota), *The Inventory* (North Carolina), and *The Signet* (Virginia).[10] The message of 12-Step recovery was first carried to addicts in prison by Houston S., an AA member without a history of other drug addictions.[11]

Houston S. developed a severe drinking problem after his training as a civil engineer at the Virginia Military Institute (1910-1914) and service in the U.S. Marine Corps (1918-1919).[12] Family members repeatedly nursed him back to temporary health until Houston finally found permanent sobriety within AA in Montgomery, Alabama, in June 1944. From the earliest days of his recovery, he developed an evangelic fervor for helping others. To the occasional embarrassment of his family,

Houston would share his recovery story to anyone at



Cover to 1959 issue of The AlconAire
Courtesy South Dakota State University Librar y



Houston S.
Courtesy Mary Smith

any time. Relatives tell many stories of the men he coached into recovery, temporarily housed, and helped financially, including paying for some to go to school.[13,14] In Montgomery, Houston helped a sales executive who was addicted to both alcohol and morphine. The sales executive stopped drinking through AA, but was unable to sustain recovery from his morphine addiction in spite of his prior treatment at the Narcotics Farm in Lexington.[15] As a result of this experience, Houston became quite interested in AA members who were experiencing dual problems with alcohol and other drugs. When Houston was transferred to Frankfort, Kentucky in September 1946, just 20 miles from the Narcotics Farm,[16] he called upon the medical director of the hospital, Dr. Victor Vogel, and suggested initiating a group similar to AA for addicts. With Dr. Vogel's approval, Houston volunteered to help launch such a group inside the Lexington facility.

The first meeting of the new group was held on February 16, 1947. The members christened themselves Addicts Anonymous[17] and met regularly at Lexington from 1947 until 1966. Houston remained involved with the group until his health began to fail in 1963. Through his liaison, AA groups in Kentucky as near as Frankfort and as far as Louisville provided regular volunteers to speak at the Addicts Anonymous meetings in Lexington.[18,19] The sales executive who sparked Houston's initial interest later returned to Lexington as a voluntary patient, began attending the Addicts Anonymous meetings, and went on to achieve stable recovery.[20]



This picture of the Addicts Anonymous Steering Committee accompanied the April 27, 1950 Lexington Herald article *Addiction is Recognized as Illness by AA Group Founded to Fight It*, the ninth and final article in a series on narcotic addiction by Jack Lewyn. When the article appeared, the face of the man standing was covered to protect his anonymity.

Photo courtesy University of Kentucky

Addicts Anonymous group meetings were completely voluntary. By 1950, Addicts Anonymous had a membership of more than 200 patients at the hospital.[21] Membership declined by the 1960's when regular meeting attendance was roughly 35 men and 28 women.[22] The meetings followed a format similar to AA meetings, and guidance for personal recovery was based on an adaptation of the Twelve Steps of Alcoholics Anonymous.

Within ten months of its founding, the secretary of Addicts Anonymous began correspondence with the Alcoholics Anonymous General Service Headquarters (GSH). In a letter dated December 26, 1947, the secretary for the group requested that a letter and regular article about the group's activities be published in the *A.A. Grapevine*.[23] General Service Headquarter staff wrote back stating that they had forwarded the letter to the *Grapevine* staff.[24]
Within two months, a letter appeared in the February 1948 issue of the *Grapevine* titled "Addicts Anonymous Ends First Year."[25]

Early correspondence with the Addicts Anonymous group from employees of the General Service Headquarters was quite supportive. Charlotte L. wrote:

> *Naturally, all of us in AA want to do everything possible to help. We feel that your accomplishments in overcoming addiction through the principles of Alcoholics Anonymous, in special application to your problems, is a wonderful one and we share your joy. As many of you go into the outside world, carrying the message to others who suffer similar addiction, it is to be hoped that you will be the means of helping many others while maintaining your own recovered states. Please write to us as often as your time permits. Tell us how the group is getting along, how those on parole or completely released are making out, and above all, tell us what we can do to help*.[26]

Another GSH staff member, Bobbie B., corresponded with Clarance B., secretary of the Addicts Anonymous group, in March and April of 1949. Bobbie provided very supportive and encouraging words to Clarance and the members of the Addicts Anonymous group:

> *We, too, know that some of you who have recovered from drug addiction can be greatly helped by joining Alcoholics Anonymous groups. I, personally, know several who have made the grade and are some of our finest members. On the whole, I think our AA members are extremely tolerant and kind to all who come to them. And, why shouldn't we be? We have been through some pretty harrowing times with our alcohol addiction and who are we to criticize others who may have used something else? May I send a little suggestion: give yourselves every break you can in obtaining recovery. Use any help no matter from where it comes. That's what we alcoholics had to do so why not you people? Underneath it all, are we really so different? Doesn't it add to the belief that underneath the few surface differences, we are much the same? You people are pioneers in this field of drug addiction. One day, Addicts Anonymous may be as well known as Alcoholics Anonymous. When that day comes, how grateful you all will be for the work and clear thinking of now. Just keep in mind that Bill and the very early members of AA went through the same problems of this misunderstanding that you people now face. And, most misunderstandings are based on ignorance*.[27]

One of the most remarkable gestures of goodwill to the Addicts Anonymous group came when Bobbie mailed complimentary literature to Addicts Anonymous and suggested that, in the absence of their own literature, members could substitute the word *drugs* for *alcohol* when reading the AA material.[28]

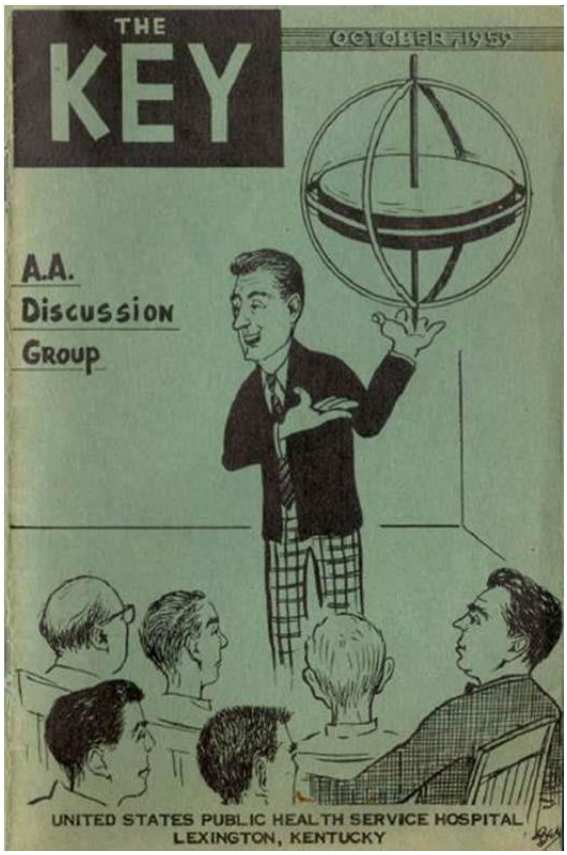
Bill W. also corresponded with the Addicts Anonymous group, but tended in his letters to focus upon the differences and tension that existed between alcoholics and addicts—a subject we will return to later in more detail. In a letter to Clarance B., secretary of the Addicts Anonymous group, dated April 2, 1949, Bill writes:

> *While I make no doubt that underlying causes of alcohol and drug addiction are quite identical, it is a fact that the alcoholic feels himself a quite different, even a superior creature. To make the score a tie, it is probably true that the average addict looks down on the alcoholic. In fact I have seen that myself. Alcoholics and addicts are mutually exclusive and snobbish*.[29]

Many of the Addicts Anonymous members who left Lexington were successfully helped by Alcoholics Anonymous groups in their local communities.[30] Communication with members who had left Lexington

came through an Addicts Anonymous newsletter, *The Key*, which was published by members working in the Narcotics Farm's Vocational and Educational Unit.[31] This newsletter discussed issues of concern to those undergoing treatment in Lexington or who were readjusting to community life as a person in recovery.

The spread of Addicts Anonymous from institutional settings to the community began with one man, Danny C., who like Houston S., became something of a recovery evangelist.



The Key (1959)
Courtesy Willingway Foundation

Danny C.: The Rise and Fall of the First NA

Danny C. was born July 7, 1907, in Humacao, Puerto Rico. Following the death of both his parents in Danny's early childhood, he was taken in by a physician and later relocated to St. Joseph, Missouri. There, Danny lived a fairly uneventful life until his first exposure to opiates sparked a 25-year addiction to morphine and heroin.[32]



Danny C.
Courtesy Listen Magazine

At the age of 16 my foster mother, who was a staff physician in the hospital where we resided, gave me morphine for the relief of pain caused by an abscessed ear. I liked the feeling the morphine gave me and, after the operation, when the drug was no longer administered, I asked for more, but was refused. I knew where the pills were kept, and helped myself to them, not even knowing what narcotics were.[33]

His mother arranged for treatment for Danny and even moved to an isolated rural community where she thought he would be free of temptation—all to no avail. Danny spent nine of his next twenty years in prison on drug-related convictions.[34] Danny C. was among the first patients admitted in 1935 to the newly opened U.S. Public Health Service Hospital for addicts in Lexington, Kentucky. It was the first of his eight admissions over the ensuing 13 years. Following a suicide attempt and final readmission in 1948, Danny participated in Addicts Anonymous meetings and had a profound spiritual experience that served as a catalyst for his sustained recovery.[35] It was during this time that Danny came under the mentorship of Houston S., who *"inspired me to learn to hope, and to have faith, at long last…*.[36]

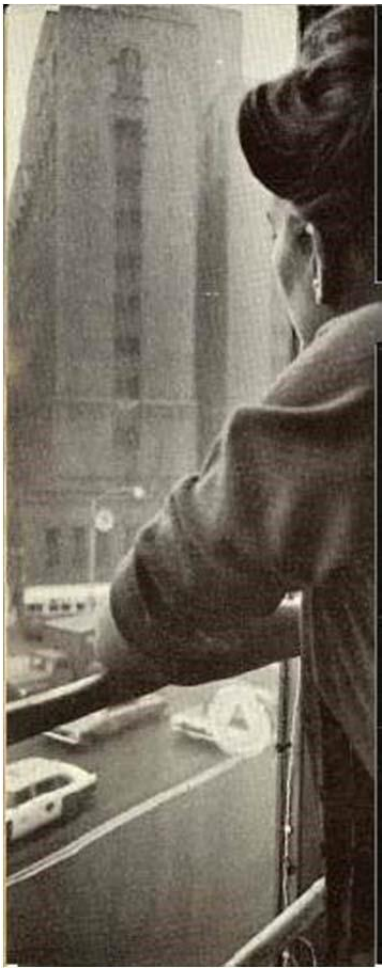
Following his final discharge from Lexington in April of 1949, Danny started Addicts Anonymous in New York City.[37] He called the new group Narcotics Anonymous (NA) to avoid the potential confusion of two AAs.[38] The NA created by Danny C. was not the NA that exists today, but Danny's efforts first brought the NA name to national attention.

The first NA meeting was held at the Women's House of Detention,[39] and it was there that Danny met Major Dorothy Berry of the Salvation Army. Major Berry offered NA the use of the Lowenstein Cafeteria in the Salvation Army located on 46th Street in the area of New York City known as Hell's Kitchen. By January 1950, the first community-based 12-Step meetings were started for addicts.[40,41] Major Berry, who became Director of the Eastern Territorial Correctional Service Bureau for Women in 1945 and later worked with female addicts at the House of Detention, was NA's first patron.[42,43] A corner of her office was the New York-based NA's first headquarters.

The application for the incorporation of Narcotics Anonymous is dated January 25, 1951. Danny also created an organizational umbrella for NA—the National Advisory Council on Narcotics (NACON)—and organized an educational support group for parents of addicts (Committee for Medical Control of Narcotics Addiction).[44] NACON mailings listed Danny's full name as the Founder of NA and listed a board of directors that included Marty Mann of the National Committee on Alcoholism and Dr. Marie Nyswander, later co-developer of methadone maintenance. In 1953, NACON was unsuccessful in its attempt to solicit funds to support plans for a public education campaign and developing hospitals for the treatment of drug addiction.[45]

Early NA efforts were plagued by a lack of money and meeting space, perceptions by some in the community that NA was just a ruse for addicts to meet to exchange drugs and connections, and fear among addicts that NA was infiltrated by police undercover agents and informers.[46] Few organizations welcomed the new group. Following the closing of the Salvation Army cafeteria, NA meetings were held on the Staten Island Ferry until meeting space was found at the McBurney Branch of the YMCA.[47] An open meeting was held every Tuesday night with 10-30 persons attending, and a closed meeting ("ex-addicts only") was held every Friday night that drew more than 25 persons.[48] When NA celebrated its first anniversary in 1951, six members had achieved a year of sustained recovery.[49] Three years later, a total of 90 members had achieved stable, drug-free living.[50] Danny continued to lead New York NA meetings until his death at age 49 on August 19, 1956.[51]

Following Danny's passing, leadership within NA passed to Rae L., who worked for the Narcotics Coordinator's Office of the New York City Department of Health[52]—the first NA member working in a paid role within what would soon be an emerging field of community-based addiction treatment.



This picture appeared in the article *The Junkie Priest* by John D. Harris that appeared in the January 1965 issue of Pageant.

The caption that accompanies the picture reads "From the First Halfway House, an addict stares at the House of Detention."

Later support was also provided by non-addicts, such as Father Dan Egan, who was also known as the "Junkie Priest." Father Egan was ordained in 1945 and sustained a special ministry to the addicted (and later to people with AIDS) until his death at age 84 in 2000.[53] The New York NA group remained relatively small, with only 4 meetings a week in 1963, but there was some NA growth reported outside of New York City in Newark, Chicago, Los Angeles, Cleveland, Philadelphia, and Vancouver, Canada. In 1965, the New York-based NA reported "chapters" in 14 cities, 10 states, and 3 foreign countries.[54]

The first NA literature from Danny C. and the New York group—the pamphlet *Our Way of Life-An Introduction to NA*—was published in 1950.[55] During the 1950s and early 1960s, New York NA, as well as the Lexington-based Addicts Anonymous, achieved considerable visibility in prominent newspapers (the *New York Times*, the *New York Herald Tribune*, the *New York Post*, and the *Chicago Sun Times*), magazines (the *Saturday Evening Post*, *Time*, *Newsweek*, *Look Magazine*, *Family Circle*, *Confidential Magazine*, *Down Beat Magazine*), and in books bearing such titles as *Narcotic Menace*, *Merchants of Misery*, *The Junkie Priest*, *Monkey on My Back*, *Mainline to Nowhere*, *Narcotics: An*

American Plan, and *The Addict as a Patient*

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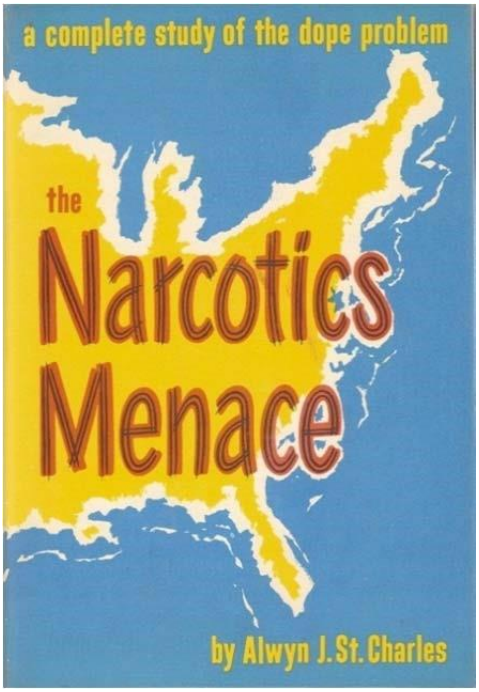
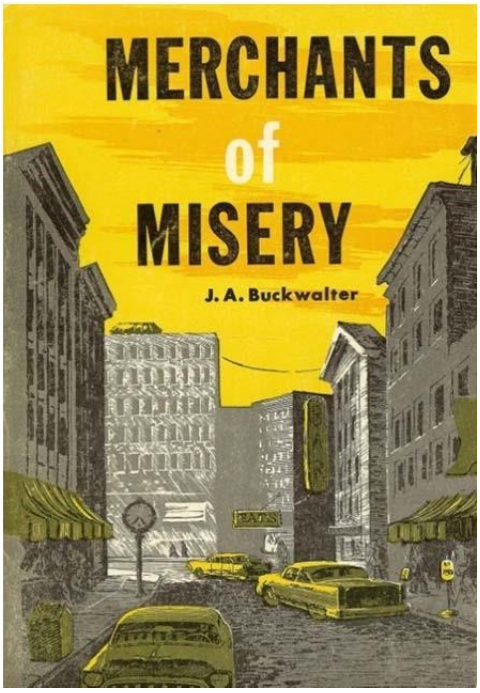
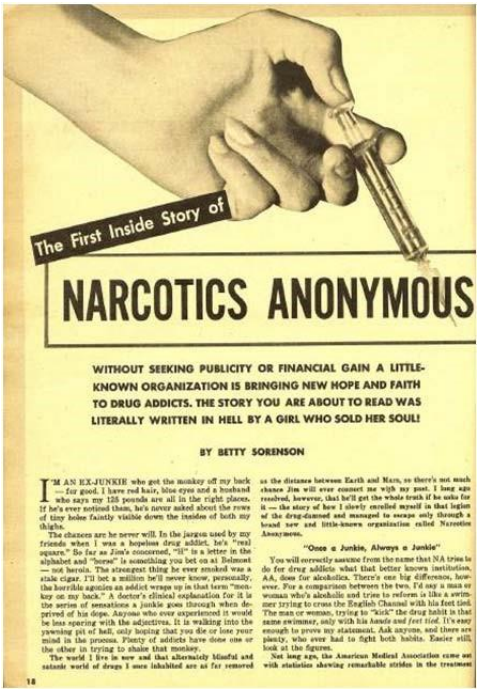






Downbeat Magazine – May 5, 1954 (Upper Left)
The Narcotics Menace – 1952 (Upper Right)
Merchants of Misery – 1956 (Lower Left)
Page from Confidential Magazine – November 1956 (Lower Right)

After Danny's passing, NA was promoted in New York City through pamphlets authored by Fr. Dan Egan in which he characterized addiction as a "disease of the whole person— physical, mental, emotional and spiritual" and suggested NA as its best solution.[56] Other publications related to NA included the *N.A. Newsletter*, produced in the early 1960s by the Fellowship House group at St. Augustine's Presbyterian Church in the Bronx.[57]

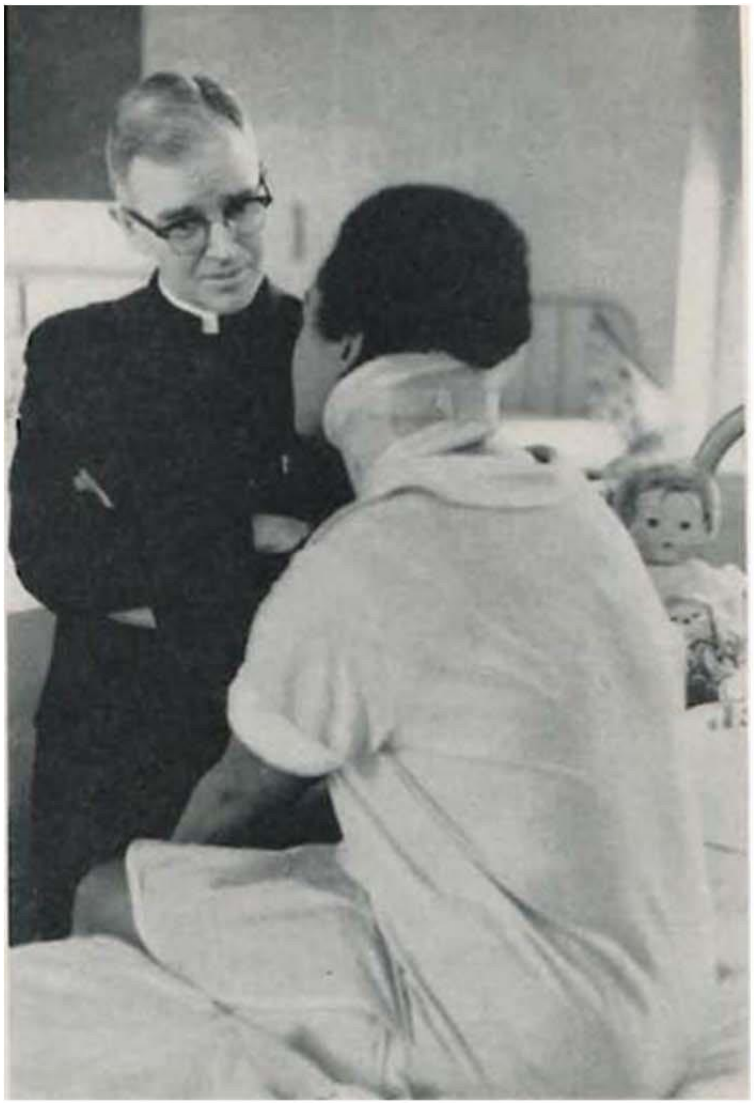
Growth of NA outside of New York City is illustrated by events in Cleveland. Marvin S. had been treated in the U.S. Public Health Service hospitals in Lexington and Fort Worth, Texas. While at Lexington, he participated in Addicts Anonymous, serving as secretary of the Men's group in 1962.[58] Upon his return to Cleveland, he attended AA meetings and helped start a local NA group under the organizational sponsorship of Captain Edward V. Dimond of the Salvation Army Harbor Light Center. Weekly meetings began November 6, 1963, but ceased in late 1964 when meeting attendance plummeted following Marvin's relapse and return to Lexington[59] (Marvin later helped organize NA in the Miami/West Palm Beach area of Florida).[60] NA meetings in Cleveland resumed in 1965 and continued until they were disbanded on October 1, 1970, due to "other groups now providing service in this area."[61]



Rae L. (left) and Brigadier Dorothy Berry
Jubilee Magazine courtesy of Mike R.

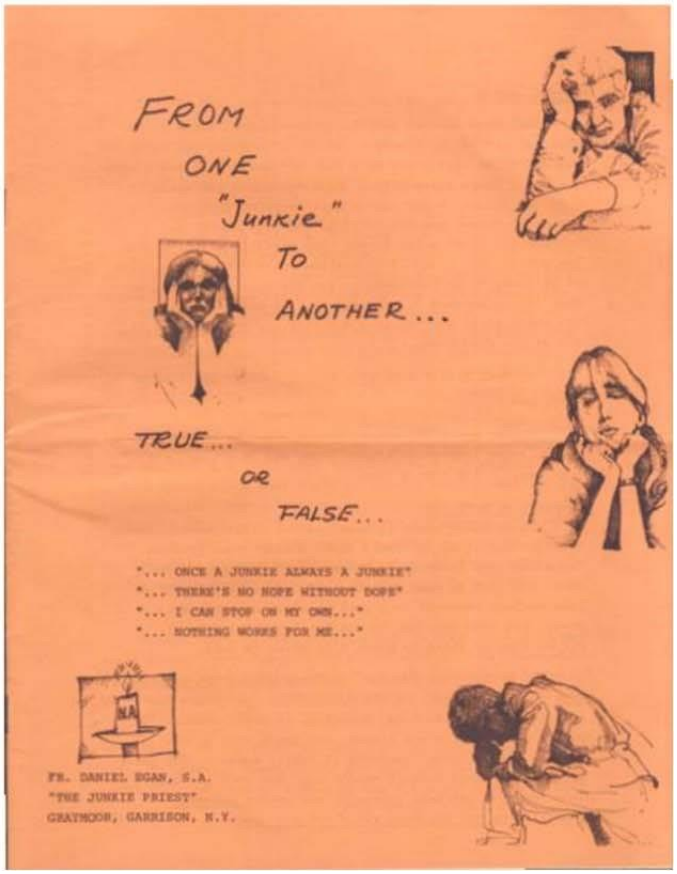
The NA created by Danny C. and others existed not as an organized fellowship but as isolated groups lacking connection through a common service structure. Some of the groups even chose names other than Narcotics Anonymous. The Chicago group, for example, referred to itself as Drug Addicts Anonymous. While attempts to adapt AA's Steps are evident across these groups, there is a marked absence of references to the use or adaptation of AA traditions, which were first formulated in 1946 and formally adopted by AA in 1950.

Because of the lack of a central service structure, it is unclear how many NA groups actually spread from the original New York-based NA. Evidence of these groups exists primarily within the oral history of later NA groups and as artifacts in NA archival collections. The early NA groups spawned under the original leadership of Danny C. dissipated in the mid-1960s and early 1970s in the wake of harsh new anti-drug laws and the death of Rae L. in 1972. But a new NA—NA as it is known today—was poised to rise on the West Coast.[62] For the beginnings of that story, we must return to Los Angeles in the early 1950s.



In Bellevue Hospital Father Daniel Egan visits an addict whose neck was broken when a man threw her out a window after a quarrel over money - Jubilee Magazine courtesy of Mike R. (left).

Later publication written by Father Egan – Courtesy of Danny M. (below)



Betty T., Jack P., and the West Coast AA/Lexington Connection

Betty T. left treatment at the Narcotics Farm in 1950[63] and shortly thereafter began correspondence with Houston S., Danny C., and AA co-founder Bill W. about her interest in starting a support group meeting for addicts in Los Angeles. Betty, a nurse, was addicted to narcotics and then alcohol and Benzedrine before beginning her recovery in AA on December 11, 1949.[64] Her interest in starting a recovery support group for addicts grew out of her own personal background and the growing number of people in AA she witnessed experiencing problems with drugs other than alcohol. On February 11, 1951, Betty hosted the first Habit Forming Drugs (HFD) meeting at her home—a special closed meeting for AA members who were also recovering from other drug addictions. These meetings continued weekly, then monthly, then as a special meeting for newcomers hosted as needed over the next few years.[65]

Betty became concerned over whether such a special meeting within AA or a special group separate from AA was needed. She discussed this question in a series of letter exchanges with AA co-founder Bill W. in 1951 and 1957, sharing her growing sense that a separate group was not needed for AA members with drug problems. She agreed with Bill W. that addicts who were not also alcoholics could attend open AA meetings but could not become AA members or attend closed AA meetings. That left open the need for a group for "pure addicts," but Betty felt she was not the person to start such a group, that Addicts Anonymous was not being accepted in Los Angeles, and that Danny C.'s New York-based Narcotics Anonymous groups were not adhering to the Twelve Traditions (e.g., Danny C.'s use of

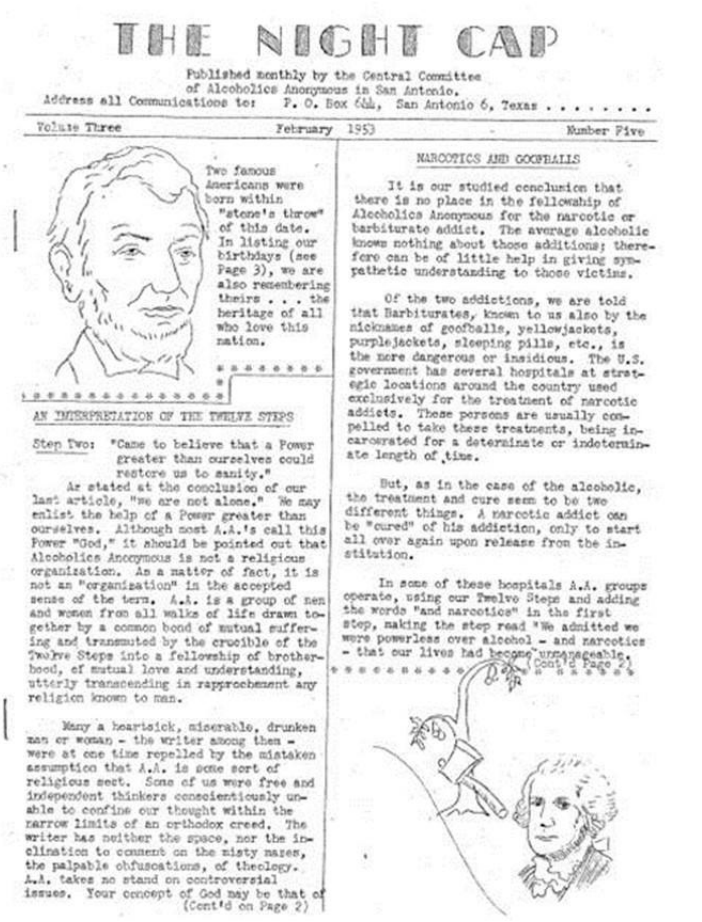
his full name in the press).[66] She particularly objected to new groups that dropped "alcohol" from the Steps: "They do not stress the danger of alcohol as a substitute for drugs!"[67]

The exchanges between Betty T. and Bill W. afford a window into the ambivalent attitudes of AA members toward drugs other than alcohol. Betty was quite candid about the "pill problems" she was observing in AA, and she was encouraged early on by the effects the HFD group was having on AA:

> *Throughout the L.A. area and as far down as San Diego the addict [who also admits he or she is powerless over alcohol] is one of us…many older members of AA that never told of a problem with drugs, are openly speaking of it at the meetings…I know that many narcotic and barbiturate addicts are sponsored in various groups by members of AA, and they never see an addicts group!*[68]

Bill W., for his part, frequently noted the strong mutual aversion between alcoholics and "dope addicts" and reported that in some areas there had been "violent opposition to drug addicts attending AA meetings."[69]

Such ambivalence and resistance is evident in early AA newsletters of this period. For example, the 1953 issue of the *The Night Cap*, a newsletter from the Central Committee of Alcoholics Anonymous in San Antonio, Texas, notes: "It is our studied conclusion that there is no place in the fellowship of Alcoholics Anonymous for the narcotic or barbiturate addict."[70] In a 1954 issue of *The Key*, a patient describes attitudes toward addicts in Las Vegas AA meetings: "all manner and kinds of people are made welcome, the thieves, conmen, crooked gamblers…, but 'NO DOPE ADDICTS' are permitted there."[71] Such declarations did not change the fact that many people addicted to drugs other than or in addition to alcohol were finding recovery within the fellowship of AA.



THE NIGHT CAP

Published monthly by the Central Committee of Alcoholics Anonymous in San Antonio.
Address all Communications to: P. O. Box 6th, San Antonio 6, Texas . . . . . .

Volume Three — February 1953 — Number Five

Two famous Americans were born within "stone's throw" of this date. In listing our birthdays (see Page 3), we are also remembering theirs . . . the heritage of all who love this nation.

AN INTERPRETATION OF THE TWELVE STEPS

Step Two: "Came to believe that a Power greater than ourselves could restore us to sanity."

As stated at the conclusion of our last article, "we are not alone." We may enlist the help of a Power greater than ourselves. Although most A.A.'s call this Power "God," it should be pointed out that Alcoholics Anonymous is not a religious organization. As a matter of fact, it is not an "organization" in the accepted sense of the term. A.A. is a group of men and women from all walks of life drawn together by a common bond of mutual suffering and transmuted by the crucible of the Twelve Steps into a fellowship of brotherhood, of mutual love and understanding, utterly transcending in rapprochement any religion known to man.

Many a heartsick, miserable, drunken man or woman - the writer among them - were at one time repelled by the mistaken assumption that A.A. is some sort of religious sect. Some of us were free and independent thinkers conscientiously unable to confine our thought within the narrow limits of an orthodox creed. The writer has neither the space, nor the inclination to comment on the misty mazes, the palpable obfuscations, of theology. A.A. takes no stand on controversial issues. Your concept of God may be that of

(Cont'd on Page 2)

NARCOTICS AND GOOFBALLS

It is our studied conclusion that there is no place in the fellowship of Alcoholics Anonymous for the narcotic or barbiturate addict. The average alcoholic knows nothing about those additions; therefore can be of little help in giving sympathetic understanding to those victims.

Of the two addictions, we are told that Barbiturates, known to us also by the nicknames of goofballs, yellowjackets, purplejackets, sleeping pills, etc., is the more dangerous or insidious. The U.S. government has several hospitals at strategic locations around the country used exclusively for the treatment of narcotic addicts. These persons are usually compelled to take these treatments, being incarcerated for a determinate or indeterminate length of time.

But, as in the case of the alcoholic, the treatment and cure seem to be two different things. A narcotic addict can be "cured" of his addiction, only to start all over again upon release from the institution.

In some of these hospitals A.A. groups operate, using our Twelve Steps and adding the words "and narcotics" in the first step, making the step read "We admitted we were powerless over alcohol - and narcotics - that our lives had become unmanageable.

(Cont'd Page 2)

The Night Cap (February 1953 Vol. Three, Number Five)
Courtesy of Mike R.

The tension around the issue of addicts attending AA meetings peaked in October 1957. Dr. George M. wrote the General Service Headquarters with the request of registering a new "habit forming drugs group" held at the Angola prison in Louisiana. Before registering the group, Anne M. of the GSH sought to clarify the composition of the group members, indicating that "AA's sole purpose is to help the sick alcoholic recover."[72] In her response to Dr. George M., she quoted Bill W. from his correspondence in May with a woman in Montreal:

> *Betty T., the gal on the coast of whom I referred you, has been able to take addicts to AA meetings for observation and she has been able to secure the help of many AAs in working with addicts. But at no time has she been able to make addicts into AA members and have them received as they should be. What I want to impress upon you is that she has really tried to do this, and has failed.*[73]

Dr. George M. forwarded Anne's reply to Betty T., sparking a flurry of letters between her and the GSH and Bill W. on such issues as the distinction between "dual problem alcoholics" and "simon-pure alcoholics," dissension caused by straight addicts "making testimonies" in AA meetings, the question of need for "dual purpose groups" (i.e., alcoholism and sedative use; alcoholism and depression), whether alcoholism is a condition distinct from other drug addiction, and the decision to remove the Habit Forming Drugs Group from the AA world directory. Bill wrote:

> *Therefore the friction has sprung up, here and there, that an alcoholic is a narcotic, even though he has no sedatives or drugs. And, vice versa narcotics who never guzzled a pint of liquor, sometimes claim they are alcoholics, because alcohol is a narcotic. Personally I think this is kind of a rationalization that won't work practically and at best it's only a half truth. Supposing that a homosexual to say I've never had an alcoholic history but I do have a compulsion. Alcoholics also have a compulsion therefore I'm an alcoholic. That would be absurd, wouldn't it? Therefore for AA purposes I think we have to forget about the theory that alcoholics are narcotics and narcotics are alcoholics. A single person may have both addictions. But if he only has one it doesn't mean that he has the other.*

He went on in this communication to share his decision to write an article for the *Grapevine* to show "where AA begins and where it leaves off in these matters."[74] The February 1958 issue of the *Grapevine* included Bill's promised article, *Problems Other Than Alcohol: What Can Be Done About Them?* The article, by clarifying the boundaries of AA's primary purpose, set the stage for the later development of a distinct NA fellowship.

Betty T. was not the only one writing Bill W. in these years about the problem of drug addiction. Lynn A. corresponded with Bill W. about a Narcotics Anonymous meeting she started on December 23, 1954, in Montreal after correspondence with Danny C. At the heart of her letters was the proposal that use of the term "addiction" instead of "alcoholism" could further widen the doorways of entry into recovery and allow AA to help a greater number of people. She even pleaded with Bill to concede that he was an alcohol addict.[75]

As noted previously, Bill struggled with the ability for addicts to become AA members and often attributed this to perceived differences between alcoholics and addicts. But Bill was convinced that alcoholics and addicts could not be mixed, as he suggested in the following anecdote:

> *The failure has to do with an almost inexplainable* (sic) *distrust and dislike of alcoholics and addicts for each other. It is an absurd and crazy business, but a fact nevertheless. One day, years ago, I met a man in the corridor of Towns Hospital, where I used to go as a patient. I was there on a 12-Step job. I asked him for a match to light my cigarette. Haughtily he drew himself up and said, "Get away from me you goddamn alcoholic."*[76]

In July of 1952, Jack P., a member of AA's Los Angeles Institutional Committee, sent a letter to Bill W. informing him of a request that had come to AA from the Los Angeles Sheriff's Department to help start a "Narcotics Anonymous" group in the Women's Division of the County Jail. Jack asked Bill for copies of existing literature on narcotics published by the Alcoholic Foundation; a list of known groups for "narcotics"; and any "thoughts, ideas, advice and knowledge" that might be helpful.[77] Jack went on to note that he and Mrs. Bea F., chair of the local AA Institutional Committee, were helping start such a group as private individuals and not as AA members.[78] Bill W. expressed interest in this "narcotics project" and went on to elaborate on his earlier stated views:

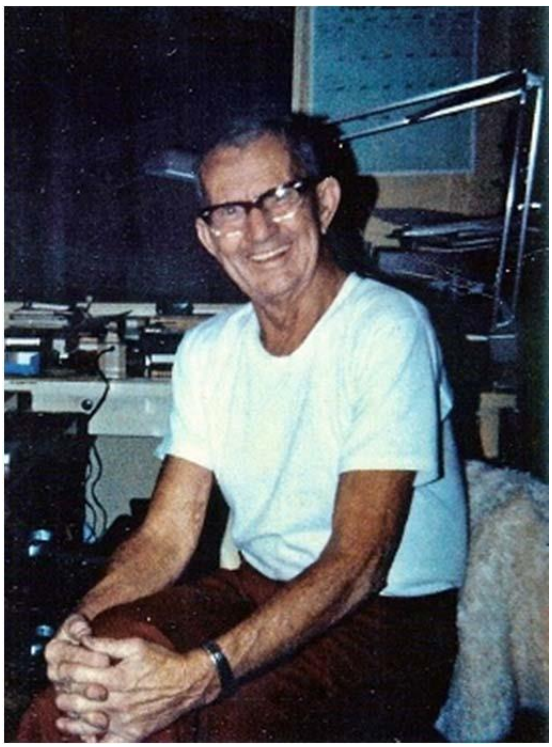
> *Their experience indicates that the narcotic who was formerly an alcoholic can transmit straight to the narcotic himself. To a narcotic, that is, who was never an alcoholic. However, that doesn't mean that you people in L.A. can't jump the gap. I certainly think you ought to try though I agree*

it should not be in the least under A.A. auspices. For some reason hard to fathom alcoholics do not care for narcotics. And narcotics as a class disdain us – they think we're gutter snipes![79]

About ten months passed between Bill's letter and the next known development in the formation of an actual group. In the middle of June 1953, the planned meeting of NA was held at the Unity Church on Moorpark Street in Van Nuys.[80] One of the AA members attending was Jimmy K., who took over the leadership of this group in July of 1953.[81] Jimmy would later say, "…we started long before NA was a reality, even in name…we grew out of a need and we found those of us who were members and had come into AA and found we could recover."[82] Another group that met briefly in the early 1950s was called Hypes and Alcoholics (HYAL), some of whose members were later involved in the founding of Synanon—the first ex-addict-directed therapeutic community.

When Bill W. was repeatedly asked for guidance on starting groups for "mainline addicts," he suggested that "bridge members" (AA members who were also recovering from drug addiction) could serve as catalysts to develop such support.[83] As it turns out, that is precisely what happened. The man who served as this bridge in the summer of 1953 was Jimmy K.—widely considered the founder (or co-founder) of NA as it exists today.[84]

Jimmy K. and the Birth of Today's NA



Jimmy K.
Courtesy of Cathie Kinnon Lindner

Jimmy K. was born April 5, 1911, to James and Lizzie K. in Paisley, Scotland, his family having first migrated from Ireland in the mid1830s. The K. extended family was a close-knit Irish Catholic clan in which drinking, singing, dancing, and storytelling were woven into the fabric of daily life.[85] As a child, Jimmy K. befriended a Mr. Crookshank, the "town drunk." When Jimmy later visited Mr. Crookshank in a local asylum, he vowed to his mother that he would one day help men like Mr. Crookshank.[86] What would have been unclear then was the arduous path required to fulfill that oath.

Jimmy's father migrated to the United States in 1921, and two years later, Jimmy, his mother, and four younger siblings joined him. The family settled first in a working class neighborhood in northeast Philadelphia and later relocated to California. Jimmy progressed from sneaking sips of paregoric and altar wine as a child to daily runs of whiskey and pills through his young adulthood. A self-described "lone wolf," Jimmy's excessive use of codeine, pills, and alcohol had left him "bankrupt physically, mentally and spiritually" and an "abject failure as a man, a husband, and a father."[87] It was in that state that he began his recovery in Alcoholics Anonymous on February 2, 1950.

Like Houston S., Danny C., Betty T., and Jack P., Jimmy developed a passion for helping others recover. Every encounter for him was an opportunity for service. Jimmy's daughter Cathie recalls an incident in which an intoxicated driver crashed into her car while it was parked in front of the family home. Jimmy brought the drunken man into his home, offered him a cup of coffee, and as the police took him away, encouraged the man to get some help and offered his assistance.[88] An NA member would later say of Jimmy, "There was something very magical about the way Jimmy carried the message—when people got close to him, their natural inclination was to recover."[89]

When Jimmy K. began attending AA in 1950, he introduced himself as an "alcoholic addict" and developed an early interest in helping those with multiple addictions. He attended early meetings of

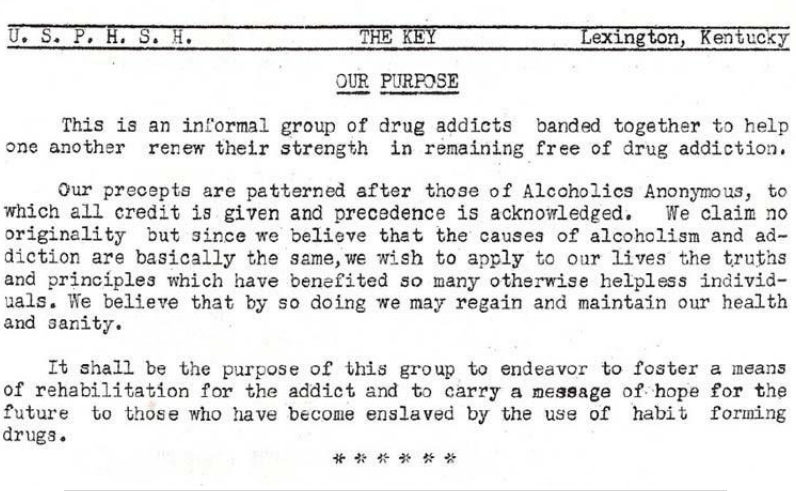
Habit Forming Drugs and Hypes and Alcoholics and communicated with Danny C. in the early 1950s about the NA group that Danny had started in New York City.[90] In a 1984 interview, Jimmy K. indicated that he had corresponded with Danny and that he was concerned that there was no ongoing NA group in NYC.[91] While in conversation with Dorothy S., another member of AA, Jimmy stated that he needed to write Danny again. Dorothy shared that she had written Danny after Jimmy had shared Danny's address with her and that she had just received a response dated January 2, 1952.[92] It is assumed that in her letter to Danny, Dorothy requested copies of their booklet *Our Way of Life* because Danny responded that they were temporarily out. Danny did include a copy of *Facts About Narcotics*—a four-page educational pamphlet."[93]

The 1984 interview with Jimmy and correspondence from Danny C. to Dorothy S. clearly establish an awareness of and influence of Narcotics Anonymous in New York City upon the efforts to start a group for addicts in North Hollywood, California, but the nature of that influence is difficult to assess. Jimmy would later state that the only thing the California group took from NA in New York was the name.[94]

On August 17, 1953, the first organizational meeting of the group met at 10146 Stagg Street, Van Nuys, California, with six people present (Frank C., Doris C., Guilda K., Paul R., Steve R., and Jimmy K.). Jimmy K. was nominated as president September 14, 1953. Since the AA name could not be used, the name was changed to Narcotics Anonymous—a name suggested by Jimmy based on his knowledge of NA in New York City.[95] The NA bylaws passed August 17, 1953, state: "This society or movement shall be known as Narcotics Anonymous, and the name may be used by any group which follows the 12 steps and 12 traditions of Narcotics Anonymous."[96] An "Our Purpose" statement was incorporated into the NA bylaws from *The Key*:

Our Purpose

> *This is an informal group of drug addicts, banded together to help one another renew their strength in remaining free of drug addiction.*
>
> *Our precepts are patterned after those of Alcoholics Anonymous, to which all credit is given and precedence is acknowledged. We claim no originality but since we believe that the causes of alcoholism and addiction are basically the same we wish to apply to our lives the truths and principles which have benefited so many otherwise helpless individuals. We believe that by so doing we may regain and maintain our health and sanity.*
>
> *It shall be the purpose of this group to endeavor to foster a means of rehabilitation for the addict, and to carry a message of hope for the future to those who have become enslaved by the use of habit forming drugs.*[97]



U. S. P. H. S. H. THE KEY Lexington, Kentucky

OUR PURPOSE

This is an informal group of drug addicts banded together to help one another renew their strength in remaining free of drug addiction.

Our precepts are patterned after those of Alcoholics Anonymous, to which all credit is given and precedence is acknowledged. We claim no originality but since we believe that the causes of alcoholism and addiction are basically the same, we wish to apply to our lives the truths and principles which have benefited so many otherwise helpless individuals. We believe that by so doing we may regain and maintain our health and sanity.

It shall be the purpose of this group to endeavor to foster a means of rehabilitation for the addict and to carry a message of hope for the future to those who have become enslaved by the use of habit forming drugs.

* * * * * *

The Key (August 20, 1954 Vol. 7 No. 5)
Courtesy Stepping Stones Foundation

Minutes of early meetings reflect concern for traditions, establishment of closed and open meetings, restriction of speakers to those recovering from drug and/or alcohol addiction, and plans for a wide variety of community promotional activities (e.g., development of signs, meetings with heads of Narcotics Divisions of local Police Departments, outreach to social workers, lectures in local schools, newspaper ads).[98] An ongoing meeting was established by the NA organizational committee, with the first meeting held October 5, 1953, at Cantara and Clyborn Streets at a place called "Dad's Club" in Sun Valley, California. Twenty-five people attended. Attendance at early meetings ranged from 10-35. In a further connection to pre-NA roots on the east coast, a collection was taken up some time in late 1953 for Jimmy to attend a conference at Lexington.[99]

Many problems plagued this early effort. Personality conflicts ensued, and all original members of the NA organizing committee had resigned their leadership positions by the end of 1953. Negotiations with local police were required to minimize surveillance and harassment of those attending meetings. The first NA group moved to "Shier's Dryer"—a sanitarium for alcoholics[100]—and NA members continued to attend AA meetings in addition to the one NA meeting per week. Most people entering NA at this time were heroin addicts, and people approaching NA without a history of heroin injection were viewed as having questionable addict credentials.[101] As one early NA member describes:

> *We came strictly from the streets, if they used anything other than heroin, we didn't think they were addicts for real. Cause our definition of an addict was that person who stuck that spike into his arm.*[102]

NA meetings were often held in people's homes for lack of any place else to meet—a coffee pot and set of Depression glass cups moving from location to location.[103] Jimmy K. continued his contact with NA during these early years, but avoided leadership roles due to his alarm over changes that were occurring within NA.

There were significant differences between the modes of operation in New York and California NA groups. New York NA members, more "pure" morphine or heroin addicts, had little concern about alcohol and little contact with AA. In contrast, three of the California founders of NA had histories of alcohol and other drug addictions, brought in prior affiliations with AA, and emphasized strict adherence to the Steps and Traditions as adapted from the AA program. When NA groups veered from those principles, those so-called "bridge members" left NA and returned to AA. Danny C.'s east coast meetings and the west coast groups shared the name Narcotics Anonymous, but they were not the same organization, with East Coast NA exerting only a peripheral influence on the west coast NA that evolved into NA as it is known today.

The new NA that was rising on the west coast maintained a fragile existence throughout its first six years, but its future was by no means assured. One of the things that influenced its fate was a choice of words.

The Steps

The adaptation of the Steps of Alcoholics Anonymous as a guide to recovery from other drug addictions is not as straightforward as it might seem, and the nature of these adaptations exerted a profound influence on the subsequent history of NA and the larger arena of addiction recovery.

Lacking enduring leadership in the face of constant patient turnover at Lexington, the Steps of Addicts Anonymous vary across time. A 1951 volume of *The Key* presents Steps One and Twelve as follows:

> *Step One: We admitted we were powerless over alcohol and drugs—that our lives had become unmanageable.*
>
> *Step Twelve: Having had a spiritual experience (or awakening) as a result of these steps, we try to carry this message to alcoholics and addicts and to practice these principles in all our affairs.*[104]

Here, we see a substitution of the phrase "alcohol and drugs" for AA's "alcohol" in Step One and "alcoholics and addicts" for AA's "alcoholics" in Step Twelve. By 1959, The First Step read, "We admitted we were powerless over drugs…that our lives had become unmanageable," and the Twelfth Step read, "carry this message to addicts."[105]

Members of the Habit Forming Drugs group in Los Angeles, as a special meeting of Alcoholics Anonymous, used AA's Twelve Steps, but Betty T. did pen "12 Suggestions That May Be of Help to Anyone Addicted to Drugs." Her suggestions emphasized the absolute and permanent ("no compromise") need to abstain from alcohol, drugs, and all medications not prescribed by a physician knowledgeable about addiction.[106]

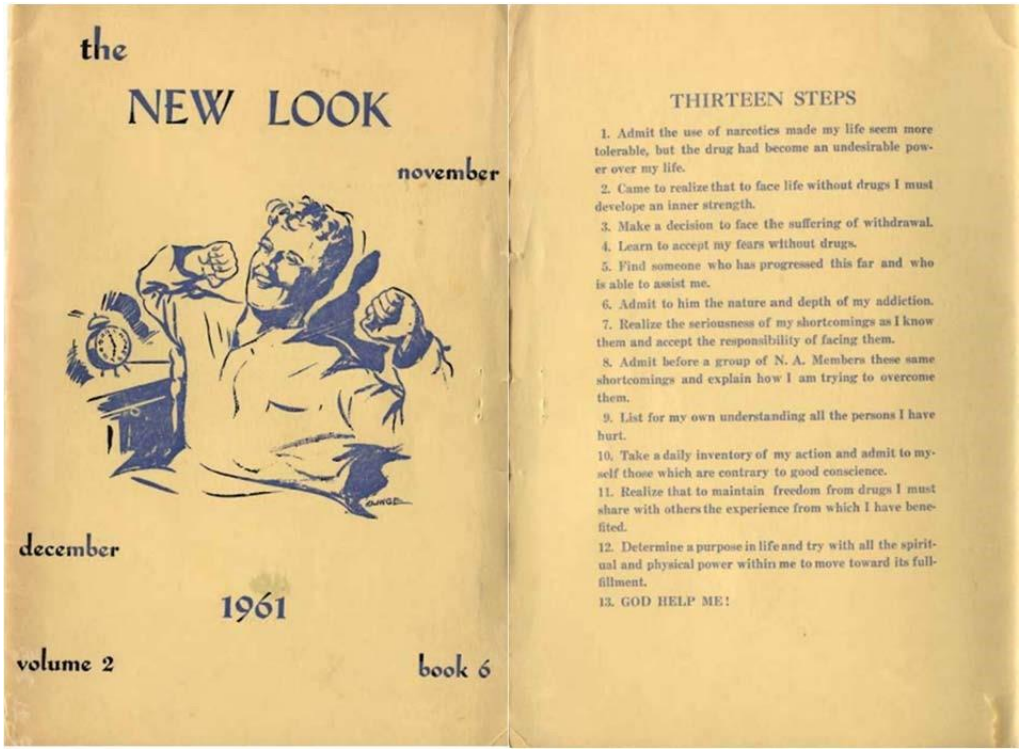
Since the early New York-based NA existed as independent meetings without a unifying service structure, the Steps varied by group. Most early New York City NA meetings, as well as Cleveland NA (1963), used the Twelve Steps that were outlined in the Addicts Anonymous pamphlet, *Our Way of Life*, which substituted the phrase "powerless over drugs" for the phrase "powerless over alcohol" in Step One, and substituted "carry this message to narcotic addicts" for "carry this message to alcoholics" in Step Twelve.[107]

A Thirteen-Step version can be found in the early 1960s literature of NA groups from Fellowship House in the Bronx and in a newsletter from the New Look Group of Narcotics Anonymous held at the State Prison of Southern Michigan (Jackson, Michigan)—the latter one of several prison groups Rae L. helped start by mail.[108]

1. *Admit the use of narcotics made my life seem more tolerable, but the drug had become an undesirable power over my life.*
2. *Come to realize that to face life without drugs I must develop an inner strength.*
3. *Make a decision to face the suffering of withdrawal.*
4. *Learn to accept my fears without drugs.*
5. *Find someone who has progressed this far and who is able to assist me.*
6. *Admit to him the nature and depth of my addiction.*
7. *Realize the seriousness of my shortcomings as I know them and accept the responsibility of facing them.*
8. *Admit before a group of N.A. members these same shortcomings and explain how I am trying to overcome them.*
9. *List my own understanding of all the persons I have hurt.*

10. *Take a daily inventory of my actions and admit to myself those which are contrary to good conscience.*
11. *Realize that to maintain freedom from drugs I must share with others the experiences from which I have benefited.*
12. *Determine a purpose in life and try with all the spiritual and physical power within me to move towards its fulfillment.*
13. *God Help Me! These three words summarize the entire spirit of the 12 preceding steps. Without God I am lost. To find myself I must submit to Him as the source of my hope and my strength*.[109]

Use of the Thirteen Steps by some NA groups on the east coast continued into the mid1960s. The New Look NA group, which was started in 1959, shifted in 1968 to the use of west coast NA Steps and literature.[110]



Michigan Prison in Jackson, Michigan. New Look courtesy of anonymous NA Member

Thirteen Steps that appear in the bi-monthly publication for N.A. members at the Southern

Within the emerging California-rooted NA, there was considerable debate in 1954 over how to phrase the Steps. Jimmy K. prevailed in these discussions in getting the phrase "our addiction" inserted into the First Step rather than such alternatives as *alcohol and drugs*, *narcotic drugs*, or *drugs*.[111] This is somewhat remarkable in light of the fact that *addiction* was a word rarely heard in the AA circles that exerted such an early influence on NA.[112] This innovation is also of considerable historical significance. NA Trustees would later note:

> *Drugs are a varied group of substances, the use of any of which is but a symptom of our addiction. When addicts gather and focus on drugs, they are usually focusing on their differences, because each of us used a different drug or combination of drugs. The one thing we all share is the disease of addiction. It* [defining NA's First Step in terms of addiction] *was a masterful stroke. With that single turn of a phrase the foundation of the Narcotics Anonymous Fellowship was laid.*[113]

AA, New York-based NA, and later Twelve-Step groups staked their institutional identities and the process of mutual identification on a particular drug choice. In contrast, the NA rising on the west coast in the early 1950s forged its identity and internal relationships not on the shared history of narcotics (the dominant drug choice of early members), but on a shared process of addiction. Jimmy K.'s writings are very clear on this singular point:

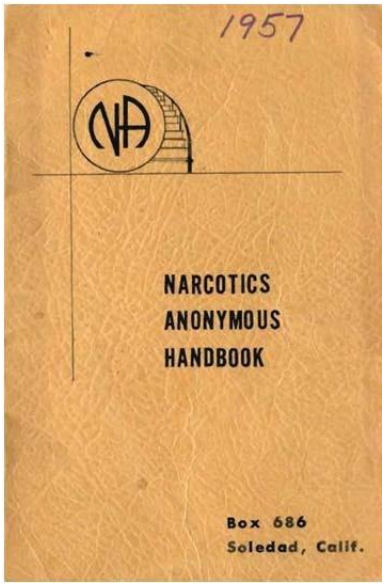
> *Addiction is a disorder in its own right…*[114]*--an illness, a mental obsession and a body sensitivity or allergy to drugs which sets up the phenomenon of craving, over which we have no choice, as long as we use drugs.*[115]

This had three effects. First, it addressed the frequently encountered problem of drug substitution by embracing renunciation of all drugs, including alcohol, within the concept of recovery. Second, it opened the potential for people to enter NA with drug choices other than opiates. Third, it explicitly defined addiction as a "disease" and the addict as a "sick" person.

This early understanding is revealed in the Narcotics Anonymous Handbook developed by NA members at Soledad Prison in 1957:

> *At our meetings of Narcotics Anonymous, we join together in fellowship, where we tell our stories in an effort to arrest our common disease—addiction.*[116]

> *Here* [in NA] *we have come to realize that we are not moral lepers. We are simply sick people. We suffer from a disease, just like alcoholism, diabetes, heart ailments, tuberculosis, or cancer. There is no known cure for these diseases and neither is there for drug addiction. But, by following the principles of Narcotics Anonymous completely, we can arrest our disease of addiction to narcotics.*[117]



Handbook for Narcotics Anonymous group in Soledad Institution . Courtesy of anonymous NA member.

NA's definition of the problem as a process of "addiction" that transcended one's drug choice and required a common recovery process may be viewed by future historians as one of the great conceptual breakthroughs in the understanding and management of severe alcohol and other drug problems. This is all the more remarkable coming at a time that substance-specific disorders were still thought to be distinct from each other, as were their treatment and recovery processes. In *addiction*, NA found an organizing concept similar to the 19th century concept of *inebriety* and anticipated future professional efforts to create such an umbrella concept (e.g., *chemical dependency*) and future scientific findings that addiction to multiple drugs is linked to common reward pathways in the brain.

For Jimmy K. to have made this conceptual leap in the early 1950s is a remarkable achievement deserving of wider recognition from the scientific and professional communities. What this meant within the NA experience as NA grew across the country was expressed by one of the early NA members in Philadelphia:

> *We wanted the door to be as wide open as possible. We wanted to drop all that street shit: "I'm cooler than you because I shot meth, and you just drop Black Beauties." We had to come to the point: "We're all addicts. Drugs kicked our asses, and it really doesn't matter whether you're strung out smoking reefer every day or you're shooting a couple thousand bucks of heroin a week." It's about addiction—drug addiction.*[118]

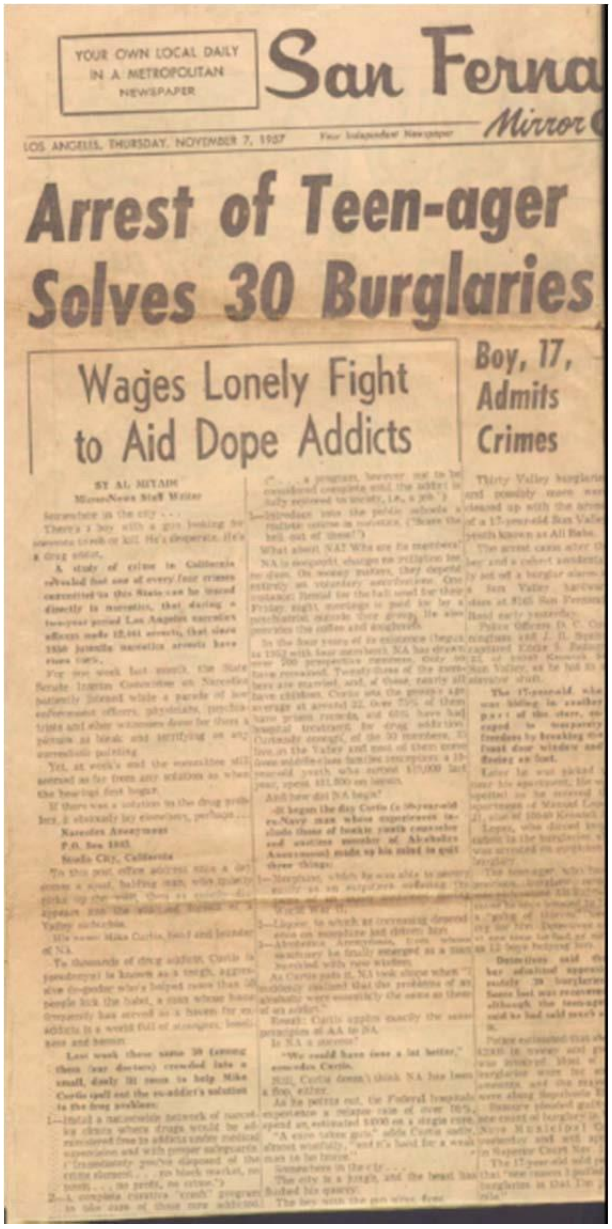
The contemporary emergence of "addiction" and "recovery" as conceptual frameworks for the professional field of addiction treatment and as frameworks for the larger cultural understanding of severe alcohol and other drug problems and their resolution is historically rooted in NA's formulation of its Twelve Steps in 1954. However, this breakthrough did not assure NA's survival as an organization.

NA's Near-Death Experience

Between 1953 and 1958, the fledgling NA group in California continued to meet, but meetings were, at best, "periodic or sporadic."[119] Several factors contributed to the dissipation and near death of NA, including NA coming under the influence of Cy M., who took over the chairman role on September 23, 1954.[120] Cy was an AA member who had also been addicted to painkillers following wartime combat injuries. Jimmy recruited Cy to be the speaker at the first meeting that was held on October 5, 1953, because of Cy's history and his previous comments that addicts should find another place to go besides Alcoholics Anonymous.[121] Cy's dominance (he sometimes referred to himself as the "founder of NA"[122]) and aggressive promotion of NA extended NA's early reach into places like San Quentin Prison, but the resulting personality conflicts engendered by his leadership style led to the resignation of all of the original founding members.[123] Jimmy later described this period:

> *So, the very first meeting, it wound up, oh God, it was a riot. Everybody was fighting with each other. Within two weeks, we only had one or two people left of the original group*.[124]

Several changes in NA philosophy and practice occurred during Cy's leadership tenure. The new directions unfolding in these years are indicated by a description of an NA meeting appearing in a November 7, 1957, article in the *San Fernando Valley Mirror*. The article describes those at the meeting setting forth a 3-part plan to solve the nation's drug problem: 1) create a nationwide network of clinics where confirmed addicts would be administered free drugs under medical supervision, 2) create a "crash program" for treatment and social rehabilitation, and 3) introduce a course in narcotic education into the schools with the goal to "scare the hell out of them."[125] There were also reports during this period that the tenor of NA meetings changed when Cy began using a confrontational "hot seat" technique in the meetings— before such techniques were popularized by Synanon.[126]



YOUR OWN LOCAL DAILY IN A METROPOLITAN NEWSPAPER

San Ferna Mirror

LOS ANGELES, THURSDAY, NOVEMBER 7, 1957

Arrest of Teen-ager Solves 30 Burglaries

Wages Lonely Fight to Aid Dope Addicts

Boy, 17, Admits Crimes

San Fernando Valley Mirror article (Nov. 7, 1957)

Courtesy of NAWS, Inc.

By 1959, the only NA meeting was at Shier's Dryer, and Jimmy K. had stopped attending that meeting because of his strong feelings on the need for NA non-affiliation and self-support.[127] The notes Jimmy K. would later use to guide his presentations on early NA history contain references to this period that are telling, e.g., "One Man Domination—No Growth," "Personalities—Resentments, Resignations," and "new committee almost completely dropped traditions."[128] A critical final turning point in NA's 1959 collapse was Cy and another member (who was suspected of being loaded at the time) appearing on a television show in the fall of 1959. As conflict grew, Cy withdrew from leadership, and NA meetings ceased for a short time.[129]

When NA ceased meeting in late 1959, Jimmy K., Sylvia W., and Penny K. met to see what they could do to rekindle NA. There were no existing members, no money in the treasury, and no literature.[130] NA was reborn when they started the Architects of Adversity NA Group at Moorpark, later known within NA as the "Mother Group."[131] Members came and went in this reborn NA, but it was Jimmy's tenacious presence that held the group together. Bob B., who was in and out of NA at that time before becoming one of NA's long-term members, later reflected:

...there was only usually one or two of the old crowd still there at any given time. Every time I'd go out and come back to see who was still there, there was usually Jimmy and one other...Jimmy always seemed to be the one who was always standing there with the door open saying, "Come on in and have a cup of coffee."[132]

NA learned painful lessons through its near-death experience, including the dangers of relying on a single, dominant leader, the risks of abandoning adherence to NA Traditions, and the need for a distinctive NA culture. NA was reborn in late 1959 with those lessons in mind. NA's near-death experience cleaved its history into "before" and "after," with the phrase "NA as we know it today" used to denote the new NA that rose in 1959 from the ashes of the old.[133] As earlier members returned and new members joined, NA began its slow growth into the present. By 1964, NA had grown to a core of 20-25 members in the L.A. area, most of whom had histories of intravenous heroin use and past jail or prison experience.[134] The severity and chronicity of their past addictions offered living proof of the transformative power of NA as a framework for long-term recovery.

This collapse and rebirth of NA in California occurred at a time that Addicts Anonymous meetings continued at Lexington and NA meetings continued in New York City and other Eastern cities. Whether any of these groups would survive was still open to question. To survive and grow, NA—like AA

before it—needed a core body of literature to help carry its message and prevent corruption of its basic program.

NA Literature and NA's Basic Text

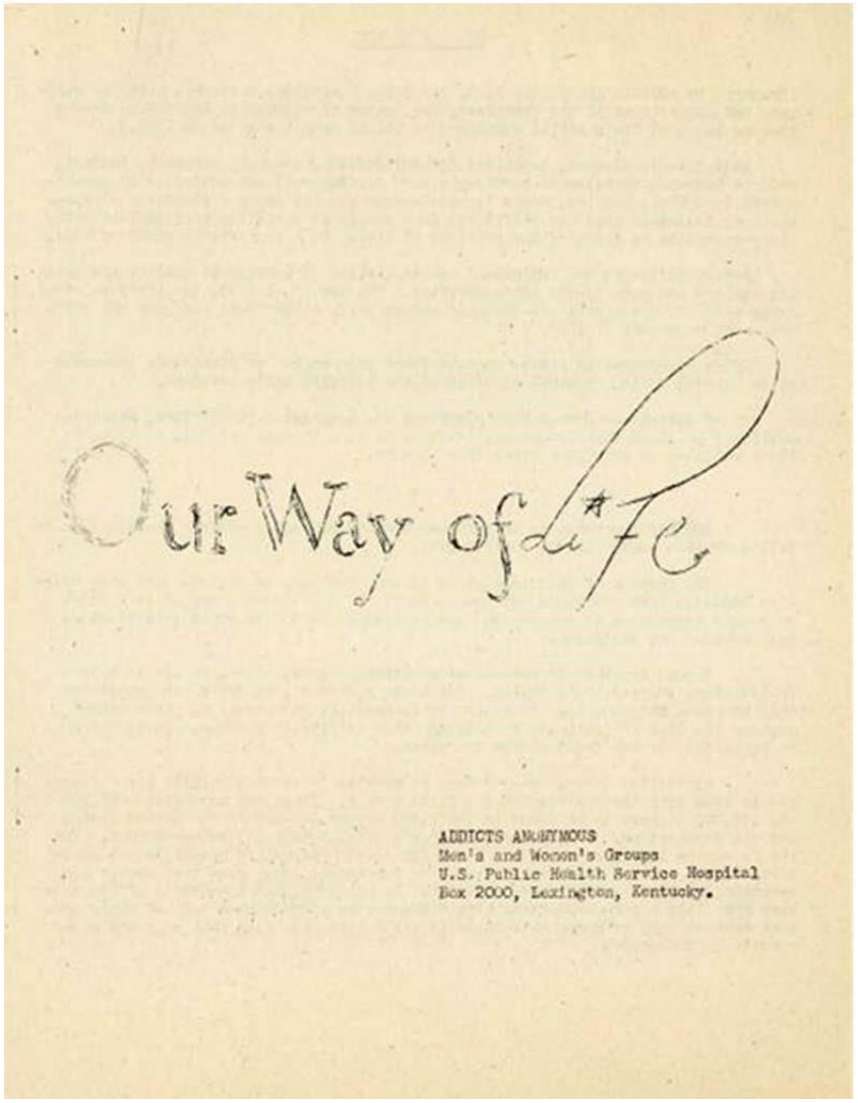
The book *Narcotics Anonymous*, commonly referred to as the *Basic Text*, is for many NA members as much a part of their recovery as meetings, sponsorship, and service work. NA literature evolved through the substitution of words within or mimicking of AA literature to the emergence of authentic voices of NA recovery experience.

The first generation of literature written by and for addicts originated from the Addicts Anonymous Group in Lexington, Kentucky. Though the exact publication date is unknown, by April 1949, the Addicts Anonymous group had produced the pamphlet *Our Way of Life*, which was adapted directly from the Alcoholics Anonymous pamphlet, *A Way of Life*.[135] Bobbie B. of the Alcoholics Anonymous General Service Headquarters wrote quite prophetically to Clarance B., secretary of the Addicts Anonymous group:

> *I have just finished going over the mimeographed booklet "Our Way of Life" and I find it good. Isn't it wonderful how simple a transition can be made of our Twelve Steps from one illness to another?*[136]

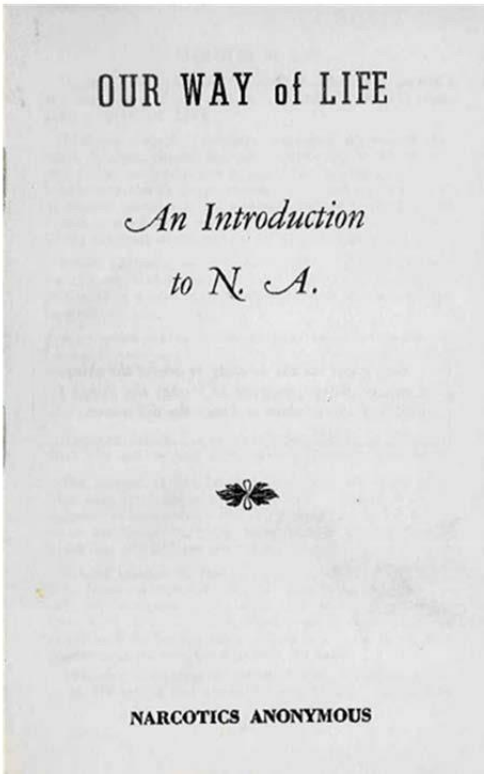
A significant development in the history of literature for recovering addicts occurred between 1954 and 1956 when the California-based NA developed a pamphlet authored by Jack P., Cy M., and Jimmy K. that is variably known as the *Little Brown Book*, the *Buff Book*, or the *Little Yellow Book*.[137] In addition to the "addiction" terminology appearing in Step One, the "Just For Today" passage from this pamphlet continues to be a mainstay in many NA meetings.[138]

Following the near death of NA in 1959, Jimmy K., Silvia W., and Penny K. undertook the writing of new NA literature. *Who Is an Addict?*, *What Can I Do?*, *What Is the NA Program?*, *Why Are We Here?*, and *Recovery and Relapse* were all written during 1960, and *We Do Recover* was completed in 1961. These writings, along with the Steps and Traditions, were consolidated into a publication called the *Little White Booklet*—also known as the *White Book*— which was first published in 1961[139] and to which personal stories were added in 1966.[140] The *White Book* served as the primary piece of NA literature for the next 20 years and provided the framework for the later development of NA's *Basic Text*.

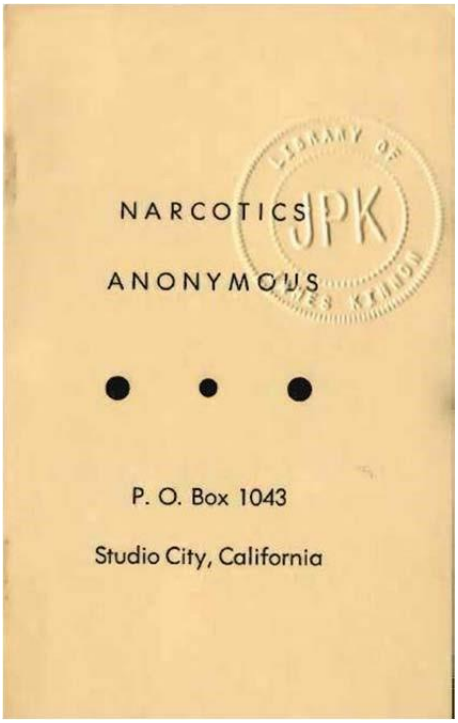


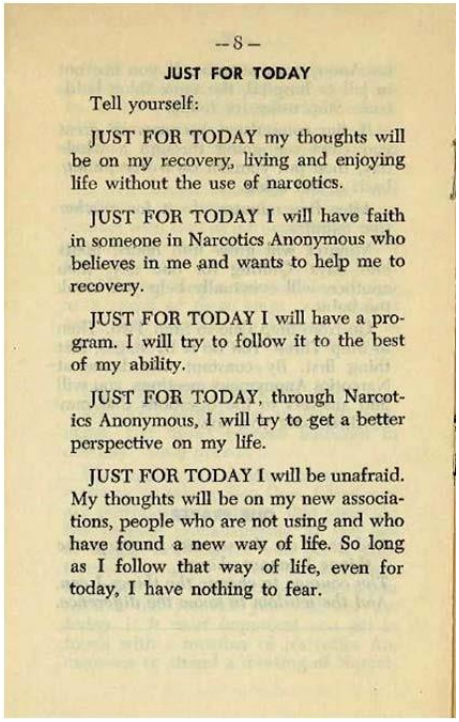
First known published literature for addicts by addicts – Our Way of Life (left). Danny C. quickly adapted this publication for Narcotics Anonymous; which was reviewed in the American Journal of Public Health in February 1951 (below).

Courtesy G.S.O. Archives, AAWS, Inc.



In 1971, NA Trustees explored the idea of publishing a book intended to be "somewhat analogous to AA's *Big Book*."[141] A proposal to just edit the *Big Book* to read more like an NA publication was rejected, and in 1972, a letter was sent from the "Book Committee" at the NA World Service Office asking the Fellowship for help in preparing a hardcover book to be titled *Narcotics Anonymous* that would "present the NA program of recovery and way of life in terms that are meaningful to the newcomer who cannot identify with alcoholism."[142] The lack of response to this letter from NA membership provided no means for the Committee to move forward with the book project at that time. A more modest effort emerging from Northern California NA in 1972 was *This Is NA*, which involved minor word substitution from the *This Is AA* pamphlet—a fact that led to its later removal as NA literature.[143,144]





– 8 –

JUST FOR TODAY

Tell yourself:

JUST FOR TODAY my thoughts will be on my recovery, living and enjoying life without the use of narcotics.

JUST FOR TODAY I will have faith in someone in Narcotics Anonymous who believes in me and wants to help me to recovery.

JUST FOR TODAY I will have a program. I will try to follow it to the best of my ability.

JUST FOR TODAY, through Narcotics Anonymous, I will try to get a better perspective on my life.

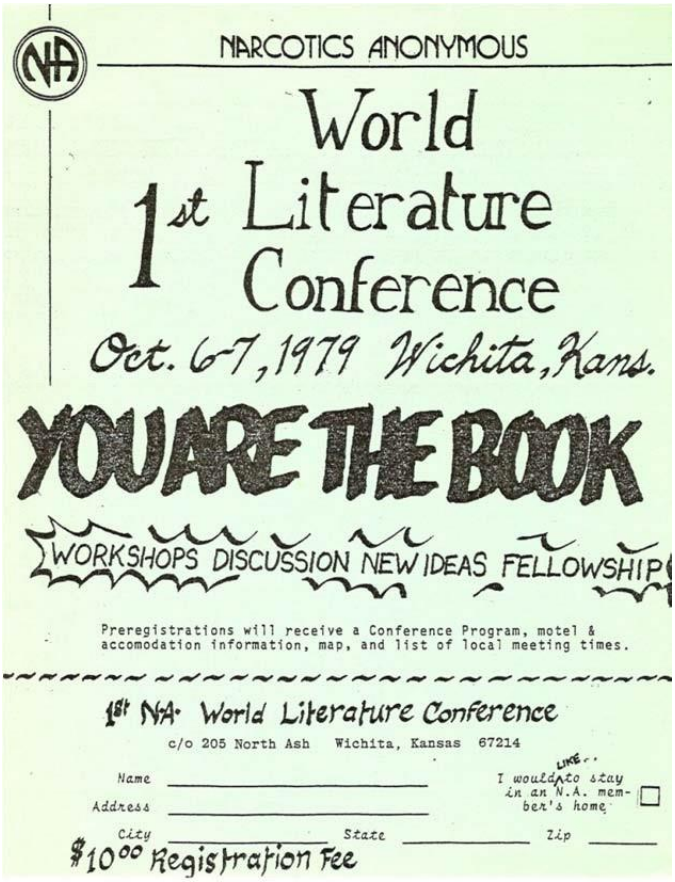
JUST FOR TODAY I will be unafraid. My thoughts will be on my new associations, people who are not using and who have found a new way of life. So long as I follow that way of life, even for today, I have nothing to fear.

Brown (Buff) Book, which contains the Just For Today reading; the oldest known piece of literature that is still read regularly in NA meetings today. Courtesy of anonymous NA member.

Despite these early 1970s efforts, the only significant literature developments in the next 10 years were five informational pamphlets printed in 1976 (*We Made A Decision*, *So You Love An Addict…*, *Another Look*, *Recovery and Relapse*, and *Who*, *What*, *How and Why*).[145] Renewed effort to create the equivalent of AA's *Big Book* for NA came from NA members in Atlanta, GA. The spark for this project was ignited when Bo S. attended the 7th World Conference in San Francisco in 1977 and spoke with many of those present about the need for an NA *Basic Text*. Bo returned to Atlanta with the support and validation to pursue work on the *Basic Text* from two influential California NA members, Jimmy K. and Greg P. The book was written between 1979 and 1982 over seven World Literature Conferences that involved over 400 recovering addicts in NA. NA's *Basic Text* was approved in 1982 and officially released in 1983.

The writing of the *Basic Text* was achieved through a massive grassroots effort characterized by inclusiveness and great sacrifice. The 1st World Literature Conference (Wichita, KS, 1979) resulted in the *Handbook for Narcotics Anonymous Literature Committees*. The handbook established certain values that guided the process of creating a book for the NA Fellowship. All members were encouraged to contribute material with the hope of being able to create the best possible book.[146]

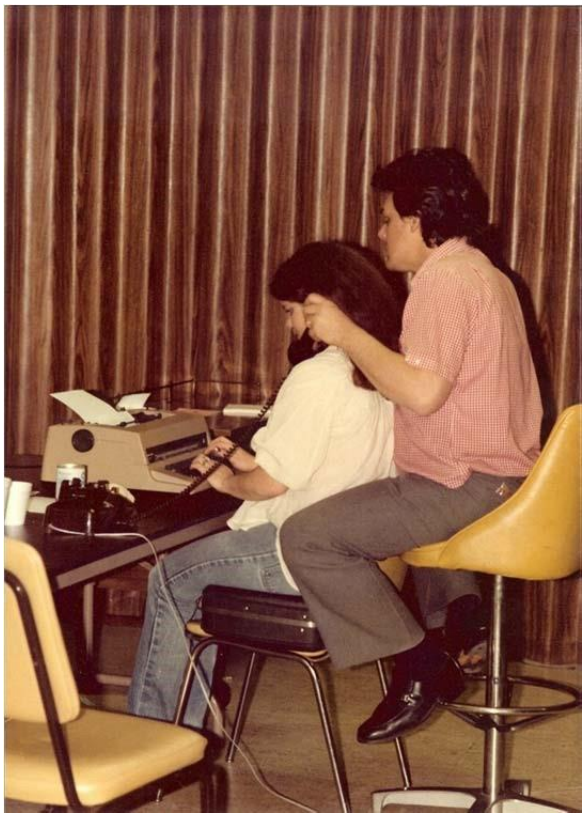
Sally E., who attended three World Literature Conferences, recalls barely legible input submitted on a napkin that was carefully deciphered because of its potential import.[147] Jim N., who hosted the 2nd World Literature Conference (Lincoln, NE, 1980), needed postage in order to send flyers about the upcoming conference to every known group. Sitting around the kitchen table, he and four other members realized that they had sold blood to support their habits, and they could do the same to support their recovery in NA. They each donated a pint of plasma and received $15.00, which they used to pay for the mailing.[148] Registration flyers for upcoming World Literature Conferences included the option of staying in an NA member's home.[149] During the 3rd World Literature Conference, Greg P. in Oregon dictated an entire chapter over two phone calls that totaled over 9 hours to Molly P. in Memphis, Tennessee. Molly sat on a suitcase while members held the phone to her ear.[150,151] Greg's phone was disconnected following this effort due to the long-distance expenses incurred.[152] Typical of the dedication that went into this process was Doug W., who rode his bicycle from Lincoln, Nebraska to the 6th World Literature Conference in Miami, Florida, staying in NA members' houses along the way.[153]



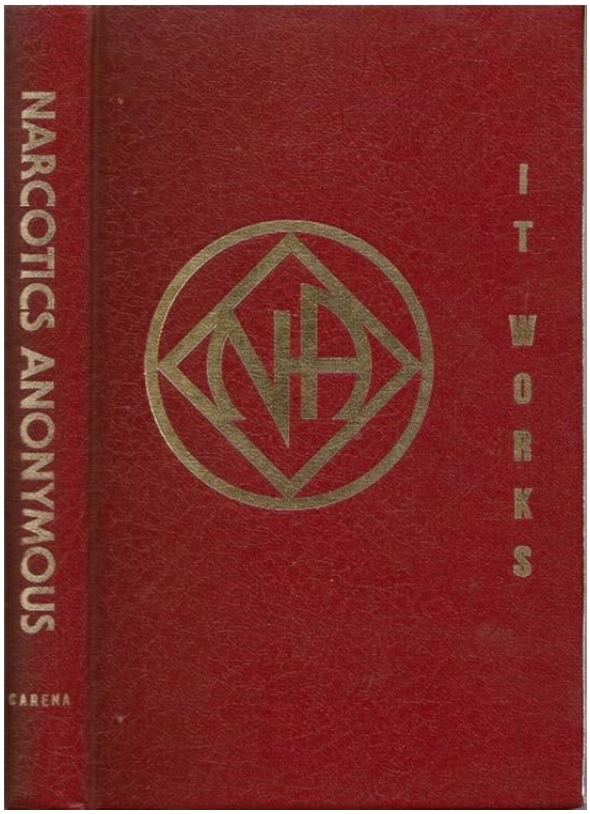
Flyer for 1st WLC Flyer. Courtesy of Kermit O.

Following the publication of the *Basic Text*, NA focused much of its publication efforts on *It Works – How and Why*, a collection of essays on the Twelve Steps and Twelve Traditions. *Just for Today*, a book of daily meditations, followed closely afterwards. Further efforts included a workbook on the Steps titled *The Step Working Guide* and a collection of sponsorship experiences simply called *Sponsorship*. Currently in development is *Living Clean –The Journey Continues*, a collection of experiences from NA members—many with twenty, thirty, or more years clean—on a variety of topics that many addicts face as they mature in their recovery. Similar to other mutual aid fellowships, NA experienced internal conflicts related to its literature approval process, the cost of literature, and the reproduction and distribution of literature by members.[154] NA entered uncharted waters in 1990 when a civil lawsuit was brought against one of several NA members who were reproducing and distributing a free, unauthorized version of NA's *Basic Text*.[155] Individuals involved with the reproduction and distribution of the "Baby Blue" text justified their actions on grounds that the *Basic Text* was overpriced and that unauthorized changes had been made to the *Basic Text* without approval from NA groups. The lawsuit finally resulted in a negotiated settlement[156] that led to the Fellowship Intellectual Property Trust (policies protecting NA's name, trademarks, and recovery literature) and a literature approval process that today involves input, review, and approval at the group level.

NA's *Basic Text* was the first substantial piece of literature created by addicts for addicts, and marked the emergence of NA's own language and culture. It provided a vehicle for NA growth throughout the world, and income from its sales provided the support for NA's subsequent growth. Since its initial publication, more than 7.3 million copies of the NA *Basic Text* have been distributed in 18 languages.[157]



Bo S. holding the phone for Molly P. as Greg P. dictates the Traditions. Courtesy of Bo S.



1st Edition of the NA Basic Text.
Courtesy of anonymous NA member

Explosive Growth

NA faced unique obstacles to growth from its earliest days: 1) the problem of members getting high together after spending time in meetings recounting episodes of drug use—before there was a well-developed NA recovery culture, 2) the presence of drug dealers and undercover agents at or near early NA meetings, and 3) the lack of sufficient personal clean time and maturity to sustain the functioning of local groups.[158] Jimmy K. reflected on these early days:

> *Nobody trusted nobody—you know they thought it was staked out. They wouldn't believe us when we told them there was no surveillance. And we weren't just too sure in the beginning ourselves.*[159]

After nearly dying in the late 1950s, NA growth extended from five meetings in 1964 to 38 meetings in 1971, 225 meetings in 1976, 2,966 meetings in 1984, 7,638 meetings in 1987, 15,000 meetings in 1990, 19,000 meetings in 1993, 30,000 meetings in 2002, more than 43,900 meetings in 2007, and 58,000 meetings in 2010.[160]

There are many contributing factors to the growth of Narcotics Anonymous. One that cannot be overstated is the tireless support and encouragement from Jimmy K. to addicts living in communities that lacked NA meetings. Jimmy consistently encouraged lone addicts to start meetings in their local communities.[161] He would even record meetings and talks that he would send to emerging groups in order to provide them with the Narcotics Anonymous message of recovery.[162] Another significant event was the decision to hold the 8th World Convention in 1978 in Houston, Texas—the first time it had been held outside of California. Growth of NA occurred wherever a World Convention was held as isolated

addicts found one another, exchanged phone numbers, and began to see tangible evidence that recovery through NA was a reality.[163] The expansion of NA groups was stimulated, in part, by growth of the addiction treatment industry and the growing cooperation between NA and treatment institutions. Such cooperation began early, with NA working with the Chrysalis Foundation—the first addiction treatment program to specifically emphasize NA philosophy.[164]

The profile of members also diversified over the course of NA's history. The latest (2009) NA membership survey reveals a membership that is gender balanced (58% male, 42% female), predominately middle-aged, ethnically diverse (73% Caucasian, 14% African American, 10% Hispanic, 7% other), and highly productive (71% working full- or part-time, 7% retired, 7% full-time students, 4% homemakers). Members attend an average of 4.2 meetings per week, with 57% of members having 6 or more years of continuous recovery.[165]

Comparisons of membership surveys from 1989 to present reveal increased involvement of women and Caucasians in NA and a membership that has more average clean time and is getting older—due in great part to members remaining involved in NA through the transition from recovery initiation to long-term recovery maintenance. This is evident in the growth of average clean years of NA members from 7.4 years in 2003 to 9.1 years in 2007. NA recovery feeds on itself—with those first attending NA due to the influence of an NA member increasing from 29% in 1989 to 58% in 2007. The influence of treatment center referral has also continued to increase between 1989 and 2007.[166]

Growth of NA outside North America began slowly, with NA meetings in only three foreign countries in 1972, and then accelerated to more than a dozen countries in 1983, 60 in 1993, 127 in 2007, and 131 in 2010. NA literature is now available in 39 languages, with translations into an additional 16 languages in process.[167] A landmark was reached in 2009, with more NA meetings being held outside the United States than in the United States. Equally remarkable, and deserving of its own written history, is the fact that 28.9% of all NA meetings now occur in one country outside the U.S.—Iran—where NA growth has been explosive since its inception there in 1994.[168]

The sustained growth of NA exposed long-standing problems with NA's organizational and service structure—problems NA sought to solve through creation of the NA Tree.

The NA Tree and Beyond

Most of the published literature on recovery mutual aid societies focuses on descriptions of their personal program of recovery, with little attention to how such groups structure and sustain themselves as ever-larger and increasingly complex organizations. The transition from a self-encapsulated recovery mutual aid meeting to a recovery mutual aid fellowship requires a structure for communication (e.g., information dissemination and mutual support between groups), service (e.g., assistance in starting new meetings, literature distribution, collaborating with other organizations), and governance (e.g., collective decision making on issues affecting the fellowship as a whole). There is in the history of such fellowships a pervasive tension between any founder/leader, national or worldwide governing body, local leaders, and the mass of fellowship members. That tension breeds questions of:

- authenticity (Who best represents the aspirational values of the fellowship?),
- authority (Who has the right to make decisions and/or speak on behalf of the organization?),
- connection (What are the means through which individuals and groups within the fellowship can communicate with each other?),
- assistance (Who is responsible for addressing the needs of local groups, offering support to those wanting to start new groups, and responding to external professional and public requests for information and service?), and
- stewardship (What is the best use of the fellowship's human and financial resources?).

NA has wrestled with these questions since the first NA bylaws were written on August 17, 1953.[169] During the 1960s, an NA Board of Trustees (two NA members and two nonaddicts) was created (1964),

with the subsequent selection of six NA members to serve as "Permanent Trustees" (1969).[170] In 1976, approval of the NA Tree, authored by Greg P. and Jimmy K., established a new service structure that continued to be amplified, revised, and supplemented via:

- an evolving NA Service Manual,[171]
- the work of key committees (e.g., the World Policy Committee, 1983; the Select Committee on the Service Structure, 1984),[172]
- efforts to more clearly define the purpose and functions of an NA group (1990),[173]
- articulation of the guiding principles of NA Service structure (Twelve Concepts, 1992),[174]
- the creation of new elements of the service structure (e.g., the World Board, the Human Resource Panel, and the World Pool, 1998), and
- a Service System Project (2008) designed to address continuing problems within the service structure at the regional and local level.[175]

These and other numerous efforts confirm the challenges faced in creating a viable structure that can serve the needs of a rapidly evolving and growing recovery fellowship. Although how that is best accomplished remains a subject of considerable discussion within NA, the ultimate intended purpose of that service structure has become clearer over the course of NA's history. The 2010 NA World Service Conference adopted the following refined vision for NA Service:

> *All of the efforts of Narcotics Anonymous are inspired by the primary purpose of our groups. Upon this common ground we stand committed.*
>
> *Our vision is that one day:*
> - *Every addict in the world has the chance to experience our message in his or her own language and culture and find the opportunity for a new way of life;*
> - *Every member, inspired by the gift of recovery, experiences spiritual growth and fulfillment through service;*
> - *NA service bodies worldwide work together in a spirit of unity and cooperation to support the groups in carrying our message of recovery;*
> - *Narcotics Anonymous has universal recognition and respect as a viable program of recovery.*
>
> *Honesty, trust, and goodwill are the foundation of our service efforts, all of which rely upon the guidance of a loving Higher Power.*

Looking from the outside in, today's addiction professionals and recovery support specialists might view NA service and support structure as beginning with the individual member attending local meetings hosted by one or more named NA groups. Sponsor-sponsee relationships (mentorship of new members) take place in the context of these meetings, and it is common for members to select a home group that they regularly attend and at which they can vote on matters of group conscience affecting the home group or NA as a whole. Members in each home group have the opportunity for service in many roles, both formal and informal. Members who pursue such service work are referred to as trusted servants. Formal service positions, which are generally elected positions through group conscience, include secretary, treasurer, group service representative (GSR), and GSR-Alternate. Examples of informal positions, which some consider the highest level of service, include opening the meeting door, making the coffee, putting out the literature, leading the meeting, and greeting people at the door. Local NA groups form an Area Service Committee to provide coordinated NA services for a particular geographical area and to carry the conscience of the groups to Regional and World levels. Area Service Committees elect their own trusted servants (Area Chairperson, Vice Chairperson, Secretary, Treasurer, and Regional Committee Member) and also maintain standing service committees such as:

- Public Relations Committee (PR)/Public Information (PI) – informs the public, prospective members, and professionals about Narcotics Anonymous through local NA web pages, printed meeting schedules, phone lines, and fellowship development (outreach).[176]
- Hospitals and Institutions (H & I) Committee – carries the NA message to those who do not have access to NA meetings in the community, e.g., those in hospitals, treatment centers, or correctional facilities.
- Convention Committee – raises money and plans an Area NA Convention.
- Activities Committee – promotes unity in the fellowship through events such as dances, cook-outs, celebrations, and speaker jams.
- Policy Committee – maintains local policy and procedure for the Area Service Committee.
- Literature Committee – participates in input and development of new literature and maintains an adequate supply of literature available to groups at Area Service Meetings.

Standing committees will vary from Area to Area. Similar to the structure and function of Area Service Committees, Regional Service Committees are comprised of Areas from a particular geographical area.

The operational chart changes at the World Level from how most, but not all, Regions and Areas provide service. Narcotics Anonymous World Services (NAWS) is comprised of the World Board and the World Service Office (WSO). The World Board, WSO, and Regions work together to hold the World Service Conference every two years, where issues of importance to the worldwide NA fellowship are discussed. There are no standing Committees at the World Level. Instead, a task (e.g., writing new literature) is voted on by members of the World Service Conference (Regional Delegates, World Board, and Human Resources), and if approved, the Human Resource Panel draws from the World Pool NA members they think will be the most qualified to be on a workgroup to complete the approved task.

The Narcotics Anonymous World Service structure signifies another level of differentiation from Alcoholics Anonymous. Alcoholics Anonymous World Services consists of groups, districts, and areas from the U.S. and Canada that participate in an annual General Service Conference. There are 58 autonomous International General Service Offices listed on the AAWS, Inc. website that do not participate in the North American General Service Conference. Narcotics Anonymous World Services consists of groups, areas, and regions from the entire world that participate in a World Service Conference every two years. Zonal Forums have become an important vehicle for NA communities from around the world to participate in service-oriented sharing, communicating, cooperation, and growth. While existing outside of NA's formal decision-making system, zonal forums help developing and emerging NA communities and make contributions at the World Service Conference.

As can be seen from this brief summary, decision making at the level of World Services has become increasingly complex in tandem with NA's growth (from support for 2,966 meetings located primarily in the United States in 1983 to support for today's 58,000+ meetings in 131 countries). While tensions still exist within NA, there has been significant maturation in the service system. As the service system continues to evolve, Narcotics Anonymous will continue to strive for better communication, more inclusiveness, less redundancy, greater efficiency, and more assertive outreach to the still suffering addict.

What is important for the student of recovery is that such struggles reflect normal, although potentially distressing, growing pains of recovery mutual aid societies. The ultimate tasks of such coming of age involve decentralizing leadership, surviving the passing of the first generation of pioneers, achieving and protecting organizational autonomy, maintaining mission fidelity, and developing a viable and evolving service structure.

NA Comes of Age

Throughout much of its history, NA existed in the shadow of AA—the stepchild of its famous parent. NA's predecessors, such as Addicts Anonymous, drew their Steps framework of recovery from

the Twelve Steps of AA, and their meeting formats mirrored AA meetings, e.g., use of the Serenity Prayer and Lord's Prayer.[177] The NA that exists today was founded by "bridge members" of AA who based the NA program of recovery on AA's Twelve Steps and Twelve Traditions and who used AA participation as a support for their own recoveries. Interviews with early NA members are replete with references to reading AA literature, having AA sponsors, attending AA meetings—even meetings with two podiums, one on which was listed the Twelve Steps of AA and the other draped with the Twelve (or Thirteen) Steps of Addicts Anonymous or Narcotics Anonymous.[178]

During its first two decades, many NA members also attended AA meetings. As Dave F., a member of early NA in Pennsylvania, reports:

> *...everybody went to AA. Nobody would have even attempted—it would have been viewed as foolhardy and half-stepping—to try to stay clean solely on NA meetings. NA members simply didn't have the clean time.*[179]

NA literature, NA meeting rituals, and the larger culture of NA developed in the shadow of AA. But a "purist movement"[180] and, more importantly, a larger consensus emerged within NA in the mid-1980s that challenged NA to step away from AA's shadow and distinguish itself as a distinct recovery fellowship. This process began in the early 1980s, but was perhaps most exemplified in a 1985 communication from NA Trustees entitled, "Some Thoughts on Our Relationship with A.A." This communication, written at the request of Bob Stone by a WSO staff writer and subsequently reviewed and published by the Trustees in the WSO's *Newsline*, opened with an acknowledgement of NA's gratitude to AA. It noted NA's departure from AA in the choice of language used in NA's First Step and then elaborated on this important divergence:

> *The A.A. perspective, with its alcohol oriented language, and the N.A. approach, with its clear need to shift the focus off the specific drug, don't mix very well….When our members identify as "addicts and alcoholics," or talk about "sobriety" and living "clean and sober," the clarity of the N.A. message is blurred. The implication in this language is that there are two diseases, that one drug is separate from the pack, so that a separate set of terms are needed when discussing it. At first glance this seems minor, but our experience clearly shows that the full impact of the N.A. message is crippled by this subtle semantic confusion.*[181]

This communiqué went on to define the essential NA message:

> *We are powerless over a disease that gets progressively worse when we use any drug. It does not matter what drug was at the center for us when we got here. Any drug use will release our disease all over again….Our steps are uniquely worded to carry this message clearly, so the rest of our language of recovery must be consistent with those steps. Ironically, we cannot mix these fundamental principles with those of our parent fellowship without crippling our own message.*[182]

The communiqué then called for a distinct NA culture:

> *…each Twelve Step Fellowship must stand alone, unaffiliated with everything else. It is our nature to be separate, to feel separate, and use a separate set of recovery terms, because we each have a separate, unique primary purpose….N.A. members ought to respect our primary purpose…and share in a way that keeps our fundamentals clear…Our members who have been unintentionally blurring the N.A. message by using drug-specific language such as "sobriety," "alcoholic," "clean and sober," dope fiend" etc. could help by identifying simply and clearly as addicts and using the words "clean, clean time and recovery" which imply no particular substance. And we all could help by referring to only our own literature at meetings, thereby avoiding any implied endorsement or affiliation. Our principles stand on their own.*[183]

The statement was presented at the NA World Service Conference in 1986 and became World Service Trustee Bulletin #13.

That same year, a letter appeared in the *AA Grapevine* by an NA member who shared the story of how he had attended AA in an effort to recover from his drug addiction. He described how he had learned all the "passwords" to avoid offending oldtimers with references to his drug use and also got involved in NA, which at the time had little of its own literature, few seasoned sponsors, and little service structure. Multiplied by thousands, he suggested that before NA came into its own in the 1980s, many addicts had used AA in a way that stunted NA growth and tested AA traditions. His letter thanked AA for offering its program for adaptation by NA and for their strict adherence to their own Traditions, which had helped push NA toward its current development. He concluded by noting the new growth and development of NA:

> *By going exclusively to NA, doing my service in NA, growing in my understanding of the NA message, I have left the AA groups just a little freer to focus on their own primary purpose….I also want to assure you that strong, stable, long-term recovery is available today in NA….*[184]

In addition to AA and key AA members, non-addicts have also played significant roles in NA and its predecessors, including Dr. Victor Vogel, Major Dorothy Berry, Father Dan Egan, Major Edward Dimond, Robert McQuire, Dorothy Gildersleeve, Dr. Ralph Worden, Dr. Louis Quitt, David Stewart, Reverend Herbert Schneider, Judge Leon Emerson, Dr. Mike Bohan, Bob Stone, and Jim Delizzia, to name a few of the most significant. Shaping an authentic and autonomous NA culture required NA to both acknowledge the help of its benefactors at the same time it drew increasing strength from within its growing fellowship.

The consensus forged in the 1980s on the need for a distinct NA culture has continued to grow and solidify. With this consensus came more widespread abandonment of AA- and treatment-infused language (e.g., "drugs and alcohol," "cross-addicted," "addict and alcoholic," "clean and sober," and "sobriety") and the embrace of NA language ("addiction," self-identification as an "addict," "clean," and "recovery from the disease of addiction"). Etiquette surrounding meeting language and rituals was further clarified through the widespread distribution of the "Clarity Statement" (an excerpt from NA World Services Board of Trustees Bulletin #13) and the pamphlet *An Introduction to NA meetings*. Those attending NA today are more likely to encounter only NA literature and NA speakers, a focus on solution-focused rather than problem-focused communications, heightened and sustained NA service activity, and rigorous efforts to adhere to NA Traditions. Also evident are NA members in long-term recovery remaining active in NA rather than disengaging or migrating to another fellowship. The days when those seeking recovery found only a few local NA meetings, only a few NA members with more than three years of clean time, and no distinct NA culture faded as NA came of age, and continues to come of age, in community after community. Before his death, Jimmy K. was able to reflect in his private journaling that in the past, many addicts with and without alcohol problems had found help in AA, but that "today the Society of Narcotics Anonymous is available to meet the responsibility of carrying its message to the addict."[185]

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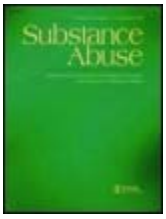

The 10 Year Course of AA Participation and Long-Term Outcomes: A Follow-up Study of Outpatient Subjects in Project MATCH

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ABSTRACT

This study investigates the 10-year course and impact of AA-related helping (AAH), step-work, and meeting attendance on long-term outcomes. Data were derived from 226 treatment-seeking alcoholics recruited from an outpatient site in Project MATCH and followed for 10 years post-treatment. Alcohol consumption, AA participation, and other-oriented behavior were assessed at baseline, end of the 3-month treatment period, and one year, three years, and 10 years post-treatment. Controlling for explanatory baseline and time-varying variables, results showed significant direct effects of AAH and meeting attendance on reduced alcohol outcomes and a direct effect of AAH on improved other-oriented interest.

Keywords: Alcoholics Anonymous, Project MATCH, Meeting Attendance, Step-work, AA-related helping

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INTRODUCTION

Alcoholics Anonymous (AA) has distinguished itself within the alcohol problems arena through its membership size and geographical dispersion (more than 2.1 million members and 100,766 groups in 150 countries), its influence on the modern treatment of alcohol use disorders, and through the volume and growing methodological rigor of research studies on the effects of AA participation (1-3).-analytic reviews of the effects of AA involvement report a positive association between AA participation and abstinence across diverse populations as well as reductions in substance-related health care costs (4-8). Efforts to date to isolate the active ingredients of AA participation have focused primarily on meeting attendance, step-work, and service (9,10).Meeting attendance has been associated with abstinence and a higher number of sober friends (11-13). More step-work at a 3-year follow-up has been associated with decreased alcohol consumption at a 10-year follow-up (14) AA-related helping activities (AAH) are associated with greater abstinence at 1-year and 3-year follow-ups and reduced depression (15-20).

There are several theoretical interpretations of the evolution of service within the 12-step program. First, AAH can be viewed as an application of Riesman's "helper therapy principle (HTP)"; one's own problems diminish through the process of helping others (21). AAH applies the long "wounded healer" tradition whereby survivors of a life-altering disorder or experience develop special sensitivities, insights, and skills to be uniquely helpful to others with the same condition (22,23) —a process AA's co-founder Bill Wilson characterized as "the sublime paradox of strength coming out of weakness"(24). Second, just as an evolutionarily adaptive gene may promote the replication and survival of a particular species (25), AA's primary purpose, to stay sober and help other alcoholics, may have evolved to sustain the program's survival. Service positions such as chairperson or secretary further ongoing AA group functioning. Third, AAH can also be understood within AA's posited theory of self-centeredness as a central factor in the development and maintenance of alcoholism. AA's main textbook is filled with admonitions of the dangers of *selfishness*, *self-centeredness, self-absorption, self-justification*, *self-pity,* and *self-deception*. The collective experience of AA's original 100 members acknowledges *self-knowledge*, *self-reliance*, *self-control,* and *self-sufficiency* as failed paths to sustaining sobriety (26). Whereas mutual aid alcoholic societies in the 19th century viewed self-assertion as liberating the alcoholic from the disease (27,28), AA's founders characterized the illness as stemming from the "bondage of self" (26) which could only be broken by personal surrender and self-transcendence.

AA's main textbook emphasizes key exercises for ego reduction, which others reference as the foundation of recovery (29,30).The AA recovery process involves: a) surrender–admission of powerlessness and personal limitations (Step 1) ("…we had to quit playing God"); b) transcendence of self via reliance on a power greater than self (Step 2); c) witnessed confession of wrongs done to others (Step 5); d) repair of family and social relationships through making amends (Step 9); e) carrying a message of hope to other alcoholics (Step 12), which is often done in ritualized storytelling within a community of recovering people; and f) personal anonymity as a spiritual principle–a metaphoric and literal shedding of self (Tradition 4) (31). Seen in this light, AA is not a "self-help" program but a mutual-help program that rests on the premonition that sustained sobriety

cannot be achieved alone (32). AAH enacts many of these exercises designed to increase other-orientation and self-transcendence which occurs quickly for some and slowly for others.

Long-term, prospective study of the course of AA participation across major programmatic activities and impact on behavior is limited. Of the few studies with 5-years or more follow-up post-treatment, Kaskutas and colleagues (33) delineated four long-term patterns regarding AA meeting attendance: 1) low, 2) medium, 3) descending, and 4) high, with highest meeting attendance occurring in the first year following treatment. Long-term participation patterns in other program activities such as step-work and AAH are less clear. While higher meeting attendance in the initial post-treatment period is associated with more improved drinking outcomes (7,34-49), few have studied the long-term influence of other major components on decreased substance use. Further, long-term alcohol investigations of AA's impact on clinical outcomes beyond drinking are rare. A handful of early studies considered the potential effect of AA participation on a transformation from self-centeredness to increased other-orientation (29,50).Reinert and colleagues (51,52) hypothesized a decline in self orientation with increased years in recovery, but did not find such declines over short periods of time in a sample of AA members.However, increased other-regard, if it occurs through such mechanisms as step-work or AAH, may span years of AA participation.

This paper builds upon prior prospective AAH research to explore the course and impact of AA participation across three major programmatic activities: meeting attendance, step-work, and AAH. In this study, we examine: 1) the 10-year course of AA participation, drinking, and other-oriented behavior, 2) the influence of 12-step facilitated treatment (TSF) on AA programmatic activities and outcomes over time, and 3) the influence of time-varying participation in AA programmatic activities on subsequent drinking and other-oriented behavior.

METHODS

Participants

Data were derived from Project MATCH, a prospective longitudinal investigation of the efficacies of three behavioral treatments for alcohol use disorders delivered over a 3-month treatment period (53). Project MATCH recruited subjects from 4 aftercare sites (n = 774; 80% male) and 5 outpatient sites (n = 952; 72% male).This report presents 10-year outcome data collected at one outpatient site in Project MATCH (n = 226). intake, the clinical profile of the study sample was similar to other outpatient site samples in Project MATCH, with exception to being younger at intake ($P < .0001$), less education ($P < .0001$), and greater Hispanic representation ($P < .0001$, Table 1). During follow-up, over 85% of the original 952 outpatients in Project MATCH was retained in the three years post-treatment, with no significant site differences in attrition (54,55).

Extensive attritional analyses also compared study participants who did and did not complete a 10-year interview, which was completed on average 117 months (SD = 9.54) post-randomization. Of the original 226 outpatient subjects, 23 (10%) did not provide

consent for the 10-year follow-up interview and 22 (10%) had died since the 39-month interview, confirmed by obituaries death certificates from the New Mexico Office of Medical Records.Of the surviving, eligible subjects (n = 181), 148 (82%) completed a 10-year follow-up interview, 28 (15%) were unable to be located, and 5 (3%) refused to participate. There were no significant differences between study participants with and without 10-year evaluations (Table 2).

The general aims, research design, and organization of Project MATCH can be read about in detail elsewhere (56). The study procedures were approved by the Human Subjects Review Committee at University of New Mexico, written informed consent was obtained in accordance with the standards of the Committee on Human Experimentation with the Helsinki Declaration of 1975 (54,57), and a Certificate of Confidentiality from the National Institute on Alcohol Abuse and Alcoholism was obtained.

Measures

Background characteristics were assessed at baseline. Time-varying variables (percent days abstinent, 3 indices of AA participation, other-oriented interest) were assessed at baseline, 3-, 15-, 39-, and 120-months post-randomization.

Background Characteristics. Baseline demographic and clinical characteristics included gender, race, marital status, full-time employment status, age, years of education, anti-social personality disorder (ASPD), chemical dependency treatment history, and receipt of Twelve-step Facilitation (TSF). Receipt of TSF versus no TSF (Cognitive Behavioral Therapy, Motivational Enhancement Therapy) was ascertained from Project MATCH's randomized treatment assignment (42).

Alcohol Use. Alcohol use was defined as percent days abstinent (PDA) using the semi-structured Form 90 (59). The Form 90 is a calendar-based daily drinking estimation method that incorporates a grid-averaging approach to provide a comprehensive and efficient assessment of a person's drinking over a designated period of time (90 days in this study). It has demonstrated test-retest reliability for treatment-seeking alcoholics (60) and problem use of illicit drugs (61). Given the negatively skewed distribution, PDA variables received an arcsine transformation, as was done in the primary MATCH outcome analyses (54).

AA Participation. Three indices of AA participation variables were measured: 1) AAH, 2) AA meeting attendance (MTG), and 3) step-work. AAH was assessed with the 13-item Alcoholics Anonymous Involvement (AAI) questionnaire (62), a well-validated measure of AA affiliation developed for use in Project MATCH (62). Using criterion from prior work (9), AAH was defined by endorsement of two AAI items: being a sponsor and/or completion of the 12th step in the last 90 days.MTG was assessed from one item on the Form 90, “How many AA meetings have you attended in the past 90 days?” and converted into percent of days attending AA (number of days attending AA/ number of days in the assessment period), for a score ranging from .00-1.00. Because of a positively skewed distribution, MTG was log transformed. Step-work was measured from the continuous AAI item ascertaining completed steps (0-11) in the assessment period, and

summed. Using Cohen's effect size *r* estimates (63), there was a small correlation between AAH and MTG at any assessment (r = .18-.24, P < .001), a moderate correlation between AAH and step-work (r = .26-.43, P < .001), and a moderate correlation between MTG and step-work (r = .42-.60, P < .001).

Other-Oriented Interest (OOI). One item from the Beck Depression Inventory (BDI;64) was used as an index of AA's espoused behavior towards others (i.e., "…trying each day to be a little more thoughtful and considerate to those with whom we came in contact" (65; p356). With regard to interest in others in the past week, participants rated the OOI item from 0 (no loss of interest) to 3 (lost all interest). Similar single-item measures have been used in other alcohol investigations (66,67).

Statistical Analysis

Statistical analyses were performed using SAS version 9.1.3 (SAS Institute Inc., 2004). Depending on the type of variables (continuous or discrete), the Fisher's Exact Test for binary variables or Kruskal-Wallis Chi-Square Test for continuous variables was performed to evaluate demographic and clinical differences between subjects. We used hierarchal linear modeling (HLM) to examine the course of time-varying variables (AA variables, outcomes). Variables were mean centered to reduce multi-collinearity (68).

We used pairs of time points in which time-varying AA covariates (AAH, meeting attendance, step-work) were analyzed in relation to lagged time-varying outcomes (e.g., AAH at 3-months predicting PDA at 15-months, AAH at 15-months predicting PDA at 39-months, and AAH at 39-months predicting PDA at 120-months). We used HLM to predict PDA, with adjustments for lack of independency among the multiple observations for each person. We used generalized estimation equations (GEE) methods to predict OOI, with an unstructured correlation matrix and correction for over-dispersion (69). A non-significant linear time co-efficient between data collected in the initial three years and at the ten year interview suggested no marked change in slope to raise concern of the interval time lag. All models controlled for baseline assessments of AA variables and the dependent variable. addition, to help rule out the possibility that variables other than AA were responsible for improved outcomes, we included baseline covariates linked to treatment outcomes: gender, age, marital status (married/not married), race/ethnicity, full-time employment (yes/no), ASPD diagnosis (yes/no), and prior treatments (14,16). To achieve this, we used an empirical backward elimination procedure to test whether baseline covariates were related to outcomes. Results revealed that age, marital status, full-time employment, and prior treatments were significantly related to study outcomes, and thus, were maintained as control variables. To limit hypothesis testing and to maintain the recommended 15:1 predictor/subject ratio (70), we first evaluated evidence of direct effects of TSF and time-varying AA variables on outcomes at any time during the study. Analytic models were then rerun to include all interaction terms between TSF, the time-varying AA variable, and time.

Although missing data patterns were non-monotone (i.e. intermittently missing), and importantly, not associated with PDA or OOI outcomes, we used the Markov Chain Monte Carlo (MCMC) method for multiple imputation (71,72). For any given assessment

through month 39, data reconstruction for independent variables ranged from 4-6% for study participants. These rates are similar to those constructed for other outpatient samples in Project MATCH (73). The statistics reported for variables in our analyses are the averaged results across the ten imputations performed. degrees of freedom for the reported t-statistics for each regression coefficient vary from analysis to analysis given the recommended use of adjusted degrees of freedom (74). When multicollinearity diagnostics of the two fitted models were examined, tolerances were .50 and above, indicating low concern of multicollinearity (69). We reported all two-tailed tests with significance values greater than 95% ($P < .05$).

RESULTS

Table 1 shows the demographic and clinical characteristics of the outpatient sample at baseline. majority of participants were male (76%) and single (76%).Approximately half of the sample were Caucasian (48%), Hispanic (51%), and employed full-time (44%). average, subjects were 33 years old (M = 33.12 years), had a high school diploma (M = 12.73 years of education), and 13% met diagnostic criteria for ASPD. entered treatment with low PDA, few prior treatments, and low prior exposure to AA.-three percent (n = 75) of the outpatient sample was randomly assigned to TSF.

Course of Outcomes. Figure 1 shows the population-averaged estimates of the 10-year course of PDA and OOI. A significant direct effect for time was found for PDA ($F = 40.15$, $P < .0001$) but not for OOI scores ($F = 2.11$, $P = .15$). The average PDA at the three month interview approximately doubled from baseline and declined thereafter. At no assessment did the rate of abstinence exceed 13%, a rate similar to other long-term investigations of problem drinkers (34). The proportion of subjects reporting some to all lost interest in others was lowest at the 3-month interview (16%), and returned to pre-treatment levels by the 120-month interview (36%). At any assessment, there was a small, negative correlation between PDA and OOI scores ($rs = -0.16$ thru -0.20, $P < .001$).

Course of AA Participation. The 10-year course of MTG, step-work, and AAH following the index treatment is shown in Figure 1. Significant fluctuations in MTG were observed over time ($F = 10.82$, $P < .0001$); as shown in Figure 1, MTG at the 3-month interview (0 years in Figure 1) more than doubled from baseline, declined by 6% at the 15-month interview (1 yr on Figure 1), further declined at the 39-month interview (3 years on Figure 1) to a level that was relatively constant at the 120-month interview. In contrast, the average number of steps completed remained low over the decade following the index treatment ($F = 2.01$, $P = 0.11$); notably, approximately two-thirds of the sample were not working any steps at any point. However, as shown in Figure 1, those who worked at least one step during the index treatment continued to progress in step-work over time ($F = 10.21$, $P < .0001$).The rate of AAH was also relatively constant over time ($F = 2.62$, $P = .06$); approximately 9-10% of the population were AAH participants at any point during follow-up.At the 15-month interview, however, only 5% of the outpatient sample was participating in AAH.

TSF and Course of AA Participation. The 3-month treatment period, TSF recipients had greater participation in AAH (15% vs. 6%; $\chi^2 = 5.17$, $p<.05$), step-work (1+ steps worked, 68% vs. 29%; $\chi^2 = 29.90$, $P < .0001$), and MTG (M = 23.73 vs. M = 5.93, $F = 38.81$, $P < .0001$). the 15-month interview, this pattern continued in TSF recipients in terms of greater participation in AAH (10% vs. 1%; $\chi^2 = 10.54$, $p<.001$), step work (1+ steps worked, 53% vs. 26%, $\chi^2 = 11.98$, $P < .001$), but not MTG ($F = 0.61$, $P = .23$). However, TSF did not distinguish long-term AA participation patterns beyond the 15-month interview. to TSF, AAH initiation steadily increased from 3% at the 15-month interview to 11% at each subsequent assessment. At any point in the study, AAH participants versus non-AAH participants had higher levels of MTG ($F = 5.03$, $P < .0001$) and step-work ($F = 11.54$, $P < .0001$).

AA Participation and Outcomes Over Time. Table 3 shows the parameter estimates of baseline covariates and time-varying covariates (variables assessed at each follow-up) in relation to PDA over time. Controlling for baseline covariates, results showed significant direct effects of MTG ($P < .01$) and AAH ($P < .05$) on PDA outcomes. Results also revealed age, prior treatment, and being married approached significance ($P < .10$). Similar to prior results found in Project MATCH (75), there was no significant direct effect of TSF nor interaction with time to indicate greater efficacy of TSF vs. other treatments on PDA during or following the index treatment episode.

Results also demonstrated significant direct effects of MTG ($P < .05$) and AAH ($P < .05$) on OOI outcomes (Table 4). The significant coefficient for AAH (-0.37) indicated an adjusted odds ratio of 0.69 (i.e., exp (-0.37)), the reciprocal of which translated into a 50% increased likelihood for AAH participants versus non-participants to be in the lower OOI category (i.e. higher interest in others), controlling for explanatory variables in the model. The coefficient for MTG (-0.126) revealed that with each one-unit increase in MTG, the odds of being in a lower OOI category rose by 13% (i.e. 100[exp(-.126)-1]. Prior treatment was significantly related to OOI ($P < .05$), whereas being married and TSF receipt approached significance ($P < .10$).

DISCUSSION

This study provides a snapshot of what can be expected of outpatients' AA participation in the decade following their index treatment and highlights the importance of meeting attendance and AAH to long-term behavioral change. Meeting attendance during treatment and in the following decade parallels patterns reported in other prospective 12-step investigations (76,77) meeting attendance was highest during treatment and steadily declined thereafter. In contrast, a relatively stable rate of AAH (9%) and low levels of step-work were observed during and following treatment. Despite a lowered rate of AAH at the 15-month assessment, AAH participants did more step-work and attended more meetings than non-AAH participants at any study interval. TSF treatment significantly boosted AAH participation and step-work relative to the other treatment conditions, but effects were lost after the initial year post-treatment. Extended effects of TSF beyond the initial year post-treatment may be seen with coordination of other 12-step facilitation approaches such as "Bridging the Gap" (78,79), or periodic booster sessions post-treatment, such as Case Monitoring (R01 AA009907; 80).

We next explored the relationship between participation in 3 AA programmatic activities on subsequent drinking and other-oriented behavior over time. Consistent with prior work (6-8,15,16,62), results showed direct effects of meeting attendance and AAH on greater abstinence across time, but not differential benefit of TSF. Controlling for pretreatment levels of OOI, those engaged in AAH were significantly more likely to report higher interest in others. These findings suggest the importance of meeting attendance to abstinence as a newcomer and in long-term recovery, and support AA's suggestion to help others as way to stave off an urge to drink and increase interest in others.

There are several limitations of this study that warrant attention. This outpatient sample was representative of other outpatient sites in Project MATCH with exception to age and education. Findings may not generalize to non treatment-seeking populations or those with more severe addiction. However, alcohol consumption patterns were similar to 10-year course patterns observed in other samples of problem drinkers (34). Second, treatment effects in this study are limited to the randomized index treatment. Third, our estimates of AAH and OOI are likely to be on the low end of true rates given their 1-2 item assessments.

Limitations aside, this study is the first to explore the 10-year course of meeting attendance, step-work, and AAH and their concurrent influence on long-term outcomes. Psychometrically sound measures employed in Project MATCH were consistently collected at each study interval, with 10-years of month-to-month estimates of drinking outcomes reliably assessed with the Form-90. Other strengths of this study include: a high representation of Hispanic problem drinkers seeking outpatient treatment; an 82% retention rate at 10-years post-treatment; and advanced statistical techniques including multiple imputation that produced robust parameter estimates. The HLM methods employed controlled for all stable measured and unmeasured characteristics of subjects correlated with model covariates (69), thereby eliminating potentially large sources of bias.

Treatment provides a time-limited opportunity during which patients may be receptive to professional input and advice. The significant correlation in our study between worse alcohol outcomes and less interest in others suggests that clients may benefit from increasing other-oriented behaviors as part of their recovery program. The current practice of encouraging meeting attendance could be honed by encouraging service involvement at meetings that do not require extended sobriety time (e.g. helping setup chairs, tables, or coffee). Step-work activity during and following treatment was low; on average, two out of three alcoholics worked no steps during treatment and in the decade following. Formal step-work exercises, a common practice of treatment programs, may require more clinician guidance to increase clients' understanding of steps worked and their completion. Future studies are warranted to explore the impact of working all 12-steps on behavioral change as well as sequencing of AAH activities in relation to length of time sober.

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Table 1 Baseline Characteristics of Outpatient Sites in Project MATCH

	Outpatient Site				
	Albuquerque	*Buffalo*	*Farmington*	*Milwaukee*	*West Haven*
Variable	226 (24%)	200 (21%)	201 (21%)	178 (19%)	147 (15%)
Male	166 (73%)	140 (70%)	145 (72%)	115 (65%)	122 (83%)
Caucasian	120 (53%)	173 (87%)	190 (95%)	165 (93%)	135 (92%)
Hispanic	103 (46%)***	2 (1%)	3 (1%)	4 (2%)	4 (3%)
Married	44 (19%)***	72 (36%)	98 (49%)	59 (33%)	68 (46%)
Employed Fulltime	95 (42%)	79 (40%)	125 (62%)	103 (58%)	83 (56%)
ASPD	28 (14%)	14 (7%)	11 (6%)	21 (12%)	7 (6%)
Treatment Assignment					
CBT	72 (32%)	67 (33%)	61 (30%)	51 (29%)	50 (34%)
MET	79 (35%)	72 (36%)	66 (33%)	55 (31%)	44 (30%)
TSF	75 (33%)	61 (31%)	74 (37%)	72 (40%)	53 (36%)
Age (M, SD)	33.25 (8.50)***	40.17 (10.62)	41.93 (10.07)	37.53 (10.66)	43.25 (11.01)
Education (M,SD)	12.70 (1.90)***	13.50 (2.09)	14.16 (2.16)	13.50 (2.13)	13.49 (2.24)
PDA (M,SD)	36.45 (8.47)	31.25 (6.93)	28.49 (7.60)	43.50 (7.07)	31.83 (9.40)
Prior Treatment (M, SD)	1.11 (2.89)	0.83 (1.67)	0.82 (1.32)	1.17 (1.75)	1.30 (1.92)
AA Attendance (M,SD)	0.03 (0.08)	0.02 (0.06)	0.04 (0.12)	0.02 (0.07)	0.05 (0.14)

* $P<.05$, ** $P<.01$, *** $P<.001$, **** $P<.0001$

Table 2 Baseline Characteristics of Outpatient Sample by 10-Year Interview Status

	Participant Status at 10-Year Interview				
	Interview Completed	*Ineligible*	*Refused*	*Deceased*	*Unable to Schedule*
Variable	148 (66%)	23 (10%)	5 (2%)	22 (10%)	28 (2%)
Male	104 (70%)	19 (83%)	4 (80%)	17 (77%)	22 (79%)
Caucasian	71 (48%)	13 (57%)	4 (80%)	16 (73%)	16 (57%)
Hispanic	75 (51%)	10 (43%)	1 (20%)	6 (27%)	11 (39%)
Married	35 (24%)	4 (17%)	1 (20%)	1 (6%)	368 (11%)
Employed Fulltime	65 (44%)	10 (43%)	3 (60%)	7 (32%)	10 (36%)
ASPD	16 (13%)	7 (35%)	1(20%)	3 (16%)	1 (4%)
Treatment Assignment					
CBT	49 (33%)	8 (35%)	0 (0%)	6 (27%)	9 (32%)
MET	48 (33%)	11 (48%)	4 (80%)	7 (32%)	9 (32%)
TSF	51 (34%)	4 (17%)	1 (20%)	9 (41%)	10 (36%)
Age (M, SD)	33.12 (8.56)	32.43 (9.00)	37.60 (10.41)	36.18 (7.77)	31.54 (11.01)
Education (M,SD)	12.72 (1.97)	12.57 (1.78)	11.80 (0.45)	12.91 (2.27)	12.68 (1.47)
PDA (M,SD)	36.21 (8.72)	33.27 (9.59)	44.11 (4.85)	29.45 (9.00)	43.29 (5.60)
Prior Treatment (M, SD)	1.11 (3.43)	1.09 (1.65)	1.00 (1.73)	1.50 (1.26)	0.79 (1.07)
Meeting Attendance (M,SD)	0.02 (0.07)	0.03 (0.06)	0.12 (0.23)	0.04 (0.13)	0.04 (0.07)

Table 3 Estimates and p values for final model of percent days abstinent over time in an outpatient sample in Project MATCH[a]

Variable	*β*	CI Lower	CI Upper	*t*	*P*
Time-varying Covariates					
Follow-up Month[1]	0.027	-0.313	0.170	1.04	0.299
AAH[2]	-0.041	0.059	0.380	1.81	0.033
Meeting Attendance	0.144	0.026	0.216	2.60	0.009
Step-work[3]	0.045	-0.086	0.176	0.65	0.519
TSF Assignment	0.095	-0.102	0.294	0.95	0.341
AAH X Month	0.093	-0.030	0.216	1.50	0.137
Meeting Attendance X Month	-0.069	-0.155	0.017	-1.44	0.128
Step-work X Month	-0.054	-0.123	0.016	-1.54	0.129
TSF X Month	-0.068	-0.154	0.017	-1.48	0.122
Baseline Covariates					
PDA[4]	0.263	0.146	0.380	4.43	<.0001
AAH	-0.117	-0.313	0.169	-0.58	0.562
Meeting Attendance	-0.025	-0.123	0.073	-0.51	0.613
Step-work	0.047	-0.101	0.194	0.63	0.531
Age	-0.010	-0.014	-0.002	-1.81	0.067
Prior Treatment	0.013	0.001	0.026	1.65	0.059
Married	-0.103	-0.216	0.011	-1.78	0.077

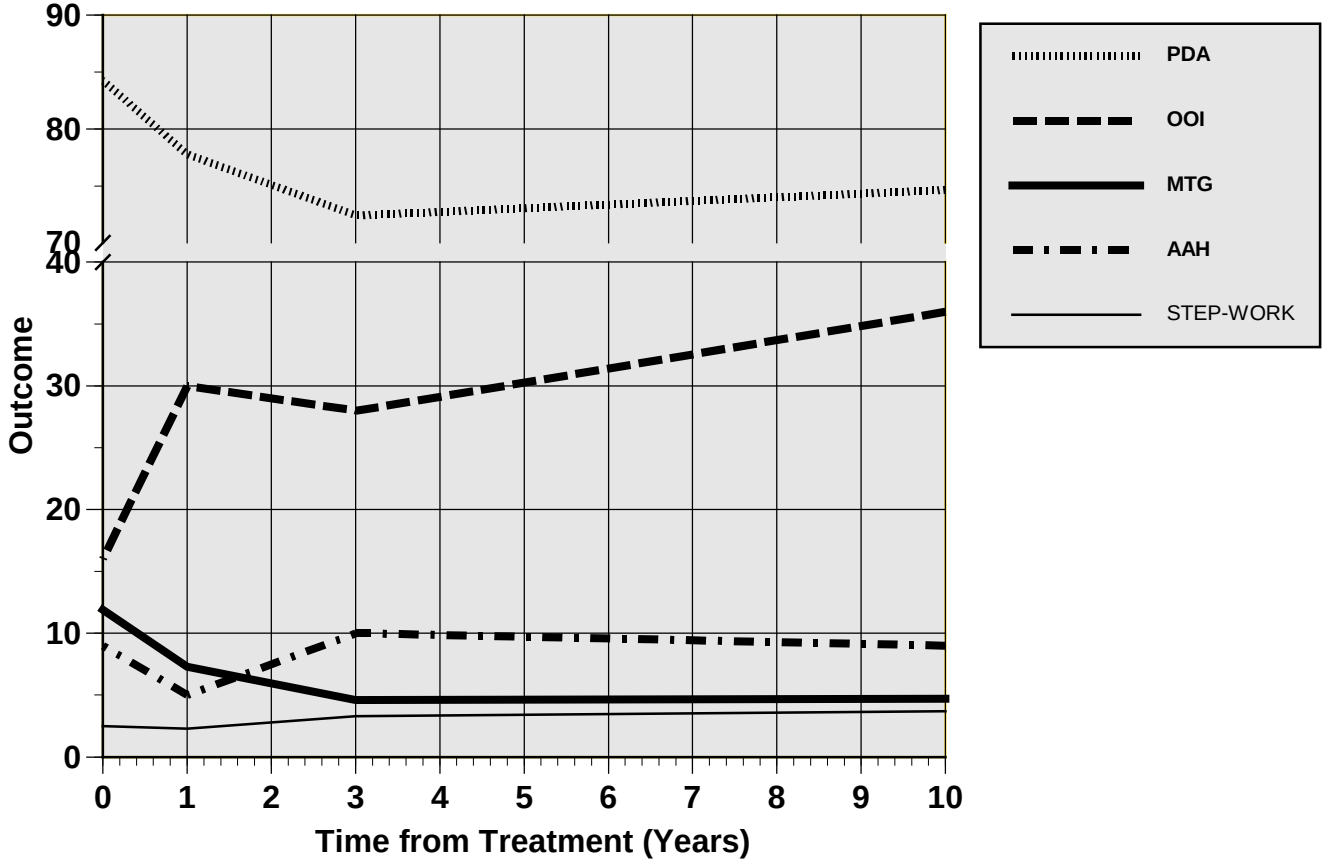
Notes: [a]Lagged-panel HLM results with multiple imputation; [1]Follow-up month after intake: 3-month, 15-month, 39-month, 120-month; [2]AAH = AA-related helping; [3]Step-work = no. of steps worked (1-11); [4]PDA=percent days abstinent.

Table 4 Estimates and p values for final model of other-oriented interest over time in an outpatient sample in Project MATCH[a]

Variable	*β*	CI Lower	CI Upper	*t*	*P*
Time-varying Covariates					
Follow-up Month[1]	0.003	-0.072	0.032	0.08	0.938
AAH[2]	-0.371	-0.772	-0.036	-2.81	0.013
Meeting Attendance	-0.126	-0.252	-0.026	-2.00	0.033
Step-work[3]	-0.080	-0.263	0.103	-0.86	0.391
TSF Assignment	-0.222	-0.475	0.032	-1.73	0.096
AAH X Month	-0.052	-0.227	0.122	-0.59	0.556
Meeting Attendance X Month	0.031	-0.057	0.119	0.68	0.496
Step-work X Month	0.043	-0.043	0.129	0.99	0.323
TSF X Month	0.097	-0.026	0.219	1.57	0.122
Baseline Covariates					
OOI[4]	0.229	0.125	0.333	4.36	<.0001
AAH	-0.049	-0.198	0.099	-0.65	0.514
Meeting Attendance	0.005	-0.122	0.134	0.90	0.368
Step-work	0.011	-0.120	0.142	0.17	0.866
Age	0.001	-0.007	0.009	0.28	0.783
Prior Treatment	0.013	0.001	0.025	2.20	0.028
Married	0.073	-0.085	0.231	0.67	0.095

Notes: [a]Lagged-panel GEE results with multiple imputation; [1]Follow-up month after intake: 3-month, 15-month, 39-month, 120-month; [2]AAH = AA-related helping; [3]Step-work = no. of steps worked (1-11); [4]OOI = other-oriented interest.

Figure 1 10-Year Course of Outcomes and AA Participation



NOTES:
[a]PDA = percent days abstinent in the assessment period; [b]OOI = other-oriented interest, proportion endorsing some to all lost OOI in the assessment period; [c]AAH = AA-related helping; [d]MTG = percent days attending AA in the assessment period; [e]STEP-WORK = number of steps worked among participants working 1+ steps in the assessment period.

Al-Anon, Alateen, and Professional Studies of Alcoholism and the Family: A Chronology

Compiled by William L. White and Christopher K. Budnick

Introduction

This year (2011), Al-Anon is celebrating the sixtieth anniversary of its founding. Over the course of these years, Al-Anon has emerged as the prevailing long-term support model for families facing alcoholism and other conditions—particularly chronic health disorders—that threaten their stability, health, and quality of life. Through its growth in North America and international dispersion and its wide adaptation to family problems other than alcoholism, Al-Anon has much to be proud of at this special time in its history.

The sixtieth anniversary of Al-Anon seemed a fitting time to review some of the historical milestones within Al-Anon and to set these milestones within the larger context of the evolving professional and scientific views on alcoholism and the family. The primary audiences for this chronology include addiction professionals, research scientists, and students who are interested in conducting research on Al-Anon and the history of worldwide responses to the impact of alcoholism on the family. The goal was not to list all relevant research, but to provide a representative sampling of publications that could convey the evolution of interest and understanding about alcoholism and the family.

For ease of use, the Al-Anon and Alateen milestones are indented once and the listing of scientific studies, other publications, and contextual milestones are indented twice.

To facilitate easier navigation of this document, the following hyperlinks in blue font will take the reader to specific years. Selecting the hyperlinked years in the document (also in blue font), will return the reader to this page.

1808 - 1919	Early 1940's	1956	1972	1987	1999
1842	1941	1957	1973	1988	2000s
1870s & 1880s	1942	1959	1974	1989	2001
1891	1945	1960s and 1970s	1975	Late 1980s	2002
1890s	Late 1940s	1960	1976	1990s	2003
1907	1949	1961	1977	1990	2004
1915	1950	1962	1978	1990 – 1995	2005
1918	1940s- Early 1950s	1963	1979	1991	2006
1928 – 1930	1950s & 1960s	1964	1980s	1992	2007
1934	1951	1965	1981	1993	2008
1935	1951 – 1953	1967	1982	1994	2009
1936	1953	1968	1983	1995	2010
1937	1954	1969	1984	1996	2011
1939	1955 – 1960	1970	1985	1997	
1940	1955	1971	1986	1998	

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To aid future historians, abbreviations used to note other sources include the following:

AF: White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-37.

AAG: *Alcoholics Anonymous Grapevine*

AT: *ALATEEN—Hope for children of alcoholics* (1982). New York: Al-Anon Family Group Headquarters, Inc.

CMAG White, W. (2011). *Chronology of addiction recovery mutual aid groups.* Posted at www.williamwhitepapers.com.

FS: Al-Anon Family Groups (1986). *First Steps: Al-Anon...35 years of beginnings*. New York: Author.

LR: Wilson, L. (1994). *Lois remembers: Memoirs of the co-founder of Al-Anon and wife of the co-founder of Alcoholics Anonymous*. New York: Al-Anon Family Group Headquarters, Inc.

MVOJ: Al-Anon Family Groups (2011). *Many voices, one journey*. Virginia Beach, VA: Author.

SD: White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

TN: *Al-Anon: Then and now*, 1986

WRT: Fitzpatrick, M. (2011). *We recovered too: The Family Groups' beginnings in the pioneers own words*. Center City, Minnesota: Hazelden.

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PRE-AL-ANON MILESTONES

1808 – 1919

Concern about the effects of drunkenness on families is a constant motif within the American temperance movement, with temperance plays such as *The Drunkard*, *One Cup More*, and *The Doom of the Drunkard* portraying the alcohol-related violence, the economic hardship, and abandonment experienced by families (AF).

1842

Martha Washington Society founded to support wives and children of inebriates—particularly those whose husbands and fathers have joined the Washingtonian Temperance Society (SD).

1870s & 1880s

The "Women's Crusade" and "Children's Crusade" against alcohol is led by family members affected by the alcoholism of their family members (AF).

1891

Lois B., future wife of Alcoholics Anonymous co-founder Bill W., is born to Clark and Matilda B. (March 4th).

1890s

Early evidence of wives being blamed by professional addiction specialists for the alcoholism of their husbands:

Palmer, in his 1898 treatise *Inebriety*, had the following to say about wives: "The universality of good wives to intemperate husbands suggests an inquiry into the connection they may bear and the influence they may exercise, however innocently, in the downfall of their husbands." (Palmer, C. (1898). *Inebriety: Its source, prevention, and cure.* Philadelphia: Union Press, p. 42.)

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PRE-AL-ANON MILESTONES

1907

Cutten, in his *Psychology of Alcoholism* text, notes: "The kindest wife and most indulgent parents are very much in the way of numerous cures, and prove to be, instead of the best friends, the worst enemies the alcoholic has." (Cutten, G. (1907). *The psychology of alcoholism*. New York: Charles Scribner's Sons, p. 325.)

1915

Lois B. becomes engaged to Bill W.

1918

Lois B. marries Bill W. (January 24th)

1928 – 1930

Bill W. makes repeated pledges to Lois W. in the family Bible that he will stop drinking (October 20, 1928; November 29, 1928 [Thanksgiving]; January 12, 1929; and September 3, 1930).

1934

On November 11, Bill W. is re-admitted for the fourth time to Charles Towns Hospital for treatment of his alcoholism. It was during this last stay that he had a profound spiritual experience that marked the beginning of his permanent sobriety. Lois would later reflect that when she first saw Bill after this experience, she recognized that he had undergone a significant change and from that moment shared his hope for the future (LR, p. 89).

1935

In search of another alcoholic to talk to while on a business trip to Akron, Ohio, Bill W. meets Dr. Robert S. on May 12 (LR, p. 95). Their meeting and "Dr. Bob's" subsequent last drink in mid-June will mark the founding of Alcoholics Anonymous. Lois W. later described how Alcoholics Anonymous during this period was a "family affair" (LR, p. 171).

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PRE-AL-ANON MILESTONES

1936

Anne S., wife of Alcoholics Anonymous co-founder Dr. Bob, organizes a group for the wives of AA members (WRT, p. 8).

1937

Bill and Lois W. sever ties with the Oxford Group; Dr. Bob and Annie will do the same in 1939 (FS, 16).

Moore and Gray, in a 1937 article on alcoholism note, "the person with the greatest need of psychiatric treatment is the marital partner who has *not* become alcoholic" (pp. 381-388). (Moore, M., & Gray, M. (1937). The problem of alcoholism at the Boston City Hospital. *New England Journal of Medicine, 217*, 381-388.)

There is an emerging trend in the 1930s for therapists to see family members of alcoholics as possessing great pathology and interfering with the treatment of the alcoholic (e.g., Strecker, E., & Chambers, F. (1938). *Alcohol: One man's meat*. New York: MacMillan; Knight, R. (1938). The psychoanalytic treatment in a sanatorium of chronic addiction to alcohol. *Journal of the American Medical Association, 111*, 1443-1446.)

1939

AA's basic text, *Alcoholics Anonymous*, includes a chapter "To Wives" authored by AA co-founder Bill W. Lois later shared her disappointment that Bill had not asked her to write this and the "The Family Afterward" chapters (LR, p. 114).

1940

When AA members at AA's first clubhouse in New York City begin "alcoholics only" meetings, the wives begin meeting together and sharing their stories (September 12) (LR, p. 172).

Early 1940's

Wives (and later, wives and husbands) of AA members began to band together for mutual support in such places as Long, Beach California; Richmond, Virginia; and Chicago, Illinois (SD, p. 221).

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PRE-AL-ANON MILESTONES

1941

Bill and Lois W. buy Stepping Stones – their home at 62 Oak Road in the village of Katonah in Bedford, New York.

1942

Lois and Anne B. – future co-founders of Al-Anon – first meet when Anne seeks help for her husband (MVOJ, p. 18; WRT, 160).

1945

The first family group is registered by the Alcohol Foundation (the latter will evolve into the AA General Services Organization (GSO) (MVOJ, p. 21). They first refer to themselves as AAA / Triple (Alcoholics Anonymous Auxiliary) and AA NAA (Non-Alcoholics Anonymous) (WRT, p. 21).

Landis-Benson, Y. (1945). Excessive drinking and the institution of the family. *Alcohol, science and society*. Westport, CT: Greenwood Press, p. 223-238.

Late 1940s

A.A. Grapevine articles (30 family-focused articles between 1945 – 1950) and news reports reveal considerable family activity (MVOJ, 33), including the following sources:

- Family groups make headway in California. (1947). *A.A Grapevine, 3*(12), May, p.1.
- Non-A.A. group formed in Austin. (1947). *A.A Grapevine, 4*(12), July, p.3
- Non-alcoholic wives form A.A. Auxiliary. (1948). *A.A Grapevine, 5*(2), May, p.7.
- Enthusiasm key word. (1948). *A.A Grapevine, 8*(3), July, p.5
- California - THE San Diego AA Associate Group. (1951). *A.A Grapevine, 19*(9), August, p.38.
- The Al-Anon story. (1963). *A.A Grapevine, 19*(9), February, p. 2-9.

Alcoholics Anonymous Associates organizes in San Diego, CA (AAG).

Family Groups organized in San Pedro and Sugar Hill, CA (AAG).

A.A. Auxiliary" (AAA) formed in Rome, GA (AAG).

"Non-A.A. Group" (NAA) created for family members in Austin, TX (AAG).

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PRE-AL-ANON MILESTONES

Late 1940s

Rochester, NY Non-AA Group adapts AA's Twelve Steps for use by the husbands and wives of alcoholics (AAG).
Other names of early family groups include A.A. Helpmates, Al-Anon, Alono, and Onala (SD).
In 1949, Lois W. authors "One Wife's Story" in the *A.A. Grapevine* (AAG).
In 1949, Ruth G., a San Francisco Al-Anon member, develops the newsletter, the *San Francisco Family Chronicle* – later renamed *The Family Forum* – the forerunner of today's newsletter used as the primary instrument of communication among the nation's Al-Anon groups (LR, 173; WRT, p. 81).
In July 1949, a *Coronet Magazine* article entitled "New Help for Alcoholics" marks the first national publicity for the emerging family groups (MVOJ, 24).
A family group begins meeting weekly in Mount Kisco, New York; its membership includes Lois W. and Anne B.—future co-founders of Al-Anon (MVOJ, 28-29).

1949

Anne S., wife of Dr. Bob, dies June 1; her early work with families will serve as an inspiration for what will soon become Al-Anon (WRT, 203).

1950

Wives of still-drinking alcoholics not involved in AA begin participation in family group meetings (FS, 159).
Bill W. returns from visits to AA groups across the US and Canada; in response to his seeing so many family groups, he encourages Lois to open a service office to support these groups (LR, 173).

1940s- Early 1950s

Wives of alcoholics are increasingly depicted in the professional alcoholism literature as having chosen alcoholics in order to meet their own dependency needs, e.g., Futterman, S. (1953). Personality trends in wives of alcoholics. *Journal of Psychiatric Social Work*, *23*, 37-41. Whalen, T. (1953). Wives of alcoholics: Four types observed in a family service agency. *Quarterly Journal of Studies on Alcohol*, *12*, 632-641.

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AL-ANON AND RELATED MILESTONES

1950s & 1960s

Two themes that permeate family studies of alcoholism in the 1950s and 1960s: the personal and role adaptations that occur within the family in response to alcoholism and the alcoholism-related deterioration in the role performance of family members (AF).
Wives of alcoholics continue to be portrayed as choosing and remaining with alcoholic husbands as a result of their own psychopathology (See Corder, B., Hendricks, A., & Corder, R. (1964). An MMPI study of a group of wives of alcoholics. *Quarterly Journal of Studies on Alcohol*, *25*, 551).

1951

Lois W. and Anne B. set up a service office at Stepping Stones, Bill & Lois W.'s home – called the Clearinghouse Committee – to support the 49 and growing family groups meeting in tandem with AA (WRT, p. 91).
The Committee identified 87 groups operating in May, 1951 (WRT, p. 117).
145 groups have registered with the Clearinghouse (SD, p. 221).
Lois W. and Anne B. author *Purposes and Suggestions* (MVOJ, 42).

1951 – 1953

Lois W. adapts AA's Twelve Steps and Twelve Traditions for Al-Anon; The Al-Anon Family Groups agree to accept the adapted Steps; there are 300 registered Al-Anon groups (LR, p. 199).
Anne B. and volunteers create the first Al-Anon World Directory (FS, 72; MVOJ, 78).

1953

There are 441 registered Al-Anon groups (LR, p. 178; WRT, 162).
Henrietta S. becomes Al-Anon's first paid worker in her role as General Secretary/ Executive Director (TN).
Futterman, S. (1953). Personality trends in wives of alcoholics. *Journal of Psychiatric Social Work*, *23*, 37-41.

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AL-ANON AND RELATED MILESTONES

1953

Whalen, T. (1953). Wives of alcoholics: Four types observed in a family service agency. *Quarterly Journal of Studies on Alcohol, 12*, 632-641.

1954

The Clearinghouse Committee incorporates itself as Al-Anon Family Group Headquarters, Inc. (MVOJ, p. 67).

There are 500 registered Al-Anon Groups (FS, 64).

Joan Jackson publishes her article, "The Adjustment of the Family to the Crisis of Alcoholism" in the *Quarterly Journal of Studies on Alcohol*. Jackson went on to study how alcoholism elicited a wide variety of developmental problems in children of alcoholics (Jackson, 1964).

1955 – 1960

Al-Anon's growth is spurred on by articles in such publications as the *Saturday Evening Post* (July, 1955), *Christian Herald* (1953), *Life Romances* (April, 1953), *Life Today* (April, 1953),*Time* (May 16, 1960), *Life* (1961), and *Guideposts* (March, 1960) and by Abigail Van Buren and Ann Lander's positive treatment in their advice columns (e.g., March 24, 1960). Some of these publishing events generate more than 10,000 letters of request for help from Al-Anon (FS, 149). Al-Anon had been featured earlier in radio (e.g., Second Chance) and television programs (e.g., Lamp Unto My Feet) (MVOJ, 55).

1955

Al-Anon's Twelve Traditions, which Lois W. had begun drafting in 1952, are officially ratified in 1955 by the Alcoholics Anonymous General Service Conference (FS, 85).

First printing of the book *The Al-Anon Family Groups*, authored by Lois W. with assistance from Alcoholics Anonymous cofounder Bill W., Margaret D., and Ralph P., is distributed at the AA International Convention in St. Louis (LR, p. 180).

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AL-ANON AND RELATED MILESTONES

1955

The first special session about children of alcoholics was hosted by Al-Anon at the AA International Convention in St. Louis (LR, p. 183); early signs of a rising Alateen begin as early as 1954 (WRT, 157).
J.E.S. (1955). It's a family disease. *AA Grapevine*, *12*(3), August.

1956

Frank, J. D., Gliedman, L. H., Nash, H. T., & Rosenthal, D. (1956). Group therapy of alcoholics with concurrent group meetings of their wives. *Quarterly Journal of Studies on Alcohol*, *17*, 655-670.
MacDonald, D. (1956). Mental disorders in the wives of alcoholics. *Quarterly Journal of Studies on Alcohol*, *17*, 282-287.

1957

On November 10, the story of Al-Anon is featured on *The Loretta Young Show* (FS, 141).
Alateen is started by a Pasadena, California adolescent whose parents were in AA and Al-Anon. Alateen provides a support-group structure for people ages 12 to 20 whose lives have been affected by the alcoholism of someone close to them, most often a parent. Within a year, there are 45 Alateen groups established (AT). This is the first organization for children of alcoholics since the Junior Washingtonian Societies of the early 1840s (SD).
C.W. (1957). What Al-Anon means to me. *A.A. Grapevine*, 14(1), May.

1959

Ross, A.B. (1959). Al-Anon help alcoholic's wives. *Hospital Progress*, *40*(4), 70-72.

1960s and 1970s

A growing number of alcoholism treatment institutions begin to experiment with "family programs." The conceptualization of addiction as a "family disease" opened the door to exploring how this disease altered family structure (roles and subsystem interactions), family

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1960s and 1970s

rules, family rituals, and the family's boundary transactions with the outside world as a natural process of adaptation rather than from the psychopathologies of husband and wife (AF).

1960

At the AA International Convention in Long Beach, CA, Al-Anon members vote to hold a trial World Service Conference the following year (MVOJ, p. 93).
The growing visibility of women recovering from alcoholism and the related growth of men in Al-Anon is recognized by a new genre of Al-Anon literature bearing such titles as *The Stag Line*, *What's Next? Asks the Husband of an Alcoholic*, *My Wife is an Alcoholic*, and *Al-Anon IS for Men* (SD, p. 222).
A revision of Al-Anon's basic text, *The Al-Anon Family Groups*, is revised and published as *Living with an Alcoholic* (LR, p. 200).
There are about 100 Alateen groups (LR, p. 200).
Alateen article, "My Mother is an Alcoholic," is published in *Guideposts* magazine in March (MVOJ, 91).
Fox, R. (1960). Al-Anon's role in the alcoholic's home. *AA Grapevine*, *17*(1), June.
McNamara, J. (1960). The disease conception of alcoholism: Its therapeutic value for the alcoholic and his wife. *Social Casework, 41*, 460-465.

1961

There are 1,500 Al-Anon groups (LR, p. 200); Al-Anon hosts its first World Service Conference (FS, 128; MVOJ 96); Since 1963, it has been held annually (WRT, 156).
The first autonomous Alateen convention is held in Philadelphia in June (LR, p. 186).
Alateen receives national media coverage in such magazines as *Life*, *Time*, *American Weekly*, *Seventeen*, and *Teen Etiquette*; there are 154 Alateen groups (AT).

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AL-ANON AND RELATED MILESTONES

1961

Bailey, M. (1961). Alcoholism and marriage: A review of the research and professional literature. *Quarterly Journal of Studies on Alcohol, 22*, 81-97.
Day, B. (1961). Alcoholism and the family. *Marriage and Family Living, 23*, 253-258.
Dr. Ruth Fox presents The Effect of Alcoholism on Children, Alcohol Is a Family Disease at the Int'l Congress for Psychotherapy, 1961.

1962

Bailey, M.B. (1962). Family agency and social casework in treatment of the spouse and family of the alcoholic. In A. Kuhn, (ed.), *What family agencies can do to help alcoholics and families* (pp. 35-46). Springfield, IL: Illinois Division of Alcoholism.
Jackson, J. (1962). Alcoholism and the family. In D. Pittman & C. Snyder (Eds.), *Society, culture and drinking patterns* (pp.472-492). New York: John Wiley & Sons.
Kellermann, J. L. (1962). *Guide for the family of the alcoholic*. New York: Al-Anon Family Group Headquarters.
Cork, M. (1962). Alcoholics Anonymous and Al-Anon as resources for the alcoholic and his family**.** In A. Kuhnn, *What family agencies can do to help alcoholics and families*. Springfield, IL: Illinois Division of Alcoholism.
Fox, R. (1962). Children in the alcoholic family. In W. C. Bier (Ed.), *Problems in addiction: Alcoholism and Narcotics*. New York: Fordham University Press.

1963

There are 1,500 Al-Anon registered groups (SD, p. 221).
The Al-Anon story. (1963). *AA Grapevine*, *19*(9), February.
There are 262 Alateen groups spurring in part by many new groups outside the United States (AT).
Shipp T. (1963). *Helping the alcoholic and his family*. Englewood Cliffs, NJ: Prentice Hall.

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AL-ANON AND RELATED MILESTONES

1964

First studies appear that question the 1950s portrayal of the alcoholic wife as having selected and remained with her husband out of her own deep emotional disturbance.

Corder, B., Hendricks, A., & Corder, R. (1964). An MMPI study of a group of wives of alcoholics. *Quarterly Journal of Studies on Alcohol*, *25*, 551.

Blaine, H.T., & Meyers, W.R. (1964). Psychological test score changes from wives of alcoholics during periods of drinking and sobriety. *Journal of Clinical Psychology*, *20*(2), 230-232.

Jackson, J. (1964). Drinking, drunkenness, and the family. In R. McCarthy (Ed.), *Alcohol education for classroom and community* (pp. 155-166). McGraw-Hill.

Presnall, L.F. (1964). *The wife of an alcoholic: A pattern to happiness*. Salt Lake City, UT: Utah Alcoholism Foundation.

1965

Al-Anon Faces Alcoholism is published. Al-Anon's growth is reflected in 3 Spanish-speaking staff at the Al-Anon World Service Office who provide support to 3,000 Spanish-speaking and 800 Portuguese-speaking groups now meeting in 20 countries (FS, 123).

Bailey, M. (1965). Al-Anon family groups as an aid to wives of alcoholics. *Social Work, 10,* 68–74.

1967

The Dilemma of the Alcoholic Marriage is published.

The Al-Anon program is adapted by Nar-Anon and in subsequent years, Families Anonymous (1971), Co-anon (1985), and Recovering Couples Anonymous (1988).

Bailey, M.B. (1967). Psychophysiological impairment on wives of alcoholics as related to their husband's drinking and sobriety. In R. Fox (Ed.), *Alcoholism: Behavioral research, therapeutic approaches* (pp. 134-144). New York: Springer.

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AL-ANON AND RELATED MILESTONES

1968

One Day at a Time in Al-Anon is published. By 1986, it will be in its 18th printing and have sold more than two million copies.

1969

There are 701 Alateen groups, sparked in part by dramatic growth of Alateen outside the United States (AT).

Cork, M. (1969). *The forgotten children.* Toronto: Addiction Research Foundation.

Joseph Kellerman's booklet, *Alcoholism, a Merry-Go-Round Named Denial*, is published.

1970

Al-Anon's Favorite Forum Editorials (by Margaret D.) is published.

Meeks, D., & Keely, C. (1970). Family therapy with families of recovering alcoholics. *Quarterly Journal of Studies on Alcohol, 31*, 399-413.

1971

The film *Lois's Story* recounting the early years of Al-Anon is released.

Families Anonymous founded (CMAG).

Cheek, F.E., Franks-Cyril, M., & Laucius, J. (1971). Behavior modification training for wives of alcoholics. *Quarterly Journal of Studies on Alcohol, 32*(2), 456-461.

Cohen, P.C., & Krause, M.S. (1971). *Casework with wives of alcoholics.* New York: Family Service Association of America.

James, J.E., & Goldman, M. (1971). Behavior trends of wives of alcoholics. *Quarterly Journal of Studies on Alcohol, 32*(2), 373-381.

Scott, E.M. (1971). *Struggles in an alcoholic family***.** Springfield, IL: Charles C. Thomas publisher.

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AL-ANON AND RELATED MILESTONES

1972

The "Three Cs" ("I didn't cause it, can't control it, and can't cure it.") first appear *Al-Anon Family Groups Forum* (MVOJ, 163).

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The first Al-Anon adult children of alcoholics group is registered (MVOJ, 175).

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1976

Blueprint for Progress: Al-Anon's Fourth Step Inventory is published and sells more than 90,000 copies in the next year (MVOJ, 185).

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Former President Ford and First Lady Ford announce that Mrs. Ford has sought treatment for alcohol and drug dependence. Her entrance into treatment following a family intervention sparks great interest in the role of family in addiction recovery.
Founding of Adult Children of Alcoholics.
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Friedrich, W.N., & Loftsgard, S.O. (1978). Comparison of two alcoholism scales with alcoholics and their wives. *Journal of Clinical Psychology*, *34*, 784-786.
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W., L. (1979). *Lois remembers: Memoirs of the co-founder of Al-Anon and wife of the co-founder of Alcoholics Anonymous.* New York: Al-Anon Family Group Headquarters, Inc. is published.
There are 14,000 Al-Anon groups (LR, 194); the first Al-Anon groups in Japan begin meetings (MVOJ, 207).
The Stepping Stones Foundation is created with the mission of "preserving the historic home of Bill and Lois W., co-founders respectively of Alcoholics Anonymous and Al-Anon Family Groups, and to commemorating their achievements in the field of recovery from alcoholism" (FS, 152; quotation from http://www.steppingstones.org/).
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AL-ANON AND RELATED MILESTONES

1979

There are 2,200 Alateen groups (LR, p. 194).

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1980s

A growing focus on the special needs of children of alcoholics leads to the concepts of "co-alcoholism" or "para-alcoholism" (Greenleaf, 1981), the graphic description of the psychological and developmental consequences of parental alcoholism on children, and a focus on how these consequences continued to affect children of alcoholics in their adult lives. These spark full blown COA/ACOA and Codependency movements that become something of a social phenomenon.

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1980s

There are 2,000 Spanish-speaking Al-Anon groups meeting in Mexico, Latin America, and Spain (MVOJ, 208).

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1981

Al-Anon's Twelve Steps and Twelve Traditions is published.

There are more than 15,000 Al-Anon groups meeting worldwide (MVOJ, 219).

There are 2,300 Alateen groups meeting worldwide (MVOJ, 219).

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1981

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1985

As We Understood… is published – Al-Anon's first book focused on spirituality.
Al-Anon has an annual budget of more than $5 million and processes more than 50,000 literature orders per year (FS, 76).
There are Al-Anon groups in 81 countries (FS, p. 121).
Representatives from 54 countries who speak 23 different languages participate in Al-Anon's first International Convention in Montreal, Canada (FS, p. 159).

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1986

First Steps: Al-Anon – 35 Years of Beginnings is published; there are 27,201 Al-Anon groups, and Al-Anon literature has been translated into 24 languages (LR, p. 201, 126); Al-Anon hosts its first permanent International General Services Meeting.

There are 3,196 Alateen groups (LR, 201).

Co-Anon founded (CMAG).

Co-Dependents Anonymous is founded; 1,600 groups will register by 1990 (AF).

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1987

Psychoactive Drugs, *19*, 257-268.

1988

Lois W., Al-Anon co-founder, dies on October 5 at the age of 97. (Borchert, 2005; MVOJ, 262)

John Bradshaw publishes *Healing the Shame That Binds You*; a highly popular PBS television series is based on the book. A whole nation seemed to be riveted on the exploration of the "dysfunctional family" (AF).

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1989

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Late 1980s

Al-Anon members first begin to reach out to one another on Internet Bulletin Boards.

1990s

Al-Anon members communicate online in such Internet forums as *Tranquility; CyberSerenity; Al-Anon Chatters; Friends of Lois W.; American Families Online; Courage to Change; Experience, Strength and Hope, A Serenity Place, Men's One Day at a Time, Undernet Al-Anon Group, Awakenings, Key to Harmony, Saturday Night Butterflies, Al-Anon Beginners Chat, Heart-to-Heart Al-Anon Chat* and *Fifth Tradition*.

Stephanie Brown and Virginia Lewis conduct sustained research on the effects of alcoholism on the family and the further destabilization of the family during early recovery from alcoholism (AF).

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1990

An Alateen membership survey reveals that 30% of Alateen membership is younger than age 12 (MVOJ, 273); there are more than 4,000 Alateen meetings worldwide (MVOJ, 279).

The National Association for Children of Alcoholics (NACoA) grows to more than 1,500 local groups by 1990. (Brown, S. (1991). Adult children of alcoholics: The history of a social movement and its impact on clinical theory and practice. In M. Galanter (Ed.), *Recent Developments in Alcoholism* (vol. 9, pp. 267–285). New York: Plenum.)

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1990 – 1995

A co-dependency backlash movement casts aspersions on the ACOA and codependency movements and on mutual help groups in general.

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1994

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There are 3,300 Alateen groups (LR, 201).

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Kurtz, L. F. (1994). Self-help groups for families with mental illness or alcoholism. In T.J. Powell (Ed.), *Understanding the self-help organization: Frameworks and findings* (pp. 293-313). Thousand Oaks, CA: Sage.

Molina, B.S.G., Chassin, L., & Curran, P.J. (1994). A comparison of mechanisms underlying substance use for early adolescent children of alcoholics and controls. *Journal of Studies on Alcohol*, *55*, 269-275.

O'Farrell, T.J. (1994). Marital therapy and spouse-involved treatment with alcoholic patients. *Behavior Therapy*, *25*(3), 391-406.

Okazaki, N., Fujita, S., Suzuki, K., Niimi, Y., Mizutani, Y., & Kohno, H. (1994). Comparative study of health problems between wives of alcoholics and control wives. *Japanese Journal of Alcohol Studies and Drug Dependence*, *29*(1), 23-30.

Saulnier, C. F. (1994). Twelve steps for everyone? Lesbians in Al-Anon. In T.J. Powell (Ed.), *Understanding the self-help organization: Frameworks and findings* (pp. 247-271). Thousand Oaks, CA: Sage.

Wallace, B.C. (1994). Drugs, alcohol, and the dysfunctional family: Male/female differences. In R.R. Watson (Ed.), *Addictive behaviors in women: Drug and alcohol abuse reviews 5* (pp. 71-96). Totowa, NJ: Humana Press.

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1995

The first Al-Anon List Serv (Bulletin Board) begins.

AA Grapevine Volume 51, #7 - Special Section: A Family Affair. (1995). New York: AA Grapevine, Inc.

Barthwell, A.G. (1995). Alcoholism in the family: A multicultural exploration. In M. Galanter (Ed.), *Recent developments in alcoholism: Volume 12. Alcoholism in women* (pp. 387-407). New York: Plenum Press.

Driscoll, J.C. (1995). Spouse, parent, worker: Drinking and well-being as a function of women's role. *Dissertation Abstracts International, 55*(8), 3563B-3564B.

Humphreys, K., & Kaskutas, L.A. (1995). World views of Alcoholics Anonymous, Women for Sobriety, and Adult Children of Alcoholics/Al-Anon mutual help groups. *Addiction Research, 3*(3), 231-243.

Kaufman, E. (1995). Family therapy in substance abuse treatment. In G.O. Gabbard (Ed.), *Treatments of psychiatric disorders*: *Volume 1* (pp. 848-859). London: American Psychiatric Press.

Keinz, L.A., Schwartz, C., Trench, B.M., & Houlihan, D.D. (1995). An assessment of membership benefits in the Al-Anon program. *Alcoholism Treatment Quarterly*, *12*(4), 31-38. (Main findings are that self-esteem and the quality of marital adjustment improve with duration of Al-Anon involvement.)

Minnick, A.M. (1995). "Came to believe": An examination of the context, meaning, and significance of Al-Anon, a contemporary American site of spiritual and moral renewal. *Dissertation Abstracts International*, *55*(9), 2875A.

Edwards, M., & Steinglass, P. (1995). Family therapy treatment outcomes for alcoholism. *Journal of Marital and Family Therapy*, *21*(4), 475-509.

Rolls, J.A. (1995). Recovering female alcoholic: A family affair. *Contemporary Family Therapy*, *17*(3), 317-329.

Rotunda, R.J., Scherer, D.G., & Imm, P.S. (1995). Family systems and alcohol misuse: Research on the effects of alcoholism on family functioning and effective family

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1995

interventions. *Professional Psychology: Research and Practice*, *26*(1), 95-104.

Schmid, J. (1995). Alcoholism and the family. In S. Brown & I.D. Yalom (Eds.), *Treating alcoholism*: *Jossey-Bass library of current clinical technique* (pp. 353-396). San Francisco, CA: Jossey-Bass.

1996

Al-Anon World Service Office and its 56 staff move from New York to Virginia.

Courage to Be Me is published, containing Alateen members' stories of how they've applied the Steps and Traditions to their lives.

Curran, P.J., & Chassin, L. (1996). A longitudinal study of parenting as a protective factor for children of alcoholics. *Journal of Studies on Alcohol, 57*, 305-313.

Friedemann, M.L. (1996). Effects of Al-Anon attendance on family perception of inner-city indigents**.** *American Journal of Drug and Alcohol Abuse*, *22*(1), 123-134.

Humphreys, K. (1996). World view change in adult children of Alcoholics/Al-Anon self-help groups: Reconstructing the alcoholic family. *International Journal of Group Psychotherapy*, *46*(2), 255-63.

Kelly, V.A., & Myers, J.E. (1996). Parental alcoholism and coping: A comparison of female children of alcoholics with female children of nonalcoholics. *Journal of Counseling and Development, 74*, 501-504.

Kodandaram, P. (1996). Personality of wives of alcoholics. *Indian Journal of Clinical Psychology*, *23*(1), 21-23.

Kokin, M. (1996). Differentiating wives of alcoholics by family history of parental alcohol problems. *Dissertation Abstracts International*, *57*(6), 4090-B.

McBride, J.L. (1996). Family functioning and Alcoholics Anonymous attendance. *Alcoholism Treatment Quarterly*, *14*(3), 103-106.

Raymer, M. (1996). When death comes to the alcoholic family. *American Journal of Nursing*, *96*(12), 58-60.

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1996

Thomas, E.J., Yoshioka, M., & Ager, R.D. (1996). Spouse enabling of alcohol abuse: Conception, assessment, and modification. *Journal of Substance Abuse*, *8*(1), 61-80.
Zuboff-Rosenzweig, L. (1996). Degree of similarity concerning abuse within the family backgrounds of Al-Anon members and controls. *Alcoholism Treatment Quarterly*, *14*(4), 81-101.

1997

Adult Children of Alcoholics World Service Organization (1997). *An interview about the early history of ACA*. Torrance, California: ACA World Service Organization
Barber, J.G., & Gilbertson, R. (1997). Unilateral interventions for women living with heavy drinkers. *Social Work*, *42*(1), 69-78.
Dassi, S., & Bocchia, M. (1997). Role of Al-Anon in the management of alcohol problems**.** *Alcologia: European Journal of Alcohol Studies*, *9*(1), 23-27.
Hughes, J.M. (1997). Adolescent children of alcoholic parents and the relationship of Alateen to these children. *Journal of Consulting and Clinical Psychology*, *43*(5), 946-947. (Main finding was that children of alcoholics participating in Alateen have better emotional health than children of alcoholics who do not participate in Alateen.)
Leonard, K.E., & Jacob, T. (1997). Sequential interactions among episodic and steady alcoholics and their wives. *Psychology of Addictive Behaviors*, *11*(1), 18-25.
Maynard, S. (1997). Growing up in an alcoholic family system: The effect on anxiety and differentiation of self. *Journal of Substance Abuse*, *9*, 161-70.
Rychtarik, R.G., & McGillicuddy, N.B. (1997). Spouse situation inventory**:** A role-play measure of coping skills in women with alcoholic partners. *Journal of Family Psychology*, *11*(3), 289-300.

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1998

In Salt Lake City, Utah, 4,500+ Al-Anon members participate in Al-Anon's Third International Convention. The book, *Having Had a Spiritual Awakening*, is introduced (MVOJ, 321).

Adger, H., Jr. (1998). Children in alcoholic families: Family dynamics and treatment issues. In A.W. Graham, T.K. Schultz, & B.B. Wilford (Eds.), *Principles of addiction medicine* (Second Edition, pp. 1111-1114). Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Grubisic-Ilic, M., Ljubin, T., & Kozaric-Kovacic, D. (1988). Demographic and sociological characteristics of alcoholics' wives. *Alcoholism: Journal on Alcoholism and Related Addictions, 34*(1-2), 15-24.

Prest, L.A., Benson, M.J., & Protinsky, H.O. (1998). Family of origin and current relationship influences on codependency. *Family Process, 37*(4), 513-528.

Vetere, A. (1998). Family systems perspective**.** In R. Velleman, A. Copello, & J. Maslin (Eds.), *Living with drink: Women who live with problem drinkers* (pp. 113-127). New York: Addison Wesley Longman Limited.

Waldron, H.B., & Slesnick, N. (1998). Treating the family. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (Second Edition, pp. 271-283). New York: Plenum Press.

1999

Grief After Substance Passing (GRASP) founded for family members who have lost a loved one to addiction (CMAG).

Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery, a developmental model*. New York: Guilford Press.

Brown, S., & Schmid, J. (1999). Adult children of alcoholics: A multidimensional view. In R. Tarter, R. Ammerman, & P. Ott (Eds.), *Sourcebook on substance abuse: Etiology, epidemiology, assessment and treatment.* Allyn & Bacon.

Demers, A., Bisson, J., & Palluy, J. (1999). Wives' convergence with their husbands' alcohol

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1999

use: Social conditions as mediators. *Journal of Studies on Alcohol, 60*(3), 368-377.

Miller, W.R., Meyers, R.J., & Tonigan, J.S. (1999). Engaging the unmotivated in treatment for alcohol problems: A comparison of three intervention strategies. *Journal of Consulting and Clinical Psychology, 67*, 688-697.

O'Farrell, T.J., & Fals-Stewart, W. (1999). Treatment models and methods: Family models. In B.S. McCrady & E.E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (pp. 287-305). New York: Oxford University Press.

2000s

Al-Anon telephone meetings begin (See http://www.al-anon.alateen.org/electronic-meetings). Telephone and online meetings are collectively referred to as "electronic meetings" to distinguish them from face-to-face meetings.

AA World Services. (2000). *Box 1980 - Special Section: The family afterward - Now and not now - A long journey. The International Monthly Journal of AA.* New York: The AA Grapevine, Inc.

Brown, S., Lewis, V., with Liotta, A. (Fall 2000). *The family recovery guide: A map for healthy growth*. Oakland: New Harbinger Publications.

Brown, S. (May 2000). ACA's today: A new idea all grown up. *New Times*. San Jose: Resource Alliance, 3-4.

Johnson, H. (2000). Role of alcohol in male partners' assaults on wives. *Journal of Drug Issues, 30*(4), 725-740.

Kinney, J. (2000). Effects of alcohol problems on the family. In J. Kinney, *Loosening the grip: Handbook of alcohol information* (pp. 209-225). Boston, MA: McGraw-Hill.

McConnell, T. (2000). Military wives' recognition of alcoholism. *Journal of Addictions Nursing, 12*(2), 83-88.

O'Farrell, T.J., Murphy, C.M., Neavins, T.M., & Van Hutton, V. (2000). Verbal aggression among male alcoholic patients and their wives in the year before and two years after

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2000s

alcoholism treatment. *Journal of Family Violence*, *15*(4), 295-310.
Osterman, F., & Grubic, V.N. (2000). Family functioning of recovered alcohol-addicted patients: A comparative study. *Journal of Substance Abuse Treatment*, *19*(4), 475-479.
Richter, L., Chatterji, P., & Pierce, J. (2000). Perspectives on family substance abuse: The voices of long-term Al-Anon members. In J. Delva (Ed.), *Substance abuse issues among families in diverse populations* (pp. 61-78). New York: The Haworth Press, Inc.
Zvirbulis, L.M. (2000). Correlations of resiliency among adult children of alcoholics involved or noninvolved in Alateen, Al-Anon, or ACoA groups. *Dissertation Abstracts International*, *60*(8),4198-B.

2001

There are 24,000 Al-Anon groups meeting in 130 countries (MVOJ, 331).
Adult children of alcoholics groups that for a period considered organizing independently of Al-Anon are now mostly integrated within Al-Anon (MVOJ, 329).
Al-Anon Family Groups hosts a Family Recovery Luncheon in a U.S. Senate building in Washington D.C. Claudia Black is the keynote speaker addressing the U.S. Center for Substance Abuse Treatment's Recovery Month Planning Partners and executives from national non-profit organizations. Congressman and Senator Paul Wellstone, MN U.S. Senate and Congressman Jim Ramstad issue proclamations acknowledging Al-Anon Family Groups as a community resource that has helped countless Americans affected by a relative or friend's drinking in honor of Al-Anon's 50th anniversary.
Al-Anon Family Groups hosts a Family Recovery Luncheon in Ottawa, ON in cooperation with the Canadian Centre on Substance Abuse in honor of Al-Anon's 50th Anniversary. Claudia Black is the keynote speaker. Executives from Canadian nongovernment organizations, government agencies, Members of Parliament Senators(MPS), and embassies attend. A Standing Order is read in Canada's Parliament record.
There are 2,300 Alateen groups (MVOJ, 331).

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2001

Living Today in Alateen is published—a second daily reader for Alateen members.

Harkness, D. (2001). Testing Cermak's hypothesis: Is dissociation the mediating variable that links substance abuse in the family of origin with offspring co-dependency? *Journal of Psychoactive Drugs*, *33*(1), 75-82.

Harkness, D., Swenson, M., Madsen-Hampton, K., & Hale, R. (2001). The development, reliability, and validity of a clinical rating scale for co-dependency. *Journal of Psychoactive Drugs*, *33*(2), 159-171.

Krishnan, M., Orford, J., Bradbury, C., Copello, A., & Velleman, R. (2001). Drug and alcohol problems: The users' perspective on family members' coping. *Drug and Alcohol Review*, *20*(4), 385-393.

Lewis, V., & Allen-Byrd, L. (2001). Alcoholic family recovery typology: A new theoretical model. *Alcoholism Treatment Quarterly*, *19*(3), 1-17.

O'Farrell, T.J., & Fals-Stewart, W. (2001). Family-involved alcoholism treatment. An update. *Recent Developments in Alcoholism*, *15*, 329-56.

Stallings, M.C., Hewitt, J.K., Lessem, J.M., Young, S.E., Corley, R., Mikulich, S.K., & Crowley, T.J. (2001). Familial transmission of alcohol dependence symptom counts in clinical and control family pedigrees. *Drug and Alcohol Dependence*, *63*(suppl.1), s151.

Tarter, R.E., Schultz, K., Kirisci, L., & Dunn, M. (2001). Does living with a substance abusing father increase substance abuse risk in male offspring? Impact on individual, family, school, and peer vulnerability factors. *Journal of Child and Adolescent Substance Abuse*, *10*(3), 59-70.

Thomas, C., & Corcoran, J. (2001). Empirically based marital and family interventions for alcohol abuse: A review. *Research on Social Work Practice*, *11*(5), 549-575.

2002

Hope for Today, a meditation reader for adult children of alcoholics, is published and sells more than 110,000 copies in the next year (MVOJ, 339).

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2002

Conlan, C.J. (2002). Relationship among wives' self-esteem, perception of husband's drinking behavior, and her drinking behavior. *Dissertation Abstracts International, 62*(10), 4835B.

Copello, A., & Orford, J. (2002). Addiction and the family: Is it time for services to take notice of the evidence? *Addiction, 97*(11), 1361-1363.

Johnson, P. (2002). Predictors of family functioning within alcoholic families. *Contemporary Family Therapy, 24*(2), 371-384.

Meyers. R.J., Miller, W.R., Smith, J.E., & Tonigan, J.S. (2002). A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. *Journal of Consulting and Clinical Psychology, 70*(5), 1182-5.

Rohrbaugh, M.J., & Shoham, V. (2002). Couple treatment for alcohol abuse: A systemic family-consultation model. In S. G. Hofmann & M.C. Tompson (Eds.), *Treating chronic and severe mental disorders: A handbook of empirically supported interventions* (pp. 277-295). New York: The Guilford Press.

Rotskoff, L.E. (2002). Sober husbands and supportive wives: Gendered cultures of drink and sobriety in twentieth-century America, 1910-1965.*Dissertation Abstracts International, 62*(12), 4218A.

Rumpf, H.J., Bischof, G., Hapke, U., Meyer, C., & John, U. (2002). Role of family and partnership in recovery from alcohol dependence: Comparison of individuals remitting with and without formal help. *European Addiction Research, 8*(3), 122-127.

Velleman, R., & Templeton, L. (2002). Family interventions in substance misuse. In T. Petersen & A. McBride (Eds.), *Working with substance misusers* (pp. 145-153). New York: Routledge.

Walker, C.M. (2002). Wives' marital attributions: What are their relationships to husbands' drinking and personal marital satisfaction. *Dissertation Abstracts International, 62*(8), 3818B.

Whitney, S.D., Kelly, J.F., Myers, M.G., & Brown, S.A. (2002). Parental substance use,

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2002

family support and outcome following treatment for adolescent psychoactive substance use disorders. *Journal of Child and Adolescent Substance Abuse, 11*(4), 67-81.

Wilens, T.E., Biederman, J., Bredin, E., Hahesy, A.L., Abrantes, A., Neft, D., Millstein, R., & Spencer, T.J. (2002). Family study of the high-risk children of opioid-and alcohol - dependent parents. *American Journal on Addictions, 11*(1), 41-51.

2003

Bloom, N.L. (2003). Family factors that influence self-resolution of alcohol problems: The drinker's perspective. *Dissertation Abstracts International, 63*(8), 3904B.

Boyd-Ball, A.J. (2003). Culturally responsive, family-enhanced intervention model. *Alcoholism: Clinical and Experimental Research, 27*(8), 1356-1360.

Harkness, D. (2003). To have and to hold: Codependency as a mediator or moderator of the relationship between substance abuse in the family of origin and adult-offspring medical problems. *Journal of Psychoactive Drugs, 35*(2), 261-270.

O'Farrell, T.J., & Fals-Stewart, W. (2003). Alcohol abuse. *Journal of Marital and Family Therapy, 29*(1), 121-46.

Roberts, L.J., & McCrady, B.S. (2003). *Alcohol problems in intimate relationships: Identification and intervention. A guide for marriage and family therapists.* Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

2004

Brown, S. (July 2004). Addiction as a family disease. In D. Pinsky et al., *When painkillers become dangerous* (pp. 139-164). Center City, MN: Hazelden.

Meyers, R. J., & Wolfe, B.L. (2004). *Get your loved one sober: Alternatives to nagging, pleading and threatening.* Center City, MN: Hazelden Publishing & Educational Services.

Rouhbakhsh, P., Lewis, V., & Allen-Byrd, L. (2004). Recovering alcoholic families: When is normal not normal and when is not normal healthy? *Alcoholism Treatment Quarterly,*

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2004

22(2), 35-53.

Smith, J.E., & Meyers, R.J. (2004). *Motivating substance abusers to enter treatment: Working with family members*. New York: Guilford Press.

Trim, R.S., & Chassin, L. (2004). Drinking restraint, alcohol consumption and alcohol dependence among children of alcoholics. *Journal of Studies on Alcohol, 65*, 122-125.

2005

Al-Anon Family Groups host family recovery lunches in Washington DC and Ottawa, ON in honor of its 55th anniversary. Robert J. Ackerman is the keynote speaker. Representatives from national nonprofit organizations and federal government agencies attend the events in their respective countries.

Borchert, W.G. (2005). *The Lois Wilson story: When love is not enough*. Center City, MN: Hazelden.

Brown, S., & Abbott, S. (Nov/Dec. 2005). Children of alcoholics: Clinical update. *Family Therapy Magazine*, 46.

Meyers, R.J., Smith, J.E., & Lash, D.N. (2005). A program for engaging treatment-refusing substance abusers into Treatment: CRAFT. *International Journal of Behavioral and Consultation Therapy, 1*(2), 90-100.

Rychtarik, R.G., & McGillicuddy, N.B. (2005). Coping skills training and 12-step facilitation for women whose partner has alcoholism: Effects on depression, the partner's drinking, and partner physical violence. *Journal of Consulting and Clinical Psychology, 73*(2), 249-61.

White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-37.

2006

Al-Anon's new outreach magazine, *Al-Anon Faces Alcoholism 2007*, is released.

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AL-ANON AND RELATED MILESTONES

2006

Al-Anon WSO begins experiments with an online Alateen bulletin board to provide teens a safe and secure meeting room on the Internet (MVOJ, 368).

Fernandez, A.C., Begley, E.A., & Marlatt, G.A. (2006). Family and peer interventions for adults: Past approaches and future directions. *Psychology of Addictive Behaviors*, *20*(2), 207-13.

2007

Opening Our Hearts, Transforming Our Lives is released; the book is focused on grief and loss and includes the shared experiences of more than 700 Al-Anon members (MVOJ, 370).

Meyers, R.J., (Author), & Yu, J. (Director). (2007). Getting an addict into treatment: The CRAFT approach [television series episode]. In J. Hoffman & S. Froemke (Producers), *The HBO addiction series: Why can't they stop?* New York: HBO.

Wainwright, A.T., & Poznanovich, R. (2007). *It's NOT okay to be a cannibal - How to keep addiction from eating your family alive*. Center City, MN: Hazelden Foundation.

2008

Al-Anon WSO launches its first blog (MVOJ, 371).

Discovering Choices, Al-Anon's book on relationships, is released.

Lovelidge G. (2008). *Recovery Today - Vol. 13, #5, May Issue - Recognizing family recovery*. Round Rock, TX: Institute of Chemical Dependency Studies.

Roth, J.D. (2008). Spirituality and recovery from familial aspects of alcohol and other drug problems: Analysis of an online Al-Anon meeting. *Alcoholism Treatment Quarterly*, *26*(4), 399-426.

Smith, J. E., Meyers, R. J., & Austin, J. L. (2008). Working with family members to engage treatment-refusing drinkers: The CRAFT program. In O. J. Morgan & C. H. Litzke (Eds.), *Family interventions in substance abuse*. West Hazleton, PA: Haworth Press. (Co-published simultaneously as *Alcoholism Treatment Quarterly*, *26*(1/2), 169-193.)

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2009

Al-Anon Membership Survey reveals an average of 14 members per Al-Anon group; 84% of members are female; an average age of membership of 56; 93% of membership is white; 99% graduated from high school and 56% have a college degree; the average household income is $71,542; 58% are married; 29% of those who said they had a life partner report a same sex life partner; 95 percent who said they were married had a spouse of the opposite sex; average years of Al-Anon membership is 12.7 years; average weekly meeting attendance is 1.8 and 6% participate in a weekly on-line meeting; 75% have a sponsor and 50+% sponsor others; 44% of Al-Anon members were referred by a professional; 30% of members begin because of concern about a person with a drug problem; 42% of those persons whose drinking Al-Anon members are most concerned about are AA members and 49% are reported to be actively drinking; 95% of members surveyed report that Al-Anon participation has affected their lives "very positively."

Al-Anon WSO launches blog, "Using the Traditions in our Personal Lives," with audio podcasts and member comments (MVOJ, 377).

2010

The total number of Al-Anon and Alateen groups worldwide is 25,452.

"Using Al-Anon's Steps in Our Personal Lives" blog is launched (MVOJ, p. 379).

Gould, T. (Producer), & Harrison, J. K. (Director). (2010). *When love is not enough: The Lois W. story* [Motion picture]. Hallmark Hall of Fame.

Roozen, H.G., de Waart, R., & van der Kroft, P. (2010). Community reinforcement and family training: An effective option to engage treatment-resistant substance-abusing individuals in treatment. *Addiction*, *105*(10), 1729-38.

2011

Al-Anon Family Groups celebrates its 60th anniversary.

There are more than 25,500 Al-Anon groups regularly meeting in more than 130 countries (MVOJ, p. 3). There are 30 email Al-Anon meetings (English, French, Spanish, Portuguese, Estonian, Russian,

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2011

and German), 6 chat meetings (English, French, and Spanish), 7 bulletin board meetings (English, Danish, German, and Russian), and 42 telephone meetings (41 English and 1 Spanish).

Keller, P.S., Gilbert, L.R., Koss, K.J., Cummings, E.M., & Davies, P.T. (2011). Parental problem drinking, marital aggression, and child emotional insecurity: A longitudinal investigation. *Journal of Studies on Alcohol and Drugs*, *72*, 711-722.

Velleman R., Orford J., Templeton L., et al. (2011). 12-month follow-up after brief interventions in primary care for family members affected by the substance misuse problem of a close relative. *Addiction Research and Theory*, *19*(4), 362–374.

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Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2012). Commentary: Are the AA and NA skies falling? *Addiction Research and Theory*, 20(2), 105-106. Posted at **www.williamwhitepapers.com**

Are the AA and NA skies falling?

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The provocative opinion piece authored by Phoebus Zafiridis and Sotiris Lainas will likely stir considerable discussion within recovery mutual aid and addiction treatment circles. There are two central premises of their essay: 1) peer-based addiction recovery mutual aid societies such as Alcoholics Anonymous and Narcotics Anonymous are fundamentally different from professional addiction treatment organizations and should remain so, and 2) the integrity and very existence of A.A. and N.A. are being threatened by the commodification, professionalization and commercialization of the Twelve Steps via the rise of private addiction treatment centres in Greece (and presumably around the world). The issues raised in this article are important in any community in which A.A. and N.A. and professional addiction treatment organizations coexist. They are also of concern to the growing network of secular and religious addiction recovery mutual aid societies and to a host of new recovery community support institutions (recovery advocacy organizations, recovery community centers, recovery homes, recovery schools, recovery ministries, recovery cafés, etc.) that exist in the ambiguous space between addiction treatment and recovery mutual aid societies.

The Zafiridis/Lainas essay first underscores the need for an international recovery research agenda—including research on AA, NA and other recovery fellowships--that can provide objective data on assertions made in the paper.

- Are AA/NA elders disengaging from active participation due to their increased marginalization and displacement in status by AA/NA members working in addiction treatment?
- How are engagement and recovery outcomes affected, if at all, in AA/NA groups with a higher proportion of members employed in addiction treatment?
- How do other key factors (e.g., degree of spiritual versus professional/medical orientation of local groups, percentage of members externally mandated to attend, etc.) affect recovery outcomes and affect long-term group growth and survival?

Profit, property, power, prestige, politics and personalities have historically constituted the most significant threats to recovery mutual aid societies, and the relationship between recovery mutual aid societies and professional treatment has always brought a mix of benefits and risks to both parties. The issues raised by Zafiridis/Lainas suggest the need for two quite distinct courses of action.

First, addiction treatment organizations and addiction counseling as a distinct profession must articulate organizational values and codes of ethical and professional practice to assure role clarity and separation between professional treatment/counseling and service roles within recovery fellowships. If treatment is nothing more than a superficial introduction to recovery principles and practices available without charge from AA, NA and other recovery support groups, then addiction treatment has no foundation for its present or future legitimacy as a cultural institution. Further, if professionalized support progressively supplants the voluntary service ethic within indigenous recovery communities, then addiction treatment as an institution will have done great harm in the name of good.

Second, AA and NA must continually elevate knowledge of their respective histories and traditions to assure their organizational integrity and to remind members who work in addiction treatment of the guidelines established within the fellowships to avoid role ambiguity and role conflicts, particularly the problem of double agentry (e.g., participation in AA/NA for purposes of treatment marketing rather than self and mutual support). Sponsorship in the name of counseling and counseling in the name of sponsorship are not acceptable on either side of the treatment-AA/NA equation.

While the Zafiridis/Lainas essay ends on a note of pessimism (suggesting that AA and NA could become "caricatures of themselves" and "take their turn at failure"), I would argue as a recovery historian that AA and NA's resilience should not be underestimated. Both fellowships have survived near death experiences, periods of explosive growth, efforts to hijack them for ideological and financial purposes, and external and internal attacks on their core beliefs and practices. The source of that organizational resilience rests in the genius of the Twelve Traditions that have governed the organizational lives of AA and NA and sparked periodic processes of renewal that have, to date, protected AA and NA from the forced that led to the demise of their predecessors. The Zafiridis/Lainas essay is also missing references to the long history of positive and mutually beneficial collaborations between AA and NA and treatment organizations and the role treatment organizations can play in enhancing long-term personal and family recovery.

Recovery mutual aid organizations (and addiction treatment organizations) must avoid becoming closed incestuous systems plagued by charismatic leadership and the risk of complete implosion (e.g., Synanon), and they must also avoid being hijacked by more powerful and corrupting forces in their institutional environments. If the Zafiridis/Lainas essay prompts a serious re-examination of what distinguishes mutual aid and professional treatment and how these cultural institutions can best relate to each other and the outside world, then it will have done a great service.

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Broadening the Base of Addiction Recovery Mutual Aid

John F. Kelly, PhD and William L. White, MA

Abstract

Peer-led mutual help organizations addressing substance use disorder (SUD) and related problems have had a long history in the United States. The modern epoch of addiction mutual help began in the post-prohibition era of the 1930s with the birth of Alcoholics Anonymous (AA). Growing from two members to two million members, AA's reach and influence has drawn much public health attention as well as increasingly rigorous scientific investigation into its benefits and mechanisms. In turn, AA's growth and success has spurred the development of myriad additional mutual help organizations. These alternatives may confer similar benefits to those found in studies of AA, but have received only peripheral attention. Due to the prodigious economic, social, and medical burden attributable to substance-related problems and the diverse experiences and preferences of those attempting to recover from SUD, there is potentially immense value in societies' maintaining and supporting the growth of a diverse array of mutual help options. This article presents a concise overview of the origins, size, and state of the science on several of the largest of these alternative additional mutual help organizations in an attempt to raise further awareness and help broaden the base of addiction mutual help.

Keywords: Mutual help; mutual aid; self help; Alcoholics Anonymous; narcotics anonymous; SMART recovery; Secular organization for Sobriety; Women for Sobriety; Moderation Management.

1. Introduction

At first glance, the notion of individuals with serious, objectively verifiable, cognitive and social impairments being able to facilitate life-saving changes in similarly impaired individuals may seem a little incongruous; from a derisory standpoint, a clear case of "the blind leading the blind". It is therefore striking to observe that peer led mutual-help organizations comprised of such individuals have been shown to facilitate the same kinds of salutary behavior changes as trained professionals (Humphreys & Moos, 2001; Humphreys & Moos, 2007; Moos & Moos, 2006; Timko, Moos, Finney, & Lesar, 2000; Timko,

Sempel, & Moos, 2003). A potential reason for at least some of these mutual help group benefits may lie in the humorous quip frequently expressed within recovery circles, "We may be sick, but we're not all sick on the same day".

In the addiction field, examples of mutual help organizations have been well known, even synonymous with addiction recovery for more than 200 years (White, 1998). Alcoholics Anonymous (AA) is by far the largest and most recognized and its size and impact have garnered much public health and research attention (Emrick, Tonigan, Montgomery, & Little, 1993; Kelly & Yeterian, 2012; Tonigan, Toscova, & Miller, 1996). However, many other mutual help organizations have emerged since AA began, either inspired by, or in opposition to, it. These AA alternatives have received only limited attention, but due to their similar social orientation and group format may confer benefits comparable to those of AA. Given the diverse experiences and preferences of individuals seeking recovery from substance use disorder and the valuable role that mutual help organizations have been shown to play, raising the profile of a broader array of available mutual help options may enhance the chances of recovery for more people. To this end, the purpose of this article is to describe six of the largest addiction recovery mutual help AA alternatives: SMART Recovery, Secular Organization for Sobriety, Moderation Management, LifeRing, Women for Sobriety, and Celebrate Recovery. We begin by providing a brief review of the growth and impact of AA followed by a summary of the origins, growth, size and reach, and state of the science on these alternative recovery mutual help organizations.

2.1 Alcoholics Anonymous

AA experienced an inconspicuous beginning in Akron, Ohio, amid the post-prohibition era of the 1930's. AA has since grown from two members to more than two million members in 2011, and has been adapted and successfully assimilated into a variety of cultures globally (Alcoholics Anonymous, 2001; Mäkela, 1996). Despite originating under the auspices of a quasi-religious organization known as the Oxford Group (Alcoholics Anonymous, 1957; Oxford Group, 1933) and operating at a grass-roots community level, AA's language and concepts also have profoundly influenced our *professional* clinical approaches to addressing alcohol and other drug problems (McElrath, 1997; Roman & Blum, 1999; White, 1998), and its philosophy and concepts have imbued our broader language and culture (Travis, 2009).

AA's growing influence and purported success at facilitating long-term addiction recovery has garnered increasing public health and scientific scrutiny (Ferri, Amato, & Davoli, 2006; Institute of Medicine, 1990; McCrady & Miller, 1993). In terms of its verifiable impact, hundreds of published studies, many in top scientific journals, have supported the beneficial effects of AA in helping alleviate alcohol and other drug problems. This body of scientific literature has been summarized in narrative reviews as well as quantitatively, through rigorous meta-analyses (Emrick, et al., 1993; Ferri, et al., 2006; Humphreys, et al., 2004; Kaskutas, 2009; Kelly, 2003; Kownacki & Shadish, 1999; Tonigan, et al., 1996; White, 2009). AA participation is associated with producing and maintaining salutary changes in alcohol and other drug use that are on par with professional interventions while simultaneously reducing reliance on professional services and thus lowering related health care costs (Humphreys & Moos, 2001; Humphreys & Moos, 2007; Humphreys, et al., 2004; Kelly & Yeterian, 2012). Despite some earlier concerns regarding AA's ability to cater effectively to women, young people, people of color, those with co-morbid psychiatric illnesses, and non-religious/spiritual persons, research has found that AA confers similar benefits to women as men (Del Boca & Mattson, 2001; Kelly, Stout, Zywiak, & Schneider, 2006); to young people (Alford, Koehler, & Leonard, 1991; Chi, Kaskutas, Sterling, Campbell, & Weisner, 2009; Kelly, Brown, Abrantes, Kahler, & Myers, 2008; Kelly, Dow, Yeterian, & Kahler, 2010; Kelly, Myers, & Brown, 2000; Kennedy & Minami, 1993) to many

(e.g., Ouimette, et al., 2001; Timko, Sutkowi, Cronkite, Makin-Byrd, & Moos, 2011), but not all, persons with psychiatric conditions (e.g., those with severe social impairments and/or psychotic spectrum illness (Bogenschutz & Akin, 2000; Kelly, McKellar, & Moos, 2003; Noordsy, Schwab, Fox, & Drake, 1996; Tomasson & Vaglum, 1998); and to those individuals who are non or less religious/spiritual (Kelly, et al., 2006; Winzelberg & Humphreys, 1999).

Additional anecdotal concerns have centered around AA's position on potentially helpful medications. In general, surveyed AA members have been found to be supportive of the use of psychotropic (e.g., anti-depressants, anti-psychotics) and relapse prevention medications (e.g., naltrexone, acamprosate, disulfiram), although there may be a vocal minority who oppose it (Meissen, Powell, Wituk, Girrens, & Arteaga, 1999; Rychtarik, Connors, Dermen, & Stasiewicz, 2000; Tonigan & Kelly, 2004). However, it is unclear whether this oppositional minority is specific to AA membership or is a more general facet of individuals attempting to recover; at least one study of alcohol dependent individuals found that AA participation was unrelated to opposition to the use of medications (Tonigan & Kelly, 2004). Given the importance of this issue, however, AA itself has published a pamphlet on this matter in which it states that it is plainly wrong to deny any member the right to psychiatric medications (Alcoholics Anonymous, 2001).

More rigorous evidence in support of AA emerging in the past 20 years, in particular, has moved AA from a peripheral status as a "nuisance variable" and potential obstacle to progress in the field, to playing a more central role in a recovery-oriented system of care (Kelly & White, 2011; Kelly & Yeterian, 2012; White, 2008). Stemming from these findings on AA's broad reach, effectiveness and cost effectiveness, professional interventions have been developed and tested, designed specifically to engage patients with these community mutual help resources during and post-treatment. These "Twelve-Step Facilitation" (TSF) interventions have been found to enhance patient outcomes in randomized controlled investigations (Kahler, Read, Ramsey & Brown, 2004; Kaskutas, 2009; Litt, Kadden, Kabela-Cormier, & Petry, 2009; Project MATCH Research Group, 1997; Sisson & Mallams, 1981; Timko & DeBenedetti, 2007; Timko, Debenedetti, & Billow, 2006; Walitzer, Dermen, & Barrick, 2009) and, consequently, TSF is now an "empirically supported treatment" as defined by the American Psychological Association and US federal agencies.

With the emergence and increasing availability of illicit substances, addiction to drugs other than alcohol has become more prevalent. This led to adaptations of AA's formula to address the needs of individuals addicted to drugs other than alcohol. The largest among these is Narcotics Anonymous founded in 1953, which addresses all substances, but other 12-step based organizations soon emerged focusing on specific substances, such as Potsmokers Anonymous (1968), Pills Anonymous (1975), Marijuana Anonymous (1989), Cocaine Anonymous (1982), Nicotine Anonymous (1985), and Crystal Meth Anonymous (1994). With the increased acknowledgement of the overlap between co-morbid psychiatric disorders and SUD (e.g., (Regier, Narrow, & Rae, 1990) "dual-focused" mutual help organizations have emerged providing support for both sets of problems simultaneously (e.g., Dual Disorders Anonymous [1982], Dual Recovery Anonymous [1989], and Double Trouble in Recovery, [1993]). The needs of family members, themselves gravely affected by addiction among loved ones, developed their own mutual help groups based on the same 12-step and 12 tradition template as AA. The most notable among these were Al-Anon (1951) and Alateen (1957), and Nar-Anon (1968).

All of the above organizations are based on AA's organizational template of the 12 steps and 12 traditions (Alcoholics Anonymous, 1953). However, several other recovery organizations have emerged specifically to serve as secular and religious alternatives to AA and other 12-step programs. In the next section, we describe

the origins, size and reach, and state of the science of several of the largest and earliest of these alternatives. Specifically, we describe: SMART Recovery, Secular Organization for Sobriety, Moderation Management, LifeRing, Women for Sobriety, and Celebrate Recovery.

2.2. Self Management and Recovery Training (SMART Recovery)

SMART Recovery® began in 1994 as an offshoot of Rational Recovery (Horvath & Yeterian, in press). The stated goals of SMART Recovery are to "support individuals who have chosen to abstain, or are considering abstinence from any type of addictive behavior (substances or activities), by teaching how to change self-defeating thinking, emotions, and actions; and to work towards long-term satisfactions and quality of life." It teaches self-empowerment and self-reliance and views addictions/compulsions as complex maladaptive behaviors with possible physiological factors. It teaches tools and techniques for self-directed change and encourages individuals to recover and live satisfying lives.

The SMART Recovery meetings have a contemporary cognitive-behavior orientation, are educational and include open discussions. It also explicitly advocates the appropriate use of prescribed medications and psychological treatments. It draws on evidence-based practices, and "evolves as scientific knowledge evolves." The main processes of recovery stated by SMART are enhancing and maintaining motivation to abstain, coping with urges, problem solving (e.g., managing thoughts, feelings and behaviors) and lifestyle balance achieved and reinforced through meeting participation. Professionals and peers serve as volunteer facilitators of SMART meetings.

As of December, 2011, SMART Recovery is reported to have over 650 groups throughout the world, with most of them in the United States. The SMART Recovery website maintains a current listing of face-to-face meetings (which are available in most US states) and daily online meetings (which offer either voice and/or text connection). In the most recent SMART participant survey (N=513; http://www.surveymonkey.com/sr.aspx?sm=mYZaRq3wlN9vAaQhcXBXp4Aj82eJeDLX_2ftPftMvLLbI_3d) most SMART participants were Caucasian (93.2%), 42.7% were female, and had a median age of approximately 50 years old. Slightly over half (53.5%) of those surveyed reported being SMART members for less than one year. Despite SMART having a secular orientation and providing an alternative to 12-step organizations, 60.7% of members reported believing in some kind of God or Higher Power, and 85.2% reported attending AA or other 12-step organizations in addition to SMART. Thus, although there is a large overlap in 12-step participation among SMART members, it seems that SMART offers something potentially unique and appealing that is not offered in 12-step organizations.

Research on the effectiveness of SMART Recovery is limited. Two cross-sectional, survey studies examined characteristics of SMART Recovery members (e.g., religiosity, locus of control) relative to members of other mutual-help organizations, such as AA (Atkins & Hawdon, 2007; Li, Feifer, & Strohm, 2000). One of these studies (Atkins & Hawdon, 2007) found a significant relationship between the duration of continuous abstinence and the extent of participation in mutual-help groups, which included SMART Recovery. This relationship did not differ by type of mutual-help organization. This suggests that the benefits from SMART Recovery participation may be similar to that of other mutual help organizations (Horvath & Yeterian, in press).

Although not a test of SMART Recovery as a mutual-help organization, a related study compared professionally-led 12-step- and SMART-based intensive outpatient treatment programs for dually diagnosed patients (Brooks & Penn, 2003). Findings revealed SMART Recovery-based treatment was less effective at reducing alcohol use than the 12-step-based treatment, but more effective at improving participants' employment status and medical

concerns. Several limitations were apparent in this study, however, including a high dropout rate and unequal treatment exposure across conditions. Also, as alluded to above, intensive outpatient treatment is not comparable to the context in which real-world SMART Recovery groups are run, and this study sample was composed of dually diagnosed individuals who may not be representative of most SMART Recovery members (Horvath & Yeterian, in press).

SMART is beginning to make successful forays into other countries besides the USA. A small pilot study in Great Britain about participant (N=65) perceptions of SMART (MacGregor & Herring, 2010) found that the majority of SMART Recovery attendees (79%) found groups to be very helpful and intended to continue attending within the next three months. Most had attended other mutual help groups, such as AA, but reported SMART Recovery was more useful to them.

SMART Recovery is an interesting hybrid mutual-help organization in that it takes evidence-based motivational and cognitive-behavioral strategies evaluated in professional clinical settings and populations, and implements these in a community mutual-help group context. It is growing nationally and internationally and future research evaluation will reveal whether this translation of evidence-based clinical practice to a mutual-help context results in stronger engagement, retention, and recovery outcomes. Given the limited empirical literature on SMART, there are myriad research opportunities available to expand knowledge of its effectiveness, health care cost offset potential, and potential for benefitting particular types of individuals, such as atheists and agnostics.

2.3. Secular Organization for Sobriety

Secular Organization for Sobriety (SOS) was started in 1986 by James Christopher, a disaffected AA member looking to eradicate the spiritual/religious elements from the recovery mutual aid offered through 12-step fellowships. The organization refers to itself as “a self-empowerment approach to recovery” without any spiritual or religious involvement. Its therapeutic processes and general organizational principles are quite similar to AA however, and much of the organizational language is very similar to AA’s 12 Traditions. Meetings are typically 90 minutes in duration and each group is autonomous and self-supporting through its own voluntary contributions.

SOS does not possess a clear, sequential program of action, like AA, but does advocate honest sharing, association with others including other alcoholics, and a focused ‘Sobriety Priority” of abstaining from alcohol “no matter what”. The organization’s group meetings typically encourage self admission of alcohol addiction, a daily reminder of this fact, the goal of enhanced quality of life (“the good life”), honest and confidential sharing with other affected individuals, and personal responsibility for recovery (Christopher, 1988). The course of action needed to achieve sobriety is largely left up to the individual to decide for him or herself, but is encouraged to be sought using the experience of those SOS members who have found it.

Despite its size and longevity, there has been very little research conducted on SOS to date. The largest survey of 158 members was published in 1996 by Connors and Dermen. The response rate was very low, however, ranging from somewhere between 15-29% (Connors & Dermen, 1996). Most of the members who responded were White (99%) male (73%), well educated (79.5% reported at least some college or more education), and were about 40 years old on average. The majority (70%) reported no current religious affiliation and 70% described themselves as atheist or agnostic and another 22% as spiritual but not religious. Respondents liked the lack of religious emphasis the best and found the interpersonal aspects of the organization the most helpful. The average number of years of sobriety was 6.3. About 30% were also attending AA meetings in addition to SOS. Average attendance during the past year was about 2 to 3 times per month and the total number of SOS meetings attended was 45.4 (Connors & Dermen, 1996).

With the limitation of the low response rate noted, it appears that in keeping with its goals and orientation, SOS tends to attract atheist/agnostic and non-religious individuals and the average meeting attendance figures suggests it is able to engage individuals over the long term. Although about one third of members also attended AA, the majority benefited from SOS and much like AA, which has 50% of its members with more than 5 years of sobriety, appeared to find continued benefits despite an average of more than 6 years of sobriety. Its growth and staying power warrant further research on its member composition, its effectiveness in helping individuals stay sober and improve quality of life, dropout rates, and mechanisms of change.

2.4. Moderation Management

Moderation Management (MM), founded in 1994, is the only substance-focused mutual help organization that explicitly advocates moderate, non-harmful, use of alcohol, and not complete abstinence. Given that the largest portion of the burden of disease, disability, and negative social and economic impact is attributable to this segment of hazardous/harmful drinking individuals, MM has immense public health potential.

MM embodies four major principles: self-management, balance, moderation, and personal responsibility. MM's main aim is to share strategies for successful moderation and the "restoration of balance", which include both changes in behavior and the management of emotions. Its main therapeutic process is through self-monitoring of drinking to keep within healthful limits. This is supported by MM group participation. A primary tool used in MM is "awareness". Daily drink charting is intended to bring an unconscious habit back to consciousness and within control. The very act of counting the number of drinks consumed each week is one of the key processes of therapeutic change. MM advocates nine steps (http://www.moderation.org/readings.shtml#9steps) that include an initial 30 day period of abstinence during which the member can assess how alcohol has affected them, set drinking limits, and begin to make lifestyle changes. MM members are asked to limit drinking to no more than nine drinks per week, no more than three per day, for women; and no more than 14 per week, no more than four per day for men. These limits are the same as those recommend by the US National Institute on Alcohol Abuse and Alcoholism (NIAAA). Even after moderate drinking is begun within the context of MM, MM still recommends not drinking every day, but rather, to abstain from alcohol completely on at least 3-4 days per week.

In terms of evidence for its beneficial effects, there have been no longitudinal studies or experimental efficacy studies. Two independent surveys have been conducted and show that MM appears to attract problem drinkers who are less severely dependent than those who seek to join AA, and who possess greater social resources (Humphreys & Klaw, 2001; Kosok, 2006). These surveys have supported the notion that non-dependent "problem drinkers" utilize MM and are mostly drinking in the harmful/hazardous range as opposed to the dependent range (Humphreys & Klaw, 2001; Kosok, 2006).

MM fills an important gap in the range of options for the large number of individuals who are non-dependent drinkers but nevertheless are suffering from a range of alcohol-related problems. MM can therefore provide support and reduce harms attributable to alcohol without requiring abstinence. This is often an attractive option for many who do not see themselves needing to abstain completely. It can also provide an opportunity to gain support and structure while assessing, experientially, whether individuals can successfully moderate drinking behavior. The goal of a 30 day initial period of complete abstinence followed by a prescribed non-continuous weekly drinking pattern and limiting quantity to within NIAAA guidelines, is likely to quickly separate those individuals who will continue to benefit from MM from those for whom abstinence may be the easier and optimal goal. Typically in the course of alcohol

dependence sufferers possess a strong desire to be able to successfully regulate alcohol consumption. Although, MM's explicit focus is to cater to those wishing to continue to moderate over time, it may therefore also play an intermediate role by providing an opportunity for those dependent on alcohol to realize they are unable to stop or control their alcohol use in a supportive environment without criticism.

2.5. Life Ring

LifeRing for Secular Sobriety is a cognitive-behaviorally oriented support group that emphasizes tradition of positive psychology rather than spirituality or religious ideas. Founded in 2001, it has grown to about 140 face to face meetings as well as online meetings with about 1,000 participants. It has already begun surveys of its membership (sample responded =401) indicating 58% were male, average age was 47.8 years old, more than 80% reported attending some college, and 44% had a bachelors degree. The average sobriety was 2.74 years. In the past year, 40% reported attending a religious service of some kind. In keeping with its goal of targeting any kind of substance dependence, survey respondents primary substances covered a full range of substances if misuse including tobacco.

The LifeRing approach centers on empowerment of the "Sober Self" characterized by three major components: recognition, activation, and mastery. Recognition emphasizes insight and empowerment by realizing that the "sober self" is a part of who individuals are and have helped them access help and get to this point in their lives ("Your Sober Self brought you here!"). Activation is about living in sobriety and facing the challenges of recovery which is discussed in group meetings. Mastery is supported through empowering individual members to develop their own "Personal Recovery Program (PRP)". Individuals' PRP can be allowed to occur naturally as things progress, or more strategically by working through the organization's *Recovery by Choice* workbook. This facilitates the formation of the PRP across nine different recovery related domains.

The LifeRing approach is essentially a grass roots experientially based mutual help group, but is informed by the latest treatment and recovery research. Consequently, it incorporates ideas from cognitive-behavioral, motivational, humanistic, existential, and positive psychology areas. No studies have been conducted on LifeRing, but its continued expansion is evidence of its value to many individuals suffering a variety of substance addiction problems. Future research should focus on which individuals may be likely to engage with the organization, as well as its effectiveness in helping individuals maintain recovery.

2.6. Women for Sobriety

Women for Sobriety was established in 1975 by Jean Kirkpatrick, a woman in recovery, who found that AA did not meet all her needs. She believed that women needed their own groups, free from men and role expectations, in which to share their experiences and grow stronger. WFS has between 1,000 and 2,000 members in Canada and the United States and approximately 300 face to face meetings (Humphreys, 2004). Almost all these members are Caucasian, well-educated, and middle class (Kaskutas, 1992). The WFS program "is an affirmation of the value and worth of each woman," as exemplified in its Thirteen Statements of Acceptance (Kirkpatrick, 1978). Kirkpatrick (1978) maintains that these statements can lead women to see themselves more positively, increase their self-confidence, and learn to see themselves as able to overcome their drinking and other problems. The changes they experience are reinforced by the group. WFS groups provide acceptance, nurturing, and a sense of belonging and are a place to release anxiety, share fears, and learn to trust.

A comprehensive survey of WFS membership (response rate = 73%, n = 600) was conducted by (Kaskutas, 1994). Respondents reported their reasons for attending WFS as well as AA, and also

reported their reasons for not attending AA. Study participants reported that they attended WFS for support and nurturance (54%), for a safe environment (26%), for sharing about women's specific issues (42%), and because of its positive emphasis (38%) and focus on self esteem (39%). They reported attending AA primarily as insurance against relapse (28%), for its wide availability (25%), and for sharing (31%) and support (27%). Women who did not attend AA reported feeling as though they never fitted in to AA (20%), found AA too negative (18%), disliked the "drunkalogs" (14%) and the focus on the past (14%), and felt that AA was geared too much to men's needs (15%).

WFS is the only major organization specifically for women seeking recovery from alcohol addiction. It takes a positive and affirming stance through its focus on enhancing self esteem, self empowerment and acceptance, emotional growth and spirituality: "Emotional growth is happiness; spiritual growth is peace. Together these create a competent, loving woman." (Kirkpatrick, 1978). Like SOS, AA, and others, WFS encourages continued involvement over the long haul, and similar to AA advocates a day at a time approach. WFS has not grown rapidly in the US or other countries since its beginning in the 1970s. Yet, its evident staying power and sizeable membership indicates that it plays an important role for alcohol addicted women. Research is needed on its overall effectiveness and unique potential to engage women reluctant to attend AA.

2.7. Celebrate Recovery

In contrast to the other organizations mentioned previously, Celebrate Recovery (CR) is an explicitly Christian-based religious recovery support organization functioning under the auspices of formal church organizations. CR was founded in 1991 at Saddleback Church in Lake Forest, California. It was started by John Baker, an alcoholic who found recovery in AA, but who felt constricted in his ability to openly discuss his Christian beliefs within the AA context. He became inspired to begin a separate group where celebration of his addiction recovery along with his Christian values and beliefs could be expressed candidly. After obtaining the blessing and encouragement from his Pastor (Rick Warren) from the Saddleback Church, he began the first CR meeting. This was initially based on AA's 12-steps but as things developed into the more formally known, Celebrate Recovery organization, eight principles were derived based on the Beatitudes found in Christian Scripture (Matthew 5:1-12). These principles describe a very similar sequential process and content as the 12 steps of AA (Baker, 2005; Headley, Olges, & Sickinger, unpublished). The organization does not focus exclusively on recovery from substance-related problems; instead, allowing anyone to attend who is having difficulty changing problematic and troubling patterns of behavior (i.e., it is open to those "healing from hurts, habits, and hang ups"; www.celebraterecovery.com). It is somewhat similar in this regard to SMART Recovery which encourages membership for those suffering from substance or behavioral addiction problems.

Celebrate Recovery meetings possess a similar format to 12 step meetings. However, the curriculum of CR is strictly monitored by the national organization (Headley, et al., unpublished). In order to use the CR name and materials, a leader must agree to abide by the expectations listed in "The DNA of an Authentic Celebrate Recovery Meeting". Typical CR meetings begin in a single, large, group then break into smaller groups separated by gender and organized by content. Unlike AA, but similar to other secular mutual help organizations, members are discouraged from identifying themselves as their particular problem (e.g., "I'm Susan and I am an alcoholic"); with preference given to self identifying as, "a Christian who is struggling with…" Similar to the AA model, CR encourages individual mentoring (like an AA sponsor), but in addition, has a small support network referred to as "Accountability Partners". In CR, sponsors fulfill largely the same role as an AA sponsor but more explicitly support spiritual growth through prayer and discussion of members' concerns and questions. The Accountability

Partners are exclusive to CR and are described as a group of at least three to four people who are at a stage of recovery and who share the same challenge as the focal member. Such homogeneity in content and recovery stage may enhance therapeutic cohesion and universality (Yalom & Leszcz, 2005). Accountability Partners pray for each other and give and seek support through phone calls between face to face meetings (Headley, et al., unpublished).

CR has grown considerably since its beginning in 1991. According to the CR website (www.celebraterecovery.com) more than 170,000 individuals have completed the CR program and there are approximately 17,000 CR group ministries operating around the world in approximately 50 countries. The structure of CR is noteworthy. Specifically, its broader focus on behavioral problems and concerns beyond substance use is likely to attract a larger number of potential members than would be the case if its sole focus was on substance-related problems alone. A potential downside of a broader focus, however, could be less group cohesion, universality, and mutual identification. That said, the meeting format of breaking into smaller subgroups with similar concerns and issues may help maintain and strengthen these therapeutic group elements. CR's rapid growth and popularity presents some evidence of its potential benefit. However, little is known about its ability to engage, and retain members over time or whether it helps reduce relapse rates and enhances the odds of long-term recovery.

3. Discussion and Conclusions

Stemming from the rapid growth and influence of AA, a variety of secular, spiritual, and religious alternative mutual help organizations have emerged during the past 40 years. This multitude of new groups reflects a reality of the diverse needs and preferences of individuals suffering from SUD. However, these alternatives, the largest of which are described herein, have experienced relatively slow growth and acceptance as the mutual help landscape in the United States has been dominated largely by 12-step organizations such as AA and NA. There are several possible reasons for this slow growth and acceptance of these non 12-step alternatives in the U.S. Some of these reasons may relate to differences in operational structure among the various organizations themselves; some may also relate to the degree of fit within the broader cultural context in which they have emerged, while others may pertain to a clinically driven "catch 22" scenario, whereby clinicians are reluctant to refer to smaller organizations or to organizations without a local presence, which in turn, continues to limit their growth. This in turn, makes it difficult to conduct the kinds of research studies that have been conducted on larger organizations, such as AA, which have increased confidence in its effectiveness and thus, led to more referrals. We discuss each of these below.

In terms of operational differences, one reason for the rapid growth of AA and other 12-step mutual help organizations may be in part due to these organizations' decentralized and "horizontal" authority structure: there is no CEO, President, or leaders in the usual sense issuing top-down instructions; rather, only "trusted servants" who are elected by the group and encouraged to rotate regularly; also each group itself is completely autonomous and financially self-supporting and able to make its own decisions based on the democratically expressed collective "group conscience"; it is merely suggested that 12-step groups adhere to the guidelines (the "12 Traditions") outlined in the book, Twelve Steps and Twelve Traditions, (Alcoholics Anonymous, 1953). Consequently, anyone can start an AA meeting of any kind at any time provided the new group tries to adhere to these traditions. AA's co-founder, Bill W., himself described AA as a kind of "benign anarchy" because of this laissez-faire approach (Alcoholics Anonymous, 1957). This policy of individual and group autonomy may be a major reason why AA and other similar organizations have grown so large. A possible downside of this approach, however, is that this "hands-off" policy affords no oversight, or "quality control", increasing potential variability in group

dynamics, content, and any potential therapeutic benefit (Kelly, Stout, Magill, Tonigan, & Pagano, 2011; Tonigan, Miller, & Connors, 2001). AA membership growth may also be linked to its strong service ethic and its implicit expectation for prolonged, if not lifelong, participation (many of the alternatives profiled here expect participation only as long as needed and then encourage members to leave and get on with their lives). Indeed, almost half of the AA membership has five or more years of sobriety (Alcoholics Anonymous, 2008).

In contrast, other organizations, such as SMART Recovery, possess a more typical centralized organizational structure, with a President, and require trained facilitators to run group meetings. Some other mutual help organizations require certification for group leaders or otherwise possess a more "vertical" organizational structure that exerts elements of control of its groups. The consequence of these different policies may mean that the freedom inherent in 12-step organizations' facilitates rapid growth, whereas growth may be constricted more by the barriers of consultation, training, and oversight that is often required in other mutual help organizations.

The ultimate question, of course, may be one of "reach" vs. "effectiveness" (Glasgow, Lichtenstein, & Marcus, 2003) or more commonly, "quantity vs. quality". That is to say, does the greater oversight and centralized structure, designed to enhance model adherence and provide "quality control", actually result in sufficiently superior effectiveness and member benefit to justify the more tightly controlled approach, despite placing potential limitations on growth. Currently, there are no comparative effectiveness studies of mutual-help organizations to test this. In general, however, it may be that most recovery focused mutual-help organizations confer broadly similar benefits. Generalizing from the results of comparative trials of professional treatments, this could well be the case (Morgenstern & Longabaugh, 2000), especially since all of the mutual help organizations share common therapeutic elements, such as their social structure and group format (Humphreys, 2004; Yalom & Leszcz, 2005). These social components have been shown to be the major pathway through which AA confers its beneficial recovery effects (Kelly, Hoeppner, Stout, & Pagano, 2012). Renowned psychoanalyst, Carl Jung, asserted also that "the protective wall of human community" was one of the major general pathways to addiction recovery (Alcoholics Anonymous Grapevine, 1968).

Another reason why AA and other 12-step organizations have grown so rapidly, particularly in the US, may have to do with cultural fit and context. AA's emphasis on spirituality and its use of religious language may be particularly appealing in a country like the US, where the majority of the population (85%) believes in some kind of deity or God (Kosmin & Keysar, 2009). As noted previously, even among some of the newer secular alternatives that have conducted membership surveys in the US, almost half or more express religious beliefs and/or behaviors. Also, due to the disinhibiting effects of alcohol and other drugs individuals suffering from SUD have often engaged in behaviors which run counter to their own values or moral code. Over time, this can lead to chronic self-denigration and self-blame. AA and similar 12-step organizations offer spiritual and quasi-religious concepts that by their nature may provide an appealing and compassionate framework for self-forgiveness for those suffering from alcohol and other drug addiction that is not present in other mutual help organizations (Kelly, Stout, Magill, Tonigan, & Pagano, 2011).

Finally, another possible reason why non 12-step mutual help alternatives have not grown as rapidly as 12-step organizations, may be due to a clinically-related "catch 22" scenario: clinicians are reluctant to refer patients to groups, such as Women for Sobriety or LifeRing, because of the limited community availability of such groups; and, fewer referrals, in turn, perpetuates this limited availability. Furthermore, smaller numbers of groups adds to the difficulties of conducting research, positive findings from which, could

enhance confidence in their clinical utility and impact. The issue of conducting rigorous research on community organizations is not without challenges even under optimal conditions, particularly conducting the gold-standard of treatment research: the randomized controlled trial (RCT). The tightly controlled and highly insulated context of an RCT runs counter to the way real-world MHGs are conducted. Nearly all are attended anonymously and (usually) voluntarily. No records are kept regarding who attends and what is said. Groups vary widely in their size and content. Because MHGs are freely accessible in the community, it can be seen as unethical to randomly assign some RCT participants to attend and prohibit the attendance of others. These issues have led researchers to examine MHGs mostly through other methods, such as through naturalistic, prospective effectiveness studies, but RCTs have been conducted on professionally-delivered "Twelve-Step Facilitation" (TSF) interventions designed to engage individuals with these groups such as AA. These kinds of studies would be fairly to straightforward to implement also with other MHGs, such as SMART or Lifering.

It is hoped that this "Catch 22" trend can be reversed by greater clinical open-mindedness and willingness to take an extra step to learn more about the local availability of alternatives in order to present patients with an informed choice that may ultimately increase the chances of some kind of engagement with a recovery resource (Kelly, Humphreys, & Yeterian, 2012).

The more recent non 12-step mutual-help alternatives may never grow as large as AA for some of the reasons outlined above. Nevertheless, they play a vital role in our society's overall response to the prodigious social, medical, and economic burden attributable to substance misuse by providing an array of potentially appealing alternatives. These alternatives merely reflect the demographic diversity as well as the varieties of addiction experiences and recovery preferences held by individuals suffering from SUD. Providing and supporting greater choice and more options will broaden the base of addiction mutual help. This, in turn, is very likely to enhance the chances of recovery for more individuals.

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The 10-year Course of Alcoholics Anonymous Participation and Long-term Outcomes: A Follow-up Study of Outpatient Subjects in Project MATCH

ABSTRACT

This study investigates the 10-year course and impact of AA-related helping (AAH), step-work, and meeting attendance on long-term outcomes. Data were derived from 226 treatment-seeking alcoholics recruited from an outpatient site in Project MATCH and followed for 10 years post-treatment. Alcohol consumption, AA participation, and other-oriented behavior were assessed at baseline, end of the 3-month treatment period, and one year, three years, and 10 years post-treatment. Controlling for explanatory baseline and time-varying variables, results showed significant direct effects of AAH and meeting attendance on reduced alcohol outcomes and a direct effect of AAH on improved other-oriented interest.

http://www.helpingotherslivesober.org/documents/Pagano_2013_10_Year_Course.pdf



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Co-participation in 12-Step Mutual Aid Groups and Methadone Maintenance Treatment: A Survey of 322 Patients

William L. White, MA; Michael D. Campbell, PhD; Corinne Shea, MA; Howard A. Hoffman, MD; Brian Crissman, & Robert L. DuPont, MD

Abstract. In spite of more than four decades of scientific research confirming the efficacy and effectiveness of methadone maintenance treatment (MMT) as a treatment for chronic opioid addiction, MMT patients have faced considerable public and professional stigma and unique obstacles to participation in mainstream addiction recovery mutual aid groups. This study reports the levels of Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) participation among 322 patients enrolled in MMT in an urban community in the Northeastern United States. Survey results reveal high rates of past year NA/AA participation (66%), high rates of self-reported helpfulness of AA and NA (72-77%), but much lower rates of participation in key 12-Step program ingredients: having a home group (50%), having a sponsor (26%), sponsoring others (13%), attending 12-step social events (23%), and active step work (21%). One-quarter (25%) of NA/AA-involved patients reported a negative experience within NA or AA related to their MMT patient status. Only 34% of patient NA/AA members disclosed their MMT status to their sponsors and at meetings.

Key Words. Methadone maintenance treatment, Alcoholics Anonymous, Narcotics Anonymous, Methadone Anonymous, medication-assisted treatment, medication-assisted recovery, recovery mutual aid

Introduction

Methadone maintenance treatment (MMT) has been a primary modality for the treatment of opioid addiction for more than four decades. MMT's safety, efficacy, and effectiveness have been rigorously tested and affirmed by innumerable studies and scientific panels (Kleber, 2008; Kreek & Vocci, 2002; National Consensus Development Panel, 1998; National Institute on Drug Abuse, 1999). There are currently 1,203 opioid treatment programs (OTPs) in the United States with a collective daily treatment capacity of more than 260,000 patients (Parrino, 2008). In spite of its potentially positive effects on numerous areas of personal functioning, MMT, like other

addiction treatment modalities, is limited by high rates of patient attrition prior to the achievement of maximum benefit.

MMT was originally conceptualized as a prolonged and potentially lifelong treatment for opioid addiction (Dole & Nyswander, 1967; Dole, Nyswander, & Kreek, 1966). Evidence confirms that MMT outcomes improve with the duration of treatment, including long-term outcomes for those patients who eventually cease MMT participation (Dole, 1994). Idealized views of the optimal time in medication-assisted treatment are challenged by seven stark realities:

1) Between 80-100% of surveyed MMT patients expect to end MMT at some time in the future (Langrod, Des Jarlais, Alksne, & Lowinson, 1983; Stancliff, Myers, Steiner, & Drucker, 2002).
2) One-year retention rates in MMT are less than 50% (Deck & Carlson, 2005).
3) Only a small percentage of MMT patients end their treatment in a planned manner (11% of those discharged in 2005; Substance Abuse and Mental Health Services Administration, 2008).
4) Post-treatment monitoring, support, and early re-intervention are not standard practices within mainstream addiction treatment or within OTPs in the United States (White & Torres, 2010).
5) The majority of patients who are discharged from MMT eventually return to heroin or other illicit opioid use (Gossop, Green, Phillips, & Bradley, 1989; Joseph, Stancliff, & Langrod, 2000; Magura & Rosenblum, 2001).
6) Patients who end MMT are at significantly increased risk of infectious disease and death following treatment termination (Clausen, Ancherson, & Waal, 2008).
7) The majority of MMT patients who choose to taper from MMT do not successfully complete the tapering process as planned (Calsyn, Malcy, & Saxon, 2006; Nosyk et al., in press).

These findings underscore the potential importance of non-pharmacological recovery supports for MMT patients during induction and treatment, while tapering, and following treatment, and they underscore the more specific role participation in recovery mutual aid groups could potentially play in long-term recovery from opioid addiction (Gossop, Stewart, & Marsden, 2008). There is substantial evidence that participation in recovery mutual aid organzitions like Alcoholics Anonymous (AA) exert positive effects on long-term recovery outcomes (For reviews, see Kaskutas, 2009; Kelly & Yeterian, 2008; White, 2009), but non-pharmacological support during MMT has historically relied on ancillary psychosocial supports provided within OTPs (McLellan, Arndt, Metzger, Woody, & O'Brien, 1993) rather than on linking patients to community-based recovery mutual aid organizations like AA, Narcotics Anonymous (NA), or other recovery mutual aid groups (White & Torres, 2010).

Attempts to apply 12-Step approaches to MMT treatment (Obuchowsky & Zweben, 1987; Ronel, Gueta, Abramsohn, Caspi, & Adelson, 2011; Zweben, 1987) have faced obstacles related to professional attitudes toward 12-Step groups (Laudet & White, 2005) and the acceptance of MMT patients within 12-Step groups, e.g., restrictions on MMT patients' right to claim "clean time," speak at meetings, sponsor others, or hold service positions based on their MMT status (White, 2011). The stigma and discrimination MMT patients face when seeking participation within mainstream recovery mutual aid groups are, in part, expressions of the larger professional and cultural stigma attached to MMT in the United States (Murphy & Irwin, 1992; Vigilant, 2004). Negative experiences within NA, AA, and other support groups prompted creation of an alternative mutual aid framework, Methadone Anonymous (MA), specifically for current and former MMT patients. MA has grown since its inception in 1991, but it is not widely available in the U.S. at the present time (Gilman, Galanter, & Dermatis, 2001; Ginter, in press; Glickman, Galanter, Dermatis, & Dingle, 2006; McGonagle, 1994; White, 2009).

There is evidence that attitudes toward medications within recovery mutual aid groups may be shifting (Rychtarik, Connors, Dermen, & Stasiewics, 2000; Tonigan & Kelly, 2004), or at

least being re-evaluated within local groups (White, 2011), and recent definitions of recovery are encompassing people in medication-assisted recovery who meet such definitional criteria as sobriety, improvement in global health, and citizenship (Betty Ford Consensus Panel, 2007).

In spite of continued discussions in professional circles about the challenges faced by MMT patients as they seek participation in NA, AA, and other addiction recovery mutual aid organizations, no in-depth survey has been published regarding the actual rate of participation of MMT patients in such groups. This article presents data on the rate of mutual aid participation of 322 MMT patients and their experiences within and perception of NA, AA, and other recovery support groups.

Methodology

Setting. The survey was conducted at Partners in Drug Abuse Rehabilitation and Counseling (PIDARC), which was founded in 1971 in response to a request from Washington DC's Narcotic Treatment Agency to create a private alternative to the city's then expanding network of methadone treatment programs. Today, PIDARC is a 501(c)3 not-for-profit, comprehensive OTP treating more than 650 patients with a staff of 24 counselors, nurses, physicians, and administrative support staff. The program is housed in a large medical office building on the edge of a major university with two dormitories and a small hotel immediately adjacent. The PIDARC treatment philosophy is based on the belief that opioid addiction is a chronic, life-threatening illness best treated with long-term medication maintenance and participation in a rich menu of clinical and recovery support services. PIDARC treatment focuses on helping patients in all relevant domains, i.e., mental and physical health, family relationships, housing, legal problems, employment, and recovery-enhancing leisure activities. Specialized groups are provided for women who have experienced abuse, patients struggling with co-occurring alcohol or cocaine dependence, and patients with co-occurring mental illness. A specialized harm reduction group is offered for patients with continued problems of opioid addiction.

The majority of PIDARC patients are poor, African American, and aging (85% over the age of 45), with prolonged past histories in the criminal justice system. Many present with a long series of past treatment failures and current medical problems, including Hepatitis C and/or HIV. Patients admitted to MMT are individually assigned to a phase one orientation group during induction and subsequently assigned to a primary counseling group that they are expected to attend at least twice a month. Medication take-home privileges are partially contingent upon such participation. There are no onsite NA, AA, or MA meetings held at the clinic and no formal 12-Step orientation lectures. Patients are verbally encouraged in the groups to attend local meetings, meeting lists are visibly posted at the clinic, and a non-clinical staff person who is a member of NA and who has daily contact with patients assertively promotes NA involvement. Participation in NA, AA, or other recovery mutual aid groups is not a requirement for treatment participation, but may be part of an individual treatment plan, particularly when an individual is considering tapering from MMT. .

Purpose. Discussions within PIDARC about how to further improve long-term recovery outcomes sparked a decision to conduct a pilot survey of patients to determine baseline levels of community-based recovery support activities, including participation in NA, AA, and other recovery mutual aid groups.

Survey Questionnaire. The survey instrument consisted of 53 questions, 29 of which focused specifically on recovery mutual aid group participation. Responses to questions could be provided by check marking appropriate boxes, inserting numbers, and choosing from forced choice and scaled answers. Following each of the key questions, space was provided for any volunteered comment related to the particular topic.

Survey Administration. The survey was introduced to all patients attending primary counseling groups during a randomly selected week (November 7-11, 2011). Counselors leading their respective home groups that week explained the purpose of the survey to the patients, assured patients that the survey was completely voluntary, provided assurances that choosing to participate or not participate would have no bearing on their treatment, and assured patients that their responses were completely confidential. No compensation or other incentives for survey completion were provided. Of 323 patients attending home groups on the target week, 322 agreed to participate in the survey—51% of the total 625 MMT patients enrolled in treatment the week the survey was conducted. Each group leader distributed the survey forms, read each survey question (to ensure inclusion of patients with reading difficulties), and provided time for group members to enter a response to each question. The surveys contained no personally identifying information, and upon completion were placed in an envelope, sealed, and delivered to a research consultant for analysis.

Data Analysis. SPSS for Windows version 15 was used for the analyses. Demographic variables and survey responses of subgroups of respondents were analyzed using chi-square statistics and analysis of variance for comparisons of proportions and means, respectively. All available data were included in the analyses, and the total number of respondents to each survey question was noted for each calculation. Missing data points were not replaced with averages or other estimates based on the characteristics of those for whom data were available.

Results

Survey Participant Profile. Slightly more than half of surveyed participants were male (55%); 45% were female. The ages of participants ranged from 21 years to 79 years, with a mean of 53 years. The number of months in continuous MMT ranged from 1 to 288 (24 years) with a mean of 33 months, or 2.75 years. The self-reported, estimated percentage of days in the past year abstinent from alcohol and non-prescribed drugs ranged from 0% to 100% with a mean of 69%.

Primary Affiliation. Two hundred fifty-nine (259) of 322 respondents (80.4%) identified a primary affiliation related to their recovery support. As seen in Table 1, the two primary affiliations were NA (67.6%) and Other Community Support (11.2%). Although many survey respondents reported participation in AA (exclusively or in tandem with NA), only 7.3% reported AA as their primary affiliation. Other community support most often involved church or the primary counseling group to which each patient is assigned at PIDARC.

Table 1: Primary Recovery Support Affiliation

Self-reported Primary Affiliation	(n =259)
NA	67.6%
AA	7.3%
Both NA and AA	7.7%
Other 12-Step	1.5%
Other Community Support	11.2%
AA Plus Other	0.4%
NA Plus Other	4.2%

Current NA/AA Participation. Patients who reported attending either NA or AA since admission to MMT treatment were considered current participants in these 12-step programs. Each of the 322 respondents was categorized into one of four groups based on current participation status: No Current NA/AA participation (34.2%), NA Only (31.7%), AA Only (5.0%), and Both NA and AA (29.2%). Statistical comparisons revealed no significant differences across the four groups on age, gender, or months in MMT.

Intensity of Participation. Intensity of participation was measured both by meeting attendance and by participation in particular aspects of 12-Step programs. Table 2 displays the average number of meetings attended over three spans of time by individuals currently active in NA and/or AA. For example, 151 survey respondents attended an average of 36.98 NA meetings after beginning MMT. These same individuals had attended 34.96 NA meetings on average in the past year and 228.24 such meetings during their lifetime. In addition to attending NA and/or AA meetings, 27 respondents had participated in other 12-Step groups since treatment admission, and 61 had participated in other community support groups. Frequency of participation in these other groups was lower on average than for NA or AA.

Table 2: Lifetime, Past Year, and Since Treatment Admission Participation in Support Groups

	Types of Meetings Attended			
Time Period of Meeting Attendance	NA (n = 151)	AA (n = 80)	Other 12-Step (n = 27)	Other Community Support (n = 61)
Lifetime	228.24	200.26	110.73	104.25
Past Year	34.96	34.70	14.95	20.30
Since Treatment Admission	36.98	34.24	19.56	28.16

Table 3 illustrates the level of participation in key ingredients of 12-Step programs by individuals currently active in NA and/or AA. Statistical comparisons revealed that those who participated only in NA were significantly less likely (p <.05) to participate in 7 of the 9 areas than were those who attended AA, either alone or in combination with NA. In regard to sponsoring others, a significantly greater proportion of those in both NA and AA (20.2%) engaged in this activity than did those participating in just NA or AA (7.8% and 6.3%, respectively).

Table 3: Levels of Participation in Various Aspects of 12-Step Programs

	Current Participation Group				
Area of Participation	**NA Only (n = 102)**	**AA Only (n = 16)**	**NA & AA (n = 94)**	**Total (n = 212)**	***p* Value***
Home Group	33.3%	50.0%	52.1%	49.9%	.025
Have a Sponsor	16.7%	37.5%	34.0%	25.9%	.012
Sponsoring Others	7.8%	6.3%	20.2%	13.2%	.027
Speak at Meetings	24.5%	56.3%	48.9%	37.7%	.001
Socialize Before/After Meetings	34.3%	37.5%	48.9%	41.0%	ns
Attend 12-Step Social Events	11.8%	31.3%	34.0%	23.1%	.001
Active Step Work	10.8%	31.3%	29.8%	20.8%	.003
Helping other Addicts	10.8%	31.3%	35.1%	23.1%	<.001
Involved in NA/AA Service Work	5.9%	25.0%	28.7%	17.5%	<.001

*Level of significance (2-sided) from Pearson chi-square statistic

Self-Perceived Effects of Participation. Over three-quarters of respondents (77.2%) currently participating in NA said that it was very or extremely helpful to them; 72.4% of current AA participants rated this activity as very or extremely helpful. Only about 3.5% of each group said that NA or AA was not helpful. When given a forced choice of whether AA or NA was more helpful to their recovery, 38.1% of 155 respondents reported that both were equally helpful, 48.4% reported that NA was more helpful, 12.3% reported that AA was more helpful, and 1.3% reported that neither were helpful.

Among patients who found AA and NA equally helpful, written comments reflected the fact that AA and NA share sobriety goals and provide effective support. Among individuals who said AA is more helpful, comments generally reflected the perception that AA provided more structure and had a stronger spiritual base than NA. Among individuals who said NA was more helpful, participants noted that they identified more easily with a drug-focused fellowship since many did not drink nor have a history of alcohol problems, and that they related more easily to people attending NA meetings. When asked what aspects of AA or NA involvement were most helpful, responses clustered on social aspects of participation—talking, listening, sharing, learning from others, meetings, and socialization outside of meetings.

Among the small number of individuals who reported NA (2) or AA (2) was hurtful to them, comments noted that the stories sometimes provided new drug contacts or increased cravings to use. One person reported being asked to leave an NA meeting and not come back after revealing his or her methadone treatment status.

AA/NA Response to MMT Patient Status. Almost a quarter (24.4%) of respondents (with current or past involvement in NA or AA) reported having had a serious problem within NA or AA related to their status as a methadone patient. Table 4 identifies the frequency with which respondents faced particular challenges.

Table 4: NA and AA Responses to MMT Patient Status

Response to MM Patient Status	**NA (n=228)**	**AA (n=142)**
Received negative comments about methadone use	43.0%	45.1%
Were pressured to reduce the dose of methadone	21.9%	23.2%
Were pressured to stop taking methadone	32.9%	34.5%
Were denied the right to speak at a meeting because of being in methadone treatment	14.5%	14.1%
Were denied the right to become a sponsor because of being in methadone treatment	8.8%	9.9%
Were denied the right to chair a meeting or do other service work because of being in methadone treatment	8.3%	9.9%
Experienced other forms of stigma or discrimination related to methadone treatment	19.7%	19.7%

Patterns of Disclosure of MMT Patient Status. When queried about how they managed disclosure of their MMT patient status in the context of NA and AA, 168 respondents with current or past NA or AA involvement reported three major patterns: sharing MMT patient status with a sponsor but not the group (25.6%), sharing MMT patient status with a sponsor and the group (33.9%), or refraining from sharing MMT patient status with either their sponsor or the group (40.5%). Patients self-reported that they were more likely to discuss their involvement in MMT with family members or friends than in NA/AA settings.

Patient Recommendations on AA/NA Linkage. Seventy-eight percent of all patients surveyed believed that new and current MMT patients should be linked to NA and/or AA, but when specifically asked whether this should include all patients or only those who request such linkage, 35.4% recommended all patients, and 64.6% recommended only those who requested it. Patients were also split on whether linkage to NA/AA should be made at admission (51.3%) or after 3 months in treatment (48.7%).

Limitations

There are several limitations to this study. First, MMT programs vary considerably in philosophy, clinical practices, and levels of encouragement for patient participation in community-based recovery mutual aid groups (White & Torres, 2010), and there is considerable variation from community to community regarding the attitudes of NA and AA groups towards medication-assisted treatment of addiction in general and methadone maintenance treatment for opioid addiction in particular (White, 2011). Lacking comparative surveys, it is unclear the extent to which these findings are applicable across the United States or in other countries.

Second, although efforts were made to achieve a sizeable random sample of clinic participants, it is unclear how those patients not surveyed may have differed from those who participated in the survey. Seventy-five (75) patients with 13 and 27 days of take-home medication were not scheduled to be at the clinic for groups the week the survey was conducted. It is unclear how their omission may have influenced the outcomes.

Third, the lack of normative data on mutual aid participation rates across addiction treatment modalities limits any determination on how the rates in this survey compare with other OTPs and programs that do not offer medication-assisted treatment.

In spite of these limitations, the present study is one of the first systematic efforts to measure the rate and intensity of 12-Step group participation by MMT patients at an OTP in the United States. Further research is needed on the utilization of NA, AA, and other recovery

support groups by patients in medication-assisted treatment and the effects of such participation on short- and long-term recovery outcomes.

Discussion

The special obstacles MMT patients face in participating in mainstream addiction recovery mutual aid groups have been noted in the professional literature (White, 2011; Zweben, 1987), but the actual level of such participation has not been formally investigated. The present study surveyed 322 MMT patients in a private, non-profit addiction treatment program in an urban Northeastern United States community. The questions focused on the level of patient participation in and perceptions of NA and AA. The survey found a high rate of past year NA/AA participation (66%) and high rates of reported helpfulness of AA and NA (88-89%). The participation and helpfulness ratings are higher than might be expected given the negative attitudes toward methadone that MMT patients may encounter in their interactions within 12-Step groups (White, 2011). Staff members at the survey site attributed this high rate of NA/AA exposure to one staff member who was an NA member and who strongly encouraged NA involvement through his daily interactions with patients. Although AA/NA co-attendance was common among this sample (29%), a clear majority (68%) of those participating in mutual aid groups claimed NA as their primary affiliation, in spite of NA's stance on medication-assisted treatment of opioid addiction (Narcotics Anonymous World Services, Inc., 1996).

Research in the past decade on 12-Step groups has isolated a number of "active ingredients" beyond meeting attendance that influence long-term recovery outcomes (Kaskutas, Bond, & Humphreys, 2002; Kelly, Hoeppner, Stout, & Pagano, 2011; Moos, 2008; Morgenstern, Labouvie, McCray, Kahler, & Frey, 1997; Zemore, 2007; Zemore, Kaskutas, & Ammon, 2004). The survey sought to identify the level of participation in such ingredients and found, compared to meeting attendance, much lower rates of having a home group (50%), having a sponsor (26%), sponsoring others (13%), attending 12-Step social events (23%), and active step work (21%). One possible interpretation of these survey findings is that patients at this clinic have high NA/AA exposure rates in spite of encountering some negative attitudes toward methadone, but fail to be fully integrated into NA/AA cultures because of such attitudes. One-quarter (25%) of NA/AA-involved patients in this survey reported a negative experience related to their MM patient status, which likely also influenced the low level of self-disclosure (34%) of that status to sponsors and at meetings. The lack of studies on normative attitudes in NA and AA on the pharmacotherapeutic treatment of opioid addiction prevents comparison of our findings in one clinic and one city with NA and AA in other communities. The field could benefit from studies of existing AA/NA norms as well as studies on how participation or denial of participation in key 12-Step ingredients affects recovery outcomes for patients in MMT and other medication-assisted treatment.

This pilot study suggests that methadone patients may be participating in 12-Step fellowships at a much higher rate than might be expected. While a sizable minority reported problems with NA and AA, the overall majority of these MMT patients were not deterred by these problems and believed that they benefited from concurrent participation in MMT and 12-Step groups.

There is a growing body of literature on the value of addiction treatment programs assertively linking patients to AA (Sisson & Mallams, 1981; Timko, DeBenedetti, & Billow, 2006; White & Kurtz, 2006) as well as manualized procedures for facilitating such linkage for adolescents and adults (Passetti & Godley, 2008; Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009). These procedures have not been fully adapted to NA, particularly for the special circumstances of MMT patients. Such linkages and the quality of NA participation for MMT patients could be enhanced by exploring such options as developing formal relationships with NA service committees, hosting NA orientation and "starter meetings" onsite at OTP facilities, actively coaching OTP patients about how to handle their patient status in the context of NA/AA,

implementing assertive linkage protocols to local NA and other recovery mutual aid meetings, and co-hosting educational programs on medication-assisted treatment and recovery with local recovery community organizations. OTPs could also play a potentially active role in encouraging the development of local Methadone Anonymous meetings and other recovery support meetings for patients in medication-assisted recovery. Future studies should further evaluate patterns of participation in recovery mutual aid groups by patients in medication-assisted treatment and the effects of such participation on multiple dimensions of recovery.

Methadone maintenance is a substance-specific treatment, but addiction is not a substance-specific disorder. Treatment programs, including OTPs, must address complex patterns of concurrent and sequential drug use presented by their patients (Backmund et al., 2005; Dobler-Mikola et al., 2005). Increasing patient participation in recovery mutual aid groups may prove helpful in addressing patterns of multiple drug dependencies. Although the common conceptualization of methadone use is "for life," the reality is that few patients who enter OTPs stay for their lifetimes. Clinical experience has shown us that many, if not most, patients who leave OTPs leave on current doses of methadone without planned tapering and support for the transition to recovery maintenance without medication support. The risk of relapse is great under these circumstances and remains a lifelong risk; 12-Step fellowships and other recovery mutual aid groups may provide a source of critical support for patients seeking stable long-term recovery during and following discharge from OTPs.

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Addiction Recovery Support: Contrasting and Transcending Professional and Peer Models

Tom Litwicki and William L. White

ABSTRACT

Resources beyond self and family to resolve significant alcohol and other drug problems have historically been provided in two venues: professionally directed addiction treatment and peer-based recovery mutual aid. Recently, recovery support organizations have emerged that share characteristics of both venues, what we identify as hybrid mutual aid (HMA). The purpose of this article is to offer a conceptual framework for HMA followed by analysis of the philosophical positions and practices of two contemporary HMA groups. The integration of these practices has the potential to impact group emergence and maintenance, while raising significant ethical questions related to governance and fiscal management.



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Patterns of Abstinence or Continued Drug Use among Methadone Maintenance Patients and their Relation to Treatment Retention

Abstract

The efficacy and effectiveness of methadone maintenance treatment (MMT) in the medical management of opioid addiction has been well-established, but treatment outcomes are compromised by the continued use of licit and illicit drugs during MMT. The present study examined the relationship between in-treatment illicit drug use and retention and drop-out of 604 MMT patients in Washington D.C. Sixty-eight percent of patients did not test positive for an unprescribed drug during the study period. Of patients who tested positive for an illicit drug during the baseline period, 55% tested positive for cocaine, 44% for opiates, 23% for THC, 20% for benzodiazepines, 7% for PCP, and 4% for amphetamines. Those testing positive were three times more likely to leave treatment than those who did not test positive. Testing positive for one drug doubled the rate of attrition; testing positive for multiple drugs quadrupled the risk of attrition. Non-prescribed opioid or benzodiazepine use was a predictor of MMT dropout, but prescribed opioid or benzodiazepine use was not. Continued illicit drug use poses significant risk for subsequent premature termination of MMT. Assertive clinical management of continued illicit drug use could provide mechanisms to enhance MMT retention and long-term recovery outcomes.

Keywords: Methadone maintenance, medication-assisted treatment, treatment retention, benzodiazepines

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Gendered members of Alcoholics Anonymous (AA): Varieties of Spiritual Experience

ABSTRACT

Women and men share similar as well as different strategies in developing their spirituality as part of their overall 12-step experience. Special attention is paid to gender differences to account for a variety of spiritual experiences in recovery. The language and use of metaphors as women and men work the 12 steps in achieving a “spiritual awakening” is explored, recognizing the predominantly male ethos of AA since its inception. The influence of age in expressions of spirituality, distinguishing between young adults, middle-age adults and older adults, is referenced. Need for further understanding of gender differences, with a focus on the spiritual dimensions of recovery, is recommended.

KEYWORDS: Alcoholics Anonymous, Gender, Metaphors, Spirituality

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The Integration of Peer Recovery Supports within Philadelphia's Crisis Response Centers: An In-progress Report from the Field

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Abstract

The provision of peer recovery support services are being integrated into recovery-focused behavioral health systems transformation efforts throughout the U.S. and in other countries, but little information exists regarding such integration within crisis services. This paper describes efforts underway to integrate peer recovery support services within the City of Philadelphia's network of Crisis Response Centers, including the history of this initiative, the stages and current status of service implications, obstacles to peer integration and some of the key issues addressed through the implementation process. Peer services may have a unique role to play within behavioral health crisis interventions services, but many questions remain unanswered as to the best implementation processes and their short- and long-term effects on recovery outcomes.

Introduction

Recovery has recently emerged as a new organizing paradigm for behavioral health care in the U.S. (Davidson, et, al, 2005, 2007; El-Guebaly, 2012; White, 2005, 2008) and the U.K. (Berridge, 2012; Humphreys & Lembke, 2012; Wardle, 2012). Calls to shift acute and palliative care models of treatment to models of sustained recovery management have increased (Davidson, et al, 2007; Kelly & White, 2011), as have calls to wrap the latter models within larger recovery-oriented systems of care (Anthony, 2000; Clark, 2007; White, 2008;). Recovery is becoming a conceptual and practice bridge in the integration of mental health and addiction treatment services (Davidson & White, 2007, 2010, Gagne, White & Anthony, 2007; White & Davidson, 2006; White, Boyle & Loveland, 2004). In both service systems, the call for increased recovery orientation has been accompanied by the growing involvement of people with lived experience of recovery in the planning, delivery and evaluation of services, as well

as in the expansion of peer-based recovery support services (Kaplan, 2008; Laudet & Humphreys, 2013; Valentine, 2011; White, 2009; White, W., Humphreys, K., Bourgeois, et al, 2013).

Peer-based support services are being delivered in numerous contexts, including recovery mutual aid groups, recovery community organizations, behavioral health service organizations and allied health and human service organizations (Davidson, Chinman, Kloos, et al, 1999; White, 2009). Peers are being used within service roles that span outreach and early engagement, case management, support during hospitalization, promotion of a peer recovery support culture within the treatment milieu, facilitation of education or support groups, ongoing recovery coaching, assertive linkage to indigenous recovery community institutions, post-treatment monitoring, advocacy and support and within treatment outcome research (Galanter, Castaneda & Salamon, 1987; Ryan, Choi, Hong, et al, 2008; White, 2009, 2010). The Veterans Health Administration, through Vet2Vet and other peer support programs, has recently hired more than 800 peer specialists (Barber, Rosenheck, Armstrong, et al, 2009; Resnick, Armstrong, Serrazza, et al, 2004; Rosenheck, Resnick, Herbert, et al, 2009), and an increasing number of states are developing certified peer specialist roles and reimbursing such services through Medicaid. Such expansions are exerting pressure to develop national standards and ethical guidelines for the delivery of peer-based recovery support services (Salzer, Schwenk & Brusilovskiy, 2010).

Evaluations of peer support within behavioral health services suggest that such models can serve as a catalyst of recovery initiation, enhance service engagement, reduce symptom severity, reduce emergency room utilization, decreased hospital readmissions and increase participants' sense of hope, self-care, connection to community and quality of life (Blondell, Behrens, Smith, et al, 2008; Blondell, Looney, Northington, et al, 2001; Davidson, Bellamy & Miller, 2012; Cook, Copeland, Corey, et al, 2011; Landers & Zhou, 2011; Repper & Carter, 2011). Recent reviews of existing research have reported no evidence of harm resulting from peer recovery support services (Pitt, Lowe, Hill, et al, 2013), and suggest that the delivery of such services has positive effects on those in the delivery role, including reductions in services needed and enhanced quality of personal recovery (Salzer, Darr, Calhoun, et al, 2013). Multiple stakeholders have collaborated on the development of general guidelines to address the structure and process of delivering peer-based recovery support services (Grant, Daniels, Powell, et al, 2012). Studies of implementation of peer recovery support services have noted challenges related to selection, training and supervision of peers; integration of peers within professional care teams; role transitions from service recipient to service provider; continued problems of role ambiguity and inadequate support for peer service providers (Cabral, Strother, Muhr, et al, 2013; Gates & Akabas, 2007; Mancini & Lawson, 2009; Walker & Bryant, 2013).

Although the literature on peer-based recovery support services is growing, few studies have focused on the process of implementing peer supports within crisis intervention services. The purpose of this paper is to review the status of efforts to incorporate peer recovery support services within the City of Philadelphia's network of Crisis Response Centers.

Philadelphia's Behavioral Health Transformation Process

Recovery-focused systems transformation efforts in the City of Philadelphia begin with the creation of the Department of Behavioral Health and Intellectual disAbilities Services (DBHIDS) in 2004 and the recruitment of Dr. Arthur Evans, Jr. to lead behavioral healthcare systems innovations. The creation of the DBHIDS within Philadelphia City Government combined the Office of Intellectual disAbility Services (IDS) with the

three elements of Philadelphia's behavioral health system: Office of Mental Health (OMH), Office of Addiction Services (OAS) and Community Behavioral Health (CBH), Philadelphia's Medicaid Managed Care entity. The resulting efforts involved substantial changes in the core systems values and concepts, constituency relationships, service practices, and funding and regulatory policies. These changes have been described elsewhere (Achara-Abrahams, Evans, & King, 2011) in considerable detail and are briefly summarized below.

The behavioral health system transformation in Philadelphia began by involving all community stakeholders in the process—particularly recovering people and their families. The resulting vision was to create an integrated behavioral health care system for the citizens of Philadelphia that promotes long-term recovery, resiliency, self-determination, and a meaningful life in the community. A Recovery Advisory Committee developed a consensus definition of recovery and nine core recovery values: hope; choice; empowerment; peer culture, support, and leadership; partnership; community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach. The recovery definition and recovery core values were then used to guide the system transformation process in both mental health and addiction service settings.

Sustained efforts have aimed at restructuring system's relationship based on a partnership model. Relationships between service practitioners and service consumers and between DBHIDS and its local service providers have transitioned from authority-based relationships to relationships based on mutual respect and collaboration. Recovery representation has been promoted at all levels of system decision making. The focus on recovery has also resulted in expansion of the availability, quality, and sustainability of recovery support services and expansion of the settings in which such services are available. New relationships, such as the linkage between treatment agencies, the faith community, and other indigenous recovery support institutions are also a visible part of the system transformation process.

Changes in service practices have focused on the following areas:

1. Engagement: Greater focus on early identification via outreach and community education; emphasis on removing personal and environmental obstacles to recovery; shift in responsibility for motivation to change from the client to service provider; loosening of admission criteria; and focus on the quality of the service relationship.

2. Assessment: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.

3. Retention: Increased focus on service retention and decreasing premature service disengagement.

4. Role of Client: Shift toward philosophy of choice rather than prescription of pathways and styles of recovery; greater client authority and decision-making within the service relationship; emphasis on empowering clients to self-manage their own recoveries.

5. Service Relationship: Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."

6. Clinical Care: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment.

7. Service Dose/Duration: Increased dose and duration of total services with accompanying decline in number and

duration of acute care episodes; emphasis has shifted from crisis stabilization to ongoing recovery coaching.

8. Service Delivery Sites: Emphasis on transfer of learning from institutional to natural environments; greater emphasis on home-based and neighborhood-based service delivery; greater emphasis on building and revitalizing indigenous recovery supports in neighborhoods where they are absent or weak.

9. Post-treatment Checkups and Support: Emphasis on recovery resource development (e.g., supporting alumni groups and expansion/diversification of local recovery support groups); assertive linkage to communities of recovery; face-to-face, telephone-based, or Internet-based post-treatment monitoring and support; stage-appropriate recovery education; and, when needed, early re-intervention. (For additional detail, see Abrahams, Ali, Davidson, Evans, et al, 2012).

The conceptual, relationship, and practice changes described above necessitated accompanying changes in funding and regulatory policies. The focus to date has been on providing regulatory relief (reducing duplicative and excessive regulatory requirements), generating more recovery-focused regulatory standards, shifting the focus of program monitoring from one of policing to one of consultation and support, generating new RFPs for recovery-focused service initiatives, and exploring models for long-term funding of recovery support services.

Peer Recovery Support Services within the Philadelphia Systems Transformation Process

DBHIDS' expansion of peer recovery support services (PRSS) within its Crisis Response Centers is part of a larger effort to expand peer recovery support services within the whole system of care. Critical steps and achievements in this process include:

- a sustained partnership between DBHIDS and the Pennsylvania Recovery Organization - Achieving Community Together (PRO-ACT)
- the opening of Philadelphia's first recovery community center and its subsequent delivery of PRSS to more than 5,400 individuals
- findings based on an evaluation of 39,000 hours of PRSS that PRSS enhanced abstinence outcomes as well as increases in employment, educational involvement income, housing stability and parental custody of children.
- Expansion of peer roles to provide system-wide and program-level guidance on service design, street outreach, support during treatment, solicitation of feedback from clients on the quality of their treatment experience, and providing sustained post-treatment monitoring and support.

These specific achievements were part of a larger effort to culturally mobilize local communities of recovery for recovery support and recovery advocacy. Mobilization activities over the past eight years included hosting national speakers to address local communities of recovery about recovery advocacy and peer recovery support initiatives, a 12-week peer leadership academy (averaging 60 graduate a year), 34 Certified Peer Specialist trainings (611 trainees to date), 92 recovery storytelling workshops (1,532 participants to date), 31 peer group facilitator trainings (519 trainees to date), and 285 Taking Recovery to the Streets presentations to individuals in treatment provided by more than 50 trained peers. DBHIDS has used a federal Access to Recovery grant to deliver PRSS through a

network of 52 community and faith-based service providers that collectively employ 22 Peer Recovery Specialists. More than 8,500 individuals were served through this initiative between 2011 and 2013. Since 2005 DBHIDS has also sponsored two major professional/peer recovery conferences, co-sponsored Amends in Action events (involvement of people in recovery in community service projects), and co-hosted an annual public recovery celebration event (with more than 18,000 participants in 2012) (White & Evans, in press).

The History of Philadelphia's Crisis Response Center (CRC) Network

The City of Philadelphia opened a small Crisis Intervention Unit within the Health Department in 1953 to address a wide spectrum of acute mental health concerns; such crises had become a serious public health challenge that had not received adequate attention. This original unit provided counseling, consultation, guidance, technical advice, information and referrals to individuals who exhibited an acute episode of disturbed thought, behavior, mood or social relationships. The unit also routinely accepted calls from individuals who had suicidal thoughts or intentions as well as calls from persons seeking assistance for family members or friends who were in crisis.

This unit also provided mental health evaluations and some brief psychotherapy conducted by psychiatrists, clinical social workers and psychologists. Home visits were frequently made by the staff, particularly when a mental health application needed to be made to the court for an involuntary inpatient treatment order for a person who was dangerous to themselves and/or others. In the absence of any other public patient evaluation center, persons involuntarily committed were further assessed for treatment options by the State Reception Center located on the grounds of the now defunct Philadelphia General Hospital.

The 1966 Pennsylvania State Mental Health and Mental Retardation Act provided funding to the counties for a wide range of mandated services. Psychiatric Emergency Services (PES) were established on an around the clock basis and grew to seven PES centers dispersed throughout the City of Philadelphia. The PES centers were located in or in close proximity to hospitals. They significantly expanded the capacity of the county to perform in-depth comprehensive mental health crisis evaluations, to develop treatment plans and to implement the plans. The PESs were operated by contractual providers that functioned as clinical extensions of the county's Acute Services Unit. This transferred and expanded key aspects of the clinical functions of the Acute Services Unit to the PESs. The Acute Services Unit began operating around the clock providing telephone crisis intervention and some clinical management functions. The unit was also charged with maintaining ongoing communication, collaboration and problem solving within the now expanded Crisis Services Delivery System. In 1966, the County Mental Health Administrator was assigned authority to issue warrants for Involuntary Emergency Examination and Treatment with those duties then delegated to staff in the Acute Services Unit and no longer performed by the court.

The Psychiatric Emergency Services were mandated in DPW-MH & MR Manual 5223.1 as follows:

- Psychiatric emergency services need to be provided, consisting of observation, treatment and close supervision to be available any hour of the day or night to persons with a mental disability in need of immediate care.
- Psychiatric emergency services must not be denied to any person needing such care.
- Psychiatric emergency care may be required to prevent aggressive behavior by the patient toward himself or others.

- Psychiatric emergency Services must be made available on a voluntary basis to those persons where prompt treatment increases the likelihood of recovery from emotional disturbance.
- Psychiatric inpatient hospital care must be available to the psychiatric emergency service.
- When it becomes necessary to make an involuntary commitment for emergency detention, Section 405 of the Act becomes applicable(the Mental Health Procedures Act of 1976—revised in 1978 contains Section 302 which is the present day commitment procedure and supplants Section 405).

In the late 1990s, Psychiatric Emergency Services and the City's larger crisis response system underwent evaluation. This resulted in implementation of a comprehensive plan to restructure crisis intervention services. Some of the main features emerging from this restructuring included the following:

- The new crisis centers, called "Crisis Response Centers (CRC)," are designed to meet the needs of persons with serious behavioral health challenges, including mental illness, drug- and alcohol-related problems and co-occurring mental illness and substance use disorders as well as other special populations.
- Numerous regulations, directives and procedures were written to clearly specify structural and functional standards of the CRCs, including standards related to space requirements and accessibility, staffing levels, staff credentials and training, continuity of care, client evaluations and documentation, and laboratory services.
- The CRCs provide triage and assessment; acute psychiatric drug and alcohol evaluation and intervention; crisis counseling and support; and referral and linkage.
- CRCs perform important functions in the processing of 302 Applications for the Behavioral Health System. The Pennsylvania Mental Health Procedures ACT of 1976 (amended 1978): Section 302 provides a procedure for involuntarily committing a person who has a mental disability, is considered to be dangerous to self or others and refuses to seek help voluntarily for an examination at a Crisis Response Center and subsequent treatment if deemed necessary by the examining psychiatrist for a period of up to five days. The CRCs also have other related responsibilities pertaining to this process, including assisting families and other concerned persons to file 302 Applications when necessary and appropriate, as well as calling 302 Applications into the staff of the Acute Services Unit for possible approval and issuance of a warrant for involuntary examination and treatment.
- CRCs establish linkages and move persons in crisis quickly to such services and do follow-up to assure that clients get enrolled and engaged in these various programs.
- No CRC, under any circumstances, is allowed to close its doors or turn away a person in need of emergency services.

A monitoring team was established and made up of professional staff from the Acute Services Unit, CBH and the Behavioral Health System. This team conducts site visits to the CRCs on a regular basis to review all aspects of the program to determine if the centers are in compliance with regulations and performance standards, and to provide technical assistance as needed. One aspect of this monitoring is to assure that services are trauma-informed and recovery-based, individualized, comprehensive, flexible, person-first

(culturally responsive), and designed to support health and wellness.

Five CRCs have served the City of Philadelphia since this restructuring of crisis services in 1998: Einstein Crisis Response Center at Germantown Hospital (North/Northwest); Friends Crisis Response Center at Friends Hospital (Northeast); Hall Mercer Crisis Response Center at Pennsylvania Hospital (Center City/South); Temple/Episcopal Crisis Response Center at Temple/Episcopal Hospital (North Central /East); and Mercy Crisis Response Center at Mercy Hospital (West /Southwest). In addition to the five CRCs, the John F. Kennedy (JFK) Behavioral Health Center is contracted to provide 24/7 Mobile Crisis Services available to all residents of Philadelphia. Known as the Mobile Emergency Team (MET), they are dispatched by the DBHIDS Acute Services Unit (The Delegates) to intervene where a crisis has developed, to help people petition to have someone committed involuntarily, and to provide other mental health-related interventions.

The Crisis Intervention System continues to evolve concurrently within the larger systems transformation process underway in Philadelphia. A key area in which the transformation has influenced the CRCs is in the emerging plan to integrate peer recovery support services within the CRCs. This planning process included development of a set of core values for the CRCs (Appendix A) and development of organizational readiness criteria for implementation of CPRS within the CRCs (Appendix B). The remainder of this paper will explore aspects of this early integration process.

Early Vision for Peer inclusion within CRCs

The staffing requirements for the five CRC's include a CRC Director who meets the State requirements for a Mental Health Professional, a Medical Director who is a Board Certified Psychiatrist, adequate number of licensed physicians who have completed at least a PG1 level in Psychiatry, Certified Registered Nurse Practitioners (CRNP) who may be deployed in roles otherwise filled by a physician, Behavioral Health Associates who meet the State requirements for a Mental Health Crisis Intervention (MHCI) service medical assistant, and medical personnel who can immediately assess and treat emergent medical conditions on a 24/7 basis. The CRCs must have one physician at least at the attending level (board eligible) on site or available on an on-call basis at all times both for consultation with on-site staff and with CBH. The staff of the CRC also includes personnel to meet the special needs of persons receiving services. These personnel include addiction specialists, staff who are responsible for referrals and follow up of persons who use the CRC and staff to offer services to family members.

As the recovery transformation process evolved, interest grew in the integration of peers within the staff of each CRC. The original push for peer inclusion in the CRCs came from CBHISA leadership (Dr. Evans and Sade Ali) with discussions beginning at the CRC Director's meetings in 2009. Early discussions at the CRC level included hopes that peers might increase quality of services by bringing experiential knowledge, styles of engagement and dimensions of support not previously available within the CRCs. Various concerns and uncertainty related to peer integration were also expressed regarding issues of recruitment and selection, orientation and training, team relationships, and legal/professional liability.

Implementation Status

Two of the five CRCs—Einstein/Germantown and Friends Hospital--have begun providing peer services within their units. Einstein/Germantown hired a Certified Peer Specialist in 2011 to provide services five days a week. This role has been filled since then, but the plan to add a second has not materialized due to lack of funding for this second position. Friends

Hospital now has two Certified Peer Specialists, one full time in the CRC and the other primarily assigned to the inpatient units, but occasionally consulting in the CRC. JFK hired three peers in 2012 and presently has two CPSs working within their Mobile Emergency Team. Their primary role is engaging participants, sharing their stories where applicable and doing telephone follow ups. They provide education, information and act as community liaisons. They also record the information they collect on a log called Certified Peer Specialist Participant Engagement Log. It includes the participant's demographics, presenting situation, the engagement and follow up and or recommendations. The CPSs are dispatched by the MET to participants, family members in crisis or to assist other community service providers responding to a crisis.

Although two CRCs and JFK have integrated peers within their respective service operations, integration of peers within the other CRCs has been held up for more than two years because of lack of funding for these roles. All sites report being internally ready (e.g., policies developed, job descriptions, etc.) for greater peer integration pending approval of funding for these services.

Major Obstacles to Implementation

The use of peers in crisis services in Philadelphia has been championed at multiple levels of the system since discussions of their potential value began. The delay in wider implementation of peer recovery support services within these venues has been administrative and fiscal rather than one of any attitudinal resistance. The ability of the Crisis Response Centers (CRCs) in Philadelphia to hire peers seemed initially to be relatively straightforward (i.e. negotiate a payment rate that covers the cost of peer specialists with those organizations operating the CRCs). However, this has turned out to be much more complicated than expected. In Philadelphia, the Crisis Response Centers (CRCs) were all recently required to become licensed by the State as Crisis Walk-in Centers and then to become enrolled as Medicaid providers. This turned out to be a much slower process than anticipated with only two CRCs enrolled and a third in the process of being enrolled. The remaining two CRCs have been licensed as Crisis Walk-in Centers but they have yet to be enrolled by the State as Medicaid providers. What will continue to present as a challenge is how the CRCs have been functioning to date financially. Each year they report costs that well exceed their allocations, forcing them to continue to carry a large "agency contribution" line to balance their budgets. This issue comes up when they are asked to change or enhance their services but are not offered additional funding for new personnel and thus supervisory costs. Facilitating resolution of these challenges was impeded by staff changes within DBHIDS. At present, the Medicaid Managed Care entity, Community Behavioral Health (CBH) is working with providers to achieve the presence of certified peer specialists within every unit of the CRC network.

Experience to Date with Key Issues

Job Descriptions and Duties Sample job descriptions for peers working within Philadelphia's Crisis Response Centers are included in Appendices C and D. The general requirements for working as a peer in these settings include a high school education (with preference for post-secondary education), successful completion of the DBHIDS Certified Peer Specialist Training Program, prior experience working in a health or mental health service setting, skills in verbal and written communication, and skills and comfort sharing one's personal recovery experience. CRC supervisors also note that it is beneficial if the Peer Specialist has worked as a peer in another level of care before working within the crisis response setting.

The duties required of the peer specialists within the CRCs generally include:

- contributing to the development of a strong culture of recovery within the CRC treatment milieu (See sample CPS Schedule in Appendix E)
- helping orient patients and their family members to the facility and its treatment program
- observing, monitoring and reporting status of each patient
- providing emotional support to patients and families
- facilitating group activities within the treatment milieu
- assisting patients with development of plans for continued recovery stabilization and maintenance in the community
- assertively linking patients to recovery support resources within the community, and
- conducting ongoing telephone or face-to-face recovery check-ups on each discharged patient (See sample post-discharge follow-up consent form in Appendix F and sample follow-up call documentation form in Appendix G).

Recruitment and Selection The recruitment of peer specialists was achieved through newspaper advertisements, online postings, and reaching out to peers already working within other units of the CRC organizations. CRC leaders also expressed plans for future recruitment that would be expanded to postings through the mental health association, local recovery advocacy organizations and other organizations in the community who utilize peers to deliver recovery support services. Recruitment responsibilities were generally shared by the human resource departments of the hospitals in which the CRCs were located and CRC administrators and supervisors.

Beyond the requirements noted for the peer specialist positions, CRC supervisors noted other characteristics they were seeking within the screening of candidates. These characteristics included:

- Insight: understanding of the potential necessity and potential therapeutic benefits of involuntary commitment
- Empathy: capacity to be with and remain with people on what may well be the worst day of their lives
- Initiative: ability to self-initiate contact and respond to patient needs as they arise without direct supervision
- Assertiveness: ability to speak out on issues of import to quality of patient care
- Mutual respect: willingness to collaborate within the larger care team
- Self-care: capacity to handle the emotional distress/drama/unpredictability of the crisis setting via capacity for self-monitoring their own emotional responses to crisis situations (See later discussion)
- Acceptance of Limitation: Recognition/acceptance of limits on one's role and ability to practice within those limitations; ability to work within the context of crisis without being involved in the long-term outcome.

Orientation, Training and Supervision The initial orientation of peers working within the CRCs generally combines a 2-3 hour one-on-one orientation with progressive integration into the care-giving process. Training activities that have supported CPS integration within the CRCs include a 2-day CRC workshop (See Appendix H for sample Agenda) and a Certified Peer Specialist training course that is completed prior to CPSs entering their roles (See Appendix I for Training Manual).

The Certified Peer Specialist (CPS) initiative was developed to assist people with behavioral health challenges become re-acclimated to the community in which they live as well as empower them to cope with

their challenges. This 2-week training culminates with a graduation and job fair with prospective employers. College credits are also awarded upon successful completion of the training. CPS training candidates must have a high school diploma or GED and one year of relevant volunteer or paid work experience. Upon employment, a CPS is a paid staff person who is willing to self-identify as a person with a serious behavioral health disorder (mental illness, substance use disorder, or co-occurring disorder) with lived experiences.

To date, most of the selections for peer specialists to work within the CRCs have worked out very well, but supervisors were insistent on providing each peer a guilt free exit from this role if there was evidence of role-person mismatch within the CRC. Discussions with the supervisors elicited numerous references to the fact that not everyone (regardless of personal/professional background) was suited for the crisis response role. To wit, some very well-qualified CPSs who could work very effectively in other settings may not be a good fit with the fast paced and high acuity environment of a CRC.

The structure of peer supervision within the CRCs generally included brief daily check-in, an open door policy regarding any issue arising within the service process, and more formal supervisor-supervisee meetings (ranging from monthly to quarterly across the CRC sites). The supervision structure is also individualized based on each peer's level of functioning and comfort and generally proceeds from a high to lower frequency and intensity of contact. At Einstein, each CPS submits a monthly report that is reviewed in supervisory meetings. The report format elicits monthly activities, challenges and successes.

Some supervisors noted having participating in a specialized training event on supervision of peer specialists that was sponsored by the local mental health association The Certified Peer Specialist Supervisor's Training is a 2-day training for staff who will be responsible for hiring and supervising Certified Peer Specialists (See Appendix J). This training is designed to increase knowledge about operating a peer support service as well as the supervisory techniques needed to support CPS in the workplace. This training is approved by the NASW for 13.5 Social Work continuing education contract hours. It is set up for a maximum capacity of 20 participants.

When asked about lessons learned in the supervision of peers within the CRCs, supervisors noted the following lessons:

1. Good supervision applies to all roles: there are not substantial differences between supervision of peer specialists and other roles within the team.

2. Due to the newness of the peer specialist position, it is important to clearly define this role, address any areas of role ambiguity or role conflict and identify and respond to concerns about role-person mismatch as early as possible.

3. Maintaining openness and continuity of contact and support within the supervisory relationship is critical to successful adjustment to and performance within the crisis context.

<u>Importance of Clarity of the Peer Specialist Role and Team Integration</u> If there was a single concern most often expressed by CRC supervisors about the peer specialist role, it was the linked issue of role clarity and team integration. Supervisors first noted that ambivalence towards the peer specialist role by traditional professionals was normal. Such ambivalence or defensiveness is common when experiential models of knowing are integrated with professional/scientific/clinical models of knowing. Professional staff trained to rigorously maintain boundaries between themselves and their clients are also unsure of the ethics and etiquette of interacting with peer specialists. It often takes 3-4 months for professional members to recognize peer specialists as full team member with this timing depending on the individual and their fit with the team. Our experience is that early ambivalence or even outright resistance to peers specialists gave way to growing respect for the value of peer specialist working within the crisis response setting.

This occurred through processes of communication and relationship building between the peer specialists and professional team members and observing peer specialist making exemplary contribution within the service process. It also helped to continually clarify roles through the integration process and to assure existing staff that their professional duties were not being turned over to peer specialists.

An unanticipated side-effect of integrating peer specialists within the CRCs was that it increased the visibility and unacceptability of some of the "MASH humor" used as an adaptive response to the distress of working within the crisis settings and staff views ("My way or the highway") couched within the rubric of "tough love" that could at times migrate into disrespectful communications. It is the view of the CRC supervisors that the presence of peer specialists helped shape much more respectful and recovery-oriented service milieus within the CRCs. Furthermore, having clinicians working alongside peer specialists has affected a realignment of staff members' understanding of life with a mental illness and expectations of patient outcomes. As is often the case in acute-care settings, staff members will often focus on the high-utilizing patients when constructing mental schema about what it means to be a mental health consumer, as opposed to the many patients who move on to the next stage of their recovery. This availability heuristic (i.e. basing assumptions on the most readily available information) often leads to inaccurately high estimates of hospital readmission, and low expectations for recovery following discharge. Having peer specialists interacting with clinicians on a regular basis is invaluable on-the-job training for what recovery can look like.

Vulnerability of Peers in Crisis Services Conversations with the CRC supervisors continually elicited references to the uniqueness of crisis services and that integration of peer specialists needed to be understood within the context of such uniqueness. Crisis services have a "battle front" atmosphere and a level of unpredictability, intensity, and exposure to trauma rarely seen elsewhere in behavioral healthcare. They are characterized by clinical complexity, service volumes, and a speed of required decision-making which often exceed other levels of care. Not everyone is as well-suited to confront such life and death intensity, patient threats of harm to self and others (including to staff), legal and physical constraints and interaction with police and other community members whose attitudes may be less than ideal toward people in crisis who suffer from a psychiatric or substance use disorder. Responding to such intensities may be particularly difficult for peer specialists who may have had similar experiences in their journey to achieve stable recovery. Extra care is needed in these environments to prevent and minimize the effects of vicarious traumatization. Although this is a noteworthy point for *any* staff member working in such a setting, the importance is specifically heightened for CPSs, who may intermix these experiences with their own.

Supports for Peer Specialists All of this suggests the need for careful selection and special supports for those working within crisis services. CRC supervisors noted a number of strategies that they believed would be of benefit to peers working within crisis services. These strategies included the following (of note is the fact that each suggestion is similar to supports already in place for other mental health professions):

- Defining potential career ladders for peer specialists
- Local networking (mutual support) of peers working within crisis, treatment and recovery support settings
- Exploring the potential for a local association of peer specialists
- Regular training conferences for peer specialists
- Workshops for peer specialists on compassion fatigue and self-care
- Consciously creating frameworks of support for both patients and staff

(e.g., JFK defines this framework as CREST: Commonsense, Respect, Empathy, Support and Trust)

Ethical Concerns or Dilemmas for Peers A wide range of ethical issues can arise within the context of peer-based recovery support services. These issues, according to the earlier work of White and the PRO-ACT Ethics Workgroup (2007), span the arenas of:

1. *Peer personal conduct* arising in such areas as self-care, personal impairment, personal bias, pre-existing relationships, personal/professional role conflicts, personal advocacy activities, and personal/professional conflicts of interest.
2. *Conduct within the Peer-Organization Relationship* arising in such areas as exploitation of the peer and representation of personal history and credentials at point of hiring.
3. *Peer Conduct within Service Relationships* arising in such areas as autonomy/choice versus paternalism, relationship boundaries—including emotional/sexual/financial exploitation of service consumers, boundaries of competence, confidentiality and discretion and duty to report.
4. *Peer Relationships with other Service Providers* arising in such areas as representation of credentials and responding to unethical conduct of other service providers.

When CRC supervisors in Philadelphia were polled as to ethical issues that had arisen within the context of peer recovery support services, there was a consensus that experience to date with peer specialists was too limited to accurately identify ethical issues unique to these roles. No organizational liability issues have yet risen related to the integration of peer recovery support services within Philadelphia's crisis response system. There was awareness of the potential of ethical/legal issues arising within the conduct of peer specialists and the need to address this potential within the context of orientation, training and supervision.

Perceived Outcomes It is far too early in the implementation of peer recovery support services within Philadelphia's CRCs to report specific outcomes related to the integration of peer recovery support services. No systematic evaluation has been conducted of the impact of peer services within the CRCs on key outcome measures. Persons served by the CRCs do complete evaluations of their CRC experiences (See Appendix K for sample evaluation form) and do sometimes note the helpful role of peers. The following comments drawn from those forms convey typical responses.

"Having someone who has been where I am, and who has been through what I am going through come and approach me was such a relief. At first I was surprised because they had this guy actually working here, and I wasn't sure I could believe him. Talking to Alex gave me a little hope that things can get better and that I might actually be able to do something once I get better."

"It was real nice having a person who really knew a little bit about what I was going through. He treated me real nice. You couldn't even tell he ever had issues."

"Places like this need to have more people like him."

"It's very good that you all hire people who can relate to patient's personal struggles. Sometimes when you talk to doctors, you feel like they don't get it, but Alex really did get it. It was like having a friend there who was on your side."

"He didn't tell me what I need to do. He just listened and shared a personal story of his own. I didn't feel alone and I didn't feel like I had to impress him. I could just talk and be me and knew he couldn't judge me because the same thing happened to him."

"He offered to keep in touch with me since I was going to [Facility]and told me about peer support in the community. I didn't know there

was such a thing. I hope I get to see him again. Maybe I can do something like this too if I can get it together."

Peer specialists also regularly express what this form of service work has meant to them personally. As one CPS recently communicated:

Working with MET and learning about crisis situations has improved the quality of my life. It is comforting/educational to us to observe your interactions with participants and their families. We [CPSs] didn't realize the danger and or the stressful situations. We appreciate the opportunity to share our stories with other participants.

There is a consensus among the administrators and supervisors of the CRCs that future evaluations of peer services within the CRCs should include at least four discrete dimensions: 1) the effects of peer recovery support services on the recovery outcomes (recovery initiation, stabilization, maintenance and quality of life) of the individuals and families served by the CRCs, 2) the effects of working as a peer specialist on recovery and quality of life measures of the peer specialists, 3) the effects of integrating peer specialists on the recovery orientation of each CRC, and 4) the effects of CRC integration on key recovery-focused systems performance measures (e.g., costs of care, lengths of stay, re-hospitalization rates)

Summary and Next Steps in Peer Integration

The City of Philadelphia is in the process of integrating peer specialists within its behavioral health crisis response system. This paper has reviewed the history of this process and our experience to date with key issues related to the implementation process. The next steps in this process include:

1) adding peer specialists within those CRCs not presently providing peer services via completion of enrollment of the remaining CRCs as Medicaid providers and completing the hiring, orientation and training of certified peer specialists within all CRCs ,

2) exploring systems-level supports for the peer specialists via mechanisms of mutual support, training and explorations of career ladders for peer specialists, and

3) promoting research on the effects of peer recovery support services within the CRCs.

We would be very interested in hearing how other communities have integrated peer recovery support services within their crisis response systems. Correspondence can be sent to Dr. Margaret Minehart (Margaret.Minehart@phila.gov).

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Appendix A

Core Values of CRC's as set forth in DBHIDS Request for Proposals

1. **Strength-based Approaches that Promote Hope:** A strengths perspective is woven throughout system-transformation efforts. Services are focused on identifying and building strengths, assets, resources and protective factors within the individual, family, peer group and community, rather than focusing solely on identifying and addressing problems or challenges in the individual's or family's life. These strengths are mobilized to support the individual's and the family's journey to wellness. A focus on hope is equally essential—the message that people can and do show resilience in the face of adversity, and can and do recover from behavioral health conditions. Change is always possible, and the extent to which people's lives can change is often beyond what we can imagine. We learn hope by seeing others lead meaningful lives in their communities, listening to their stories and having opportunities to give to others. Hope-inducing environments can help people of all ages in their recovery processes.

2. **Community Inclusion, Partnership and Collaboration:** The focus of care is on integrating individuals and families into the larger life of their communities, connecting with the support and hospitality of the community, developing community resources that support recovery and resilience and encouraging service contributions to and from the larger community. Resilience, recovery and wellness can be tapped, initiated, catalyzed and promoted in care settings, but can be maintained only in the context of people's natural environments. Connecting services, individuals and families with the community is no longer considered optional, but is understood as an integral factor in sustaining wellness.

3. **Person and Family-Directed Approaches:** In recovery and resilience-oriented systems, service designs shift from an expert model to a partnership/consultation model, in which everyone's perspective, experience and expertise is welcomed and considered. Each person's and each family's values, needs and preferences are respected and considered central to any decision-making process. Services and supports are individualized, built with and around each person and family. All parties in the system recognize that there are many pathways to recovery and that people have a right to choose their own paths. People have the opportunity to choose from a diverse menu of services and supports and to participate in all decisions that affect their lives and those of their children. Multidisciplinary teams that include participants and family members reduce fragmentation and ensure the delivery of comprehensive, effective services.

4. **Family Inclusion and Leadership:** Family members are actively engaged and involved at all levels of the service process. Families - and particularly parents of children and youth - are seen as an integral part of policy development, planning, service delivery and service evaluation. Assessment and service planning are family focused. The system and its providers recognize that families come in many varieties. Families of birth, foster and adoptive families and families of choice are respected, valued and involved in meaningful ways. When multiple family members are involved in care in different programs and agencies, providers take steps to ensure that services are integrated.

5. **Peer Culture, Support and Leadership:** Service systems and providers recognize the power of peer support and affirm that recognition by: a) creating environments in which peers can support one another in formal and informal ways and providing opportunities for that support; b) hiring people to provide peer support to individuals and/or families; c) ensuring representation of youth and people in recovery at all levels of the system; d) developing respectful, collaborative relationships between behavioral health agencies and the service structures of local recovery mutual-aid societies and assertively linking people to peer-based support services (e.g., mutual/self-help groups, other recovery community support institutions and informal peer support); e) acknowledging the role that sharing stories of lived experience can play in helping others initiate and sustain the recovery process; and f) developing opportunities for people in recovery and youth to engage in active leadership roles at all levels of the system.

6. **Person-First (Culturally Competent) Approaches:** The title of this core value reflects the fact that services that are appropriate to and respectful of culture - often referred to as culturally competent - must also respect the individuality and centrality of each unique individual. In a person-first (culturally competent) service system, all staff and volunteers are able to work effectively with individuals and families from different cultures. They possess knowledge of the values, worldviews and practices of the major cultural groups they serve - and, equally important, the humility to know the limits of their knowledge. They address culture broadly, not forgetting the importance of ethnicity, nation of birth and primary language, but also acknowledging the implications of gender, age, sexual orientation, religion, socioeconomic factors and other key characteristics. Rather than merely developing a generic understanding of the people they serve, however, they are also skilled at using cultural knowledge to develop an accurate and individualized understanding of each person they serve, each family and each community. Providers also possess an understanding of their own cultural worldview, the ways in which it enriches their work and the ways in which it may constrain their work.

7. **Trauma-Informed Approaches:** All components of the service system are designed with an understanding of the role that serious adverse events can play in the lives of individuals and families. Services are delivered in safe and trustworthy environments and through respectful, nurturing relationships to promote healing and avoid inadvertent re-traumatization. Individuals and families are always assessed for the extent to which the spectrum of traumatic experiences may have affected their lives and their ability to participate in care and establish recovery. They are offered services and supports that will help them reduce the destructive effects of traumatic experiences and maximize the growth that can emerge from the healing process.

8. **Holistic Approaches toward Care:** Services and supports are designed to enhance the development of the whole person. Care transcends a narrow focus on symptom reduction and promotes wellness as a key component of all care. In attending to the whole person, there is an emphasis on exploring and addressing primary care needs in an integrated manner. Providers and peers also explore, mobilize and address spirituality, sexuality and other dimensions of wellness in service settings.

9. **Care for the Needs and Safety of Children and Adolescents:** Service systems and providers recognize the incredible resilience of children and adolescents, along with their unique vulnerabilities and the complexities that attend their need for services and support. As a result, providers employ a developmental approach in the delivery of services. Like adults, children and their families are shown respect and given a partnership role in services and supports. Screening and assessment processes are informed by knowledge of the ways in which children and adolescents' strengths, symptoms, needs and progress tend to differ from those of adults and of the ways of honoring those differences. Providers also recognize that attention to the safety,

needs and well being of children and adolescents includes attention to the safety, needs and well-being of their families—and back up that recognition with concrete action.

10. **Partnership and Transparency:** This system transformation effort is built upon the values of partnership and transparency at all levels of the system. This applies to the ways in which system administrators strive to work with providers, as well as the ways in which providers aim to collaborate with the individuals and families receiving services.

Appendix B:

READINESS CRITERIA FOR IMPLEMENTATION OF CPRs WITHIN THE CRCs:

These Readiness Criteria have been developed to assist DBH in determining the degree to which providers are prepared to implement recovery oriented services and supports including the addition of Certified Peer Specialists to the CRC staff. Meeting these criteria can set the stage for the implementation of high quality recovery focused programs, but will not guarantee success. Establishing a recovery culture of services and supports is more complicated than these criteria indicate, but the criteria are a step in the right direction. These criteria have been developed based upon the experience gained to date in various levels of care and provider specific programs. They are intended to assist in clarifying expectations. Assisting people in recovery (PIR) and program personnel to understand and embrace the recovery philosophy and orientation will require a concerted effort by all stakeholders.

Program readiness will be determined by:

1. Creation and submission of a "Readiness Plan"
2. A DBH site visit and/or kickoff meeting have proven beneficial in the effort to confirm "Readiness."
3. A meeting between program staff, PIRs, (Provider's Change Management Team) and the DBH CRC Transformation Team

Once providers have submitted the Readiness Plan the DBH will develop their plan to provide any needed supports to the CRC's.

Readiness Plan Criteria: Plans must be formatted using the headings provided below.

1. Establishment of an internal change management team who must be formed at the outset of this process that includes top level management (or easy access to this level), program leadership staff, psychiatric leaders, direct staff, people in recovery and family members. This team must be empowered to envision the change, direct the change and plan for the change. It is their responsibility to track the pace of the change, to solicit continuous feedback from all stakeholders regarding the change and to be nimble enough to alter plans and processes on the basis of this feedback. As programs mature, the structure of Change Management Teams maybe modified, but they remain an essential mechanism to track change, explore innovations and energize the vision for transformation.

2. Program Description: All programs must submit or amend and submit their program description to be completed in partnership with peer representation and the Change Management Team. The following must be included in the description:

    a. Vision: Describe your vision of the transformed service. Please use this is an opportunity to "re-think" the role and purpose(s) of CRC to move beyond what is offered today. The peer leadership group and/or a stakeholder group are required to play a tangible role in the formation of this vision. The vision should reflect the desires, aspirations and hopes of PIRs regarding recovery as well as reflecting the vision of the change management team. From its inception, the process of developing the vision should utilize the core principles of PIR self-direction and choice.
    b. Recovery Approaches: The plan should describe the recovery approach(es) the organization intends to employ; how this differs from current practice; how will the fundamental pillars of the recovery transformation will be addressed (assertive outreach and initial engagement, screening, assessment, service planning and delivery, continuing support and early intervention, and community connection and mobilization). It is expected that the narrative to this "recovery approaches" section will provide a comprehensive picture of your intended program which will ultimately lead to a "repurposing" of the CRC. Additional assistance in addressing this question is contained in the Practice Guidelines.

c. Roles: Identify all staff roles and how they will change to accomplish your vision and support your approach(s);
d. Voices: Explain how you will ensure inclusion of all voices (psychiatric staff, recovery coaches, CPSs, other non-medical staff, PIR & families) in the ongoing transformation of your program and in developing new roles and supporting collaborative relationships consistent with your recovery approach.
e. Leadership Support and Staff Supervision: Present your approach for providing staff and peer leaders with support as well as sustaining motivation as this complex and at times unsettling change process moves forward**.** Outline the methods and frequency of staff supervision (including specifying who will have direct responsibility for the supervision of CPSs).

3. Job Descriptions: The Readiness Plan will include completed job descriptions appropriate to the program approach and a strategy for orienting and training staff to perform their new roles. The orientation of staff should include an overview of changing roles, and strategies for supporting connections to other providers and community resources.

4. Certified Peer Specialist: Pending DBH authorization, at least one FTE Certified Peer Specialist (CPS) needs to be hired in conjunction with the development of the Readiness Plan. In addition, appropriate staff need to complete CPS orientation and supervisor training provided by the Mental Health Association of Southeastern Pennsylvania, prior to hiring CPS staff.

5. Screening and Assessment Process: In a recovery- and resilience-oriented organization or system, assessment is conducted in a strength-based fashion, giving priority to the identification of assets, interests and resources as well as difficulties. A person-first assessment is based on strengths and embraces the principles of cultural competence, weaving clinical knowledge and its application within the cultural context of the individual and family seeking services and the community in which they live. Evidence that the current practice around screening and assessment has been evaluated and any gaps in accomplishing the above have been planned for.

6. Peer Run Groups: The Readiness Plan should indicate progress made concerning

7. Walk-In Crisis License: All required material will have been submitted to OMHSAS in pursuit of a new Crisis license.

8. Evaluation: Initial development of a plan to evaluate the development of a recovery and resilience based Crisis Center will be created.

Appendix C

SAMPLE Peer Specialist Job Description

Certified Peer Specialist
Principle Duties and Responsibilities

FRIENDS HOSPITAL

JOB DESCRIPTION / EVALUATION

POSITION TITLE: Certified Peer Specialist

DEPARTMENT: Spiritual Care/Clinical Services

SERVICE: Adult or Geriatric

POPULATION SERVED: Adult, Older Adult

TIME: Full Time

REPORTS TO: Director of Spiritual Care

JOB SUMMARY:

Performs duties and responsibilities as required in the delivery of patient care services on a patient unit under the supervision of the professional nurse; provides peer support services; serves as an advocate; provides information and peer support for patients in an inpatient setting; contributes to the development and implementation of treatment plans as determined by the treatment team; participates in Performance Improvement and in-service education; supports development, customer service and community relations activities.

JOB SPECIFICATIONS:

Graduate of accredited High School or successful completion of GED

Current credentialing as a Certified Peer Specialist through the Department of Behavioral Health and Intellectual Disability Services

Ability to clearly communicate, both verbally and in writing

Computer literacy required

Demonstrates potential and skill to be trained in delivery of patient care

1-2 years experience in health care or mental health care setting preferred

%	Task	Evaluation
20%	1.0 Observes and monitors the patient's status and safety; delivers physiologic and interpersonal care according to standards which is consistent with multidisciplinary treatment and discharge plan, care directives, and expected discharge outcomes; observes and maintains safety, comfort and aesthetics of the unit milieu. (1,2,3,5,6,7) 1.1 Observes, intervenes and reports relevant patient behavior, including patient response to interpersonal, intrapersonal and extrapersonal events and awareness of / ability to meet basic needs. 1.2 Participates in and contributes to the establishment of a consistent therapeutic environment in keeping with the unit philosophy and the needs, treatment goals and care directives of each individual. 1.2.1 Works within the larger context of the unit milieu. 1.2.2 Intervenes to reduce the level of anxiety in the interpersonal environment. 1.2.3 Implements nursing care directives and physician's orders under the supervision of the professional nurse. 1.2.4 Assists in the preparation of patients for evaluative and diagnostic studies. 1.2.5 Leads patients in group activities focusing on patient education outcomes. 1.2.6 Leads patients in group activities which are not insight-oriented in purpose or scope. 1.2.7 Communicates in a therapeutic manner with families / significant others. 1.2.8 Participates in treatment groups in keeping with the goals and practices of the service unit. 1.2.9 Provides or assists with patients' basic physical needs, including food, fluid, air, rest/exercise, protection from temperature extremes; assists the professional nurse with basic nursing treatments and with preparation, treatment and aftercare of persons receiving electroconvulsive therapy (ECT). 1.2.10 Assists the patient to maintain integrity of personal and physical environment, such as hygiene, room and belongings. 1.2.11 Provides support services as needed to facilitate patient care, such as unit errands, escorting, and timely delivery of specimens and request slips. 1.2.12 Demonstrates working knowledge of the discharge planning process.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**

	1.3 Responds appropriately to physical, psychological and environmental crises, in order to maintain safety. 1.3.1 Verbally de-escalates patients with potential for violence. 1.3.2 When necessary, using the least restrictive measures, may intervene physically to prevent patients from harming themselves and/or others. 1.3.3 Demonstrates safe care according to standards for the patient whose care requires the use of restraints. 1.4 Performs direct patient care utilizing Universal Precautions, in order to maintain safety and infection control. 1.4.1 Performs or assists in safe and appropriate collection, storage and transport of specimens, including body fluids.	
60%	2 Provides direct services to patients to aide in their recovery 2.0 Assists patients transitioning from an inpatient setting to an outpatient setting by offering hope, assisting the patient in navigating through the process of starting in services, and providing on-going peer support. 2.1 Promotes an emphasis on the strengths, skills, talents, and abilities of the patient and to increase the patient's independence and self-sufficiency in the community. 2.2 Works collaboratively with the treatment team in identifying program and service environments conducive to recovery, which will lead to effective and efficient patient care. 2.2.1 Records accurate and complete documentation of patient information on traditional and computerized records, according to standards. 2.2.2 Works cooperatively to promote an atmosphere conducive to teamwork and mutual accountability. 2.2.3 Attends and participates in unit meetings 2.2.4 Participates in the implementation and evaluation of unit goals. 2.3 Educate and role model the value of every individual's recovery experience. 2.4 Assists patients in articulating personal goals for recovery and determining the objectives the patient needs to take in order to teach his or her recovery goals. 2.5 Assists patients in creating a Wellness Recovery Action Plan (WRAP). 2.6 Helps patients develop and/or maintain relationships with family, friends, neighbors, and other social supports in the community.	**☐Exceptional** **☐Competent** **☐ Needs Development**

	2.7 Aides in the acquisition, development and maintenance of vocational skills by providing linkage to vocational opportunities in the community as appropriate. 2.8 Facilitates group activities on the unit such as recovery-oriented topics and themes 2.9 Documents interactions and groups in a timely manner through progress notes, treatment plans, and follow-up contacts according to agency policy and procedure. 2.10 Conducts post-discharge aftercare follow-up through phone contacts with patients 1 week, 1 month, and 3 months post-discharge.	
5%	3.0 Accepts flexible arrangement of assignments when necessary, for optimal distribution and utilization of staff to assure quality patient care. (2,5,6) 3.1 Performs clerical duties as needed, as part of the Clinical Services team. 3.1.1 Maintains a quiet, organized work area with easily accessible materials and logical work flow. 3.1.2 Contributes to the implementation of the individualized Treatment Plan, and the timely accomplishment of patient care goals and directives. 3.1.3 Contributes to the integrity and completeness of the Medical Record. 3.1.3.1 Follows procedures and standards for facsimile (FAX) transmission and receipt of all electronic patient information. 3.1.3.2 Facilitates availability of sufficient blank chart pages for documentation by each clinical discipline. 3.1.3.3 Stamps each page with patient identifying information on both sides according to standards. 3.1.3.4 Organizes chart in standard order post discharge.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**
10%	4.0 Demonstrates leadership through role modeling, accountability and attainment of individualized performance goals. (1,2,4,5,6) 4.1 Participates in service- and unit-based inservice programs, including workshops, and incorporates content into performance. 4.2 Offers recommendations for educational programs and identifies both general and situation-specific learning needs. 4.3 Safeguards the confidentiality of patient-related information, documents and work materials.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**

	4.4 Demonstrates responsible use of work time and benefit time, including punctuality and adequate notice of absence for emergency or illness. 4.5 Follows hospital policies and unit protocols. Meets Criteria for Age-Specific Patient Care as relevant to practice area. ADULT 4.6 Immediately reports possible signs / symptoms of domestic abuse to professional nurse or supervisor, for appropriate and timely assessment and follow-up. GERIATRIC 4.6 Immediately reports possible signs / symptoms of abuse or neglect to professional nurse or supervisor, for appropriate and timely assessment and follow-up.	
5%	5.0 Participates in centralized Clinical Services department activities, including education, performance improvement, and committee work, in order to maintain department standards.(2,5,6) 5.1 Participates in department in-service programs and Workshops, and incorporates content into performance. 5.2 Serves on committee as appointed. 5.3 Demonstrates knowledge and support of Performance Improvement initiatives. 5.3.1 Assists in the collection of data; participates in its interpretation and use.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**
5%	6.0 Performs other duties as assigned, in order to support the smooth functioning of the service team and the Clinical Services department, the timely attainment of their objectives, and their effective relationship with the larger hospital system. (1,2,4,5,6,7) 6.1 Participates in hospital, medical staff, departmental, or unit team committees and task forces as assigned. 6.2 Supports development, community relations, customer service and human resources activities. 7.0 Performs other duties as needed, requested or assigned.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**

RATIONALE FOR ESSENTIAL FUNCTIONS:

1. The performance of this function is the reason the job exists.

2. There are limited employees among whom the performance of this function can be distributed.
3. This function occupies a great deal of the employee's time.
4. This function is highly specialized. Employees are hired for the skill/ability to perform this.
5. Failure to perform this function may have serious consequences.
6. The function was performed by past employees, and is performed by current employees.
7. Exposure to blood borne pathogens that requires use of personal protective equipment.

WORKING CONDITIONS:

1. Work with potentially aggressive individuals; physically intervene in aggressive behaviors.
2. Care for patients with infectious diseases.
3. Occasional exposure to unpleasant patient elements.
4. Contact with patients under a wide variety of circumstances.
5. Handle emergency or crisis situations; may perform emergency care.
6. Exposure to wetness in patient areas (tub, shower room).
7. Requires judgment/action which could result in death of a patient.
8. Participate in manpower pool.
9. On occasion, escort patient off the grounds.
10. Requires sufficient stamina to be able to rotate shifts and remain alert on the night shift.
11. Requires reporting to work in spite of inclement weather and other external events.
12. Requires remaining with assignment until relieved.
13. Use computer to enter and retrieve information.
14. Requires reaching, stooping, bending, kneeling.
15. Occasionally subjected to irregular hours.
16. Occasionally asked to transport patients or accomplish errands in the hospital vehicle, after receiving Approved Driver status.
17. Must agree to record searches in accord with Pennsylvania statute.

The above statements are intended to describe the general nature and level of work being performed. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of personnel so classified.

_____Date_____

Director, Human Resources

_____Date_____

Director of Spiritual Care

I have reviewed this job description with the employee and provided a copy to the employee.

_____ _____ _____

Supervisor Signature Job Title Date

I have received and reviewed a copy of this job description. I understand that my performance evaluation is based upon the content of this job description.

_____ _____

Employee Signature Date

Director of Spiritual Care –Internship-Externship Programs 12/2012,

Appendix D

Peer Specialist Position Description, JFK

Title: Certified Peer Specialist, MET Team

Reports To: Division Director

Location: JFK Behavioral Health Center

112 North Broad Street

Job Purpose: To promote and contribute to a culture of recovery within and outside JFK by creating hope and optimism for their peers.

Duties and Responsibilities

1. Assist in the development of a culture of recovery and self-determination through building peer relationships, sharing personal achievements, and exposure to successful experiences.

2. Engage with persons in recovery, by identifying their strengths and existing supports and linking them with community resources.

3. Create a partnership with peers and family members by sharing information about support services and resources available through the community.

4. Provide education for persons in recovery, staff, and family members.

5. Serve as a community liaison.

6. Complete all required program documentation.

7. Attends staff meetings to contribute to case conferences.

8. Attend other required meetings, trainings, and continuing education courses as recommended by direct supervisor.

9. Adhere to all JFK polices and procedures including confidentiality, HIPAA, compliance, etc.

10. Assist in handling peer crisis situations at JFK and in the community.

11. Perform outreach activities to re-engage peers in program activities, in person or by telephone.

12. Perform other duties and responsibilities as directed by the Division Director, and/or designee.

Appendix E

Certified Peer Specialist, MET Team – page 2

Position Qualifications Required:

I. Education, Training and Experience:

- Peer Specialist Certification. Must take CEU credits to maintain certification.
- Current or former recipient of mental health, and/or co-occurring services with a willingness to share personal recovery experiences.
- High school diploma or GED.
- 12 months paid or volunteer experience over the past three years, or one-year post secondary education totaling 24 credit hours.

II. Other Requirements:

- Proficient in verbal and written communication
- Ability to share recovery experiences and support others in their recovery process.
- Ability to establish relationships with peers.
- Strong interpersonal and problem solving skills.
- Ability to work a flexible schedule, including nights and weekends.

<u>Physical Requirements/Working Conditions:</u>

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. Travel is required for this position.

1. Frequent stair climbing, walking within the community even under inclement weather conditions such as heat, cold, ice, etc..
2. Ability to sit, stand, bend and walk for extended periods of time.
3. Must be able to lift and/or move up to 10 lbs.
4. Must be proficient in English with ability to read, write and speak.

_____ _____

Employee Signature Date

_____ _____

Manager Signature Date

Append	Monday	Tuesday	Wednesday	Thursday	Friday
8:30	Preparation	Preparation	Preparation	Preparation	Preparation
8:45					
9:00		Community Meeting – TE1	Community Meeting - TW1	Community Meeting – TE2	Community Meeting – TW2
9:15					
9:30					
9:45	Community Meeting – BN2				
10:00			Hillside Group		
10:15					Orientation for TW2 New Clients
10:30					
10:45	*Break*	*Break*	*Break*	*Break*	*Break*
11:00			Follow-Up Calls (CRC)	Orientation for TE2 New Clients	Follow-Up Calls (CRC)
11:15		Recovery Road Show – TE1			
11:30					
11:45					
12:00					
12:15	*Lunch*	*Lunch*	*Lunch*	*Lunch*	*Lunch*
12:30					
12:45	Unit Introduction for BN2 New Clients		Unit Introduction for TW1 New Clients		
13:00		Unit Introduction for TE1 New Clients			
13:15				Discharge Check-in for TE2 Clients	Recovery Road Show – TW2
13:30			Recovery Road Show – TW1		
13:45					
14:00					
14:15	Discharge Check-in for BN2 Clients				
14:30		*Break*	*Break*	*Break*	Break
14:45	*Break*	Discharge Check-in for TE1 Clients		Recovery Road Show – TE2	
15:00					
15:15	Recovery Road Show	Follow-Up Calls (CRC)			
15:30					
15:45			Discharge Check-in for TW1 Clients		Discharge Check-in for TW2 Clients
16:00					
16:15	Statistics	Statistics	Statistics	Statistics	Statistics

Appendix F

Post-Discharge Follow-up Consent Form

FRIENDS HOSPITAL	**Post- Discharge Follow-up Call Consent**	

What is a post-discharge follow-up call?

A follow-up call is a telephone call you can receive in the days following your discharge from the hospital. It is made by a staff person whom you met during your hospital stay. The staff person will ensure that you have the information about aftercare that you received from your treatment team. For some people, having a familiar voice on the phone is a nice way of transitioning back to their life outside of the hospital.

Do I have to get a follow-up call?

No – this is a service you can choose. No one will call you unless you sign this consent form.

How many follow-up calls can I get?

Typically people who choose to receive a follow-up call are telephoned twice.

Will the person leave a message?

If you choose, the staff person can leave a message. The message will not contain any private information, but the person will say that he or she is from Friends Hospital.

Can I call the staff person to talk?

You are welcome to call the hospital's Warmline if you feel speaking with a Certified Peer Specialist would be helpful. The warmline is open ___ between ___ and ___. The number is _____.

Consent for Follow-Up Call	
My preferred contact phone number is:	If you cannot reach me, it's okay to call: Name:_____ Phone:_____ Relationship:_____
The best time of day to reach me is: _____Morning _____Afternoon	
If the call goes to voice mail, you may leave a message. Yes_____ No_____	Interpreter Needed? Yes No Language_____

By signing below, I give consent for a Friends Hospital Representative to contact me after I am discharged in order to provide support for my recovery.

Individual's Signature:	Date:	Time:
FHP Staff Signature:	Date:	Time:

Appendix G

Sample Follow-up Call Documentation Form

FRIENDS HOSPITAL	Follow Up Call Documentation *(Pilot)*	

Client Name:
Discharge Date:
Inpatient attending psychiatrist:

Caller:	
Date of call:	**Time of call:**
☐ Initial Call	☐ Follow-Up Call (Number) __
Caller left message: **Y N**	

Follow-up call check-list (outgoing follow-up calls)			**Comments**
Personal Empowerment Plan reviewed with client	Yes	No	
Outpatient appointments reviewed with client	Yes	No	
Client asked about additional resources accessed	Yes	No	
Client guided through resource directory	Yes	No	
Client directed to crisis support	Yes	No	
Client directed to inpatient treatment team member	Yes	No	

DRAFT

Signature & Credentials	
Signature/Title:	Date / Time: April 9, 2020 10:24 AM

Appendix H

Draft Instructor's Agenda

People **E**ngaging and **E**mpowering **R**ecovery **R**esponses Through Crisis

Philadelphia Crisis Response Centers 2-Day Institute

For: Institute for Recovery & Community Integration (A program of MHASP)

Description: This 2-Day Institute is intended for multi-stakeholder groups seeking to further recovery-oriented practices into crisis response support services. Participants will be engaged in facilitated dialogues to learn from experiential perspectives, understand current research and be a part of planning next steps for implementation.

Objectives: Through this Institute participants will be able to:

1. Define recovery principles into their practice of support
2. Describe a recovery based response to crisis situations
3. Identify several key tasks of peer support in a CRC setting
4. List challenges, tools and actions steps to implementation of recovery and peer support

8:30 -8:45 **Registration**

8:45 -9:30 am **Welcome/Introductions**

- Welcome
- *Context of the initiative*
- *Overview of the schedule*
- *Learning objectives*

9:30-10:15 **Keynote "Help that Helps and Help that Hurts"**

- *An engaging presentation that based on presenters journey of recovery including support that helped and didn't help.*

10:15 – 10:30 **BREAK**

10:30 -10:45 **Participant Introductions and Guidelines for Learning**

10:45 am – 11:30 **Recovery to Practice**

- Institute speaker presents on foundation recovery orientation providing information on background, need, research, literature and basic principles of recovery.

11:30 -12:30 pm **Crisis and Peer Support Creating a Culture of Recovery**

- This section focuses on the concept, literature, research and principles of peer support as well as peer specialist as a method of offering peer support formally as a part of our services.

- **Peer Support and Crisis-**After going over the didactic information ask participants to think about the qualities of peer support they said was helpful on those lists made earlier as well as points made in the presentation. In small groups they should discuss barriers need in the crisis centers that might make it difficult to implement those helpful qualities of a peer support relationship. Reconvene as a large group to discuss those barriers and prioritize 5, or less, barriers.

12:30 - 1:30 **LUNCH**

1:30 – 2:30 **Panel Presentation (Psychiatrist CPS, other's who have implemented CPS in Crises Centers)**

2:30 - 2:30 **BREAK**

2:30 - 3:15 **Team Wellness Recovery Action Planning**

- Introduce a basic overview of WRAP® and the value on a personal and team level. Present the key concepts as a basis for our thinking to create change around the barriers we just discussed.

3:15 -3:45 **Planning for Recovery & Peer Support**

- Using the 5, or less, themed changes that have been captured previously break into teams to begin to tackle the need for change. Each group has two tasks: 1) develop a "wellness toolbox," list of accessible and doable tools that can help in addressing these challenges.) 2) Describe what peer and recovery supports "look like" when it is implemented well in the CRCs, i.e. what are the kinds of things that the peers are doing, what do all staff interactions look like etc…

3:45 - 4:00 **BREAK**

4:00 - 4:30 **Planning for Recovery & Peer Support cont'd**

4:30 -5:00 pm **Evaluations, Preview of next day and Check Out**

Day Two

8:30 – 8:45 **Registration**

8:45 -10:00 **Welcome Back**

- *Institute trainer checks in with the group inviting people help review what was discussed in the previous day or ask "what was a big take away lesson you got from the day?" Flip chart these responses. Next you might ask what new questions or unanswered questions do you now have about Recovery and Peer*

support. Orient people to the day's agenda including that today you will be taking the barriers mentioned in the previous days and the "tools" to develop team action plans to.

10:00 -10:45 **Peer Specialist and Trauma Informed Care**

- This module will be more on the role of Peer Specialist and other peer based resources that promote alternative crisis responses. We make the connection on the values and ethics of good peer support as a natural fit to the principles of trauma informed care. Key point is that people in crisis are most likely responding to what has happened to them not what is "wrong with them." This section could conclude with a role pay by the Institute modeling both peer based responses and non-peer based response and tasking the group to discuss what they are seeing.

10:45 – 11:00 **BREAK**

11:00 am – 11:45 **Keynote**

11:45 -12:30 pm **Action Planning**

- Preparing for the rest of the day of action planning facilitate the "comfort agreement" in the context of moving forward with the changes discussed in this course and working together the rest of the day to develop next steps. With a large group you may have people break into small groups to develop their guidelines and come back to the group to share what their group guidelines are. This should be a document and process for the CRCs to continue in their working together not just for today.

12:30- 1:30 **LUNCH**

1:30 – 2:30 **Action Planning Continued**

- After checking back in, have group go back to their small groups. Their tasks are to take the barriers previously identified and come up with at least three essential steps. Steps should address individual member's taking action and administrative/organizational actions that can be observed and have time frames. They should be referred to the "Toolbox" for resources on these steps and the "what we look like" for the possible observable change from the action steps.

2:30 -3:30 **Sharing Implementation Planning**

- Large group reporting

3:30 – 3:45 **BREAK**

3:45- 4:30 **Team Wellness Recovery Action Planning**

- Come back to WRAP® but now in the context of individual "burn out" and even trauma that is present for all crisis service workers. Engage audience to think about their wellness tools, Daily Maintenance Plans but be clear that this is only a teaser to how it could benefit the workforce. Conclude with next steps on how an organization can offer WRAP to its workforce.

4:30 -5:00 pm **Evaluations, Preview of next day and Check Out**

www.mhrecovery.org

CERTIFIED PEER SPECIALIST TRAINING

COURSE OVERVIEW



The Institute for Recovery and Community Integration is a program of the Mental Health Association of Southeastern Pennsylvania

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Curriculum Table of Contents

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Recovery and Peer Support

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Session 2 Recovery and Peer Support

Module 1 – Visioning Our RecoveryModule 2 – Exploring Peer Support

WRAP: The Wellness Recovery Action Plan (Copeland)

Session 3 Introduction to WRAP: The Wellness Recovery Action Plan

Module 1 – Key Recovery Concepts and Developing a Wellness Toolbox

Module 2 – The Daily Maintenance Plan and Identifying Triggers

Session4 Introduction to WRAP: The Wellness Recovery Action Plan

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Session 7 Working With People Who Appear Unmotivated

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Module 1 – Introduction to Co-Occurring Disorders

Module 2 – Boundary Issues in Peer Support

Session 10 Workplace Issues and Practices

Module 1 – Proficiency Test Workplace Practices

Module 2 –Test

Attachments Session Evaluation Forms

Introduction

The course material in this manual has been developed within the framework of a ten- session format. It is designed for a maximum of 20 participants. Each session corresponds to one day of training. Additionally, each session contains two modules (a morning module and an afternoon module), sometimes covering distinct topics, and sometimes a continuation of the same topic. The training sessions are designed to run from 9:00AM – 5:00PM each day. Each module is approximately 3 ½ hours in length with a scheduled 15-minute break. A one-hour lunch period is included in this time frame.

This curriculum is designed to give a general overview, or a thorough introduction to the topics presented. It is comprehensive in its scope in that it covers a wide variety of material. It is also a curriculum that is designed to be presented in 10 days. As such, it cannot present all the material that there is to know about a particular topic. Participants will use this training experience as a starting point as well as a stepping-stone to increasing their

knowledge and expertise in providing peer support services. It is important that the trainers emphasize this point with participants numerous times throughout the length of the curriculum presentation.

Participants' prior knowledge of the material and current understanding of the material as it is presented can serve as an assessment for their understanding of their own developmental needs as peer support specialists. That is to say, it will ground them in the key philosophies of recovery and peer support, develop and/or enhance their helping skills set, and identify the areas where they need continued growth and education.

The key philosophical mind shift that trainers want to observe in the participants is the notion of what it is that makes peer support services different than traditional mental health services (see accompanying Shery Mead articles, Peer Support: A Theoretical Perspective, 2001; and Peer Support: What Makes it Unique, 12/04). Traditional mental health services are often predicated on the medical model, focusing on diagnosis, functional deficits, maintenance of symptoms, dependence on the system, and one-sided power relationships. Peer support services are founded on a recovery-oriented model that focuses on mutual relationship, collaboration, individual consumer strengths, skills development, personal choice, interdependence and community integration.

Peer specialists do not pathologize an individual's experience, that is to say, relegate all their thoughts and feelings to the category of symptoms of illness, rather they help individuals understand their subjective experiences and develop strategies and skills to maintain wellness. Peer specialists do not create dependency and attempt to solve an individual's problem, rather they help the person thoroughly explore the issue that is presenting difficulty, and teach the necessary skills for individuals to successfully identify and follow through on their own solutions. Peer specialists work with individuals to help them identify and participate in valued roles of their choice in the community beyond that of "mental patient." Peer specialists must not simply become "consumers" providing mental health services in the traditional medically-oriented model.

A Note About Confidentiality

A key concern in all group work and a key norm to be established in the Peer Specialist Training is that of confidentiality. It is not only the trainers who have the responsibility to keep the confidences of the participants, but the participants themselves who are bound to keep each other's confidences. All group members are responsible to respect the confidentiality of all of the personal sharing done by participants throughout the training – including the large group discussions, small group exercises, and role playing exercises. This point should be reviewed periodically by the trainers throughout the length of the course.

Additionally, participants should be reminded regularly that they have the right to control the personal information that they share in the large and small group discussions. They are in charge of their self-disclosures and need only disclose that which they are comfortable disclosing. Hopefully, as the trusting environment builds over the course of the training curriculum, participants will feel comfortable in appropriately disclosing more of themselves.

Training Design

The **Certified Peer Specialist** curriculum is designed with recovery as the core value. It places the consumer at the center of decision-making, believing that personal choice is a fundamental element of a recovery-oriented system of care. Recovery is a deeply personal and unique experience and it is this participant internal resource that the training is designed to develop and nurture. The curriculum is developed within the framework of a three-tiered design focusing on providing:

1. education,

2. skill building, and
3. an experiential process.

1. Education:

Training sessions are designed to provide an atmosphere that is conducive to learning core philosophies, helper attitudes, concepts, and skills related to recovery and peer support. Education is important component in a recovery model. It is a key factor in making good decisions about treatment, lifestyle, career, relationships, living arrangements, recreation and free time.

2. Skill Building:

Training sessions are designed to provide a "hands-on" experience translating concepts and skills into practice. Skill development is a key focus with time allotted for skill demonstration, participant behavioral rehearsal, instructor feedback, large/small group process and discussion. Key skills such as active listening, group facilitation, personal sharing, helping skills, problem solving, and others are incorporated into the training program.

3. Experiential Group Process:

Training sessions are designed to provide an experiential process to parallel potential Certified Peer Specialist practice expectations. The curriculum is designed to help solidify learning by relating each session of the training encounter to the participant's personal experience of recovery. Training participants will participate in small group dialogues throughout which will give them the opportunity to do this.

By participating in the training, it is expected that participants will:

a. gain new knowledge;

b. develop new skills;

c. increase their personal awareness; and

d. enhance their personal recovery.

Session Goals and Module Objectives

Each session starts with a statement of the goals for that particular training session. These goal statements give a broad outline of what each session is designed to facilitate. Following the goal statements is a more specific listing of the teaching objectives for each module. It is important that each trainer understands the goals and objectives for each session and the incorporated modules. Additionally, a description of the resources needed to facilitate the module, resources or handouts provided to the participants (see **participant workbooks** below), and approximations of the time needed for the module are presented. As noted above, trainers need to be thoroughly familiar with the content of all the article handouts prior to conducting the training.

Module Agendas

The primary teaching instructions in the manual are provided in the format of a module agenda. Each module agenda lays out the time frames for each of the lecturettes, power point presentations, large group discussions, and small group exercises. Accompanying time frames for each of the segments of the module, including scheduled breaks are carefully noted.

Morning Check-in

At the beginning of each session (starting at session 2) the trainers will facilitate the morning check-in process. The purpose of the check-in is to provide participants an opportunity to ask questions or make comments on any issues covered in the previous day's session. Trainers facilitate the discussion and ask if there are any issues or points of clarification needed. Depending on the time frame, group participation, and assessment of the previous day's session, the trainers may also provide a brief review of the previous day's material.

Additionally, this time is used for individual participants (who are willing) to share excerpts from their journaling or other forms of creative expression (see **homework assignments**). Trainers encourage all group members to share their journal entries across the length of the 10-day course. At their discretion, trainers may also facilitate an appropriate group "icebreaker" to start the day.

Session Review, Closure Activities and Evaluation

Daily Summary

At the end of each session, trainers take a few minutes to briefly walk participants through a review of the day's material highlighting the important topics that were covered. Trainers welcome participant comments and questions during this time. The objective is to give the trainers the opportunity to highlight the key points discussed throughout the day as well as to give participants the opportunity to clarify any information that remains unclear to them.

Preview of Next Session

The trainers should briefly inform the participants what topics/issues will be presented at the next session. Trainers will need to have reviewed the agenda for the next day at this point. Any preparation that might be expected of the participants should be discussed at this time (see homework assignments).

Homework Assignments

Homework assignments can be used as a way to help training participants integrate the material they are learning throughout the course of the training. In this curriculum, homework is optional and the trainers do not check to see if participants have completed it. That being said, the trainers strongly encourage each participant to follow through with homework assignments. Generally, there are three types of assignments used regularly in this curriculum: (1) reading the supplemental articles at the back of each session in the participant workbook; (2) preparing for self-disclosure to be used in group exercises scheduled for a given day; and (3) journaling.

1. **Reading the Supplemental Articles**

Some of the training sessions have additional reading material included in the Participant Manual. These are generally in the form of articles on which the material for the session was founded or that attempt to provide supplemental information to the session. When these articles are present, the trainers should refer participants to them and encourage them to review the material at their leisure.

2. **Preparing for Self-disclosure**

Some of the training sessions (e.g., skill building modules such as active listening, problem solving) expect some level of role-play self-disclosure on the part of the participants. Participants are free to completely role-play their part, that is to say, "make it up as they go along" or share something real from their personal life. In any case, the role-play scenarios should not be overly complicated so as to make it too difficult to pay attention to the skills being demonstrated. When the following session will require this kind of participation from the group,

trainers need to inform the members what will be expected of them so that they can be prepared at the appropriate times.

Important Note: The focus of the role-playing and the self-disclosure during these skill-building modules is solely on the role of the peer specialist demonstrating the skill being presented. Participants playing the role of the "consumer" in these role plays need to understand that the role play is not designed for the group to focus on the issues that they bring to the role play – it is on the skill being learned. More often than not, participants will not come to a resolution of the issues they bring to the role-play scenario. Because of time constraints, the role-play will be cut off and the feedback from the group will focus solely on the skills performed and how they can be enhanced by the person demonstrating them. Training participants need to understand this so that they do not bring potentially emotionally charged material or issues that they have not resolved into the role-play.

Additionally, it is important to remind the group about the importance of confidentiality as it was identified in the **Session 1** discussion on setting group norms or guidelines. All group members are responsible to respect the confidentiality of all of the personal sharing done by participants throughout the training – including the large group discussions, small group exercises, and role playing exercises.

3. Journaling

The benefits of journaling include, providing an out let for participant thoughts and feelings related to the course material, recovery, or any issues that are present as a result of exposure to the course material; an opportunity to think about and review the days training material; an opportunity to reflect on important issues related to recovery, peer support, employment; and an opportunity for other forms of creative self-expression, e.g., poetry, short stories, personal narratives, etc.

> **Journaling Exercise**: Participants are encouraged to experiment with journaling throughout their training experience. Participants are instructed to use the journals to document their experience in the training and their individual responses to the training program via poetry, prose, artwork, etc.

Alternatives like the one described below can be provided at the trainers' discretion.

> **Building Bridges Exercise**: Participants build (draw) a bridge on paper (or in their journal), the bridge shows how the participant might incorporate what he or she has learned today into their work or personal life (from Warm Ups and Wind Downs: 101 Activities for Moving and Motivating Groups, S. Hazouri and M. McLaughlin, Educational Media Corp., 1993).

Participants are informed that each morning session will start with an opportunity for them to share their journal entries (see **morning check-in** above).

Closing Check-out

It is extremely important for each trainer to recognize that the material covered in each session, or the information shared in both the large group and small group discussions may trigger difficult thoughts and feelings for program participants. Just as the trainers "check-in" with participants at the start of each day, so too should they do a final "check-out" at the close of the day. This check-out will give participants the opportunity to verbalize any difficulty they are experiencing or think they may be likely to as a result of the day's session. The group can offer "peer support" for an individual if it is necessary and appropriate at this point and/or the trainers can spend one-on-one time with a participant if necessary to help develop a plan to deal with whatever issues may have arisen for the participant.

In the closing checkout participants go around the group and share one word that describes how they are feeling. Participants can check-in with each other regarding feelings shared to get clarification on what each member is communicating. Facilitators remind the group that we are all a support resource for each other throughout the training and that if individuals need support, they need to ask for it.

An alternative checkout activity can be substituted here at the trainers' discretion as long as it meets the objectives for the exercise as described above.

Session Evaluations

Getting participant feedback on a daily basis is an important component in the ongoing design and development of the training curriculum. Individual training evaluation forms are included in the participant workbooks for each session. It is the trainers responsibility to make sure that participants are given a moment to complete the evaluation form at the end of each session and to see that the forms are all regularly collected so they can be analyzed upon completion of the training curriculum.

Knowledge and Skills Assessment

Training participants will have to pass a knowledge-based test, either true-false, multiple choice, or a combination of both.

Additionally, participants will be asked to demonstrate appropriate skills taught throughout the course, for example, active listening, problem solving, and motivational enhancement strategies. All facilitators meet after each week to discuss participants using the following weighted performance evaluation. The lead facilitator will ensure that participants receive their WRAP Certifications, and week one test score along with an evaluation letter in a sealed envelop for confidentiality. One facilitator should be designated to be available during breaks or lunch to address participants' questions or concerns about their evaluation. Feedback should be provided to participants at the beginning of the second week about their strengths and areas of improvement as well as the points they are accomplishing (see evaluation letter). The purpose of this is to allow the participant to successfully meet the requirements and gage where they stand mid-way. Facilitators use the sign in sheets to track attendance, indicate punctuality, and note whether home work was shared. Participants must have at least 140 points total for certification.

The following is a weighted scale to judge the participants progress.

- Exam 60 points
- Attendance 30 points (-5 for each unexcused day absent)
- Punctuality 10 (-1 Each day participant is 5 minutes late -2 if 10 min or more)
- Participation: 100 points
    - Participant demonstrates active listening in group activities and class discussion -20 points
    - Participant volunteers as a speaker or recorder for the group; shares homework or discloses personal story to enhance classroom discussion pertinent to the topic -20 points
    - Participant asks relevant questions frequently -20 points
    - Demonstrates understanding of new material in class discussion -20 points
    - Interacts with peers in group consistent with the principles of peer support. - 20 points

Certified Peer Specialist Training

Group Participation Guidelines

In an effort to ensure our work together is productive, collaborative, and safe, we recommend the following group participation guidelines.

Respect

Trust

Confidentiality

Listen

One Person Speaks at a Time

Personal Responsibility

No Criticism (of self or others)

Be on Time

Use “I” Statements / Speak About Own Experience

Others:

Values and Competencies

This document outlines the recovery values embraced by the Institute for Recovery and Community Integration Certified Peer Specialist Program and the competencies that certified peer specialists (CPS) will have following training.

Recovery Values

Hope

Hope is the foundation for recovery—the belief in an individual’s potential to experience a full and satisfying life and the belief that change is possible.

Individuality

Recovery is a unique and personal journey. It is directed by and embraces the individual rather than dwelling on the illness. Recovery respects individuals’ cultural and spiritual differences as well as their special needs.

Self Awareness

By observing and monitoring our thoughts, feelings and behaviors, we become more self aware and empowered to take positive steps toward our own recovery.

Self Determination

Everyone is encouraged to make his or her own informed choices about his or her life and support systems and is personally responsible for these choices.

Meaningful Life

Everyone is entitled to an individually determined life that allows him or her to pursue various roles beyond that of consumer.

Respect

Everyone treats themselves and one another with respect and is respectful of their own and others' choices.

Peer Support

Peer support is a highly valued resource that offers hope through the unique empathy and understanding that come from peer relationships.

Community Focus

A recovery supportive environment provides the opportunity to live in, be connected to and flourish within the community of one's choosing, with access to those community supports and resources that will best promote one's own recovery.

Advocacy

Everyone is offered opportunities to be his or her own advocate and a voice for recovery.

CPS Competencies

Respect

Have a positive demeanor and be empathetic and calm. Be able to respect the desires of the individuals receiving services and their reference group or culture.

Engagement and Mutual Trust

Be able to relate to the individual receiving services based upon where he or she is in the recovery process, utilizing strategies such as affirmation, to build an open relationship and develop mutual trust.

Communication

Have the skills necessary to adapt verbal and written communication to the language style of the individual receiving services and his or her family. Demonstrate active listening skills.

Social and Cultural Factors

Be knowledgeable about how cultural and socioeconomic status affects the recovery of the individual receiving services. Be able to identify social and cultural resources that can facilitate recovery.

Confidentiality

Maintain and reinforce the importance of confidentiality while encouraging inclusion of support system members.

Minimizing Stigma

Understand the importance of reducing prejudice and discrimination. Be able to confront personal prejudices, manage discrimination and advocate for reducing discrimination in the community.

Goals

Be able to help the individual receiving services identify and organize personal goals in the areas of learning, work, leisure and living. Be able to help the individual gain employment, education and/or meaningful activity, when desired. Know how to support his or her unique pace toward goal achievement.

Basic Needs

Know how to elicit choices regarding basic needs (such as financial resources, food, shelter and safety) from the individual receiving services.

Community Resources

Be able to help individuals receiving services access housing, transportation, self-help organizations, mutual support groups and peer companion services. Be able to provide information regarding other treatment and rehabilitation programs and opportunities.

Family and Natural Support System

Be skilled at assessing the preferences of the individual receiving services regarding family involvement. Be knowledgeable about the role of the family and others in recovery and rehabilitation. Be able to help him or her identify and utilize natural supports.

Education

Be able to educate about mental illness, medications and rehabilitation. Be able to communicate the value of recovery, rehabilitation and medication treatment.

Rehabilitation

Be skilled in using current recovery and psychiatric rehabilitation approaches. Be able to teach goal-setting and problem-solving skills, and living, social and illness self-management skills.

Coordination of Care

Be skilled at coordinating service planning and provision. Know the importance of having a fixed point of responsibility for implementation of an integrated care plan, and of including all service providers, the individual receiving services and his or her support system.

Crisis Resolution

Know how to use and teach effective crisis intervention approaches and be aware of the preferences of the individual receiving services regarding previous, successful interventions.

Some material excerpted from “Set of Core Clinical Competencies for Providing Care to Individuals with Severe Mental Illness,” Young, Forquer, Tran et al. *Journal of Behavioral Health Services and Research, 2000.*

Session 1: Orientation to the Certified Peer Specialist Program

Session 1 Goals:

- Educate participants about the Certified Peer Specialist Program expectations;
- Identify participant training expectations;
- Educate participants about the CPS program Values and Core Competencies;
- Identify guidelines for group participation throughout the program;
- Provide participants with a small group experience where they can begin to get to know each other, develop trusting relationships, and experience group process;
- Introduce the concept of boundaries in relationship development;
- Provide background for current support of recovery beliefs in the field
- Gain a firm understanding about the role of Peer Specialists and what they do.

Session 1 - Module 1: Program Orientation and

Participant Introductions

Objectives: By the conclusion of this training module

participants will be able to:

- Identify program and personal expectations for their training experience;
- Identify program values and core competencies;
- Identify at least one unique characteristic about the members in their small group;
- Share personal information about their own life stories;
- Identify qualities of the group process that made it safe for them to discuss information about themselves;
- Discuss the need for boundaries in relationship development;
- Identify one core competency they want to develop over the course of the training.

9:00 – 9:15 ***Welcome and Trainer Introductions***

9:15 – 9:45 ***Introductions of Training Participants***

9:45 – 11:00 ***Orientation to Training Program***

11:00 – 11:15 ***BREAK***

11:15 – 11:30 ***Stepping Stones Exercise: Part 1***

11:30 – 12:00 ***Stepping Stones Exercise: Part 2***

12:00 – 12:30 ***Process Stepping Stones Exercise.***

12:30 – 1:30 ***LUNCH***

Session 1 - Module 2: The Emergence of Recovery Concepts in Behavioral Health

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify personal definitions of recovery;
- ❖ Discuss common recovery themes identified in the literature;
- ❖ Understand the current focus on recovery in the field of behavioral health;
- ❖ Discuss how assigning behavioral health diagnoses can be dehumanizing when not coupled with People First language.
- ❖ Contrast traditional versus recovery belief worldviews of participants.

1:30 – 2:00 ***Teaching Session: Concepts of Behavioral Health Recovery***

2:00 – 2:45 ***Activity: Seeing Ourselves and the World through Our Diagnosis***

2:45 – 3:00 **BREAK**

3:00 -3:20 ***Activity: Advantages of Knowing about Our Diagnoses***

3:20-4:00 ***Recovery Initiatives***

4:00 – 4:30 ***Activity – Overcoming the Shackles of the Medical Model***

4:30 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 2: Recovery and Peer Support

Session 2 Goals:

- ❖ Continue to provide participants with a small group experience where they can work to develop trusting relationships, experience group process, and to share their recovery story;
- ❖ Lead participants to explore and discuss their own definition/vision of recovery;
- ❖ Educate participants about the role of *peer support* in recovery, and explore personal experiences with peer support in personal recovery.

Session 2 - Module 1: Visioning Our Recovery

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Creatively identify and express their own definition/vision of recovery through arts and crafts.

9:00 – 9:30 ***Check-in***

9:30 – 10:00 ***What Recovery Means To Me Exercise: Part 1 – Individual Work***

10:00 – 11:00 ***What Recovery Means To Me Exercise: Part 2 – Group Presentation***

11:00 – 11:15 ***BREAK***

11:15 – 11:30 **Continue *What Recovery Means To Me Exercise:***

Part 2 – Group Discussion

11:30 -12:30 ***Exploring Peer Support Exercise***

12:30 – 1:30 **LUNCH**

Session 2 - Module 2: Exploring Peer Support

Objectives: By the conclusion of this training module

participants will be able to:

- ❖ Identify and discuss the core components of peer support;
- ❖ Identify and describe peer support activities helpful in supporting another person in recovery;
- ❖ Share their personal experience with peer support throughout their recovery;
- ❖ Practice a strengths based approach to learning about their fellow peers.

1:30 – 2:15 ***Teaching Session*: *Exploring Peer Support***

2:15 - 3:15 ***Defining the Role of the Peer Specialist***

3:15 – 3:30 ***BREAK***

3:30 – 4:30 ***Activity: Getting to Know Your Peers***

4:30 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 3: Introduction to WRAP: The Wellness

Recovery Action Plan

Session 3 Goals:

- ❖ Provide training participants with a small group experience where they can continue to develop trusting relationships, experience group process, and share their recovery story;
- ❖ Educate training participants about the key behavioral health recovery concepts of hope, personal responsibility, education, self-advocacy, and support (Copeland);
- ❖ Educate training participants about the development of a Wellness Recovery Action Plan (WRAP);
- ❖ Provide training participants with the experience of developing their own WRAP;
- ❖ Provide training participants with stress reduction/ relaxation exercises and peer listening experience.

Session 3 - Module 1: Key Recovery Concepts &

Developing a Wellness Toolbox

Objectives: By the conclusion of this training module

participants will be able to:

- ❖ Identify and explain the key recovery concepts of hope, personal responsibility, education, self-advocacy, and support (Copeland);
- ❖ Share personal information about how one or more of these concepts plays a role in their personal recovery;

- ❖ Understand and discuss the concept of the Wellness Toolbox;
- ❖ Develop their own personal Wellness Toolbox;
- ❖ Identify and experience at least 2 stress reduction techniques.

9:00 – 9:15 ***Check-in***

9:15- 9:30 **Brief Introduction to WRAP and its 7 Areas (slides 1-8)**

9:30 – 10:15 ***Teaching Session***: ***Key Recovery Concepts***

10:15 – 10:45 **Issues that need to be Addressed (Slides 22-26)**

10:45 -11:00 **BREAK**

11:00-11:45 **Teaching Session: Developing a Wellness Toolbox**

11:45 – 12:15 **Rela*xation and Stress Reduction Techniques***

12:15 – 12:30 ***General Process Session***

12:30 – 1:30 ***LUNCH***

Session 3 - Module 2: The Daily Maintenance Plan

& Identifying Triggers

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify and explain the *daily maintenance plan* and *identifying triggers* components of the Wellness Recovery Action Plan (Copeland);
- ❖ Share personal information in the development of these sections of their own WRAP;
- ❖ Explain the benefits of "peer listening" and identify the steps involved in a peer listening relationship.

1:30 – 2:30 ***Teaching Session***: ***The Daily Maintenance Plan***

2:30-3:00 ***Teaching Session***: ***Triggers (Slides 46-47)***

3:00 – 3:15 ***Break***

3:15-3:45 ***Teaching Session***: ***Triggers Action Plan (Slides 48-49)***

3:45 – 4:15 ***Peer Listening Experience***

4:15 – 4:45 ***Process the Peer Listening Experience: Large Group.***

4:45 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 4: Introduction to WRAP: The Wellness Recovery Action Plan

(continued)

Session Goals:

- ❖ Provide training participants with a small group experience where they can continue to develop trusting relationships, experience group process, and share their recovery story;
- ❖ Educate training participants about the development of a Wellness Recovery Action Plan (WRAP);
- ❖ Provide training participants with the experience of developing their own WRAP;
- ❖ Educate training participants about the development of the Crisis and Post Crisis Planning components of the Wellness Recovery Action Plan (WRAP);
- ❖ Provide training participants with the experience of beginning their own Crisis and Post Crisis Planning components of WRAP.

Session 4 - Module 1: Early Warning Signs and

When Things Are Breaking Down

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify and explain the early *warning signs* and *when things are breaking down* components of WRAP;
- ❖ Identify and explain the *crisis* and *post crisis* sections of the WRAP;
- ❖ Share personal information in the development of these sections of their own WRAP.

9:00 – 9:15 ***Check-in***

9:15 – 10:45 ***Teaching Session***: ***Early Warning Signs and Early Warning Signs Action Plan (Slides 50-53)***

10:45-11:00 **BREAK!**

11:00-12:30 ***When Things Are Breaking Down and When Things Are Breaking Down Action Plans (Slides 54-57)***

12:30 – 1:30 ***LUNCH***

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify and explain the key *crisis planning* and *post crisis planning* components of the Wellness Recovery Action Plan (Copeland);
- ❖ Share personal information in the development of their own WRAP Crisis Plan.

1:30-3:00 **Teaching Session Crisis Plan (58-74)**

3:00- 3:15 **BREAK!**

3:15-4:00 ***Teaching Session Post Crisis Planning (Slides 75-79)***

4:00-4:30 **Lifestyle Issues (Slides 82-96)**

4:30 - 4:45 ***Video Presentation – Large Group Discussion***

4:45 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

5: Communication Skills

Session 5 Goals:

- ❖ Continue to provide participants with a small group experience where they develop trusting relationships, experience group process, and share their recovery story;
- ❖ Review and relearn the core components of effective communication;
- ❖ Educate participants in *Active Listening*, including non-verbal or attending skills, and verbal or reflecting skills;
- ❖ Examine individual attitudes that may serve as barriers to effective communication;
- ❖ Practice communication skill building.

Session 5 - Module 1: Active Listening

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify and explain the core components of effective communication;
- ❖ Understand and discuss the process of active listening;
- ❖ List and discuss common barriers to effective communication.

9:00 – 9:15 ***Check-in***

9:15 – 9:30 ***Basic Model of Communication***

9:30 – 10:30 ***Active Listening Techniques***

10:30– 10:45 ***Barriers to Effective Communication***

10:45- 11:00 ***BREAK***

11:00 – 12:30 ***Skill Building Practice Session#1***

Non-Verbal/Attending Skills

12:30 – 1:30 ***LUNCH***

Session 5 - Module 2: Active Listening Skills Practice

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Demonstrate understanding of and ability to practice the major listening skill clusters in the process of active listening.

1:30 – 3:00 ***Skill Building Practice Session #2***

Verbal/Reflecting Skills

3:00 – 3:15 **Break**

3:15 – 4:00 ***Large Group Demonstrations and Feedback***

4:00-4:30 **Quiz on week one topics**

4:30 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 6: Managing Our Differences

Session 6 Goals:

- Introduce participants to the concept of cultural competence, broaden their understanding of what culture is, provide an opportunity to process the impact that certain aspects of culture have had on their lives;
- Increase participants understanding of the importance of cultural influences/factors on personal recovery.
- Continue to provide participants with a small group experience where they develop trusting relationships, experience group process, and share their recovery story;
- Educate participants about the stages of group development, roles within the group process, and develop group facilitation skills.

Session 6 - Module 1: Cultural Competence

Objectives: By the conclusion of this training module participants will be able to:

- Define and discuss the many different aspects of culture;
- Explore and discuss their own cultural heritage with group members;
- Identify at least 2 critical roles that culture plays in the recovery process;
- Identify and discuss a four step process for developing cultural competency;
- Identify at least one positive step that they can take to begin to increase their cultural competency.

9:00- 9:15 **Check In**

9:15-10:45 ***Teaching Session: Introduction to Cultural Competence***

- Ice Berg Exercise
- Cultural Heritage Exercise

10:45- 11:00 **BREAK**

11:00- 12:30 ***Teaching Session: Introduction to Cultural Competence***

- Continue with Cultural Heritage Exercise.

12:30-1:30 **LUNCH**

Session 6- Module 2: Group Facilitation Skills

Objectives: By the conclusion of this training module participants will be able to:

- Identify and discuss the stages of group development,
- Understand and identify the roles that group members have within the group process,
- Discuss effective group facilitation skills to handle difficult situations that may arise in the group.

1:30 – 2:30 **Teaching Session: *Group Facilitation Skills***

2:30 – 3:00 **Group Exercise: Part 1** (slides 19-20)

3:00 – 3:15 **BREAK**

3:15 – 3:45 **Group Exercise: Group B**

3:45 – 4:00 **Large Group Process of Exercise**

4:00 – 4:30 **Handling Difficult Situations** (slides 23-36)

4:30 – 5:00 **Wrap-up, Homework Assignment, and Check-out**

Session 7: Working With People Who

Appear Unmotivated

(Based on the Pat Deegan video series:

Beyond the Coke and Smoke Syndrome)

Session 7 Goals:

- Educate participants about differing perspectives on motivation, including drug induced apathy, moral judgments, learned helplessness, and stages of change;
- Educate participants about possible action steps to take to address issues brought up by each different perspective;
- Provide participants with additional resources for self-help strategies dealing with troubling symptoms;
- Provide participants with a small group experience where they continue to develop trusting relationships, experience group process, and share their recovery story

Session 7 - Module 1: Reframing the Question

of Motivation – Part 1

Objectives: By the conclusion of this training module participants will be able to:

- Discuss Pat Deegan's concept of the *coke and smoke syndrome*;
- Discuss reasons for looking at an individual's apparent "lack of motivation" from different perspectives;
- Identify and discuss the key principles of the following perspectives:
  - drug induced apathy,
  - moral judgments;
- Identify and discuss possible action steps to take to address each different perspective;
- Share personal experiences of their own recovery with group members.

9:00 – 9:30 ***Check-in***

9:30 – 10:00 ***Teaching Session*: *Video Tape Module 1***

10:00 – 11:00 ***Teaching Session: Video Tape Module 2***

11:00 – 11:15 ***BREAK***

11:15 – 12:30 ***Teaching Session: Video Tape Module 4***

12:30 – 1:30 ***LUNCH***

Session 7 -Module 2: Reframing the Question of Motivation – Part 2

Objectives: By the conclusion of this training module participants will be able to:

- Discuss reasons for looking at an individual's apparent "lack of motivation" from different perspectives;
- Identify and discuss the key principles of the following perspectives:

- learned helplessness,
- stages of change;

- ❖ Identify and discuss possible action steps to take to address each different perspective;
- ❖ Share personal experiences of their own recovery with group members.

1:30 – 2:30 ***Teaching Session: Video Tape Module 6***

2:30 – 3:30 ***Teaching Session: Video Tape Module 7***

3:30 – 3:45 ***BREAK***

3:45 – 4:00 ***Individual Work: Motivation Exercise***

4:00 – 4:30 ***Small Group Work***

4:30 – 4:45 ***Large Group Process***

4:45 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 8: Engagement Strategies & Problem Solving

Session 8 Goals:

- ❖ Continue to provide participants with a small group experience where they develop trusting relationships, experience group process, and share their recovery story;
- ❖ Educate participants about the cycle of engagement in relationship development;
- ❖ Educate participants about Peer Support interventions related to the stages identified in the Recovery Process Model;
- ❖ Role play engagement strategies as Peer Specialists;
- ❖ Educate participants in effective problem solving strategies;

Session 8 - Module 1: The Cycle of Engagement

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Understand and discuss the cycle of engagement including, outreach, engagement, relationship, and empowerment;
- ❖ Identify and discuss the key ingredients of engagement, empathy, listening, affirmation, encouragement, and acceptance;
- ❖ Identify and discuss peer support interventions related to the recovery Process Model.

9:00 – 9:15 ***Check-in***

9:15 – 9:45 ***Teaching Session: The Cycle of Engagement***

9:45 – 10:15 ***Teaching Session: Recovery Process with CPS Interventions***

10:15 – 10:45 ***Engagement Role Plays***

10:45 – 11:00 ***BREAK***

11:00 – 12:00 ***Engagement Role Plays (continued)***

12:00 – 12:30 ***Large Group Process of Engagement Strategy Session***

12:30 – 1:30 ***LUNCH***

Session 8 - Module 2: Problem Solving

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify the negative consequences to which ineffective problem solving can lead;
- ❖ Identify common pitfalls of effective problem solving;
- ❖ Identify and discuss the signal value of distress;
- ❖ Discuss and demonstrate effective problem solving strategies;
- ❖ Lead a one-on-one peer discussion teaching the problem solving method.

1:30– 2:30 ***Teaching Session***: ***Introduction to Problem Solving***

2:30-3:00 ***Group Process in Problem Solving***

3:00- 3:15 ***BREAK***

3:15- 4:30 ***Small Group Work in Pairs***

4:30-4:45 ***Large Group Process of Exercise***

4:45- 5:00 **Wrap-up, Homework Assignment and Check Out Session Evaluations!**

Session 9: Intro to Co-occurring Disorders & Workplace Issues and Boundaries

Session 9 Goals:

- ❖ Provide training participants with a small group experience where they continue to develop trusting relationships, experience group process, and share their recovery story;
- ❖ Understand the definition and role of co-occurring disorders in our community
- ❖ Discuss the relationship between addiction and mental illness and effective approaches for the peer specialist
- ❖ Educate participants about the development of professional ethics and the concept of dual relationships in the context of providing peer support services;
- ❖ Review developments in the behavioral healthcare environment that have led to changes in traditional medical model boundary delineations;
- ❖ Teach participants sound principles of ethical decision-making and explore boundary dilemmas that may be encountered in their work.

Session 9 – Module 1: Introduction to Co-occurring Disorders

Objectives: By the conclusion of this training module

participants will be able to:

- ❖ Discuss the prevalence of co-occurring disorders;
- ❖ Identify the historical obstacles to receiving effective treatment for co-occurring disorders;
- ❖ Identify and discuss the commonalities between addictions and mental illness;
- ❖ Identify and discuss the benefits of integrated treatment;
- ❖ Understand and describe the relationship between the stages of change and the stages of treatment;

- ❖ Identify helpful peer support interventions appropriate to stages of change.

9:00 – 9:15 ***Check-in***

9:15- 10:45 ***Teaching Presentation: Introduction to Co-occurring Disorders***

10:45-11:00 ***BREAK***

11:00-11:30 ***Teaching Session: Motivational Approaches***

11:30 – 12:30 ***Group Work: Case Studies***

12:30 -1:30 **LUNCH**

Session 9 - Module 2: Boundary Issues in Peer Support

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Understand the development of professional ethics;
- ❖ Understand and discuss the concept of dual relationships in the context of providing peer support services;
- ❖ Identify and discuss recent developments in the behavioral healthcare environment that have led to changes in traditional medical model boundary delineations;
- ❖ Understand and practice sound principles of ethical decision making in their roles as Certified Peer Specialists;
- ❖ Explore and resolve a number of potential boundary dilemmas they may encounter in their peer support relationships.

1:30-3:00 ***Teaching Session: Identifying Boundaries in Peer Support***

3:00- 3:15 ***BREAK***

3:15- ***3:45 – Ethical Decision Making Boundary Scenarios*** (slide 39)

Small Group Work

3:45-4:15 – ***Ethical Decision Making Boundary Scenarios*** (slide 39)

Large Group Discussion

4:15- 4:45 – ***Clear Boundary Violations*** (slides 40-46)

4:45 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 10: Work place Issues and Boundaries (continued)

Session 10 Goals:

- ❖ Provide training participants with a small group experience where they continue to develop trusting relationships, experience group process, and share their recovery story;
- ❖ Explore ambivalences about eminent work experiences;
- ❖ Facilitate group process in the development of a workplace WRAP;
- ❖ Review common workplace standard operating procedures.

Session 10 - Module 1: Workplace Practices

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Verbalize anxieties and fears related to approaching employment experience;
- ❖ Verbalize strengths they believe they bring to their new position;
- ❖ Develop a workplace WRAP to help deal with workplace stressors.
- ❖ Understand and discuss standard workplace operating procedures, including calling out sick, supervision, handling conflicts, complying with agency policies and procedures.

9:00- 9:30	**Check In**
9:30- 11:00	***Teaching Session***: ***Workplace Practices***
11:00-11:15	**BREAK!**
11:15 – 12:30	***Teaching Session***: ***Workplace Practices (Continued)***
12:30 – 1:30	**Lunch**
1:30 – 2:15	**Course Review**
2:15 – 3:00	**Proficiency Test**
3:00 – 5:00	**Celebration and Check Out**

Certified Peer Specialist Curriculum

Resources

(References bolded are included in the CPS Instructor Manual)

Session One

Anthony, William (1993). Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990's. Psychosocial Rehabilitation Journal, 16 (4), 11-23.

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Mead, S. & Copeland, M. E. (2000). What Recovery Means to Us: Consumers' Perspectives. Community Mental Health Journal, 36 (3), 315-328 (www.mentalhealthrecovery.com).

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Copeland, Mary Ellen. What Do We Want From Others When We Are Having a Hard Time? www.mentalhealthrecovery.com.

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Mead, Shery (2003). Defining Peer Support. www.mentalhealthpeers.com.

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Session Three

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Copeland, M.E. (2001). Winning Against Relapse: A Workbook of Action Plans for Recurring Health and Emotional Problems. Peach Press: West Dummerston, Vermont.

Copeland, M.E. (1996). Mental Health Recovery Education Curriculum: Facilitators Training Manual. Peach Press: West Dummerston, Vermont

Session Four

Copeland, M.E. (1997). Wellness Recovery Action Plan, Peach Press: West Dummerston, Vermont.

Copeland, M.E. & Mead, S. (2004). Wellness Recovery Action Plan & Peer Support: Personal, Group, and Program Development. Peach Press: West Dummerston, Vermont.

Copeland, M.E. (2001). Winning Against Relapse: A Workbook of Action Plans for Recurring Health and Emotional Problems. Peach Press: West Dummerston, Vermont.

Copeland, M.E. (1996). Mental Health Recovery Education Curriculum: Facilitators Training Manual. Peach Press: West Dummerston, Vermont.

Session Five

Bolton, R. (1979). People Skills: How to Assert Yourself, Listen to Others, and Resolve Conflicts. Simon & Schuster: New York, N.Y.

McKay, m., Davis, M., & Fanning, P. (1983). Messages: The Communication Skills Book: How to Improve Your Relationships and Personal Effectiveness by Mastering These Essential Skills. New Harbinger Publications: Oakland, California.

Session Six

Deegan P. Beyond the Coke and Smoke Syndrome: Working With People Who Appear Unmotivated – excerpts from the Training Guide.

Session Seven N/A

Session Eight

Elias, D., and David, P. (1983). A Guide to Problem Solving. The 1983 Annual for Facilitators, Trainers, and Consultants.

Session Nine

Brunette, M., and Drake, R. (Eds.). Integrated Dual Disorders Treatment Implementation Resource Kit. U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2004, www.samhsa.gov).

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Session Ten N/A

Appendix J

Mental Health Association of Southeastern Pennsylvania
Institute for Recovery and Community Re-integration

Certified Peer Specialist Supervisors' Orientation Training

Overview: This two day session is designed to equip managers and supervisors with the knowledge and skills to operate a peer specialist service as well as support Peer Support Specialists in the workplace. Through shared experiences which include individual and group activities, participants will learn theoretical, historical, and practical aspects of recovery and community integration as they pertain to peer support services. This training also includes a review of Performance Management concepts and skills which incorporates Blanchard's Situational Leadership Model.

Day One: Recovery and Peer Support

Learning Objectives:

 Be able to readily discuss the principles of recovery, peer support and the role of the Certified Peer Specialists.

 Delineate the necessary steps for successfully implementing a peer support initiative within their agencies and program teams.

 Become familiar with the state Medicaid requirements for Peer Support

Services.

Day Two: Performance Management and Peer Support Specialists

Learning Objectives:

 Describe the process of Performance Management, its sub-component parts, and its relationship to Peer Support Specialists.

 Learn how to utilize their agency's performance management system to supervise peer specialists.

 Review ADA guidelines and OMHSAS' Clarification of Act 169 as it pertains to Peer Support Specialists.

THIS PROGRAM IS APPROVED BY THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (PROVIDER #: 886566365-9635) FOR 13.5 SOCIAL WORK CONTINUING EDUCATION CONTACT HOURS.

Appendix G Einstein/Germantown Crisis Response Center Evaluation Form

Please tell us how you feel about this visit…

Please answer the following questions about your experience here at the Crisis Response Center.

Name_____(optional) Date of Visit_____ Time of Visit_____

Strongly Disagree Disagree Neutral Agree Strongly Agree

I felt that the staff cared about me.

The nursing staff treated me with courtesy and respect.

I felt safe at the Crisis Center.

I felt empowered to make choices.

I felt included in forming my treatment goals.

I felt supported in identifying my strengths.

I feel like people listened to my issue.

I understood the plan of treatment.

I believe the plan will help me reach my goals.

I believe that my decisions have an impact on my Recovery.

I feel hopeful about my Recovery.

I feel my personal values and beliefs were honored.

I learned something about myself or my illness.

I was satisfied with the outcome of the visit.

Comments:



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W.L., Campbell, M.D., Spencer; R.A., Hoffman, H.A., Crissman, B. & DuPont, R.L. (2014) Participation in Narcotics Anonymous and Alcoholics Anonymous and abstinence outcomes of 322 methadone maintenance patients. *Journal of Groups in Addiction and Recovery*, 9(1), 14-30. Posted at **www.williamwhitepapers.com**

Participation in Narcotics Anonymous and Alcoholics Anonymous and Abstinence Outcomes of 322 Methadone Maintenance Patients

William L. White, MA; Michael D. Campbell, PhD; Robert A. Spencer; Howard A. Hoffman, MD; Brian Crissman; & Robert L. DuPont, MD

Abstract

In a survey of 322 patients enrolled in methadone maintenance treatment (MMT) in a Northeastern United States urban community, more than one-third (36.3%) of patients reported being 100% abstinent from alcohol and illicit drug use in the past year. Continuous abstinence was associated with a longer duration of MMT treatment, but there was no significant association between abstinence and past-year 12-Step meeting attendance or other 12-Step-related activities. Surveyed patients reported high rates of past-year 12-Step meeting attendance (66%) and high rates of perceived helpfulness of 12-Step programs (more than 70%), but lower levels of involvement in key 12-Step program ingredients.

Keywords: Methadone maintenance treatment, Alcoholics Anonymous, Narcotics Anonymous, Methadone Anonymous, medication-assisted treatment, medication-assisted recovery, recovery mutual aid

Introduction

The pioneers of methadone maintenance treatment (MMT) shared a deep interest in the potential role of recovery mutual aid in long-term addiction recovery. Dr. Vincent Dole served as a nonalcoholic Trustee of Alcoholics Anonymous (AA; Dole, 1991), and Dr. Marie Nyswander served on the Board of Directors of the National Advisory Council on Narcotics—the organization that oversaw the early development of Narcotics Anonymous (NA) in New York City (White, Budnick, & Pickard, 2011). In spite of these early connections, participation in recovery mutual aid groups was not integrated into MMT as it was in other addiction treatment modalities in the United States (White, 1998). There is a rapidly growing body of research on the role participation in addiction recovery mutual aid groups can play in long-term addiction recovery outcomes

(Humphreys, 2006; Kaskutas, 2009; Kelly & Yeterian, 2008, 2012; Moos, & Moos, 2006), but few studies exist on the level and effects of such participation for methadone maintenance patients.

In an earlier study (White et al., in press), the authors surveyed the level of recovery mutual aid group participation of 332 patients enrolled in MMT in an urban community in the Northeastern United States. We found high rates of past year NA/AA participation (66%) and self-reported helpfulness of AA and NA (72% and 77% respectively), but considerably lower rates of participation in key 12-Step program ingredients: having a home group (50%), having a sponsor (26%), sponsoring others (13%), attending 12-step social events (23%), and active step work (21%). The present study extends these findings by evaluating the effects of participation in 12-Step meetings on rates of self-reported abstinence from illicit drugs and alcohol among the same 332 MMT patients.

Although MMT patients sometimes occupy a marginal status in 12-Step groups and may face restrictions on their degree of participation due to their daily consumption of prescribed methadone (White, 2011), we hypothesized that: 1) MMT patients with higher rates of mutual aid participation would have higher rates of self-reported abstinence than MMT patients with minimal or no mutual aid participation, and 2) key ingredients of 12-Step participation (e.g., sponsorship, step work, service work) would be more predictive of self-reported abstinence than would 12-Step meeting attendance.

Previous studies on the characteristics of MMT patients and the nature of MMT treatment and post-treatment responses inform the present study. Alcohol and multiple illicit drug use has been reported as the norm among opioid-addicted patients admitted to MMT (Backmund et al., 2005; Dobler-Mikola et al., 2005; Rittmannsberger, Silberbauer, Lehner, & Ruschak, 2000; Srivastava, Kahan, & Ross, 2008). Continued use of illicit drugs (e.g., heroin, non-prescribed methadone, cocaine, benzodiazepines, cannabis) and alcohol during treatment poses a major clinical challenge to substance-specific pharmacotherapies such as MMT (Best et al., 2000). Continued drug use remains a significant cause of MMT termination (Davstad et al., 2007; Magura & Rosenblum, 2001). Understood clinically, continued drug use has multiple roots: withdrawal distress (often linked to subtherapeutic doses of methadone), dysphoric emotional states, pleasure-seeking, and impulsive responses to social opportunities to use (Best et al., 2000).

In addition to the common profile of multiple drug use, MMT patients often present with a broad spectrum of medical, psychiatric, family, legal, economic, and social impairments in addition to multiple drug use that inhibit substance use disorder remission, impede the achievement of broader levels of global health, and increase mortality risks (Musselman & Kell, 1995; Puigdollers et al., 2004). These problems collectively impede the achievement of sustained abstinence and contribute to the high mortality rates associated with opioid addiction (Scott, Dennis, Laudet, Funk, & Simeone, 2011). Given this dominant MMT patient profile, recovery mutual aid groups that define recovery as requiring abstinence from alcohol and all illicit drugs, as well as achieving broader levels of physical, emotional, relational, and spiritual health, and offering a program of support to achieve these goals could be useful for MMT patients. Positive outcomes in MMT have been linked to a number of key factors, including optimum medication dosages (Faggiono, Vigna-Tagliantiu, Versino, & Lemma, 2003); duration of treatment participation (Greenfield & Fountain, 2000; Simpson, Brown & Joe, 1997); number and duration of counseling sessions (Simpson, Joe, Rowan-Szal, & Greener, 1995, 1997), positive attitudes of staff towards medication maintenance (Caplehorn, Lumley & Irwig, 1998); access to ancillary medical, psychiatric, and social services (Friedmann, Zhang, Hendrickson, Stein, & Gerstein, 2003; McLellan et al., 1998), and post-treatment monitoring and early re-intervention (Zanis, McLellan, Alterman, & Cnaan, 1996). The role of recovery mutual aid participation in enhancing MMT outcomes remains a subject of needed investigation.

Although MMT was originally conceived as a lifelong process of medication support (Dole & Nyswander, 1967; Jaffe, 1972; Joseph, Stancliff, & Langrod, 2000), the majority of MMT patients hope and expect to end MMT in the future (Langrod, Des Jarlais, Alksne, & Lowinson, 1983; Stancliff, Myers, Steiner, & Drucker, 2002). Most patients will terminate MMT treatment within a year of admission (Deck & Carlson, 2005) and will not be provided assertive ongoing monitoring, support, and early re-intervention following their discharge from MMT (White & Torres, 2010). Most importantly to the current study, the majority of discharged MMT patients will return to heroin or other illicit opioid use, often soon after leaving MMT (Davoli et al., 2007; Gossop, Green, Phillips, & Bradley, 1989; Joseph et al., 2000; Magura & Rosenblum, 2001), and will be at increased risk for infectious disease and death—including overdose deaths—following termination of MMT (Clausen, Ancherson, & Waal, 2008). These findings suggest the potential for enhancing post-MMT-treatment outcomes through in-treatment and post-treatment participation in recovery mutual aid groups.

Abstinence rates in MMT have been generally measured by a combination of self-report and drug testing, with a high concurrence between the two in research settings (Grella, Anglin, & Wugalter, 1997), but lower self-report reliability in clinical settings where patients may experience negative consequences for admitted drug use, e.g., loss of medication take-home privileges (Chermack et al., 2000). Comparison of rates across programs is difficult due to variability in clinical populations and differences in frequency and methods of drug testing.

Monitoring in-treatment abstinence rates—abstinence here defined as no use of alcohol and non-prescribed drugs—serves three clinically important functions. First, abstinence rates in the first two weeks of MMT is predictive of subsequent positive responses to treatment, whereas continued drug use during early MMT is indicative of difficulties in engagement, retention, and post-treatment prognosis (Chatham, Rowan-Szal, Joe, & Simpson, 1997; Morral, Belding, & Iguchi, 1999). Identifying those patients at high risk for poor outcomes can help focus clinical resources on those patients in greatest need of more intense service interventions (Rowan-Szal, Chatham, & Simpson, 2000). Second, when continued drug use is identified, specialized clinical interventions can be employed that have been shown to reduce rates of drug use during MMT (Gerra et al., 2011; Magura, Rosenblum, Fong, Villano, & Richman, 2002; Petry & Martin, 2002). Third, aggregate patient abstinence rates provide a benchmark for evaluating overall program-level recovery outcomes and the strength of the culture of recovery within a particular MMT milieu (White & Torres, 2010). In the present study, self-reported past year continuous abstinence rates and aggregate drug test results will be used to answer three questions:

1. What is the rate of sustained abstinence achieved by MMT patients in a non-research service setting?
2. Does participation in NA, AA, or other recovery mutual aid groups affect abstinence outcomes among MMT patients?
3. Does participation in key ingredients of recovery mutual aid programs other than meeting attendance affect abstinence outcomes?
4.

We hypothesize that abstinence rates will rise in tandem with increases in recovery mutual aid meeting attendance and participation in other key ingredients of recovery mutual aid involvement.

Methodology

Setting. This study was conducted at Partners in Drug Abuse Rehabilitation Counseling (PIDARC), a private, nonprofit addiction treatment center located in Washington, DC whose services include MMT. Each patient is assigned to one of 28 primary counseling groups, which he or she is required to attend at least twice a month. Each one-hour primary counseling group

focuses on problem solving and lifestyle reconstruction and is co-led by two of PIDARC's 14 addiction counselors. The center also offers a variety of treatment enhancements for its more than 650 MMT patients, including specialized gender-specific groups, groups for patients continuing to struggle with co-occurring alcohol or cocaine dependence, and a daily harm reduction group. Take-home medication privileges are awarded for timely and consistent attendance and negative drug test results. Random drug tests are collected at PIDARC by two trained urine technicians and evaluated by an independent laboratory with confirmatory evaluation of all positive tests. On-site drug testing at PIDARC is conducted for patients receiving take-home medication and for any patient suspected of being intoxicated. All on-site tests are sent for independent laboratory confirmation. Frequency of drug testing is determined by insurance provisions, with frequency ranging from weekly to monthly. Twelve-Step meetings such as Narcotics Anonymous or Alcoholics Anonymous are not held at this treatment center but are available in the community, and participation is encouraged. The patient population is gender mixed (60% male; 40% female) and age diversified (8.7% 20-39; 5.3% 30-39; 20.7% 40-49; 51.3% 50-59; 18.6% 60-69; 0.8% 70-79), with a wide span of time in MMT (27% less than one year; 29.7% 1-3 years; 19.6% 3-5 years; 23.7% 5 or more years). The majority of PIDARC patients are poor, African American, and aging (85% over the age of 45), with prolonged past histories in the criminal justice system.

Data Collection. 322 participants enrolled in methadone maintenance treatment completed an anonymous survey November 7-11, 2011 (See White et al., in press for complete description of the survey methodology). Of the 53 questions on the survey, 29 specifically focused on participation in 12-Step (AA/NA) groups. The survey also asked questions related to the frequency and pattern of drug use, with abstinence defined as no use of alcohol or illicit drugs. The survey was conducted by clinical staff at the treatment site as part of a larger effort to evaluate and enhance clinical protocol. Data were then sent for analysis to a group of independent consultants (White, Campbell, Spencer, & DuPont) who volunteered to assist with data analysis.

Analysis. Aggregate reports of abstinence from the survey (322 patients) were compared to aggregate drug test results for all patients with drug test data (663 of 674 patients) served during the 90 days preceding survey administration (August 1-November 1, 2011). The drug test data contained the total number of positive tests, the number of positive tests for each specific substance in the drug test panel, and the number of negative tests. The drug test panel included amphetamines, benzodiazepines, cocaine, opioids, PCP, and THC. Data from the survey and drug tests were analyzed using SPSS for Windows version 15. No patient names or other personally identifying information were linked to the survey or drug test data.

Results

Self-reported Abstinence Rates for Surveyed Patients. Of the 322 MMT patients surveyed, 270 self-reported their level of abstinence in the previous year. More than one-third (36.3%) of these patients reported being 100% abstinent from alcohol and illicit drugs during the year prior to the survey. There were no significant age or gender differences when the abstinent and non-abstinent groups were compared, but the former were more likely to have been in MMT longer: mean of 41 months for those 100% abstinent and 27 months for those less than 100% abstinent ($t = 2.63$, $df=213$, $p<.01$).

Comparison with Drug Test Results for All Clinic Patients. Analysis of drug tests taken by 663 patients during the 90 days prior to the survey (mean of 4.3 tests per patient) revealed negative drug tests for all illicit drugs by 443 (67%) of the patients. Of the 220 testing positive, 18% tested positive for opioids only, 26% were positive for opioids and other drugs, and 56% were positive for drugs other than opioids (in order of frequency: cocaine, cannabis, benzodiazepines, phencyclidine, and amphetamine). There were no significant gender

differences in test results. Older adults were less likely to have positive tests and younger patients were more likely to be positive for multiple drugs. Those in MMT less than one year were more likely to have positive tests for illicit drugs (51%) and have more substances detected (mean of 2.42 substances over 3 months) than patients in MMT for a year or more (27% positive for illicit drugs with a mean of 1.04 substances over 3 months).

12-Step Meeting Attendance and Abstinence Outcomes. Comparison of self-reported abstinence and 12-Step meeting attendance within the sample was made by two groupings—No NA/AA exposure and NA/AA meeting exposure—with a further analysis using four styles of participation: Neither NA nor AA attendance (34.2%), Only AA (5.0%), Only NA (31.7%), and Both NA and AA (29.2%). There was no consistent relationship between time in MMT and likelihood of attending AA or NA meetings. As the data in Table 1 indicate, about the same percentage of patients in NA/AA (35%) as patients not in NA/AA (38%) reported being 100% abstinent over the past year. Lowering the cut-point for abstinence to 90% or more did not produce differences between the two groups. The number of NA/AA meetings attended in the past year also was not significantly related to self-report of 100% abstinence. About the same percentage of patients in NA/AA (35%) as patients not in NA/AA (38%) report being 100% abstinent over the past year (Chi-square=0.18, df=1, p=.690).

Influence of Other NA/AA Program Ingredients on Self-reported Abstinence. Table 1 shows the percentage of clients in each abstinence-level group who said they participated in each activity. No single activity was associated with a greater level of abstinence.

Table 1: Percentage of Patients Participating in Various Aspects of NA/AA 12-Step Programs by Reported Level of Past Year Abstinence

	Abstinence Group				
Area of Participation	**0 – 50% (n = 61)**	**51 – 99% (n = 54)**	**100% (n = 63)**	**Total (n = 178)**	***p* Value ***
Home Group	41%	46%	37%	41%	.562
Service Work at Meetings	34%	32%	37%	34%	.849
Have a Sponsor	30%	28%	27%	28%	.876
Weekly Contact with Sponsor	20%	22%	22%	21%	.925
Sponsor Others	12%	9%	14%	12%	.699
Weekly Contact with Sponsees	8%	9%	16%	11%	.344
Speak at Meetings	38%	41%	38%	42%	.937
Socialize Before/After Meetings	36%	52%	40%	41%	.205
Attend 12-Step Social Events	16%	28%	25%	23%	.301
Active Step Work	25%	15%	25%	22%	.318
Help other Addicts	18%	24%	24%	22%	.665

Involved in NA/AA Service Work	18%	13%	21%	17%	.545
Encourage Family to Participate	25%	33%	25%	28%	.517

*Level of significance (2-sided) from Pearson chi-square statistic

Discussion

The authors surveyed 322 patients to test the relationship between continuous abstinence and 12-Step participation within the context of MMT. Of the 270 patients who reported abstinence status in the past year, 36.3% self-reported continuous past-year abstinence from alcohol and illicit drugs. This self-report rate was lower than the 67% of all patients at this site whose drug tests were negative for all drugs in the 90 days preceding the survey. Such differences could be related to the longer window of time for self-reported abstinence (one year versus past 90 days for the drug testing), inclusion of alcohol in the definition of abstinence (no tests for recent alcohol use were included in the drug test data), and the potential for drug use that was not detected via the random testing schedule. Comparing abstinence rates across studies is complicated by varying definitions of abstinence in available surveys and by different drug testing procedures and reporting periods. While MMT outcomes are often reported in terms of reduced frequency of drug use and related behaviors, patient self-report data and drug testing data from this survey site confirm that a significant portion of MMT patients are achieving continuous abstinence from illicit drug use and alcohol within the context of MMT.

There were no significant associations between age or gender and self-reported abstinence status, but patients who self-reported continuous abstinence were more likely to have been in treatment longer, suggesting a potential link between abstinence outcomes and duration of MMT—a finding that has been confirmed in other studies (Gossop, Marsden, Stewart, & Treacy, 2002). Negative drug test results were associated with older age and longer time in treatment, suggesting both maturational effects and cumulative treatment effects.

Two hypotheses were tested related to the effects of 12-Step participation and continuous past-year abstinence. First, the authors hypothesized that those MMT patients who self-reported participation in 12-Step meetings would have higher rates of self-reported continuous abstinence in the year prior to the survey than those who did not self-report participation in such meetings. This predicted finding was based on earlier studies confirming that participation in 12-Step meetings enhanced abstinence outcomes in patients treated for alcohol and drug dependence (For review, see Kelly & Yeterian, 2008) as well as studies finding that combinations of professional treatment and participation in mutual aid groups produce recovery outcomes greater than either activity in isolation (Dawson, Grant, Stinson, & Chou, 2006; Fiorentine & Hillhouse, 2000). Contrary to our predicted outcome, study findings revealed that past-year continuous abstinence was related to longer duration of time in MMT treatment, but was not related to 12-Step meeting attendance.

The reasons for absence of abstinence effects from 12-Step meeting participation among this group of MMT patients are unclear. Potential explanations of this finding include the potential lack of potency of 12-Step group participation for MMT patients. This interpretation is challenged by the high rates of reported voluntary past-year participation in 12-Step groups (66%) and the high reported rates of helpfulness by those who do participate (77% for NA, 72% for AA). It is possible that these MMT patients received many benefits from participation in 12-Step meetings (e.g., social support, enhanced emotional health, enhanced life purpose and meaning), but that the primary influence on their abstinence status comes from professional treatment or sources other than 12-Step meetings. The lack of abstinence effects may also have been influenced by the lack of integration of 12-Step concepts and practices into this treatment program and the

lack of assertive 12-Step group linkage procedures. In spite of such integration and linkage procedures, rates of patient participation in these groups and their reported helpfulness were quite high.

In light of increased studies confirming that a significant proportion of 12-Step group members decrease or stop meeting participation but sustain abstinence and other recovery-related activities (Kaskutas et al., 2005; Tonigan, 2005; Tonigan et al., 2002; Weiss et al., 2005), it is also possible that MMT patients who once attended but did not attend NA or AA in the past year could be hidden within the non-NA/AA involved group—resulting in an underreporting of NA/AA effects on abstinence. In fact, 27.3% of survey participants who were not active in NA/AA in the past year had previously attended one or both of these 12-Step programs. Transitions from compulsive opioid use to occasional use to abstinence following help-seeking have also been documented in earlier studies (Gossop et al., 1989). It is possible that a measure of 100% past year abstinence may fail to capture such progressive changes within the recovery process.

Second, we hypothesized that self-reported participation in key ingredients of 12-Step programs (e.g., sponsorship, step work, service work) would be more predictive of past year continuous abstinence than would self-reported meeting attendance alone. Other studies have confirmed that such ingredients as step work, reading 12-Step literature, socializing with others in recovery, applying recovery principles to daily problem-solving, having a sponsor, and sponsoring others may be more potent in influencing abstinence outcomes than the factor of meeting attendance (Crape, Latkin, Laris, & Knowlton, 2002; Humphreys, Moos, & Cohen, 1997; Montgomery, Miller, & Tonigan, 1995; Pagano, Friend, Tonigan, & Stout, 2004; Sheeren, 1988; Weiss et al., 2005; Zemore, Kaskutas, & Ammon, 2004). For example, a study of 487 cocaine dependent outpatients found no relationship between 12-Step meeting attendance and subsequent drug use outcomes, but did find a relationship between subsequent drug use outcomes and these core 12-Step activities (e.g., reading program literature, calling a sponsor) beyond meeting attendance (Weiss et al., 2005).

Again unexpectedly, the present survey data reveal no significant association between such key 12-Step activities beyond meeting attendance and self-reports of past year continuous abstinence among our sample of MMT patients. The absence of such effects is difficult to explain in light of research on these factors with patients in other addiction treatment modalities. The picture emerging from this survey is that the sampled MMT patients have a high rate of past year exposure to 12-Step meetings, but they have much lower rates of participation in key 12-Step program ingredients. One possibility is that the marginalized status MMT patients occupy in some 12-Step groups (e.g., denial of right to speak, claim “clean time,” celebrate recovery anniversaries, sponsor new members, hold service roles; White, 2011) inhibits full participation in NA and AA and prevents many MMT patients of reaping the benefits of such participation. Such marginalized status is confirmed in part by our earlier finding that one-quarter (25%) of NA/AA-involved patients in this sample reported a negative experience within NA or AA related to their MMT status (e.g., negative comments about methadone, pressure to reduce methadone dose or stop MMT, denied right to speak at or chair a meeting). Further indicative is the fact that only 34% of the NA/AA-involved patients disclosed their MMT status to their sponsors and at meetings (White et al., in press).

It should not be concluded from this study that NA and AA participation failed to exert an influence on abstinence outcomes in MMT patients. This study revealed that MMT patients achieve abstinence both with and without recovery mutual aid involvement and that the proportion of NA/AA-involved MMT patients who self-reported 100% abstinence in the past year was not different than the proportion of non-NA/AA-involved patients who self-reported 100% past year abstinence. The support mechanisms used to sustain abstinence in the latter group were not identified in the survey and remain unknown.

Further research is needed on the degree and effects of MMT patient participation in 12-Step meetings and other aspects of 12-Step programs. There are also growing varieties of

secular, spiritual, and religious alternatives to 12-Step programs (Humphreys, 2004; White, 2009; White & Kurtz, 2006), including recovery support structures designed specifically for MMT patients (e.g., Methadone Anonymous, Medication-Assisted Recovery Support; Gilman, Galanter, & Dermatis, 2001; Ginter, 2012; McGonagle, 1994). Future research should compare the differences in abstinence outcomes of MMT patients across these various recovery support groups in comparison to no mutual aid participation. Future MMT patient surveys should also collect information on their perceptions of 12-Step and other community support and the influence of such participation on their alcohol and other drug use and on rates of continuous abstinence. More also needs to be known about how continually abstinent MMT patients who are not involved in formal recovery mutual aid groups are sustaining their abstinence. It is possible, for example, that long-term involvement in the primary counseling group at this MMT clinic has taken over functions usually associated with recovery mutual aid groups. It is also possible, as suggested by PIDARC clinical staff, that many non-NA/AA-involved African American patients in this sample are utilizing culturally indigenous recovery support structures (recovery-supportive relationships within their families, extended families, and kinship networks; abstinence-based cultural and religious revitalization movements; church-based recovery ministries; patient peer support rituals [e.g., meeting informally for breakfast each morning], and external monitoring and support resources related to work or supervision by criminal justice or child welfare authorities) as an alternative to 12-Step groups to sustain their abstinence (Achara-Abrahams et al., 2012; Evans, Achara, Lamb, & White, 2012; Sanders & Powell, 2012; White & Sanders, 2008). Much more knowledge is needed about MMT patients involved with 12-Step groups and the alternative support mechanisms that are helping MMT patients sustain long-term recovery without 12-Step involvement.

This study has numerous limitations. While we were able to compare aggregate data on self-reported abstinence and aggregate negative drug tests, we were not, because of the anonymous nature of the survey, able to match self-report to drug test results for particular patients. The self-reported rate of abstinence could be lower than reported, and the rate of negative drug tests may inflate assumed abstinence levels due to drug use not detected within the random testing schedule. Similarly, the rate of reported involvement in NA/AA could be lower than that reported due to staff encouragement and expectation for such participation. There may also be distinct characteristics of the clinical population at this study site (e.g., predominance of older African American patients) that limit transfer of findings to other clinical populations.

Comparison of these findings to other studies is also severely limited due to such factors as the widely varying definitions of abstinence in MMT outcome studies, the dearth of research on NA (Toumbourou, Hamilton, U'Ren, Stevens-Jones, & Storey, 2002), and the paucity of research on the level and effects of recovery mutual aid participation on opioid-addicted patients involved in MMT and other treatment modalities.

In spite of these limitations, the present study confirms the existence of NA/AA-involved and NA/AA non-involved MMT patients who are continually abstinent from alcohol and illicit drugs; confirms a high rate of MMT patient participation in, and self-reported helpfulness of, 12-Step recovery support groups; raises important questions about the potential effects of MMT patient marginalization within 12-Step groups on abstinence outcomes; and suggests the potential existence of alternative, culturally indigenous recovery support structures that may help MMT patients maintain continuous abstinence. It is the authors' hope that these preliminary findings will mark the beginning of long-overdue studies on the potential role of recovery mutual aid groups, culturally indigenous recovery supports, other peer-based recovery support services, and professionally directed treatment groups in elevating in-treatment and post-treatment recovery outcomes for MMT patients.

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Participation in Narcotics Anonymous and Alcoholics Anonymous and Abstinence Outcomes of 322 Methadone Maintenance Patients

William L. White, MA; Michael D. Campbell, PhD; Robert A. Spencer; Howard A. Hoffman, MD; Brian Crissman; & Robert L. DuPont, MD

Abstract

In a survey of 322 patients enrolled in methadone maintenance treatment (MMT) in a Northeastern United States urban community, more than one-third (36.3%) of patients reported being 100% abstinent from alcohol and illicit drug use in the past year. Continuous abstinence was associated with a longer duration of MMT treatment, but there was no significant association between abstinence and past-year 12-Step meeting attendance or other 12-Step-related activities. Surveyed patients reported high rates of past-year 12-Step meeting attendance (66%) and high rates of perceived helpfulness of 12-Step programs (more than 70%), but lower levels of involvement in key 12-Step program ingredients.

Keywords: Methadone maintenance treatment, Alcoholics Anonymous, Narcotics Anonymous, Methadone Anonymous, medication-assisted treatment, medication-assisted recovery, recovery mutual aid

Introduction

The pioneers of methadone maintenance treatment (MMT) shared a deep interest in the potential role of recovery mutual aid in long-term addiction recovery. Dr. Vincent Dole served as a nonalcoholic Trustee of Alcoholics Anonymous (AA; Dole, 1991), and Dr. Marie Nyswander served on the Board of Directors of the National Advisory Council on Narcotics—the organization that oversaw the early development of Narcotics Anonymous (NA) in New York City (White, Budnick, & Pickard, 2011). In spite of these early connections, participation in recovery mutual aid groups was not integrated into MMT as it was in other addiction treatment modalities in the United States (White, 1998). There is a rapidly growing body of research on the role participation in addiction recovery mutual aid groups can play in long-term addiction recovery outcomes

(Humphreys, 2006; Kaskutas, 2009; Kelly & Yeterian, 2008, 2012; Moos, & Moos, 2006), but few studies exist on the level and effects of such participation for methadone maintenance patients.

In an earlier study (White et al., in press), the authors surveyed the level of recovery mutual aid group participation of 332 patients enrolled in MMT in an urban community in the Northeastern United States. We found high rates of past year NA/AA participation (66%) and self-reported helpfulness of AA and NA (72% and 77% respectively), but considerably lower rates of participation in key 12-Step program ingredients: having a home group (50%), having a sponsor (26%), sponsoring others (13%), attending 12-step social events (23%), and active step work (21%). The present study extends these findings by evaluating the effects of participation in 12-Step meetings on rates of self-reported abstinence from illicit drugs and alcohol among the same 332 MMT patients.

Although MMT patients sometimes occupy a marginal status in 12-Step groups and may face restrictions on their degree of participation due to their daily consumption of prescribed methadone (White, 2011), we hypothesized that: 1) MMT patients with higher rates of mutual aid participation would have higher rates of self-reported abstinence than MMT patients with minimal or no mutual aid participation, and 2) key ingredients of 12-Step participation (e.g., sponsorship, step work, service work) would be more predictive of self-reported abstinence than would 12-Step meeting attendance.

Previous studies on the characteristics of MMT patients and the nature of MMT treatment and post-treatment responses inform the present study. Alcohol and multiple illicit drug use has been reported as the norm among opioid-addicted patients admitted to MMT (Backmund et al., 2005; Dobler-Mikola et al., 2005; Rittmannsberger, Silberbauer, Lehner, & Ruschak, 2000; Srivastava, Kahan, & Ross, 2008). Continued use of illicit drugs (e.g., heroin, non-prescribed methadone, cocaine, benzodiazepines, cannabis) and alcohol during treatment poses a major clinical challenge to substance-specific pharmacotherapies such as MMT (Best et al., 2000). Continued drug use remains a significant cause of MMT termination (Davstad et al., 2007; Magura & Rosenblum, 2001). Understood clinically, continued drug use has multiple roots: withdrawal distress (often linked to subtherapeutic doses of methadone), dysphoric emotional states, pleasure-seeking, and impulsive responses to social opportunities to use (Best et al., 2000).

In addition to the common profile of multiple drug use, MMT patients often present with a broad spectrum of medical, psychiatric, family, legal, economic, and social impairments in addition to multiple drug use that inhibit substance use disorder remission, impede the achievement of broader levels of global health, and increase mortality risks (Musselman & Kell, 1995; Puigdollers et al., 2004). These problems collectively impede the achievement of sustained abstinence and contribute to the high mortality rates associated with opioid addiction (Scott, Dennis, Laudet, Funk, & Simeone, 2011). Given this dominant MMT patient profile, recovery mutual aid groups that define recovery as requiring abstinence from alcohol and all illicit drugs, as well as achieving broader levels of physical, emotional, relational, and spiritual health, and offering a program of support to achieve these goals could be useful for MMT patients. Positive outcomes in MMT have been linked to a number of key factors, including optimum medication dosages (Faggiono, Vigna-Tagliantiu, Versino, & Lemma, 2003); duration of treatment participation (Greenfield & Fountain, 2000; Simpson, Brown & Joe, 1997); number and duration of counseling sessions (Simpson, Joe, Rowan-Szal, & Greener, 1995, 1997), positive attitudes of staff towards medication maintenance (Caplehorn, Lumley & Irwig, 1998); access to ancillary medical, psychiatric, and social services (Friedmann, Zhang, Hendrickson, Stein, & Gerstein, 2003; McLellan et al., 1998), and post-treatment monitoring and early re-intervention (Zanis, McLellan, Alterman, & Cnaan, 1996). The role of recovery mutual aid participation in enhancing MMT outcomes remains a subject of needed investigation.

Although MMT was originally conceived as a lifelong process of medication support (Dole & Nyswander, 1967; Jaffe, 1972; Joseph, Stancliff, & Langrod, 2000), the majority of MMT patients hope and expect to end MMT in the future (Langrod, Des Jarlais, Alksne, & Lowinson, 1983; Stancliff, Myers, Steiner, & Drucker, 2002). Most patients will terminate MMT treatment within a year of admission (Deck & Carlson, 2005) and will not be provided assertive ongoing monitoring, support, and early re-intervention following their discharge from MMT (White & Torres, 2010). Most importantly to the current study, the majority of discharged MMT patients will return to heroin or other illicit opioid use, often soon after leaving MMT (Davoli et al., 2007; Gossop, Green, Phillips, & Bradley, 1989; Joseph et al., 2000; Magura & Rosenblum, 2001), and will be at increased risk for infectious disease and death—including overdose deaths—following termination of MMT (Clausen, Ancherson, & Waal, 2008). These findings suggest the potential for enhancing post-MMT-treatment outcomes through in-treatment and post-treatment participation in recovery mutual aid groups.

Abstinence rates in MMT have been generally measured by a combination of self-report and drug testing, with a high concurrence between the two in research settings (Grella, Anglin, & Wugalter, 1997), but lower self-report reliability in clinical settings where patients may experience negative consequences for admitted drug use, e.g., loss of medication take-home privileges (Chermack et al., 2000). Comparison of rates across programs is difficult due to variability in clinical populations and differences in frequency and methods of drug testing.

Monitoring in-treatment abstinence rates—abstinence here defined as no use of alcohol and non-prescribed drugs—serves three clinically important functions. First, abstinence rates in the first two weeks of MMT is predictive of subsequent positive responses to treatment, whereas continued drug use during early MMT is indicative of difficulties in engagement, retention, and post-treatment prognosis (Chatham, Rowan-Szal, Joe, & Simpson, 1997; Morral, Belding, & Iguchi, 1999). Identifying those patients at high risk for poor outcomes can help focus clinical resources on those patients in greatest need of more intense service interventions (Rowan-Szal, Chatham, & Simpson, 2000). Second, when continued drug use is identified, specialized clinical interventions can be employed that have been shown to reduce rates of drug use during MMT (Gerra et al., 2011; Magura, Rosenblum, Fong, Villano, & Richman, 2002; Petry & Martin, 2002). Third, aggregate patient abstinence rates provide a benchmark for evaluating overall program-level recovery outcomes and the strength of the culture of recovery within a particular MMT milieu (White & Torres, 2010). In the present study, self-reported past year continuous abstinence rates and aggregate drug test results will be used to answer three questions:

1. What is the rate of sustained abstinence achieved by MMT patients in a non-research service setting?
2. Does participation in NA, AA, or other recovery mutual aid groups affect abstinence outcomes among MMT patients?
3. Does participation in key ingredients of recovery mutual aid programs other than meeting attendance affect abstinence outcomes?
4.

We hypothesize that abstinence rates will rise in tandem with increases in recovery mutual aid meeting attendance and participation in other key ingredients of recovery mutual aid involvement.

Methodology

Setting. This study was conducted at Partners in Drug Abuse Rehabilitation Counseling (PIDARC), a private, nonprofit addiction treatment center located in Washington, DC whose services include MMT. Each patient is assigned to one of 28 primary counseling groups, which he or she is required to attend at least twice a month. Each one-hour primary counseling group

focuses on problem solving and lifestyle reconstruction and is co-led by two of PIDARC's 14 addiction counselors. The center also offers a variety of treatment enhancements for its more than 650 MMT patients, including specialized gender-specific groups, groups for patients continuing to struggle with co-occurring alcohol or cocaine dependence, and a daily harm reduction group. Take-home medication privileges are awarded for timely and consistent attendance and negative drug test results. Random drug tests are collected at PIDARC by two trained urine technicians and evaluated by an independent laboratory with confirmatory evaluation of all positive tests. On-site drug testing at PIDARC is conducted for patients receiving take-home medication and for any patient suspected of being intoxicated. All on-site tests are sent for independent laboratory confirmation. Frequency of drug testing is determined by insurance provisions, with frequency ranging from weekly to monthly. Twelve-Step meetings such as Narcotics Anonymous or Alcoholics Anonymous are not held at this treatment center but are available in the community, and participation is encouraged. The patient population is gender mixed (60% male; 40% female) and age diversified (8.7% 20-39; 5.3% 30-39; 20.7% 40-49; 51.3% 50-59; 18.6% 60-69; 0.8% 70-79), with a wide span of time in MMT (27% less than one year; 29.7% 1-3 years; 19.6% 3-5 years; 23.7% 5 or more years). The majority of PIDARC patients are poor, African American, and aging (85% over the age of 45), with prolonged past histories in the criminal justice system.

Data Collection. 322 participants enrolled in methadone maintenance treatment completed an anonymous survey November 7-11, 2011 (See White et al., in press for complete description of the survey methodology). Of the 53 questions on the survey, 29 specifically focused on participation in 12-Step (AA/NA) groups. The survey also asked questions related to the frequency and pattern of drug use, with abstinence defined as no use of alcohol or illicit drugs. The survey was conducted by clinical staff at the treatment site as part of a larger effort to evaluate and enhance clinical protocol. Data were then sent for analysis to a group of independent consultants (White, Campbell, Spencer, & DuPont) who volunteered to assist with data analysis.

Analysis. Aggregate reports of abstinence from the survey (322 patients) were compared to aggregate drug test results for all patients with drug test data (663 of 674 patients) served during the 90 days preceding survey administration (August 1-November 1, 2011). The drug test data contained the total number of positive tests, the number of positive tests for each specific substance in the drug test panel, and the number of negative tests. The drug test panel included amphetamines, benzodiazepines, cocaine, opioids, PCP, and THC. Data from the survey and drug tests were analyzed using SPSS for Windows version 15. No patient names or other personally identifying information were linked to the survey or drug test data.

Results

Self-reported Abstinence Rates for Surveyed Patients. Of the 322 MMT patients surveyed, 270 self-reported their level of abstinence in the previous year. More than one-third (36.3%) of these patients reported being 100% abstinent from alcohol and illicit drugs during the year prior to the survey. There were no significant age or gender differences when the abstinent and non-abstinent groups were compared, but the former were more likely to have been in MMT longer: mean of 41 months for those 100% abstinent and 27 months for those less than 100% abstinent ($t = 2.63$, $df=213$, $p<.01$).

Comparison with Drug Test Results for All Clinic Patients. Analysis of drug tests taken by 663 patients during the 90 days prior to the survey (mean of 4.3 tests per patient) revealed negative drug tests for all illicit drugs by 443 (67%) of the patients. Of the 220 testing positive, 18% tested positive for opioids only, 26% were positive for opioids and other drugs, and 56% were positive for drugs other than opioids (in order of frequency: cocaine, cannabis, benzodiazepines, phencyclidine, and amphetamine). There were no significant gender

differences in test results. Older adults were less likely to have positive tests and younger patients were more likely to be positive for multiple drugs. Those in MMT less than one year were more likely to have positive tests for illicit drugs (51%) and have more substances detected (mean of 2.42 substances over 3 months) than patients in MMT for a year or more (27% positive for illicit drugs with a mean of 1.04 substances over 3 months).

12-Step Meeting Attendance and Abstinence Outcomes. Comparison of self-reported abstinence and 12-Step meeting attendance within the sample was made by two groupings—No NA/AA exposure and NA/AA meeting exposure—with a further analysis using four styles of participation: Neither NA nor AA attendance (34.2%), Only AA (5.0%), Only NA (31.7%), and Both NA and AA (29.2%). There was no consistent relationship between time in MMT and likelihood of attending AA or NA meetings. As the data in Table 1 indicate, about the same percentage of patients in NA/AA (35%) as patients not in NA/AA (38%) reported being 100% abstinent over the past year. Lowering the cut-point for abstinence to 90% or more did not produce differences between the two groups. The number of NA/AA meetings attended in the past year also was not significantly related to self-report of 100% abstinence. About the same percentage of patients in NA/AA (35%) as patients not in NA/AA (38%) report being 100% abstinent over the past year (Chi-square=0.18, df=1, p=.690).

Influence of Other NA/AA Program Ingredients on Self-reported Abstinence. Table 1 shows the percentage of clients in each abstinence-level group who said they participated in each activity. No single activity was associated with a greater level of abstinence.

Table 1: Percentage of Patients Participating in Various Aspects of NA/AA 12-Step Programs by Reported Level of Past Year Abstinence

	Abstinence Group				
Area of Participation	**0 – 50% (n = 61)**	**51 – 99% (n = 54)**	**100% (n = 63)**	**Total (n = 178)**	***p* Value ***
Home Group	41%	46%	37%	41%	.562
Service Work at Meetings	34%	32%	37%	34%	.849
Have a Sponsor	30%	28%	27%	28%	.876
Weekly Contact with Sponsor	20%	22%	22%	21%	.925
Sponsor Others	12%	9%	14%	12%	.699
Weekly Contact with Sponsees	8%	9%	16%	11%	.344
Speak at Meetings	38%	41%	38%	42%	.937
Socialize Before/After Meetings	36%	52%	40%	41%	.205
Attend 12-Step Social Events	16%	28%	25%	23%	.301
Active Step Work	25%	15%	25%	22%	.318
Help other Addicts	18%	24%	24%	22%	.665

Involved in NA/AA Service Work	18%	13%	21%	17%	.545
Encourage Family to Participate	25%	33%	25%	28%	.517

*Level of significance (2-sided) from Pearson chi-square statistic

Discussion

The authors surveyed 322 patients to test the relationship between continuous abstinence and 12-Step participation within the context of MMT. Of the 270 patients who reported abstinence status in the past year, 36.3% self-reported continuous past-year abstinence from alcohol and illicit drugs. This self-report rate was lower than the 67% of all patients at this site whose drug tests were negative for all drugs in the 90 days preceding the survey. Such differences could be related to the longer window of time for self-reported abstinence (one year versus past 90 days for the drug testing), inclusion of alcohol in the definition of abstinence (no tests for recent alcohol use were included in the drug test data), and the potential for drug use that was not detected via the random testing schedule. Comparing abstinence rates across studies is complicated by varying definitions of abstinence in available surveys and by different drug testing procedures and reporting periods. While MMT outcomes are often reported in terms of reduced frequency of drug use and related behaviors, patient self-report data and drug testing data from this survey site confirm that a significant portion of MMT patients are achieving continuous abstinence from illicit drug use and alcohol within the context of MMT.

There were no significant associations between age or gender and self-reported abstinence status, but patients who self-reported continuous abstinence were more likely to have been in treatment longer, suggesting a potential link between abstinence outcomes and duration of MMT—a finding that has been confirmed in other studies (Gossop, Marsden, Stewart, & Treacy, 2002). Negative drug test results were associated with older age and longer time in treatment, suggesting both maturational effects and cumulative treatment effects.

Two hypotheses were tested related to the effects of 12-Step participation and continuous past-year abstinence. First, the authors hypothesized that those MMT patients who self-reported participation in 12-Step meetings would have higher rates of self-reported continuous abstinence in the year prior to the survey than those who did not self-report participation in such meetings. This predicted finding was based on earlier studies confirming that participation in 12-Step meetings enhanced abstinence outcomes in patients treated for alcohol and drug dependence (For review, see Kelly & Yeterian, 2008) as well as studies finding that combinations of professional treatment and participation in mutual aid groups produce recovery outcomes greater than either activity in isolation (Dawson, Grant, Stinson, & Chou, 2006; Fiorentine & Hillhouse, 2000). Contrary to our predicted outcome, study findings revealed that past-year continuous abstinence was related to longer duration of time in MMT treatment, but was not related to 12-Step meeting attendance.

The reasons for absence of abstinence effects from 12-Step meeting participation among this group of MMT patients are unclear. Potential explanations of this finding include the potential lack of potency of 12-Step group participation for MMT patients. This interpretation is challenged by the high rates of reported voluntary past-year participation in 12-Step groups (66%) and the high reported rates of helpfulness by those who do participate (77% for NA, 72% for AA). It is possible that these MMT patients received many benefits from participation in 12-Step meetings (e.g., social support, enhanced emotional health, enhanced life purpose and meaning), but that the primary influence on their abstinence status comes from professional treatment or sources other than 12-Step meetings. The lack of abstinence effects may also have been influenced by the lack of integration of 12-Step concepts and practices into this treatment program and the

lack of assertive 12-Step group linkage procedures. In spite of such integration and linkage procedures, rates of patient participation in these groups and their reported helpfulness were quite high.

In light of increased studies confirming that a significant proportion of 12-Step group members decrease or stop meeting participation but sustain abstinence and other recovery-related activities (Kaskutas et al., 2005; Tonigan, 2005; Tonigan et al., 2002; Weiss et al., 2005), it is also possible that MMT patients who once attended but did not attend NA or AA in the past year could be hidden within the non-NA/AA involved group—resulting in an underreporting of NA/AA effects on abstinence. In fact, 27.3% of survey participants who were not active in NA/AA in the past year had previously attended one or both of these 12-Step programs. Transitions from compulsive opioid use to occasional use to abstinence following help-seeking have also been documented in earlier studies (Gossop et al., 1989). It is possible that a measure of 100% past year abstinence may fail to capture such progressive changes within the recovery process.

Second, we hypothesized that self-reported participation in key ingredients of 12-Step programs (e.g., sponsorship, step work, service work) would be more predictive of past year continuous abstinence than would self-reported meeting attendance alone. Other studies have confirmed that such ingredients as step work, reading 12-Step literature, socializing with others in recovery, applying recovery principles to daily problem-solving, having a sponsor, and sponsoring others may be more potent in influencing abstinence outcomes than the factor of meeting attendance (Crape, Latkin, Laris, & Knowlton, 2002; Humphreys, Moos, & Cohen, 1997; Montgomery, Miller, & Tonigan, 1995; Pagano, Friend, Tonigan, & Stout, 2004; Sheeren, 1988; Weiss et al., 2005; Zemore, Kaskutas, & Ammon, 2004). For example, a study of 487 cocaine dependent outpatients found no relationship between 12-Step meeting attendance and subsequent drug use outcomes, but did find a relationship between subsequent drug use outcomes and these core 12-Step activities (e.g., reading program literature, calling a sponsor) beyond meeting attendance (Weiss et al., 2005).

Again unexpectedly, the present survey data reveal no significant association between such key 12-Step activities beyond meeting attendance and self-reports of past year continuous abstinence among our sample of MMT patients. The absence of such effects is difficult to explain in light of research on these factors with patients in other addiction treatment modalities. The picture emerging from this survey is that the sampled MMT patients have a high rate of past year exposure to 12-Step meetings, but they have much lower rates of participation in key 12-Step program ingredients. One possibility is that the marginalized status MMT patients occupy in some 12-Step groups (e.g., denial of right to speak, claim “clean time,” celebrate recovery anniversaries, sponsor new members, hold service roles; White, 2011) inhibits full participation in NA and AA and prevents many MMT patients of reaping the benefits of such participation. Such marginalized status is confirmed in part by our earlier finding that one-quarter (25%) of NA/AA-involved patients in this sample reported a negative experience within NA or AA related to their MMT status (e.g., negative comments about methadone, pressure to reduce methadone dose or stop MMT, denied right to speak at or chair a meeting). Further indicative is the fact that only 34% of the NA/AA-involved patients disclosed their MMT status to their sponsors and at meetings (White et al., in press).

It should not be concluded from this study that NA and AA participation failed to exert an influence on abstinence outcomes in MMT patients. This study revealed that MMT patients achieve abstinence both with and without recovery mutual aid involvement and that the proportion of NA/AA-involved MMT patients who self-reported 100% abstinence in the past year was not different than the proportion of non-NA/AA-involved patients who self-reported 100% past year abstinence. The support mechanisms used to sustain abstinence in the latter group were not identified in the survey and remain unknown.

Further research is needed on the degree and effects of MMT patient participation in 12-Step meetings and other aspects of 12-Step programs. There are also growing varieties of

secular, spiritual, and religious alternatives to 12-Step programs (Humphreys, 2004; White, 2009; White & Kurtz, 2006), including recovery support structures designed specifically for MMT patients (e.g., Methadone Anonymous, Medication-Assisted Recovery Support; Gilman, Galanter, & Dermatis, 2001; Ginter, 2012; McGonagle, 1994). Future research should compare the differences in abstinence outcomes of MMT patients across these various recovery support groups in comparison to no mutual aid participation. Future MMT patient surveys should also collect information on their perceptions of 12-Step and other community support and the influence of such participation on their alcohol and other drug use and on rates of continuous abstinence. More also needs to be known about how continually abstinent MMT patients who are not involved in formal recovery mutual aid groups are sustaining their abstinence. It is possible, for example, that long-term involvement in the primary counseling group at this MMT clinic has taken over functions usually associated with recovery mutual aid groups. It is also possible, as suggested by PIDARC clinical staff, that many non-NA/AA-involved African American patients in this sample are utilizing culturally indigenous recovery support structures (recovery-supportive relationships within their families, extended families, and kinship networks; abstinence-based cultural and religious revitalization movements; church-based recovery ministries; patient peer support rituals [e.g., meeting informally for breakfast each morning], and external monitoring and support resources related to work or supervision by criminal justice or child welfare authorities) as an alternative to 12-Step groups to sustain their abstinence (Achara-Abrahams et al., 2012; Evans, Achara, Lamb, & White, 2012; Sanders & Powell, 2012; White & Sanders, 2008). Much more knowledge is needed about MMT patients involved with 12-Step groups and the alternative support mechanisms that are helping MMT patients sustain long-term recovery without 12-Step involvement.

This study has numerous limitations. While we were able to compare aggregate data on self-reported abstinence and aggregate negative drug tests, we were not, because of the anonymous nature of the survey, able to match self-report to drug test results for particular patients. The self-reported rate of abstinence could be lower than reported, and the rate of negative drug tests may inflate assumed abstinence levels due to drug use not detected within the random testing schedule. Similarly, the rate of reported involvement in NA/AA could be lower than that reported due to staff encouragement and expectation for such participation. There may also be distinct characteristics of the clinical population at this study site (e.g., predominance of older African American patients) that limit transfer of findings to other clinical populations.

Comparison of these findings to other studies is also severely limited due to such factors as the widely varying definitions of abstinence in MMT outcome studies, the dearth of research on NA (Toumbourou, Hamilton, U'Ren, Stevens-Jones, & Storey, 2002), and the paucity of research on the level and effects of recovery mutual aid participation on opioid-addicted patients involved in MMT and other treatment modalities.

In spite of these limitations, the present study confirms the existence of NA/AA-involved and NA/AA non-involved MMT patients who are continually abstinent from alcohol and illicit drugs; confirms a high rate of MMT patient participation in, and self-reported helpfulness of, 12-Step recovery support groups; raises important questions about the potential effects of MMT patient marginalization within 12-Step groups on abstinence outcomes; and suggests the potential existence of alternative, culturally indigenous recovery support structures that may help MMT patients maintain continuous abstinence. It is the authors' hope that these preliminary findings will mark the beginning of long-overdue studies on the potential role of recovery mutual aid groups, culturally indigenous recovery supports, other peer-based recovery support services, and professionally directed treatment groups in elevating in-treatment and post-treatment recovery outcomes for MMT patients.

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Review and Commentary
The Paucity of Attention to Narcotics Anonymous in Current Public, Professional, and Policy Responses to Rising Opioid Addiction

William White, M.A., Marc Galanter, M.D., Keith Humphreys, Ph.D., and John Kelly, Ph.D.

Recent surges in opioid addiction and opioid overdose deaths in the United States have triggered considerable public and professional alarm, including their emergence as an issue in the 2016 Presidential campaign.[1] Public health responses have focused primarily on 1) suppression of illicit opioid markets, 2) public education on opioid addiction risks, 3) prescription medication disposal campaigns, 4) opioid-focused physician training and prescription monitoring, 5) new non-opioid protocols for non-cancer pain management, 6) introduction of abuse-deterrent opioid formulations, 7) increased legal access and distribution of naloxone (Narcan®) for overdose intervention, and 8) efforts to expand access to addiction treatment—particularly medication-assisted treatment (MAT).[2]

[1] Brady, K.T., McCauley, J.L., & Back, S.E. (2016). Prescription opioid misuse, abuse, and treatment in the United States: An update. *American Journal of Psychiatry*, *171*(1), 18-26; Maxwell, C. (2015). The pain reliever and heroin epidemic in the United States: Shifting winds in the perfect storm. *Journal of Addictive Diseases*, *34*(2-3), 127-40; Rudd, R.A., Aleshire, N., Zibbell, J.E., & Gladden, R.M. (2016). Increases in drug and opioid overdose deaths – United States, 2000-2014. *MMWR Morbidity and Mortality Weekly Report*, *64*(50-51), 1378-82. Haddon, H. (2015). Drug deaths becoming a 2016 presidential election issue. *The Wall Street Journal*, November 3, 2015. Accessed May 16, 2016 at http://www.wsj.com/articles/drug-deaths-becoming-a-2016-presidential-election-issue-1446596075.

[2] Binswanger, I.A., & Gordon, A.J. (2016). From risk reduction to implementation: Addressing the opioid epidemic and continued challenged to our field. *Substance Abuse*, *37*(1), 1-3; Califf, R.M., Woodcock, J., & Ostroff, S. (2016). A proactive response to prescription opioid abuse. *New England Journal of Medicine*. doi: 10.1056/NEJMsr1601307; Clarke, J.L., Skoufalos, A., & Scranton, R. (2016). The American opioid epidemic: Population health implications and potential solutions: Report from the National Stakeholder Panel. *Population Health Management*, *19*, Suppl 1, S1-S10; Compton, W.M., Boyle, M., & Wargo, E. (2015). Prescription opioid abuse: Problems and responses. *Preventive Medicine*, *80*, 5-9; Dowell, D., Haegerich, T.M., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain—United States—2016. *Journal of the American Medical Association*, *315*(15), 1624-1645; Kunins, H.V. (2015). Abuse-deterrent opioid formulations: Part of a public health strategy to reverse the opioid epidemic. *JAMA Internal Medicine*, 175(6), 987-8; Nelson, L.S., Juurlink, D.N., & Perrone, J. (2015).

As long-tenured addiction researchers, the authors have supported these efforts, but have been struck by the scant attention given to the role recovery mutual aid organizations such as Narcotics Anonymous (NA) can play and are playing in the national response to opioid addiction. If NA is mentioned at all in public or policy discussions of opioid addiction, it is as a fleeting reference to its existence as a post-treatment referral option, or, more frequently, in criticism of its alleged hostility toward maintenance medications in the management of opioid addiction.[3] This omission, which extends to professional reports on mitigation strategies for opioid addiction[4], is puzzling given that NA is the one surviving recovery mutual aid organization whose birth in the early 1950s focused almost exclusively on recovery from heroin and other opioid addiction.[5]

Recent one-hour specials on ABC[6] and CNN[7] and a CBS *60 Minutes* segment[8] on prescription opioid and heroin addiction as well as numerous shorter reports all failed to even acknowledge the existence of NA or other recovery mutual aid fellowships devoted specifically to supporting recovery from addiction to opioids (e.g., Heroin Anonymous, Methadone Anonymous, Advocates for the Integration of Recovery and Methadone, and Mothers on Methadone). Further, brief mention of "AA and other Twelve-Step programs" when they do occur in media, professional, and policy discussions convey the impression of NA as an Alcoholics Anonymous (AA) clone and fail to convey NA's distinct history, culture, and program of recovery.[9]

The present commentary explores potential misconceptions about NA that may account for this lack of attention to NA as a recovery support resource for opioid addiction. While research on NA remains limited compared to the prodigious volume of studies of AA, the discrepancies between public and professional observations we have heard stated about NA are striking when compared to the findings of NA studies conducted in recent decades. Below we review eleven such discrepancies.

Misconception 1: *NA is a <u>treatment</u> for opioid addiction and other substance use disorders.* Understanding NA first requires understanding the difference between "treatment" and what have been generically christened recovery self-help groups, or more accurately, mutual help or mutual aid societies.[10]

Treatment takes place within the context of a business environment and a fiduciary relationship that is externally regulated and monitored through the mechanisms of professional accreditation and state licensing standards. Treatment is theory-driven; delivered by licensed or certified professionals; and involves a formal

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Addressing the opioid epidemic. *Journal of the American Medical Association*, 314(14), 1453-4; Voon, P. & Keer, T. (2013). "Nonmedical" prescription opioid use in North America: A call for priority action. *Substance Abuse Treatment, Prevention, and Policy*, *8*, 39.

[3] Manchikanti, L., Helm, S., Fellows, B., Janata, J.W., Pampati, V., Grider, J.S., & Boswell, M.V. (2012). Opioid epidemic in the United States. *Pain Physician*, *15*:ES9-ES38; Olsen, Y. & Sharfstein, J.M. (2014). Confronting the stigma of opioid use disorder—and its treatment. *Journal of the American Medical Association*, *311*(14), 13931394. Also see http://khn.org/news/opioid-epidemic-spurs-rethink-on-medication-and-addiction/

[4] SAMHSA (2016) Substance Abuse and Mental Health Services Administration. (2016). Sublingual and transmucosal buprenorphine for opioid use disorder: Review and update. *Advisory*, *15*(1), 1-12; Volkow, N.D., & McLellan, A.T. (2016). Opioid abuse in chronic pain—misconceptions and mitigation strategies. *New England Journal of Medicine*, *374*, 1253-63.

[5] Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press; White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[6] ABC David Muir Reporting, *20/20. Breaking Point: Heroin in America*, March 11, 2016.

[7] CNN *Anderson Cooper 360*. *Prescription Addiction: Made in the U.S.A.*, May 11, 2016.

[8] CBS *60 Minutes. The Heroin Epidemic*, April 24, 2016.

[9] White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor*, *12*(2), 10-15, 22-27, 36-39, 46-50.

[10] Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,…Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, *26*(3), 151-158.

diagnosis, a treatment plan, and service documentation within a formal medical record. It involves payment (often substantial), is governed by professional standards of ethics, is focused primarily on recovery initiation and stabilization, and is accessible only at limited times and for a limited (and historically ever-briefer) duration.

Recovery mutual aid societies, including NA, take place within the context of a voluntary community of shared experience whose members regularly meet to offer support to one another. NA defines itself as a "Fellowship of men and women who are learning to live without drugs."[11] Recovery mutual aid societies are not externally regulated, are based on experiential rather than expert knowledge, make no formal diagnoses, maintain no medical records, and require no service fees. Member and group actions are guided by core values ("traditions"), group conscience, and informal etiquette. Their primary focus is on recovery maintenance, support for daily coping, and enhanced quality of personal and family life in long-term recovery.[12]

Twelve-Step Facilitation (TSF) is a professionally-directed, manualized treatment for substance use disorders whose primary mechanisms of change involves orienting patients about Twelve-Step recovery principles and assertively linking patients to Twelve-Step groups such as AA and NA. TSF has been rigorously studied, including within randomized clinical trials[13], and is recognized as an "evidence-based" treatment within the Substance Abuse and Mental Health Service Administrations (SAMHSA) National Registry of Evidence Based Programs and Practices (NREPP). Although TSF is not AA or NA, its benefits when formally tested using mediational analyses are explained by TSF patients' greater involvement in AA and NA following the intervention.[14] NA, per se, however, is not considered an evidence-based treatment because Narcotics Anonymous is <u>not</u> a professionally-directed treatment for substance use disorders.[15]

Considerable harm to individuals, families, organizations, and communities can accrue from ill-defined boundaries between professionally-directed addiction

[11] Narcotics Anonymous World Services, Inc. (NAWS, 2008c). *Narcotics Anonymous (6th ed.)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 10.

[12] White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[13] See for example: Crits-Christoph P., Siqueland, L., Blaine, J., Frank, A., Luborsky, L., Onken, L.S., Muenz, L.R., Thase, M.E., Weiss, R.D., Gastfriend, D.R., Woody, G.E., Barber, J.P., Butler, S.F., Daley, D., Salloum ,I., Bishop, S., Najavits, L.M., Lis, J., Mercer, D., Griffin, M.L., Moras, K., & Beck, A.T. (1999). Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Archives of General Psychiatry*, *56*(6), 493-502; Donovan, D.M., Daley, D.C., Brigham, G.S., Hodgkins, C.C., Perl, H.I., Garrett, S.B., Doyle, S.R., Floyd, A.S., Knox, P.C., Botero, C., Kelly, T.M., Killeen ,T.K., Hayes, C., Kau'iBaumhofer, N., Seamans, C., & Zammarelli, L. (2013). Stimulant abuser groups to engage in 12-Step: A multisite trial in the National Institute on Drug Abuse Clinical Trials Network. *Journal of Substance Abuse Treatment*. *44*, 103–114; Project Match Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7–29; Project MATCH Research Group. (1998). Matching alcoholism treatments to client heterogeneity: treatment main effects and matching effects on drinking during treatment. *Journal of Studies on Alcohol. Vol. 59;* Litt, M.D., Kadden, R.M., Kabela-Cormier, E., & Petry, N.M. (2009) Changing network support for drinking: Network support project two-year follow-up. *Journal of Consulting & Clinical Psychology*, *77*(2), 229-42; Walitzer, K.S., Dermen, K.H., & Barrick, C. (2009). Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial. *Addiction*, 104(3), 391-401.

[14] Litt, M.D., Kadden, R.M., Kabela-Cormier, E., & Petry, N.M. (2009) Changing network support for drinking: Network support project two-year follow-up. *Journal of Consulting & Clinical Psychology*, *77*(2), 229-42; Walitzer, K.S., Dermen, K.H., & Barrick, C. (2009). Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial. *<u>Addiction</u>*, *104*(3), 391-401; Longabaugh, R., Wirtz, P.W., Zweben, A., & Stout, R.L. (1998). Network support for drinking, Alcoholics Anonymous and long-term matching effects. *Addiction*, *93*, 1313–1333.

[15] Nowinski, J., & Baker, S. (2012). The twelve Step facilitation handbook: A systematic approach to recovery from substance dependence. Hazelden Publishing; Ries, R.K., Galanter, M., & Tonigan, J.S. (2008). "Twelve-step facilitation." *The American psychiatric publishing textbook of substance abuse treatment*, 373-386.

treatment (and allied professional services) and addiction recovery mutual aid. When addiction treatment drifts across the border into mutual aid (e.g., clinical abandonment), those served fail to receive care at current standards of acceptable practice, and they pay for activities that are free within mutual aid organizations. When mutual aid drifts across the line into treatment, those served can be harmed by untrained peers acting beyond the limits of their education, training, and experience, e.g., practicing medicine, psychology, social work, or addiction counseling without proper credentials.[16]

NA is not a *treatment* for opioid addiction, though it can serve as an adjunct or, in some cases, an alternative to such professional treatment—the latter noted by the 15 percent of surveyed NA members who report no prior history of addiction treatment.[17] The potential potency of combining professional treatment and NA effects is enhanced when addiction treatment providers use assertive rather than passive styles of linkage to local NA resources.[18]

Misconception 2: *NA meetings and the NA program are not widely accessible.* U.S. population surveys on the degree of Twelve-Step group exposure in the general population are limited. Room and Greenfield reported in 1993 that 9 percent of the adult population had attended an Alcoholics Anonymous meeting in their lifetime, and that 2.8 percent reported lifetime attendance at NA or another Twelve-Step group other than AA.[19] A subsequent survey[20] reported that 6.4 percent of the adult population had attended self-help meetings for a substance use problem (with no breakdown by particular mutual aid fellowship). We know of no subsequent national population studies on the national prevalence of NA exposure. In 2004, there were an estimated 185,000 NA members.[21] In 2010, SAMHSA reported that 2.3 million American adults had sought help for a substance use problem through a mutual aid group such as AA or NA during the previous 12 months, but did not provide an NA-specific membership estimate.[22]

There are presently more than 67,000 NA meetings per week in 139 countries, with 27,475 weekly NA meetings in U.S. states and territories.[23] The number of available NA meetings worldwide has more than doubled in the past 15 years.[24] These face-to-face meetings are supplemented by a growing network of online NA meetings and chatrooms, NA telephone meetings, and a growing portfolio of NA literature.[25] Also of note is the ever-expanding range of other

[16] Kurtz, E. (1996). Spirituality and recovery: The historical journey. Blue Book (National Clergy Conference on Alcoholism), *47*, 5-29; White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[17] Galanter, M., Dermatis, H., Post, S. & Santucci, C. (2013). Abstinence from drugs of abuse in community-based members of Narcotics Anonymous. *Journal of Studies on Alcohol and Drugs*, *74*, 349-352.

[18] Timko, C., & DeBenedetti, A. (2007). A randomized controlled trial of intensive referral to 12-Step self-help groups: one-year outcomes. *Drug and Alcohol Dependence*, *90*, 270-279; Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-step self-help groups and 6-month substance use disorder outcomes. *Addiction*, 101, 678-688; White, W., & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: IRETA/NeATTC

[19] Room, R., & Greenfield, T. (1993). Alcoholics anonymous, other 12-step movements and psychotherapy in the US population, 1990. *Addiction*, *88*(4), 555-562.

[20] Kessler, R. C., Mickelson, K. D., & Zhao, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy*, *27*(3), 27-45.

[21] Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,…Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, *26*(3), 151-158.

[22] SAMHSA (2010) *Substance Abuse and Mental Health Services Administration. Results from the 2009 National Survey on Drug Use and Health: Volume 1. Summary of national findings (NSDUH Series H-38A, HHS Publication No. SMA 10-4856)*. Rockville, MD: Office of Applied Statistics.

[23] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[24] White, W., , C., & Pickard, B. (2013). Narcotics Anonymous comes of age: A 60th anniversary professional tribute. *Counselor*, *14*(50), 54-57.

[25] Narcotics Anonymous World Services, Inc. (NAWS, 2011). Membership survey. Retrieved March 2, 2013 from http://www.na.org/admin/include/spaw2/uploads/pdf/PR/

recovery support activities organized by NA members outside the official structure of NA. Such activities include NA-themed social media activity on Facebook, YouTube, Pinterest, and Twitter; posted NA talks and informational podcasts; NA apps; social clubs for NA members; and a wide spectrum of social activities organized by and for NA members.[26] NA, like other Twelve-Step programs, has also witnessed the development of a parallel program to support family members affected by addiction (i.e., Nar-Anon).

Though increasingly rare, the absence of local NA resources should not preclude referral to other recovery mutual aid organizations. Co-attendance or sequential attendance across Twelve-Step groups and between secular, religious, and spiritual recovery mutual aid groups out of preference, necessity, or convenience is not uncommon.[27] A recent study of individuals dependent on drugs other than alcohol who were attending AA meetings revealed recovery outcomes similar to those involved only in NA, and the former group did not have higher drop-out rates than those attending NA.[28]

***Misconception 3**: NA suffers from a lack of members in long-term recovery. (Variations: There are no "oldtimers" in NA like those found in AA. There is too much street culture in NA. Opioid addicts should be referred to AA rather than NA because AA has a stronger recovery culture. I referred a client to NA, and they were offered drugs at their first meeting. Don't most NA members have criminal backgrounds? My clients would be offended by the profanity at NA meetings.*) The only requirement for participation in NA is "a desire to stop using"[29], which means that there will be people present at NA meetings who have not yet achieved stable abstinence. These individuals are usually a small minority at any meeting and, if not, other meetings should be sought out. It may be hard for a newcomer to distinguish between established NA members and those like he or she who are just arriving. This is particularly true where a treatment center or a drug court sends 20 people into an NA meeting that has 15 regular members. Under such circumstances, a newcomer may be offered drugs, but not by regular NA members. Cooperation between local NA groups and NA referral sources can go a long way in minimizing such incidents.

The average duration of continuous abstinence of NA members has increased as NA has matured as a global fellowship, just as this rate increases over time as NA groups are established in other countries and, in particular, local communities. Globally, NA members currently have an average of more than eight years of continuous abstinence. Ninety-one percent of NA members have more than one year of continuous abstinence, and 47 percent of NA members have 11 or more years of continuous abstinence.[30] This pattern of recovery stability within NA is also reflected in a pervasive service ethic: 85 percent of NA members have a service and/or

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NA_Membership_Survey.pdf; White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor*, *12*(2), 10-15, 22-27, 36-39, 46-50.

[26] Hall, M. J., & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*, *24*(2), 161-167.

[27] Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction*, *103*(1), 119-125; Horvath, T. (2014). The dual citizenship phenomenon. Accessed April 10, 2016 at: http://www.rehabs.com/pro-talk-articles/the-dual-citizenship-phenomenon-2/; White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

[28] Kelly, J.F., Greene, M.C. & Bergman, B.C. (2014). Do drug-dependent patients attending Alcoholics Anonymous rather than Narcotics Anonymous do as well? A prospective, lagged, matching analysis. *Alcohol and Alcoholism*, 1-9, doi:10.1093/alcalc/agu066

[29] Narcotics Anonymous World Services, Inc. (NAWS, 2008c). *Narcotics Anonymous (6th ed.)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 60.

[30] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

sponsorship commitment.[31] Helping others within and beyond NA, above and beyond attendance at NA meetings, has been found to be a strong indicator of recovery stability.[32]

The image that *NA* is only appropriate for "hard core drug addicts"--an impression regularly reinforced via television portrayals of NA, e.g., *Breaking Bad*, *Nurse Jackie*, *Dexter*[33] —is challenged by the wide range of problem severity and problem duration reported by NA members prior to their involvement in NA. Only 15 percent of NA members attended their first NA meeting at the suggestion or mandate of the criminal justice system; most arrive at their first NA meeting through suggestion of an NA member, a family member, or an addiction treatment professional. NA's latest membership survey reveals that 76 percent of current NA members are employed or in school, and 63 percent of NA members have completed an associate (or trade school) degree, a college degree, or a graduate degree.[34] As NA's own literature suggests:

> *Admittedly there is a stereotype of the "typical" candidate for NA—urban, criminal, a needle-user—and that narrow vision does describe some of us, but we are also professionals, parents, and students, and so on, living in cities, small towns, and rural communities in countries all over the world*.[35]

Scientific evidence to date, limited as it is, confirms such diversity of NA membership.

Misconception 4: *Opioid-dependent youth should not be referred to NA due to concerns about its effectiveness and safety.* Three reviews of the research literature affirm the potential value of mutual aid group participation in enhancing recovery of adolescents with substance use disorders.[36] Studies to date indicate that youth who attend Twelve-Step groups after residential treatment are more likely to remain abstinent, engage in less frequent substance use, and have better post-treatment outcomes than those who do not participate in such groups.[37] Studies to date have generally shown that Twelve-Step participation by youth and young adults strengthens outcomes beyond that achieved

[31] Ibid

[32] Crape, B. L., Latkin, C. A., Laris, A. S., & Knowlton, A. R. (2002). The effects of sponsorship in 12-step treatment of injection drug users. *Drug and Alcohol Dependence*, *65*(3), 291-301.

[33] Withers, R. (2014). Six myths about Narcotics Anonymous you probably believe. Accessed April 11, 2016 at (http://blog.com.blog/6-myths-about-narcotics-anonymous-you-probably-believe)

[34] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[35] Narcotics Anonymous World Services, Inc. (NAWS, 2008). *Narcotics Anonymous (6th ed.)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. xviii.

[36] Bekkering, G.E., Mariën, D., Parylo, O., & Hannes, K. (2016). The effectiveness of self-help groups for adolescent substance misuse: A systematic review. *Journal of Child & Adolescent Substance Abuse*, *0*(0), 1-16; Kelly, J.F., & Myers, M.G. (2007). Adolescents' participation in alcoholics anonymous and narcotics anonymous: Review, implications and future directions. *Journal of Psychoactive Drugs*, *39*(3), 259-269; Sussman, S. (2010). A review of Alcoholics Anonymous/ Narcotics Anonymous programs for teens. *Evaluation & the Health Professions*, *33*(1), 26-55.

[37] Kelly, J.F., & Urbanoski, K. (2012). Youth recovery contexts: The incremental effects of 12-step attendance and involvement on adolescent outpatient outcomes. Alcoholism: Clinical & Experimental Research, *36*(7), 1219-1229; Kelly, J.F., Brown, S.A., Abrantes, A., Kahler, C.W., & Myers, M.G. (2008). Social recovery model: An 8-year investigation of youth treatment outcome in relation to 12-step group involvement. *Alcoholism: Clinical & Experimental Research*, *32*(8), 1468-1478. Kelly, J. F., & Myers, M. G. (1997). Adolescent treatment outcome in relation to 12-step group attendance. Abstracted in *Alcoholism: Clinical and Experimental Research*, 21, 27A. Kelly, J.F., Myers, M.G., & Brown, S.A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, *14*, 376-389; Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, 63(3), 293-304; Kelly, J.F., Myers, M.G., & Brown, S.A. (2005). The effects of age composition of 12-Step groups on adolescent 12-Step participation and substance use outcome. *Journal of Child and Adolescent Substance Abuse*, *15*, 63-72.

from professional treatment alone.[38] Reviews of teen involvement in Twelve-Step meetings have drawn similar conclusions about their potential value, particularly for youth presenting with the most severe and complex substance use disorders. However, we are aware of no study that looked specifically at these outcomes for opioid dependent youth. Youth dropping out of NA and AA most often do so from boredom or a sensed lack of fit with its Twelve-Step program than from any expressed concern about their safety.[39]

A study of the safety of youth participating in NA concluded that such safety concerns were rare (though more common than in AA), and, that decisions to discontinue NA participation were unrelated to any safety issues. The study authors concluded that "youth should not be discouraged from attending AA or NA groups due to safety concerns" but also recommended "clinicians should continue to monitor adolescents' Twelve-step experiences and assess the specific nature of any reported concerns."[40]

Twelve-Step groups and meetings can vary in their degree of safety and recovery orientation.[41] The perceived attraction, value, and safety of NA and other mutual aid meetings for youth are enhanced in groups with closer age homogeneity.[42] Safety concerns can be addressed through discussion of safety prior to linkage to NA, linkage to meetings with strong recovery cultures and substantial youth representation, and ongoing monitoring of any safety issues that arise following referral.[43] Also of potential assistance is literature NA has developed specifically for youth and their parents or guardians.[44]

Misconception 5: *NA does not effectively serve women, ethnic minorities, and other historically disenfranchised populations.* NA membership is the most culturally diverse of any major addiction recovery mutual aid organization. NA membership is 41 percent women—the highest rate of any abstinence-based recovery support group other than Women for Sobriety.[45] Twenty-five percent of NA members are people of color, including 11 percent African American, 6 percent Hispanic, 3 percent Asian, 1 percent

[38] Kelly, J. F., Dow, S. J., Yeterian, J. D., & Kahler, C. W. (2010). Can 12-step group participation strengthen and extend the benefits of adolescent addiction treatment? A prospective analysis. *Drug and Alcohol Dependence*, *110*(1-2), 117-125; Kelly, J.F., Stout, R.L., & Slaymaker, V. (2013). Emerging adults' treatment outcomes in relation to 12-step mutual-help attendance and active involvement. *Drug and Alcohol Dependence*, *129*(1-20, 151-7; Kingston, S., Knight, E., Williams, J., & Gordon, H. (2015). How do young adults view 12-Step programs. A qualitative study. *Journal of Addictive Diseases*, *34*(4), 311-22.

[39] Kelly, J.F., Yeterian, J., & Rodolico, J. (2008). What do adolescents exposed to Alcoholics Anonymous [and Narcotics Anonymous] think about 12-step groups? *Substance Abuse*, *29*(2), 53-62.

[40] Kelly, J.F., Dow, S.J. Yeterian, J.D., & Myers, M. (2011). How safe are adolescents at AA and NA meetings? A prospective investigation with outpatient youth. *Journal of Substance Abuse Treatment*, *40*(4), 419-428; Kelly, J.F., Urbanoski, K.A., Hoeppner, B.B., & Slaymaker, V. (2012). "Ready, willing, and (not) able" to change: young adults' response to residential treatment. *Drug and Alcohol Dependence*, *121*(3), 224-30.

[41] Sussman, S. (2010). A review of Alcoholics Anonymous/ Narcotics Anonymous programs for teens. *Evaluation & the Health Professions*, 33(1), 26-55.

[42] Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, *63*(3), 293-304; Labbe. A.K., Greene, C., Bergman, B.G., Hoeppner, B. & Kelly, J.F. (2013). The importance of age composition of 12-step meetings as a moderating factor in the relation between young adults' 12-step participation and abstinence, *Drug and Alcohol Dependence*, *133*(2), 541-7; Passetti, L. L., & White, W. L. (2008). Recovery support meetings for youths: Considerations when referring young people to 12-Step and alternative groups. *Journal of Groups in Addiction and Recovery*, *2*(2-4), 97-121.

[43] White, W. (2016) Recovery and personal safety, Accessed April 16, at http://www.williamwhitepapers.com/blog/2016/02/recovery-and-personal-safety.html

[44] Narcotics Anonymous World Services, Inc. (NAWS, 2008a). *By young addicts for young addicts*. Van Nuys, CA: Narcotics Anonymous World Services, Inc.; Narcotics Anonymous World Services, Inc. (NAWS, 2008b). *For the parents or guardians of young people in NA*. Van Nuys, CA: Narcotics Anonymous World Services, Inc.

[45] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

Native American, and 4 percent multiracial.[46] The increased cultural diversity of NA is underscored by the growth of NA meetings within communities of color, the cultural diversity represented in the stories in *Narcotics Anonymous* (the 6th Edition of NA's Basic Text), and the growth of common needs meetings for women, youth, LGBT, agnostics, veterans, people living with HIV / AIDS, and various professional groups.[47] Also of note is the increased representation of people of color within qualitative studies of NA-based recovery from opioid addiction.[48] NA is rising and thriving in quite diverse cultural, religious, and political contexts.[49]

Compared to women in AA, women in NA are younger, more ethnically diverse, less educated, less likely to be married, more likely to earn less than $20,000 per year, more likely to be addicted to multiple substances, and more likely to have experienced physical abuse or assault. Early feminist criticisms of Twelve-Step programs as disempowering and apolitical have given way to a deeper appreciation of how NA participation can serve as a platform for personal transformation and broader community involvement and activism. Studies of women in NA reveal there is a long history of women's leadership within NA and that women in NA value both general and women's meetings, while using the latter to address some of the special recovery issues faced by women in NA, e.g., overcoming trauma and victimization, gender oppression, and shame.[50]

Other populations who have found NA a useful recovery support resource include military veterans[51] and physicians participating in physician health programs.[52]

Misconception 6: *NA is anti-treatment*. NA members have considerable direct experience with addiction treatment. More than 85 percent of NA members have been in addiction treatment prior to joining NA, and 25 percent report prior psychiatric treatment.[53] Nearly half (46 percent) of current NA members report attending their first NA meeting as a result of referral of a treatment or counseling agency.[54]

NA members with whom we discussed this misconception noted that negative comments about treatment can be sometimes heard at NA meetings and in pre and post meeting communications as well as

[46] Ibid

[47] Narcotics Anonymous World Services, Inc. (NAWS, 2016). *Special interest meetings*. Retrieved April 16, 2016 at: https://www.na.org/?ID=bulletin18

[48] Flaherty, M.T., Kurtz, E. White, W.L., & Larson, A. (2014). An interpretive phenomenological analysis of secular, spiritual, and religious pathways of long-term addiction recovery. *Alcoholism Treatment Quarterly*, *32*(4), 337-356.

[49] Flora, K., & Raftopoulos, A. (2007). First description of Narcotics Anonymous and Alcoholics Anonymous members in Greece: Prior treatment history and opinions about professionals. *Contemporary Drug Problems*, *34*(1), 163-170; Galanter, M. (2016). *What is Alcoholics Anonymous? A path from addiction to recovery*. New York: Oxford University Press; Raftopoloulos, A., & Flora, K. (2011). Substance use related behavior of the members of Narcotics Anonymous and Alcoholics Anonymous in Greece. *Journal of Psychoactive Drugs*, *43*(3), 238-244. Ronel, N. (1997). The universality of a self-help program of American origin: Narcotics Anonymous in Israel. *Social Work Health Care*, *25*(3), 87-101; Toumbourou, J., Hamilton, M., U'Ren, A., Stevens-Jones, P., & Storey, G. (2002). Narcotics Anonymous participation and changes in substance use and social support. *Journal of Substance Abuse Treatment*, *23*(1), 61-66; Wells, B. (1987). Narcotics Anonymous (NA): The phenomenal growth of an important resource. *British Journal of Addiction*, *82*(6), 581-582.

[50] Sanders, J. (2011). Feminist perspectives on 12-step recovery: A comparative descriptive analysis of women in Alcoholics Anonymous and Narcotics Anonymous. *Alcoholism Treatment Quarterly*, *29*, 357-378; Sanders, J. (2014). *Women in Narcotics Anonymous: Overcoming stigma & shame*. New York, NY: Pelgrave Macmillan a division of St Martin's Press LLC.

[51] Galanter, M., Dermatis, H., & Sampson, C. (2014). Narcotics Anonymous: A comparison of military veterans and non-veterans. *Journal of Addictive Diseases*, *33*(3), 187-95.

[52] Merlo, L.I., Campbell, M.D., Skipper, G.E., Shea, C.L., & DuPont, R.L. (2016). Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in Physician Health Programs. *Journal of Substance Abuse Treatment*, *64*, 47-54.

[53] Galanter, M., Dermatis, H., Post, S., & Sampson, C. (2013). Spirituality-based recovery from drug addiction in the Twelve-Step fellowship of Narcotics Anonymous. *Journal of Addiction Medicine*, *7*(3), 189-195.

[54] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

in online exchanges between NA members. Such communications range from the projected blame of the newcomer (for past failed efforts to sustain abstinence) to legitimate concerns NA members express about treatment program policies or practices they have experienced in the past, including administrative discharge policies (being kicked out of treatment for confirming their diagnosis), financial exploitation (i.e., exorbitant costs, profiteering, charging fees for Twelve-Step activities), and being mandated by a treatment program to go to AA without the option of NA meeting attendance. NA members can also be heard expressing concerns with treatment programs that prohibit visits with sponsors during inpatient treatment, schedule groups that conflict with NA meeting times, host staff-led "NA meetings" closed to those not in treatment, and group transport practices—often arriving late and leaving early, while denying their patients the benefits of pre- and post-meeting social interaction. Also heard are expressed concerns about the actions of addiction treatment staff, e.g., attending NA meetings with clients without clarifying whether the staff member is in the meeting as an NA member or as a treatment professional, wearing a treatment center nametag while in the meeting, and not clarifying when they are speaking as an NA member or as an addiction professional.

While NA Traditions dictate no opinion on issues outside of NA and a stance of non-affiliation with any "related facility or outside enterprise"[55], there are NA meetings held within addiction treatment facilities, and NA has developed a strong service culture that includes Hospitals and Institutions (H & I) subcommittees that bring the NA message of recovery to people who do not have access to regular NA meetings.[56] Collaboration between treatment facilities and NA is enhanced when the former provide their clients basic information on NA and its culture (e.g., reviewing the NA pamphlet *An Introduction to NA Meetings*) BEFORE referring clients to local NA meetings.

NA participation is being increasingly integrated with professionally directed addiction treatment.[57] Many new developments within the addiction treatment field, such as the shift from acute care models of treatment to models of sustained recovery management, are highly congruent with NA principles. For example, NA's early conceptualization of addiction as a chronic disease analogous to cancer, diabetes, and heart disease requiring lifelong and assertive self-management predates the modern conceptualization of addiction as a chronic disorder by decades.[58]

Misconceptions 7: *People addicted to opioids do not seek help from NA due to its stance on maintenance medications. People in medication-assisted treatment for opioid addiction should not be referred to NA due to NA's attitudes toward maintenance medications.* NA has outlined its stance on maintenance medications in three earlier publications (*In Times of Illness*, *Bulletin #29: Regarding Methadone and Other Drug Replacement Programs,* and *NA Groups and Medication*), and is in the process of drafting a new statement *Narcotics Anonymous and Persons Receiving Medication Assisted Treatment*. These

[55] Narcotics Anonymous World Services, Inc. (NAWS, 2008c). *Narcotics Anonymous (6th ed.)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 69.

[56] Narcotics Anonymous World Services, Inc. (NAWS, 1997). *Hospitals & Institutions Handbook*. Retrieved April 24, 2013 from http://www.na.org/admin/include/spaw2/uploads/pdf/handbooks/H&I%20Handbook.pdf

[57] Troyer, T. N., Acampora, A. P., O"connor, L. E., & Berry, J. W. (1995). The changing relationship between therapeutic communities and 12-step programs: A survey. *Journal of Psychoactive Drugs*, *27*(2), 177-180; Monico, L.B., Gryczynski, J., Mitchell, S.G., Schwartz, R.P, O'Grady, K.E., & Jaffe, J.H. (2015). Buprenorphine treatment and 12-Step meeting attendance: Conflicts, compatibilities, and patient outcomes. *Journal of Substance Abuse Treatment*, *57*, 89-95.

[58] Narcotics Anonymous World Services, Inc. (NAWS, 2008). Narcotics Anonymous (6th ed.). Chatsworth, CA: Narcotics Anonymous World Services, Inc.; McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000) Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation., *Journal of the American Medical Association*, *284*(13), 1689-1695.

publications define the NA program as one of complete abstinence, including abstinence from maintenance medications used in the treatment of addiction. NA is particularly well-suited for individuals addicted to opioids who find medication-assisted treatment (MAT) undesirable or who are in safety sensitive occupations that would preclude MAT.[59] NA extends a warm welcome to people prescribed such medications who hope to later sustain recovery without such medication and who wish to explore NA as a long-term recovery support solution.

The number of people in medication-assisted treatment for opioid addiction who are dissuaded from seeking help from NA because of NA's stance on maintenance medications is unknown, though their presence has been reported in the professional literature.[60] In the most recent NA membership surveys (2015), 68 percent of NA members reported past use of opiates or opioids, and 22 percent of members reported opiates as their primary drug.[61] Only a small percentage of members (less than one percent) reported in the most recent NA membership survey that they were currently using prescribed methadone or buprenorphine.[62]

A recent study of NA and other Twelve-Step participation among people in methadone or buprenorphine maintenance treatment revealed a high rate of past year NA or other Twelve-Step attendance and positive self-evaluations of the role of NA participation in recovery stability and quality of life. However, this same study revealed a significant portion of NA-involved patients in methadone maintenance who did not disclose their medications status within the context of Twelve-Step participation.[63] A recent study found that clinicians rarely discuss such disclosure issues with patients when linking patients in medication-assisted treatment to NA.[64] Another recent study found that opioid-addicted patients in buprenorphine treatment had improved outcomes when concurrently participating in Twelve-Step recovery support meetings.[65]

In a 2008 survey of opioid treatment programs in the United States, 46 percent of programs reported offering recovery support groups to their patients either through linkage to community meetings or onsite meetings, 43 percent offered some form of peer mentoring/support, and 37 percent reported using a Twelve-Step Facilitation approach to treatment.[66]

The Twelve Steps have been adapted for specific use with people in medication-assisted treatment[67], and traditional abstinence-based treatment programs (e.g., Hazelden Betty Ford) have begun

[59] Merlo, L.I., Campbell, M.D., Skipper, G.E., Shea, C.L., & DuPont, R.L. (2016). Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in Physician Health Programs. *Journal of Substance Abuse Treatment*, *64*, 47-54.

[60] White, W. L. (2011). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual disability Services.

[61] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[62] Ibid

[63] White, W., Campbell, M.D., Shea, C., Hoffman, H.A., Crissman, B., & DuPont, R.L. (2013). Co-participation in 12 Step mutual aid groups and methadone maintenance treatment: A survey of 322 patients. *Journal of Groups in Addiction and Recovery*, *8*(4), 294-308.

[64] Suzuki, J. & Dodds, T. (2016). Clinicans recommendation of 12-step meeting attendance and discussion regarding disclosure of buprenorphine use among patients in office-based opioid treatment. *Substance Abuse*, *37*(1), 31-4.

[65] Monico, L.B., Gryczynski, J., Mitchell, S.G., Schwartz, R.P, O'Grady, K.E., & Jaffe, J.H. (2015). Buprenorphine treatment and 12-Step meeting attendance: Conflicts, compatibilities, and patient outcomes. *Journal of Substance Abuse Treatment*, 57, 89-95.

[66] SAMHSA, Office of Applied Studies (January 28, 2010b). *The N-SSATS Report: Overview of Opioid Treatment Programs within the United States: 2008*. Rockville, MD.

[67] Gilman, S.M., Galanter, M., & Dermatis, H. (2001). Methadone Anonymous: A 12-Step program for methadone maintained heroin addicts. *Substance Abuse, 22*(4), 247-256; Ginter, W. (2012). Methadone Anonymous and mutual support for medication-assisted recovery. *Journal of Groups in Addiction and Recovery*, *7*(2-4), 189-201;
Glickman, L, Galanter, M., Dermatis, H., & Dingle, S. (2006). Recovery and spiritual transformation among peer leaders of a modified Methadone Anonymous group. *Journal of Psychoactive Drugs*, *38*(4), 531-533;
Glickman, L, Galanter, M., Dermatis, H., Dingle, S., &

integrating Twelve-Step recovery principles and the use of selected maintenance medications as adjuncts in the treatment of opioid addiction.[68] Also of note is the predicted expansion of MAT for opioid addiction within the criminal justice system.[69]

The issue of recovery support for people in MAT is a critical one given the number of affected people--estimated in 2011 at more than 230,000 patients enrolled in methadone maintenance and more than 800,000 patients receiving prescriptions for buprenorphine.[70] Equally critical is the fact that the vast majority of people who begin treatment with methadone, buprenorphine, or naltrexone do not remain on these medications for prolonged periods of time.[71] A major problem with MAT is disengagement from MAT prior to recovery stabilization. In 2011, there were more than 75,000 discharges from Opioid Treatment Programs in the U.S., with average treatment duration of 133 days. Only 12 percent of those discharged completed treatment as planned, and 80 percent reported no mutual aid involvement in the month prior to discharge.[72] The recurrence of opioid addiction is high under such circumstances.[73] Referral to NA or alternative mutual aid resources is highly indicated as a source of enhanced recovery stability during medication maintenance and a source of sustained recovery support during and following tapering of medication maintenance.[74]

The key to mutual aid engagement and sustained affiliation, whether we are talking about women, youth, people of color, people with co-occurring disorders, or people in MAT, is the chemistry of mutual identification. Mutual identification involves each newcomer experiencing both a level of attraction that leads to one's choosing affiliation and a sense that one has been

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Hall, L. (2004). Pathways to recovery: Adapting 12-step recovery to methadone treatment, *Journal of Maintenance in the Addictions*, *2*, 77-90; McGonagle, D. (1994). Methadone Anonymous: A 12-step program. Reducing the stigma of methadone use. *Journal of Psychosocial Nursing*, *32*(10), 5-12.

[68] Seppala, M. (2013). A comprehensive response to the opioid epidemic: Hazelden's approach. *Minnesota Medicine*, *96*(3), 45-7; White, W. (2015). Recovery-focused addiction psychiatry: An Interview with Dr. Marvin Seppala. *Alcoholism Treatment Quarterly*, *33*(4), 458-473. Also See: Obuchowsky, M., & Zweben, J.E. (1987). Bridging the gap: The methadone client in 12-Step programs, *Journal of Psychoactive Drugs*, *19*(3), 301-302; Sorensen, J.L., Deitch, D.A., & Acampora, A. (1984). Treatment collaboration of methadone maintenance programs and therapeutic communities. *American Journal on Drug and Alcohol Abuse*, *19*(3), 347-359; Sorensen, J.L., Deitch, D.A. & Acampora, A. (1984). From maintenance to abstinence in a therapeutic community: Preliminary results. *Journal of Psychoactive Drugs*, *16*(1), 73-77; Zweben, J.E., Aly, T., Martin, J., Wengrofsky, S., Bacci, J., & Meddaugh, R. (1999). Making residential treatment available to methadone clients. *Journal of Substance Abuse Treatment, 17*(3), 249-56.

[69] Ludwig, A.S., & Peters, R.H. (2014). Medication-assisted treatment for opioid use disorders in correctional settings: An ethics review. *International Journal of Drug Policy*, *25*(6), 1041-6.

[70] White, W., Parrino, M., & Ginter, W. (2011). A dialogue on the psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions. Commissioned briefing paper for SAMHSA's A Dialogue on Psychopharmacology in Behavioral Healthcare conference, October 11-12, 2011. Accessed April 19, 2016 at http://www.williamwhitepapers.com/pr/2011%20SAMHSA%20Acceptance%20of%20Medication-assisted%20Treatment.pdf.

[71] Deck, D., & Carlson, M.J. (2005). Retention in publicly funded methadone maintenance treatment in two Western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60; Gryczynski, J., Mitchell, S.G., Jaffe, J.H., Kelly, J.H., Myers, C.P., O'Grady, K.E., Olsen, Y.K., & Schwartz, R.P. (2013). Retention in methadone and buprenorphine treatment among African Americans, *Journal of Substance Abuse Treatment*, *45*(3), 287-92.

[72] SAMHSA, (2014). Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS): 2011. *Discharges from Substance Abuse Treatment Services. BHSIS Series S-70, HHS Publication No. (SMA) 14-4846.* Rockville, MD: Substance Abuse and Mental Health Services Administration, pp. 49-50.

[73] Fiellin, D. A., Schottenfeld, R. S., Cutter, C. J., Moore, B. A., Barry, D. T., & O'Connor, P. G. (2014). Primary care-based buprenorphine taper vs maintenance therapy for prescription opioid dependence: A randomized clinical trial. *JAMA Internal Medicine*, *174*(12), 1947–1954; Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine*, *68*, 62-74.

[74] White, W. L., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.

chosen by the group for inclusion, e.g., a sense of belonging and coming home.[75] Crucial to achieving recovery from opioid addiction is a sense of such connection with the larger mainstream community or finding the social space where a recovery process can be incubated to maturity—within NA, another mutual aid setting, a treatment milieu, or within one's own family and social network. Key processes within NA-based recovery include a reconstruction of personal identity and reconstruction of one's social relationships—both of which flow from mutual attraction, mutual identification, and reciprocal person-community connection.[76]

Attitudes toward maintenance medications vary among NA groups.[77] Addiction professionals can attend open NA meetings and discuss this issue with medication-assisted treatment (MAT) providers and patients to identify NA meetings that are more medication-friendly and to identify local mutual aid alternatives where such alternatives are needed for people in medication-assisted recovery.[78]

Misconception 8: *People with a co-occurring psychiatric illness should not be referred to NA because they will be encouraged to cease using their medications.* Drug use disorders, and opioid use disorders in particular, often present with a co-occurring psychiatric illness. [79] In a 2014 study, Bergman and colleagues concluded that young adult patients with co-occurring substance use and psychiatric disorders "participate and benefit as much as SUD-only patients, and may benefit more from high levels of active involvement, particularly having a Twelve-step sponsor."[80] In studies of Twelve-Step participation among people with co-occurring disorders that employed multiple points of evaluation, the most common finding is that Twelve-Step participation at each point of evaluation predicts abstinence at the following point of evaluation.[81] The one counter-finding in these studies is that, compared to other psychiatric diagnoses, people with a diagnosis of schizophrenia or schizoaffective disorder have lower AA and NA participation rates and may require

[75] Kurtz, E. (1996). Spirituality and recovery: The historical journey. *Blue Book* (National Clergy Conference on Alcoholism), 47, 5-29; Labbe, A.K., Slaymaker, V., & Kelly, J.F. (2014). Toward enhancing twelve-step facilitation among young people: A systematic qualitative investigation of young adults' 12-step experiences. *Substance Abuse*, 35(4), 399-407.

[76] Davey-Rothwell, M.A., Kuramoto, S.J., & Latkin, C.A. (2008). Social networks, norms, and 12-Step group participation. *American Journal of Drug and Alcohol Abuse, 34*(2), 185-93.

[77] Narcotics Anonymous World Services, Inc. (NAWS, 2016, PR Pamphlet Draft). *Narcotics Anonymous and persons receiving medication assisted treatment*. Chatsworth, CA: Narcotics Anonymous World Services, Inc.

[78] White, W. L. (2011). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual disability Services.

[79] Seal, K.H., Shi, Y., Cohen, G., et al. (2012). Association of mental health disorders with prescription opioids and high-risk opioid use in veterans of Iraq and Afghanistan. *Journal of the American Medical Association, 307*(9), 940-947; Grant, B.F., Stinson, F.S., Dawson, D.A., Chou, P., Ruan, J., & Pickering, R.P. (2004). Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 61*(4), 361-368; Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L., & Goodwin, F.K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association*, *264*(19), 2511-2518.

[80] Bergman, B.G., Greene, M.C., Hoeppner, B.B., Slaymaker, V., & Kelly, J. (2014). Psychiatric comorbidity and 12-step participation: A longitudinal investigation of treated young adults. *Alcoholism: Clinical and Experimental Research, 38*(2), 501-510, quotation from page 510. For similar findings, see: Green, C.A., Yarborough, M.T., Polen, M.R., Janoff, S.L., & Yarborough, B.J. (2015). Dual recovery among people with serious mental illness and substance problems: A qualitative analysis. *Journal of Dual Diagnosis, 11*(1), 33-41; Laudet, A. B., Magura, S., Vogel, H. S., & Knight, E. L. (2003). Participation in 12-step-based fellowships among dually-diagnosed persons. *Alcoholism Treatment Quarterly*, *21*(2), 19-39; Timko, C., Cronkite, R.C., McKellar, J., Zemore, S. & Moos, R. (2013). Dually diagnosed patients' benefits of mutual-help groups and the role of social anxiety. *Journal of Substance Abuse Treatment*, 44(2), 216-23.

[81] Bogenschutz, M. P., Rice, S. L., Tonigan, J. S., Vogel, H. S., Nowinski, J., Hume, D., & Arenella, P. B. (2014). 12-step facilitation for the dually diagnosed: a randomized clinical trial. *Journal of Substance Abuse Treatment*, *46*(4), 403-411.

special supports to enhance Twelve-Step engagement and retention.[82]

Magura and colleagues found that participation in a Twelve-Step program for people with co-occurring psychiatric and substance use disorders (i.e., Double Trouble in Recovery) improved medication adherence.[83] While there have yet to be formal studies on NA members' attitudes about psychiatric medications comparable to those conducted on AA[84], NA's official position on the use of psychiatric medications is clear: "Some members recover in NA with mental illness that requires medication. Just as we wouldn't suggest that an insulin-dependent diabetic addict stop taking their insulin, we don't tell mentally ill addicts to stop taking their prescribed medication. We leave medical issues up to doctors."[85] In a recent survey of 22,803 NA members, 22 percent reported current use of a prescribed medication for a mental health condition.[86]

In our research and clinical activities over the collective span of more than four decades, we have witnessed significant shifts in NA attitudes toward psychotropic medications. There have been quite legitimate concerns that symptoms common to early recovery were being pathologized into self-contained illnesses and suppressed with blunt instrument medications that actually inhibited or slowed the recovery process. Such concerns have decreased as psychiatric training and psychiatric medications have improved and as NA experience has grown related to its members effectively managing concurrent psychiatric disorders.

Misconception 9: *People should not be encouraged to attend NA unless they have a pre-existing religious orientation that would make a Twelve-Step program acceptable to them.* NA's Basic Text includes the recovery story of an atheist in NA, and it outlines NA's stance on religion and spirituality.

> "At some point, we realized that we needed the help of some Power greater than our addiction. Our understanding of a Higher Power is up to us. No one is going to decide for us. We can call it the group, the program, or we can call it God. The only suggested guidelines are that this Power be loving, caring and greater than ourselves. We don't have to be religious to accept this idea."[87]

The degree to which NA's perceived religious/spiritual orientation inhibits attraction to NA or contributes to NA drop-out is unclear. Some studies report that past religious involvement is a predictor of Twelve-Step group engagement[88], while others have found that people with less

[82] Jordan, L. C., Davidson, W. S., Herman, S. E., & BootsMiller, B. J. (2002). Involvement in 12-step programs among persons with dual diagnoses. *Psychiatric Services, 53*(7), 894–896.

[83] Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., & Knight, E. (2002). Adherence to medication regimens and participation in dual-focus self-help groups. *Psychiatric Services, 53*(3), 310-316.

[84] Meissen, G., Powell, T.J., Wituk, S.A., Girrens, K., & Arteaga, S. (1999). Attitudes of AA contact persons toward group participation by persons with a mental illness. *Psychiatric Services, 50*(8), 1079–81; Rychtarik, R. G., Connors, G. J., Demen, K. H., & Stasiewicz, P. R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol, 61*(1), 134-138; Tonigan, J. S., & Kelly, J. F. (2004). Beliefs about AA and the use of medications: A comparison of three groups of AA-exposed alcohol dependent persons. *Alcoholism Treatment Quarterly, 22*(2), 67-78.

[85] Narcotics Anonymous World Services, Inc. (2010). *In times of illness*. Van Nuys, CA. Narcotics Anonymous World Services, Inc., p. 20.

[86] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[87] Narcotics Anonymous World Services, Inc. (NAWS, 2008c). *Narcotics Anonymous (6th ed.).* Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 24.

[88] Kelly, J. F., & Moos, R. (2003). Dropout from 12-step self-help groups: Prevalence, predictors, and counteracting treatment influences. *Journal of Substance Abuse Treatment*, 24(3), 241-250; Kelly, J.F., Pagano, M.E., Stout, R.L., & Johnson, S.M. (2011). Influence of religiosity on 12-Step participation and treatment response among substance-dependence adolescents. *Journal of Studies on Alcohol and Drugs*, *72*, 1000-1011.

religious orientation who participate in Twelve-Step groups experience benefits similar to those with greater religious orientation[89].

More than half (65 percent) of NA members describe themselves as "spiritual but not religious," only 25 percent of NA members report monthly church attendance, and 4 percent describe themselves as neither spiritual nor religious[90]. Also of note is the growth of NA in more secular (e.g., the UK) and non-Christian (e.g., Iran) countries, the acceptability of and positive responses to NA and other Twelve-Step programs among persons being treated for drug dependence in those countries, and the enhanced five-year post treatment recovery outcomes among those participating in NA in those countries[91].

While spirituality is unquestionably a component of NA-based recovery[92], other mechanisms of change operating within the NA program are congruent with secular approaches to addiction treatment and recovery support[93]). There is a growing secular wing within Twelve-Step programs (e.g., AA Agnostica, NA meetings for agnostics) and increased evidence of a shared spirituality across secular, spiritual, and religious frameworks of recovery. This shared foundation of experience is reflected in the prepositions *within* (discovery of inner strengths), *between* (mutual identification), *beyond* (higher purpose and meaning) and in six shared dimensions of the recovery experience: release (freedom from addiction), gratitude, humility, tolerance, forgiveness, and being-at-home (connection to community)[94]. The degree to which such secularization has and will affect NA has not been investigated. There is also a growing network of secular recovery mutual aid organizations in the U.S. (e.g., Women for Sobriety, Secular Organizations for Sobriety, SMART Recovery, Lifering Secular Recovery), but the extent to which these organizations are or could be a resource for individuals seeking recovery from opioid addiction has not been investigated.

Misconception 10: *NA (Twelve-Step) involvement is another form of dependency (one addiction for another) that personally and politically disempowers its members, compromises quality of life, and perpetuates social isolation within a drug-oriented social network*.

Some individuals entering NA leave behind lives completely dominated by addiction, including prolonged enmeshment in cultures of addiction. It is not unusual for such individuals for a time to become deeply enmeshed in NA as an alternative culture (White, 1996). Some of these individuals remain enmeshed in an NA-dominated lifestyle in ways that casual observers might

[89] Brown, B.S., O'Grady, K.E., Farrell, E., Flechner, I.S., & Nurco, D.N. (2001). Factors associated with the frequency of 12-Step attendance by drug abuse clients. *American Journal of Drug and Alcohol Abuse*, 271, 147-60; Christo, G., & Franey, C. (1995). Drug users' spiritual beliefs, locus of control and the disease concept in relation to Narcotics Anonymous attendance and six-month outcomes. *Drug and Alcohol Dependence*, 38(1), 51-56; Winzelberg, A., & Humphreys, K. (1999). Should patients' religiosity influence clinicians' referral to 12-Step self-help groups? Evidence from a study of 3,018 male substance abuse patients. *Journal of Consulting & Clinical Psychology*, 67(5), 790-794.

[90] Galanter, M., Dermatis, H., Post, S., & Sampson, C. (2013). Spirituality-based recovery from drug addiction in the Twelve-Step fellowship of Narcotics Anonymous. *Journal of Addiction Medicine*, 7(3), 189-195.

[91] Best, D. W., Harris, J. C., Gossop, M., Manning, V. C., Man, L. H., Marshall, J., & Strang, J. (2001). Are the Twelve Steps more acceptable to drug users than to drinkers? A comparison of experiences of and attitudes to Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) among 200 substance misusers attending inpatient detoxification. *European Addiction Research*, 7(2), 69-77; Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction*, 103(1), 119-125.

[92] Galanter, M., Dermatis, H., Post, S., & Sampson, C. (2013). Spirituality-based recovery from drug addiction in the Twelve-Step fellowship of Narcotics Anonymous. Journal of Addiction Medicine, 7(3), 189-195; Zemore, S.E., (2007). A role for spiritual change in the benefits of 12-Step involvement. *Alcoholism: Clinical & Experimental Research*, 31(10), Supplemental, 76s-79s.

[93] Moos, R. H. (2007). Theory-based processes that promote the remission of substance use disorders. *Clinical Psychology Review*, 27(5), 537-551.

[94] Kurtz, E., & White, W. (2015). Recovery spirituality. *Religions*, 6(1), 58-81.

cast as "addicted to NA," but it is our collective observation from decades of professional observation that most NA members maintain mutually supportive NA relationships while progressively integrating into the larger life of the community. Studies of the effects of NA participation on community participation and community service have concluded that the majority of NA members initiate wider community involvement and service after their involvement in NA, and also note that such involvement came at the encouragement of NA sponsors and other NA members.[95] Such community involvement can be a key element in forging a pro-social identity in recovery and creating more positive community attitudes towards people in addiction recovery.[96] The finding that NA involvement enhances community involvement suggests an opposite effect from what has been alleged. Even when continued enmeshment in NA is required for recovery stability, most would consider this a far better alternative than being drawn back to the social world of active addiction and its eventual consequences on health, social functioning, and mortality.

Most NA meetings are more focused on recovery-based coping than a detailed recounting of drug use tales that might serve as triggers for drug-craving and drug-seeking (such "drugalogs" are discouraged within NA). As a whole, NA meetings are more focused on how one lives without drugs than the details of how one lived with them[97], as is emphasized in *Living Clean*--NA's guide for living in recovery.[98]

People treated for drug dependence who participate in weekly NA following treatment are more likely to achieve sustained abstinence than those who do not participate in NA.[99] Research to date suggests that participation in NA enhances quality of life in a number of key areas, including reduced drug craving, reduced HIV/HCV risk, and enhancement of emotional health (decreased anxiety and depression and increased self-esteem), housing stability, stability of intimate relationships, family unification and support, social network reconstruction, connection to community, and enhanced life meaning and purpose via service to others.[100]

The mechanisms of change within NA include meeting attendance, mutual

[95] Kurtz, L. F., & Fisher, M. (2003a). Participation in community life by AA and NA members. *Contemporary Drug Problems, 30*(4), 875-904; Kurtz, L.F., & Fisher, M. (2003b). Twelve-Step recovery and community service. *Health & Social Work, 28*(2), 137-145.

[96] Best, D. (2016). An unlikely hero? Challenging stigma through community engagement. *Drugs and Alcohol Today, 16*(1), 106-116.

[97] Withers, R. (2014). Six myths about Narcotics Anonymous you probably believe. Accessed April 11, 2016 at (http://blog.com.blog/6-myths-about-narcotics-anonymous-you-probably-believe)

[98] Narcotics Anonymous World Services, Inc. (2012). *Living clean: The journey continues*. Van Nuys, CA. Narcotics Anonymous World Services, Inc.

[99] Christo, G., & Franey, C. (1995). Drug users' spiritual beliefs, locus of control and the disease concept in relation to Narcotics Anonymous attendance and six-month outcomes. *Drug and Alcohol Dependence, 38*(1), 51-56; Galanter, M., Dermatis, H., Post, S., & Santucci, C. (2013). Abstinence from drugs of abuse in community-based members of Narcotics Anonymous. *Journal of Studies on Alcohol and Drugs, 74,* 349-352; Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction, 103*(1), 119-125; Fiorentine, R. (1999). After drug treatment: Are 12-step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse, 25*(1), 93-116.

[100] Christo, G., & Sutton, S. (1994). Anxiety and self-esteem as a function of abstinence time among recovering addicts attending Narcotics Anonymous. *British Journal of Clinical Psychology, 33*, 198-200; Narcotics Anonymous World Services, Inc. (NAWS, 2013). Membership survey. Retrieved April 17, 2016 from https://www.na.org/admin/include/spaw2/uploads/pdf/PR/NA_Membership_Survey.pdf; DeLucia, C., Bergman, B.G., Formoso, D., & Weinberg, L. (2015). Recovery in Narcotics Anonymous from the perspectives of long-term members. *Journal of Groups in Addiction & Recovery*, *10*(1), 3-22; Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,…Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment, 26*(3), 151-158; Orwat, J., Samet, J. H., Tompkins, C. P., Cheng, D. M., Dentato, M. P., & Saitz, R. (2011). Factors associated with attendance in 12-step groups (Alcoholics Anonymous/Narcotics Anonymous) among adults with alcohol problems living with HIV/AIDS. Drug and Alcohol Dependence, *113*(2-3),

identification/affiliation, step work, spiritual awakening, identity reconstruction, and the therapeutic effects of helping others.[101] These processes of change resemble elements found within evidence-based treatments for substance use disorders, e.g., exposure to abstinence norms and role models, abstinence-specific social support, goal-setting, monitoring, contingent reinforcement, self-efficacy, acquisition of coping skill, and exposure to pleasurable drug-free activities.[102] Such effects experienced within NA are a function of both intensity of involvement (number of meetings and other Twelve-Step activities) and duration of recovery support activities, underscoring the fact that recovery stabilization and enhanced quality of life require both active participation and time.[103] These effects of NA participation have been documented for adults[104] and for adolescents[105], and may be further amplified when combined with professional treatment.[106]

Misconception 11: *NA does not have a role in reducing the social costs of opioid addictions nor in other social contributions.* No specific studies of the economic and social contributions of NA have been conducted, but studies of AA and Twelve-Step programs for those with co-occurring disorders have concluded that Twelve-Step participation reduces continuing care costs[107] and post-treatment health care costs.[108]

165-171; Rafalovich, A. (1999). Keep coming back - Narcotics Anonymous narrative and recovering-addict identity. *Contemporary Drug Problems*, *26*, 131-157; Sibthorpe, B., Fleming, D., & Goould, J. (1994). Self-help groups: A key to HIV risk reduction for high risk drug users? *Journal of AIDS, 7*(6), 592-598.

[101] Crape, B. L., Latkin, C. A., Laris, A. S., & Knowlton, A. R. (2002). The effects of sponsorship in 12-step treatment of injection drug users. *Drug and Alcohol Dependence, 65*(3), 291-301; Galanter, M., Dermatis, H., & Sampson, C. (2014). Narcotics Anonymous: A comparison of military veterans and non-veterans. *Journal of Addictive Diseases, 33*(3), 187-95; Rafalovich, A. (1999). Keep coming back - Narcotics Anonymous narrative and recovering-addict identity. *Contemporary Drug Problems*, *26*, 131-157; Toumbourou, J., Hamilton, M., U'Ren, A., Stevens-Jones, P., & Storey, G. (2002). Narcotics Anonymous participation and changes in substance use and social support. *Journal of Substance Abuse Treatment, 23*(1), 61-66.

[102] Moos, R. H. (2007). Theory-based processes that promote the remission of substance use disorders. *Clinical Psychology Review*, *27*(5), 537-51; Moos, R. H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction, 103*, 387-396.

[103] Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction, 103*(1), 119-125; Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-step self-help groups and 6-month substance use disorder outcomes. *Addiction, 101*, 678-688.

[104]Christo, G., & Franey, C. (1995). Drug users' spiritual beliefs, locus of control and the disease concept in relation to Narcotics Anonymous attendance and six-month outcomes. *Drug and Alcohol Dependence, 38*(1), 51-56; Christo, G., & Sutton, S. (1994). Anxiety and self-esteem as a function of abstinence time among recovering addicts attending Narcotics Anonymous. *British Journal of Clinical Psychology, 33*, 198-200; Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction, 103*(1), 119-125.

[105]Kelly, J. F., Dow, S. J., Yeterian, J. D., & Kahler, C. W. (2010). Can 12-step group participation strengthen and extend the benefits of adolescent addiction treatment? A prospective analysis. *Drug and Alcohol Dependence, 110*(1-2), 117-125; Kelly, J.F., & Myers, M.G. (2007). Adolescents' participation in alcoholics anonymous and narcotics anonymous: Review, implications and future directions. *Journal of Psychoactive Drugs, 39*(3), 259-269; Sussman, S. (2010). A review of Alcoholics Anonymous/ Narcotics Anonymous programs for teens. *Evaluation & the Health Professions*, *33*(1), 26-55.

[106] Chen, G. (2006). Social support, spiritual program, and addiction recovery. *International Journal of Offender Therapy & Comparative Criminology, 50*(3), 306-23; Krentzman, A. R., Moore, B. C., Robinson, E. A. R., Kelly, J., Kurtz, E., Laudet, A.,…Zemore, S. (2011). How Alcoholics Anonymous and Narcotics Anonymous work: Cross-disciplinary perspectives. *Alcoholism Treatment Quarterly*, *29*(1), 75-84.

[107] Humphreys, K., & Moos, R.H. (2007). Encouraging posttreatment self-help group involvement to reduce demand for continuing care services: Two year clinical and utilization outcomes. *Alcoholism: Clinical and Experimental Research, 31*(1), 64-68.

[108] Humphreys, K., & Moos, R.H. (1996). Reduced substance-related health care costs among voluntary participants in Alcoholics Anonymous. *Psychiatric Services, 47*(7), 709-713; Humphreys, K. & Moos, R.H. (2001). Can encouraging substance abuse patients to participate in self-help groups reduce demand for health

The potential reduction of social costs related to opioid addiction is substantial given NA's contribution to long-term recovery outcomes, its geographical availability, and its 24-hour accessibility at no cost to the government or private insurers. Humphreys and Moos sum up the work to-date on the potential cost-offsets from adult recovery mutual aid participation:

> *Certain tasks supportive of recovery, such as encouragement, social activities, friendship, monitoring and spiritual support, can probably be accomplished by peer-based services as well as they can by health care professionals, and at greatly reduced cost. This has a 2-fold benefit: greater likelihood of long-term recovery for the addicted individual and greater targeting of scarce professional resources to those patients who require such assistance….self-help group involvement is a useful method of extending the benefits of treatment while lowering its ongoing costs.*[109]

Similar to adult findings, Mundt and colleagues examined the effects of Twelve-Step participation among youth following treatment for a substance use disorder within one of four Kaiser Permanente Northern California treatment programs. They found that health care costs declined in tandem with increases in Twelve-Step meeting attendance. At one-year follow-up, those adolescents who attended 10 or more Twelve-Step meetings experienced a 65 percent reduction in health care costs—primarily related to cost reductions in inpatient hospital admissions, psychiatric visits, and further substance use treatment.[110]

The integration of NA and other recovery mutual aid organizations within current health reform efforts (e.g., assertive linkage to NA by primary care physicians) could play a potentially critical role in reducing the social costs of opioid addiction in the United States[111], to say nothing of what NA-guided recoveries would add to local and national economies via income generation and taxes, business development, and charitable contributions.

Seen as a whole, the above misconceptions state or imply the potential for detrimental effects of NA participation. These and other related criticisms of NA can be subjected to scientific analysis within the context of future NA studies.

There is a long history of harm in the name of help within a broad spectrum of policy, treatment, and recovery support initiatives.[112] Recent reviews of iatrogenic (treatment-caused) effects of professionally-directed psychosocial interventions for substance use disorders note that 7-15 percent of patients experience clinical deterioration during or immediately following such interventions.[113] Although reports of such harm within NA, and more frequently AA, can be found in online discussions and a growing body of Twelve-Step backlash literature, the existence, nature, and prevalence of such injuries have not been

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care: A quasi-experimental study. *Alcoholism: Clinical and Experimental Research, 255*, 711-6.

[109] Humphreys, K. & Moos, R.H. (2007). Encouraging posttreatment self-help group involvement to reduce demand for continuing care services: Two year clinical and utilization outcomes. *Alcoholism: Clinical and Experimental Research, 31*(1), 64-68. Quotation from page 67.

[110] Mundt, M.P., Pathasarathy, S., Chi, F.W., Sterling, S., & Campbell, C.I. (2012). 12-step participation reduces medical costs among adolescents with a history of alcohol and other drug treatment. *Drug and Alcohol Dependence, 126*(1-2), 124-30.

[111] Kelly J. F., & Yeterian, J. (2012). Empirical awakening: The new science on mutual help and implications for cost containment under health care reform. *Substance Abuse, 33*, 85-91.

[112] White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems; White, W.L., & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals. *Counselor, 9*(6), 10-17. .

[113] Moos, R. H. (2005). Iatrogenic effects of psychosocial interventions for substance use disorders: Prevalence, predictors, prevention. *Addiction, 100*(5), 595-604; Ilgen, M. A., & Moos, R. (2006). Exacerbation of psychiatric symptoms during substance use disorder treatment. *Psychiatric Services, 57*, 1758-1764.

reported in the scientific literature, with the exception of one adolescent study noted above on safety at AA and NA meetings.[114]

In closing, there are limitations on all of the above-cited evidence, but these studies represent the most current and credible scientific data available on NA and the effects of NA participation on recovery outcomes. The number and methodological rigor of AA studies have increased exponentially[115], and we expect the same for NA studies of the future. NA World Services is collaborating with addiction researchers to expand the number and quality of studies conducted on NA.[116] Such studies will help separate what we know from the standpoint of science about NA from the far more widely disseminated myths, misconceptions, and speculations.

Conclusions

Media coverage and professional discourse related to opioid-related deaths and devastation heighten awareness and fear, but all too often reveal little if any information on the lived solutions to opioid addiction as experienced within NA and other peer-based recovery support institutions. As one anonymous reviewer of this paper attested:

> *Stories on addiction and recovery in the press have tended to focus on late addiction and early recovery and/or celebrities, because that's where the drama is. A focus on the lives of people in long term recovery are dramatic only by virtue of contrast with their former lives of active addiction, but just aren't as sexy as a good, recent crash and burn followed by the hopefulness of a person fresh out of treatment. These untold long-term recovery stories, however, are where the real hope lies….Telling that story is where the press could make a significant contribution toward the common good.*

We believe the reviewed misconceptions about NA contribute to the paucity of such attention. Increased coverage of people in long-term recovery from opioid addiction and the role of NA and other recovery support institutions in such achievement would help move the national conversation on opioid addiction from a focus on the problem to a focus on the lived solutions that now exist in communities across America. NA has distinguished itself for more than 60 years as an organization with the singular goal of supporting addiction recovery. It is time such contributions were more fully appreciated at public and professional levels, more research attention was conducted on NA, and NA resources were more fully integrated within public health responses to rising opioid addiction.

How might the individual, family, and community trajectory of opioid addiction be altered if every naloxone administration, every treatment admission and discharge (regardless of modality or setting), every drug-related visit to a general practitioner or health clinic, and every drug-related HIV or HCV screening were accompanied by assertive linkage to NA or other recovery mutual aid resources? We believe it is time to test that potential. Forging an assertive, long-term public health response to opioid addiction will require more than a rising sense of urgency; it will require forging partnerships with those individuals and

[114]Kelly, J. F., Dow, S. J., Yeterian, J. D., & Kahler, C. W. (2010). Can 12-step group participation strengthen and extend the benefits of adolescent addiction treatment? A prospective analysis. *Drug and Alcohol Dependence, 110*(1-2), 117-125.

[115] Kelly J. F., & Yeterian, J. (2012). Empirical awakening: The new science on mutual help and implications for cost containment under health care reform. *Substance Abuse, 33*, 85-91.

[116] Galanter, M., Dermatis, H., Post, S., & Sampson, C. (2013). Spirituality-based recovery from drug addiction in the Twelve-Step fellowship of Narcotics Anonymous. *Journal of Addiction Medicine, 7(3)*, 189-195.

organizations who understand the need for such urgency in its most human terms.

There is a pervasive pessimism about the long-term prospects of recovery from opioid addiction. Tens of thousands of NA members in long-term recovery from opioid addiction stand as a living refutation of such pessimism. That fact is the least told story in media and professional discussions of opioid addiction. Innumerable individuals, families, and communities will be ill-served if we neglect the role NA and other recovery mutual aid organizations can play in supporting long-term recovery from opioid addiction.

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Galanter, M., White, W., Ziegler, P., & Hunter, B. (2020). An empirical study on the construct of “God” in the Twelve Step process. *American Journal of Drug and Alcohol Abuse*. https://doi.org/10.1080/00952990.2020.1789870

ABSTRACT

Background: The term God, included in 5 of the 12 Steps of Narcotics Anonymous (NA) and Alcoholics Anonymous (AA), self-designated spiritual fellowships, has not been studied empirically relative to members’ experiences. A greater understanding of this can be clinically useful and can shed light on the 12 Step process of recovery.

Objectives: To determine how NA members understand the 12-step concept “God as we understood Him” and the relationship between their understanding of God and the intensity of their craving and depressive symptoms.”

Methods: 450 (59% male) NA members completed a survey related to their experiences relative to their relationship with “God.” The relationship among these variables and comparisons to the general population was analyzed. Craving and depressive symptoms were assessed by self-report.

Results: 98% of the NA participants believe in God explicitly or some other higher power (vs 89% of a probability sample of the US population), 67% believe that God determines what happens to them some or all of the time (vs 48%), 78% (vs 28%) report hearing God talking to them “in their mind”; and 37% report that God talks to them “out loud.” Acceptance of 12 Step God-related variables inversely predicted a significant portion of the variance of scores on craving (7.5%) and depression (13.5%). Conclusions: Respondents’ understanding of God in NA varied considerably and was predictive of their depressive symptoms and craving intensity. These findings can serve as a basis for research into mechanisms underlying NA/AA recovery experiences and can also aid clinicians in how to employ these programs.



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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Addiction Risk Factors and Recovery Story Construction

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Those of us with a personal or professional stake in the alcohol and other drug problems arena find ourselves questioning the differences between:

1) people who use alcohol and other drugs (AOD) without developing a substance use disorder (SUD) versus those who develop such a disorder of great severity, complexity, and chronicity;

2) people who resolve AOD/SUD problem without formal participation in recovery mutual aid groups and/or addiction treatment versus those who benefit from significant involvement with such resources;

3) people who resolve alcohol or opioid use disorders without medication support or only a brief course of such support versus those who require prolonged medication for successful recovery stabilization and maintenance; and

4) people who resolve AOD/SUD-related problems by decelerating AOD use versus those who are able to achieve successful recovery only through sustained AOD abstinence.

At a personal level, understanding these distinctions is critical to assessing one's own substance use disorder (SUD) risk and for identity/story construction within the recovery process. For those seeking recovery, such understandings provide answers to such questions as:

"Why me?"

"How did this happen?"

“What must I do to escape this situation?”

“How do I prevent getting in this situation again?”

At professional, peer, and family support levels, understanding the nuanced answers to such questions enhances our effectiveness as helpers.

I have returned to these questions on numerous occasions in my books, monographs, and articles. Newly published reviews of the scientific literature, one led by Kelly Green and another by Angelica Morales, summarize advancements in assessing and predicting SUD risk. Drawing on a lifetime of clinical observation, my previous writings, and the Green et al and Morales et al reviews, the checklist below highlights key SUD risk factors. The below checklist may be used as a self-assessment instrument or completed with the aid of a peer recovery coach or professional therapist.

Place an (X) before each risk factor that to the best of your knowledge applies to your personal circumstances:

Biological Vulnerability

___ Parental, sibling, extended family, and/or past generational history of AOD problems
___ Male
___ Prenatal AOD exposure
___ Potential dopamine deficiency as indicated by such symptoms as muscle cramps/spasms/tremors/stiffness, memory impairment, low motivation, impaired concentration, or depression
___ High or low AOD tolerance from onset of use (compared to one’s peers)
___ Enhanced pleasure from drug use, e.g., euphoric recall of your first physical/emotional response to alcohol and/or another drug

Medical/Psychiatric Vulnerability

___ Low tolerance for pain
___ Use of AOD to reduce chronic physical pain
___ Use of AOD to counter sleeping difficulties
___ Use of AOD to mask or self-medicate sexual dysfunction
___ Use of AOD as masking, self-medication, or manifestation of psychological distress or psychiatric condition, e.g., anxiety, post-traumatic stress disorder, depression, bipolar disorder, attention deficit hyperactivity disorder, schizophrenia, mild autism)
___ Multiple medical/psychiatric conditions

Pattern of Use Vulnerability

___ Drugs of choice with high addiction potential (e.g., tobacco, alcohol, opioids, stimulants)
__ Multiple drug use (concurrent or sequential use of alcohol, tobacco, and other drugs)
___ Higher-risk mode of ingestion (e.g., drug injection, smoking)
___ High volume and frequency of drug use
___ Solitary drug use
___ Impairment in high-risk contexts (AOD use while driving, swimming, or other high-risk physical activities)
___ Loss of control cluster (diminished control over frequency, timing, quantity, settings, and consequences of AOD use; failed pledges to cease or reduce AOD use; radical personality change while using)

Personality Trait Vulnerability

___ Extraversion
___ Conduct disorder in childhood/adolescence (school adjustment problems, aggressive behavior, stealing, vandalism, cruelty to animals, deceitfulness, sexual acting out)
___ Borderline personality disorder
___ Antisocial personality disorder
___ Impulsivity
___ Risk-taking / Sensation-seeking
___ Narcissism (self-centeredness)

Family/Developmental Vulnerability

___ Historical trauma (membership in a historically oppressed group that continues to experience stigma, discrimination, and microaggressions)
___ Low or high financial insecurity of family during childhood/adolescence
___ Housing instability or homelessness in childhood
___ Food insecurity in childhood
___ Parental neglect (weak parental supervision / low parental involvement during childhood and adolescence)
___ Early abandonment and loss (e.g. parental or sibling death/separation)
___ Victimization, (e.g., physical/sexual abuse or assault (particularly in presence of traumagenic factors, i.e., early age of onset, long duration of victimization, multiple perpetrators, perpetrators from within family or social network, disbelief or blame following victimization disclosure, and paucity of healing resources)
___ Horrification (exposure to victimization of others, e.g., witnessing parental or neighborhood violence, war casualties, terrorism, genocide, forced mass migration)
___ Family conflict during childhood
___ Parental (biological, adoptive, stepparent) modeling of excessive substance use and related problems
___ Provision of alcohol or other drugs to you by parents or older sibling
___ Low or high level of academic performance
___ Early onset of puberty

___ Early age of onset of AOD use/intoxication
___ Onset of AOD-related problems between before age 18 or after age 65 (developmental windows for problem onset vulnerability)
___ Single, divorced, or widowed
___ Complicated (prolonged and excessive) grief from loss of significant people, property, or positions
___ Unemployed or retired
___ High cumulative lifetime adversities
___ Weak extended family and social support relationships

Environmental Vulnerability

___ High availability of alcohol, tobacco and other drugs within one's living environment, work environment, and/or neighborhood
___ High exposure to drug-related promotional media (alcohol, tobacco and drug advertising; exposure to drug-promoting music, films, and literature)
___ Close peers who frequently use alcohol, tobacco, and other drugs
___ Close friends with AOD-related problems

Checklist Experience

___ I denied or minimized items in this checklist that I know I should have checked
___ The number or risk factors checked would have been higher for me if family members and friends had completed this on my behalf

There are 52 risk factors listed above. How many of these risk factors apply to your personal circumstances?

Unfortunately, there is no clear cutoff score predicting SUD risk because studies to weigh the relative import of each factor are limited, nor are there definitive studies on the combination of risk factors most predictive of SUD development. In sorting out the implications of the risk factors you identified, consider the following.

*The above list is not complete. There are risk factors not noted above, such as gene-mediated neurobiological differences in drug sensitivity and subsequent cellular adaptations to the drug experience that may heighten SUD vulnerability—differences and adaptations that we will likely be able to medically screen for in the future. For now, the above list includes those risk factors that can be most easily self-assessed.

*The sheer volume of SUD risk factors affirms that there are as many pathways into AOD problems as there are pathways of problem resolution, suggesting skepticism when hearing anyone claiming discovery of THE singular cause or cure of addiction.

*Risk factors are not destiny. It is possible to have a low number of risk factors and still develop significant AOD/SUD-related problems; it is possible to have a high number of risk factors and not develop a SUD, particularly in the presence of numerous protective factors (e.g., recovery capital). The low predictive power of a single risk factor is not unique to SUD and is common across a wide spectrum of medical and psychiatric

disorders. The risk factor checklist above is about probabilities, not certainties, but the list may help you understand things that unfolded in your life that are otherwise inexplicable.

*Protective factors are internal and external resources, relationships, experiences, and activities that that have the power to offset risk factors and increase the probability of SUD resistance, resilience, and recovery. Examples of such protective factors include adult onset of AOD exposure, medical/psychiatric health, family health and stability, neighborhood safety and stability, positive role models and mentors, academic and occupational success, effective coping skills, early access to problem-solving resources, and life purpose and meaning.

*Some risk factors bear significant greater power for SUD prediction. For example, studies to date suggest that family history (genetic vulnerability) accounts for more than half of the overall risk for SUD development, with persons with an addiction family history having 10 times the risk of SUD development compared to those without such a history. Other than family history, the predictive power of any single risk factor alone is weak.

*Risk factors vary by drug choice, with some factors predictive of alcohol use disorder or opioid use disorder, but not other SUDs.

*We are at an early stage of determining how risk factors interact with each other and with other influences. Risk factors are likely additive and synergistic, meaning the greater the number of risk factors (particularly when combined with SUD family history), the great the risk for problem development. There may also be particular combinations or sequences of risk factors that dramatically elevate the risk of SUD onset, a prolonged course, and a worse long-term outcome. The volume of risk factors and the particular combination of risk factors interact with personal characteristics (such as gender and drug choice) to create an ignition point of dramatically heightened SUD risk and dictate the speed and severity of SUD progression. Future scientific studies will likely identify these potent combinations and sequences.

*Combining risk assessment and assessment of recovery capital provides a framework for self-assessment, for exploring the viability of various recovery pathways, and for determining the best level of care needed at a particular point in time. The goals are to provide guidance to personal decision-making and at a policy level to allocate limited prevention, harm reduction, early intervention, treatment, and recovery support services to those at high risk of developing the most severe, complex, and chronic SUDs.

My overall conclusion? The risk of SUD development, the need for peer and professional recovery support in achieving SUD remission, the need for medication support for successful recovery maintenance, and the greater viability of abstinence versus moderation resolution strategies all increase as the number of SUD risk factors increases and the number of protective factors decline. In short, the answer to “Who is at highest risk for addiction and why?” provides the same answer to “Who is most likely

to need peer and professional support, most benefit from medication support, and most benefit from abstinence versus moderation approaches to problem resolution?"

At present, the best we can do in terms of assessment technology is to help people identity combinations of risk factors and protective factor deficiencies that are associated with the highest SUD severity/complexity/duration. While this may help some individuals make future drug use decisions and increase self-monitoring, the greatest value of risk research will likely be in helping people seeking recovery answer the "Why me?" and "What now?" questions as part of recovery story construction.

Also worth noting: before we blame addiction on the poor choices or weak character of the individual, we should note how many SUD risk factors are beyond one's personal control. For people at risk for or experiencing these problems, what IS within our control is the decision to mobilize resources to prevent, neutralize, and overcome these risk factors. Insight into SUD causative factors does not, in itself, spontaneously initiate stable recovery, but it can be an important anchor to building a personal recovery story and reducing risk of SUD recurrence. Understanding these factors and how they interact can also increase the effectiveness of those providing recovery support services. I hope the checklist provided here will help achieve those multiple purposes. It is my hope that future research weighing the import of particular risk and protective factors will result in a brief SUD prediction checklist.

In closing, I would be remiss if I did not also acknowledge the potential dark side of AOD/SUD risk prediction technologies. Such technologies could produce unintended harm via discrimination against people labeled "at SUD risk" via discrimination in education, employment, public benefits, health and life insurance, etc. Claims of genetic risk for alcoholism, for example, led to the inclusion of addicted people in mandatory sterilization laws during the height of the eugenics movement in the United States during the early twentieth century and to the attempted genocidal elimination of addicted people in Nazi Germany. We must remain mindful of the potential misuse of risk prediction and insure safeguards that prevent such misuse.

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Addiction and Recovery in American Comic Books and Graphic Novels[1]

Alisha White, PhD and Bill White, MA



Representations of addiction and addiction recovery in literature, music, art, film, theatre, and comedy simultaneously reflect and shape the historical evolution of these experiences. This paper explores the portrayal of drug use and addiction in American comic books and graphic novels.

Comic books in the United States began as syndicated series within newspapers and then emerged in the 1930s as independent publications—spurred in great part by the enormous popularity of Jerry Siegel and Joe Shuster's *Superman.* The success of *Superman* spawned the "superhero" genre of American comic books, including Captain America, Plastic Man, Flash, Green Lantern, Captain Marvel, and numerous others. Topically, comic books expanded exponentially into the arenas of science fiction, fantasy, adventure, romance, police procedurals, animal stories, horror, cultural satire, and pornography. New formats emerged as compiled collections, webcomics, graphic novels, and graphic biographies and memoirs. Comic books evolved into a social subculture and industry whose central characters have been further popularized in television and film.

In 1954, the Comics Magazine Association of America banned all drug references in its "Comics Code" based on the belief that such references would trigger youth curiosity and drug experimentation. Stan Lee, Editor-in-Chief at Marvel Comics, challenged this code in 1971 by portraying addiction and its consequences in *The Amazing Spider-Man* series #96 - #98. Lee's action, and the positive public response to the series, opened the door for the portrayal of drug use and addiction in American comic books. Lee's actions were part of his larger effort to address social issues of his day, including civil rights, disability rights, gay rights, war, and civil disobedience. Lee's efforts set the stage for the subsequent portrayal of addiction and recovery in American comic books and graphic novels.

Since *The Amazing Spider-Man*, superhero comic books have weaved authentic human struggles, and specifically mental health disorders, within their storylines. American comic books and graphic novels have been effective vehicles for conveying information on a broad spectrum of health challenges, including childhood trauma, depression, bipolar disorder, schizophrenia, obsessive-compulsive Disorder, anorexia, and a wide spectrum

[1] This paper merges a collection of five blogs posted by the authors at www.williamwhitepapers during December 2020 and January 2021.

of substance use disorders (A. White, 2020).

The authors are currently investigating the historical portrayal of addiction and recovery within American comic books and graphic novels. To date, we have identified 35 comic books and 9 graphic novels and graphic biographies and memoirs that portray drug use, addiction, and addiction recovery within their storylines. Below are some preliminary observations on the portrayal of drug use and addiction.

Format Limitations

Drug use, addiction, and recovery in American comic books appear in a few panels or page spreads, often unfolding across multiple volumes, within a larger dramatic storyline. In addition, characters often come in and out of storylines across different titles often called crossovers. For example, both Carol Danvers and Tony Stark have addiction related plots that cross over between *The Invincible Ironman* and *The Avengers* series. This can make it difficult to track down each relevant plotline in long running comic book series. In contrast, graphic novels, such as *The Abominable Mr. Seabrook*, *The Brandon Novak Chronicles*, and *Sobriety: A Graphic Novel* provide a more focused, nuanced portrayal of addiction and recovery.

Addiction as Inevitable Consequence of Drug Use

The portrayal of addiction and recovery is a subset of the much larger portrayal of alcohol and other drug use within American comic books and graphics novels. American comic books, mirroring popular and professional conceptions, make little distinction between drug use (particularly illicit drug use) and drug addiction, with drug use portrayed primarily as an inevitable precursor to addiction. Portrayal of positive aspects of drug use are rare (e.g., *Animal Man*) and mostly contained in such counter-culture classics as *The Fabulous Furry Freak Brothers*, *James Bong*, and *Marijuana Man*. Illicit drug use is portrayed dichotomously as abstinence (good) or addiction (evil). American comic books portray addiction as a progressively accelerating process of personal deterioration, social estrangement, and economic impoverishment.

Addiction as an Intrapersonal Vulnerability

American comic books and graphic novels portray addiction in highly personal terms (i.e., individual vulnerability) with little reference to its political, economic, and social ecology. Such portrayal is congruent with biological and psychological models of addiction but ignore environmental influences on the etiology and long-term course of addiction. The portrayed class context of drug use follows two lines: impoverished inner-city environments or the subculture of wealth and celebrity. This dichotomy can be seen clearly when comparing Holly Robinson's narration in *Catwoman: Crooked Little Town* of drug use within life on the streets with Tony Stark's alcohol use as part of a lavish celebrity lifestyle in *The Invincible Ironman: Demon in the Bottle*.

The Drug Menu

American comic books portray addiction to a broad spectrum of drugs

and other compulsive behaviors (i.e., shoplifting, pornography, self-injury). The addictive substances include those with a traditional pedigree (alcohol, cocaine, methamphetamine, opium, heroin, prescription drugs, ketamine, designer drugs) as well as fictionalized substances such as Venom, Miraclo, Rave, Chocos, Mutant Growth Hormone, Kryptonite, and Substance D that possess a wide range of narcotic, hallucinogenic, or performance-enhancing properties. The rarity in which cannabis appears in addiction/recovery storylines within American comic books is interesting in light of both increased clinical interest in cannabis dependence and changing legal and social policies toward cannabis. Rather than portrayal in fictional comic books, cannabis is a topic explored through graphic nonfiction, such as Box Brown's *Cannabis: The Illegalization of Weed in America*.

Single versus Multiple Drug Use

Addiction in American comic books is most often portrayed as dependence upon a single substance, in contrast to the polydrug use pattern most prevalent among those currently entering addiction treatment in the U.S.

Addiction Demographics

Early comic book culture in the U.S. was dominated by 20- and 30-something White men. Although comic book characters have evolved toward greater diverse representation, the portrayal of women, people of color, and LGBTQ within addiction/recovery storylines remains missing or narrowly subscribed.

Addiction Gender

Addicted women are portrayed physically, morally, and sexually degraded beings devoid of self-agency. Stoddart (2006) suggests this portrayal fits the poisoned maiden archetype: "the female drug addict who is preyed upon by villainous men and saved by heroic men." Left untold are the transformations that unfold for female characters through the recovery process—an issue we will explore in more depth in a forthcoming blog.

Portrayed Color and Sexual Orientation of Addiction

Addiction-related American comic storylines present characters of color as part of the multi-hued illicit drug culture—a stage for the actions of White superheroes. The only key characters of color in addiction story lines were Cecelia Reyes (*X-Men*), Eli Bradley (*Young Avengers*), and Tyrone Johnson (*Cloak & Dagger*). Although gay characters are beginning to appear in comic books (e.g., *Iceman, Young Avengers*), we found only two LGBTQ characters appearing in an addiction/recovery storyline—Holly, a lesbian and recovering heroin addict (*Catwoman*), and Klaus, a gay white male (*The Umbrella Academy*). There are yet to be stories highlighting the cultural contexts of addiction among people of color and cultural pathways of addiction recovery.

The Roots of Addiction

The complete addiction story answers many questions. Who was the addicted person prior to drug exposure? What were the motivations and circumstances of initial and continued drug use? What personal or

environmental factors contributed to loss of control over drug use and its related consequences? Is there a recovery and life after recovery story?

The end of the addiction story is a product of how affected individuals and families and their communities answer such questions. In this second of our series, we explore how a sample of 35 American comic books and 9 graphic novels and graphic biographies and memoirs with addiction storylines portray the root causes of addiction.

Addiction as Mystery

Some comic books present the etiology of addiction as an unanswered mystery. For example, Wilty, in the early (1949) Wash Tubbs comic series, experiences drinking problems that lead him to an exchange with Ben, a member of Alcoholics Anonymous. Ben explains:

> He happened to belong to that 5% of drinkers who are alcoholics. And didn't know that until it was too late….Unlike the ordinary drinker, the alcoholic's mind is so affected that he no longer has the choice of quitting without proper help.….I am an ex-victim myself. ….Doctors have found it's a form of allergy. But they still don't know why it is only present in certain people, any more than why certain others are allergic to pollen.
>
> "It's in my blood."

American comic books and graphic novels often portray the root cause of addiction in terms of a unique genetic or biological vulnerability. A family history of addiction is the backdrop for addiction storylines in several comics and graphic novels, including the heroin addictions of the characters Leslie in Hey Kiddo and Holly Robinson in the Catwoman series and the alcoholism of Julia Wertz in Drinking at the Movies and the AA member Larry in Sobriety. William Seabrook (*The Abominable Mr. Seabrook*) suggests family history as an explanation for his uncontrolled drinking: "Grandma Piny [who was addicted to opium] may be responsible for the drunken dreamer I am today." Similarly, Matthew Parker (*Larceny in My Blood*) offers a similarly simple explanation when asked the reason for his addiction and compulsive stealing: "It's in my blood." A clue to this unique vulnerability was sometimes one's very first response to intoxication, Ruben, the central character in *Buzzkill*, expresses this fatalistic epiphany: "From the day I took my first drink, I knew it was only ever going to end like this. It was only ever going to end in screams."

Adverse Family and Childhood Experiences

American comic books and graphic novels commonly note the role of family turmoil and early age of onset of drug exposure as causative or contributing factors within their addiction storylines. Parental addiction, adverse childhood experiences (abuse, abandonment), or a turbulent family environment are pre-addiction contexts in the storylines of William Seabrook (The Abominable Mr. Seabrook); Leslie (Hey Kiddo); Matthew Parker (Larceny in My Blood), and Alex, Larry, and Debby (Sobriety). Alex describes how the older

boys became his father figures and led to his selling marihuana for them in the estates (projects) and Leslie laments,

> "Ma's drinking was out of control. It was nothing but yelling and screaming between the two of us. I couldn't take it anymore. Nobody could take it anymore. I had started using before I moved out, but things got worse fast once I got my own place."

Matthew Parker, as a context for his own drug use, described his mother's involvement in smuggling and selling drugs and her enlisting his help in selling drugs when he was just 13. Within three years, he was injecting heroin.

Lost Control of Performance Enhancement

Comic book characters who used drugs to enhance their performance prior to their addictions include Batman, Dr. Cecilia Reyes (*X-Men*), Rose Wilson (*Teen Titans*), Johnny Quick, Bart Allen, Ultimate Colossus, and Ruben (*Buzzkill*). Ruben initially introduces himself as follows:

> "My name is Ruben and I'm a superhero. Who happens to get his powers from drinking alcohol and doing drugs. It doesn't make me one of you. It doesn't make me weak, and it does not make me an addict. It makes me a hero."

Rose Wilson, in the Fresh Hell storyline notes the performance enhancing properties of drugs and the diminishment of that power over time:

> "Sometimes all you need to keep going… is direction. That's what epinephrine gives me. A signpost. A glimpse of what's to come. Or at least it used to."

Using drugs to offset diminishment of personal powers is also noted in the storylines of Tony Stark (*Ironman*) and Carol Danvers (*Captain Marvel*). Tony uses alcohol in response to his Iron Man suit not working, and Carol uses alcohol when her powers aren't working. Klaus, in *The Umbrella Academy*, uses drugs to offset the emotional distress related to his special powers (e.g., using drugs to quell voices and images of the dead.

Self-medication of Emotional Pain

Using drugs to self-medicate emotional pain is also a common theme among the addicted characters in American comics and graphic novels. Such emotional distress includes unrequited love (Karen Page / *Daredevil*), breakups of intimate relationships (Harry Osborn / *Spider-Man*), grief following death of a friend (Alex / Sobriety), paternal abandonment (Julia Wertz / *Drinking at the Movies*), and PTSD related to wartime experiences (*Wash Tubbs*) or trauma (Jessica Jones / *Alias*).

Emotional pain is a central theme in the portrayal of the onset, maintenance, and progression of addiction. After Matthew Parker experienced the death of two brothers—one murdered and one by suicide, he

records, “I took to heroin with a vengeance.” The character Hannah (*Sobriety*) suggests:

> “It gets to the point where you’re willing to go to any lengths to get to a place where there isn’t any pain. It’s not about getting high anymore—it’s about just stopping the pain.”

The Addictive Personality

Addiction vulnerability is also attributed to temperament and character excess (e.g., an “addictive personality”) in American comic books and graphic novels. The character Hannah (*Sobriety*) illustrates such attribution related to rebellion, excessive behavior, risk-taking, and sensation seeking: “I’m what you call a high achiever. When I want something, I go all out. So, summer before college, I hit it [drug use] hard.”

Social Influences

The role of intimate and social relationships in the onset of addiction also appears prominently in American comic books and graphic novels. As Hannah (*Sobriety*) notes, “He [boyfriend] liked to drink and party. Pretty soon, I did too.” Peer influence in the onset of drug use and subsequent addiction play prominently in the storylines of Debbie O’Hara (*New Teen Titans Drug Awareness Special Issue*), Karen Page (*Daredevil*), and Marjane Satrapi (Persepolis). Maryjane describes her first exposure to drugs:

> “I didn’t like to smoke, but I did it out of solidarity….The communal life went hand in hand with the use of all kinds of mood enhancers.”

Famed writer William Seabrook similarly described how his drinking fulfilled his perception of great writers as great drinkers within a social world of heavy-drinking authors and celebrities.

The roots of addiction are in some cases linked to predatory influences and encounters with “bad characters.” Examples include the forced injection of Venom (designer steroid) into Bane by the evil Dr. Ruger and Rose Wilson’s addiction to adrenaline by her farther, Clock King. In a flashback scene, Rose sees her father saying to her: “This right here, this will make you something greater. You’ll have my strength. My speed. And more.” When she says she’s not sure she wants to take it, he says “You misunderstand me. This isn’t an offer.”

Addiction Consequences

Physical Consequences

Physical deterioration was among the most prominent consequences of addiction conveyed within the comic books and graphic novels reviewed. Physical manifestations of addiction included portrayals of hangovers and morning drinking as an attempted cure (Julia Wertz / *Drinking at the Movies;* Tony Stark / *The Invincible Iron Man*), memory blackouts (Ruben / *Buzzkill*), as well as an overall erosion of self-care and personal hygiene. Addiction was graphically portrayed via images of dirty, ashen skin, unshaven faces, and disheveled clothing. Physical emaciation of addicted characters was common as was self-expressed concerns about

physical health (Karen Page / *Daredevil*; William Seabrook / *The Abominable Mr. Seabrook*). A typical scene has the central character looking in a mirror and reflecting, “My skin’s a bit green and I pissed blood the other morning. But it’s easier said than done, to kill yourself with booze.” (*The Abominable Mr. Seabrook*).

Physical insults from addiction also included physical injury from accidents while intoxicated (William Seabrook / *The Abominable Mr. Seabrook*; Larry and Alex /*Sobriety*), painful drug withdrawal (Bane), and alcohol or other drug overdose and hospitalization (Tony Stark / *The Invincible Ironman*, Carol Danvers / *The Invincible Ironman;* Rose Wilson / *Teen Titans*). Drug-related death by overdose or suicide were also represented (Leslie / *Hey Kiddo;* Larry and Alex / *Sobriety*; and William Seabrook / *The Abominable Mr. Seabrook*).

Psychological Consequences

The comic books and graphic novels reviewed detailed early psychological effects of addiction. Such effects included embarrassment from drinking behaviors—drunk calls, texts, emails and social media posts, and Amazon buying in Julia Wertz / *Drinking at the Movies*), getting into fights while using (Ruben / *Buzzkill*), sexual encounters while drunk (Jessica Jones / *Alias*), the diminishment or loss of superpowers (Rose Wilson / *Teen Titans*), and cognitive impairment (inability to concentrate, impaired decision-making as illustrated by Tony Stark in *The Invincible Ironman: Demon in a Bottle*. The accumulation of secrets and shame was a common theme. As Ruben (Buzzkill) reflected:

> “Every addict or junkie has their own secrets. Things they’ve done or said. People they’ve hurt… We tell ourselves that the meetings and the journaling will help us to deal with these secrets…What it amounts to is baring every nerve, forcing yourself to face the parts of your story that don’t want to be told. Facing them and making them submit. Dragging them, scrabbling and screaming into the light.”

As addiction progressed within the comic book and graphic novel storylines, early psychological effects were followed by two dominant experiences. The first was radical personality changes while using and overall psychological deterioration marked by hallucinations, paranoia and fear of insanity (Marjane Satrapi / *Persepolis*; Rose Wilson / *Teen Titans*; Matt / *Sobriety*), sometimes requiring psychiatric hospitalization (Klaus / *The Umbrella Academy*). As William Seabrook’s alcoholism progressed, he vacillated between periods of self-loathing and a grandiose sense of self-importance accompanied by a hyper-criticalness of others. In the Amazing Spider-Man series, the character Freak, while addicted to heroin, breaks into a laboratory and injects himself with loaded syringes he believes to be heroin but contain instead animal stems cells that turns him into a

monster—a metaphor for the deforming experience of addiction.

A Dr. Jekyll / Mr. Hyde portrayal of addicted characters is common in American comic books and graphic novels, with references to "feral anger" and portrayal of characters with a "monkey on their back" as rabid—wild eyes, sneering mouth, clenched muscles (*Ironman*). Larry, the Alcoholics Anonymous member in the graphic novel *Sobriety* explains such transformations: "Put a drop of booze or mood-altering chemical in us and we change, we become that which we never thought we would: manipulative, lying, stealing, self-centered people…only headed to jails, institutions, or death."

The second dominate experience involves loss of volitional control over drug use decisions and complete domination of one's life by drug seeking and drug use. Several central characters describe such effects.

> Bane: "I was driven by Venom…It controlled me, not the other way around…the Venom weakened my judgment and I lost everything."
>
> Larry (*Sobriety*): "And that's the thing about alcohol use: For a while I thought I was managing it. That's not really the way it was: It was managing me. I would come to learn that my addiction would, in due course, demand priority over everything, even the woman I married."
>
> Holly Robinson (*Catwoman*) "And when you're a junkie that's all you do—wait to score, wait to shoot up, wait for it to wear off, wait for the guy who gives you more money to score again, do anything he wants to get it, wait to score, wait to shoot up…And, then when you quit, it's all waiting-to not see the world in junkie-vision, I guess…I wonder when that starts"
>
> Matthew Parker (*Larceny in my Blood*): "Heroin was the dictator of my higher brain functions at the time…2 + 2 = heroin. The capital of Thailand is opium. I think, therefore, I am a junkie." P. 33; "I couldn't conceive of a world without heroin. I loved it that much." P. 213
>
> Brandon Novak (*The Brandon Novak Chronicles*): When asked if he believed in true love, Novak responds, "I believe I truly love heroin!" When asked if he would eat poop for a million dollars, Novak responds, "I'd do it for free if you dipped it in heroin!"

Effects on Social Functioning

The physical and psychological effects of addiction as represented in American comic books and graphic novels/biographies/memoirs exacerbated multiple areas of social

functioning within the affected characters:

- Dropping out of college: Ruben (Buzzkill)
- Employment challenges (Julia Wertz / *Drinking at the Movies*); loss of leadership position (Tony Stark / *Avengers*); court martial (Carol Danvers / *Avengers*)
- Financial distress (*The Abominable Mr. Seabrook*),
- Indebtedness (Matthew Parker / *Larceny in my Blood*),
- Housing instability and homelessness (Matthew Parker / *Larceny in my Blood*; Matt / *Sobriety;* Holly Robinson / *Catwoman*);
- Loss of driving privileges (Ruben / *Buzzkill*), and
- Drug-related arrests, imprisonment, and revocation of probation or parole (Leslie / *Hey Kiddo*; Matthew Parker / *Larceny in my Blood*; Matt and Hannah / *Sobriety*.)

The addiction-crime link is vividly described in *The Brandon Novak Chronicles*:

> "In the daily life of a Junkie, at any given time there is a crime of the moment….Dope provides the addict with the relentless compulsion to lie, cheat, and steal at every opportunity in order to score, and this transformation robs the dope fiend of his humanity."

Relationship Effects

American comic books and graphic novels also depict the devastation addiction inflicts on interpersonal relationships. Such effects encompass addiction-related family conflict and family dissolution (Karen Page / *Daredevil*), intimate and collegial relationship conflict over drug use (Tony Stark / *Ironman*; Holly Robinson / *Catwoman*; Jessica Jones / *Alias*; Carol Danvers / *Avengers*), parent-child alienation and lost custody of children (Wilty / *Wash Tubbs*; Debby / *Sobriety*; *Hey Kiddo*), and multiple divorces (William Seabrook / *The Abominable Mr. Seabrook*). The strain on social and intimate relationships is revealed in the storylines of numerous characters.

> Matthew Parker (*Larceny in my Blood*): "I was crazy about Maria. But I was crazy for narcotics first."
>
> Ruben (*Buzzkill*): "None of my friends will talk to me anymore. I understand why. I get it, but it's just hard."
>
> Brandon Novak (*The Brandon Novak Chronicles*): "I am a predator and a tortured soul. She [former girlfriend] is my prey and my savior."

The Portrayal of Addiction Recovery

Limited Portrayal of the Recovery Experience

While addiction is a central thread within many American comic book and graphic novel storylines, the addiction recovery process receives scant attention. For example, Julia Wertz's graphic memoir, *Drinking at the Movies*,

portrays the evolution of her drinking throughout the book, but devotes only one page at the end to her decision to stop drinking. *Hey Kiddo* shows Jarrett visiting Leslie in the halfway house, but it isn't until much later that Leslie describes her recovery to him. There is within the brief recovery storylines a sense of being free and an awakening of previously unrecognized inner strength. Bane, for example, declares, "I am free of Venom. I am truly free for the first time in my life….I didn't need Venom then. I don't need it now."

Recovery as an Incremental Process

American comic books and graphic novels portray addiction recovery as a difficult process often involving multiple efforts before recovery is sustainable. This pattern of repeated recovery attempts is present in the character storylines of Tony Stark(*Ironman*) , Roy Harper (*Green Arrow*), Bane, Bruce Wayne (*Batman*), Katina "Katchoo" Choovanski (*Strangers in Paradise*), Carol Danvers (*Avengers, Ironman*), Allan Quartermain (*The League of Extraordinary Gentlemen*), and Rose Wilson (*Teen Titans*). Comic book storylines often portray stable recovery preceded by failed promises and resolutions to stop drug use (Matthew Parker) and by experiments in drug substitution. Matthew Parker (*Larceny in My Blood*) laments, "I'm bent on substituting the slobbering inebriation of alcohol for the nihilism of heroin" before relapsing once again to heroin addiction.

The transition between active addiction and recovery initiation is preceded by elaborate defenses to sustain drug use, e.g., denial, minimization, rationalization, projection of blame, and anger/aggression. These are elaborately detailed over three years (1998-2000) in the sustained storyline of Carol Danvers crossing over from *Avengers* to *Quicksilver* and *Ironman* and eventually ends with Carol going to AA with Tony. Comic book storylines portray the movement towards recovery as a tortured effort to see oneself and the world as they really are. Regarding the distortions that commonly precede recovery, Willie Seabrook's second wife Marjorie Worthington described Willie's repetitive lies in his written work and in his life: "Willie always told the truth: His truth."

Motivation for Recovery

Momentum for addiction recovery as portrayed in American comic books and graphic novels rises in tandem with the erosion of drug effects, escalating consequences, and experiences within active addiction that serve as a catalyst of recovery. Brandon Novak (*The Brandon Novak Chronicles*) describes the diminishment of drug effects: "But there is one law that every drug fiend is incapable of breaking: The law of diminished returns."

Other push forces toward recovery include fear of loss of one's powers (Dr. Cecilia Reyes) and fear of death if they don't stop and if they do. Willie Seabrook, his drinking at its worst, prophetically writes his publisher, "I think I'll die if I don't stop drinking." Carol Danvers (*Iron Man*) and Rose Wilson (*Teen Titans*) are both told by doctors that continued drug or alcohol use will lead to their deaths. Rose Wilson is told, "…You don't lay off the epinephrine, you'll be dead" because of the damage to

her heart. She's warned of the effects from prolonged epinephrine use including "migraines, tremors, blurred vision. Oxygen deprivation. Heart failure."

Comic books and graphic novels also note positive forces within the addiction experience itself that can serve as push factors toward recovery.

> "As devious as we have become, junkies are still capable of emotion, compassion, generosity, and charity. And sometimes we depend on each other to extend kindness, and through this selfless act our humanity can be restored, even if only for a few hours." (*The Brandon Novak Chronicles*)

There are references in comic books and graphic novels to what today would be called "interventions" (e.g., Batman's role in the recovery of Martian Manhunter), there is a surprising lack of references to institutions of control that play such a prominent role in the lives of addicted men and women (e.g., law enforcement, courts, prison, and the child welfare system). In one example we noted (*Hey Kiddo*), Leslie's sobriety is implicitly tied to her time in prison. When she is released on probation and gets a job, her family worries that if she does not stay clean and keep her job she will return to prison. In another example, Carol Danvers (*Avengers*) is court martialed after making serious mistakes due to excessive drinking during a mission. The court martial scene is drawn like an intervention with each Avenger giving a statement about the impact her alcohol use has had, but she quits Avengers before they can demote her.

Styles of Recovery Initiation

There are varied styles of recovery initiation portrayed in American comic books and graphic novels. Recovery for most is portrayed as an incremental, stage-dependent process—a progressive accumulation of drug-related consequences. The turning point is often depicted as a "hitting bottom" experience. The alcoholic character Wilty in the *Wash Tubbs* comic series proclaims, "I'm through saying I can quit if I have to…I can't. I don't drink any more to get a lift, I drink to stay alive….I'm licked."

An AA member in the graphic novel *Sobriety* laments, "This is the case for many of us. We don't want sobriety until it hurts badly enough." Later, that same AA member notes the varieties of recovery experience: "Different people have different spiritual experiences. A few are sudden and dramatic… A lot of people—in fact, most—have similar experiences [more gradual and prolonged] that come as a result of working the steps."

Comic book and graphic novel storylines where the change process was portrayed as unplanned, positive, and permanent include the character of Bane. While imprisoned in solitary confinement, Bane reviews the traumas of his life (e.g., in prison since his birth, subjected to experimental drugs, victimized by other prisoners) and experiences a vision conveying the message that he had "the strength of innocence to overcome the poison [Venom]." That vision marked the

beginning of his recovery process. There are also examples of altered states of consciousness or sudden epiphanies that marked recovery initiation. Klaus (*The Umbrella Academy*) experienced a vision of himself in a stark white desert where he hears God commanding, "Stay off the drugs, Klaus." Julia Wertz (*Drinking at the Movies*) experienced a sudden realization that she has been drowning in self-pity and blaming everything but herself for her problems. Matthew Parker, who had resisted NA and AA and varied treatments, had an epiphany in jail that marked his recovery initiation:

> "I was totally, irrevocably, utterly in their control and had been for the past 13 years….I wasn't a thorn in the side of The Man, but rather old meat trapped in his intestines….I therefore decided, right then and there, to quit using. To turn my life around."

Viewed as a whole, recovery initiation in American comic books and graphic novels is portrayed as an intersection of pain and hope.

The Need for Sustained Vigilance

Even successful recovery, as in the case of Tony Stark (*The Invincible Iron Man*), is accompanied by the need for sustained vigilance against cravings and impulses to use: "It's always with me…whispering to me." Holly Robinson in *Catwoman* is constantly reminded of her addiction during the early months of her recovery: "…And I just can't stop seeing these streets in junkie-vision…Or noticing how easy it would be to give in…".

The need for sustained vigilance against impulses to use are well illustrated in the *Wash Tubbs* comic series, as Ben (AA member) describes Wilty's continued vulnerability during the early days of Wilty's recovery:

> "Let's get that straight…there is no cure. I'm what we call a permanently arrested case….one of perhaps 50,000 in AA who will never take another drink but we'll always be alcoholics because we're still allergic to alcohol. However, we can live normal lives! We've quit kidding ourselves that we can ever be social drinkers."

> "Gig's [Wilty's] chief danger now is a false sense of security, as he gradually loses his urges to drink. Unless we help him keep his guard up, an emotional upset...fatigue…an impulse to join friends in a "quick one"…or even a sudden piece of good luck could cause a relapse. "

An AA speaker in the graphic novel *Sobriety* shares similar sentiments:

> "Addiction isn't just in our heads—it's in our bodies and our spirits too. ….As an alcoholic I will always "have it"—but it doesn't have to have me!"

> "There's no cure as yet—It's a chronic illness that needs to be managed, like diabetes. But there's a spiritual solution in the Twelve Steps."

Recovery Support Resources

Recovery was often achieved in American comic books and graphic novels through reliance on resources and relationships beyond the self. Examples of this include Batman's rescue and detoxification by his assistant Alfred, Captain America detoxing with the aid of Black Widow, the support Tony Stark received from his girlfriend and butler, Theresa Cassidy's (*X-Force*) recovery with the aid of Warpath, Speedy's cold turkey withdrawal with aid of Black Canary, and Harry Osborn's rescue by Spider-Man. In the X-Men series, Dr. Cecelia Reyes achieves recovery after being rescued by the X-Men and through the support of Xavier through her drug withdrawal process. After Carol Danvers achieves sobriety with the aid of Tony Stark, she later helps him when he returns to drinking following revelation of his true identity. After Danvers achieves sobriety, she rejoins the Avengers on the condition that she be supervised and continue her AA involvement.

In the *Catwoman* series, Holly Robinson's friends Selena and Karon serve as key support to her recovery. Leslie (*Hey Kiddo*) describes how she and her boyfriend support each other's recovery, "He's getting treatment, just like me." (p. 229) … "Miguel and I are on this road to recovery together." (p. 230). All five characters in the graphic novel *Sobriety* are involved in a Twelve-Step program, and one of the characters (Alex) references living in a recovery residence.

While in France, Willie Seabrook asked the famed author Gertrude Stein for guidance on his drinking problem. Her advice was simple: "stop drinking so much and return to writing….You must stop drinking and you must begin to write again." Following that advice, Willie wrote his publisher in September 1933 asking for help. His publisher responded by making arrangements for Willie to return to America and be admitted to Doctors Hospital under the care of Dr. Alexander Lambert.

Character Transformation in Recovery

Recovery within American comic books and graphic novels provides an opportunity for the acquisition of new powers and altered qualities of character. Following Bane's recovery from Venom addiction, he uses this period of isolation to strengthen his body through extreme physical exercise and strengthen his mind through meditation. Many American comic book characters who transitioned from addiction to recovery went on to develop a recovery-focused service ethic. Batman, after his own recovery, was involved in supporting the recoveries of three other characters: Arsenal, Speedy, and The Martian Hunter. Arsenal then goes on to become a drug counselor and law enforcement officer. Batman served as a recovery role model and recovery coach for others. Other examples of such service activities after recovery initiation include Dr. Cecilia Reyes' volunteer activities at a homeless shelter (*X-Men*) and Karen Page's

operation of a legal clinic in Hell's Kitchen (*Daredevil*).

Wilty, in the *Wash Tubbs* comic series, reflects on the therapeutic effects of helping others as part of one's own recovery: "I had to call on Ben (AA member) again last night. He took me with him to see a very pathetic case. I think we helped him, but it helped me even more." Holly Robinson in the *Catwoman* series worked undercover to take down drug dealers following her recovery from heroin addiction. Reflecting on this work, she explains, "I can use my life experience to my advantage for a change…And that makes me feel stronger…Prouder."

In the graphic novel *Sobriety*, Dan and Alex describe their lives in recovery

> "I once had a life that was destroyed by drugs and alcohol…But I got life back because of the Twelve Steps. It's different than it was before. It isn't perfect…But it's full of surprises. And it's worthwhile… Sobriety is more than the definition we find in a dictionary. It's a new lifestyle that we embrace. It gives us real existence."

> "Now, I've left that life. I'm selling fine automobiles in London. And I'm happier than ever."

Matthew Parker (*Larceny in my Blood*) described channeling his propensity for excess into his recovery process, using education as a pathway to recovery: "Being an excellent student also makes it easier to stay clean. I now channel my compulsion into more productive activities. Compared to the hard work involved in being a junkie, becoming an honor student is ridiculously easy." Describing his experience in college and his writing aspirations, Parker describes the irony of his new circumstances: "Credit [to pay for school] is my new heroin, and debt its walls and razor wire."

The Role of Recovery Mutual Aid Groups

The supportive role of recovery mutual aid groups was limited exclusively to Twelve-Step groups (Alcoholics Anonymous) within American comic books and graphic novels that contained addiction storylines.

Characters seeking recovery through AA include Tony Stark, Carol Danvers, Katina ("Katchoo") Choovanski, and five characters in the graphic novel *Sobriety*. Tony Stark and Carol Danvers even go to the same AA meetings in multiple issues. In *Iron Man: Resolutions* #313, Tony spends New Year's Eve at an AA meeting reflecting on his early exposure to alcohol as a pre-teen and current struggles with alcoholism. The role of an AA sponsor is portrayed through the character of Dr. Black, who serves as Ruben's (*Buzzkill*) sponsor:

> "The rest [beyond admitting you have a problem] is going to be tough, but I'll be here to guide you. I've been through this before. It's not impossible, Man."

All five characters in the graphic novel *Sobriety* were involved in a Twelve-Step program. Larry noted his early perceptions of rehab and AA: “Look at rehabs: They’re invested on getting reimbursement from health insurance companies—the very same companies that require a medical treatment. It seems to me that the Twelve Steps are about something else; it’s like a cult!”

Several characters report getting sober through the help of other AA members. The character Matt (*Sobriety*) describes how the Twelve-Step program works:

> “The problem is easy: we have a disease of the body that causes us to lose control when we drink or drug, and an obsession of the mind that causes us to drink and drug. That’s the powerlessness that step one describes…The solution to that irreconcilable dilemma is that the other steps give us a way to restore purpose and meaning to our lives.”

Resistance to Twelve-Step programs was portrayed via the character of Matthew Parker in *Larceny in My Blood*. At one of his parole hearings, Parker declares: “Well, I’ll tell you what I won’t do. I won’t go to NA meetings, or AA meetings, or any of that other crap.” (He was then paroled based on his honesty). In speaking of a later parole hearing, he recalls: ”I told them what I really thought of their rehabilitation policies and 12-Step programs in particular. I just think it’s all bullshit.”

There were no references to secular, spiritual, or religious recovery mutual aid alternatives to Twelve-Step programs in the comic books and graphic novels we reviewed. Given the national and international growth and diversification of alternative groups such as Women for Sobriety, SMART Recovery, LifeRing Secular Recovery, Celebrate Recovery, and numerous others, it is somewhat surprising that they have yet to appear within comic book and graphic novel addiction storylines.

Portrayal of Addiction Treatment

The representation of addiction treatment in American comic books is limited. Natural recovery is far more common than professional treatment, and comic book storylines offer few details related to the actual nature of treatment beyond medical withdrawal. In spite of the portrayal of opioid addiction in numerous storylines, there is little portrayal of the pharmacotherapy of opioid addiction. Recovery most often involved heroic rescue or was portrayed as an isolated episode that when shaken off allows other storylines to proceed without continued references to a recovery process. Below are the few treatment references we located.

In the *Batman* series, there are references to Doctor Leslie Thompkins and Tiffany Fox operating addiction treatment programs without reference to what such treatment involved. The DC Fandom Wiki explains, “Doctor Thompkins ran the free Thomas Wayne Memorial Clinic for criminals and drug addicts in Gotham City. While the majority of her patients were repeat offenders, she continued to do her job with great perseverance and

determination." Dr. Thompson later ceased her helping role and became a vigilante.

There are numerous examples over multiple decades of Tony Stark seeking treatment for alcoholism, however they rarely show details of what that treatment entailed. In *Iron Man: Deliverance* #182, Tony is admitted to a hospital for detoxification and later shown attending AA meetings. In *Vengeance of Bane*, the psychiatrist Dr. Flanders, who Bane saw while in prison, is portrayed as empathic and skilled.

The character Leslie in *Hey Kiddo* references going to a clinic after her release from prison and getting involved with another patient there: "He's getting treatment, just like me….Miguel and I are on this road to recovery together." She relapses and later dies of a heroin overdose.Alex (*Sobriety*) entered a government-sponsored rehab for four weeks following an overdose. He warmly describes his counselor, who introduces him to the Twelve Steps: "David was a guy who listened—really listened—to me. He was in recovery himself. And he let me see the truth of my life: that it had spun out of control and was insane."

The most detailed of addiction treatment appears in *The Abominable Mr. Seabrook*. William Seabrook's physician admitted him to Doctors Hospital, dried him out with the aid of "prescription booze", and then discharged him as cured. The images of this episode show Seabrook looking through bars. Following his discharge from Doctors Hospital, he immediately returned to heavy drinking and was subsequently committed to the Bloomingdale Insane Asylum. Seabrook was a challenging patient, often objecting to various rules of the institution. Treatment at Bloomingdale consisted of "cold turkey" withdrawal from alcohol, hydrotherapy (baths and wetpacks), and psychotherapy to address his "addictive personality" and his sexual perversions. Seabrook was discharged after seven months and later detailed his experience there in his book *Asylum*. At the end of *Asylum*, he proclaimed himself cured, that he could now drink without excesses of the past and that he had conquered his writer's block. "I'm now able to take a drink or two without desiring another and I seem to be cured of drunkenness." Seabrook's drinking again raged out of control.

Matthew Parker provides the most detailed account of treatment resistance in his graphic memoir, *Larceny in my Blood*. Parker describes being ordered into a halfway house by a judge: "I was allowed to go to work and report back to the rehab each night, which made it easy to maintain my habit." When arrested for failing a drug test, he "played the contrite junkie." At a later 28-day rehab, he sarcastically describes his superficial compliance: "Oh, yes, I've seen the light. Hit rock bottom. I'm powerless over my addiction. I have to give it away to keep it." Then released to Maverick House, he described feeling like he was "being conned."

On Addiction Recurrence

Addiction recurrence following a period of recovery is described in several comic book and graphic novel storylines. Carol Danvers experienced a recurrence of drinking at a time she is struggling with writer's block. Another time, she follows the Avengers into a bar on a mission commenting that she will need to stay

vigilant to avoid another recurrence. Tony Stark experienced multiple relapses across his many storylines. Below is scene from *Ironman: Demon in the Bottle* that offers a typical depiction of the tensions that often precede a recurrence:

> "For days, the stalemate rages—until at long last, emotional blocks begin to crack, then crumble—and Tony Stark spills his pent-up pain like milk from a spilt pail. He sighs, he shudders…and he shakes." The purge helps and he returns to work. He apologizes to Jarvis saying he has "a handle on it now," and Jarvis responds, "You have an illness. I quite understand." While he's at the Avenger's mansion, Tony knows there's a bottle in his room but says, "I don't need the booze…I can handle this on my own without any counterfeit courage at all." Later back at the mansion, Tony starts to pour a drink and Beth stops him. His face is sweating, eyes are down, he's frowning, his hands are shaking. It's described as the "hardest battle of his life." Beth reminds him of his life's dream, and shaking he recaps the bottle.

The self-talk that feeds addiction recurrence is vividly displayed in *The Abominable Mr. Seabrook*. Following treatment and a period of sobriety, Seabrook tires of the sober life and proclaims: "I'm tired of being a cripple. From now on, I'm going to prove that I can take a drink or leave it alone, like any other man." After losing control over his drinking again, he would pledge sobriety anew but soon became bored and commence his drinking binges. His repeated refrain when talking to himself in the mirror: What do drunkards do? They drink themselves to death." At a later stage of his story, Seabrook's lover and third wife-to-be plunged his hands in boiling water to scald the skin so that he would be unable to pick up a drink. Seabrook continues drinking from a liquor bottle using a straw. He was committed to the Hudson State Hospital in mid-1945. A few months later and after his release, Seabrook committed suicide with sleeping pills and whiskey on September 20, 1945.

Brandon Novak (*The Brandon Novak Chronicles*) re-experienced heroin addiction after publishing his book, *Dreamseller*, in which he recounted losing his career as a professional skater due to his heroin addiction. In his graphic memoir, he describes coming back from his "insatiable appetite for heroin."

Addiction, Recovery, and the Family

An area of scant attention in the addictions storylines of American comic books and graphic novels is the effect of addiction upon the family or the involvement of affected families in family support groups or addiction treatment. The few conclusions that can be drawn related to family include the following.

Addiction inflicts repeated episodes of humiliation, helplessness, worry, guilt, anger, and loss on the family

(*The Abominable Mr. Seabrook*; *Drinking at the Movies, Hey Kiddo*).

Addiction can become so imbedded within the marital relationship that recovery may pose more of a threat to the relationship than continued addiction. Willie Seabrook's second wife reveals, "I confess, Willie had handled the teetotaling better than I did."

Sustained family support can play a crucial role in addiction recovery. Jarrett's grandfather (*Hey Kiddo*) purchases a house for Leslie when she finishes the release program to support her new sobriety. Matthew Parker in *Larceny in my Blood* recounts such support:

> "But as pissed as she [his mother] was, I always had a place to live. She was too kind and I used her…. At 41 years old and on my fifth trip to prison, she [mother] saw no reason for hope…But my mom never gave up on me—I think because our shared struggles showed how bad it could get….We were still family, not despite but because of all that we had lost."

Sustained recovery brings indescribable relief to the family. Again, Matthew Parker reflects:

> "She [mother] was not convinced of my commitment to kick heroin until a year after my release, during my second semester at SCC….I think that was the first time in 40 years that my mom could relax."

Closing Reflections

Comic books and graphic novels provide a unique vehicle to convey information about addiction, addiction treatment, and addiction recovery. We envision a day when research scientists and recovery advocates will collaborate with the creators of American comic books and graphic novels to create more science-based and recovery-focused portrayals of alcohol and other drug problems.

One of the initial challenges faced by addicted individuals and their family members is answering questions that mark the starting point of recovery: Who was I before I became addicted? Why and how did I become addicted? What has my addiction cost me? What will it take to recover my old life or discover a new life? One can look to many sources for answers to such questions and find possible answers in unexpected places, including in American comic books and graphic novels. This suggests interesting possibilities for future collaborations between addiction scientists, clinicians, and recovery advocates and the writers and graphic artists who portray addiction and recovery within the growing legions of American comics and graphic novels.

The addictions field has historically been dominated by theoretical siloes that each proposed a primary causative pathway of addiction, a common course of progression of the disorder, a narrow approach to treatment, and a singular regimen of successful recovery maintenance. Such

siloed views are giving way to more nuanced understandings of the multiple pathways of addiction entrance and egress that differ across clinical populations and cultural contexts. In our review of the portrayal of factors of addiction vulnerability in American comic books, we found many such noted influences. In future blogs in this series, we will explore how these same media portray addiction consequences and pathways of addiction recovery.

American comic books and graphic novels have revealed perceived roots and consequences of addiction within their storylines. The depth and texture of such portrayals could increase through collaboration between addiction professionals, recovery advocates, and the authors and illustrators of comic books and graphic novels.

While limited in the range and depth of storylines, American comic books and graphic novels have portrayed recovery as part of addiction-related storylines, including the motivations for recovery, styles of recovery initiation, and the potential of recovery as a medium of personal transformation and service to others. The portrayal of the role of recovery mutual aid organizations in the process of addiction recovery is limited within the storylines of American comic books and graphic novels to Twelve-Step fellowships. In spite of their recent growth in the U.S. and internationally, the existence of secular, spiritual, and religious mutual aid alternatives have yet to be portrayed. Addiction treatment is briefly referenced within the addiction storylines of American comic books and graphic novels without substantial details related to the nature of such treatment or its degree of effectiveness. Addiction recurrence following an initial recovery attempt is common within the addiction storylines, with trajectories ranging from death to a final re-stabilization of recovery. American comic books and graphic novels have yet to fully portray the effects of addiction on the family and the processes, stages, and long-term effects of family recovery from addiction.

We anticipate a future in which collaborations between addiction professionals, recovery advocates, and the writers and illustrators will produce a new generation of addiction storylines within American comic books and graphic novels that more accurately portray the prevalence, pathways, stages, and styles of long-term addiction recovery.

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Appendix

Comic Books and Graphic Literature with Addiction/Recovery Storylines

Comic Book Characters

[Character Name, Codename(s) (Series Name, Volume or issue #, year)]

*Alphabetical by character's last name

Bane (Batman, Vengeance of Bane, Special #1)

Billy Batson, Captain Marvel (Justice League)

Tandy Bowen (Cloak & Dagger, Spectacular Spiderman, #64, 1982)

Eli Bradley, Patriot (Young Avengers, Vol. 1, #1, 2005)

Theresa Maeve Rourke Cassidy, Siryn / Banshee (X-Men, X-Force #31, 1994)

Katina "Katchoo" Choovanski, none (Strangers in Paradise, Sanctuary, Vol. 7, 2009)

Carol Danvers, Captain Marvel (Avengers, Iron Man, ongoing)

Steve Dayton, Mento (Doom Patrol)

Klaus Hargreeves (The Umbrella Academy, ongoing)

Roy Harper, Speedy/Arsenal (Green Arrow/Green Lantern, Vol. 12, #85-86, 1971)

Tyrone Johnson (Cloak & Dagger, Spectacular Spiderman #64, 1982)

Jessica Jones, none (Alias, ongoing)

J'onn J'onzz, The Martian Manhunter (The Martian Manhunter, ongoing)

Kal-Il, Ultraman, (The New 52, Forever Evil #1, 2013)

Laura Kinney, X-23 (X-23)

Henry Philip "Hank" McCoy, Beast (X-Men, Amazing Adventures Vol 2. #11, 1972)

Jack Monroe, Bucky/Nomad (Captain America #345, 1988)

Michael Morbius, The Living Vampire (Spider-Man)

Harry Osborn, Green Goblin (The Amazing Spider-Man #96-98, 1971)

Karen Page (Daredevil #227-232, 1987)

Allan Quatermain (The League of Extraordinary Gentlemen Vol 1, 1999)

Danny Rand, Ironfist (Immortal Iron Fist #1, 2006)

Cecelia Reyes, none (X-Men #101-113, 2000-2001)

Holly Robinson, none (Catwoman, Crooked Little Town, 2003)

Steve Rogers, Captain America (Captain America)

Ruben (Buzzkill, 2013)

Marc Spector, Moon Knight (Moon Knight #1, Vol 5, 2006)

Tony Stark, Ironman (Ironman, Avengers, ongoing)

Starfire (Teen Titans, Red Hood and the Outlaws, #1 and #36, 2011)

Eugene “Flash” Thompson, Agent Venom (Spectacular Spider-man 249-250, 1997, Amazing Spider-man # 654, 1999)

Rex Tyler, Hourman (# 48 Adventure Comics, 1940)

Richard "Rick" Tyler, Hourman II (Infinity Inc. #31, 1986)

Wash Tubbs (April4-May 14, 1949; Daily newspaper comic strip from 1924 to 1949)

Bruce Wayne, Batman (Batman, Dark Knight #16,1993)

Rose Wilson, Ravager (Teen Titans, #72-73, 2009)

Graphic Novels/Biographies/ Memoirs

John "Derf" Backderf (My Friend Dahmer)

Jarrett J. Krosoczka (Hey Kiddo)

Daniel D. Maurer and Spenser Amundson (Sobriety: A Graphic Novel)

Brandon Novak (The Brandon Novak Chronicles)

Joe Ollman (The Abominable Mr. Seabrook)

Matthew Parker (Larceny in My Blood)

Marjane Satrapi (Persepolis 2 The story of a return)

Julia Wertz (Drinking at the Movies, The Infinite Wait and Other Stories)

David Wheatley (Qualification: A Graphic Memoir in Twelve Steps)

Graphic Non-Fiction

Cannabis: The Illegalization of Weed in America (Box Brown)

Galanter, M., White, W., & Hunter, B. (2021). Virtual twelve step meeting attendance during the COVID-19 period: A study of members of Narcotics Anonymous. *Journal of Addiction Medicine*. DOI: 10.1097/adm.0000000000000852 PMID: 33870953

Abstract

Objectives: Face-to-face meetings are key components of Twelve Step (TS) fellowships' support of members' abstinence. Home confinement during COVID-19 made this less feasible. Our objective was to ascertain whether a transition to virtual online meetings among TS members took place, and whether it was potentially effective.

Methods: Two thousand one hundred fifty-two long-standing USA members of Narcotics Anonymous (NA) were surveyed to ascertain their recovery-related experiences and their relation to the transition to virtual meetings.

Results: During the previous week (ie, 'during COVID-19') respondents attended more virtual meetings ($\bar{x}$ ¼ 4.13[SD4.64]) than they had attended both face-to-face meetings before COVID-19 ($\bar{x}$ ¼ 3.35[SD2.05]), and also face-to-face meetings during COVID-19 ($\bar{x}$ ¼ 0.75[SD1.8]). Many of the meetings were accessed from sites remote from their homes (44.4%), even overseas (21.5%). The majority (64.9%) found virtual meetings at least as effective in promoting their abstinence as were face-to-face meetings, and 41.8% estimated the same for newcomers. A shorter period of antecedent abstinence from drugs and increased loneliness were associated with increased craving during the transition period. Relative to Whites, Black respondents were less distressed, with a lesser increase in craving, and currently attended more virtual meetings. Data provided by a national program reflected a large increase in virtual TS attendance since the onset of the pandemic.

Conclusions: In a survey of well-established NA members, most had made a successful transition from face-to-face to virtual meetings, relative to their antecedent characteristics. This successful transition suggests the possibility of an enhanced opportunity for stabilizing TS membership.

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Narcotics Anonymous Members in Recovery from Methamphetamine Use Disorder

Marc Galanter, William White & Brooke Hunter

Abstract

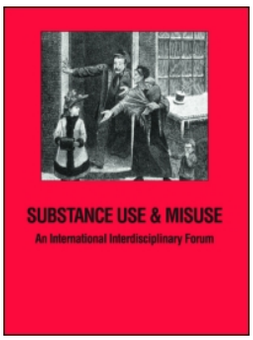
Background and Objectives: Methamphetamine use disorder (MUD) is a major public health problem, but there are no evidence-based, best-practice, pharmacologic, or behavioral treatments for it. Narcotics Anonymous (NA) may provide an option for referral for such patients.

Methods: Two waves of surveys were sent to a sample of NA members to evaluate demographic, drug use, and NA-related issues. Of 4445 responses received from US residents, 647 listed themselves as abstinent from their worst drug problem, methamphetamine. Twelve possible sources of support were scored by these latter respondents for how important each was for their own recovery.

Results: Methamphetamine respondents were longstanding NA members, with their first NA meeting 30.2 years ago, 84.3% having served as sponsors for other members, and with little current craving (0.65 out of 10). Although now abstinent for an average of 13.4 years, at some point over the course of the membership, 47.4% had experienced a relapse, for an average of 16.7 months. In a factor analysis of resources scored, 29.6% of the variance fell under NA social and 29.2% spiritual; and 11.8% under outside professional support.

Discussion and Conclusions: NA served as a resource for supporting abstinence for some members with MUD. They scored social resources of NA support higher than both spiritual and outside institutional ones.

Scientific Significance: NA can serve as a community-based resource for MUD. Determining the nature of recovery that members with MUD have in NA can be useful for further research of socially grounded support for recovery in substance use disorders.



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Internal and External Resources Relied on by Established Twelve Step Fellowship Members for Their Recoveries

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ABSTRACT

Background: The Twelve Steps described by Narcotics Anonymous (NA) and Alcoholics Anonymous denote key aspects of how members can achieve abstinence from alcohol and other drugs. However, there are limited empirical findings on what long-term members rely on to support their ongoing recovery. *Method:* In order to clarify the members' reliance on those latter resources, we surveyed 2,293 long-term NA members through the internet on items they rely on for their recovery. They scored nine NA-related resources (e.g., their sponsor) and three non-NA institutional ones (e.g., a professional therapist). *Results:* Three factors accounted for 53.6% of the variance in the respondents' scores of the 12 items. We labeled them, with the percent of variance accorded, as NA-based social (24.9%) support, spiritual (17.8%) support, and outside professional (10.9%) help. While NA-based resources ranked highest, outside resources (a house of worship, a therapist, or medications for psychological distress) were scored by 75.4% of the respondents. Analysis by subgroups of respondents reflected the diversity of resources members draw on. The use of internet-based meetings during the COVID-19 period reflected the resilience of the NA format. *Conclusion:* Members of Twelve Step programs can be studied to shed light on options that they rely on for support for their ongoing recovery, both within the fellowships and outside them. Long-term members can apparently rely on resources inside the fellowship and simultaneously on professional ones, as well. These findings can be helpful for researchers in considering mechanisms that underlie long-term Twelve Step-related recovery and for clinicians in employing both these fellowships and outside resources as adjuncts to their professional care.

KEYWORDS

Narcotics anonymous; alcoholics anonymous; long-term members

Introduction

In this paper, we consider the way members of Narcotics Anonymous (NA) report on how they employ the support available to them to sustain their recovery from substance use disorders (SUDs). NA and Alcoholics Anonymous (AA) are the two principal fellowships whose members employ the Twelve Steps, originally developed in the 1930s for achieving abstinence from addictive substances.

There is benefit in determining mechanisms that underlie given therapies for SUDs, in that they can help optimize treatment approaches for these disorders. In response to a request for applications on this issue by the US National Institute on Drug Abuse (National Institute of Health, 2003), Moos (2008) formulated an approach to better understand the Twelve Step (TS) process. This was based on related social psychological theories such as social learning, role modeling, and self-efficacy. His model was developed further by Rettie et al. (2021) in surveying a variety of groups oriented around addiction recovery, the TS model included, to clarify psychological mechanisms that apply across these different approaches. Change mechanisms associated with spiritual practices, sponsorship, and meeting attendance were reviewed by Magill et al. (2015), while Kelly (2017) and Tonigan et al. (2013) considered the specific role of the construct of spirituality in this process. Specific issues and activities may, however, be selected by TS members themselves as supportive of their recovery. We examine here the way established members report on a group of practices and experiences they see as important to their recovery, those related to specific TS activities, and professionally supported options outside the TS regimen. We also compared which resources respondents relied on both before and during COVID-19.

Materials and methods

Procedure

An agreement was made with the NA World Service Office, located in Chatsworth, CA, for their office to email an anonymous survey to subscribers of the NA newsletter. It was explained that the purpose of the survey was to assess the mechanisms of support, within and outside of NA, that members relied upon to support their recovery. The study was approved by the Institutional Review Board

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of Chestnut Health Systems, with no consent required. An email was sent to approximately 10,000 NA members who had solicited an online newsletter. It stated that they could volunteer to respond to an attached anonymous survey if they chose to do so. The survey was emailed on March 8, 2021, and data collection was open through the end of May 2021. A total of 3,465 surveys were returned. Only responses from respondents living in the U.S. were analyzed, of which 816 were excluded for non-completion, for a final sample of 2,293. Anonymous responses were analyzed by the authors, after which the files were deleted to protect respondents' personal information. Descriptive statistics were generated to describe the US respondents.

Measures

Respondents were asked to answer items on basic demographics, substance-related experiences, and NA engagement, as described in our previous studies (Galanter et al., 2017; 2022). Twelve resources that reflect the potential for support for recovery were then presented. Respondents were asked to score them relative to the degree to which they felt each resource provided support for their own recovery. The roles of these resources may be based on a variety of experiences relevant to a given respondent, such as their psychological well-being or quality of life. These sources of support were chosen based on the experience of two of the authors' (MG and WLW) past interviews of NA and AA members and their published related research. The terminology for these resources was also clarified in discussion with NA members to properly characterize the specific items and terms to be employed by them and reflect the resources they represent (Jane Nickels, email correspondence, May 5, 2020). The resources were scored by respondents on a zero to four scale in accordance with the format developed by Likert (Likert, 1932). The resources for support were: *Other members* you got to know, *face-to-face* meetings, NA Basic Text and *NA literature*, *My sponsor*, Your own *service work*, *God, NA Prayers, Spiritual awakening,* and *Meditation*. Three institutionally sanctioned items outside the umbrella of NA were also designated: Professional *Therapist*, *Medication* for psychological distress, and *Attendance at a House of worship* (like a church). These labels are abbreviated in the text and tables as italicized above. Respondents were asked to score each of these 12 items for how important they were for support for their recovery from SUD: 0 for not important, 1 for slightly important, 2 for fairly, 3 for very, through 4 for extremely important. The scoring was made for two periods, *Before COVID-19* and *Currently* (i.e., during the COVID-19 period), to ascertain any differences between the two periods. The former represents the more typical pattern of membership, while the latter reflects how it changed during the COVID-19 period. Respondents were also asked to characterize the degree they craved alcohol or drugs during each of the two respective periods (before and during COVID-19), employing a 10-point scale (0-10; 10 being the highest) as originally employed by Volpicelli et al. (Volpicelli et al., 1992), and later employed in relation to craving-based physiologic responses to alcohol triggers (Galanter et al., 2017).

Analysis plan

A factor analysis (FA) was executed on the 12 items for the *Before COVID-19* time period using alpha factoring with an equamax rotation and suppression threshold of 0.30. The *Before COVID-19* time period was compared to the *Current* time period using paired samples t-tests. The *Before COVID-19* time period was further analyzed by dichotomizing Likert responses in order to compare respondents who indicated a score of 0 (not important) for an item versus those who indicated a score of 1—4 (i.e., important to some degree) using a non-parametric chi-square test.

We elected to characterize some respondents who did not turn at all (score zero) to some of the specific resource choices. In order to do this, we selected those respondents who scored zero on the highest-ranking resources in each of the three factors, namely *other members, God,* and *professional therapist.* We then examined which resources those respondents did rely on (scores 1-4). Due to the relatively large effect sizes for many comparisons, the current study focuses on results where a Cohen's *d* or *h* had an absolute value > 0.5 (medium and large effects) (Cohen, 1992).

A positive *d* or *h* value for a given item indicates the item was designated by respondents as more important compared to other respondents in the respective subgroups. A negative *d or h* value indicates that the item was scored by respondents, on average, as less important compared to other respondents in that subgroup. Finally, group differences for the 12 items *Before COVID-19* were assessed for the following comparisons using independent samples *t*-tests: male versus female and Black versus White. All analyses were conducted in SPSS Statistics version 26.

Results

Table 1 characterizes the respondents by demographics, their "biggest" drug problem, and NA-related experiences. Table 2 lists the items queried for respondents' reliance on sources of support for their recovery and provides results of a factor analysis of the scores accorded by respondents for each of the respective item choices. The rotated solution revealed a simple structure and explained 53.55% of the total variance. The items were loaded onto three factors, with respective portions of the associated variance for each. For identification purposes, the respective factors can be labeled by inspection as: 1—social (25%), 2—spiritual (15%), and 3—professional (11%), approximating the type of roles that the factors played in the respondents' recovery process.

Table 3 provides the mean scores for items. It also provides the results for the non-parametric chi-square tests comparing the proportion of respondents who indicated an item was *important* to some degree (Likert scores 1-4) versus *not important* (score zero) during the *Before COVID-19* time period. It includes the mean scores (on the 0-4 scale)

Table 1. Background characteristics (N = 2293).

Characteristic	Mean (SD), %
Age, years	52.0 (12.9)
Gender	
Male	46.1
Age at first meeting	30.8 (11.2)
Referred by health care professional	34.4
Meetings attended last week:	
Face-to-face	3.9 (1.38)
Virtual	1.86 (1.21)
Ethnicity	
Asian	0.6
Black	11.5
Hispanic	7.0
White	75.9
Other	5.0
Biggest Drug Problem	
Alcohol	9.2
Marijuana	4.5
Cocaine or crack	16.8
Stimulants/medicines	1.1
Heroin	12.3
Other opiates	8.2
Crystal meth	13.3
Methadone or Buprenorphine	0.3
Multiple Drugs	44.3
How many years ago did you go to your 1st meeting?	17.7 (12.3)
Have you ever relapsed?	41.0
How many years ago?	10.4 (11.0)
How many months did it last?	19.5 (44.9)

Table 2. Factor analysis was executed using alpha factoring with an equamax rotation and suppresion threshold of 0.30.

	Factor		
Item	1	2	3
Other members	0.74		
Face-to-face meetings	0.737		
NA literature	0.723	0.374	
My sponsor	0.707		
Service work	0.624	0.346	
God		0.747	
NA Prayers	0.397	0.653	
Spiritual awakening	0.411	0.615	
Meditation	0.34	0.445	
House of worship		0.426	
Therapist			0.833
Medication			0.741
Rotation sums of squared loadings	2.99	2.13	1.306
Percentage of total variance	24.92%	17.75%	10.88%
Number of items	5	5	2

NOTE: Items that did not load on the respective factors are indicated in parantheses.

Table 3. Comparison of 'Important' versus 'Not Important' for 'Before COVID-19' items using non-parametric chi-square test (N = 2,293).

Components	Mean (SD)	Important[a]	χ^2	Cohen's *d*
Face-to-face	3.50 (1.00)	95.80%	97***	2.32
Other members	3.40 (0.97)	96.50%	81***	2.39
Spiritual awakening	3.31 (1.04)	96.40%	82***	2.38
NA literature	3.30 (1.05)	95.70%	98***	2.31
My sponsor	3.27 (1.12)	94.10%	135***	2.16
God	3.19 (1.27)	91.30%	200***	1.94
Service work	3.15 (1.10)	95.20%	110***	2.26
NA Prayers	2.78 (1.32)	90.50%	217***	1.89
Meditation	2.74 (1.25)	92.20%	179***	2.01
Therapist	1.46 (1.50)	58.00%	963***	0.32
Medication	1.42 (1.61)	50.20%	1142	0.01
House of worship	1.08 (1.50)	40.80%	1358***	−0.37
Institutionally Sanctioned Support		75.40%	565***	1.07

[a]Grouping of anchors 'slightly important' through 'extremely important' (ie scores 1–4).

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

For dichotomized importance ratings prior to the onset of restrictions related to COVID-19, the mean difference rating was given for each of the resources that respondents scored.

respondents ascribed to supporting their recovery, all p <.001, and the percent of respondents who scored them as important. The majority of items (9/12) were rated as important to some degree by the overwhelming majority of respondents (> 90%). The remaining three items were outliers with regard to their relative importance to recovery for the sample, but fully 58% of respondents indicated that a *therapist* was important to some degree, 40.8% scored *house of worship* as important, and 50.2% rated *medication* as important. The three items, *house of worship, therapist,* and *medication,* reflected support provided from institutionally sanctioned resources outside the TS process and had the lowest mean scores of the resources for providing support for recovery. Based on these findings, an additional item was created that reflected institutionally sanctioned support; and has a value of 1 if a respondent rated *therapist*, *medication*, or *house of worship* as important, and 0 if the respondent rated none of the three items as important. At least one of these three non-NA supports was rated as important by 75.4% of respondents.

Table 4 addresses the resources with the highest loadings in each of the respective three factors, namely: *Other members* for factor 1, *God* for factor 2, and *therapist* for factor 3. Some respondents scored zero for each of these three respective items, i.e., not important for their recovery. Although these respondents rated these three items as ones they did not rely on for their recovery (score zero), they did designate scores among the other eleven items for those they did rely on. The percentage of those eleven items that scored as at least somewhat important to their recovery (ie scores 1-4) are listed. This lends clarity to what other items were relied on by the respondents who did not rely on the three items that ranked highest in each respective factor. Cohen's d indicates the size of effect distinguishing those who scored 1-4 vs those who scored zero on those resources. For example, 200 respondents scored *God* as zero, whereas 79% of them scored *members* as important (ie, 1, 2, 3, or 4). Thus, a positive value of Cohen's h for *members* among those respondents indicates that the majority (79%) of this subgroup scored 1-4 designating that *other members* were important to some degree (ie, score of 1, 2, 3, or 4).

Some respondents indicated that *other members* were not important to their recovery, but did rate *God*, *spiritual awakening*, and *medication* as important to their recovery. However, no items were endorsed as important to recovery by the majority of this group, meaning that respondents who did think that *other members* were important to their recovery were likely to respond that either any social items or items related to outside institutions were important to their recovery. Conversely, respondents who indicated that *God* was not important to their recovery were more likely to rate other social items as important to their recovery; and were least likely to rate *prayer* or *house of worship* as important. Respondents who indicated that *therapist* was

Table 4. Item scores for those who rated "Members," Good and "Therapist," as providing no support.

	Portion of respondents who scored items as zero					
	Members (n = 81)		God (n = 200)		Therapist (n = 963)	
Items they scored > zero	%	*h*	%	*h*	%	*h*
Other members	---	---	79.0***	1.24	94.5***	2.19
Face-to-face	13.6***	−1.63	78.5***	1.21	94.7***	2.21
NA literature	14.8***	−1.56	73.5***	0.98	93.8***	2.14
Sponsor	13.6***	−1.63	70.5***	0.84	91.5***	1.96
Service work	24.7***	−1.06	72.0***	0.91	93.3***	2.09
God	48.1	−0.08	---	---	90.1***	1.86
NA prayer	17.3***	−1.43	44	−0.24	87.2***	1.68
Spiritual Awakening	44.4	−0.22	72.0***	0.91	95.0***	2.24
Meditation	38.3*	−0.47	70.5***	0.84	88.7***	1.77
House of Worship	19.8***	−1.3	2.5***	−2.51	28.5***	−0.89
Therapist	34.6**	−0.63	52.5	0.1	---	---
Psych Meds	32.1**	−0.73	43.5	−0.26	18.3***	−1.37

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

not important to their recovery were more likely to rate all other items as more important to their recovery.

There are no differences that met the criterion for inclusion (based on the allowable size of effect scores listed in the Methods section) for: male vs female, before COVID-19 vs currently, and history of relapse vs none. There was also no difference that met the criteria for a small effect size between scores on resources during COVID-19 or before. Black respondents, however, scored higher than White respondents on *house of worship* (d = 0.80), *NA prayers* (d = 0.79), and *God* (d = 0.68).

Discussion

Manualization of treatment for SUDs is a well-established approach for systemizing clinical modalities. For example, results of a study on different manualized adaptations of cognitive-behavioral treatment can be analyzed, leaving options for applying this modality open (Kiluk et al., 2018). In many respects, the text of the Twelve Steps, developed by laypeople, spells out in a descriptive manner a way of achieving abstinence for both Narcotics Anonymous (NA),) (1993) and AA (W, 1952). There is value, however, in examining how established members rate these approaches a considerable time after recovery initiation. This can be heuristically valuable, even without the option of formal manualization, to ascertain how lay members, in practice, employ different aspects of this TS format, and how they use outside supports as well.

To this end, we selected nine aspects of NA members' reliance on the fellowship and, as a complement, three aspects of outside institutional help, that a respondent could score for the degree to which he/she relied on each aspect to support their own recovery. Scoring on these items can be useful in characterizing the way members can adapt the resources available to them. This can be useful both for clinicians in how they can better utilize TS resources and for researchers in conceptualizing the mechanisms underlying the programs' effectiveness.

Respondents were longstanding members, most commonly male and middle-aged, with their first NA meeting two decades before. An appreciable number (41%) had relapsed in the past, and for those who did, the relapse was substantial in that it lasted for an average of almost two years. Nonetheless, there was no distinction in items relied on for those who reported a history of relapse and those who did not. Scoring on resources was not significantly different before vs during COVID-19. The patterns were sustained despite the transition in meetings between the two periods. This reflects relative adaptability among longstanding members in the face of a major transition in meeting options.

A factor analysis (Table 2) and the respondents' scores for the items queried (Table 3) revealed the relative importance ascribed to the items available. Based upon inspection, respective factors subsumed in the factor analysis can be labeled as social (25%), spiritual (15%), and professional (11%), approximating the role that each factor plays in respondents' recovery process. It is notable that the interpersonally NA items scored highest, followed by spiritually related ones. Items scoring lower, but commonly employed for help with recovery were outside the NA umbrella, namely professionally related ones, and also *house of worship*. Further research would be valuable in clarifying the nature of mobilizing response and mechanism operative from an empirical and statistical standpoint. These could include an assessment of quality of life and psychological well-being. This would expand beyond the generic sense of these words.

Examples of diversity

Analyses were undertaken to illustrate the diversity of members in terms of the different patterns of the resources they relied on. There is value in looking at the pattern of reliance by different subgroups of respondents to illustrate how individual members may differentially make use of supports available to them (score zero). To this end, we elected to examine three different subgroups of respondents as indicated in Table 4, namely those who scored three items as not important to them and were then able to compare them to other members of that respective subgroup. We did this by selecting the items that rated highest in the three respective factors in the factor analysis.

A small number of respondents did not indicate reliance on *other members* (the item that ranked highest in the factor analysis). As illustrated in Table 4, the only NA-related items they

indicated that they relied on most were *God*, *spiritual awakening*, and *meditation*, which happened to be spiritually related items rather than NA interpersonal items or professional care.

Similarly, a portion of respondents did not indicate that *God* was a source of support for them. In practice, they may fall into the cohort of members who most likely self-designate as *atheists* or agnostic, which is similar in prevalence to a probability sample of the US population (Lipka, 2016). It is notable that those who did not indicate *God* as a device for support relied on social (factor 1) aspects of the fellowship at rates similar to other members of this subgroup. Those who scored *therapist* as zero do rely on social aspects of the fellowship (factor 1), as well as *spiritual awakening* and *meditation*. Unlike the other two subgroups first mentioned, they scored higher on *medication*, apparently reflecting that a group of patients indicated reliance on medication without relying on *therapy*, as such. The incidence of COVID-19 clearly impacted the feasibility of members meeting face-to-face on a regular basis, a key resource for supporting recovery. This could potentially have an impact on the viability of the Twelve Step format. Despite this, we found that the longstanding members were able to adapt to this situation by switching to an internet-based format without altering the relative reliance on other resources they drew on to support their recovery. This finding reflected the resilience of the fellowship for stabilizing recovery in long-term members. Diversity, however, merits further research, particularly with regard to the context in which each of the resources studied here is relevant to the respective individuals' recovery-related experiences, such as cultural context and professional help available in a given setting.

Gender and ethnicity

In an attempt to address key demographic issues impacting recovery, we chose to look at both gender and race in response patterns, as they are ones that have been studied in relation to stigma (Kulesza et al., 2016), opioid use disorder (Wood & Elliott, 2020), and alcohol use disorder (Holzhauer et al., 2020). Our study sample, however, pertains to methamphetamine, as well. This is useful because there are no such data available in the literature relative to methamphetamine.

One study on persons recently referred to AA indicated that men and women may respond to different needs at the time of entry into AA (Kelly & Hoeppner, 2013). It is notable, however, that there were no items in this study where there was a difference (that met criteria) between the genders on the nine items under the NA umbrella or the three outside NA itself. This suggests that over the long term, for those respondents who are committed, members of both genders were apparently making similar use of the supports for stabilizing sobriety.

In a probability sample of US residents, (Diamant, 2021), Black respondents were found to be more likely to believe in God or a Higher Power than Whites, and more likely to pray frequently. Similarly, in a cross-sectional study of persons who reported that they had recovered from SUD (Kelly & Eddie, 2020), Blacks were more likely than Whites to indicate that spirituality had made "all the difference" in their recovery more so than other options of support for recovery that were listed. This differential is reflected in relation to Black respondents in this study. Black respondents scored higher on religiously oriented items than Whites, namely NA *prayer* and *God*. They also scored higher on interpersonal items, reflecting a commitment to the fellowship overall, but apparently augmenting their orientation with a religious source outside the fellowship itself.

Spirituality and spiritual awakening

Among our respondents, the role of *spiritual awakening* was ranked third after only *other members* and *NA meetings*. Findings on this issue are worth noting. Spirituality has been reported in different settings to play an important role in recovery among patients in community treatment settings (Tonigan et al., 2013) and among respondents in the cross-sectional sample cited above of persons who reported "recovery" from SUD and indicated that overall, spirituality, more than religion, had made "all the difference" in terms of their recovery (Kelly & Eddie, 2020).

Regarding spiritual awakening as such, patients discharged from SUD treatment who reported experiencing a spiritual awakening were three times more likely to be abstinent after discharge than other patients (Bond et al., 2003). Members of a group of physicians in recovery who reported the experience of spiritual awakening reported decreased craving for drugs or alcohol following the spiritual awakening (Galanter et al., 2014). Among our respondents, it was the item that scored third highest after the two leading interpersonal items.

Service work and sponsorship

The large majority of respondents marked service work (helping other members and persons with SUDs) as very important to them. One key aspect of such service for long-term members is serving as a sponsor for other more recently engaged members. In this respect, the experience of helping fellow TS members has been associated with a positive outcome in recovery (Pagano et al., 2009). Acquiring a sponsor is key to TS membership because the sponsor is tasked with guiding a member in working through each of the Twelve Steps and supporting their abstinence. Sponsorship roles can also play a role in a sponsee's emotional support (Whelan et al., 2009). A positive clinical outcome of acquiring a sponsor has been associated with a diversity of treatment contexts, such as outpatient care for stimulant use disorder (Wendt et al., 2017) and with persons introduced to AA with prior TS exposure (Subbaraman et al., 2011). Benefit has also been found in maintaining a sponsor over the long-term of membership and not just early in membership (Witbrodt et al., 2012).

Prayer and meditation

As stated in the 11th Step, prayer and meditation provide the means for established TS members to improve their

contact with "God, as we understood Him." Outside the realm of TS practice, Krause and Hayward (2013) reported on a large cohort of persons surveyed in a national probability sample by the US Center for Medicine and Medical Services who reported practicing prayer. They were found to have lower consumption of alcohol, and this effect was greater for those whose prayer was reinforced by congregational or prayer group support. Among AA members studied in a laboratory setting (Galanter et al., 2017), active engagement in prayer was associated with the experience of lesser alcohol craving when exposed to drinking cues. Among our sample, the large majority (90.5%) reported that *NA prayers* were important to their recovery.

Professional help

The benefit derived from psychotherapy among AA members has been considered relative to different applied approaches, such as psychodynamic, cognitive-behavioral, and mindfulness-oriented treatments (Marcovitz et al., 2020). Among our respondents, reliance on a professional therapist was associated with a lesser reliance on average than NA-related items. That is to say, persons who did not rely on therapy were more likely to rely on the TS-related items; Or, stated otherwise, there was less reliance on NA resources among those who relied on a therapist.

Additionally, the outcome of psychotherapy relative to AA members has also been evaluated relative to respective patient characteristics, such as prior treatment experiences and level of education (Terra et al., 2007). Benefit from psychotropic medication was also adjudged to be helpful by half of our respondents. NA policy acknowledges that members may employ non-addictive medications for mental health. Their literature, however, stipulates that they should be taken as advised by a licensed health professional and includes an advisory that a given member should share their experience with such medication with their sponsor and/or a close friend in the fellowship (Narcotics Anonymous World Services & Inc, 2007).

The majority of our respondents indicated reliance on professional help. This suggests an acceptance by their program's fellowship as being compatible with professional care, and respondents not being committed to the TS process itself as singularly relevant to SUD recovery. A sizeable minority of respondents, however, scored zero on this (not at all), and their responses to items in Factors 1 & 2 indicated greater reliance on NA-related items than other respondents in their subgroup.

Limitations

This study evaluates different sources of support for recovery that long-term NA members turn to, both inside and outside the fellowship. The resulting findings are, however, delineated by the following limitations: Responses were obtained from a minority of members contacted as some did not have access to the NA newsletter, others may have dropped out of NA early or were recent recruits, and others may not be fully committed to NA, or inclined to respond to the survey format. The term Twelve Step is used here, but the option of generalizing results to AA members or even the general SUD population is limited.

In order to assure that the length of the survey did not dissuade members from replying, certain, potentially relevant information was not solicited, such as respondents' reliance on sources of support like family and non-TS peer relationships; reliance on maintenance medication; and respondent characteristics, such as DSM-diagnostic and employment status. External corroboration of responses, such as urinalysis confirmation of abstinence, was also not available. In order to illustrate different respondent subgroups, profiles of respondents who did not indicate reliance on three of the items of support were analyzed. Clearly, there are many other subgroups of respondents who could be characterized. Altogether, the deficits cited here illustrate the complexity of resources that different TS members may turn to for long-term support. Further research into gaining an understanding of the way different subgroups of members choose to avoid relapse is therefore needed.

Conclusion

Long-term members of TS programs can be studied in order to shed light on sources of support for their recovery, both within the fellowships and outside of them. Of particular interest from our findings is therefore the comparison of resources employed both inside and outside the NA fellowship. For example, a majority of the long-term members surveyed employed professional help (therapy and medications for psychological problems), indicating TS membership for SUD is compatible with ongoing clinically-based care.

Our findings can be helpful for researchers in considering mechanisms that underlie Twelve Step-related recovery, and for clinicians in employing these fellowships and complementary outside resources as adjuncts to their professional care. There is a need, however, to gain further understanding of the diversity of TS members' experiences once abstinence has been established for furthering recovery and preventing relapse. Future studies can further illuminate if and how mechanisms of support change across the long-term stages of recovery. Resources members rely on may be different at different points in their NA recovery. They may reflect other issues, such as improved psychological well-being or quality of life.

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Declaration of interest

The authors declare that they have no conflict of interest. The authors alone are responsible for the content and writing of the article.

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ABSTRACT

Background: A Zoom-based website was developed in 2020 that offers continuous access to online Narcotics Anonymous (NA) meetings for the first time. This website provides immediate access for persons with substance use disorder to support abstinence from substance-related addictive disorders.

Objectives: This study is designed to characterize attendees employing this online format; to evaluate their experiences for gaining support to maintain abstinence; and to compare the 24/7 experience to face-to-face (FF) meetings they attend.

Methods: An anonymous 33-item survey was made available on the 24/7 NA website that links to the 24/7 meetings. Persons accessing the site could choose to fill out the survey.

Results: 530 respondents completed the survey (64.9% female/35.1% male). Most had stable prior involvement in NA. They had attended more 24/7 meetings (14.9, SD 19.7) than FF meetings (4.6, SD 7.8) in the previous month. 86% had previously attended FF meetings, 48% had served as sponsors, and 92% reported that the 24/7 meetings were more comfortable for them than the FF meetings ($p < .001$, Cohen's $d = 0.65$) and more supportive of abstinence ($p < .001$, Cohen's $d = 0.91$). Of the respondents, 8% were still using drugs, of whom 52% had previously completed some of the Twelve Steps.

Conclusions: The 24/7 format provides a new and easily accessible way for NA members to gain support for abstinence and is positively rated by attendees seeking support for recovery from substance use disorders. It may serve as a valuable adjunct to the traditional FF format.

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Abstract

Online Narcotics Anonymous:

An Option for Addressing Methamphetamine Use Disorder

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Objective: Although 11% of all US drug overdose deaths have been attributed to methamphetamine, there are limited treatments for it that have a substantial impact on clinical outcomes. Online access to the community-based fellowship Narcotics Anonymous (NA) may offer support for remission for some persons with methamphetamine use disorder (MUD). Our objective was to characterize the role that online NA participation can play in remission of MUD.

Methods: Persons who accessed a website for participating in online NA meetings were offered the option of participating in an anonymous, structured survey consisting of items related to their clinical status, substance use, and prior experience with the website. Responses of those who designated their primary drug problem as methamphetamine were analyzed.

Results: Of the 1645 respondents who accessed the NA online meeting site in 2023, 356 indicated that methamphetamine was their principal drug problem. Levels of remission by respondents who reported turning to the website primarily for MUD were analyzed for those: (1) new to the online site (44%), (2) longtime abstinent (mean 2.3 y), or (3) still using methamphetamine (13%). Respondents' subjective experiences, such as their belief in the 12 Steps, spiritual awakening, and level of relief provided from distress, were also associated with remission.

Conclusions: Online NA meetings can provide support for promoting abstinence for some persons with MUD, and can be studied relative to their clinical status. Such meetings can therefore be useful for professional referral, and their function and utility merit further investigation.

Galanter, M., White, W., Dennis, M., Hunter, B., Passettie, L and Lustig, D. (2025) Patient characteristics associated with their level of twelve-step attendance prior to entry into treatment for substance use disorders. Addiction Science & Clinical Practice, 20:16. https://doi.org/10.1186/s13722-025-00542-5

Abstract

Background: The availability of the fellowships of Alcoholics Anonymous and Narcotics Anonymous in community settings is extensive and patients admitted to treatment programs for substance use disorder may therefore have previously attended meetings of these two Twelve Step (TS) programs. Data on such prior attendance and related clinical findings, however, are not typically available. They can, however, be relevant to how ensuing treatment is planned. We therefore undertook this study to ascertain the feasibility of evaluating how the level of TS attendance prior to treatment entry can be evaluated, and to determine clinically relevant findings that are associated with such attendance.

Methods: Over the course of 2022, 3,125 patients were admitted to a large urban multimodal United States-based treatment center. All patients were administered the structured interview-based Global Appraisal of Individual Needs upon admission. This instrument is employed to evaluate substance use, demographics, and related psychosocial variables. Clinically related variables were analyzed relative to whether given respondents have a history of any TS group attendance prior to admission.

Results: Distinctions were found between the 57.3% of respondents who had previously attended any TS meetings and the 42.6% who had not attended any meetings. Compared to respondents who had never attended TS meetings, those who had ever attended scored higher on emotional problems (p <.001, d = -0.58), and had more likely undergone previous SUD treatment (p <.001, d = 0.80). They were less likely to use substances in unsafe situations (p <.001, d = -0.55) and were less likely to express reluctance to remain abstinent (p <.001, d = -0.50). The 11% of respondents who considered themselves regular TS members reported a lower frequency of recent substance use (p <.001, d = -0.80) and were more likely to have attended intensive outpatient (p <.001, 0.46) and residential (p <.001, 0.44) treatment than patients who did not consider themselves regular attenders.

Conclusions: Examination of TS attendance prior to treatment admission is feasible. Findings can be clinically relevant for differential treatment planning and can also serve as a basis for further research into the role of TS participation in community settings.