SPIRITUALITY & CULTURE

Spirituality, Culture and Addiction Recovery

William L. White — Selected Papers, Volume V

32 Papers

White's writings on the spiritual dimensions of recovery, cultural factors in addiction and healing, and the role of faith communities in supporting long-term recovery.

Papers by William L. White, freely shared for educational use.
Source: William White Library, Chestnut Health Systems / Lighthouse Institute
chestnut.org/li/william-white-library

TABLE OF CONTENTS

SPIRITUALITY, CULTURE — AND ADDICTION RECOVERY

No.	Title	Year
1	Healing Ourselves	1983
2	Metaphors of Transformation	1992
3	Spirituality Essay	1992
4	Addiction Recovery in Native America	2002
5	Alcohol Problems in Native America	2002
6	Introduction Red Road to Wellbriety	2002
7	Native American Addiction	2004
8	Alcohol Problems in Native America	2006
9	Recovery in Native America	2006
10	Spirituality & Addiction Counseling	2006
11	Spirituality and Recovery	2006
12	American Culture of Recovery	2008
13	American Culture of Recovery	2008
14	Intergenerational Resilience and Recovery	2008
15	Spiritual Guidance & Long term Recovery	2008
16	Preface Wellbriety Movement Comes of Age	2011
17	Ethnic-Specifc Recovery Support	2012
18	Intergenerational Resilience & Recovery	2012
19	Intergenerational Resilience & Recovery	2012
20	Intergenerational Resilience & Recovery	2012
21	Mel Schulstad Tribute	2012
22	Recovery Communities as Indigenous Cultures	2013
23	Breaking Intergenerational Cycles of Addiction	2014
24	David Powell Tribute	2014
25	Ernest Kurtz Historian as Storyteller & Healer	2014
26	Secular, Spiritual & Religious Pathways of Addiction Recovery	2014
27	From Trauma to Transformative Recovery	2015
28	From Trauma to Transformative Recovery	2015
29	Kurtz and White Recovery Spirituality	2015
30	Personal Tribute: Ernie Kurtz (1935-2015)	2015
31	African American Pioneers in Recovery	2016
32	Spirituality and Substance Use Disorders Review	2023



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. (1983). Healing ourselves: Taking care of the treatment family. *Focus on Alcohol and Drug Issues*, 6(4), 4-31.Posted at www.williamwhitepapers.com

Healing Ourselves: Taking Care of the Treatment Family

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

George Pollack once noted that "a science, in order to remain vital and renewed is obligated to apply its principles and methodologies to itself whenever possible." We can do no less by applying our growing knowledge of the chemically dependent family to the relationship dynamics between staff in chemical dependency programs.

The Organizational Family

We will begin by conceptualizing the staff of the chemical dependency program as an organizational family system, assuming many family dynamics are replicated in the organization systems. The organizational family system often contains the same kind of triangulations, projections, taboos, ghosts, scapegoats, double-bind communications, etc. seen in the family system.

Nearly all of us replicate at least one aspect of family culture in shaping our treatment programs. This family atmosphere, which can produce the climate of safety and intimacy so important to successful treatment, can also have its darker side. As in the chemically dependent family, our organizational family can get twisted and strained into a pattern that disrupts the health of all concerned. This disruption in the organizational family can radically alter the quality of services to clients and produce emotional casualties among organizational family members.

Incest in the Organizational Family

We have observed for many years how the chemically dependent family closes itself off from the outside world as family members individual1y and collectively adapt to the illness. Organizational families in the alcohol and drug abuse field have a similar tendency to become progressively closed systems. The closure of the organizational family is marked by dynamics remarkably similar to those described in cases of consummated incest within families. These incestuous dynamics take a variety of forms, but broadly include stages in the life of a staff-group marked by members meeting an increasing number of their personal, professional, and social and sexual needs within the boundaries of the staff-group. This closure process occurs slowly over a number of years and inevitably produces extreme

program disruption and staff casualties.

The professional closure of the organizational family is marked by the following: (1) the organization of the program around a rigid belief system; (2) reduced professional contact with outside resources; (3) the homogenization of staff, e.g. values, life styles, etc.; (4) the scapegoating and/or extrusion of staff who chal1enge tenets of the belief system; (5) excessive demands for time and emotional commitment to the program, and (6) a progressive breakdown in the boundaries between the professional and personal lives of staff. This closure eventually produces a high level of boredom, deterioration in program morale, and sense of being trapped (since there is no guilt-free way out of the closed system). As staff members begin to experience a loss of faith in program ideology, the stage is set for increased interpersonal conflict between staff, the scapegoating of organizational leaders, and a contagion of staff turnover.

During the early stage of professional closure, staff may be spending an increasing amount of social time away from work with other staff. Work has become all consuming. Non-work social relationships decrease as the world of the organizational family draws tighter and tighter. As intimacy barriers are broken down, an increasing amount of staff time is spent on the personal and inter-personal problems of staff and their significant others. Spouses may be sacrificed (with the blessing of the organizational family), rather than compromise one's emotional/time commitment to the organizational family.

As the professional and social closure continues, it is perhaps inevitable that staff work to meet sexual needs within the boundaries of the organizational family. The development of problematic sexual relationships between staff marks the violation of the final intimacy barrier within the organizational family.

The stages of professional, social and sexual closure are integrally linked and their development overlaps in time. During the final stages of this closure we see the replacement of direct communications with gossip and rumor, the splintering of the organizational family into diads and triads (a process similar to what Bateson has described in families as "the infinite dance of shifting coalitions"), and primitive struggles for status and power. In its most extreme form, this closure is broken by a high percentage of staff being extruded or choosing to leave when the emotional tension gets too excessive. (The latter cases are remarkably similar to the dynamics noted in adolescent runaways from disturbed family systems.) The organizational family cuts off sources of outside replenishment, while escalating interpersonal conflict and personal and professional stress for organizational family members.

Organizational Family Roles

In addition to the broad organizational processes, the health of individual members in both the nuclear and organizational family depends on the role expectations and role conditions placed on each member. In a study of relapse among recovering alcoholics working in alcoholism programs, this author identified 10 role stress conditions in the work environment that were associated with the incidence of relapse. These same conditions can produce a wide range of maladaptive behaviors among organizational family members. These role stress conditions included:

- **Role/Person Mismatch:** the incongruency between: (1) an individual's knowledge and skill level and the skills required to perform tasks of a given role; (2) an individual's level of stress tolerance and the level of stress endemic to a particular role; (3) an individual's style of stress management and the methods of stress management officially and informally sanctioned within an organization.
- **Role Conflict:** incongruous demands and expectations from two or more simultaneously held roles.
- **Role Integrity Conflict:** conflict between one's personal values and values inherent in the work milieu.

- **Role Ambiguity:** inadequate knowledge of: (1) role expectations; (2) task priorities; (3) methods for task completion; (4) accountability structure; and (5) rewards and punishments.
- **Insufficient Role Feedback:** the non availability of regular information on: (1) the adequacy of role performance; (2) the methods of improving performance; and (3) the adequacy of adjustment to work milieu.
- **Role Overload:** excessive and unrealistic expectations regarding quantity and/or quality of work to be completed within given time frames.
- **Role Assignment Misplacements:** the misplacement of staff with excellent skills in interior organizational positions into boundary positions where their skills may be insufficient for the job to be done there.
- **Role Connectedness Problems:** one's degree of isolation or overconnectedness to other members of the organization.
- **Role Deprivation:** the sudden or gradual removal of all significant responsibilities from an individual-forced retirement on the job.
- **Role Termination:** failure to provide permissions, procedures, and processes to allow members guilt-free exit from the organization.

We have much in our growing knowledge of roles in the chemically dependent family that can be applied to our organizational families. Is it possible in our constant emotional contact with the alcoholic and the addict that we adapt roles as staff similar to those seen in family members? Do we see the overfunctioning/underfunctioning roles in the alcoholic family mirrored in our own program staff? Can we see the family heroes, enablers, scapegoats, etc. in our own organizational family?

The Casualties

The emotional turmoil of the incestuous organizational system and the role stressors many of us work under produce a high toll of human casualties within our field. One does not have to look far to see the stress-related health problems among staff: the self-medication with psychoactive substances (let's include nicotine and caffeine here!); the loss of emotional control; the maladaptive attitudes of cynicism; grandiosity, or hopelessness; and the disruptions in relationships, e.g. emotional distancing from clients, increased problems in intimate relationships away from work, etc.

By failing to understand the dynamics within our own organizational families that contribute to this casualty process, we continue to blame the victims.

Our casualties (and I particularly include the relapse of recovering staff) receive less respect, less concern, and less understanding than would be given any client who entered our program. Once extruded, they become the pariahs and untouchables of our field, and those of us remaining continue myopically to believe what happened to them could not happen to us.

The Challenge

The challenge before us is to boldly apply to ourselves the growing knowledge of family dynamics that is emerging in our field. As our skills grow in healing the chemically dependent family, we must also learn how to promote health, and when necessary, heal the wounds within the organizational family.

As we have confronted the stigma that forces the closure of the chemically dependent family, we must confront those forces in our own programs that influence us to build walls rather than bridges. In a period where we are expected to continually do more for less, we must examine the changing role conditions under which our profession is expected to work.

Perhaps the ultimate challenge is the recognition that the major force shaping quality of care is not found in forms and procedures, but in the health and vitality of the organizational family charged with introducing people to the recovery process.



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. & Chaney, R. (1992). Metaphors of Transformation: Feminine and Masculine. Bloomington, IL: Chestnut Health Systems. Posted at **www.williamwhitepapers.com**

Introductory Note: From 1986 through the early 1990s I was deeply involved in evaluating a gender-specific treatment program (Project SAFE) that was being replicated in 24 Illinois' communities. That experience stirred a sustained meditation about how women recovered from addiction in ways that were qualitatively different than men achieving such recovery. My plan was to do two studies, one of women who recovered from addiction outside the framework of 12 step programs and a second of women who achieved recovery within 12 step programs. The paper, Metaphors of Transformation: Feminine and Masculine, constitutes the first of these exercises. In the months and years following its completion, I became enmeshed in work on the book *Slaying the Dragon* and was never able to return the second phase of this project. Large numbers of women have achieved sustained recovery through AA, NA and other 12 step programs. With this paper as a backdrop, studies are still needed to understand how these women have applied, reframed or altered the core ideas and language of the 12 step recovery program to fit their experience as women and as recovering women.
William White, 2010

Metaphors of Transformation: Feminine and Masculine

William L. White, M.A., and Rita A. Chaney, M.S.

> "...the risk of ignoring differences is greater than the danger of naming them." Deborah Tannen *You Just Don't Understand*[1]

This paper is an exploration of the differences in the experience of addicted men and women and how such men and women experience or fail to experience a recovery process. It is a study of how models based on the experience of culturally empowered men have been indiscriminately and systematically misapplied to culturally disempowered women (and other disempowered persons). Our inquiry focuses in particular on differences in the key ideas addicted men and women use to initiate, organize and sustain their recovery. We seek through our critique of current clinical practices not to demean or undermine the current models of treatment and recovery. We have more than 35 years of combined experience working within and with these models. We seek only to expand those models so they are broad enough to embrace the other half of humanity not considered in their design or evolution.

There are dangers in discussing special needs of men and women as there are in discussing any special population of people--

dangers in the very categorization of "special." Benign efforts to define and respond to this specialness and to sketch with a broad brush what has been learned through such efforts always risks ignoring the enormous diversity found in any so-called special population and in replacing old stereotypes for more modern and politically palatable stereotypes. Sweeping generalizations about men and women ignore the range of differences produced by age, ethnicity, sexual orientation, occupation, religion, region of the country, and thousands of other idiosyncratic elements of experience that would deny any classification effort.

While attempting to abstract the essence of collective group experience poses risks, the failure to venture such an investigation raises the specter of misapplied technology. While there are benefits to be gained and potential harms to be prevented, we will walk gently into this discussion guiding ourselves carefully between the dual dangers of denying or overstating the differences between the addiction and recovery experiences of men and women. In the space below we will try to sift out some of the most salient differences in the constructs and experiences that become points of transformation for addicted men and women. While reality is much more complex than the models and metaphors we use to elucidate it, these tools may help us enhance our ability to conceptualize and enhance the helping and recovery process. While these constructs do not fully reflect the complexity and uniqueness within and across gender, we do believe they capture the mainstream experience of many addicted and recovering women and men in this culture.

This study was begun with some trepidation. There were concerns about exposing our sometimes painful self-examinations of these issues amid the sense that our work on these ideas was not complete and could never be irrevocably finished. As such, this paper is more a snapshot in time of a thinking process than a set of definitive conclusions. Any paper exploring gender differences within a historically patriarchal, but rapidly changing, culture and professional field of endeavor typically incites debate and criticism, and this paper is not likely to be an exception. If the ideas contained here stir dialogue that deepens our understanding of the different recovery pathways available to addicted men and women, then the risks and any resulting bruises will have been worth it.

The Male Treatment and Recovery Paradigm

There is no question that mainstream assessment, treatment and recovery technology in the addictions field was developed based on experience with men. Most of the basic paradigms, principles and practices of the field had been hardened and set before women arrived in great numbers as clients, volunteers or professional staff.

The experiential foundation of Alcoholics Anonymous (the years from 1935-1939) that produced the 12 steps which would come to so influence our current understandings of addiction and recovery was a foundation based almost exclusively on the experience of alcoholic men. When the "Big Book" (*Alcoholics Anonymous)* of AA states, "Here are the steps we took" in introducing the 12 steps, the "we" reflected the experience of culturally empowered, alcoholic men. At the time these words were first written only two women had made short-lived contact with AA. In fact, the inscription, "The story of How More than One Hundred Men Have Recovered From Alcoholism," appeared on the title page of the 1939 first edition, and was proposed as the book's title until Florence R., who would later leave AA and return to drinking, argued it down.[2] Marty Mann, who would become the first woman to achieve sustained sobriety within AA, threw a draft of the Big Book on the floor when she first read it because of its frequent references to God and lack of references to women.[3] Charlotte Davis Kasl and others have cogently documented how the 12 step prescriptions were defined to fit the character armor of the culturally empowered male alcoholic.[4]

Professional research and clinical models of intervention with alcoholics were similarly based on experience with men. We are talking

about the experience of men whether we talk of the physiological effects of alcohol, the progression of alcoholism, the major alcoholism assessment instruments, or the heart and soul of the 28-day "Minnesota model" of alcoholism treatment. While estimates of alcoholic women in the United States range as high as 5 million, only 8 percent of the subjects in studies on alcoholism and chemical dependency conducted between 1970 and 1984 were women and many of these studies did not isolate and contrast data for men and women.[5] Vanicelli's 1987 review of alcoholism research studies could only find 3,278 women who had been included in alcoholism studies in the past 29 years![6] Women were rarely included among those designing and conducting addiction research and were not included as research subjects. The experience of women has until recently been excluded from the field's theory-building. The field has openly practiced a phenomenon sometimes referred to as the "Adam's Rib Syndrome"--the assumption that women are identical to men, that research conclusions based on experience with half of the population can be extended to include the whole. What technology exists is clearly based on the experience of men.

Women's needs and experiences have also not been reflected in our mainstream programmatic and clinical practices. When women first began to enter self-help structures (the 1940s) and treatment structures (the 1970s) in large numbers, the primary concern was not with their special needs but the extent to which their presence would serve as a distraction to men. These women entered helping systems in which their alcoholism was defined based on experience with men and their treatment and recovery was proscribed within a model defined by men, for men, in helping relationships between men. As newer and alternative models of treatment (therapeutic communities, methadone maintenance) and new specialty areas (employee assistance programs, criminal justice diversion, intervention programs for drinking drivers) these also would be crystallized primarily based on experience with men.

A large number of women have utilized these traditional male-based frameworks of intervention, treatment and recovery to support their recovery from addiction. Of the 9,394 persons who responded to AA's 1989 membership survey, for example, 35% were women.[7] Traditional frameworks of treatment and recovery have slowly evolved as more women have entered them. Many recovering women sought supplemental services (concurrent therapy) and may have gotten sober in spite of, rather than because of, such male-based frameworks of recovery. It is a testament to women's strength and resilience that they could interpret and reframe these male-based models to fit their experience and needs. Within the framework of women's meetings, women's mentoring and sponsorship of women, and shared encounters across tables in living rooms and coffee shops, this male-based recovery architecture was feminized, filtered and reinterpreted to fit the experience of women. Like oversized clothes, the traditional models had to be cut up and reassembled before they fit comfortably and yet many women would be criticized for such personalization--shamed to the point they were often silent about the interpretations and changes they were creating to make this "simple" program fit the complexity of their experience and needs.

A number of events have set the stage for the reassessment of our mainstream treatment philosophies and techniques.

- **Treatment outcome studies** confirm our clinical observation that a significant portion of alcoholics and addicts do not respond to our best treatment and recovery paradigms. A review of treatment outcome studies of the past decade reveals that from 50% to 65% of clients leaving treatment will not be abstaining from alcohol and/or other drug use two years following their discharge from treatment.[8] In the most recent (1989) survey Alcoholics Anonymous conducted of its membership, it was

found that approximately 50% of persons who come to AA will leave within three months, with progressively slower attrition rates continuing beyond this period.[9] If such programs are to be measured by their ability to generate sustained patterns of sobriety, there are many subpopulations of clients for whom this treatment and recovery technology quite simply is not working.

- **Challenges to the single pathway model of addiction** occur daily. The tenants of this model (1. Substance abuse springs from a single etiological source. 2. It presents itself in consistently homogenous characteristics. 3. The disease responds to a very narrow approach of philosophy and technique. 4. There is a single pathway of long-term recovery that all must follow.) are being challenged by a view of multiple etiological sources of substance use disorders, multiple subpopulations who present diverse patterns and needs and respond to very different treatment approaches and who may utilize a wide diversity of long-term recovery pathways. From these challenges have come new treatment approaches and self-help structures for adolescents, women, people of color, gays and lesbians, persons with physical/psychiatric disabilities. Advocates concerned over the misapplication of interventions defined to work for men to women raise two concerns: the first, that the male-based treatment technology simply fails to produce the desired results when applied to women, and second, that the male-based treatment technology when misapplied to women can actually have an iatrogenic (treatment-caused harm) effect.

- **The women's movement** forced a reassessment of the exclusion of women from professional and leadership roles within the addiction treatment field and the special needs of those women who were being served as well as those women who needed services but weren't being reached by our traditional service models.

- **The movement of women into research, clinical and administrative roles** within the addiction treatment field has provided forums from which to raise the special needs of women. These voices posit that it is not enough to bring women into the field and have them do to women clients what men have done to men clients--to practice the "state of the art" as women inherited it. It is not enough to force women into the mold of the male counselor and to mold the bodies and psyches of women clients to fit the masculine mold of addiction recovery.

- **Federal and state funding** for research on substance use disorders among women and funding for programs specializing in treating addicted women were crucial in supporting the work out of which would come much of our current knowledge about the treatment and recovery process for addicted women.

The Emergence of Women's Ways of Healing

As each month passes, a growing body of research and clinical experience accumulates to underscore the differences between patterns of addiction and recovery in men and women. Researchers have found differences in drinking and other drug consumption patterns between women and men that include:

- Alcohol consumption patterns (Women are less likely to drink, with 40% abstaining from drinking.)
- Licit drug consumption (Women are more likely to be using/abusing licit psychoactive drugs alone and in combination with alcohol.)[10]
- Alcohol metabolism (Women reach higher peak blood alcohol levels; women on oral contraceptives metabolize alcohol more slowly.)[11]
- Morbidity and mortality (Women have more severe medical problems than men with less alcohol consumed.)[12]
- Genetic risk of alcoholism (Males have higher genetic risk.)[13]
- Etiology of alcoholism (Addicted women bring other life experiences, e.g., parental alcoholism, sexual victimization in childhood/ adolescence/ adulthood that can serve as etiological forces in addiction or obstacles to their recovery.)
- Onset of excessive alcohol/drug use (Onset in women tends to be tied to identifiable events.)[14]
- Speed of progression (Progression is faster in women.)
- Stages and symptoms (Stages are less distinct for women; some early stage symptoms for men are late stage symptoms for women.)[15]
- Stage of intervention (Women, primarily because of social/family enabling and stigma, enter treatment at later stages than men.)
- Barriers to treatment (Women may have special barriers such as increased stigma, lack of child care, and concern for physical/psychological safety in male dominated treatment environment.) [16]

As clinical experience with women increases in the addiction treatment field, so has the concern about the pressure on addicted women to comply and experience treatment whose essence has been defined and whose success is measured based on the physical, psychological, social and spiritual architecture of men. The more experience we have with women experiencing alcohol/drug-related problems, the louder is the growing voice that defines and calls for a more effective response to their special needs.

This paper is a single note within a more extended composition being written within the field which posits that we need to look anew at the needs of addicted women and our response to those needs. It is part of a broader movement that says our treatment models must emerge out of the needs and experiences of our clients as opposed to programming these needs within a pre-set and perhaps alien architecture. It is the premise of this paper that treatment and recovery principles within the addictions field were designed for culturally empowered men and require significant modification to respond to the needs of women.

Masculine and Feminine Metaphors of Change

> "How can women create stories of women's lives if they have only male language with which to do it?" Carolyn G. Heilbrun, *Writing a Woman's Life* [17]

Addicted men and women both exhibit chronic self-defeating styles that serve to sustain addiction. These patterns become compulsive and progressively self-accelerating. They become individually specialized, fixated and cognitively self-perpetuating. These culturally encoded styles must be unlocked through the treatment and/or self-help process. The treatment process is a discovery of those metaphors--words, phrases, ideas, stories--that like keys

to locks and ciphers to codes can open avenues of change.

Change, whether social or personal, requires a special fire-like chemistry. There must be the required fuel and oxygen and that special igniting spark. Lacking any of these ingredients, change fails to occur or is prematurely extinguished. Ideas have long served as organizing axes that, at the right time and place, drive the process of change. Ideas can be so galvanizing in their implications that they force breakthroughs in perception--breakthroughs that create a redefinition of self and the self-world relationship. This paper focuses on particular kinds of ideas called metaphors that in their subtlety, complexity and power strike deep emotional cords that incite a process of self-assessment, self-restoration and self-creation.

Metaphors are terms or phrases--crystallizations of ideas or constructs--that through analogy and comparison label and elucidate complex experience. Metaphors can enhance understanding of one's experience and open up a vision of the course of action one must take. There are many such examples in the chemical dependency field. The construct of "allergy" has been an important notion around which many persons within AA have cognitively framed their sobriety decision. The more dominant "disease concept" is a construct whose utility far transcends its eventual disposition in scientific debate. Such constructs are "true" in the sense that they validate and make sense of otherwise incomprehensible and sanity-challenging experiences for many persons. They are metaphorically true to the extent that they provide a cognitive cornerstone through which untold numbers of addicts organize their movement from addiction to recovery.

Treatment interventions must reflect an understanding of the styles through which men and women are culturally programmed to respond to decreasing competence in their role performance. The metaphors for culturally empowered white men are so dominant within the addictions field that they have defined the field. They constitute the cognitive and emotional axis points through which all persons are expected to initiate and chart THE pathway (notice the use of the singular here) from addiction to recovery. What has been designed as a universal paradigm is actually a reflection of a narrowly prescribed band of human experience. We are not proposing that the metaphors within this paradigm be discarded; they can be life-transforming when matched to the persons for whom they were designed. There are, however, a whole range of persons--women, culturally disempowered men, people of color, youth, and others--who may not experience these metaphors as empowering. While there are many persons disempowered persons who have been aided by these mainstream metaphors, there may be a whole world of emerging and yet untapped metaphors that will prove to be much more effective and central to the liberation of disempowered persons because these alternative metaphors speak more powerfully to their needs and experiences. It is our belief that there are contrasting metaphors for men and women that can serve as the catalysts for personal transformation. Words, symbols, and constructs which men may use to free themselves may provide no such liberating influence on women and may inadvertently drive them into the darker shadows of their chemical and social imprisonment.

The character Bathsheba in Thomas Hardy's *Far From the Maddening Crowd* could have been speaking for past and current generations of addicted women entering male-based treatment and recovery programs when she said: "It is difficult for a woman to define her feelings in language which is chiefly made by men to express theirs."[18] How frustrating and demeaning it has been for recovering women to define their experience in language and metaphors developed by, and through the experience of, recovering men. Until recently, women have been forced to forge their recovery out of men's language, men's metaphors, men's models of meaning and change. More recently, women have begun to break free by telling the truth to one another--breaking silence about both their individual and collective experience. This phenomenon can

be seen within women's groups within traditional 12 step programs, in the emergence of alternative recovery models such as Women for Sobriety, in the spread of adult survivor groups, and in the growth and sophistication of groups organized to counter violence against women and children. A parallel process is reflected in the growth of women's research, the increase in specialized treatment services for women and the growth of women writing and training within the field. Through these personal and professional rituals of breaking silence have risen women's language, women's stories and women's metaphors of healing.

In the remaining pages of this discourse, we will explore the nature of the differences in feminine and masculine metaphors of transformation. Our approach to this exploration is a form of inductive anthropology through which we will compare the language, myths and metaphors that characterize the literature and oral folklore of men's and women's addiction, treatment and recovery experiences. The sources used to construct these comparisons include highlights from substance abuse research and research on gender psychology/socialization, a semantic analysis and comparison of recovery programs that have emerged based on the separate experiences of men and women, the identification of issues being consistently raised by programs specializing in the treatment of addicted women, and observations from the authors' combined clinical experiences. The comparison of recovery models contrasts Alcoholics Anonymous (male-based) with Women for Sobriety and a number of adult survivors of sexual abuse recovery frameworks (women-based). Given the exceptionally high prevalence of sexual abuse among addicted women, we feel the inclusion of adult survivor frameworks is particularly elucidating and reveals dimensions of healing excluded from male-based treatment and recovery designs.

Powerlessness versus Empowerment

> "We admitted we were powerless over alcohol--that our lives had become unmanageable." First Step, Alcoholics Anonymous[19]
>
> "I have a drinking problem that once had me." First Statement of Acceptance, Women for Sobriety[20]

Recovery within 12 Step programs begins in the first step with two metaphors: *powerlessness* and *unmanageability*. The action evoked by these two metaphors is the action of acceptance, of surrender, of giving up. What makes this ritual of acknowledged defeat such a clinical milestone, the axis upon which the initiation of recovery begins? While such acceptance is the obvious antidote and unfreezing of the alcoholic's cognitive defense structure--the denial, minimization, projection of blame, etc. that sustain drinking and protect self-esteem--there may be even more profound magic in this ritual for the men from whose experience it was framed.

The admission of powerlessness over anything for culturally empowered white men would constitute a major clinical milestone. The first step of AA marks a deep intuited understanding of how culturally empowered men are culturally programmed to respond to alcohol-induced deteriorations in personal competence: grandiosity, aggression, increased preoccupation with power and control, and/or flight. Juxtaposed against this pattern of defense, this proclamation of powerlessness and unmanageability of one's life marks a deep emotional break from the Sysiphisian effort to control one's drinking and maintain self-worth.

Cultural empowerment imbues not just a legitimacy to one's existence but a sense of entitlement, privilege and superiority. It is the inherent belief in one's power to control the fate of oneself and others. It is dominance based on differences between the superior or inferior character of one's age, gender, sexual orientation, race, religion, profession or class. Cultural empowerment bestows a mantle of superiority; cultural disempowerment creates an unending succession of wounds to one's legitimacy and value. Power is to culturally

embraced white men what water is to fish--an ever-present but invisible life support system taken for granted until its esteem-feeding oxygen is withdrawn or lost. Powerlessness for men is to experience themselves outside these cultural waters--to lose the experience that they have authority and control over their personal destiny. Thrust outside these waters, there is often a breakthrough in self-perception of such remarkable and terrifying clarity as to evoke what may be later framed a spiritual crisis. Such crises have often been noted for their ability to ignite the movement from addiction to recovery. If this breach in the male ego--this crumbling of the narcissistic illusion of power--constitutes such an emotional breakthrough for culturally empowered men, how do women (and disempowered men) respond to these metaphors of powerlessness and unmanageability? The confrontation technology that has been so commonly used to precipitate a crisis of transformation by deflating the alcoholic male's ego can re-victimize women and cultural minorities whose egos, whose senses of self-value, have been weakened under the crushing pressure of sexism and racism.

The first step of AA and the first statement of acceptance of WFS have some parallels. There is in both a breakdown or breakthrough in the denial of alcohol's debilitating effects. But the manner in which this denial is countered shows significant differences between AA and WFS. Where AA focuses on this emotional surrender and the admission of powerlessness and unmanageability, WFS focuses on an assumption of power and control. The first statement of WFS brilliantly intuits and counters how women have been programmed culturally to respond to decreasing competence via passivity, helplessness, hopelessness and dependency. In the face of such cultural assault, neither the admission of powerlessness and unmanageability nor the experience of surrender would constitute an emotional breakthrough. As one of our clients put it: "Powerless and unmanageable? So what else is new!" Acceptance and surrender can hardly be considered as clinical milestones for persons whose physical and psychological safety has been contingent upon obedience and submission. In contrast, the experience of assuming power and control may be a breakthrough. Jean Kirkpatrick, founder of WFS, illustrates this experience of assuming power when she discusses this first statement of WFS.

> "I have a drinking problem but it no longer has me. I am the master of it and I am the master of myself."[21]

The fourth and fifth WFS statements reinforce these themes of self-control, power and mastery.

> "Problems bother me only to the degree I permit them."[22]

> "I am what I think."[23]

This theme of control is further illustrated by Gannon's first step of recovery for adult survivors of childhood sexual abuse, a program like WFS based almost exclusively on the experience of women: "I have resolved the breakthrough crisis, regaining some control of my life."[24]

For culturally empowered men, recovery begins with the experience of surrender to one's powerlessness and loss of control. For culturally disempowered women, recovery begins with the experience of empowerment--recognizing and embracing the power to shape one's own destiny.

"Hitting Bottom" (Pain) Versus Seeing the Top (Hope); Enabling Versus Empowering

The addictions field has through its dominant experience with men evolved a folklore about the nature of the motivational crisis that propels one from active addiction to active and sustainable recovery. Experience with middle and upper-class men provided several evolutions in this folklore beginning with the notion that recovery springs from the experience of hitting bottom. This folklore posited that alcoholics stop drinking when the

pain of drinking gets greater than the pain of quitting and not drinking. This view suggested that when sufficient pain and loss accumulate to a kindling point, there will be a crisis out of which the recovery process is ignited. Then came the breakthrough in intervention technology based on the discovery that outsiders could raise the bottom--speed up this crisis point--by pulling out all of the enabling relationships and behaviors that help sustain drinking and by staging a loving confrontation with the alcoholic to bring home the full effect of drinking on those the alcoholic loved. And the intervention technology worked wonderfully in precipitating this crisis for culturally empowered white men. Both the old and new versions of "bottom" technology assumed the presence of some remnant of hope which culturally empowered men brought in great abundance because they had experienced their own ability to make decisions that could influence their personal destiny. But what happens when such intervention technology is applied to persons who have no such experience of hope? How does such technology fit poor addicted women of color? Is there an insufficient quantity of pain and consequences that prevent them from moving into recovery?

The focus on addiction-related pain and consequences for the culturally disempowered is impotent to effect change if it is not accompanied by an infusion of hope. In more and more programs this hope occurs in the context of a relationship--often with one or more other women who share similarly life-shaping experiences (sexual victimization) or characteristics (color, poverty, loss of children) and who are in active addiction recovery. Metaphors of hope may be more change-inciting to culturally disempowered women (and men) than the metaphors of pain to which culturally empowered men have so consistently responded.

Traditionally, any activity that prevented the addict from experiencing the pain and consequences of drinking was viewed as an enemy of the recovery process. Family members and addiction therapists alike closely guarded themselves against the shameful charge of ENABLING. Does the over-application of this concept pose risks of abandoning addicted women (and other culturally disempowered persons) for whom alternative strategies might prove more effective in achieving the goal of initiating a recovery process? In the program manual of a project which has intervened with more than 1,000 women since 1986 can be found the following words:

> Service interventions that might be viewed as "rescuing" or "enabling" for chemically dependent men, may be essential ingredients to initiate and sustain early recovery for a significant portion of chemically dependent women. The issues of treatment is not whether these women have experienced enough pain and consequences related to their alcohol and drug use. Such pain exists in high magnitude. It is the absence of hope and opportunity, not pain, that must be the focus of the intervention process.[25]

There is a consistent message emerging from programs serving addicted clients with culturally-driven and deeply imbedded characteristics of passivity, dependence and learned helplessness and hopelessness. That message is that many such clients, in spite of their strengths and survival competencies, have a marked incapacity to spontaneously initiate their own recovery solely as a response to pain. It is our energy, our caring, our hope, our belief in them--the existence of an empowering relationship--that must initiate the leap of faith into recovery. If we wait for them to hit bottom, they will die.

We (Connectedness) Versus I (Individuation)

Self-help structures for recovering men and women by definition provide a vehicle for mutual support and sharing, and yet there

seem to be differences in the recovery maps that emerge from such groups depending on whether the recovery structure was shaped on the experience of men or the experience of women. These recovery maps provided contrasting metaphors that provide men an increased experience of intimacy and attachment and women an increased experience of self.

In the 12 steps of AA, for example, the word "I" does not appear. The 17 pronouns found in the 12 steps convey the experience of connectedness: we, our, ourselves, us. There is little doubt that this emphasis on group connectedness was the intuited antidote used to transcend the narcissism, alienation and haunting experience of aloneness alcoholic men brought to AA from its earliest days. The emphasis on pronouns of inclusion and connectedness to others also serves to counter the cultural attribution of value to men based on individual achievement and the dwarfing of men's ability to experience intimacy and connectedness to others. The "We-ness" of AA opens a desperately needed pathway to sharing and belonging. "We" and "our" are metaphors that touch deep emotional needs in addicted and recovering men--metaphors that hold out hope of escape from the growing agony of their isolation.

In contrast to AA, there are 14 first person pronouns (I, my, me, myself) that appear in the 13 statements of acceptance of WFS. There are 49 first person pronouns in Poston and Lison's 14 steps of growth for incest survivors; "I" appears 30 times.[26] There are 43 first person pronouns in Gannon's 21 step recovery program for adult survivors of childhood sexual abuse; "I" appears 25 times.[27] The words "we" and "our" do not appear in any of the statements/steps of these programs. One of the few rules for communication set forth by feminist therapist Toni Laidlow, in her groups for women with compulsive disorders, is the requirement that each participant must speak for herself--must speak as the "I," and not in terms of "we," "you," "they" or other abstractions.[28] Just as the "We-ness" of AA responds to needs for connectedness, the "I-ness" of WFS and other recovery frameworks which emerged in response to the needs and experience of women responds to the need for individual identity. The "I-ness" of WFS allows women to experience themselves separate and distinct from the roles and relationships within which their personal identities have been fused and sacrificed. The repeated use of "I" within women's -based recovery models holds out hope for the discovery of self to the addicted woman.

If we construct a continuum of relatedness, we might hypothesize that men and women are culturally programmed for placement at very different points along this continuum. We could further hypothesize that the addictive experience exaggerates the forces that serve to propel individuals to the poles of this continuum. Addicted men and women may be seeking the same thing--balance and harmony--but their search begins from two very different existential positions. Each pronoun--the I and we--from our different recovery models is itself a metaphor of the experience sought and needed.

Where male identity has been structured within the framework of individual achievement (autonomy, competition, isolation), feminine identity springs from one's identification with, relationship to, and caring for others--through roles of child, spouse, or mother. Each of these gender-shaped molds within which men and women are programmed to seek their destiny is unidimensional--one restricting connectedness to others, the other limiting the experience of self. Such distortions of character become even more extreme and exaggerated through the experience of addiction. Addiction pushes men and women to the extremes of this continuum and then through its debilitating effects engenders deteriorating competence and the experience of failure within these restricted roles. Addicted men seek exaggerated efforts at independence and autonomy, e.g., preoccupations with power and control, geographical flight, etc., only to escalate dependency. Addicted women seeking exaggerated efforts to achieve

connectedness become progressively isolated and alone. While each needs the discovery of more balanced experience, men must achieve this balance through discovery of connectedness to others while women achieve this balance through the discovery of connectedness to self. He must open himself to the influence of others; she must open herself to self-definition. He must extend caring beyond the self; she must incorporate self into her value of caring and service. The metaphors of treatment and recovery must speak to these two very different pathways. Carol Gilligan describes the point of balance and harmony--the goal to which these recovery experiences are directed when she notes:

> These disparate visions in their tension reflect the paradoxical truths of human experience--that we know ourselves as separate only insofar as we live in connection with others, and that we experience relationship only insofar as we differentiate other from self.[29]

Power Greater Than (Outside) the Self Versus Power within the Self

2. Came to Believe that a Power greater than ourselves could restore us to sanity.[30]
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.[31]

The second and third steps of AA reach into the heart of the pain-induced crisis and use that crisis to propel a major shift in the characterological anchorages of the male alcoholic. Step two, first of all, taps the often unspoken theme of the alcoholic's hitting bottom crisis (fear of complete loss of sanity): fears fueled by the repeated episodes of loss of control, radical personality changes while drinking, and repeated sanity-challenging failure of promises and resolutions to others that characterize the predominantly male pattern of alcoholism that E.M. Jellinek referred to as gamma species.[32] The steps further provide the antidote for the alcoholic's escalating narcissism and failing struggle to maintain control over alcohol. The steps extend the surrender of will that began in step one and unequivocally posit that the source of hope for recovery relies on resources outside of and greater than the self. The culturally empowered male has experienced a broad range of power and control in his life but in steps one and two confronts the reality that he is impotent to control his relationship with alcohol. Steps two and three place the alcoholic within the traditions of the great religious and spiritual disciplines which call for the submergence of individual will and ego to a higher power. Spirituality--this connectedness beyond the self--is used as a further antidote to narcissism, isolation and alienation.

In contrast to AA, the program of WFS focuses not on powers beyond the self, but powers within the self. There are no references to God or higher powers in the three women's recovery programs. Although there are references to spirituality found within the affirmations of WFS and in Gannon's 21 step recovery program for adult survivors, all three recovery programs reinforce the power within each woman to think, feel and act in ways that shape her own destiny.

Anne Wilson Schaef attributes the focus on power outside the self for women to the concept of original sin--the idea that one can only be saved through the aid of some more valuable and superior force. She suggests that women have been programmed to define themselves and their value through attachment to such an outside force, usually a man.[33] Where turning their will and their life over to something outside the self might be a new experience for men, it would be business as usual for many women.

Focused Attention versus Divided Attention

When the traditional addiction treatment and recovery technology demands a singular,

obsessive focus on sobriety, it asks for a form of focused attention very familiar to men. The male alcoholic is asked to apply to his alcoholism the same singularity of focus to which they have historically excelled. Men are programmed to set aside diversions and other personal needs and sacrifice everything for the pursuit of their singular area of accomplishment. When counselors and sponsors consistently frame "secondary" obligations as "distractions" or propose the formula of "90 meetings in 90 days," they are asking for a focusing of attention that men have long been socialized to display in their professions, pastimes and pathologies. Men have been afforded such focused attention quite often because of the "little woman behind the great man." He can go to 90 meetings in 90 days because he is alone without caretaking responsibilities or because his partner continues her over-functioning as homemaker and parent, holding in check her own unmet needs as she has through the progression of his addiction. He can focus because she continues to assume a great share of his duties or responsibilities. Not only are men provided supportive roles that allow their singular focus, they are also given more financial resources which can be utilized to resolve any environmental obstacles to their recovery.

Women's lives are rarely free to pursue such a singular purpose. Women are instead challenged with what Mary Catherine Bateson calls a "sustained divided attention"--a balancing of multiple roles, responsibilities and activities.[34] Under such bombardment, response to one's own needs must be sandwiched between responses to demands springing from many other sources--demands that provoke the phrase "juggling act" anytime women are asked to describe their lives. When she is challenged to do "90 in 90," she is much more likely than her male counterpart to be confronted with insurmountable obstacles. An androcentric model of assessment might view a addicted women in this context as follows:

> During the assessment interview, this client persistently minimized her substance-related problems and instead focused on all of the other secondary problems that would prevent her from entering treatment at this time. Her use of distractions to defocus attention from her addiction appears to be a chronic pattern of self-sabotage. The client's intense resistance makes her prognosis for entering or successfully completing treatment very poor until some more intense crisis forces her to address her addiction.

There is great danger that androcentric models will interpret as attitudinal and as resistance what for many women is environmental and overwhelmingly real. To demand a singular focus on sobriety defies the reality that sobriety must be integrated into the total fabric of women's lives. While addiction recovery can be both the center of her life mosaic and the thread that ties other remnants of experience into a meaningful whole, this focus on sobriety must be integrated within rather than displace the multiple role demands placed on women. The multiplicity of women's needs must be addressed simultaneously and integrated into a meaningful whole. Where men are taught to exclude demands outside the singular focus of recovery ("Let it Go"); women must discover a way to mesh together their response to such demands. Where men are taught to exclude complexity ("Keep it simple"); role demands within women's recovery pathways inevitably involve great complexity. Within the broader problem of the "feminization of poverty" in the United States can be found addicted women for whom environmental obstacles to initiating treatment and recovery seem insurmountable.

There seems to be a greater inter-connectedness of problems--what Marilyn French has called "circularity"--for addicted women.[35] Each discrete problem interacts

with all other concurrent problems intensifying each and creating a synergism of multiple problems, each of which cannot be addressed in isolation from the others. Mechanisms that decrease or help manage these demands such as the provision of outreach and case management systems, advocacy services, homemaker services, day care services, and transportation services are more effective than a cultural double-bind that overloads the substance-abusing woman, shames her for not handling this load and then defines her as pathological if she refuses to let go of these responsibilities through a singular focus on recovery. Asking her to let go of such responsibilities, in essence, means she must let go of her entire being and meaning for existence. One single mother, when advised to enter inpatient treatment, desperately and emphatically stated, "I'll do anything you say, but I won't leave my babies or my job."

This singular focus is particularly problematic for poor women with children for whom sobriety must be placed within the competing demand for physical and emotional survival. How does a poor single parent woman with four children under age five attend meetings? How many self-help meetings offer day care or transportation? We would do well to listen to the experience of these women. What other community institution provides a supportive framework for sobriety, will welcome this woman's children and will transport her and her children? Should we be surprised by a study indicating the church was the primary sobriety-based support structure being utilized by poor, African-American women following their treatment for addiction? It is essential that we acknowledge and concretely address the environmental--social, political, economic--realities within which each client must construct her recovery and seek her personal destiny. What works is not a single fixation on sobriety, but the forging of a pattern, a process of living, a whole life that is meaningful. Such lives for women are a mosaic constructed not by plan or recipe but out of the raw material of daily experience.

Behind the oft-verbalized metaphor of the "juggling act" lies another experiential metaphor for addicted women--the metaphor of being "trapped." Trapped may reflect their specific addiction experience, but it also describes a kind of cultural imprisonment--an enslavement of one's time and emotional energy through multiple role responsibilities over which one has lost all choice and all sense of self. From this experience of entrapment come the fantasies and hunger for personal freedom. While the concept of "freedom" may galvanize action to confront addiction, the broader implications of this term make it a particularly powerful and liberating metaphor for recovering women.

Men's recovery is described in a language that is hierarchical, linear and obsessively focused. The hierarchical and linear qualities of male recovery paradigms are apparent in the focus on numbered steps and moving from point A to point B. Even positing that women may have different recovery pathways than men still uses a metaphor—pathway--that suggests movement through a predetermined course of action and experiential territory. Metaphors that appear in women's oral folklore and in women's literature--metaphors such as the circle, the mandala, the web, the mosaic, the net, the collage or the patchwork quilt--may more realistically capture the real life realities and complexity of experience of recovering women.

Men's models of recovery which focus on doing one thing at a time and in sequence miss another reality of recovering women. The men's model implies that one thing is done and then you go on to the next recovery task. Many women's problems are dimensions of living that don't get permanently fixed at a particular point in recovery. Such dimensions ebb and flow into her attention, first calling for time and effort and then ebbing into the background, lying dormant but likely to re-emerge later with a slightly altered appearance. Many developmental tasks for recovering women are addressed not through a singular episode of focused attention but rather through intermittent bursts of attention separated by periods of neglect scattered over years or a lifetime. Some of the physical healing and

corrective emotional experiences that mark women's recovery unfold internally within predictable time frames while other movements backward and forward spring from serendipitous events in each woman's life. Such a healing process defies neat depiction in a treatment plan whose duration is four to six weeks.

The traditional male paradigm dictates a single pathway for long- term addiction recovery--continued affiliation and active participation in a 12 step program. While women may indeed need support structures to sustain their recovery, a close examination of their long-term recovery experiences reveals a much broader spectrum and variety of support structures than this traditional paradigm. Male recovery paradigms emphasize recovery as the single organizing principle of one's life and taking on the focused (almost obsessive) identity of recovering alcoholic or addict. Women's recovery metaphors do not convey sobriety as a goal to be achieved through such focused obsession. The goal is "composing a life" that is whole and meaningful.

Guilt versus Shame

The aphorism, "you're only as sick as your secrets," that has been long imbedded within the folk culture of AA bears testament to the need for alcoholics and addicts to give up such secrets. When we compare, however, the content of the experiences revealed through these rituals of self-disclosure, we discover some significant differences between recovering men and women, differences that can be illuminated by exploring the distinction between guilt and shame.

If there is a dominant emotion around which AA's 12-step recovery is organized it is unquestionably that of human guilt. Anyone who has worked with persons with primary addictive diseases will not be surprised by this statement. The alcoholic and addict are caught in an escalating spiral of "I'm sorry, it will never happen again," "I promise it will be different this time," and "all I'm asking for is one more chance." Dr. Jekyll promises and the drinking Mr. Hyde violates the most sincere of commitments and intentions. For sins of omission and commission that preceded and grew geometrically through the progression of alcoholism, AA provided a framework for healing to expiate guilt over what one had done. Pulling from its spiritual predecessors, AA developed a technology to address such guilt that included self-inventory, confession, self-forgiveness, restitution, and service.

4. Made a searching and fearless moral inventory of ourselves.[36]
5. Admitted to God, ourselves and to another human being the exact nature of our wrongs.[37]
8. Made a list of all persons we had harmed, and became willing to make amends to them all.[38]
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.[39]

AA's founders instinctively knew that alcoholic men would drink themselves into oblivion or even more abruptly shorten their lives if this threat to sobriety was not contained. More positively, it provided a straightforward technology by which esteem could be salvaged--a system for personal redemption that, if not wiping the slate completely clean, at least cleaned enough toxic emotion off the slate to abate the ability of guilt to fuel self-punishing and self-destructive acts.

Where AA evolved a recovery technology to address guilt; WFS and other women-based recovery programs evolved a technology that focused on shame. Where guilt is a self-indictment for doing; shame is an internalized indictment of being. Lenora Fulani understood such self-indictment when she once observed: "Women of color who come to us for therapy see themselves not as having problems but *as the problem*."[40] Guilt is self-blame of behavior; shame is self-blame of one's character--one's very essence. Shame says, "You have no right to exist, you deserve no better, it was your fault, and you are not worthy of recovery!" The logic of shame is self-annihilation. The antidotes that

work so well to dissipate guilt cannot remove from the self the more indelible stain of shame.

Shame comes from collective as well as personal experience. It comes from the full knowledge that to be born female in this culture is to carry a culturally ascribed mantle of inferiority. Sexism, racism, homophobia and all the other self-obliterating "isms" drive this shame-based self-hatred--this growing sentiment throughout one's development that one has no value--no right to be. WFS and the other women-based recovery programs seek to initiate a radical cognitive restructuring of how each woman perceives herself and her relationship with the world.

12. I am a competent woman and I have much to give life. (WFS)[41]

16. I am entitled to take the initiative to share in life's riches. (Gannon's 21 step program for Adult Survivors)[42]

20: I see myself not only as a survivor but as a thriver in all aspects of life: love, work, parenting, and play. (Gannon's 21 step program for Adult Survivors)[43]

This individual restructuring of self-perception--how I perceive my age, race, or those who share my sex and/or sexual orientation and how I see myself within the context of my own personal history--is the essence of the transformative movement into sustained sobriety and health. It is a restructuring of both collective history and personal history. A heightening of collective consciousness of gender or race or sexual identity may provide the foundation out of which comes individual consciousness and personal transformation. Seeing one's own history as a thread in a broader community history--seeing her own victimization mirrored backward in the lives of so many women in other times and places, seeing a link between her personal destiny and the destiny of all women--can be the beginning of the awakening that unfolds into recovery.

Where the fourth step inventory of AA often involves the assumption of self-blame, women's-based recovery frameworks often involve casting off self-blame and the appropriate assignment of blame to others. Where the fifth, eight and ninth steps of AA involve confession and restitution; women's recovery steps often involve breaking silence about victimization and conducting real or symbolic confrontations. Where recovery for men focuses on resolving guilt of what they have done to others; recovery for women often focuses on expiating the shame induced by what others have done to them. Where men seek to make restitution to those they have injured; many women seek real or symbolic confrontations with those who have injured them.

There are also distinctions in how male-based and women's based recovery programs restructure identity as part of the healing process. The ritual of introduction of WFS ("Hello, my name is Mary and I'm a competent women") is quite different from the ritual of introduction ("Hello, I'm Joe and I'm an alcoholic") within AA. AA's ritual of introduction is an antidote to denial and the closing of the meeting with the Lord's Prayer, seeking forgiveness for transgressions, is consistent with this focus on diminishing guilt. WFS' ritual of introduction is a self-affirming antidote to shame, as is its ritual of closing: "We are capable and competent, caring and compassionate, always willing to help another, bonded together, in overcoming addictions."[44]

These are significant differences in the core activities and experiences that are at the heart of the healing and recovery process depending on whether we are healing perpetration, healing victimization or both. Perpetration--experienced as sins of omission and commission--has long been addressed within the 12 step framework. Victimization--experienced as an irrevocable tainting of the self--requires different processes. As we bring guilt and shame technologies into the addiction treatment field, our next step will be to transcend the gender-based application of this technology. As we move forward, we will need to be open to hearing the victimization

issues of men and the perpetration issues of women.

Self-effacement (humility) versus Self-affirmation

Tradition 12 of AA declares the spiritual significance of anonymity.[45] By placing "principles before personalities" and calling on each alcoholic "to practice a genuine humility," this framework reigns in grandiosity and suppresses the "I" of the male alcoholic ego. The achievement of humility is an antidote to the culturally programmed (and alcoholism-amplified) male pattern of adaptation to decreased competence: increased preoccupation with power and control and increased propensity for aggression, projection of blame, grandiosity, and geographical flight. The culture of the 12 step program is profuse with self-effacement and self-deprecating humor: the neutralizing agent for narcissistic and grandiose temperament of the actively drinking and recently sober alcoholic. The language of AA (embedded in the 12 steps and 12 traditions) was designed to break the narcissistic bubble of the male alcoholic. It did this through a language of ego-confrontation and submission: words like powerless, unmanageable, wrongs, defects of character, and shortcomings.

The culture of WFS and the milieu of most women's-centered addiction programs is distinctly different. Jean Kirkpatrick commented on this difference in a 1987 interview: "I've never met a single alcoholic woman who needed more humility. I believe that women need exactly the opposite--the self-confidence to stay sober." [46] Rather than self-effacing, women's-centered programs are infused with self-affirmation. The language of WFS (imbedded in the 13 statements) was designed to empower the will of the alcoholic woman. It did this through a language of ego-affirmation: words like happiness, life, love, emotional and spiritual growth, enthusiasm, competent, responsible. Nearly all women-based models of transformation focus on self-esteem as both the primary obstacle and primary medium of change. Mary Catherine Bateson once noted, "It is not easy to cherish oneself when one's whole life has been organized around cherishing others."[47] Women's-centered treatment programs balance this love of others with a focus on acceptance and love of self. The work of Maureen McEvoy embodies this power of self-affirmation in her work with survivors of sexual abuse. She has built into her groups regular rituals of affirmations whereby group members express compliments and appreciations to each other. To counter women's conditioning to resist and discount such acknowledgements, McEvoy and her co-facilitators have created a "rule" which asks each woman receiving an appreciation to respond with "Thank you." Later in the group process the rule is amended so each group member is to respond with "Thank you, I agree," a shift in the ritual that is greeted with "howls of protest and laughter" when it is first introduced.[48]

Softening Judgment versus Learning to Judge

As the self-esteem of the male alcoholic deteriorates, a cognitive defense structure emerges to sustain drinking and maintain his sense of personal power. Elements of this defense structure include grandiosity, hypercriticalness, black-white thinking and heightened irritability and resentfulness. For recovering men, the achievement of humility and tolerance, the management of resentments, the "easy does its" and "let it gos", are all antidotes designed to soften this defense structure. The traditional recovery technology is also designed to fit two other primary defense mechanisms of male alcoholics: projection of blame and intellectualization. . There is an assumption not only that the alcoholic can think--but that he thinks too much. e.g., "Your best thinking got you here." Slogans (designed to reprogram self-talk) like "Keep it simple, stupid!" constitute antidotes to such defense mechanisms.

In contrast to alcoholic men, the defense structure of alcohol and drug dependent women is more likely to involve passivity and

self-blame. The shame-based indictment of the alcoholic woman creates an existential position within which she has no right to judge others, in which she is incapable of thinking and judging, in which she is not worthy of judging others. Where the focus for the recovering alcoholic male has been one of faith and acceptance--a distinctly anti-intellectual tradition, the focus for recovering women may be more appropriately focused on the development of critical thinking skills, developing confidence in those skills and in the verbal assertion of those beliefs and judgments. For her, to think, to know, to judge and to give voice to that judgment is to acquire power and visibility.

Achieving Silence versus Breaking Silence

> *"We've only just begun to fashion a vocabulary to deal with the 'silences' of our lives."* Toni Cade Bambara[49]

We live in a culture where "women cultivate their capacities for listening while encouraging men to speak."[50] Culturally empowered men have inherited a language developed by men and the power to speak in ways that define the world in their own image and experience. When the power to perform major role functions deteriorates in addicted men, language skills become an important tool to ward off environmental confrontations. Language becomes the primary defensive weapon used to sustain addiction. It is through language that the addict's denial, projection of blame and intellectualization are actualized in interaction with others. It is in this manner that the culturally empowered addict's voice becomes an obstacle to his own recovery. This elaborately constructed and oft-activated linguistic defense structure must be silenced and reformulated for addicted men to enter into a recovery process. For addicted men, silence is something to be achieved.

Addicted men achieve transcendence over their ego-centrism by discovering silence and then opening themselves to the act of listening. Constructing and telling their own story while an important developmental stage in recovery is an extension of their historical narcissism. It is in listening to and actually hearing and experiencing the stories of others through which the male addict's existential position is fundamentally shifted. It is the act of listening--achieving self-silence--that is the precursor to empathic identification and connectedness to others. It is the medium through which the addicted man breaks out of isolation. It is the beginning of self-inventory and self-renewal.

Metaphors of silence and voice have a central place in feminist thought and writings. Silence can be the act of homage and surrender to external authority. Silence can be the obedience that says women, like children, should be seen and not heard. Silence can be the systematic devaluation that occurs in a world in which men are taught to speak and women are taught to listen--a world that convinces her she has nothing of value to say. Silence can be the seal that hides victimization. There are numerous circumstances that intensify silence for chemically dependent women--familial histories of alcoholism, physical and sexual victimization, the special stigma and shame attached to substance abuse and women--and addicted mothers, in particular, in this culture. This silence can be literal--verbal passivity in a woman who has become increasingly word phobic out of the experience that words have been weapons used against her and that her own words can provoke violations of safety.[51] This silence can also be symbolic--a kind of noisy silence in which one's true feelings and self are hidden behind a screen of safe and shallow chatter, evasion, or tears. She may gain voice through the experience of intoxication, and yet it is a false and distorted voice--one that is diminished from the culturally-induced shame of intoxication. Silence is the existential position from which most addicted women begin.

"Breaking silence" is a powerful metaphor for recovering women. Liberation for chemically dependent women involves the act of telling the truth to one another--breaking

silence about their individual and collective experience. This discovery of voice is not just the discovery of words and speech, is not just the act of speaking. It is the experience of being heard. To be heard, to be believed and to be understood are the beginnings of her empowerment.

Consciousness generated from this truth-telling incites the commitment to break free from such collective and personal history. The act of breaking silence is liberating. Out of her own voice comes the discovery of personal power. Breaking silence is a screaming declaration of one's existence--a refutation of invisibility. Breaking silence is a shift from obedience to external voices to respect for and obedience to her internal voice. Breaking silence is rebirth.

When silence is first broken, the newly discovered voice--this reborn self--is very fragile and must be nurtured until it gains strength. It is often in the chemistry of mutual support between recovering women that this rebirth of self occurs. Discovering and externalizing these inner voices is generating women's language, women's metaphors and women's stories. It is feminizing the culture of recovery throughout the United States.

These distinctions suggest that the experiential pathways of recovery for addicted men and women can be quite divergent. Her silence and his grandiose and aggressive speech both anchor addiction. Where he must learn to walk softly on the earth without scarring it, she must learn to leave a footprint. Where he must discover silence, she must break silence.

Service to Others versus Acts of Self-Care

Brought forward from AA's spiritual godparents (the Oxford and Emmanuel movements), service plays a central role in the 12-step recovery program. AA's beginning is crystallized in an act of service--the meeting of Bill W. and Dr. Bob. Service is the antidote for the cultural suppression of empathy and caring in men. For the male alcoholic--narcissistic, alone and lonely, adrift in a chemical autism-- service is a medium for getting outside his own ego and a means to connect emotionally with other human beings. It provides a way for him to escape the roar of his own pain and own needs and experience connectedness. As a further antidote to guilt, acts of service functions as a kind of generic restitution for past wrongs--a balancing of the karmic bank account. In a type of poetic paradox of justice, service provides the medium through which the narcissist becomes the servant, the predator becomes the rescuer.

What life experience or existential position of addicted women would alter the role of service in the recovery process? Women have been culturally scripted for service. They have been charged with what Gomberg has called "the keepers of personal relationships," programmed for service roles within families (wife, mother, homemaker) and, until recently, provided only service roles as the primary occupational pathway out of the family (nursing, teaching, clerical). Where empathy and caring have been culturally suppressed in men, these same traits have been culturally imbedded to excess in women. At the same time, women have been made to feel "selfish" for such "masculine" traits as self-assertiveness, competitiveness, decisiveness, and risk-taking. Such characteristics in women were viewed as a betrayal of what sociologist Jessie Bernard, in her wonderful book *The Female World,* called the "female ethos of love/duty."[52] Such programming is even more intensified for women who spring from generations of male alcoholism. Women born into such families experience from their earliest breath the message that other people's (particularly men's, and, even more specifically, addicted men's) needs are more important than their own. Service for women in early recovery, particularly service directed to men and children, provides not a new and transformative experience but a return to her most basic psychosocial position. Programs that emphasize service as an early stage recovery task reinforce the culturally programmed value of self-sacrifice for women.

If recovery requires experiencing oneself differently--a break from one's existential

position--then acts of self-care and the discovery of relationships based on mutual self-interest rather than sacrifice provide the foundation of recovery for addicted women. Discovering mutuality and reciprocity in relationships with other women—a growing consciousness of womanness as a component of individual identity--may be the equivalent of service for women. Service within women's recovery frameworks focus, not on sacrifice, but on the value and capabilities each woman has to offer others and on a mutuality of support between women. This difference in focus can be seen within the WFS program and its evolution since the early years of its development (1973-1975). The original 12th and 13th statements of WFS read as follows:

> "I Am a Competent Woman and Have Much to Give Others"
> "I Am Responsible for Myself and My Sisters."[53]

Jean Kirkpatrick, the founder of Women for Sobriety, says that her first formulation of these steps was influenced by her own "gender conditioning," creating the caretaking mother as the model for women's recovery. As a result of this realization, statements 12 and 13 of the WFS program were changed in 1987 to read as follows:

> "I Am a Competent Woman and Have Much to Give Life"
> "I am Responsible for Myself and for My Actions."[54]

For an alcohol and drug dependent woman to experience service as a sacrificial flight from self is not progress, but regression into the self-refutation of the legitimacy of her own needs, and ultimately her own existence. Learning to reward oneself, to feel one deserves one's share of life's riches, to feel some innate and earned entitlement to opportunity is the foundation of self-care. On the continuum from narcissistic preoccupation with self to self-flight through sacrificial fusion with another, recovering men and women each need to find balance and harmony in the middle although each, like in the earlier continua we described, must travel this pathway toward moderation from very different beginning points and may require different metaphors to mark and speed their journey.

Dependency versus Autonomy: Codependency--A Cultural Double Bind for Women

While many persons have noted men's zeal for autonomy and individual achievement and women's zeal for attachment and affiliation, there are at least three divergent paradigms from which to view and judge these differences.

The most recently emerging paradigm is one which posits that these female traits, while culturally devalued, are superior and should become the guiding values of the future. The writings of Riane Eisler[55] and Jean Shinoda Bolen[56] are illustrative of this paradigm.

A second paradigm (reflected in the basic framework of this paper) holds that women's propensity for affiliation and attachment are noble virtues but that such virtues have been achieved at a high price--sacrifice and suppression of self. This view calls for a balancing of accounts whereby women are freed to explore personal achievement and men are freed to explore intimacy and attachment.

The third paradigm posits that women's zeal for affiliation and caretaking is pathological. The first group of proponents of this paradigm includes the mainstream proponents of developmental psychology. From writings on development spanning Freud and Erikson through Vaillant and Levinson [57], the model of healthy human development has been judged on markers of separation, individuation and autonomy. Works by Miller[58], Gilligan[59] and others have emerged to challenge this androcentric view of development and to challenge the process by which women are socialized for affiliation and connectedness and then defined as

inferior for their absence of male-defined virtues. Some of the most visible proponents of the pathology paradigm include the leaders of the codependency movement within the United States. The remainder of this section will critique the utility of "codependency" as a metaphor in the recovery of addicted men and women.

The 1980s saw the emergence of a new industry in the United States organized around lectures, books, tapes and new self-help groups and treatments for a newly conceptualized disease: codependency. That this concept of codependency touched a deep emotional chord within the culture and within women in particular is evident from the success of this industry. That a large number of individuals have found this movement a source of emotional healing is also unquestionable. And yet as we move into the 1990s, a growing number of voices are emerging challenging both the basic premises and the over-extension of this concept. From the full-scale indictment of Katz and Liu in *The Codependency Conspiracy*[60] to the feminist critique of Carol Tavris in *The Mismeasure of Woman*[61], critics are challenging the theoretical and practice applications of this concept. Major points of criticisms include the following points.

- The definitions of codependency are so broadly inclusive that the term has lost its clarity and utility.
- The alleged symptoms of codependency (Beattie[62] lists 254) while all encompassing, inordinately target those characteristics that most women have been raised to cultivate and possess.
- The characteristics the codependent is encouraged to develop through recovery--detachment, independence, self-reliance, ability to say no to other's demands--constitute the characteristics of the stereotypical male in this culture.
- "Codependency" turns problems of environment--particularly, social oppression--into problems of psychopathology. By internalizing pain, women's energy and anger are channeled into personal recovery rather than environmental change.
- By defining the condition of women ("who love too much") in medical (disease) rather than political (oppression) language, we fail to hold abusive men responsible for their neglectful, demeaning and violent behavior. Critics contend that if codependency is a disease, then it is a social disease--a disease of culture through which half the population are taught to deny the legitimacy of their own individual needs while the other half are taught that the world revolves around their needs.
- The codependency movement encourages women to "bond in pain instead of power."[63]
- The codependency movement infantalizes its members by calling them "adult children" and encourages their self-centeredness and self-indulgence--an infusion of the cultural values of the 1980s out of which the movement was born.
- Self-help groups within the codependency movement "promote dependency under the guise of recovery," leaving members "trapped at an immature stage of development."[64]

What is to be made of such criticisms and to what extent does the concept of codependency serve as a metaphor around which change can be initiated and sustained in addicted women? Our critique can be summarized as follows.

1. A significant portion of addicted women present themselves to

treatment with familial histories of addiction and past and current intimate relationships with addicts.

2. Continued contact with addicted family members, intimate partners and friends constitutes a major source of sabotage of recovery for addicted women.
3. Any concepts--including the concept of codependency--which help heal emotional pain from one's family of origin and enhance the physical and emotional disengagement of the addict from such relationships will diminish the risk of relapse and support the early recovery process.
4. Concepts which help label a problem and which help energize the initial change process may not have the power to sustain a long term process of transformation. Because the codependency movement has utilized an adaptation of the 12-step male-based recovery model, we would anticipate that many women will find this framework inadequate for their long term developmental needs and that alternative recovery models will emerge that flow directly out of the needs and experiences of women.
5. The future of the codependency movement hinges on its ability to evolve dynamically in response to the above criticisms. Achieving or failing to make such evolution will determine whether codependency becomes a viable and sustainable recovery concept or an historical artifact, a developmental stage on the way to concepts and structures not yet visible.

Blindness to Safety versus Sensitivity to Physical/Psychological Safety

Male-based treatment and recovery paradigms show a marked absence of concern related to physical safety perhaps springing from the assumption that men must either take responsibility for their own safety issues or deny with exaggerated bravado that any such threats to safety exist. The most cursory review of the institutionalized violence against women in this culture underscores why safety is a central issue for women. One in six women has been raped. Three out of every four women in the U.S. will experience at least one violent crime during her lifetime. Half of all women seeking emergency medical services are battered. More than 20% of married women report physical abuse by their partners. A man beats a woman every 12 seconds in the United States and four women each day die from such beatings.[65] Surveys of employed women reveal that at least two thirds have experienced some form of sexual harassment in the workplace. All women live their daily lives in this culture awash in violent sexual imagery reminding them of the tentativeness and uncertainty of their personal and psychological safety.

For the addicted woman entering the recovery process, the issue of personal safety is likely to be even more intense. She is much more likely than a non-addicted woman to have been sexually abused and her sexual abuse is more likely to have involved multiple traumagenic factors: early age of onset, multiple rather than single episodes of abuse, multiple versus single perpetrators, and violence or threat of violence as a component of the abuse experience.[66] Her addiction quite frequently brings her into deep involvement with a culture of addiction in the United States that is increasingly predatory and violent. Her substance abuse is often bound up in toxic intimate relationships. Her addiction cannot be unraveled without unraveling the threads of exploitation and violence within which it is bound. As she begins to disengage her life (and the lives of her children) from such toxic intimate relationships, her co-addicted partner will often seek to squelch such sparks of independence through verbal intimidation or physical brutality. In short, the addicted

woman's survival has been conditioned within a world where trust is violated and safety is an illusion.

Women's programs are instinctively aware that issues of safety and trust are paramount in the treatment of addicted women. They are particularly aware that the de-stabilization of toxic intimate relationships produced by a woman's sobriety poses risks of psychological sabotage and physical retaliation. Women's-based treatment addresses such issues through gender-exclusive residence and service modalities, special attention to the physical security of the treatment environment (locked doors, close screening of visitors), close links with domestic violence and sexual assault counseling services, and encouragement and advocacy related to orders of protection and use of shelters.

Effective treatment of addicted women is also extremely sensitive to how women's psychological safety has often been violated within traditional treatment models. When women fail to respond to treatment in the male-defined vision of progress, they are often defined as resistant and further shamed and stigmatized through labeling or intensified verbal confrontation. In this clinical double-bind, women are confronted as compliant people pleasers when they agree and are confronted as resistant or as being in denial when they assert their will through disagreement. The often intrusive and confrontational methods designed to penetrate and deflate the puffed up ego of the male alcoholic can be very violating to women. Such techniques can damage already fragile esteem, escalating shame and fueling continued self-destructive behavior. In contrast, women's treatment programs lean toward more supportive, less intrusive, less manipulative and less coercive treatment techniques. This style of treatment demonstrates respect and acceptance of her as an individual. Belenky, Clinchy, Goldberger and Tarule, speaking of how women learn, make the point that it is not enough for women to be told of their *capacity* or potential to become wise and good, they need to have the goodness that is already within them validated.[67] Women's recovery programs seek to reinforce this goodness within and avoid interventions that could potentially damage this sense of self-value.

The issue of physical and psychological safety is particularly paramount for the high percentage of addicted women who bring developmental histories of physical and sexual abuse. These violations could more aptly be described as processes rather than events, meaning that an act such as incest or an act of complete abandonment were often the last steps in a progressive process of over-involvement or disengagement. There are dangers that poor boundary management in male-dominated treatment programs may recapitulate such progressive violations, triggering flight or heightened defensiveness against what the client perceives to be impending seduction or impending abandonment. Sensitivity to psychological safety requires sensitivity to such boundary issues and the establishment of trust as a precursor to psychological healing. Where men's groups may struggle at times to get any level of affective disclosure, facilitators of women's groups tend to be very cognizant of the dangers of premature disclosure and build in high levels of structure and safety within which self-disclosure and self-healing can occur. Staff members of women's programs are also aware of how a too aggressive desire to help and heal can trigger panic and flight. Commenting on the need for gentleness and time as essential components of trust-building, therapist Naida Hyde, once remarked that she had "momentarily forgotten that safety for the incest survivor resides in aloneness, not relationship." Respect for the client's choice of the content of therapy and her control of the pace of the therapeutic process is the essence of psychological safety.

Another safety issue involves concern with the potential re-victimization of women within the very environments from which they seek help. A growing number of individuals and organizations are breaking silence and beginning to confront the historical sexual exploitation of women in predominantly male treatment and self-help environments.

Sensitivity to the ways in which women can be re-victimized within treatment environments is paramount. Mainstream treatment settings can address these issues by defining, monitoring and enforcing clear standards designed to promote the highest levels of professional and ethical conduct in our service relationships. While 12 step and other self-help programs have historically relied on the "group conscience" to inhibit or address such exploitation, a growing number of groups are beginning to confront much more directly the practices of seduction and exploitation referred to euphemistically as "thirteenth stepping."

Blindness to Image versus Sensitivity to Body Image

When active addiction is removed as the centerpiece of one's life, men and women begin to experience issues and problems they share in common with other non-addicted persons in the culture. Body image and its role in the self esteem of women is one such issue that is arising with increasing frequency in the treatment of addicted women. While many women may face crises of self-esteem, the potential capacity of such crises in recovering women to trigger relapse makes this issue potentially life-threatening. How the recovering woman perceives her own body, how the culture perceives her body and how these perceptions influence her sense of self-value is critical to the foundation of self-acceptance and self-love upon which women's recovery is based.

All media--movies, television, magazines and newspapers--bombard us with visual images of beauty which women are expected to emulate, images against which each woman assesses her own value. Where do these images come from and what is there cumulative effect? Naomi Wolf in *The Beauty Myth*[68] has explored how anorexic fashion models have emerged as this culture's icons of beauty and the standard by which women judge their own physical adequacy. She believes:

- The systematic effort to medicalize and pathologize that which is biologically normal for women has long been a tool of oppression--a tool that encourages women to focus their attention and define their discomfort on personal flaws rather than the external conditions that starve them economically, politically and socially.
- The construction and enforcement of arbitrary standards of beauty which are unobtainable for most women is also spawned by multi-billion dollar diet, cosmetics, exercise and surgery industries whose profits hinge on "warping female self-perception and multiplying female self-hatred." After all, "...a woman who does not feel damaged cannot be relied upon to spend money for her 'repair'."
- The beauty myth places all women in a double-bind. Women who approach the standard become fetishes and devalued in the knowledge that the source of their value is superficial and non-sustainable. Women who fail to meet the standard are set up for daily self-indictment and endless attempts at self-correction.
- The power of such enculturation is evident everywhere.
  - More than 70% of women over age 13 believe they are fat while only 25% are medically overweight; up to 45% of medically underweight women believe they are too fat.
  - Eighty-seven (87) percent of cosmetic surgery is performed on women.
  - Over 90% of anorexics and bulimics are women; the prevalence of anorexia is consistently estimated to include 5-10% of all American girls and women.

- The consequence of such socialized devaluation and assured personal failure is a weakening of women's self-esteem, a decreased sense of personal power and efficacy and increased passivity, helplessness and hopelessness.[69]

There are also connections between the "beauty myth" and the addiction of women in this culture. Studies of young women smokers consistently report a desire to keep their weight down as a motivator for smoking and fear of gaining weight as the major fear associated with quitting.[70] Eighty percent of amphetamines prescribed in the United States go to women presumably as an aid to weight loss.[71] Eating disorders among addicted and recovering women are common. Perhaps an even broader issue is how the beauty myth affects the esteem of recovering women. Where self-esteem for adult men is based on achievement of money, power or status, self-esteem for women in this culture is heavily influenced by our visual images of beauty and femininity.[72] Because self-esteem is such a critical issue within women's recovery, the related issue of self-image of one's body is an important one to integrate within the fabric of addiction treatment.

Women-based treatment programs are beginning to address these issues through such mediums as:

- Consciousness raising education that seeks to reverse the socialization that has taught women to be hypercritical of and reject their own bodies
- Assessment for and concurrent treatment of eating disorders
- Assessment, education and treatment strategies that focus on healthy nutrition, and
- Creation of new standards of beauty that in Wolf's words are "non-competitive, non-hierarchical and non-violent."[73]

The most sweeping intervention available to treatment programs is complete abandonment of the beauty myth by defining women's normal bodies as beautiful rather than ugly. Perhaps a day will come when the following Virginia Wolf dictum will be embraced by treatment centers and the women who occupy them: "One cannot think well, sleep well, love well if one has not dined well."[74]

The Metaphors of Time and Timing

What addiction recovery frameworks for men and women share is a focus on living in the present--a recognition that the alternatives of dwelling on the past and the anticipatory fear and anxiety of the future pose risks to sobriety, sanity and life. The focus on today--working a 24 hour program of recovery--is proving itself a cornerstone of recovery for both men and women. There are, however, two differences related to temporal issues that can be noted in these recovery frameworks. One involves the preferred timing or sequence of recovery activities; the other involves the duration of support activities required for successful recovery.

There has been intense interest the past few years, stimulated most notably by the work of Stephanie Brown[75], in conceptualizing a developmental model of addiction recovery. Such a model would describe predictable stages in the recovery process and the developmental task and milestones that characterize each stage. Some conceptions of a developmental model have already been incorporated within the folk wisdom of addiction treatment and recovery circles. A major tenant of this folk wisdom has been that the defense structure of the newly recovering addict is much too fragile to address emotionally volatile family of origin issues. The alcoholic or addict wishing to raise such issues has been told firmly and politely to not drink and keep going to meetings, that now was not the time to deal with such concerns, and that there was a place down the road where such issues would be addressed. There is at least one subpopulation of women

for whom this folk wisdom has created problems and that is the significant portion of addicted women who were sexually abused in childhood. For many of these women, there is growing evidence that their adult substance abuse is part of a broader pattern of post-traumatic stress disorder. In short, these women have developed patterns of excessive alcohol and drug consumption to self-medicate the emotional consequences of sexual violation. When this pattern of self-medication is removed via the crisis of entry into treatment, these clients begin to emotionally thaw with a resulting intensification of emotional experience. When they seek to discharge this intensity through disclosure of their victimization, they are often met with the above folk wisdom. Finding no vehicle for drug-free catharsis, many such clients respond with flight from treatment and a return to self-medication. It is quite clear that developmental models of recovery constructed on the emotional architecture of alcoholic men will need to be redesigned to fit the experience and needs of many recovering women. Within women's programs such redesign is already occurring by defining issues of sexual victimization as legitimate and necessary early stage recovery work. An important research agenda for the next decade is the construction of a developmental model (or, more likely, models) of recovery based on the experience of recovering women.

Another difference in temporal orientation in men's and women's recovery programs involves the proscribed and expected duration of support activities. The folklore of AA calls for continued life-long involvement in the rituals and activities of AA. The implicit message is that failure to continue one's involvement in meetings and other recovery rituals will result in deteriorating emotional health ("stinkin' thinkin'", "dry drunk") or resumption of the addictive career via relapse. Anything short of such continuing involvement is viewed as risky and stupid. In contrast to the AA forever dictate, WFS expects its members to participate for only as long as they need such group support. AA forever provides a conduit for continued male connectedness via dependency on the AA group; WFS provides a pathway for female individuation via movement out of WFS into other frameworks of personal growth and development. AA takes the alienated male and provides a healthy medium through which dependency needs can be met; WFS opens pathways for women into decreased dependency and increased individuation. Where AA frames disengagement as pathological, WFS speaks proudly of the women who have "moved onward and upward" after getting what they needed from the WFS program. "Forever" and "as long as you need" may represent different temporal metaphors for recovering men and women.

Recovery versus Discovery

We have used certain words in this paper because such language is the medium of discourse within the field and yet much of this language inadequately reflects or misrepresents women's experience. The label used to describe the movement from addiction to sobriety and sanity—recovery--implies that one can get back what one has lost, a fact challenged by a woman client who in a discussion about the relationship between her drinking and her self-esteem, once retorted, "I didn't lose it; I never had it!" Recovery is the reacquisition of that which one had but lost. It is a *re*habilitation technology. It presupposes prior levels of achievement and functioning. What is this thing that has been lost? Power and control over one's life, self-respect, sanity, mutually respectful relationships, material possessions or social status achieved through one's own competence? However we define what has been lost, for many women, the phrase "I am discovering" may be a more apt depiction of their experience of movement into health than the traditional, "I am recovering." For many women, they are not getting it back; they are moving into the future experiencing it for the first time--moving forward into discovering and becoming rather than backward into recovering. Moving out of addiction for many women is more self-creation than self-

retrieval, a fact clearly evident in WFS' self-description of itself as the "New Life Program." Kasl, in her remarkable book, *Many Roads, One Journey*, also makes the observation that "recover" connotes covering something up--hiding again that which has been hidden before. She recommends an expanded vocabulary that includes "un-covery"--a getting out from under addiction--and "dis-covery," meaning an opening up to growth and moving forward.[76]

The Helping Relationship: "Dominator Model" Versus "Partnership Model"

This paper has described different metaphors and experiential axes through which men and women experience the transformation from active addiction to sustained recovery. Just as the experience of male alcoholics formed the basis of our understanding of alcoholism and recovery, it was male helpers in their relationships with male alcoholics that defined the structure and process of the addiction counseling relationship. In this section, we will explore a fundamentally different reconstruction of the helper-helpee relationship that is occurring in women's treatment programs.

Riane Eisler in her remarkable work *The Chalice and the Blade*[77] describes two basic models--the dominator model and the partnership model--for the structuring of human relationships throughout history. These models will be adapted here to describe two very different approaches to the structuring of treatment relationships with men and women in chemical dependency treatment settings.

The dominator model of helping relationships is hierarchical, emphasizing the disparity in power between the helper and helpee. In this model, the client seeks and passively accepts the consultation of the dominator's special expertise. The dominator's advice is to be passively, appreciatively and obediently followed. The dominator model is arrogant in the extent to which it places knowledge and value on only one side of the helper-helpee relationship. The dominator model says, "Listen to me, be like me, I am the model of what you must become. Wellness is to think like me, feel like me, act like me, be me." The dominator sees the client as an object--a piece of clay to be molded in their own image. In the dominator model, the helper has ascribed power and his or her weaknesses are denied or hidden while client weaknesses are magnified.

The dominator model of structuring helper-client relationships in addiction treatment is based exclusively on experience with culturally empowered alcoholic men. In this model, the puffed up alcoholic ego is punctured by the skillful confrontations of the counselor. The alcoholic male's surrender to a higher power is thus played out symbolically in the counselor-client relationship. In the dominator model, recovery begins when the client gives up the power struggle with the counselor and abandons the defense structure that has supported his drinking.

In the partnership model, both the helper and the client are perceived as entering the relationship with strengths and weaknesses. Where the dominator model focuses on the identification of client pathology, partnership models focus on the identification of client strengths. Where the dominator model emphasizes the competence of the therapist; the partnership model emphasizes the competence of the client. Partnership models view the etiology of individual problems within an ecological perspective, noting the ability of oppressive social structures to distort individual development. Client behaviors that have become problems are viewed in the context of resilience and survival. In partnership models, control of treatment--its content and pace--remains with the client. The partnership model seeks to minimize the power differential in the helper-helpee relationship. Where the dominator model is information transmission, the partnership model is one of mutual discovery--the emergence of mutual knowledge and understanding that comes out of the relationship. Partnership models are models of *doing with* rather than doing to or doing for.

Many women's treatment programs, having become disillusioned with the utility of the male-based assumptions and approaches

they had inherited, moved toward a partnership model. Project SAFE, a treatment program for addicted mothers and their children that has treated more than 1,000 women in 14 Illinois communities, illustrates the emergence of this partnership concept. Since 1986, speakers at Project SAFE Annual Symposia have consistently intoned that:

> Project SAFE is not a model; it is a commitment! It is a commitment to assess the needs of these women and their children and let these needs define the scope and intensity of our service model. The service model at any site at any particular time flows out of this dialogue and partnership.[78]

Many women's program's evolved into the partnership model when the staff began to trust their own instincts more than the mainstream philosophies and technologies they had professionally inherited. Bonnie Brendel, Director of the Recovery Home within The Women's Treatment Center in Chicago wonderfully illustrates this transition through the following vignette.

> When the Recovery Home was opened in 1992, one of the early tasks completed was the development of a 75 page program manual that outlined basic information about the Recovery Home's philosophy, procedures and rules. Most of the content of this manual was borrowed from other residential programs whose designs were based primarily on experience of male staff worked with addicted men. As more and more women came through the Recovery Home staff became increasingly aware that the imposed structure was not working. When this awareness ripened, staff responded in the following manner. All residents of the Recovery Home were instructed to bring their program manuals to community meeting where along with all the staff, they tore up the program manuals. As of that moment, the Recovery Home's philosophy and procedures and rules grew out of a dialogue and partnership between staff and residents. This ritual affirmed that what occurred within this program was a process rather than something imposed within a hierarchical structure.[79]

This story reveals how one program's philosophy and procedures moved from something static to what Bonnie Brendel describes as a "living, breathing, dynamic process." With the ritual destruction of their original program manuals, the Recovery Center shifted from a dominator model to a partnership model of structuring relationships between the women providing and receiving services there. Such experiences tell us that the voices of the women seeking our assistance will guide us if we will listen carefully and let them become our teachers.

Stories like the above have been replicated many times within the partnership models of women's service organizations. Such organizations tend to be organized more horizontally than vertically, reflecting a more egalitarian view of staff/volunteer-client relationships. Addiction treatment programs organized by and for women tend to cultivate the personal over the "professional." They are less title-fixated. They have fewer obstacles between the helper and the client--secretaries, tape machines, desks, waiting lists. They are less procedure-obsessed. They see themselves more as a family or community than an agency. They are warm and welcoming. They recognize the existence of and utilize indigenous healers that exist within every oppressed community.

The different ways in which service relationships are structured in men's-based treatment and women's-based treatment reflect differences in the needs of addicted men and women and how such needs can best be met.

An Escape From Dualism

Through intense gender-based socialization, men and women have been forced to suppress parts of their character while exaggerating other parts, all in the name of desirable traits of manhood and womanhood. Given any core trait that could be represented on a continuum, we have tended to push men and women to the poles of such characterological definition. Men have historically sacrificed their emotional life, their capacity for empathy and intimacy, and their roles inside the family. Women have sacrificed their self-interests, their rationality, and their roles outside the family. Both men and women become fictive personalities through this process, having parts of their essential character suppressed and other dimensions elicited to excess. That men and women adapt and go forward in the midst of such cultural assault on wholeness is a testament to the resilience of the human spirit. Survival under such circumstances comes at a high cost--parts of the self must be offered in sacrifice in exchange for physical and psychological safety.

Not all women and men respond the same to gender socialization. Not all women and men are clustered at the ends of these continua. There have always been men and women who escaped or defiantly transcended such socialization, but until recently such defiance came at a high personal and social cost. Such costs made escape from the influence of gender socialization an exception. Addicted men and women have been especially susceptible to these forces of enculturation. The erosion of self-esteem that accompanies substance abuse sparks exaggerated efforts to perform, to be o.k., to get it right in the eyes of one's non-addicted peers. Such efforts at over-compensation push men and women to the extreme ends of the continua of experience upon which they must seek their daily destiny. Addiction escalates this desire to get it right at the same time drug-related impairment diminishes one's capacity for performance. Addicted men and women become caricatures of that which we idealize until the quest for this esteem is abandoned as hopeless in the later stages of addiction.

The human potential of both women and men have been shackled through unidimensional enculturation. Such potential may be discovered by accessing those specific dimensions of character that have been suppressed. The reason men and women's treatment needs to be different is that the parts of the self each must reclaim are fundamentally different. The goal of this reclamation is wholeness. It is not to turn men into women or women into men. It is to break the socially contrived, unidimensional character of each. It is to break down a system that defines by gender the limits of what one can think, feel, do and be. This reclaiming of lost parts of the self is not a peripheral growth activity but the very heart of the recovery process. Addicted men and women must struggle out of these cultural and psychological prisons toward balance and integration but must, we believe, travel different experiential journeys--journeys that will be guided by distinctly different metaphors.

In her evocative work, *A Room of One's Own*, Virginia Woolf wrote in 1929 of two sides of the self--feminine and masculine--and the inclination to suppress half of this whole:

> "It is fatal to be man or woman pure and simple; one must be woman-manly or man-womanly....Some marriage of opposites has to be consummated." [80]

The goal of women's treatment is not to destroy those dimensions of character that have been culturally defined and programmed as "feminine," in short, to ask addicted women to take on the characteristics of men in the name of recovery. The goal is to allow the cultivation of those dimensions of character which have been denied access to her. Alcoholic men and women must find balance by wandering out of the emotional and social territory that has been defined as gender appropriate. For addicted women and men

who find themselves at the extreme poles of dimensions of character and experience, salvation lies in the middle, in the consummation of Virginia Woolf's "marriage of opposites."

The distinctions made in this paper between men's and women's recovery experiences are gender-related but not necessarily gender-exclusive. The fact that more women than men share a particular characteristic may be critical in our formulation of treatment interventions but must also be based on the recognition that some women will not share this characteristic and some men will. Many of the dichotomies described here are becoming outdated today as cultural transformations affect how men and women see themselves and each other. But as long as power and value are differentially ascribed to men and women in this culture, each is likely to bring a different experiential foundation from which both addiction and recovery must be understood. As rigid patterns of gender-based enculturation weaken, the differences between men and women will dissipate, bringing closer feminine and masculine pathways of addiction and recovery. We welcome the day when changes in this culture make this paper a curious artifact of history. Until then, responsiveness to gender differences in the addiction treatment setting is essential. This responsiveness begins with the acts of listening and believing. It begins with the premise that models need to be defined and evolve out of the needs and experiences of women rather than have women's needs and experiences defined by such models. Such responsiveness must recognize, as this paper has sought to illustrate, differences in the language, ideas, metaphors, and stories around which men's and women's recovery from addiction can be inspired and sustained.

1. Tannen, Deborah *You Just Don't Understand: Women and Men in Conversation. New York: Ballantine Books,* 1990, p.16.

2. *Pass It On: The Story of Bill Wilson and How the A.A. Message Reached the World.* New York: Alcoholics Anonymous World Services, Inc., 1984.

3. Hafner, Sarah. *Nice Girls Don't Drink* New York: Bergin & Garvey, 1992, p. 215.

4. Kasl, Charlotte Davis. *Many Roads, One Journey* New York: Harper Perennial, 1992.

5. Harrison, P.A. and Belille, C.A. Women in Treatment: Beyond the Stereotype. *Journal of Studies on Alcohol* 48 (6): pp574-578, 1987.

6. Vannicelli, M., Nash, L. Effect of Sex Bias on Women's Studies in Alcoholism. *Alcoholism: Clin Exp Res, 8, pp334-336,* 1984.

7. Comments on A.A.'s Triennial Surveys, New York: Alcoholics Anonymous World Service, Inc, 1989.p.2; We suspect that a higher percentage of women than men in AA responded to the questionnaire, somewhat inflating this percentage.

8. Illinois Studies of interest include Gillman, Dorene, O'Connor, Catherin, and Grams, Gwen *Treatment Effectiveness: A Literature Review* Chicago, Illinois: Department of Alcoholism and Substance Abuse, 1991; Farrar, Charles *Treatment Outcome Research Results Summary* Illinois Hospital Addiction Treatment Administrators Forum, 1990; and Filstead, W.J. *Treatment Outcome: An Evaluation of Adult Residential Services.* Park Ridge, Illinois: Parkside Medical Services Corporation, 1990.

9. Comments on A.A's Triennial Survey, 1989.

10. Edwards, D.W. Investigation of the Use of Alcohol and Other Drugs among 50 Aged Male Alcoholics and 50 Aged Female Alcoholics. *Journal of Alcohol and Drug Education.* 30(2): pp. 24-30, 1985.

11. Jones, B.M., and Jones, M.K. Alcohol Effects on Women during the Menstrual Cycle. Annals of the New York Academy of Sciences, 273, PP. 576-587, 1976; Sutker, P.E. Acute Alcohol Intoxication: Mood Changes and Gender. Paper presented at the 13th Annual Medical-Scientific Conference of the National Alcoholism Forum, Washington, D.C., April 1982.

12. Johnson, Sandie. Recent Research: Alcohol and Women's Bodies, in Roth, Paula *Alcohol and Drugs Are Women's Issues* London: The Scarecrow Press, 1991.

13. Goodwin, Donald. *Is Alcoholism Hereditary?* New York: Ballantine Books, 1988.

14. Curlee, J. A Comparison of Male and Female Patients at an Alcoholism Treatment Center. *Journal of Psychology.* 74: pp. 239-247, 1970.

15. Spiegel, 1986.

16. A review of literature related to barriers to treatment for women can be found in White, 1990.

17. Heilbrun, Carolyn. *Writing a Woman's Life.* New York: Ballantine Books, 1988, p. 40.

18. Hardy, Thomas. *Far From the Maddening Crowd.*

19. *Alcoholics Anonymous*: New York: Alcoholics Anonymous World Services,

Inc., 1955, p.59.

20. Kirkpatrick, Jean. *Turnabout* New York: Bantam Books, 1986, p.161.

21. Kirkpatrick, 1986, p.166.

22. Kirkpatrick, 1986, p. 161.

23. Ibid.

24. Gannon, J. Patrick. *Soul Survivors.* New York: Prentice Hall Press, 1989, p.286.

25. White, William. *Project SAFE Program Handbook.* Springfield, Illinois: Illinois Department of Children and Family Services, 1990, p 93.

26. Poston, Carol and Lison, Karen *Reclaiming Our Lives* New York: Bantam Books, 1989.

27. Gannon, 1989, p.397-398.

28. Laidlow, Toni Ann Dispelling the Myths: A Workshop on Compulsive Eating and Body Image in Laidlow, T. and Malmo, C. *Healing Voices: Feminist Approaches to Therapy with Women* San Francisco: Jossey-Bass, 1990, p18.

29. Gilligan, Carol. *In a Different Voice* Cambridge, Mass: Harvard University Press, 1982, p.63.

30. *Alcoholics Anonymous*, p.59

31. Ibid

32. Jellinek, E.M. *The Disease Concept of Alcoholism.* New Haven Connecticut: College and University Press, 1960.

33. Schaef, Anne Wislon. *Women's Reality* San Francisco: Harper Collins Publisher, 1992.

34. Bateson, Mary Catherine. *Composing a Life* New York: Penguin Books, 1989.

35. French, Marilyn. *The War Against Women* New York: Summit Books, 1992.

36. *Alcoholics Anonymous, 1955, p. 59.*

37. Ibid.

38. Ibid.

39. Ibid.

40. Fulani, Lenora. *The Psychopathology of Everyday Racism and Sexism*, New York: Harrington Park Press, 1988, p.113.

41. Kirkpatrick, 1986, p.161.

42. Gannon, 1989, 397-398.

43. Ibid.

44. Women for Sobriety, *Sober Times* October, 1990.

45. *Alcoholics Anonymous*, 1955, p. 564.

46. Jean Kirkpatrick, *People Magazine*, June 29, 1987.

47. Bateson, 1989.

48. McEvoy, Maureen. Repairing Personal Boundaries: Group Therapy with Survivors of Sexual Abuse. in Laidlow, T. and Malmo, C. *Healing Voices: Feminist Approaches to Therapy with women* San Francisco: Jossey-Bass, 1990, p. 71-72.

49. Bambara, Toni Cade in Tate, Claudia *Black Women Writers at Work* England: Oldcastle Books, 1983, p. 20.

50. Belenky, Mary Field, Clinchy, Blythe McVicker, Goldberger, Nancy Rule and Tarule, Jill Mattuck. *Women's Ways of Knowing* New York: Basic Books, 1986.

51. Ibid.

52. Bernard, Jessie. *The Female World.* New York: Free Press, 1981.

53. Kirkpatrick, 1986, p. 161.

54. Women For Sobriety, *Sober Times*,

October 1990.

55. Eisler, Riane. *The Chalice and the Blade* San Francisco: Harper Collins Publishers, 1987.

56. Bolen, Jean Shinoda. *Godesses in Every Woman.* New York: Harper and Row Publishers, 1984.

57. See Gilligan, 1982, for a critique of androcentric theories of human development.

58. Miller, Jean Baker. *Toward a New Psychology of Women.* Boston: Beacon Press, 1976.

59. Gilligan, 1982.

60. Katz, Stan and Liu, Aimee. *The Codependency Conspiracy* New York: Warner Books, 1991.

61. Tarvis, Carol. *The Mismeasure of Woman* New York: Simon and Schuster, 1992.

62. Beattie, Melody. *Codependent No More* New York: Harper & Row, 1987.

63. Kasl, 1992, p.271.

64. Katz and Liu, pp. 17, 21.

65. French, 1992.

66. For recent confirmation of the many traumagenic factors present in the sexual abuse histories of substancing using women, see White, W. *Project S.A.F.E. Program Manual* Springfield, Il: Illinois Department of Children and Family Services, 1990.

67. Belenky, Clinchy, Goldberger and Tarule, 1986.

68. Wolf, Naomi. *The Beauty Myth.* New York: Anchor Books, 1991.

69. Ibid.

70. Koop, C. Everett. *KOOP* New York: Random House, 1991, p187.

71. Davis, D.J. Prevention Issues in Developing Programs. In: Engs, R.C.(Ed) *Women: Alcohol and Drugs.* Kendall/Hunt Publishing Company, 1990.

72. The industries that have fueled women's rejection of their own bodies are extending these strategies to men. Such schemes are driving men into health clubs, diet centers and cosmetic surgeons with the new adage: It's not enough to have money, status and power--you must now look good, too!"

73. Wolf, 1991, p.286

74. Woolf, Virginia, *A Room of One's Own* New York: A Harvet/HBJ Book, 1929, p.18.

75. Brown, Stephanie *Treating the Alcoholic: A Developmental Model of Recovery.* New York: John Wiley and Sons, 1985.

76. Kasl, 1992.

77. Eisler, 1987.

78. SAFE Symposium, Bloomington, Illinois, September, 1990.

79. Bonnie Brendel, Personal Interview, July 1, 1992.

80. Woolf, 1929, p. 104.



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. (1992). Spirituality: Its language and boundaries. In Spirituality and prevention (pp. 37-47). Springfield, IL: Illinois Prevention Resource Center. Posted at www.williamwhitepapers.com

The Role of Spirituality in Substance Abuse Prevention

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

> Is spirituality the breath of God or the whisper of my own deepest fears and yearnings? Whether breath or whisper, it is a power that can nurture and transform.

Religious and spiritual disciplines have long been concerned with the promotion of health and the prevention and healing of disease. Those of us in the field of substance abuse prevention and treatment would be remiss if we failed to inquire what these disciplines have learned that could contribute to the achievement of our missions. This exploration is fraught with difficulty, however. It is particularly difficult to open a discussion on spirituality within a culture that has provided us only a meager vocabulary in which to conduct such a discourse. Much of this paper will focus on the construction of language through which the potential utility of religion and spirituality to the prevention field might be explored.

History

There has been a growing interest in the role of religion and spirituality as a force for health and healing. The substance abuse field is in a unique vantage point within the spectrum of health and human service agencies because religion and spirituality are deeply intertwined in the initiation and evolution of our field. From the moment boats landed in this country, there were efforts to manage the problem of persons obsessed with psychoactive drug intoxication, and many of these efforts were based on the belief that religious experience was the avenue of resolution when the preferred choices--public humiliation and punishment--failed. The first persons to whom alcoholics were referred for assistance in this country were clergy. Temperance movements of the 1800s sought, in addition to their appeals to individual drinkers and their legislative agendas, the establishment of temperance education in public schools. These early prevention programs often conveyed strong elements of moral and religious education.

Six notorious alcoholics became caught up in the temperance movement and

launched the Washingtonian Movement—a pre-AA recovery mutual aid society. The inebriate asylums that grew out of the Washingtonian Movement understood that they were dealing with a physical disease--the American Association for the Study and Cure of Inebriety was founded in 1870 based on a disease concept of addiction. But treatment methodologies within the inebriate asylums incorporated moral education and religious and spiritual meditation. When the Salvation Army came to the United States in the 1880s, it brought a distinctly religious approach to working with alcoholic men of the Bowery and Skid Row--an approach that explicitly posited that Christian salvation was the only pathway to sobriety. In addition to the individual religious experiences that occurred within the rescue missions, alcoholics bound together to support their continued sobriety and spiritual growth, creating such groups as the Royal Order of Ex-boozers.

In the 1920s and 1930s many alcoholics were drawn to other religious structures in the hopes that such structures would provide an escape from suffering. Most notable among these were the Emmanuel Movement and the Oxford Groups. The Emmanuel Movement combined psychological and spiritual principles of alcoholism recovery that focused on total abstinence, full self-revelation in group therapy, and visits from "friendly visitors (recovering alcoholics). The Oxford Group was a non-denominational, evangelical religious group that stressed self-survey, confession, restitution and service to others. Each of these groups were part of the spiritual traditions that would be shortly crystallized in Alcoholics Anonymous.[1]

Two very different views of religion and spirituality within psychiatry would intersect within the history of the substance abuse field. Where Freud was calling religion a "mass obsessional neurosis," Jung was impressed with the transformational power of the religious or spiritual experience. When Roland H. sought advice following his relapse to active alcoholism following treatment by Jung, Jung told him that there was nothing left that medical or psychiatric treatment could do for him, that his only hope was a spiritual or religious experience--a recommendation that led Roland H. to the Oxford Group. Later in a response to a letter from Bill Wilson describing how Jung's advice played a critical role in the founding of Alcoholics Anonymous, Jung used the phrase *Spiritus contra Spiritum* to reflect his understanding of the power of the spiritual to conquer alcoholism.[2]

The founding of Alcoholics Anonymous in 1935 marks a particularly important milestone as this fellowship shaped a spiritual approach to alcoholism recovery that significantly influenced the philosophical premises and working methodologies of the field up until the present. AA's non-religious, but spiritual program of recovery focused on ego-surrender to a higher power and a moral reconstruction of one's character through self-inventory, confession, restitution and service. The 12 step model of spiritual recovery would evolve into a social movement carrying 12-step spirituality and self-help adaptations far beyond the boundaries of the substance abuse field.

The past two decades have seen the emergence of explicitly religious programs of addiction treatment and such non-religious, non-spiritual self-help alternatives as Women for Sobriety, Rational Recovery and Secular Organization for Sobriety. The treatment field is being forced to become spiritually multi-lingual given the enormous diversity of our clients.[3]

While spirituality has a visible place within the treatment side of the field, such is not the case with prevention. If we are to explore the potential of this force called spirituality within the prevention arena, we must first forge a language to guide our efforts. The challenge is to create a language broad enough to capture the phenomenon of spirituality while avoiding language so vague and diffuse that it fails to define and delineate.

Cultural and Professional Context

We enter this exploration of spirituality at a particular point in the history of our world, our culture and our professional field. Ideologies and the political and economic structures that supported them are toppling, with the cries of celebration muted by fears of

anarchy and civil war. We enter an era in which the world order is tenuous and open to the call of the best and worst within us. In our own country, we are reeling from a decade of narcissistic excess, concerned about the health of our families our neighborhoods, our schools, our places of work and our communities. We speak of a lost sense of connectedness and a shift of values from social duty and public service to self-exploration and self-indulgence. There is a cultural hunger for personal meaning and intimacy. We seem to be desperately in search of the social glue that can mend the web of our interconnectedness and mutual support.[4] Following two decades of unprecedented success, our own professional field finds itself in a crisis depicted in terms of federal and state funding cuts, restrictive third party coverage and managed care. And yet out of our explosive growth, our industrialization, our obsession with profit and regulatory compliance, and our competition with and isolation from one another, has come a growing sense that we are a field whose essential character is being shaped not from within, but from forces outside the field. A growing number of persons are calling for us to re-center ourselves, to re-articulate a vision for the future and a core set of values and principles that will guide our business and service practices. Perhaps it is not surprising in such a global, cultural and professional context, that concerns about spirituality have intensified.[5]

In the summer of 1992, the Prevention Resource Center brought together a small group of persons to define spirituality within a prevention context and explore its potential contribution to the prevention field. The ideas below emerged out of this interactive and collaborative process. This paper is testament to the belief that we can do together through a synergism of relationship that which we could not do alone. Any failure to capture and convey the clarity of our vision is my own. The purpose of the dialogue was not to draw definitive conclusions, but to lay the groundwork through which more substantive work could occur. As a result, much of our effort focused on defining spirituality and the parameters of its application to prevention.[6]

Spirituality and the Human Condition

Human beings, since the birth of consciousness and self-consciousness, have spent considerable time pondering the meaning of their existence and altering their life choices based on the conclusions drawn from these ruminations. Our awareness, our consciousness, our need to give order and meaning to life, and also our need to alter consciousness makes the issue of spirit as old as human life. Through thousands of religions, philosophies, political and economic ideologies, lifestyles, vocations and pastimes, we have sought to make sense of our world and our place in it. Through drugs, music, dance, sport, feasting, fasting, sexual frenzy, and every manner of religious ritual--through episodes of ego-surrender and ego-intoxication--we have sought to alter our experience of ourselves and our world.[7] This need for meaning and altered consciousness is the root of the spiritual experience. This need has been channeled into the highest achievements of our civilization and our most unspeakable atrocities. We will begin by distinguishing spirituality and religion and then define this phenomenon called spirituality. Our discussion will end with an exploration of the potentials and hazards the exploration of spirituality poses the prevention field.

A Brief Note on Spirituality and Religion

It will be impossible to address the issue of spirituality without defining and delineating the phenomena of religion and spirituality. Spirituality and religion are two overlapping phenomena whose differences, commonalities, and inter-relationships need to be explored at great length, particularly as they relate to prevention. An essential started point is the recognition that there are religious and nonreligious varieties of spiritual experience. In the discussions which follow, spirituality will embrace both religious and non-religious spiritual states and experiences.[8]

A Working Definition

> *Spirituality is a heightened state of perception, awareness, performance or being that personally informs, heals, empowers, connects, centers or liberates.*

There is a continuum of spiritual experience that can be plotted based on the source of the experience. There is a spirituality that springs from pain, a spirituality that springs from pleasure, and a spirituality that flows from the simplicity of daily life. The power of the spiritual to throw us beyond our normal range of experience is evident in the language of persons describing this phenomena: awakening, epiphany, rapture, psychological seizure, peak experience, defining moment, struck speechless, awe, release, sublime, rebirth, breakthrough, and ecstasy. The spirituality of fully experiencing the subtlety and depth of the ordinary is described in words such as harmony, balance, centered, bliss, serenity, and tranquility. The fact that these conditions or experiences provide alternatives to or antidotes for chemical intoxication make them a potentially important area of study in substance abuse prevention and treatment. A more detailed examination of our working definition of spirituality could explicate such potential.

Defining Spirituality for the Prevention Context

The first half of the working definition attempts to describe what spirituality is; the second half seeks to describe spirituality through its effects.

HEIGHTENED: This word implies an acute sensitivity, an intensity of consciousness that transcends the ordinary, a sense of the peculiarly authentic, an amplification and elevation of one's experience, an openness to awareness. Heightened states are often self-perpetuating--a quality reflected in Nathaniel Branden's observation on "the capacity of ecstasy to re-generate itself."[9]

STATE: State can reflect a unique, time-limited experience as in Groff's concept of "spiritual emergency"[10] and White's concept of "conversion crisis"[11] in addicts, or an enduring condition or quality, as in the statement, "She is a very spiritual person." State may or may not involve full personal consciousness of the condition. Spirituality doesn't require intentionality. The spiritual person may not have sought this state as a goal and may not self-identify himself or herself as having this quality. Intentionality and awareness not withstanding, heightened state suggests an elevated readiness to experience or respond. Spirituality as a condition is the framework of valuing out of which we commit our energies in a sustained way. Spirituality is to one's life what the brain is to one's body: it is the central processing station that integrates and gives meaning to our choices and actions.

PERCEPTION: Heightened state of perception suggests an unusually sharp clarity and depth of seeing, a capacity to see previously unseen patterns and relationships and meanings, and a breakthrough in the perception of the self, the world and the self-world relationship. There is a piercing through the superficial to see that which is of ultimate value and importance--described at its most intense as a mind-shattering vision.

AWARENESS: Heightened state of awareness implies that which is perceived is now organized into patterns of meanings. Awareness implies cognition and an ordering of sensory and emotional data into a meaningful whole. It is an understanding of relationships, an ordering of values, a framework for

choices out of which one can say yes and no. It is an ordering of priorities which reflects a deep appreciation of one's ultimate concerns and personal destiny. This heightened state of awareness that is spirituality often breaks into awareness through symbols, songs, metaphors or stories. Awareness can break through as logic, as intuitive instinct, or the gleaning of paradox. Spiritual awareness often involves seeing the great issues of one's age played out at in the microcosm of one's own life--a perceived thread between personal destiny and human destiny.

PERFORMANCE: Heightened state of performance is the execution of behavior in an extraordinary manner. It is the lost contact with everything in the universe except the instantaneous execution of this act or series of acts. It is the mother lifting her car off her child, the altruistic suicide of a soldier throwing himself or herself on a grenade to save his or her comrades, the athlete who gets "in the zone," the artist whose performance is driven by a mysterious source of power and passion. It is the acting out of one's ultimate values in a "moment of truth."

BEING: A heightened state of being is an experience of emotional harmony and balance, a feeling that one is on the correct path of self-destiny--what Joseph Campbell frequently referred to as "following your bliss."[12] It is a congruence between our aspirational values and our personal choices and actions, in short, our process of living.

The second half of our working definition describes how spirituality is experienced and to what effect. The elements below are at the same time consequences of the state of spirituality and mediums through which spirituality can be accessed or transmitted: informing, healing, empowering, connecting, centering and liberating.

THAT PERSONALLY: The experience and effects that flow from this optimal state called spirituality are experienced uniquely within each individual. There is no generic spirituality. Spirituality--the condition--and spiritual experiences--high intensity episodes within this condition--effect humans in a number of ways that have relevance to substance abuse prevention.

INFORMS: Spirituality teaches and guides. The lessons may be highly personal or may involve a personal filtering of a universal spiritual truth, e.g., you reap what you sow. Spirituality involves teachers as well as lessons--indigenous sources of wisdom and guidance within the human community, e.g., teachers, elders, high priests/priestesses, storytellers, and tricksters.

HEALS: The spiritual has long been seen as a source of healing. Spirituality brings dimensions of cleansing, self-forgiveness, a restoration or creation of wholeness. Healing can involve self-inventory, touch, confession, and restitution. Spirituality can be a powerful transformational force.

EMPOWERS: Spirituality is about power. It is a connection with powers within the self and powers beyond the self. It is inspiring, horizon-raising, energizing, galvanizing. It is contagious. It is joy and exaltation and ecstasy. Spiritual empowerment also bestows an inescapable duty and responsibility. It is the tempering of character through the fire of suffering and adversity.

CONNECTS: Connects reflects an empathic identification, the capacity to project oneself into another's experience--to link the experience of the self and other as one. It is a linking back to the past and a bridge into the future. Connection is reaching out. It is a communication of relationship. Connection is atonement and

reconciliation. It is the experience of intimacy--the experience of "we." It is the antidote to isolation and alienation. Connection is based on truth-telling and a covenant of fidelity to the proposition that our interests and destinies are irrevocably linked. It is mutuality, reciprocity and interdependence. It is a celebration of the paradox of simultaneous diversity and unity.

CENTERS: Spirituality is that ability to hour-by-hour, day-by-day re-center ourselves by bringing our choices and actions into compliance with our aspirational values. It is moving back in harmony with self and with others. It is the gyroscope that keeps us morally upright. It is discipline, duty and responsibility. Centering implies balance--an antidote to excessive behavior--a cultivation of openness, flexibility and tolerance. It is a comforting and sustaining process.

LIBERATES: Spirituality is fuel for struggle against internal and external shackles. It challenges us to cross barriers and break imposed limits. It is responding to the heart rather than mechanistic compliance with externally imposed expectations. It is the collective genius, endurance and resilience of oppressed individuals and peoples. It is detachment. It is the transcendence of biological appetites. It is the transcendence of the excesses of prosperity and hardship. It is a raw force or energy that inevitably struggles against the structures that attempt to contain it.

Spirituality in Action

What does spirituality (S) have to teach us about the prevention craft. S says everything is personal; we are touched only by that which reaches us at a personal level. We each possess spiritual receptors that can only be accessed through prevention messages couched in the specialized languages, symbols, and stories which we are able to receive. S says there are alternative states of consciousness that can compete with the seductiveness of drug intoxication. S says we can be called and challenged to higher levels of expectations because others exist at that level. S says many people who are wounded can and do get well outside the boundaries of organized treatment. S says that religious experience and religious practice is a viable alternative to drug use and a legitimate pathway of transformation from the state of self-destruction to the state of becoming. S says that there are indigenous people and indigenous institutions--weakened as they may be--that are sources of healing and reconciliation. S says that religious organizations are an underutilized resource. S says everything we do in prevention hinges on building a foundation of connectedness between all people. S says we must help build and nurture community. S says we must begin to person-by-person re-establish the web of interdependency and mutual respect that is the essence of community. S says people need opportunities for introspection and self-inventory. S says self-awareness, self-affirmation and empathic identification with others are incompatible with drug abuse.

In some ways, exploring spirituality may lead us simply to describing what we already do in prevention in a different language. There are many ways in which the functions of spirituality defined above parallel the currently articulated prevention strategies. But there may be whole new technologies available to us if we explore the mediums through which spirituality is experienced: sacred objects, sacred places, special people and roles, core ideas, core values, special language, literature, music, dance. We may through this exploration of spirituality discover

new rituals for listening, identifying, remembering, cleansing, forgiving, centering, grieving and witnessing and testifying that bolster chemical health and emotional health.

The Dangerous Side of Spirituality

While affirming the potential contribution of a more focused examination of spirituality in the prevention field, it would be best to proceed very cautiously in this exploration. Spirituality, like any power, may be bent to serve different purposes and ends. Clinebell's distinction between pathogenic (sickness fostering) religion and salugenic (wholeness fostering) religion can be applied to spirituality.[13] There is the potential for unexpected and harmful consequences in the exploration of religion and spirituality as a dimension of behavioral health. There is the danger of rigid promotion of particular brands or forms of religious or spiritual belief and practices. There is danger that the historical separation of church and state could be breached through the use of public funds to promote or otherwise advocate religious and spiritual experience, no matter how broadly defined. There is danger that a movement recognizing the legitimacy of many religious and spiritual disciplines will be attacked by those individual groups who claim exclusive legitimacy. There is the danger of the spiritual con--the manipulation of religious and spiritual forms for personal aggrandizement, political power and profit. There is danger that the utility that comes from a clearly defined concept of spirituality will be lost through a plethora of revisionist profiteering--a phenomenon some say has happened with the concept of codependency. The field has had enough contact with cults the past two decades to justify suspicion of any prevention or treatment medium that presents itself in the cloth of charismatic leadership, authoritarian structure, exclusive ownership of truth, aggressive and deceptive recruiting practices, possessive isolation of its members or participants, and a propensity for coercion, manipulation and exploitation. All of these factors pose risks to the prevention field that must be weighed and actively managed if a deeper link between prevention and spirituality is to be explored.

Finding the Beam in Our Own Eye

As we proceed cautiously through the potentials and pitfalls of an intensified exploration of spirituality for other people and other systems, we would do well to explore spirituality as a source of renewal for our own organizations and our own workers.

> To speak of spirituality in an organizational context does not rely on the religious or the mystical. It simply says that there are resources and relationships beyond the organization that can empower and imbue hope. It simply says that a commitment to service brings duties and responsibilities that transcend individual and institutional self-interest. Spirituality ...is igniting and nurturing hope within the organization and the transmission of that message of hope into the world.[14]

If spirituality is indeed a force that can be intensely explored in the prevention and treatment contexts, then perhaps a beginning point of this exploration is ourselves--those persons and institutions that practice the prevention and treatment crafts. We can provide opportunities that allow us to individually and collectively center ourselves--to get in touch with the best within our individual and collective experiences. We can test the capacity of this power (spirituality) to nurture and heal by applying it to our own organizations and our own workers. Our ability to use spirituality as a medium for personal and social transformation rests ultimately on our ability to use this power in non-coercive, non-violent, non-hierarchical, non-exclusive, non-possessive ways within our own spheres of professional influence--within our own organizations.

[1.] For a review of this early history, see White, W. *The Culture of Addiction, The Culture of Recovery*. Bloomington, Illinois: Lighthouse Training Institute, 1990.

[2.] Spiritus contra Spiritum: The Bill Wilson / C. G. Jung Letters. *Parabola* Volume 12, Number 2, pp 68-71.

[3.] The basic Text for Rational Recovery is Jack trimpey's *The Small Book* New York: Delacorte Press, 1989; The primary text outlining the Secular Organization for Sobriety Program is James Christopher's *How To Stay Sober: Recovery Without Religion* Buffalo, New York: Prometheus Books, 1988; The primary literature for Women for Sobriety includes Jean Kirkpatrick's two books: *Goodbye Hangovers, Hello Life* New York: Ballantine Books, 1986; *Turnabout* New York: Bantam Books, 1986.

[4.] For a complete study of this cultural transformation, see Bellah, R. et. al. *Habits of the Heart: Individualism and Commitment in American Life* New York: Harper and Row, 1985.

[5.] For a more detailed discussion of these observations, see White, W. In Praise of Service. Bloomington, Illinois: Lighthouse Training Institute, 1992.

[6.] Participants in this roundtable discussion included Theodora Binyon, Joan Daumen, Cy Fields, Jose Oporto, Bill White, Jim Winters and Pam Woll.

[7.] For fascinating discussions of the alteration of consciousness as a basic human drive, see either Weil, A. *The Natural Mind* Boston: Houghton Mifflin Company, 1972, or Siegal, R. *Intoxication* New York: E.P. Dutton, 1989.

[8.] For a working definition of religion to compare and contrast with the definition of spirituality, I would offer the following: Religion is a system of beliefs about the nature of the universe, the nature of the ultimate conerns in life and the meaning of personal destiny which is usually explicated and affirmed through creeds, prescriptions for living and rituals of worship.

[9.] Branden, N. *Judgement Day: My Years with Ayn Rand* New York: Avon Books, 1989.

[10.] Groff, C. *Addiction as Spiritual Emergency* Boulder, Colorado: Sounds True Audiocassette, ND.

[11.] White, 1990, pp. 458-460.

[12.] Campbell, J. *The Power of Myth* New York: Anchor Books, 1988.

[13.] Clinebell, H. *Understanding and Counseling the Alcoholic Through Religion and Psychology* New York: Abingdon Press, 1956._

[14.] White, 1992, p. 16



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: Coyhis, D. and White, W. (2002) Addiction and recovery in Native America: Lost history, enduring lessons. *Counselor*, 3(5):16-20. Posted at **www.williamwhitepapers.com**

Addiction and Recovery in Native America: Lost History, Enduring Lessons

Don Coyhis and William L. White

The persistence and revival of indigenous Amerindian healing is due, not to a lack of modern treatment services, but to a need for culture-congenial and holistic therapeutic approaches. –Dr. W. Jilek

Hear me, not for myself, but for my people.... Hear me that they may once more go back into the sacred hoop and find the good red road, the shielding tree! –Black Elk

The dawn of the twenty-first century marks a time of great cultural renewal and individual and collective healing among the Native peoples of North America. The growing sobriety movement in Indian Country represents just one dimension of this larger process of personal and tribal revitalization.

The authors have collaborated for some time on researching the history of addiction and recovery among the indigenous peoples of North America. This history is being assembled from archival records and from the oral testimony of tribal elders. In our first report of this research, we:

1) explored the historical roots of Native alcohol problems,
2) challenged the "firewater myths" that have long permeated conceptions of the etiology of Native alcohol problems,
3) detailed the role Native leaders played in organizing America's first sobriety-based, mutual aid societies, and
4) described the recent "Indianization" of Alcoholics Anonymous, the revival of Native cultural revitalization and therapeutic movements, and the development of culturally meaningful alcoholism treatment philosophies and techniques (Coyhis and White, In Press).

In this article, we will identify the movements that, for more than 250 years, have provided frameworks of alcoholism recovery for Native peoples, and explore what can be learned from these historical movements to enhance the quality of contemporary addiction counseling.

Five Movements

Five overlapping movements have provided a framework for alcoholism recovery within and across Native American tribal cultures. The first to emerge were the eighteenth and nineteenth century recovery "circles" and abstinence-based cultural

revitalization movements of the Delaware Prophets (Papounhan, Wangomend, Neolin, Scatttameck), the Shawnee Prophet (Tenskwatawa) and the Kickapoo Prophet (Kennekuk). These prophetic leaders used their own recoveries from alcoholism to launch abstinence-based, pan-Indian movements that called for the rejection of alcohol and a return to ancestral traditions. Native preachers like Samson Occom, William Apess, and George Copway used their own lives as living proof of the power of Christian conversion and worship to cure alcoholism. The development of new abstinence-based Native religions continued in the nineteenth century, including the Longhouse Religion (Code of Handsome Lake), the Indian Shaker Church and the Native American Church (White, 2000, 2001). These Native religions constitute the most historically enduring frameworks for alcoholism recovery within Native communities. The fourth movement, the "Indianization of Alcoholics Anonymous" (A.A.) (Womak, 1996), began in the 1960s, and represents the growing adaptation of A.A. steps (Coyhis, 1990) and meeting rituals (Jilek-Aall,1981) to enhance A.A. effectiveness within Native communities. The threads of these earlier movements are being woven into the contemporary Wellbriety movement (Coyhis, 2000). White Bison, Inc., an American Indian nonprofit organization and one of the leaders of this new movement, is working to expand recovery support structures within Native communities across North America. This goal is being achieved through recovery education (*Well Nations Magazine*), national recovery awareness walks ("Hoop Journeys"), training indigenous leaders to organize recovery circles ("Firestarters"), hosting recovery celebration events in local Native communities, and advocating for culturally-informed social policies and treatment approaches. One of White Bison's most recent projects is publication of *The Red Road To Wellbriety*, a Native adaptation of the basic text of Alcoholics Anonymous (see www.whitebison.org).

These five movements share many characteristics. They were created by Native men and women who entered recovery after each had been wounded by alcoholism. The religious and revitalization movements they created provided an opportunity, in healing themselves, to heal their families and communities as well. The tradition of "wounded healers" in the arena of alcoholism recovery begins in eighteenth century Native America (White, 2000). This practice drew deeply from the belief in many Native cultures that a dramatic recovery from an illness was a potential sign of one's calling as a healer. The Native leaders of America's first mutual aid societies assumed this role more through ecstatic (experiential) initiation than didactic (formal education) initiation (Jilek 1971; Jilek 1978)—a practice that was later emulated in the rise of alcoholism counseling.

Native American recovery movements rose from the prophetic visions of their leaders. These visions portrayed alcohol as a weapon of cultural conquest and sobriety as a strategy of cultural resistance. The movements identified above were multidimensional movements containing a unique combination of spiritual/religious rebirth, cultural revitalization, personal healing, and, in some cases, political advocacy. All provided a pathway and framework for recovery from alcoholism that inextricably linked the sobriety and health of the individual to the survival and health of the tribe.

.

Therapeutic Functions

Viewed as a whole, these indigenous movements provide a striking list of therapeutic benefits. In fact, one might assess current treatment designs by their ability to achieve these very utilities. Here's some of what they provided:

- *Commitment*: culturally framed rationales for radical abstinence and a call for sobriety and sacrifice to a higher purpose than self (the People).
- *Purification*: rituals of physical and emotional detoxification (fasting, purging, sweating, herbal medicines) and spiritual connection (vision

quests).

- *Substitution*: replacement of alcohol with other sacred substances, e.g., the "Black Drink," peyote, tobacco, sage, cedar.
- *Identity*: affirmation of personal and cultural identity--connection with ancestral traditions and innate knowledge (the ancestors within).
- *Reconciliation*: mending of family and social relationships.
- *Prescriptions for living*: a reconstruction of values and daily lifestyle (e.g., the Code of Handsome Lake, Peyote Way, the Red Road).
- *Re-connection to Community*: sustained affiliation with a stable network of recovering people supported by a larger cultural community.
- *Ceremony*: participation in rituals that solidify pro-recovery values and relationships.
- *Story*: the transmission of life-changing ideas through the ancient oral tradition of storytelling.
- *Meaning*: a worldview of oneself and one's sobriety within the context of Native history, culture and religion.

Legacies and Lessons

What can today's addiction counselor draw from these movements? We would suggest at least five interrelated lessons.

1. *Alcohol and other drug problems in Native America are rooted within complex historical, cultural, political, and economic processes, and the resolution of these problems must reflect a deep understanding of such processes.* Native alcohol problems emerged and continue to emerge through a collision of context and person. While the understanding of the unique vulnerability of each client is essential, so also is an understanding of the ecology within which Native alcohol problems arose and have continued. More specifically, this ecology must be understood in terms of the interconnectedness between the wounding and intergenerational healing of the individual, the family and a people: the honor of one is the honor of all…the hurt of one is the hurt of all. The resolution of Native alcohol problems must be linked to hope for a people as well as hope for the individual being counseled.

2. *The most viable frameworks of addiction recovery for Native Americans tap the deepest roots of tribal cultures*. The job of the conscientious addiction counselor is to become a student of these cultures--their histories, their organization, their values, their ceremonies and folkways, and their systems of healing. The addiction counselor can help forge a bridge between the treatment agency and tribal cultures by encouraging the involvement of family elders, tribal elders and traditional medicine people (herbalists, shamanic healers, spiritual advisors) in the design and delivery of treatment services for Native clients. The goal here is to create a menu of words, ideas, rituals and experiences within the counseling milieu that can be selectively used by Native people who bring enormous diversity in terms of their personal histories, personalities, religious and spiritual beliefs, and degree of acculturation (Weibel-Orlando, 1987). Such an approach recognizes the multiple sources and patterns of Native alcohol problems as well as the multiple pathways and styles of long-term recovery among Native peoples.

3. *Traditional treatment and mutual support require significant adaptation to enhance their effectiveness with Native Americans.* Native purification and healing practices (sacred dances, the sweat lodge, and talking circles) may have special applicability to Native people suffering from alcoholism who are also estranged from tribal identity, language, and ceremonies (Hall, 1985). Dr. Wolfgang Jilek (1978, 1981) has described the potential therapeutic effects of ceremonies (the Spirit Dance, the Sun Dance and the Gourd Dance) and the potential value in the cross-cultural collaboration between Western and Native healers in the treatment of alcoholism. Bridging the gap between Native and Western healing practices begins with the

mastery of cultural etiquette--the etiquette of respect inherent within verbal and non-verbal (e.g., eye contact, touch, boundaries of personal space) communication rituals, and the recognition that such etiquette varies across and within tribes. Bridging that gap requires delivering such assistance within the elements of particular Native cultures. Such elements include: values (e.g., patience, generosity, cooperation, humility), teaching metaphors (e.g., the medicine wheel), symbols (e.g., the sacred pipe, eagle feathers), rituals (e.g., sweat lodge, smudging ceremonies), traditional skills (e.g., carving, silversmithing), stories, and cultural events (e.g., powwows). It calls for the presence of Indian men and women within the treatment milieu who offer living proof of the redemptive power of recovery and cultural re-connection. The addiction counselor is best viewed as a midwife who helps combine and elicit these healing experiences rather than as the expert who "treats" the client.

4. *Personal recovery for Native Americans is best framed within a broader umbrella of Wellbriety--physical, psychological, relational, and spiritual health.* The concept of Wellbriety is an affirmation of the interconnectedness of all aspects of one's life. At its most practical level, the focus on Wellbriety calls for global rather than categorical assessment, treatment plans that reflect the total vulnerabilities and assets of the person/family/tribe, and advocacy for sustained recovery support systems in the client's physical and cultural environment.

5. *Addiction treatment and recovery support services are best framed within a broader concern for the global health of Native communities, rather than through a singular focus on alcohol- or other drug-related problems*. The danger in the sometimes exaggerated and narrow focus on Native alcohol problems is that one comes to see alcoholism treatment and alcoholism recovery as a panacea for individuals and tribes instead of viewing Native alcoholism as nested within a much more complex network of political, economic and social problems that are linked to the history of Native tribes within the United States (Westermeyer, 1974). It is this nexus between the individual, the community and history that has long given religious and cultural revitalization movements an important role in the resolution of Native alcohol problems. This fifth principle, by affirming the inextricable link between personal health and community health, calls upon the addiction treatment agency and the addiction counselor to become actively involved in the communities within which their clients reside or to which they identify.

This person-community link is being conveyed to Native communities across the country within the cultural model of the Healing Forest. When a sick tree is removed from diseased soil, treated, and returned and replanted in the same diseased soil, it gets sick again. What is called for instead is a healing of the tree AND the replacement of diseased elements in the soil with nurturing elements (*Red Road to Wellbriety*, in press). Personal recovery flourishes best in a climate of family health, cultural vitality, political sovereignty, and economic security. What White Bison and other Native recovery advocacy organizations are trying to do is mobilize all segments of Native communities—the tribal councils, schools, churches, service programs, and political and cultural organizations—to forge and then actualize a healing vision for the community. The goal is to create a Healing Forest that creates a synergy between personal and community wellness. Such a synergy is reflected in the words of Andy Chelsea, who as the Shuswap tribal chief at Alkali Lake, declared, "The community is the treatment center" (Abbott, 1998).

A Closing Thought

There is a long history of harm done in the name of good in the relationship between Native tribes and federal and state governments and other organizations. One of the most egregious of such injuries was the enforced removal of Native children to Indian boarding schools that were designed to destroy the "Indianness" of these children. The motto of William Pratt, the founder of the

Carlisle School in Pennsylvania, was “Kill the Indian and save the man” (Coyhis, 2000). It is instructive that this systematic dismantling of Native family structure and deculturation of Native children was implemented with promises of its potential benefit to Native peoples. A history of such misguided and harmful interventions calls upon professional helpers today to enter into our relationship with each Native client and each Native community with an attitude of quiet humility, observing the ultimate ethical mandate to “First do no harm!”. The capacity of addiction counselors to be part of this era of healing and renewal will be enhanced if we enter into partnership with Native communities, or serve these communities from within, as observers, as listeners, and as students.

Don Coyhis (don@whitebison.org) is the President and co-founder of White Bison, Inc., Colorado Springs, CO., and a member of the Mohican Nation from the Stockbridge-Munsee Reservation in Wisconsin. William White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems, Bloomington, IL., and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

References

Abbott, P.J. (1998) Traditional and western healing practices for alcoholism in American Indians and Alaskan Natives. *Substance Use and Misuse* 33(13):2605-2646.

Coyhis, D. (1990). *Recovery from the Heart: A Journey through the Twelve Steps: A Workbook for Native Americans*. Center City, Minnesota: Hazelden.

Coyhis, D. (2000). Culturally specific addiction recovery for Native Americans. In: Krestan, J. (Ed.), *Bridges to Recovery*. New York: The Free Press, pp. 77-114.

Coyhis, D. and White, W. (in press). Alcohol problems in Native America: Changing paradigms and clinical practices. *Alcoholism Treatment Quarterly*.

Hall, R. (1985). Distribution of the sweat lodge in alcohol treatment programs. *Current Anthropology,* 26(1):134-135.

Jilek, W.G. (1978). Native renaissance: The survival of indigenous therapeutic ceremonials among North American Indians. *Transcultural Psychiatric Research,* 15:117-147.

Jilek-Aall, L. (1981). Acculturation, alcoholism, and Indian-style Alcoholics Anonymous. *Journal of Studies of Alcohol,* (Suppl. 9):143-158.

Niehardt, J.G. (1932, 1961). *Black Elk Speaks*. Lincoln: University of Nebraska Press.

Red Road to Wellbriety (in press) Colorado Springs, CO: White Bison, Inc.

Weibel-Orlando, J. (1987). Culture-specific treatment modalities: Assessing client-to-treatment fit in Indian alcoholism programs. In: Cox, W.M. (Ed.), *Treatment and Prevention of Alcohol Problems: A Resource Manual*. Orlando: Harcourt Bruce Jovanovich, Publishers.

Westermeyer, J. (1974). "The drunken Indian:" Myths and realities. *Psychiatric Annals,* 4(11):29-36.

White, W. (2000). The history of recovered people as wounded healers: From Native America to the Rise of the Modern Alcoholism Movement. *Alcoholism Treatment Quarterly,* 18(1):1-24.

White, W. (2001). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly,* 19(2):1-21.

Womak, M.L. (1996). The Indianization of Alcoholics Anonymous: An examination of Native American recovery movements. Master’s thesis, Department of American Indian Studies, University of Arizona.



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: Coyhis, D., & White, W. L. (2002). Alcohol problems in native America: Changing paradigms and clinical practices. *Alcoholism Treatment Quarterly,* 20(3/4), 157-166. Posted at **www.williamwhitepapers.com**

Alcohol Problems in Native America: Changing Paradigms and Clinical Practices

By Don Coyhis, B.A. and William White, M.A.

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Abstract

Views about the sources and solutions to alcohol problems among Native Americans have undergone dramatic changes over the past quarter century. This brief article summarizes the nature of these changes, with particular emphasis on emerging principles and practices that underlie the resolution of alcohol problems among Native peoples.

Key words: Native American, cultural revitalization movements, “firewater” myths, culturally-informed treatment

Alcoholism and alcohol-related problems have long constituted a serious problem in Native American communities (Lender and Martin, 1982), but recent decades have witnessed substantial advances in understanding the sources and solutions of these problems. These advances include: 1) new evidence of the historical roots of alcohol problems among Native tribes, 2) scientific challenges to the “firewater myths” that have permeated conceptions of the etiology of Native alcohol problems, 3) the beginning recognition of the role Native leaders played in organizing America’s first sobriety-based, mutual aid societies, 4) Native adaptations of Alcoholics Anonymous, 5) a revival of Native cultural revitalization and therapeutic movements, and 6) the development of culturally meaningful alcoholism treatment philosophies and techniques.

The Rise of Native Alcohol Problems

MacAndrew and Edgerton's (1969) landmark study, *Drunken Comportment*, and the historical investigations that followed (Mancall, 1995; Unrau, 1996), collectively challenge the long-held view that initial Native American contact with alcohol was one of instant personal and cultural devastation. Three conclusions stand out in this new historical research.

First, Native tribes had a commanding knowledge of botanical pharmacology, and many tribes had long ritualized the use of psychoactive drugs, including potent forms of tobacco, datura, and peyote, in ways that minimized their harmful effects and maximized their benefit to the individual and the tribe. Contrary to popular perception, there were also tribes such as the Pima, Papago, Apache, Coahulitec, Yuma, and Pueblo that had ritualized the use of fermented alcohol long before their first contacts with Europeans. While most Native tribes in what is today the United States and Canada were not exposed to alcohol prior to European contact, some tribes had culturally managed such use for centuries before the first Europeans arrived in the Americas (Westermeyer, 1996).

Second, the initial response of Native peoples to alcohol following European contact was not one of widespread alcoholism. Rather than infatuation, most Native peoples initially responded to alcohol with distaste and suspicion. They considered drunkenness "degrading to free men" and questioned the motives of those who would offer a substance that was so offensive to the senses and that made men foolish (Andersen, 1988). Most Native people who did drink alcohol were reported to show "remarkable restraint while in their cups." Most drank alcohol only during social or trading contact with Whites. As a result, early Native drinking, in its moderation and excess, tended to mirror the consumption patterns promoted by the English, Spanish, French, Dutch, Spanish and Russians and from whom they learned the practice. Drinking and intoxication did not reflect their normal daily life and habits, but became increasingly disruptive as it was modeled on the "frontier drinking" patterns of soldiers, trappers, and traders (MacAndrew and Edgerton, 1969; Winkler, 1968).

Third, native alcohol problems and alcoholism emerged as Native tribes came under physical and cultural assault, and as alcohol shifted from a benign token of social contact between Euro-Americans and Indians to a tool of economic, political and sexual exploitation. The new historical studies confirm an almost linear relationship between the rise of Native alcohol problems and the disruption or disintegration of tribal cultures.

"Firewater Myths"

From their beginning, Native drinking behavior and alcohol problems were framed by Euro-Americans in ways that provided ideological support for the vision of "Manifest Destiny." White drunkenness was interpreted as the misbehavior of an individual; Native drunkenness was interpreted in terms of the inferiority of a race (Mosher, 1975). What emerged was a set of beliefs, known as "firewater myths," that misrepresented the history, nature, sources and potential solutions to Native alcohol problems. These myths proclaimed that Indian people: 1) had an insatiable appetite for alcohol, 2) were hypersensitive to alcohol (couldn't "hold their liquor"), 3) were dangerously violent when intoxicated, 4) were inordinately vulnerable to addiction to alcohol, and 5) could not resolve such problems on their own (Westermeyer, 1974; Leland, 1976).

The scientific literature of recent decades has challenged these myths by documenting the wide variability of alcohol problems across and within Native tribes, and by refuting claims of genetic or other biological anomalies that render Native peoples particularly vulnerable to alcoholism. Also criticized have been scientific and popular reports that, by framing all Native alcohol problems as "alcoholism" and by inflating and over-dramatizing such problems, have stigmatized whole tribes (and a whole

people) (Westermeyer and Baker, 1986; May, 1994; Mancall, 1995; Westermeyer, 1996). After reviewing the historical and scientific evidence, Dwight Heath (1983) concluded that the "stereotype of 'the drunken Indian' is not generally accurate today, and appears never to have been."

The "drunken Indian" stereotype, and the "firewater myths" that undergird it, have long served to sustain "systems of subordination and domination" (Morgan, 1983). Such perceptions and beliefs, by defining Indian peoples as biologically and culturally inferior, provided part of the conscience-salving justification for the decimation of Native tribes over the extended period of Indian-European contact and conflict. Several observers (see Mosher, 1975 and Holmes and Antell, 2001) have suggested that modern discussions of alcohol and Indians continue to reflect notions of inferiority and superiority, and may serve similar functions in maintaining relationships of unequal power and status. As these "firewater myths" and their political and economic functions have been exposed and challenged in recent decades, ethno-historical theories emphasizing social learning, cultural trauma and continued patterns of subjugation and domination are replacing biological theories on the root causes of Native alcohol problems. These emerging theories tend to shift the locus of intervention into alcohol problems from the individual alone to the community and the larger historical, political, economic and cultural contexts in which alcohol problems arise and are sustained.

Native Resistance and Recovery

The story of the rise of alcohol problems among Native tribes is not one of passive destruction, but of active resistance and recovery. Native leaders actively resisted the infusion of alcohol into tribal life by castigating alcohol as "fool's water," "the Devil' spittle," or "white man's poison" and calling attention to its destructive effects on Native peoples. They advocated the legal banishment of the exploitive whiskey trade—a practice in which traders would arrive in Native villages with 30 or 40 kegs of whiskey and, once the Natives were intoxicated, take a season's worth of skins in return for watered-down booze spiked with strychnine, red peppers, gunpowder and opium (Anderson, 1988; Kennedy, 1997).

Native leaders also birthed abstinence-based cultural revitalization and therapeutic movements that constitute the earliest organized frameworks for alcoholism recovery in America. It is only recently that the contributions of these movements to the history of alcoholism recovery in America have begun to be recognized (White, 2000, 2001). The beginning of alcoholic mutual aid societies is usually attributed to the Washingtonian revival of the 1840s, but abstinence-based support structures have much earlier and more enduring roots within Native America cultures.

Early Native recovery support structures included the Delaware prophet movements (Wyoming Woman, Papounhan, Wangomend, Neolin, and Scatttameck), the Christian Indian revivalists (William Apess and Samson Occom), the Handsome Lake movement--also known as the Longhouse Religion, the Shawnee Prophet (Tenskwatawa) and Kickapoo Prophet (Kennekuk) movements, the Indian temperance societies, the Indian Shaker Church and the Native American Church. These movements offered a culturally viable rationale for the rejection of alcohol, purification and healing rituals, a new code of living (the "Peyote Way," the "Red Road"), a new personal identity, sober role models, a means of repairing family and social relationships, and an esteem-affirming re-connection with ancestral and contemporary Native cultures. The rich and continuing history of these movements confirms that alcoholism recovery is a living reality in Native communities and has been for more than 250 years (White, 2001).

The "Indianization of AA"

Suggestions that Alcoholics Anonymous (A.A.) is not appropriate for Native Americans have been countered in

recent decades by A.A. Literature for Native Americans (*A.A. for the Native North American*, 1989), Native adaptations of A.A.'s Twelve Steps, Native refinement of A.A. meeting rituals, the growth of A.A. meetings conducted in Native languages, and an annual National/International Native American Indian AA (NAIAA) convention (Jilek-Aall, 1981; Coyhis, 1990, 2000). So-called "Indian A.A." meetings often start late and end late, provide long breaks for socializing, include family members and children, impose no time limits for speakers, integrate A.A. and Native cultural ideas and slogans, replace references to the Christian "God" with "the Creator" or "Great Spirit," and replace the affirmation of "powerlessness" with a focus on the acquisition of power over personal and tribal life (Jilek-Aall, 1981; Womak, 1996; Simonelli, 1993). A significant milestone in this "Indianization" of A.A. is the imminent release of a Native adaptation of the basic text of Alcoholics Anonymous by White Bison, Inc. that includes Native frameworks and stories of alcoholism recovery. The publication of this book culminates a trend of Indian people claiming and sharing their own stories of addiction and recovery (Manacle, 1993; Red Road).

Cultural Revitalization and Healing Movements

Many of the earlier noted abstinence-based, religious and cultural revitalization movements such as the Native American Church and the Indian Shaker Church continue to flourish today in Native communities. What is equally noteworthy is the revival of earlier cultural practices such as the sweat lodge, the Gourd Dance, the Sun Dance and the Guardian Spirit Ceremony that some Native people are using therapeutically to initiate or anchor their recovery from alcoholism (Jilek, 1978; Jilek, 1994). New movements that are expanding cultural pathways to recovery include the Red Road approach to sobriety--created by Gene Thin Elk (Lakota-South Dakota), People in Prison Entering Sobriety (PIPES), and an emerging Wellbriety Movement that places sobriety within a larger framework of physical, emotional, spiritual and relational health. The Wellbriety Movement is serving as a focal point for organizing recovery support structures in Indian Country and incorporating culturally-based recovery tools into alcoholism treatment programs (Coyhis, 1999). The birth of organizations like White Bison, Inc. signals the involvement and leadership of Indian communities in a new grassroots recovery advocacy movement in the United States (www.whitebison.org; www.recoveryadvocacy.org).

Culturally-informed Treatment

Native alcoholism treatment programs have evolved administratively through the Office of Economic Opportunity in the 1960s, the National Institute on Alcohol Abuse and Alcoholism in the early 1970s, the Indian Health Service's Office of Alcoholism Programs (beginning in 1976), and, recently, a trend toward tribal sponsorship. Through these transitions, treatment programs that serve Native populations have begun to incorporate more culturally-informed philosophies and techniques. These programs are linking treatment to Native communities via tribal sponsorship, involving tribal elders as advisors and teachers, integrating Native healers into the treatment team, recruiting and training Native addiction counselors, and using history and culture as tools of liberation. They are also incorporating culturally-grounded ideas such as medicine wheel teachings; traditional ceremonies like the Sacred Pipe and spirit dances; purification and healing rituals such as the sweat lodge and the peyote ritual; and engaging kinship and community networks for long-term support for recovery (Anderson, 1992; Abbott, 1998; McCormick, 2000). Culturally-informed treatment of Native alcohol problems is grounded in tribal values and folkways. Compared to traditional treatment, it utilizes less confrontation and questioning, is quieter (less pressure for self-disclosure and more respectful of silence), and places greater emphasis on spirituality (French, 2000).

Culturally-informed treatment seeks to understand the wounded individual in the context of the historical and continued wounding of the Native tribal culture of which he or she is a part. It recognizes that, as *The Red Road to Wellbriety* teaches, "healthy seeds cannot grow in diseased soil." It seeks not just the healing of the individual, but the healing of the community within which that individual is nested. As such, the goal of culture-congenial alcoholism treatment is viewed as a restoration of harmony between the individual, the family, the tribe, and the world. In contrast to interventions grounded in Western medicine, it is more holistic—more focused on creating a better person in the context of family and clan than on symptom suppression. Ernie Benedict, a Mohawk elder, explains:

The difference that exists is that the White doctor's medicines tend to be very mechanical. The person is repaired but he is not better than he was before. It is possible in the Indian way to be a better person after going through a sickness followed by the proper medicine (Quoted in Jilek, 1978).

Recovery and Community No recent tribal response to alcoholism has galvanized more public and professional notice than that of the community of Alkali Lake, British Columbia. The Shuswap tribal community in Alkali Lake was so plagued with alcoholism that surrounding communities referred to it as "Alcohol Lake." The change began in 1971, when Phyllis and Andy Chelsea made a commitment to stop drinking and to confront the pervasive problem of alcoholism in their community. When Andy Chelsea was subsequently elected Chief of the Shuswap Tribe, he began promoting A.A. meetings, arresting bootleggers (including his own mother), confronting the drunkenness of public officials, and staging interventions to get community members into treatment. Tribal traditions were revitalized for both the adults and children of the community. Educational and job development programs were initiated for those in recovery. Over a period of ten years, this sustained effort reduced alcoholism from nearly 100 percent of the tribe to less than 5 percent (Chelsea and Chelsea, 1985; Taylor, 1987).

The proclamation of Chief Andy Chelsea that "the community is the treatment center" (quoted in Abbot, 1998) illustrates a collectivist, as opposed to individualistic, approach to the resolution of alcohol problems. Native frameworks of recovery have always been, and continue to be, framed in terms of an inextricable link between hope for the individual and hope for a community and a people. Two and a half centuries of Native recovery movements, the current sobriety of Alkali Lake, the vitality of the contemporary Wellbriety Movement, and the infusion of tribal beliefs and ceremonies into alcoholism treatment collectively provide a compelling lesson: the most effective and enduring solutions to Native alcohol problems are ones that emerge from the very heart of tribal cultures.

REFERENCES

Abbott, P.J. (1998).Traditional and western healing practices for alcoholism in American Indians and Alaskan Natives. *Substance Use and Misuse* 33(13):2605-2646.

Anderson, T.I. (1988). *Alaska Hooch*. Fairbanks, AK: Hoo-Che-Noo.

Anderson, E.N. (1992). A Healing Place: Ethnographic notes on a treatment centre. *Alcoholism Treatment Quarterly* 9(3-4):1-21.

Chelsea, P and Chelsea, A. (1985), *Honour of All: The People of Alkali Lake*. (Video) British Columbia, Canada: The Alkali Lake Tribal Council.

Coyhis, D. (1990). *Recovery from the Heart: A Journey through the Twelve Steps: A Workbook for Native Americans*. Center City, Minnesota: Hazelden.

Coyhis, D. (1999). *The Wellbriety Journey: Nine Talks by Don Coyhis*. Colorado Springs, CO: White Bison, Inc.

Coyhis, D. (2000). Culturally Specific Addiction Recovery for Native Americans. In: Kristen, J. Ed., *Bridges to Recovery*. New York: The Free Press, pp. 77-114.

French, L.A. (2000). *Addictions and Native Americans*. Westport, CT: Praeger.

Hall, R.L. (1986). Alcohol treatment in American Indian populations: An indigenous treatment modality compared with traditional approaches. *Annals of the New York Academy of Sciences* 472:168-178.

Heath, D. (1983). Alcohol use among North American Indians: A cross-cultural survey of patterns and problems. In: *Research Advances in Alcohol and Drug Problems*, Volume 7, Ed. by Reginald Smart, et al., NY: Plenum Press, pp. 343-396.

Holmes, M and Antell, J. (2001). The social construction of American Indian Drinking: Perceptions of American Indian and White officials. *The Sociological Quarterly* 42(2):151-173.

Jilek, W.G. (1978). Native renaissance: The survival of indigenous therapeutic ceremonials among North American Indians. *Transcultural Psychiatric Research* 15:117-147.

Jilek-Aall, L. (1981). Acculturation, alcoholism, and Indian-style Alcoholics Anonymous. *Journal of Studies of Alcohol* (Suppl. 9):143-158.

Jilek, W. (1994). Traditional healing in the prevention and treatment of alcohol and drug abuse. *Transcultural Psychiatric Research* Review 31:219-256.

Kennedy, M.A. (1997) *The Whiskey Trade of the Northwestern Plains: A Multidisciplinary Study*. New York: Peter Lang.

Leland, J. (1976). *Firewater Myths: North American Indian Drinking and Alcohol Addiction.* New Brunswick, New Jersey: Rutgers Center of Alcohol Studies Monograph No. 11.

Lender, M and Martin, J. (1982). *Drinking in America.* NY: The Free Press.

MacAndrew, C. and Edgerton, R.B. (1969) *Drunken Comportment: A Social Explanation*. New York: Aldine, 1969.

McCormick, R. (2000). Aboriginal traditions in the treatment of substance abuse. *Canadian Journal of Counseling* 34(1):25-32.

Mancall, P. (1995). *Deadly Medicine: Indians and Alcohol in Early America*. Ithaca, NY: Cornell University Press.

Maracle, B. (1993). *Crazywater: Native Voices on Addiction and Recovery*. Toronto, Ontario: Viking.

May, P. (1994). The epidemiology of alcohol abuse among American Indians: The mythical and real properties. *American Indian Culture and Research Journal* 18:121-143.

Morgan, P. (1983). Alcohol, disinhibition, and domination: A conceptual analysis. In *Alcohol and Disinhibition: Nature and Meaning of the Link*, Ed. by Room and Collins. Washington D.C.: U.S. Government Printing Office, pp 405-430.

Mosher, J. (1975). Liquor legislation and Native Americans: History and perspective. Working Paper F 136. Berkeley: Social Research Group, University of California.

Simonelli, R. (1993). White Bison presents a Native view: Alcoholic recovery and the Twelve Steps. *Winds of Change* 8(3):41-46.

The Red Road to Sobriety—Video Talking Circle. San Francisco, CA: Kifaru Productions.

Taylor, V. (1987). The triumph of the Alkali Lake Indian band. *Alcohol Health and Research World* Fall, 57.

Unrau, William (1996). *White Man's Wicked Water: The Alcohol Trade and Prohibition in Indian Country, 1802-1892.* Lawrence: University Press of Kansas.

Westermeyer, J. (1974). "The drunken Indian:" Myths and realities. *Psychiatric Annals,* 4(11):29-36.

Westermeyer, J. and Baker, J. (1986). Alcoholism and the American Indian. In N.S. Estes and M.E. Heineman (Eds.) *Alcoholism: Development, Consequences, and Interventions*, 3rd edition, pp. 273-282. St. Louis: Mosby.

Westermeyer, J. (1996). Alcoholism among new world peoples: A critique of

history, methods, and findings. *American Journal on Addictions* 5(2): 110-123.

White, W. (2000). The history of recovered people as wounded healers: From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly* 18(1):1-24.

White, W. (2001). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly* 19(2):1-21.

Winkler, A.M. (1968). Drinking on the American frontier. *Quarterly Journal of Studies on Alcohol,* 29: 413-445.

Womak, M.L. (1996). The Indianization of Alcoholics Anonymous: An examination of Native American recovery movements. Master's thesis, Department of American Indian Studies, University of Arizona.

.



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. (2002). Introduction. The red road to wellbriety. Colorado Springs, CO: White Bison. Posted at **www.williamwhitepapers.com**

Introduction

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

All things come full circle. The publication of this book marks a milestone in the history of addiction and recovery among Native peoples in America. It is fitting that the *Red Road to Wellbriety* offers Native interpretations of the Twelve Steps of Alcoholics Anonymous (A.A.) for it was in Native America that the first networks of recovery support groups were formed–nearly 200 years before the founding of A.A..

The history of alcohol problems among Native American tribes is not one of passive destruction, but one of active resistance. Addiction was an alien disease injected into Native cultures, but frameworks of recovery emerged, and have continued to re-emerge, that tap the deepest and most sacred roots of these cultures. There are dark truths in this book that are almost too painful to bear, but rising from the ashes of this pain are liberating truths that burn with the brightness of the sun.

As early as the 1750s, recovery circles grew out of Native American cultural revitalization and religious movements. The beginning of any history of alcoholism recovery in America should be filled with the names of Wagomend (Assinsink Munsee), Papoonan (Unami Delaware), Neolin (and the other Delaware Prophets), Samson Occom (Ojibway), William Apess (Ojibway), Kenekuk (the Kickapoo Prophet), Tenskwatawa (the Shawnee Prophet), Kahgegagahbowh (George Copway) (Ojibway), and Zuanah (Quanah Parker)(Comanche)–the central figure in the rise of peyotism and the Native American Church. One of the earliest equivalents of A.A.'s Twelve Steps and "Big Book" was the orally-transmitted teachings–the Gai'wiiò ("Good Message") of Ganioda'yo (Handsome Lake) (Seneca) that became known as the Code of Handsome Lake following its introduction in 1799. From the Handsome Lake Movement to the Indian Shaker Church to the Native American Church to the recently emerging Wellbriety Movement, there is an enduring Native tradition of sobriety-based cultural and religious movements. It is hoped that this publication will spark interest in Native contributions to the history of alcoholism recovery in America.

What most Native recovery pioneers shared in common was a call for personal sobriety, the use of ancestral teachings to anchor sobriety, and adherence to a code of

moral conduct. This way of living has gone by many names, including the "Red Road." The Red Road is a way of achieving sobriety and healing personal and cultural wounds. The Red Road is a way of breaking the cycle of destruction that so often accompanies historical trauma and oppression.

The *Red Road to Wellbriety* is an invitation to walk the Red Road. The term *Wellbriety* is an affirmation that recovery is more than the removal of alcohol and other drugs from an otherwise unchanged life. Wellbriety is a larger change in personal identity and values and a visible change in one's relationship with others. It is about physical, emotional, spiritual, and relational health. Wellbriety is founded on the recognition that we cannot bring one part of our lives under control while other parts are out of control. It is the beginning of a quest for harmony and wholeness within the self, the family and the tribe.

True Wellbriety occurs in the context of community. The *Red Road to Wellbriety* teaches that healthy seeds cannot grow in diseased soil. It teaches that injured seeds need a "healing forest." The stories in this book make it clear that the sobriety and healing of the individual are inseparable from the sobriety and healing of the family and the tribe. In these pages are found the connecting tissue between personal sobriety, cultural renewal, nationhood, and sovereignty. (As the *Red Road to Wellbriety* teaches, "There is no sovereignty without sobriety.") The voices that fill these pages reveal how the wounds the individual and community have inflicted on each other can be healed. These voices call for a new relationship between self and community. The Wellbriety of the community creates a healing sanctuary–a culture of recovery–for the wounded individual, just as the growing Wellbriety of the individual feeds the strength of the community. On the Red Road, the individual, family and community are not separate; they are one. To injure one is to injure all; to heal one is to heal all.

The Wellbriety path does not compete with A.A. or any other pathway of personal recovery, but instead enriches those pathways by embracing them within the web of Native American tribal histories and cultures. In these pages, you will meet people who have committed themselves to live their lives on the Red Road. Here you will meet Native people whose stories embody the living history of Native American recovery. You will hear the details of their addiction and recovery journeys and feel the life and hope in their words. You will meet a woman of two cultures, a misplaced Indian who found his home, a woman who forget and then rediscovered who she was, a re-emerging man, and the children and grandchildren who have survived alcoholism. You will learn about A.A. and Al-Anon in the *Red Road to Wellbriety* but you will also learn about Talking Circles, Helping Spirits, the sweat lodge, the medicine wheel, sacred dances, smudging rituals, and praying with the eagle feather. You will hear men and women of many tribes and traditions illustrating the diversity of how they came to live sober, meaningful lives.

The tear-stained path of the Red Road leads to recovery, health, wholeness, and dignity, but it is not an easy road to walk. It calls for the power of the Creator, the wisdom of the elder, the courage of the warrior, and the heart of the mother, but like A.A., it is a path of progress, not perfection. Those who contribute their own tears to this path do so as an act of submission and an act of resistance. To walk the Red Road is to offer a silent proclamation:

> "Here the destruction stops. We will heal ourselves, we will heal our wounded relationships, we will heal our children, we will heal our nation. On this day, our future history begins."

The healing from addiction began more than 250 years ago in Native America. The teachings and stories in the *Red Road to Wellbriety* are a call to finish that healing and embark on the journey of Wellbriety. They are a call to open your heart and have faith in where this quest will lead.



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. (2004) Native American addiction: A response to French. *Alcoholism Treatment Quarterly*, 22(1), 93-97. Posted at **www.williamwhitepapers.com**

Native American Addiction: A Response to French

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Abstract

Laurence Armand French has provided a review of the origin of Native American alcohol problems and the historical and contemporary responses to such problems. This essay summarizes and discusses seven key points made by French and expands his discussion of the sources and solutions to Native alcohol problems.

Key Words: Native American, Indian, alcohol problems, alcoholism, treatment, cultural revitalization, Wellbriety movement

Introduction

Laurence Armand French has been studying and writing about alcohol-related problems in Native American communities for more than two decades. His latest contribution in the pages of *Alcoholism Treatment Quarterly* reflects themes that have permeated his writings on this subject. This brief essay summarizes and discusses the seven key points made in French's latest article.

Native Alcohol Problems: Sources and Solutions

Native alcohol problems rose in the face of increased alcohol availability, the heightened potency of alcohol, and the lack of cultural norms and rituals to prevent or contain sustained alcohol intoxication.

French's article begins where all attempts to address Native alcohol problems must begin: the historical and cultural contexts out of which these problems emerged and have been sustained. Three modern historical studies (MacAndrew and Edgerton's *Drunken Comportment*, Mancall's *Deadly Medicine*, and Unrau's *White Man's Wicked Water*) document that: 1) Native intoxicants (including alcohol in some tribes) were ritualized without significant problems prior to European contact, 2) early Native contact with alcohol following European contact was not one of instantaneous drunkenness and alcoholism,

and that 3) alcohol problems rose in tandem with the use of alcohol as a tool of political, economic and sexual exploitation and with the larger physical and cultural assault on Native tribes. Added to this historical data is an accumulating body of clinical literature debunking what have been christened "firewater myths"—notions that Native Americans have an atypical response to alcohol, can't "handle their liquor," and are genetically/biologically vulnerable to alcoholism (see Westermeyer, 1974; Leland, 1976; May, 1994).

Alcohol problems have evolved into a major health problem threatening Native American communities.

The truth of this point is evident in any report on the health of Native American tribes, but such a declaration, without qualification and elaboration stigmatizes Native communities. Several added points are essential: 1) there is enormous variability of drinking patterns and the prevalence of alcohol problems within and across Native tribes, 2) many alcohol-related health problems are more the result of "Indian drinking" (a culturally acquired pattern of episodic, group-oriented binge drinking) than traditionally defined alcoholism, and 3) castigating whole communities and all tribes based on a minority of individuals with intractable alcohol problems constitutes a pattern of racial stereotyping that injures Native communities (May, 1994).

Native Americans and Euro-Americans subscribe to fundamentally different worldviews, e.g., collaboration and harmony versus competition and conflict.

French does an excellent job illustrating these differences by revealing the differences between American Indian AA meetings and traditional AA meetings. His work here can be added to others who have made such comparisons between Native and Euro-American values and worldviews within the alcohol problems arena (see Simonelli, 1993; Coyhis, 2000).

Due to these differing world views, the indiscriminate application of culturally dominant alcoholism treatment methods have proved ineffective in Native communities.

The value differences French identifies are crucial to understanding why Eurocentric prevention and treatment approaches have not worked well in Native communities. Such approaches, in spite of their ineffectiveness, have fueled the belief that Native tribes do not have the resources within their own cultures to resolve alcohol problems.

An alternative to the application of mainstream approaches has been the emergence of culturally nuanced adaptations (the "Indianization" of Alcoholics Anonymous) and alternatives (the Native American Church) to traditional alcoholism treatment.

Efforts are emerging to elicit solutions—at both cultural and clinical levels—from the very heart of Native communities. These efforts are creating treatment hybrids that blend Native and Eurocentric methods of treating alcohol problems and are also utilizing purely Native approaches to the resolution of such problems (see Jilek, 1978, 1994; Jilek-Aall, 1981; Weibel-Orlando, 1987; Womak, 1996). While this expanded variety of treatment approaches has generated considerable support, there are calls to more rigorously evaluate both mainstream and culturally indigenous methods of treating Native alcohol problems (Weibel-Orlando, 1989; Mail & Heurtin-Roberts, 2002).

Renewed and new abstinence-based, Native American cultural revitalization movements are increasing in spite of sustained efforts to legally suppress them, e.g., the legal suppression of peyote within the Native American Church.

What could be added to French's discussion is that such abstinence-based cultural and religious movements have a

long and rich history that includes the Delaware Prophet movements, Handsome Lake and the Longhouse Religion, the Shawnee and Kickapoo Prophet movements, Indian preachers and temperance missionaries (e.g., William Apess and George Copway) and the Indian Shaker Church. There are two important points to be made here. First, Native American "recovery circles" constitute, in this author's researches, the first recovery mutual aid societies—some 200 years before the founding of Alcoholics Anonymous (White, 2000; Coyhis & White, 2003). It is time Native communities were acknowledged for this historical innovation. Second, that historical legacy continues today through the growing and increasingly vibrant Wellbriety movement (see http://whitebison.org).

A Vision for the Future

The final and most important point French makes is that tribal-centric treatment and recovery support services sustained by a combination of federal, state, and tribal resources constitute a window of hope for the future prevention and resolution of Native alcohol problems.

There is a silent revolution unfolding in Indian Country. Drinking and drunkenness, historically defined via the "firewater myths" as an essence and expression of one's Indianness, are being rejected. Growing numbers of Native peoples are embracing Wellbriety (sobriety and physical, emotional and spiritual health) as an act of personal and cultural survival and resistance. This resistance movement is reflected in a recently published Native adaptation of the "Big Book" of Alcoholics Anonymous. The *Red Road to Wellbriety* declares:

> *To walk the Red Road is to offer a silent proclamation: Here the destruction stops. We will heal ourselves, we will heal our wounded relationships, we will heal our children, we will heal our nation. On this day, our future history begins.*

The source of Native alcohol problems lies within the history of a process of cultural destruction (the decimation and domination of Native tribes); the solution to these same problems lies in the processes of cultural and religious revitalization that are rising within Native communities. Laurence Armand French has helped place these cultural revolutions in historical and clinical perspective. Readers wanting a more in-depth treatment of these issues are encouraged to explore French's book, *Addictions and Native Americans*.

REFERENCES

Coyhis, D. (2000). Culturally Specific Addiction Recovery for Native Americans. In J. Kristen (Ed.), *Bridges to Recovery* (pp. 77-114). New York: The Free Press.

Coyhis, D., & White, W. (2003). Alcohol Problems in Native America: Changing Paradigms and Clinical Practices. *Alcoholism Treatment Quarterly, 20*(3/4), 157-165.

French, L. A. (2000). *Addictions and Native Americans*. Westport, CT: Praeger.

Jilek-Aall, L. (1981). Acculturation, alcoholism, and Indian-style Alcoholics Anonymous. *Journal of Studies of Alcohol, Suppl. 9,* 143-158.

Jilek, W. G. (1978). Native renaissance: The survival and revival of indigenous therapeutic ceremonials among North American Indians. *Transcultural Psychiatric Research Review, 15,* 117-147.

Jilek, W. G. (1994). Traditional healing in the prevention and treatment of alcohol and drug abuse. *Transcultural Psychiatric Research Review, 31,* 219-256.

Leland, J. (1976). *Firewater Myths: North American Indian Drinking and Alcohol Addiction* (Monograph No. 11). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

MacAndrew, C., & Edgerton, R. B. (1969). *Drunken Comportment: A Social Explanation*. New York: Aldine.

Mail, P. D., & Heurtin-Roberts, S. (2002). Where do we go from here? Unmet research needs in American Indian Alcohol Use. In P. D. Mail, S. Heurtin-Roberts, S. Martin, & J. Howard (Eds.), *Alcohol Use Among American Indians and Alaska Natives* (NIAAA Research Monograph No. 37) (pp.459-486). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

Mancall, P. (1995). *Deadly Medicine: Indians and Alcohol in Early America*. Ithaca, NY: Cornell University Press.

May, P. (1994). The epidemiology of alcohol abuse among American Indians: The mythical and real properties. *American Indian Culture and Research Journal, 18,* 121-143.

The Red Road to Wellbriety. (2002). Colorado Springs, CO: White Bison, Inc.

Simonelli, R. (1993). White Bison presents a Native view: Alcoholic recovery and the Twelve Steps. *Winds of Change, 8*(3), 41-46.

Unrau, W. (1996). *White Man's Wicked Water: The Alcohol Trade and Prohibition in Indian Country, 1802-1892.* Lawrence: University Press of Kansas.

Weibel-Orlando, J. (1987). Culture-specific treatment modalities: Assessing client-to-treatment fit in Indian alcoholism programs. In W. Cox (Ed.), *Treatment and Prevention of Alcohol Problems: A Resource Manual*. Orlando, FL: Academic Press.

Weibel-Orlando, J. (1989). Hooked on healing: Anthropologists, alcohol and intervention. *Human Organization, 48*(2), 148-155.

Westermeyer, J. (1974). "The drunken Indian": Myths and realities. *Psychiatric Annals, 4*(11), 29-36.

White, W. (2000). The history of recovered people as wounded healers: From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly, 18*(1), 1-24.

Womak, M . L. (1996). The Indianization of Alcoholics Anonymous: An examination of Native American recovery movements. Master's thesis, Department of American Indian Studies, Tucson: University of Arizona.



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: Coyhis & White, W. (2006) Alcohol Problems in Native America: A New and Provocative History. *Counselor*, 7(4), 54-56. Posted at **www.williamwhitepapers.com**

Alcohol Problems in Native America: A New and Provocative History

Don Coyhis and William L. White

Could a book about history serve as a catalyst to change the future? Could a book about history enhance the practice of addiction counseling? Those are the dual hopes of the authors regarding their just-published *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery—The Truth about the Lie* (258 pages, $18.95)**.** This new book marks the latest in a series of recent resources (including *The Red Road to Wellbriety*) that will be a great help to addiction counselors working with Native American clients.

Alcohol-related problems constitute significant problems in many Indian communities, but the roots of those problems and the potential solutions to those problems have been misconstrued throughout American history. The centerpiece of that misconstruction has been a cluster of five "firewater myths":

Myth 1: American Indians have an inborn, insatiable appetite for alcohol

Myth 2: American Indians are hypersensitive to alcohol (cannot "hold their liquor") and are inordinately vulnerable to addiction to alcohol.

Myth 3: American Indians are inordinately prone to violence when intoxicated.

Myth 4: These very traits produced immediate, devastating effects when alcohol was introduced to Native tribes via European contact.

Myth 5: The solutions to alcohol problems in Native communities lie in resources outside these communities (Leland, 1976; Thatcher, 2004).

These firewater myths have been so widely inculcated that they constitute core beliefs with the dominant culture, within many helping professionals and even within many Indian communities. These myths persist in spite of having been investigated and debunked by addiction scientists and modern historians.

For the past five years, the authors have researched the history of alcohol problems and their resolution in Indian communities. Our research has unraveled a remarkable history of resistance to alcohol problems and a long, vibrant and virtually unknown history of recovery among Native peoples. There are twelve truths at the center of this story.

***1**. Native Americans possessed an exceptional knowledge of botanical psychopharmacology prior to European contact. They lived in harmony with the power of these plant-based substances (including alcohol in some tribes) by respecting the spirits and rules of the plants from which they were derived.* These substances include potent forms of tobacco, alcohol (in some tribes in the Southwest and Southeast), stimulants, sedatives, analgesics and hallucinogens (including datura, peyote, psilocybin, mandrake and fly-agaric).

***2**. The initial response of Native tribes to alcohol availability following European contact was not one of drunken mayhem and widespread alcoholism.* The early responses to alcohol varied within and between tribes and varied over the course of early contact, but one thing is clear: the development of alcohol problems in Indian communities emerged slowly and out of the changing relationships between Indians and Europeans, not as a function of any innate vulnerability to alcoholism.

***3**. Alcohol problems and alcoholism rose as Native tribes came under physical and cultural assault and when drinking alcohol shifted from a ritual of intercultural contact to a tool of economic, political and sexual exploitation.* Maria Brave Heart (2003) has eloquently framed the rise of alcohol problems among Native tribes as an outcome of historical trauma experienced by a whole people.

***4**. Early "firewater myths" portraying Native Americans as genetically inferior (inherently vulnerable to alcoholism) provided ideological support for the decimation and colonization of Native tribes and continue to serve that function today.* The persistence and pervasiveness of the firewater myths are striking in light of the absence of definitive evidence that Native Peoples physically respond to alcohol differently than other races or possess a unique biological vulnerability to alcoholism (Schafer, 1981; Westermeyer and Baker, 1986; May, 1994; Long, et al, 2002; Thatcher, 2004).

***5**. The legacies of the "firewater myths" include generations of stigma (the "drunken Indian" stereotype), racial shame, and a fundamental misconstruction of the sources of, and solutions to, alcohol problems in Native communities.* There is no greater obstacle to the resolution of alcohol problems in Native communities than the misidentification of the roots of those problems.

***6**. Native leaders actively resisted the infusion of alcohol into tribal life and continue to resist such infusion today.* As alcohol problems rose in Native communities, tribal leaders actively resisted the whiskey trade or tried to manage alcohol through the guidelines and rituals that had long been used to manage the potentially harmful effects of other psychoactive drugs. Native medicines and healing rituals were also used in the treatment of alcohol addiction.

***7**. Early indigenous responses to alcohol problems included the development of sobriety-based religious/cultural revitalization and healing movements that constitute the first recovery mutual aid societies in the world--a century before the Washingtonian revival of the 1840s and two centuries before the founding of Alcoholics Anonymous.* These movements included the Delaware Prophet Movements, the Handsome Lake Movement (the Longhouse Religion), the Shawnee and Kickapoo Prophet Movements, the Indian Temperance Movement, and the Indian Shaker Church and the Native American Church.

***8**. Recovery traditions in Native communities continue today through abstinence-based religions, the "Indianization" of Alcoholics Anonymous and Al-Anon (Womak, 1996), new recovery-based cultural revitalization movements (e.g., the Wellbriety Movement), and the rise of culturally-informed alcoholism treatment.* To tell the story of alcohol and other drug problems in Indian communities without telling the story of resistance and recovery is to lie by omission and further wound these communities.

***9**. The most effective and enduring solutions to Native alcohol problems have*

emerged and continue to emerge from within the very heart of tribal cultures. In the Native worldview, there is no separation between the individual, the family and the tribe. To wound one is to wound all; to heal one is to heal all. The revitalization of Native cultures is at the core of efforts to enhance resilience to and recovery from alcohol and other drug problems.

10*. The history of resistance and recovery within Native American tribes is a testimony to cultural forces of prevention and healing that continue to constitute powerful, but underutilized, antidotes to alcohol problems.* This calls for new partnerships between treatment professionals, treatment organizations and tribal elders and healers.

11. *A period of great healing, recovery, renewal and resilience has begun within Native communities.* This process is illustrated by the rise and evolution of the modern Wellbriety Movement.

12*. Recovery from alcohol problems and alcoholism is a living reality in Native American communities and has been for more than 250 years. Alcohol Problems in Native America* is more than anything else a celebration of the vibrant recovery that is spreading through Indian communities all over North America. We invite you to share in this celebration. We invite you to explore what are simultaneously new and old ways of preventing and treating alcohol problems in Indian communities.

Copies of *Alcohol Problems in Native America* (and *The Red Road to Wellbriety*) can be obtained by contacting White Bison at www.whitebison.org (719-548-1000 or 1-877-871-1495). White Bison is an American Indian non-profit organization based in Colorado Springs, Colorado. Its mission is to assist in bringing 100 Native American communities into healing by 2010. All proceeds from the sale of this book support White Bison and the Native Wellbriety Movement.

Acknowledgement: We would like to acknowledge Adele Smithers-Fornaci and the Christopher D. Smithers Foundation for their support in getting this book to Indian communities across North America.

About the Authors: Don Coyhis (don@whitebison,org) is the President and co-founder of White Bison, Inc., Colorado Springs, CO, and a member of the Mohican Nation from the Stockbridge-Munsee Reservation in Wisconsin. William White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems, Bloomington, IL, and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

References

Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35(1), 7-13.

Leland, J. (1976). *Firewater Myths: North American Indian Drinking and Alcohol Addiction.* New Brunswick, New Jersey: Rutgers Center of Alcohol Studies Monograph No. 11.

Long, J.C., Mail, P.D., Thomasson, H.R. (2002) Genetic susceptibility and alcoholism in American Indians. In Mail, P. Herutin-Roberts, S, Martcin, S. & Howard, J. Eds. *Alcohol Use Among American Indians and Alaskan Natives* (NIAAA Research Monograph No. 37). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, pp. 71-86.

May, P. (1994) The Epidemiology of alcohol abuse among American Indians: The mythical and real properties. *American Indian Culture and Research Journal 18:*121-143.

Womak, M.L. (1996). *The Indianization of Alcoholics Anonymous: An examination of Native American recovery movements*. Master's thesis, Department of American Indian Studies, University of Arizona.

Schaefer, J.M. (1981) Firewater myths revisited: Review of findings and some new directions. In Heath, D.B.; Waddell, J.O. & Topper, M.D., Eds. Cultural Factors in Alcohol Research and Treatment of Drinking Problems. *Journal*

of Studies on Alcohol Supplement 9:99-1171.

Thatcher, R. (2004). *Fighting Firewater Fictions: Moving Beyond the Disease Model of Alcoholism in First Nations.* Toronto: University of Toronto Press.

The Red Road to Wellbriety. (2002). Colorado Springs, CO: White Bison, Inc.

Westermeyer, J. and Baker, J. (1986) Alcoholism and the American Indian. In N.S. Estes, N.S. & Heineman, M.E., Eds. *Alcoholism: Development, Consequences, and Interventions.* 3rd edition, pp. 273-282. St. Louis: Mosby.



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. (2006) Recovery in Native America. Posted at **www.williamwhitepapers.com**

Recovery in Native America

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

There are two new resources about alcoholism recovery within Native American communities provide a fascinating window into the history and resolution of alcohol problems. The first, *The Red Road to Wellbriety* (278 pages, $15), is what many will see as a Native adaptation of the book, *Alcoholics Anonymous*. The first half of *The Red Road to Wellbriety* culturally reframes the Twelve Steps, integrating such things as Medicine Wheel teachings into the Steps. The second half of the book contains seventeen wonderfully told Native American recovery stories.

The second, just-released book, *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery—The Truth about the Lie* (258 pages, $18.95), is co-authored by Don Coyhis, Founder and President of White Bison Inc, an American Indian non-profit organization that works to spread recovery support groups within Indian communities across North America, and the author of this column. Don and I spent five years researching the history of alcoholism and alcoholism recovery among Native Americans, and we draw what will for many be surprising conclusions from this research.

First, we discovered the pervasive presence of "Firewater Myths" that portray Native Americans as racially hypersensitive to alcohol and biologically prone to alcoholism, and that portray the historical relationship between Native Americans and alcohol as one of instant devastation. We use the latest scientific studies and our historical research to debunk such mistruths. What readers of *Recover Magazine* may find most interesting is the long and rich history of recovery within Native tribes. We discovered "recovery circles" that existed more than 200 years before the founding of Alcoholics Anonymous. Recounted in detail are the Delaware Prophet Movements, the Handsome Lake Movement (the Longhouse Religion), the Shawnee and Kickapoo Prophet Movements, the Indian Temperance Movement, the Indian Shaker Church, the Native American Church, the "Indianization of A.A." and the current Wellbriety Movement.

The essential message of *Alcohol Problems in Native America* is that recovery from alcohol problems and alcoholism is a living reality in Native American communities and has been for more than 250 years. *Alcohol Problems in Native America* is more than anything else a celebration of the vibrant recovery that is again spreading through Indian communities all over North America. We invite you to share in this celebration. We invite you to explore what are simultaneously new and old ways of recovering from alcoholism—the Native Way.

Copies of *The Red Road to Wellbriety* and *Alcohol Problems in Native America* can be obtained by contacting White Bison at www.whitebison.org (719-548-1000 or 1-877-871-1495). All proceeds from the sale of these books support White Bison and the Native Wellbriety Movement.



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. & Laudet, A. (2006). Spirituality, science and addiction counseling. *Counselor*, *Magazine*, 7(1), 56-59. Posted at www.williamwhitepapers.com

Spirituality, Science and Addiction Counseling

William White, M.A., and Alexandre Laudet, PhD.

On the surface, the trends would seem to be contradictory: a surging science-to-practice movement and rising interest in the role of spirituality in addiction, treatment and recovery. A growing number of researchers (including the authors) are responding to these confluent trends by using scientific methods to operationally define spirituality and measure its influence on the course of addiction and recovery. The purpose of this article is to highlight some of this research and explore the implications of research findings to the practice of addiction counseling.

Defining Spirituality

The lack of a consensual definition of spirituality in the addictions field (Cook, 2004) has resulted in both theistic (belief in God) and non-theistic (inner strength, moral values) interpretations of spirituality (Kaskutas, Turk, Bond & Weisner, 2003; Arnold, Avants, Margolin & Marcotte, 2002). In its broadest meaning, spirituality can be defined by how it is experienced (a heightened state of perception, awareness, performance or being) and by what it does to and for the individual (informs, heals, empowers, connects, centers or liberates) (White, 1992). Clients describe spirituality 1s a subjective experience, a relationship (with self and/or with resources beyond the self), a core quality of character and a style of living (Miller, 2003; Corrington, 1989). Spiritual experiences are distinguished from other experiences by their acute clarity and authenticity, their intensity (transcending ordinary experience) and their catalytic power. The term *spirituality* includes but has evolved beyond its religious moorings to convey experiences that bring a heightened sense of meaning and purpose in one's life.

In order to conduct scientific studies on spirituality and addiction recovery, scientists have been forced to operationally define spirituality and develop instruments that can measure changes in the degree of one's spiritual orientation over time. These instruments include the Spirituality Self-Assessment Scale, the Spiritual Well-Being Scale, the Spiritual Belief Scale, the Brief Multidimensional Measure of Religiousness/Spirituality and also the Religious Background and Behavior Scale used in Project MATCH (Gorsuch & Miller, 1999). These instruments measure such dimensions as belief in a higher power, daily rituals of meditation/prayer, life purpose and goals, balance and wholeness, personal values (e.g., honesty, humility, compassion, forgiveness, tolerance), and personal relationships.

Scientists are using these definitions and instruments to answer several key questions about spirituality and addiction.

- Does a spiritual void in one's life heighten vulnerability for the development of a substance use disorder?
- Do self-defined spiritual experiences play a role in recovery initiation and, if so, what are the active ingredients within and measurable effects of such experiences?
- Does spirituality play a role in recovery maintenance and, if so, are these dimensions different than those that influence recovery initiation?
- What is the relationship between spirituality and religiosity as they interact over the course of addiction and recovery?
- Does a focus on spirituality within recovery mutual aid societies and the professional treatment of substance use disorders enhance long-term recovery outcomes?

Spirituality, Recovery, History

The questions now being raised about spirituality by scientists are not new. The potential role of spiritual experiences in the resolution of alcohol problems was a central theme in early Native American cultural and religious revitalization movements and within the late-eighteenth century writings of Dr. Benjamin Rush. When members of the Washingtonians described transformational experiences that did not include references to God, they were charged with the heresy of humanism. Debates raged through the 1840s over the relative merits of religious, spiritual and secular recovery experiences. It is among the lay alcoholism psychotherapists of the early twentieth century that we first see theology consciously transformed into therapy (in the work of Courtenay Baylor) and the later secularization of this approach into one emphasizing psychological technique (in the work of Richard Peabody). One of the innovations of Alcoholics Anonymous, which followed on the heels of the lay therapy movement, was to emancipate spirituality from its explicitly religious roots by charting a course between explicitly religious and secular pathways of recovery (White, 1998; White & Kurtz, 2005).

The beginnings of modern addiction counseling were marked by an emphasis on the role of spirituality in recovery. This interest in religious and spiritual influences on recovery faded in the wake of new biopsychological models of intervention, but is increasing once again. No, the questions being asked about spirituality and recovery are not new, but this is the first time in history rigorous scientific methods are being employed to answer them. This column has recently explored religious and secular styles of recovery. In this issue, we will focus our attention on what we are learning about spirituality and recovery.

Spirituality and Addiction Recovery: The Science

While research on spirituality, addiction and recovery is in its infancy, there are some consistent findings to date. First, we know that individuals with higher degrees of religiosity and spirituality are less likely to consume alcohol and other drugs and to consume less of such substances when they do use them. Conversely, studies are confirming that people with lower levels of spirituality, meaning and purpose in their lives are at increased risk for substance use disorders (Miller, 1998). Some investigators have conceptualized excessive alcohol and drug use as self-treatment for existential pain (Ventegodt, Merrick, & Andersen, 2003). Second, there is growing evidence that spirituality can serve as an antidote for substance use disorders. The most consistent finding is that clients with higher scores on measures of spirituality are more likely to be abstinent following treatment than those with lower scores (Waters and Shafer, 2005; Miller, 1998; Avants, Warburton & Margolin, 2001; Jarusiewicz, 2000). The influence of spirituality on recovery is independent of religiosity. For

example, degree of religiosity at treatment admission does not predict or only modestly predicts positive treatment outcomes, but self-reports of having had a "spiritual awakening" through involvement with A.A. are highly predictive of recovery three years following treatment admission (Kaskutas, Turk, Bond & Weisner, 2003; Project MATCH Research Group, 1997). Another finding of note is that previous religiousness or spirituality is not a prerequisite to gaining the benefits of a spiritual orientation during the stages of recovery initiation and maintenance (Christo & Franey, 1995).

Clients in treatment speak of spirituality in terms of a turning point in their lives, protection and support from a higher power, guidance of an inner voice, life meaning, gratitude and service work with others seeking recovery (Arnold et al, 2002). The depth of this spirituality rises with length of recovery (Jarusiewicz, 2000) and produces a wide range of benefits. A spiritual orientation to recovery is associated with a higher quality of life, life contentment, optimism, social support and lower levels of stress and conflict (Corrington, 1989; Pardini, Plante, Sherman & Stump, 2000). Most clients in treatment recognize the benefits of spirituality to their long-term recovery (McDowell, Galanter, Goldfarb & Lifshutz, 1996) and support the availability of spiritual components of treatment (Arnold, et al, 2002).

The authors' studies in New York City confirm many of these findings. We are conducting a NIDA-funded 5-year prospective study of 354 previously heroin- and cocaine-dependent individuals self-identified as in recovery from one month to 10+ years. Our interviews with these individuals confirm that spirituality reduces the risk of relapse by serving as a protective buffer against the stress of early recovery (Laudet & White, 2005) and that a spiritual orientation toward recovery increases as recovery progresses (Laudet, Morgen & White, in press). When other factors are controlled (e.g., problem severity, drug choice, gender, ethnicity, etc.), higher spirituality at our first interviews predicts sustained recovery at the follow-up interviews.

Spirituality, Life Meaning and Addiction Counseling

So what does all this mean for the addictions counselor? These studies confirm that spirituality can be a catalyst of recovery initiation, a protective shield in early recovery and an increasingly significant dimension of long-term recovery maintenance. As such, spirituality is a valid area to explore in the assessment and service planning processes. Clients' understandings of spirituality exhibit significant shifts in how spirituality is defined and utilized over the course of recovery. Addiction counselors would be well advised to support each client's unique, stage-dependent interpretation of spirituality (with or without belief in a higher power) and to approach spirituality within the larger framework of life meaning and purpose.

The role of spirituality in recovery initiation requires that we remain open to the power of sudden, transformative change. Many clients talk about a "turning point" in their lives in spiritual terms. Such experiences often occur in the context of near death experiences (from overdoses, suicide attempts, violent victimization), HIV/AIDS, addiction-related deaths of close friends and incarcerations. Addiction counselors can play an important role in enhancing the enduring influence of such experiences.

The evolving role of spirituality in long-term recovery dramatically underscores that recovery is much more than the removal of alcohol and other drugs from an otherwise unchanged life. Early recovery is marked by the stressors of disengaging from alcohol and other drugs and cleaning up the debris of one's addiction. The successful resolution of these tasks is often followed by existential panic: "I'm sober. Now what do I do?" (Chapman, 1991; White, 1996). Moving through this crisis involves a transformational journey marked by major changes in character, values, identity, interpersonal relationships

and lifestyle. Spirituality is a potential sense-making framework through which these transitions can be planned and retrospectively understood via story reconstruction. Addiction counselors can play an important role as a guide in this process and help each client construct a recovery-enhancing narrative of his or her life.

This 3-part series of articles has explored religious, secular and spiritual pathways of recovery—pathways that all address issues of personal values and life meaning/purpose. We end this series affirming the legitimacy of all three pathways of recovery and encouraging counselors to become knowledgeable of the ideas, language and rituals that distinguish these diverse styles of recovery.

Acknowledgment: Support for preparation of this article was provided by the National Institute on Drug Abuse (Grant R01DA14409). The opinions expressed here are those of the authors and do not necessarily reflect the official policies of the National Institute on Drug Abuse.

About the Authors: William White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Alexandre Laudet (laudet@ndri.org) is the Director of the Center for the Study of Addictions Recovery at the National Development and Research Institutes, Inc. in New York City.

References

Arnold, R., Avants, S., Margolin, A.,& Marcotte, D. (2002). Patient attitudes concerning the inclusion of spirituality in addiction treatment. *Journal of Substance Abuse Treatment, 23*(4), 319-326.

Avants, S.K., Warburton, L.A., & Margolin, A. (2001). Spiritual and religious support in recovery from addiction among HIV-positive injection drug users. *Journal of Psychoactive Drugs*, *33*(1), 39-45.

Chapman , R. (1991). Middle recovery: An introspective journey. *Addiction and Recovery*, Sept-October, 8-12.

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.

Cook, C. (2004). Addiction and spirituality. *Addiction*, *99*(5), 539-551.

Corrington, J.E. (1989). Spirituality and Recovery: Relationships between levels of spirituality, contentment and stress during recovery from alcoholism in AA. *Alcoholism Treatment Quarterly*, *6*(3/4), 151-165.

Gorsuch, R.L., & Miller, W.R. (1999). Assessing spirituality. In W.R. Miller (Ed.), *Integrating Spirituality into Treatment: Resources for Practitioners* (pp. 47-64). Washington, D.C: American Psychological Association.

Jarusiewicz, B. (2000). Spirituality and addiction: Relationship to recovery and relapse. *Alcoholism Treatment Quarterly*, *8*(4), 99-109.

Kaskutas, L.A., Turk, N., Bond, J., & Weisner, C. (2003). The role of religion, spirituality and Alcoholics Anonymous in sustained sobriety. *Alcoholism Treatment Quarterly*, *21*(1), 1-16.

Laudet, A, Morgen, K. & White, W. (in press) The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*.

Laudet, A. & White, W. (2005). The role of spirituality, faith and life meaning in the addiction recovery process. Presented at 28th Congress of the World Federation for Mental Health (WFMH) – Cairo, Egypt, September, 2005.

McDowell D, Galanter, M., Goldfarb, L., & Lifshutz, H. (1996). Spirituality and the treatment of the dually diagnosed: an investigation of patient and staff

attitudes. *Journal of Addictive Diseases*, *15*(2), 55-68.

Miller, W.R. (1998). Researching the spiritual dimensions of alcohol and other drug problems. *Addiction*, *93*(7), 979-990.

Miller, W.R. (2003). Spirituality, treatment and recovery. In: M. Galanter (ED.), *Recent Developments in Alcoholism: Volume 16: Methodology/psychosocial treatment, selected treatment topics, research priorities* (pp. 391-404). New York: Kluwer Academic.

Pardini, D.A., Plante, T.G., Sherman, A., & Stump, J.E. (2000). Religious faith and spirituality in substance abuse recovery: determining the mental health benefits. *Journal of Substance Abuse Treatment, 19*(4), 347-54.

Project Match Research Group (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

Ventegodt, S., Merrick, J., & Andersen, N. (2003), Quality of life theory I. The IQOL theory: an integrative theory of the global quality of life concept. *Scientific World Journal*, *13,* 1030-40.

Waters, P. & Shafer, K. (2005, July). Spirituality in addiction treatment and recovery, part 1. *Southern Coast ATTC Beacon* series. Tallahassee, FL: Southern Coast Addiction Technology Transfer Center, Florida Certification Board.

White, W. (1992). Spirituality: Its language and boundaries. In *Spirituality and Prevention* (pp. 37-47). Springfield, IL: Illinois Prevention Resource Center.

White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery: A Travel Guide for Addiction Professionals* (2nd ed.). Center City, MN: Hazelden.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.

White, W. & Kurtz, E. (2005). *The Varieties of Recovery Experience*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.



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: Laudet, A., Morgen, K. & White, W. (2006) The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*, 24(102), 33-73. Posted at **www.williamwhitepapers.com**

The Role of Social Supports, Spirituality, Religiousness, Life Meaning and Affiliation with 12-step Fellowships in Quality of Life Satisfaction among Individuals in Recovery from Alcohol and Drug Use

Abstract

Many recovering substance users report quitting drugs because they wanted a better life. The road of recovery is the path to a better life but a challenging and stressful path for most. There has been little research among recovering persons in spite of the numbers involved, and most research has focused on substance use outcomes. This study examines stress and quality of life as a function of time in recovery, and uses structural equation modeling to test the hypothesis that social supports, spirituality, religiousness, life meaning, and 12-step affiliation buffer stress toward enhanced life satisfaction. Recovering persons (N = 353) recruited in New York City were mostly inner-city ethnic minority members whose primary substance had been crack or heroin. Longer recovery time was significantly associated with lower stress and with higher quality of life. Findings supported the study hypothesis; the 'buffer' constructs accounted for 22% of the variance in life satisfaction. Implications for research and clinical practice are discussed.

To access full document: http://www.ncbi.nlm.nih.gov/pubmed/16892161



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. (2008). The culture of recovery in America: Recent developments and their significance. Counselor, 9(4), 44-51. Posted at **www.williamwhitepapers.com**

The Culture of Recovery in America: Recent Developments and Their Significance

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

For the past nine years, the articles in this column of *Counselor* have sought to educate addiction professionals about the rich history of addiction treatment and recovery in America and to highlight emerging trends that are of historical import. We have often noted history's propensity to repeat itself, but viewing all events in terms of these cycles can blind us to that which is fundamentally new.

For almost three centuries, people recovering from severe alcohol and other drug problems have created healing sanctuaries to share their experience, strength, and hope and to meet specific needs they faced in initiating and sustaining their recovery journeys. History suggests that when a vacuum of unmet needs reaches critical mass, recovering people, their families, and visionary professionals coalesce into movements that birth new structures of recovery support. That critical mass—spawned in great part by the restigmatization, demedicalization, and recriminalization of addiction in the 1980s and 1990s—has been reached again, and the resulting scope and depth of recovery community building activities in America is without historical precedent.

In this article, we will explore these recovery community building activities and the influence they will exert on the future of addiction treatment. We will begin by summarizing the small stories and then connect the dots of these stories to see the larger picture that is emerging and its import.

Growth and Diversification of Recovery Mutual Aid Societies

The roads to recovery are many.
--AA Co-founder Bill Wilson, 1944

Addiction recovery mutual aid groups have a long and rich history dating to the 1730s (White, 2001a; Coyhis & White, 2006). The past 30 years are striking in terms of new recovery mutual aid societies, the scope of recovery mutual aid participation (as measured by the number of registered groups and total membership of all groups) (Humphreys, 2004), and the diversification of group goals (spanning moderation and abstinence) and program

philosophies (spanning religious, spiritual, and secular pathways of recovery) (White & Whiters, 2005; White & Nicolaus, 2005; White & Laudet, 2006). Also noteworthy is the geographical dispersion of local recovery support groups throughout North America and the world (Humphreys, 2004; White, 2004).

More than any previous period in history, American communities are likely to have local recovery mutual aid meetings and a choice of such meetings within and across frameworks of recovery. The Faces and Voices of Recovery mutual aid guide contains more than 25 addiction recovery support societies (Kurtz & Kurtz, 2007). The "recovery community"—a term once used to refer collectively to members of local Twelve Step groups—has morphed into diverse "communities of recovery" who, as they interact and come together on issues of mutual interest, are forming a new consciousness of themselves. This newly emerging "recovery community" encompasses people from diverse recovery support groups and new recovery support institutions who are defining themselves as a community based on their recovery status and not the method or support group through which that recovery was achieved or sustained (White & Kurtz, 2006a). Transcending the competition and animosity that sometimes plagued their view of each other, members of these groups are more likely today to view all successful recovery pathways as cause for celebration.

Adding to the growth of recovery support structures is a renewed interest on the part of addiction treatment institutions in open-ended continuing care groups, consumer councils, alumni associations, and peer-based volunteer service programs. This marks a trend of lowering treatment intensity but increasing treatment extensity through the delivery of long-term recovery support services (Humphreys, 2006).

Virtual Recovery Communities

One of the most recent and historically significant trends is the growth of Internet-based recovery support meetings and the emergence of broader online recovery communities. What we know about these groups and communities at the present time is that they:

- began in the early 1980s and evolved in tandem with the WorldWideWeb,
- represent a broad spectrum of religious, spiritual, and secular recovery support groups,
- are rapidly growing in numbers and diversity,
- constitute both an adjunct and an alternative to face-to-face recovery support meetings, and
- attract members who would not otherwise participate in support group meetings, e.g., women, status-conscious professionals, adolescents, persons with disabilities, and persons living in isolated communities without recovery support groups (Kurtz & White, 2007).

In a recent review of Online recovery support groups, Kurtz and White (2007) expressed surprise at how many people were effectively and almost exclusively relying on online communications as their primary source of recovery support (Kurtz & White, 2007). The future of virtual recovery communities is hard to predict, but a day may come when the number of those supporting their recovery via online communication will approach and then far exceed the number of those participating in face-to-face recovery support meetings.

Recovery Advocacy Movement

Recovering people and their families and allies are forging grassroots recovery community organizations around four core activities: 1) political advocacy for pro-recovery laws and social policies, 2) public and professional recovery education, 3) the provision of non-clinical (peer-based) recovery support services, and 4) recovery celebration events. This new addiction recovery advocacy movement has arisen outside of and without affiliation with existing recovery mutual aid societies. Individuals

and families representing diverse recovery pathways are standing together, not as members of Alcoholics Anonymous, Women for Sobriety, Secular Organization for Sobriety, or Alcoholics Victorious, but as men and women in long-term recovery sharing common experiences, needs, and interests. This movement has national organizations representing its collective interests[1], a distinctive set of values and core ideas, a broad range of strategies through which it is pursuing its goals, and the financial support of recovering people and public and private organizations (White, 2006; White & Taylor, 2006; White, 2007).

The new *recovery community organizations* (RCO) that make up this grassroots movement constitute a new type of organization that existed earlier only within some of the local affiliates of the National Council of Alcoholism and Drug Dependence. RCOs stand as distinct organizational and service structures apart from both professionally-directed addiction treatment and addiction recovery mutual aid societies (Valentine, White, & Taylor, 2007). They are also creating new service institutions (e.g., *recovery community centers*) and pioneering new service roles (e.g., *recovery coaches*) that are offering a wide range of non-clinical recovery support services. A national directory of these grassroots organizations is posted at the Faces and Voices of Recovery website (see http://www.facesandvoicesofrecovery.org/regions).

Recovery Home / Colony Movement

Recovery homes are alcohol- and drug-free houses whose residents support each other in their recovery from addiction. They are NOT treatment centers nor are they "halfway houses"—staff-directed way stations between the treatment institution and the community. The current recovery home movement has been inspired to a great degree by the success of Oxford House, which was founded in 1975 and which has grown to more than 1,200 recovery homes in 48 states. More than 24,000 people in recovery a year reside in Oxford Houses. The Oxford House model has several distinctive features that have influenced the recovery home movement: democratic self-management, financial self-support of each home, reliance on support from peers rather than paid staff, no time limit on how long an individual can live at a home, and the expulsion of any individual who uses alcohol or drugs (Oxford House, 2006).

The growth of the recovery home movement was fueled by two factors. The first was the Federal Anti-Drug Abuse Act of 1988 (P.L. 100-690), which required states to establish a revolving fund for loans to recovering individuals to rent a house to establish a recovery home. The second influence was the accumulation of scientific studies documenting the exceptionally high continual abstinence rate within the Oxford Houses—research that confirms the real potential of the Oxford House slogan "Recovery without relapse." (Oxford House, 2006; Jason, Davis, Ferrari, & Bishop, 2001; Jason, Olson, Ferrari, & Lo Sasso, 2006).

Self-managed recovery homes are spreading rapidly in the U.S. A recently completed survey of recovery homes in the City of Philadelphia revealed more than 250 recovery homes that on any given day house more than 1,500 men and women (Johnson, Martin, Sheahan, Way, & White, in press). As recovery homes congregate in particular areas of a city (sometimes on the property of or in close proximity to institutions with which they are closely connected, e.g., churches, treatment institutions, or schools), they form a recovery campus that often includes a wide spectrum of recovery support services and relationships. Leonard Jason and Robyn Kobayashi (1995, p. 204) note that such "comprehensive healing environments" may

[1] Faces and Voices of Recovery, the National Council on Alcoholism and Drug Dependence, the Johnson Institute, the Legal Action Center.

be the wave of the future. Persons in recovery who purchase homes and then rent them to other people in recovery are a central part of the hidden story of the recovery home movement and its rapid growth.

Recovery colonies—at present a network or faith-based recovery communities modeled on early (Keswick Colony of Mercy) and more recent (Dunklin Memorial Camp) programs providing a mixture of a recovery-based residential community, service to the larger community and preparatory training for urban and rural recovery ministries. The reader might visualize such a colony (Dunklin)by imaging a Florida wilderness dotted with dormitories, staff residences, homes for visiting families and the families in recovery, a mess hall, tabernacle, school, computer lab, library, lumber mill, furniture workshop, hog and cattle pens, fruit groves and sugar cane fields, a health clinic, rodeo grounds, and a cemetery. This is a self-sustained recovery community built upon the shared religious vision experienced more than four decades ago by Micky and Laura Maye Evans.

Recovery Schools

One of the newest recovery community institutions is the recovery school. Between 1977 and 2000, collegiate recovery school programs were established at Brown University, Rutgers University, Texas Tech University, and Augsburg College. An additional five collegiate recovery programs were established between 2001 and 2004 at Dana College, Grand Valley State University, Case Western Reserve University, the University of Texas at Austin, and Loyola College in Maryland. Since Ecole Nouvelle (now Sobriety High) in Minnesota was opened in 1986 as the first recovery high school, the growth of high school programs specifically for recovering students has quickened. Twenty-five recovery high schools opened across the United States between 1999 and 2005. This rapid growth sparked the formation of the Association of Recovery Schools (White & Finch, 2006).

Recovery school programs vary widely but generally combine special recovery support services with an emphasis on academic excellence. The former may include special faculty guidance, recovery dorms, recovery support meetings, recovery drop-in centers, sober social activities, and peer mentoring. The latter is achieved through academic guidance, study centers, and peer-tutoring programs. Preliminary studies of these programs have noted high rates of uninterrupted abstinence (70-80%), early intervention and retention of students following a lapse, and excellent academic performance as measured by grades (above the student average), attendance (90-95%), and the number of students in recovery high schools going on to college (65%)(White, 2001b; White & Finch, 2006).

Recovery Industries

How do people who have never had legitimate employment or who have lost such employment due to their addictions enter or re-enter the mainstream workforce? The growth of recovery industries is offering one answer to this dilemma. A recovery industry is a business that purposely recruits, trains, and employs people in recovery. Such jobs may constitute a permanent employment position or a transitional position that helps a person develop a work history and references to obtain employment with mainstream businesses and industries. Recovery industries provide jobs in a recovery-conducive work environment, but they also offer recovering people an opportunity for skill development and a pathway of entry or re-entry back into conventional society. These industries play a special role in addressing the needs of individuals who are re-entering community life following prolonged addiction careers and periods of drug-related incarceration.

An example of a recovery industry is Recovery at Work (RAW), operated by a partnership between Recovery Consultants of Atlanta and Peace Baptist Church. RAW is typical of the growing phenomena of small recovery industries. RAW regularly employs

up to 20 full-time people in recovery to work within its construction and painting projects in the Atlanta area. Since its inception in 2003, RAW has hired more than 80 individuals in recovery.

Another variation of recovery industries are businesses whose owners or managers are in recovery or who have found hiring people in recovery a good business practice. These individuals have consciously created a recovery friendly work environment and seek out people in recovery to fill all open job positions. Venturetech, a Houston-based company that designs and manufactures hydraulic drills, is such a business. Its success in hiring people in recovery inspired its leaders to set up a separate not-for-profit organization to promote the practice of hiring people in recovery (See www.Americainrecovery.org) (Iverson, 2007).

Two other important workplace related developments are the growth of occupational recovery support groups and the spread of labor assistance programs. Occupational recovery support groups include such groups as International Doctors in Alcoholics Anonymous, International Lawyers in Alcoholics Anonymous, Anesthetists in Recovery, International Nurses in Alcoholics Anonymous, International Pharmacists in Alcoholics Anonymous, Veterinarians in Recovery, and the Recovered Alcoholic Clergy Association. Labor assistance programs, also called member assistance programs, are peer-based recovery support programs that are being developed by a growing number of labor unions (Bacharach, Bamberger, & Sonnenstuhl, 1996).

Recovery Ministries/Churches

Special ministries to alcoholics and addicts began in the closing decades of the Nineteenth century through religiously sponsored urban rescue missions and the creation of rural inebriate colonies. This movement was spawned by such pioneering institutions as the Water Street Mission in New York City and the Salvation Army. A resurgence of such ministries was spawned by the rise of juvenile narcotic addiction in the 1950s and 1960s—ministries that included street outreach (e.g., the work of Father Dan Egan, the "Junkie Priest", in New York City), outpatient counseling clinics (e.g., Saint Mark's Clinic in Chicago), and residential rehabilitation programs (e.g., Teen Challenge).

The involvement of the church in the problem of addiction is not new, but this involvement has taken some stunning new turns in recent years. These recent developments exist on a continuum of involvement that span:

- "Recovery friendly churches" that welcome recovering people but offer no special recovery services,
- Churches spawning new religiously sponsored recovery mutual aid groups, e.g., Celebrate Recovery, Ladies Victorious,
- Mega-churches adding a "recovery pastor" to their staff,
- Small churches using lay leaders and volunteers to lead recovery support meetings,
- Church-sponsored, recovery-focused worship services, workshops, leadership training, and children's programs,
- Recovery Churches, e.g., Central Park Recovery Church in St. Paul, Minnesota, the Recovery Church in Charlotte, North Carolina, and the Christian Recovery Fellowship in Dryden, Maine, for whom recovery is a central part of their identities as religious communities,
- New faith-based recovery colonies (residential communities), e.g., Dunklin Memorial Camp in Okeechobee, Florida,
- A new association of recovery ministries, i.e., the National Association for Christian Recovery (http://www.nacronline.com), and
- The growth of non-Christian recovery ministries and support groups, e.g., Millati Islami.

The religious branches of the American recovery movement are experiencing a period of awakening and a degree of movement into the mainstream church that is historically unprecedented. This trend is particularly evident in African American communities (Williams, 1992; Sanders, 2002).

Recovery Culture Development

Each of the preceding sections constitutes a noteworthy story in its own right, but to what extent do these individual stories tell a larger story—a story of unprecedented institution building within the American recovery community? The civil rights movement, the women's movement, and the gay rights movement—to name a few important modern social movements—each transitioned from a stage of heightened social consciousness to a stage of cultural renewal and community building. The consciousness raising stage was marked by increased group cohesion and a redefinition of personal and collective identity. The latter stage involved recapturing lost history and culture as well as forging new values, a new language of discourse, new art forms, new social institutions, and new rituals of gathering, protest, and celebration. This same process is underway in America among individuals and families recovering from addiction. A fully developed "culture of addiction recovery" is now emerging in America (White, 1996).

The institution building described above—the diversification of recovery mutual aid societies; the new recovery advocacy movement; new recovery community organizations; and the growth of recovery homes and colonies, recovery schools, recovery industries, and recovery ministries, is all unfolding within a larger process of recovery culture development. That process of cultural refinement is evident in:

- a growing interest in the history of recovery and recovery mutual aid societies,
- a growing preoccupation with and advocacy about the language of addiction and recovery (White, 2006),
- recovery literature that includes an unprecedented number of recovery biographies, serial fiction whose central characters are in recovery (e.g., James Lee Burke's Dave Robicheax, Joe Hilley's Mike Connally, Lawrence Block's Matt Scudder), daily recovery meditation books, poetry (e.g., the published work of Steven Ackerman, Patricia Allen, Shirley Ann Pendleton, Gene Quinn, George Solomon), and recovery magazines (e.g., Choices, Recovery Solutions, Wellbriety),
- Recovery themed media and entertainment, including cinema and drama, recovery radio programs (e.g., Recovery Coast to Coast, Recovery Talk, Take 12 Recovery Radio), and recovery-informed comedy (e.g. recovery influences on the work of Whoopi Goldberg, Robin Williams, Margaret Cho, and Mark Lundholm),
- Recovery themed music—the emergence of sober music festivals, recovery-themed lyrics (see also http://www.12stepradio.com/playlist.php), and popular recovery themed CDs (e.g., SHARE—Songs of Hope, Awareness and Recovery for Everyone),
- Recovery themed folk art (see http://alcoholicoutsiderartist.blogspot.com),
- the growing proliferation of personal trappings of recovery, e.g., chips, buttons, key chains, jewelry, hats, t-shirts, bumper stickers, posters, and plaques,
- the emergence of a recovery leisure industry (e.g., alcohol and drug free vacations, recovery cruises, organized social outings, pilgrimages to iconic locations, e.g., Dr. Bob's home in Akron, Ohio), and
- the growth of national and local recovery celebration and recovery advocacy events.

Addicted people have long been cloistered in subterranean subcultures with their own language, values, symbols, and folkways—worlds so complete and closed that individuals become as dependent on these cultures as the drugs these cultures celebrate. The challenge of recovery for those enmeshed in these cultures is often not an insufficient will to recover but how to escape the pull of the culture of addiction and find a new world in which to recover (White, 1996). That alternative world has been under construction for many decades and is now undergoing rapid development.

In 1976, 52 prominent Americans publicly disclosed their long-term recovery status in the National Council of Alcoholism's Operation Understanding. That "coming out" was a watershed moment in the history of alcoholism in America. In 2007, more than 30,000 recovering people and their families participated in recovery celebration events as part of National Recovery Month. Recovering people and their families are awakening both culturally and politically.

Implications

So what does this all mean for the addictions professional and the addiction treatment organization? Perhaps most importantly, it will require addiction professionals and the leaders of treatment institutions to redefine our own identities and our relationships with these increasingly diverse communities of recovery and to then find our niche within this more fully developed culture of recovery. Are we a part of this growing recovery culture/community or separate from it? What are our accountabilities to this community? How can we best serve this community and its members? What is our role in supporting continued recovery community institution building? Are there actions we could take or fail to take that would inadvertently harm this community and its future development? These are just a few of the questions we will be discussing in the days ahead.

For our clients, there is exceptionally good news to be found within these trends. The most critical tipping point in recovery is the transition from recovery initiation to long-term recovery maintenance. The success or failure of this transition often has as much to do with community recovery capital as personal recovery capital. As local communities of recovery come to see themselves as members of a larger and more embracing recovery community and build new institutions and services that address their common needs, greater numbers of our clients will find a world in which to recover. These clients will need addiction professionals to serve as knowledgeable guides of this recovery terrain. We must all become students of this burgeoning culture of recovery in America.

Acknowledgment: I wish to thank Jim Russell, of Oklahoma Faces and Voices of Recovery, for assisting me with the research for this article.

About the Author: William L. White is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.*

References

Bacharach, S. B., Bamberger, P. A., & Sonnenstuhl, W. J. (1996). MAPs: Labor-based peer assistance in the workplace. *Industrial Relations, 35*(2), 261-275.

Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.

Humphreys, K. (2006). Closing remarks: Swimming to the horizon—reflections on a special series. *Addiction*, *101*, 1238-1240.

Iverson, C. (2007). Roots of America in Recovery: Stories of strength, hope, experience in the workplace. Accessed October 24, 2007 at: http://www.facesandvoicesofrecovery.org/pdf/Publications/2006_08_Venturetech.pdf.

Jason, L.A., Davis, M.I., Ferrari, J.R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education, 31*(1), 1-27.

Jason, L.A., & Kobayashi, R.B. (1995). Community building: The next frontier. *The Journal of Primary Prevention*, *15*(3), 195-208.

Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health*, *96*, 1727-1729.

Johnson, R., Martin, N., Sheahan, T., Way, F., & White, W. (in press). *Recovery Resource Mapping: Results of a Philadelphia Recovery Home Survey*. Philadelphia, PA: Department of Behavioral Health and Mental Retardation Services.

Kurtz, E., & Kurtz, L. (2007). *Mutual Support Resources*. Retrieved from http://www.facesandvoicesofrecovery.org/resources/support_home.php

Kurtz, E., & White, W. (2007). *Telephone- and Internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Oxford House (2006). *Oxford House come of age: Oxford House—The model*. Presented at the 8th Oxford House World Convention, Wichita, KS, September 21-24, 2006.

Sanders, M. (2002). The response of African American communities to addiction: An opportunity for treatment providers. *Alcoholism Treatment Quarterly, 20*(3/4), 167-174.

Valentine, P., White, W., & Taylor, P. (2007). The recovery community organization: Toward a definition. Retrieved from http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf.

White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

White, W. (2001a) Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly, 19*(1), 1-21.

White, W. L. (2001b). Recovery university: the campus as a recovering community. *Student Assistance Journal, 13*(2), 24-26.

White, W. (2004). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction, 99*, 532-538.

White, W. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

White, W. (2007). The new recovery advocacy movement in America. *Addiction, 102,* 696-703.

White, W., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor, 7*(2), 54-58.

White, W., & Kurtz, E. (2006a). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

White, W., & Kurtz, E. (2006b). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61.

White, W., & Laudet, A. (2006). Spirituality, science and addiction counseling. *Counselor Magazine, 7*(1), 56-59.

White, W., & Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, *6*(4), 58-61.

White, W., & Taylor, P. (2006). A new recovery advocacy movement. Retrieved from www.facesandvoicesofrecovery.org

White, W., & Whiters, D. (2005). Faith-based recovery: Its historical roots. *Counselor, 6*(5), 58-62.

Williams, C. with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. New York, NY: Harper San Francisco.

Wilson, B. (1944). Bill's comments on Wylie ideas, hunches. *A.A. Grapevine, 1*(4), 4.



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. (2008). The culture of recovery in America: Recent developments and their significance. Counselor, 9(4), 44-51. Posted at **www.williamwhitepapers.com**

The Culture of Recovery in America: Recent Developments and Their Significance

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

For the past nine years, the articles in this column of *Counselor* have sought to educate addiction professionals about the rich history of addiction treatment and recovery in America and to highlight emerging trends that are of historical import. We have often noted history's propensity to repeat itself, but viewing all events in terms of these cycles can blind us to that which is fundamentally new.

For almost three centuries, people recovering from severe alcohol and other drug problems have created healing sanctuaries to share their experience, strength, and hope and to meet specific needs they faced in initiating and sustaining their recovery journeys. History suggests that when a vacuum of unmet needs reaches critical mass, recovering people, their families, and visionary professionals coalesce into movements that birth new structures of recovery support. That critical mass—spawned in great part by the restigmatization, demedicalization, and recriminalization of addiction in the 1980s and 1990s—has been reached again, and the resulting scope and depth of recovery community building activities in America is without historical precedent.

In this article, we will explore these recovery community building activities and the influence they will exert on the future of addiction treatment. We will begin by summarizing the small stories and then connect the dots of these stories to see the larger picture that is emerging and its import.

Growth and Diversification of Recovery Mutual Aid Societies

The roads to recovery are many.
--AA Co-founder Bill Wilson, 1944

Addiction recovery mutual aid groups have a long and rich history dating to the 1730s (White, 2001a; Coyhis & White, 2006). The past 30 years are striking in terms of new recovery mutual aid societies, the scope of recovery mutual aid participation (as measured by the number of registered groups and total membership of all groups) (Humphreys, 2004), and the diversification of group goals (spanning moderation and abstinence) and program

philosophies (spanning religious, spiritual, and secular pathways of recovery) (White & Whiters, 2005; White & Nicolaus, 2005; White & Laudet, 2006). Also noteworthy is the geographical dispersion of local recovery support groups throughout North America and the world (Humphreys, 2004; White, 2004).

More than any previous period in history, American communities are likely to have local recovery mutual aid meetings and a choice of such meetings within and across frameworks of recovery. The Faces and Voices of Recovery mutual aid guide contains more than 25 addiction recovery support societies (Kurtz & Kurtz, 2007). The "recovery community"—a term once used to refer collectively to members of local Twelve Step groups—has morphed into diverse "communities of recovery" who, as they interact and come together on issues of mutual interest, are forming a new consciousness of themselves. This newly emerging "recovery community" encompasses people from diverse recovery support groups and new recovery support institutions who are defining themselves as a community based on their recovery status and not the method or support group through which that recovery was achieved or sustained (White & Kurtz, 2006a). Transcending the competition and animosity that sometimes plagued their view of each other, members of these groups are more likely today to view all successful recovery pathways as cause for celebration.

Adding to the growth of recovery support structures is a renewed interest on the part of addiction treatment institutions in open-ended continuing care groups, consumer councils, alumni associations, and peer-based volunteer service programs. This marks a trend of lowering treatment intensity but increasing treatment extensity through the delivery of long-term recovery support services (Humphreys, 2006).

Virtual Recovery Communities

One of the most recent and historically significant trends is the growth of Internet-based recovery support meetings and the emergence of broader online recovery communities. What we know about these groups and communities at the present time is that they:

- began in the early 1980s and evolved in tandem with the WorldWideWeb,
- represent a broad spectrum of religious, spiritual, and secular recovery support groups,
- are rapidly growing in numbers and diversity,
- constitute both an adjunct and an alternative to face-to-face recovery support meetings, and
- attract members who would not otherwise participate in support group meetings, e.g., women, status-conscious professionals, adolescents, persons with disabilities, and persons living in isolated communities without recovery support groups (Kurtz & White, 2007).

In a recent review of Online recovery support groups, Kurtz and White (2007) expressed surprise at how many people were effectively and almost exclusively relying on online communications as their primary source of recovery support (Kurtz & White, 2007). The future of virtual recovery communities is hard to predict, but a day may come when the number of those supporting their recovery via online communication will approach and then far exceed the number of those participating in face-to-face recovery support meetings.

Recovery Advocacy Movement

Recovering people and their families and allies are forging grassroots recovery community organizations around four core activities: 1) political advocacy for pro-recovery laws and social policies, 2) public and professional recovery education, 3) the provision of non-clinical (peer-based) recovery support services, and 4) recovery celebration events. This new addiction recovery advocacy movement has arisen outside of and without affiliation with existing recovery mutual aid societies. Individuals

and families representing diverse recovery pathways are standing together, not as members of Alcoholics Anonymous, Women for Sobriety, Secular Organization for Sobriety, or Alcoholics Victorious, but as men and women in long-term recovery sharing common experiences, needs, and interests. This movement has national organizations representing its collective interests[1], a distinctive set of values and core ideas, a broad range of strategies through which it is pursuing its goals, and the financial support of recovering people and public and private organizations (White, 2006; White & Taylor, 2006; White, 2007).

The new *recovery community organizations* (RCO) that make up this grassroots movement constitute a new type of organization that existed earlier only within some of the local affiliates of the National Council of Alcoholism and Drug Dependence. RCOs stand as distinct organizational and service structures apart from both professionally-directed addiction treatment and addiction recovery mutual aid societies (Valentine, White, & Taylor, 2007). They are also creating new service institutions (e.g., *recovery community centers*) and pioneering new service roles (e.g., *recovery coaches*) that are offering a wide range of non-clinical recovery support services. A national directory of these grassroots organizations is posted at the Faces and Voices of Recovery website (see http://www.facesandvoicesofrecovery.org/regions).

Recovery Home / Colony Movement

Recovery homes are alcohol- and drug-free houses whose residents support each other in their recovery from addiction. They are NOT treatment centers nor are they "halfway houses"—staff-directed way stations between the treatment institution and the community. The current recovery home movement has been inspired to a great degree by the success of Oxford House, which was founded in 1975 and which has grown to more than 1,200 recovery homes in 48 states. More than 24,000 people in recovery a year reside in Oxford Houses. The Oxford House model has several distinctive features that have influenced the recovery home movement: democratic self-management, financial self-support of each home, reliance on support from peers rather than paid staff, no time limit on how long an individual can live at a home, and the expulsion of any individual who uses alcohol or drugs (Oxford House, 2006).

The growth of the recovery home movement was fueled by two factors. The first was the Federal Anti-Drug Abuse Act of 1988 (P.L. 100-690), which required states to establish a revolving fund for loans to recovering individuals to rent a house to establish a recovery home. The second influence was the accumulation of scientific studies documenting the exceptionally high continual abstinence rate within the Oxford Houses—research that confirms the real potential of the Oxford House slogan "Recovery without relapse." (Oxford House, 2006; Jason, Davis, Ferrari, & Bishop, 2001; Jason, Olson, Ferrari, & Lo Sasso, 2006).

Self-managed recovery homes are spreading rapidly in the U.S. A recently completed survey of recovery homes in the City of Philadelphia revealed more than 250 recovery homes that on any given day house more than 1,500 men and women (Johnson, Martin, Sheahan, Way, & White, in press). As recovery homes congregate in particular areas of a city (sometimes on the property of or in close proximity to institutions with which they are closely connected, e.g., churches, treatment institutions, or schools), they form a recovery campus that often includes a wide spectrum of recovery support services and relationships. Leonard Jason and Robyn Kobayashi (1995, p. 204) note that such "comprehensive healing environments" may

[1] Faces and Voices of Recovery, the National Council on Alcoholism and Drug Dependence, the Johnson Institute, the Legal Action Center.

be the wave of the future. Persons in recovery who purchase homes and then rent them to other people in recovery are a central part of the hidden story of the recovery home movement and its rapid growth.

Recovery colonies—at present a network or faith-based recovery communities modeled on early (Keswick Colony of Mercy) and more recent (Dunklin Memorial Camp) programs providing a mixture of a recovery-based residential community, service to the larger community and preparatory training for urban and rural recovery ministries. The reader might visualize such a colony (Dunklin)by imaging a Florida wilderness dotted with dormitories, staff residences, homes for visiting families and the families in recovery, a mess hall, tabernacle, school, computer lab, library, lumber mill, furniture workshop, hog and cattle pens, fruit groves and sugar cane fields, a health clinic, rodeo grounds, and a cemetery. This is a self-sustained recovery community built upon the shared religious vision experienced more than four decades ago by Micky and Laura Maye Evans.

Recovery Schools

One of the newest recovery community institutions is the recovery school. Between 1977 and 2000, collegiate recovery school programs were established at Brown University, Rutgers University, Texas Tech University, and Augsburg College. An additional five collegiate recovery programs were established between 2001 and 2004 at Dana College, Grand Valley State University, Case Western Reserve University, the University of Texas at Austin, and Loyola College in Maryland. Since Ecole Nouvelle (now Sobriety High) in Minnesota was opened in 1986 as the first recovery high school, the growth of high school programs specifically for recovering students has quickened. Twenty-five recovery high schools opened across the United States between 1999 and 2005. This rapid growth sparked the formation of the Association of Recovery Schools (White & Finch, 2006).

Recovery school programs vary widely but generally combine special recovery support services with an emphasis on academic excellence. The former may include special faculty guidance, recovery dorms, recovery support meetings, recovery drop-in centers, sober social activities, and peer mentoring. The latter is achieved through academic guidance, study centers, and peer-tutoring programs. Preliminary studies of these programs have noted high rates of uninterrupted abstinence (70-80%), early intervention and retention of students following a lapse, and excellent academic performance as measured by grades (above the student average), attendance (90-95%), and the number of students in recovery high schools going on to college (65%)(White, 2001b; White & Finch, 2006).

Recovery Industries

How do people who have never had legitimate employment or who have lost such employment due to their addictions enter or re-enter the mainstream workforce? The growth of recovery industries is offering one answer to this dilemma. A recovery industry is a business that purposely recruits, trains, and employs people in recovery. Such jobs may constitute a permanent employment position or a transitional position that helps a person develop a work history and references to obtain employment with mainstream businesses and industries. Recovery industries provide jobs in a recovery-conducive work environment, but they also offer recovering people an opportunity for skill development and a pathway of entry or re-entry back into conventional society. These industries play a special role in addressing the needs of individuals who are re-entering community life following prolonged addiction careers and periods of drug-related incarceration.

An example of a recovery industry is Recovery at Work (RAW), operated by a partnership between Recovery Consultants of Atlanta and Peace Baptist Church. RAW is typical of the growing phenomena of small recovery industries. RAW regularly employs

up to 20 full-time people in recovery to work within its construction and painting projects in the Atlanta area. Since its inception in 2003, RAW has hired more than 80 individuals in recovery.

Another variation of recovery industries are businesses whose owners or managers are in recovery or who have found hiring people in recovery a good business practice. These individuals have consciously created a recovery friendly work environment and seek out people in recovery to fill all open job positions. Venturetech, a Houston-based company that designs and manufactures hydraulic drills, is such a business. Its success in hiring people in recovery inspired its leaders to set up a separate not-for-profit organization to promote the practice of hiring people in recovery (See www.Americainrecovery.org) (Iverson, 2007).

Two other important workplace related developments are the growth of occupational recovery support groups and the spread of labor assistance programs. Occupational recovery support groups include such groups as International Doctors in Alcoholics Anonymous, International Lawyers in Alcoholics Anonymous, Anesthetists in Recovery, International Nurses in Alcoholics Anonymous, International Pharmacists in Alcoholics Anonymous, Veterinarians in Recovery, and the Recovered Alcoholic Clergy Association. Labor assistance programs, also called member assistance programs, are peer-based recovery support programs that are being developed by a growing number of labor unions (Bacharach, Bamberger, & Sonnenstuhl, 1996).

Recovery Ministries/Churches

Special ministries to alcoholics and addicts began in the closing decades of the Nineteenth century through religiously sponsored urban rescue missions and the creation of rural inebriate colonies. This movement was spawned by such pioneering institutions as the Water Street Mission in New York City and the Salvation Army. A resurgence of such ministries was spawned by the rise of juvenile narcotic addiction in the 1950s and 1960s—ministries that included street outreach (e.g., the work of Father Dan Egan, the "Junkie Priest", in New York City), outpatient counseling clinics (e.g., Saint Mark's Clinic in Chicago), and residential rehabilitation programs (e.g., Teen Challenge).

The involvement of the church in the problem of addiction is not new, but this involvement has taken some stunning new turns in recent years. These recent developments exist on a continuum of involvement that span:

- "Recovery friendly churches" that welcome recovering people but offer no special recovery services,
- Churches spawning new religiously sponsored recovery mutual aid groups, e.g., Celebrate Recovery, Ladies Victorious,
- Mega-churches adding a "recovery pastor" to their staff,
- Small churches using lay leaders and volunteers to lead recovery support meetings,
- Church-sponsored, recovery-focused worship services, workshops, leadership training, and children's programs,
- Recovery Churches, e.g., Central Park Recovery Church in St. Paul, Minnesota, the Recovery Church in Charlotte, North Carolina, and the Christian Recovery Fellowship in Dryden, Maine, for whom recovery is a central part of their identities as religious communities,
- New faith-based recovery colonies (residential communities), e.g., Dunklin Memorial Camp in Okeechobee, Florida,
- A new association of recovery ministries, i.e., the National Association for Christian Recovery (http://www.nacronline.com), and
- The growth of non-Christian recovery ministries and support groups, e.g., Millati Islami.

The religious branches of the American recovery movement are experiencing a period of awakening and a degree of movement into the mainstream church that is historically unprecedented. This trend is particularly evident in African American communities (Williams, 1992; Sanders, 2002).

Recovery Culture Development

Each of the preceding sections constitutes a noteworthy story in its own right, but to what extent do these individual stories tell a larger story—a story of unprecedented institution building within the American recovery community? The civil rights movement, the women's movement, and the gay rights movement—to name a few important modern social movements—each transitioned from a stage of heightened social consciousness to a stage of cultural renewal and community building. The consciousness raising stage was marked by increased group cohesion and a redefinition of personal and collective identity. The latter stage involved recapturing lost history and culture as well as forging new values, a new language of discourse, new art forms, new social institutions, and new rituals of gathering, protest, and celebration. This same process is underway in America among individuals and families recovering from addiction. A fully developed "culture of addiction recovery" is now emerging in America (White, 1996).

The institution building described above—the diversification of recovery mutual aid societies; the new recovery advocacy movement; new recovery community organizations; and the growth of recovery homes and colonies, recovery schools, recovery industries, and recovery ministries, is all unfolding within a larger process of recovery culture development. That process of cultural refinement is evident in:

- a growing interest in the history of recovery and recovery mutual aid societies,
- a growing preoccupation with and advocacy about the language of addiction and recovery (White, 2006),
- recovery literature that includes an unprecedented number of recovery biographies, serial fiction whose central characters are in recovery (e.g., James Lee Burke's Dave Robicheax, Joe Hilley's Mike Connally, Lawrence Block's Matt Scudder), daily recovery meditation books, poetry (e.g., the published work of Steven Ackerman, Patricia Allen, Shirley Ann Pendleton, Gene Quinn, George Solomon), and recovery magazines (e.g., Choices, Recovery Solutions, Wellbriety),
- Recovery themed media and entertainment, including cinema and drama, recovery radio programs (e.g., Recovery Coast to Coast, Recovery Talk, Take 12 Recovery Radio), and recovery-informed comedy (e.g. recovery influences on the work of Whoopi Goldberg, Robin Williams, Margaret Cho, and Mark Lundholm),
- Recovery themed music—the emergence of sober music festivals, recovery-themed lyrics (see also http://www.12stepradio.com/playlist.php), and popular recovery themed CDs (e.g., SHARE—Songs of Hope, Awareness and Recovery for Everyone),
- Recovery themed folk art (see http://alcoholicoutsiderartist.blogspot.com),
- the growing proliferation of personal trappings of recovery, e.g., chips, buttons, key chains, jewelry, hats, t-shirts, bumper stickers, posters, and plaques,
- the emergence of a recovery leisure industry (e.g., alcohol and drug free vacations, recovery cruises, organized social outings, pilgrimages to iconic locations, e.g., Dr. Bob's home in Akron, Ohio), and
- the growth of national and local recovery celebration and recovery advocacy events.

Addicted people have long been cloistered in subterranean subcultures with their own language, values, symbols, and folkways—worlds so complete and closed that individuals become as dependent on these cultures as the drugs these cultures celebrate. The challenge of recovery for those enmeshed in these cultures is often not an insufficient will to recover but how to escape the pull of the culture of addiction and find a new world in which to recover (White, 1996). That alternative world has been under construction for many decades and is now undergoing rapid development.

In 1976, 52 prominent Americans publicly disclosed their long-term recovery status in the National Council of Alcoholism's Operation Understanding. That "coming out" was a watershed moment in the history of alcoholism in America. In 2007, more than 30,000 recovering people and their families participated in recovery celebration events as part of National Recovery Month. Recovering people and their families are awakening both culturally and politically.

Implications

So what does this all mean for the addictions professional and the addiction treatment organization? Perhaps most importantly, it will require addiction professionals and the leaders of treatment institutions to redefine our own identities and our relationships with these increasingly diverse communities of recovery and to then find our niche within this more fully developed culture of recovery. Are we a part of this growing recovery culture/community or separate from it? What are our accountabilities to this community? How can we best serve this community and its members? What is our role in supporting continued recovery community institution building? Are there actions we could take or fail to take that would inadvertently harm this community and its future development? These are just a few of the questions we will be discussing in the days ahead.

For our clients, there is exceptionally good news to be found within these trends. The most critical tipping point in recovery is the transition from recovery initiation to long-term recovery maintenance. The success or failure of this transition often has as much to do with community recovery capital as personal recovery capital. As local communities of recovery come to see themselves as members of a larger and more embracing recovery community and build new institutions and services that address their common needs, greater numbers of our clients will find a world in which to recover. These clients will need addiction professionals to serve as knowledgeable guides of this recovery terrain. We must all become students of this burgeoning culture of recovery in America.

Acknowledgment: I wish to thank Jim Russell, of Oklahoma Faces and Voices of Recovery, for assisting me with the research for this article.

About the Author: William L. White is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.*

References

Bacharach, S. B., Bamberger, P. A., & Sonnenstuhl, W. J. (1996). MAPs: Labor-based peer assistance in the workplace. *Industrial Relations, 35*(2), 261-275.

Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.

Humphreys, K. (2006). Closing remarks: Swimming to the horizon—reflections on a special series. *Addiction*, *101*, 1238-1240.

Iverson, C. (2007). Roots of America in Recovery: Stories of strength, hope, experience in the workplace. Accessed October 24, 2007 at: http://www.facesandvoicesofrecovery.org/pdf/Publications/2006_08_Venturetech.pdf.

Jason, L.A., Davis, M.I., Ferrari, J.R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education, 31*(1), 1-27.

Jason, L.A., & Kobayashi, R.B. (1995). Community building: The next frontier. *The Journal of Primary Prevention*, *15*(3), 195-208.

Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health*, *96*, 1727-1729.

Johnson, R., Martin, N., Sheahan, T., Way, F., & White, W. (in press). *Recovery Resource Mapping: Results of a Philadelphia Recovery Home Survey*. Philadelphia, PA: Department of Behavioral Health and Mental Retardation Services.

Kurtz, E., & Kurtz, L. (2007). *Mutual Support Resources*. Retrieved from http://www.facesandvoicesofrecovery.org/resources/support_home.php

Kurtz, E., & White, W. (2007). *Telephone- and Internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Oxford House (2006). *Oxford House come of age: Oxford House—The model*. Presented at the 8th Oxford House World Convention, Wichita, KS, September 21-24, 2006.

Sanders, M. (2002). The response of African American communities to addiction: An opportunity for treatment providers. *Alcoholism Treatment Quarterly, 20*(3/4), 167-174.

Valentine, P., White, W., & Taylor, P. (2007). The recovery community organization: Toward a definition. Retrieved from http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf.

White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

White, W. (2001a) Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly, 19*(1), 1-21.

White, W. L. (2001b). Recovery university: the campus as a recovering community. *Student Assistance Journal, 13*(2), 24-26.

White, W. (2004). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction, 99*, 532-538.

White, W. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

White, W. (2007). The new recovery advocacy movement in America. *Addiction, 102,* 696-703.

White, W., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor, 7*(2), 54-58.

White, W., & Kurtz, E. (2006a). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

White, W., & Kurtz, E. (2006b). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61.

White, W., & Laudet, A. (2006). Spirituality, science and addiction counseling. *Counselor Magazine, 7*(1), 56-59.

White, W., & Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, *6*(4), 58-61.

White, W., & Taylor, P. (2006). A new recovery advocacy movement. Retrieved from www.facesandvoicesofrecovery.org

White, W., & Whiters, D. (2005). Faith-based recovery: Its historical roots. *Counselor, 6*(5), 58-62.

Williams, C. with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. New York, NY: Harper San Francisco.

Wilson, B. (1944). Bill's comments on Wylie ideas, hunches. *A.A. Grapevine, 1*(4), 4.



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. & Chaney, R.A. (2008). Intergenerational patterns of resistance and recovery within families with histories of alcohol and other drug problems: What we need to know. Posted at **www.williamwhitepapers.com**

Commentary
Generational Patterns of Resistance and Recovery Among Families with Histories of Alcohol and Other Drug Problems: What We Need to Know

William L. White, M.A. and Rita A. Chaney, M.S.

The authors have spent decades observing individuals with severe alcohol and other drug (AOD) problems achieve stable recovery and enhanced quality of life. The ability of individuals and families to enjoy the fruits of such recoveries is all too often interrupted by encounters with these same problems in the lives of extended family members, parents, siblings, or one's own children. This common dilemma within the life course of recovery is the subject of this short essay.

Clinical interventions with alcohol and other drug problems in America have been grounded historically in studies of the pathology of alcohol and drug problems (e.g., extensive studies of the history, epidemiology, psychopharmacology, and personal and social consequences of prolonged and excessive AOD use). We, as a country and as a professionalized addictions field, know a lot about psychoactive drugs, drug consumption trends, the multiple pathways through which people develop AOD problems, and the neurobiological adaptations that contribute to alcohol and other drug dependence. We have also learned a great deal from studies of various approaches to the diagnosis and treatment of substance use disorders. But what do we know from the standpoint of science as a culture and as a profession about the prevalence, neurobiology, pathways, styles and stages of long-term recovery from AOD problems? There are emerging calls to extend the field's pathology and intervention paradigms to a recovery paradigm (Erickson & White, submitted for publication; Laudet, 2008; White, 2005; White, 2007b). This shift would create a more substantive body of empirical evidence capable of answering questions that are critical to people attempting to initiate recovery, maintain recovery, and enhance the quality and meaningfulness of their lives in recovery.

A growing number of American addiction scientists and recovery advocates are calling upon the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to co-develop, co-fund, and co-disseminate the

findings of a comprehensive recovery-focused research agenda (Laudet, 2008; Laudet & White, 2008; White, 2000). A recent (May, 2008) conference in Philadelphia (*Aligning Concepts, Practices and Contexts to Promote Long-Term Recovery: An Action Plan*) sought to articulate the beginnings of just such an agenda. Similar discussions occurred among key stakeholders (systems administrators, treatment providers, researchers/evaluators, recovery support services providers, representatives from recovery mutual aid groups and recovery advocates) at the Center for Substance Abuse Treatment's 2005 Recovery Summit. A solutions-focused knowledge base is crucial for developing family and community environments that can support long-term recovery and prevent the continued development of AOD problems within our most vulnerable populations.

In this paper, we will focus on one issue—the mechanisms through which individuals with intergenerational histories of severe alcohol and other drug problems resist developing or recover from such problems. We will use this discussion to illustrate just how much we do not know about some of the most critical issues facing recovering people and their families.

Unanswered Questions

Scientific studies confirm that alcohol and drug problems can be and often are transmitted across generations via complex biological, psychological, and social processes. We are beginning to learn more about the risk factors that contribute to this problem transmission across and within generations of family members, e.g., genetic vulnerability, prenatal alcohol/drug exposure, early age of onset of AOD use, parental/sibling modeling of excessive AOD use, drug culture socialization, defective parenting, physical/emotional deprivation/trauma/abandonment, exposure to domestic violence, and isolation from support outside the family (Capone & Wood, in press; Grant & Dawson, 1997; Merickangas, Stolar, Stevens, et al, 1998; Miles, Stallings, Young, et., al, 1998; Nature Neuroscience, 2005). But unanswered as of now are perhaps the most important two questions: 1) How do individuals with a family history of AOD problems and related risk factors resist the development of AOD problems over the course of their lives? 2) How do family histories of AOD problems and the outcomes of those problems affect individual recovery prospects and processes of other affected family members?

We know that AOD use of individuals within one's immediate living environment exerts an influence on treatment/recovery outcomes (Godley, Kahn, Dennis, Godley, & Funk, 2005; Laudet, Morgen, & White, 2006; McCrady, 2004). In situations where intimate partners are both addicted, the post-treatment recovery or re-addiction of one partner is predictive of the recovery or addiction of the other partner (Hser, 2007; McAweeney, Zucker, Fitzgerald, Puttler, & Wong, 2005). But the role of recovery status of one family member in influencing intergenerational and intragenerational patterns of resistance and recovery for other family members remains a frontier of primarily unanswered questions.

Consider the more detailed questions below that are of concern to anyone imbedded within a family history of alcohol and other drug problems. The terms *resist* and *resistance* as used here refer to the process through which individuals who are high risk for the development of AOD problems successfully avoid developing such problems. The term *recovery* refers to the process through which individuals with severe AOD problems resolve these problems, improve their global health and enhance their participation in and contributions to the life of their communities (White, 2007a).

1. How is the course of a substance use disorder (SUD) and the prospects of successful long-term recovery affected by the presence or absence of SUDs in one's family history? Does recovery of family members from earlier generations or one's own generation constitute a special form of family recovery capital

that increases one's odds of successful recovery?[1] Is there any evidence of intragenerational or intergenerational learning or family adaptation to SUD risks? (The intent here is the development of a knowledge base that allows us to move beyond just treatment of individuals to strategies aimed at stemming the processes through which AOD problems are intergenerationally transmitted.)

2. What influence, if any, does an AOD-related adverse experience (e.g., hospitalization, job loss, divorce, arrest, incarceration) of one family member have on SUD resistance and recovery initiation or maintenance of other family members?

3. What influence, if any, does an AOD-related death of one family member have on the resistance, recovery initiation or recovery maintenance of other family members? Does the type of death (e.g., overdose, accident, medical complications, suicide, or victim of violence) mediate such influence? What effect does infliction of death upon another by an addicted family member (e.g., an act of violence, death of another resulting from drinking and driving) have on the resistance or recovery prospects of other family members?

4. Do identical twins born within family trees with histories of AOD problems share the same patterns of resistance and recovery? If not, what factors are related to differences in their resistance and recovery experiences?

5. If a son or daughter is at increased risk of developing a SUD because they and one or both parents share a family history of such disorders, do the children have less risk of developing a SUD if the parent is in stable recovery? If one or more children were to develop an SUD, are their prospects of recovery better because of the parent's recovery?

6. Does the degree of density of recovery among family network members with SUDs influence the resistance and recovery odds of coming generations within this family? (Density could be measured by the number or percentage of all family and extended family members with SUDs who achieved stable recovery.) Is there a recovery "tipping point" within families when intergenerational transmission slows or ceases?

7. Are intergenerational resistance and recovery gender-linked, e.g., are sons of recovering fathers less likely to develop or more likely to recover from a SUD than daughters of recovering fathers? What other factors influence resistance and recovery, e.g., role of the family member in recovery (grandparent, aunt/uncle, cousin, parent, sibling); birth order of the person in recovery (e.g., older sibling versus younger sibling), family member status (blood, adopted, foster), parental status (blood versus step-parent), degree of physical contact (e.g., recovering person residing within or outside the home), and degree of emotional attachment with the family member in recovery?

8. How do the following factors influence the resistance and recovery odds of children whose parents are in recovery: AOD problem severity of the parent, primary drug choices of the parent and the child, developmental age of child at onset of parental recovery, degree of emotional attachment in the parent-child relationship, presence and degree/duration of adverse childhood

[1] Recovery capital is the quantity and quality of internal and external resources that can be mobilized to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999). There are different types of recovery capital, including personal recovery capital, family/social recovery capital and community/cultural recovery capital (White & Cloud, in press).

experiences, and presence of surrogate parental figures?

9. What strategies of prevention and early intervention can specifically lower the SUD risks of children of recovering parents or stop the development of AOD problems at an early stage? Are different strategies more successful with different at-risk populations or at different developmental ages?

10. Does participation of a family member in specialty sector addiction treatment and/or recovery mutual aid groups affect the resistance and recovery prospects of other family members? If so, are there particular types of treatment (e.g., family therapy) that have a greater effect on resistance and recovery of other family members? How does child participation in parental or sibling treatment affect the child's future resistance and recovery prospects? Would that outcome be influenced by the post-treatment recovery status of the family member who was treated? How does participation in child-focused peer support groups (e.g., Alatot, Alateen) or a developmentally appropriate, educational support group for children and adolescents affect subsequent resistance or recovery?

11. How do preferred recovery pathways differ for individuals with and without family addiction/recovery histories? Is the preferred recovery pathway of the parent or other family members predictive of the best recovery pathway for the child in this family who develops a SUD?

12. In what would be an interesting reversal of intergenerational transmission, does the addiction and recovery of a child influence that child's parents' prospects of addiction, resistance or recovery? Are there effects on sibling resistance and recovery under such circumstances?

13. How are resistance and recovery of persons in AOD-enmeshed family trees influenced by community recovery capital (i.e., the quantity and accessibility of local resources that assist people in resisting and recovering from AOD-related problems)?

14. Within families with histories of AOD problems, do patterns of intergenerational and intragenerational resistance and recovery differ across ethnic, cultural and religious groups? If so, how?

15. What general resiliency factors[2] within families and extended family networks enhance the odds of resistance and recovery?

16. What manner of presenting one's recovery status/story has the greatest influence on the resistance and recovery of other family members? What effect does degree of exposure of family members to communities of recovery exert on resistance and recovery?

17. Are there specific family activities, events or developmental issues that pose significant challenges to resistance and recovery? If so, what works to support resistance and recovery?

18. What effect does degree of exposure of family members to communities of recovery have on resistance and recovery? Are there other community supports such as faith-based organizations or opportunities for community activities/advocacy that strengthen resistance and recovery?

[2] Family protective, resiliency and recovery factors include rituals for family gathering, family communication skills, collective problem solving, personality compatibility, collective health and hardiness, mutual affection and support, shared values, connection to community resources, optimism and hope (McCubbin, McCubbin, Thompson, et la, 1997).

19. What are the sources of resistance among individuals with family histories of AOD problems who do not go on to develop AOD problems?

20. For parents with extensive intergenerational histories of AOD problems, are there any indicators or early warning signs suggesting which of their children might be at highest risk for AOD problem development? Are there any research-grounded responses that could lower the vulnerability, increase the resistance or enhance the future recovery prospects of these children?

21. Does personal or family recovery ameliorate the effects of historical trauma?[3] Is there a tipping point of healing through which individual/family recovery breaks the cycle of passing on the effects of historical trauma to new generations, e.g., Are the resistance and recovery rates of children in Native American communities elevated within communities whose adults and elders have achieved high rates of recovery?

The Search for Answers

With addiction treatment consciously moving towards a "recovery-oriented system of care" that places emphasis on the role of the family and community in long-term recovery processes, the need to answer the above questions will become more urgent. These questions are intensely personal and important to millions of individuals in long-term recovery. Why, after decades of addiction research, do we not have answers to these questions? Why, after decades of addiction research, have we not even had studies that asked these questions? We will know a recovery research agenda is a reality when such questions are asked and answered within the country's leading research centers. We will know that achievement is real when the fruits of that knowledge are accessible to all individuals and families in recovery. That day is long overdue.

Acknowledgements: We would like to thank the following individuals for helpful comments and suggestions on an early draft of this article: Mike Flaherty, Steve Hornberger, Joan King, Alexandre Laudet, Bob Savage, Jason Schwartz, and Richard Simone.

About the Authors: William L. White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems, Bloomington, IL. Rita A. Chaney is a Licensed Mental Health Counselor at Gulf Coast Health Services, Inc, Venice, FL.

References

Erickson, C. & White, W. (submitted for publication) Commentary: The neurobiology of addiction recovery.

Capone, C. & Wood, M.D. (in press). Density of familial alcoholism and its effects on alcohol use and problems in college students. *Alcoholism: Clinical and Experimental Research.*

Coyhis, D. (2008). What is historical trauma? (Presentation slides.) Colorado Springs, CO: White Bison, Inc.

Godley, M. D., Kahn, J. H., Dennis, M. L., Godley, S. H., & Funk, R. R. (2005). The stability and impact of environmental factors on substance use and problems after adolescent outpatient treatment for cannabis use or dependence. *Psychology of Addictive Behaviors, 19*(1), 62-70.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without*

[3] Historical trauma is the collective distress emanating from immense losses and traumatic events experienced by a whole people and passed intergenerationally through parent-child interactions and interactions with extended family and community members (Coyhis, 2008).

treatment. New York: New York University Press.

Grant, B. F., & Dawson, D. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. *Journal of Substance Abuse, 9,* 103-110.

Hser, Y.I. (2007). Predicting long-term stable recovery from heroin addiction: findings from a 33-year follow-up study. *Journal of Addictive Diseases,* 26:51-60.

Laudet, A.B. (2008). Building the science of recovery. Presented at the Recovery Symposium, May 1-2, Philadelphia, PA: Sponsored by the Northeast Addiction Technology Transfer Center.

Laudet, A, Morgen, K., & White, W. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*, *24*(102), 33-73.

Laudet, A.B. & White, W.L. (2008) Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse*, 43(1), 27-54.

McAweeney, M. J., Zucker, R. A., Fitzgerald, H. E., Puttler, L. I., & Wong, M. M. (2005). Individual and partner predictors of recovery from alcohol use disorder over a nine-year interval: Findings from a community sample of married men. *Journal of Studies on Alcohol*, *66*(2), 220-228.

McCrady, B.S. (2004). To have but one true friend: Implications for practice of research on alcohol use disorders and social networks. *Addictive Behaviors*, *18*(2), 113-121.

McCubbin, H.I., McCubbin, M.A., Thompson, A.I., Han, S-Y. & Allen, C.T. (1997). Families under stress: What makes them resilient? American Association of Family and Consumer Sciences Commemorative Lecture delivered by Hamilton I. McCubbin on June 22, 1997, in Washington, D. C.

Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M.A., Fenton, B., Zhang, H., O'Malley, S.S., & Rounsaville, B.H. (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, 55, 973-979.

Miles, D.R., Stallings, M.C. Young, S.E. Hewitt, J.K., Crowley, T.J., & Fulker, D.W. (1998). A family history and direct interview study of familial aggregation of substance abuse: the adolescent substance abuse study. *Drug and Alcohol Dependence*, 49, 105-114.

Nature Neuroscience (multiple authors of special issue). (2005). Focus on neurobiology of addiction. *Nature Neuroscience*. 8(11). Available at: http://www.nature.com/neuro/focus/addiction/index.html. Accessed July 12, 2007.

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly, 23*(1), 3-15.

White, W. (2000, April). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Presented at Recovery Community Support Program (RCSP) Conference, Washington, D.C. Posted at www.bhrm.org

White, W. (2007a) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241.

White, W. (2007b). In search of the neurobiology of addiction recovery: A brief commentary on science and stigma. Posted at: http://www.facesandvoicesofrecovery.org/pdf/White/White_neurobiology_2007.pdf.

White, W. & Cloud, W. (in press). Recovery capital: A primer for addictions professionals. *Counselor.*



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. (2008). Commentary: Spiritual guidance, addiction treatment and long-term recovery. *Journal of Substance Abuse Treatment*, 35(4), 443-444. Posted at **www.williamwhitepapers.com**

COMMENTARY

Spiritual Guidance, Addiction Treatment and Long-term Recovery

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Introduction

The potential role of spirituality in the resolution of severe alcohol and other drug problems is a foundational premise within the history of addiction treatment and recovery in the United States. The cultural dominance of spiritually-oriented treatment and recovery support societies has spawned professional and public debate, secular recovery support alternatives, and efforts to scientifically evaluate the role of spirituality in addiction recovery (White, 1998).

Early studies suggested that degree of spiritual orientation and spiritual experience exert a potent influence on the etiology, course and outcome of substance use disorders (Miller, 1998; Mathew, Georgi, Wilson, & Mathew, 1996). Spiritually-based professional treatment and recovery support groups were found to be acceptable to most individuals (Arnold, Avants, Margolin, & Marcotte, 2002; Winzelberg & Humphreys, 1999), and evaluation of spiritually-oriented treatment revealed long-term recovery outcomes equal to or superior to secular, evidence-based clinical protocols (Project MATCH Research Group, 1998).

The two studies of spiritual guidance during and following addiction treatment that were conducted by Miller, Forcechimes, O'Leary, and LaNoue (2008) and published in this issue of the *Journal of Substance Abuse Treatment* constitute the most methodologically rigorous and elegant attempts to date to scientifically evaluate a spiritually-grounded intervention within addiction treatment.

The Spiritual Guidance Clinical Trials

Miller and colleagues conducted two clinical trials (one following and one during inpatient treatment) of a 12-session, manual-guided spiritual guidance (SG) intervention. Each trial compared the SG intervention and standard treatment to a standard treatment only condition. Both studies failed to support the hypothesis that SG would increase post-treatment sobriety via increased daily

spiritual practices, increased meaning in life, and an increase in private religious practices. These studies are historically noteworthy because of the rigor of their design and execution and because their findings will be widely used (and potentially misused) within the debates between professional and lay advocates of religious, spiritual, and secular frameworks of addiction recovery. Some will mistakenly declare that "the science is in" and that the alleged role of spirituality in addiction recovery is nothing more than a myth. In an era in which far more abstracts and popular press summaries are read than scientific reports, much of the subtle nuances of Miller and colleagues' discussion of their findings risks being lost. This potential justifies multiple professional commentaries on these studies and an assertive response to any misrepresentation of study findings.

The Miller et al. SG studies constitute a rigorous evaluation of one approach to spiritual guidance offered as a component of acute care in one addiction treatment setting; they do not constitute an evaluation of the role of spirituality in long-term addiction recovery. The current SG studies mark the beginning of a new era of research on spiritual guidance, not the final statement on spirituality and addiction recovery.

Unanswered Questions

The SG studies raise many questions that will benefit future studies of spirituality, addiction treatment, and addiction recovery.

- How are the following defined and delineated: *spirituality*, *spiritual awakening*, *spiritual orientation*, *spiritual practices*, and *spiritual guidance*? What is the relationship between *spirituality*, *life meaning and purpose*, and *quality of life*?
- Does the essence of spiritual experience get lost in efforts to artificially define and replicate it within a professional treatment intervention? Are the ingredients of spiritually-oriented professional interventions the same as THE ingredients that people in long-term recovery self-report as transformative?
- Will individuals entering or leaving treatment voluntarily participate in a spiritually-based intervention? It is unclear in the two SG studies whether the low participation rates (means of 2.9 and 4.8 sessions attended of 12 sessions) were a function of the characteristics of study subjects, the design and content of the intervention offered, or were influenced by staff or organizational factors.
- Are there dose, duration, and timing effects of spiritually-oriented interventions? Would different outcomes of the SG studies have been achieved if the dose (number of sessions attended) had been larger or if SG had been delivered as a program for treatment alumni with at least one year of sobriety? Are the effects of spirituality and SG different across the long-term stages of recovery?
- What is the role of choice in the spirituality experience and the SG process? Does the "having had a spiritual awakening" effect of AA's Twelve Steps result from the individual ingredients of the steps, the cumulative effects of such ingredients, or the sequence in which these actions were taken? Are there greater effects from a focused exposure to a single spiritual philosophy/practice or, as with the SG studies, self-choosing exposure to multiple spiritual practices?
- Is there an ecology of spiritual experience? The milieu of the SG studies (addiction treatment institution) is markedly different than the milieu of Twelve Step and alternative recovery support groups (community of shared experience). What effects do physical and cultural environment exert on spiritual experience?
- Does the relational context matter? There is considerable difference

between the professional-client relationship with professionals not having prior experience working with addicted and recovering people (as in the SG studies) and relationships in recovery support groups that are characterized by moral equality, mutual vulnerability, mutual support, and long continuity of relationships.

- Are there potential iatrogenic effects of SG as suggested by the slowed improvement of depression and anxiety when compared to controls in the first SG study? Could mild iatrogenic effects occur in an early stage of an SG intervention that could be followed by substantial improvements (e.g., increased anxiety and depression while going through Steps Four and Five of Alcoholics Anonymous with significant improvements in emotional health following completion of these steps)?

The publication of scientific studies that do not find potent effects of interventions are as important as those that do find such effects, and it is the incremental nature of scientific knowledge that the former often lead to the latter. The recently published studies on spiritual guidance raise many important questions that will inform studies of the future. This is science at its best.

References

Arnold, R.M., Avants. S.K., Margolin, A., & Marcotte, S.J. (2002). Patient attitudes concerning the inclusion of spirituality into addiction treatment. *Journal of Substance Abuse Treatment, 23*, 319-326.

Mathew, R., Georgi, J., Wilson, W., & Mathew, V. (1996). Retrospective study of the concept of spirituality as understood by recovering individuals. *Journal of Substance Abuse Treatment, 13,* 67-73.

Miller, W. (1998). Researching the spiritual dimensions of alcohol and other drug problems. *Addiction*, *93*, 979-990.

Miller, W.R., Forcehimes, A., O'Leary, M., & LaNoue, M. (2008). Spiritual direction in addiction treatment: Two clinical trials. *Journal of Substance Abuse Treatment,* Issue, number and pages to be determined.

Project MATCH Research Group (1998). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research*, *22*, 1300-1311.

White, W. (1998) *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

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 Clinical and Consulting Psychology, 67,* 790-794.



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. (2011). Preface. *The Wellbriety Movement Comes of Age* by Don L. Coyhis. Aurora, CO: Coyhis Publishing, Inc. Posted at **www.williamwhitepapers.com**

Preface

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

When individuals, families and communities suffer sustained wounds, revitalization movements rise from the spirit of the people to bring hope, healing and health. The historical trauma experienced by Native Peoples inflicted deep wounds that have bled across generations. That sustained bleeding has left individuals, families and communities physically and spiritually depleted, but not defeated. There is more to this history than a legacy of addiction, disease and violence. There is the deep and rich tradition of resistance, resilience and recovery. That tradition is alive today in the Native American Wellbriety Movement. *The Fulfillment of Prophecy* is the story of the birth and growth of this Movement. It is also the story of the man who has been at the center of this movement.

I first met Don Coyhis in 2000 at a planning meeting aimed at bringing together leaders of grassroots recovery advocacy organizations from all over the United States. This meeting laid the foundation for the historic 2001 Recovery Summit that served as a catalyst for the new recovery advocacy movement. In the subsequent years, I have had the opportunity to collaborate with Don and witness the fruits of the Wellbriety Movement in both Native and non-Native communities. This Movement is offering simple but profound lessons.

1. The center of change is the talking circle—a place of belonging, trust and safety.

2. Healing movements must engage the head and the heart.

3. Lies must be expunged and truths told if healing is to occur.

4. The individual, family and community are one; hurting one hurts all, healing one heals all. Body, mind and spirit are one; hurting one hurts all, healing one heals all.

5. A great healing has begun.

6. Personal, family and community healing is guided by spiritual laws—the Medicine Wheel, the Cycle of the Seasons, the Laws of Change, the Prophecies.

7. Intergenerational healing must occur within the context of the community that was traumatized; the healing of historical

trauma cannot occur without justice and forgiveness.

8. Communities must draw wisdom from their oldest members, hope from their youngest and strength from those in between.

9. Community healing requires sober/spiritual leadership.

10. Healing and health rest on living in harmony with spiritual values, e.g., respect, honesty, integrity, willingness, cooperation, humility, forgiveness, perseverance, patience, service.

11. Traditional ways can and must be integrated into modern life.

12. People who have been part of the problem can become part of the solution

These lessons are so deeply rooted in Native American culture that one would not expect them striking a vibrant cord in other cultural communities, but that is precisely what has occurred. The Wellbriety Movement is pointing the way to health and wholeness across great cultural divides and has exerted a profound influence on the larger recovery advocacy movement in the United States.

Movements are about struggle and sacrifice, but they are also about success and celebration. A new generation is coming of age and seeking involvement in the Wellbriety Movement. They are asking questions of their elders about how this Movement began, how it evolved and their potential roles in its future. So let's join Ella and Joe in the coming pages as they learn from Uncle Don about the struggles and successes of the Wellbriety Movement.

Bill White

Author, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*

Co-author (with Don L. Coyhis), *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery—The Truth about the Lie*.



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: Evans, A.C., Achara, I., Lamb, R. and White, W. (2012). Ethnic-specific support systems as a method for sustaining long-term addiction recovery. *Journal of Groups in Addiction and Recovery*. 7(2-3), 171-188. Posted at **www.williamwhitepapers.com**

Ethnic-specific Support Systems as a Method for Sustaining Long-term Addiction Recovery

Although addiction recovery mutual aid support groups have grown dramatically and now span secular, spiritual, and religious frameworks of recovery, most of what is known from the standpoint of science about these groups is based on the early participation of treated populations in Alcoholics Anonymous. Many questions remain about the effects of participation in other mutual aid groups and different pathways and styles of recovery within and across diverse ethnic groups. This paper reviews existing data on ethnic group participation in recovery mutual aid groups, summarizes the history of culturally indigenous recovery movements within Native American and African American communities in the United States, and describes strategies aimed at increasing recovery prevalence and the quality of life in recovery for persons of color in Philadelphia, Pennsylvania, USA.

KEYWORDS: Addiction recovery, mutual aid, race, ethnicity, racial disparities, recovery support, recovery mutual aid

Introduction

The prevalence of alcohol and other drug (AOD) use and related problems and access to and participation in treatment and recovery support resources are not equally distributed across racial/ethnic groups in the United States (Caetano, Baruah, & Chartier, 2011; Chartier & Caetano, 2011; Mulia, Ye, Greenfield, & Zemore, 2009; Wallace, 1999). Although non-Whites experience remission from substance use disorders at rates comparable to Whites (Arndt, Vélez, Segre, & Clayton, 2010), AOD problems within communities of color have been historically portrayed in the mainstream media through a lens of pathology rather than through the perspectives of resilience, resistance, and recovery (White & Sanders, 2008). Pejorative racial stereotypes long imbedded within anti-drug campaigns in the United States have misrepresented the source, scope, and solutions to AOD-related problems within communities of color (Helmer, 1975; Leland, 1976; Musto, 1973; Neuspiel, 1996). If there is a yet untold addictions-related story at public and professional levels, it is the rich tradition through which communities of color have actively resisted the infusion of alcohol and drugs into their cultures,

adapted mainstream recovery support resources for cultural fit, and mounted indigenous responses to the rise of AOD-related problems (Coyhis & White, 2006; James & Johnson, 1996; White & Sanders, 2002; White, Sanders, & Sanders, 2006).

This article: 1) reviews the diffusion and adaptation of recovery mutual aid resources within communities of color, 2) outlines the history of abstinence-based religious and cultural revitalization movements as frameworks of addiction recovery within Native American and African American communities, and 3) describes culturally indigenous recovery support resources that are being utilized as adjuncts and alternatives to mainstream recovery mutual aid and addiction treatment organizations in the City of Philadelphia. An introductory caution is in order. U.S. *communities of color*—as a collective concept and in reference to particular ethnic groups—are characterized by substantial intra- and inter-group differences. The resulting limitations in drawing broad conclusions will require readers to test the viability of suggested principles and strategies within their respective local communities.

Ethnic Participation in Contemporary Addiction Recovery Mutual Aid Organizations

Addiction recovery mutual aid organizations are assemblies of individuals who have joined together for the sole purpose of rendering each other peer-based, non-professional support for the resolution of alcohol and other drug problems. Such groups have risen around the world within highly diverse cultural contexts, including the Swedish Links, Vie Libre (Free Life Movement), the Polish Abstainers Club, the Danshukai movement in Japan, and the Pui Hong Self-Help Association in China, to name just a few (White, 2004a). Alcoholics Anonymous and other 12-step groups have dominated addiction recovery mutual aid in the United States even as the spectrum of secular and explicitly religious alternatives to 12-step programs has grown in recent decades. This dominance elicited early criticisms that the 12-step program was based on the experience of white men and therefore inappropriate for historically disenfranchised minorities (For review, see White, 1998).

This particular criticism has not withstood historical and scientific analysis. First, AA and other 12-step programs exist and continue to grow throughout much of the world, including Latin America, the Middle East, Africa, and Asia, and representation of people of color in 12-step programs has progressively increased in the U.S. since their founding (White, 1998, 2004a). Second, scientific studies of ethnicity and AA have concluded that:

1) AA's view of alcoholism and its solution are widely accepted within communities of color (Caetano, 1993; Goebert & Nishimura, 2011).
2) Non-Whites affiliate with AA at similar or higher rates than Whites following professional treatment (Humphreys, Mavis, & Stoffelmayr, 1991, 1994).
3) African Americans have lower dropout rates in AA than do Whites (Kelly & Moos, 2003).
4) 12-step program emphasis on mutual support with a community of shared experience and its elevation of the role of spirituality in healing personal wounds are themes quite congruent with the cultures of many communities of color (Humphreys et al., 1994; White & Sanders, 2008).

Such conclusions may challenge the experience of many clinicians who have witnessed low engagement rates of clients of color within predominately White communities and mutual aid groups. It is the authors' experience that the engagement of people of color in predominately White mutual aid groups remains difficult until a certain critical mass of participation is reached, after which ethnic representation can grow quite dramatically.

There has been very little research on ethnic group participation across the spectrum of addiction recovery mutual aid organizations, but a glimmer of such participation can be gleaned from survey data published by key recovery mutual aid organizations. Table 1 summarizes the latest available survey data reported by White (2009a) for AA, Narcotics Anonymous, Cocaine

Anonymous, Secular Organization for Sobriety, Women for Sobriety, LifeRing Secular Recovery, and Moderation Management.

Table 1: Demographic Characteristics of Recovery Mutual-Aid Societies

Membership Ethnicity	AA (2007)	NA (2007)	CA	SOS (1992)	WFS (1992a.b)	LSR (2005)	MM (2004)
Caucasian	85.1%	70%	68%	99.4%	98%	77%	98%
African American	5.7%	11%	19%	*	1%	5%	*
Hispanic	4.8%	11%	6%	*	0%	4%	*
Asian American	2.8%		1%	*	0%	1%	*
Native American	1.6%		5%	*	0%	1%	*
Other (or no answer)		8%	1%	.6%	0%	12%	2%

Table 1 suggests substantial participation of non-Whites in 12-step programs but low rates of such participation in most secular mutual aid groups, although comparison of these groups is difficult because of varying survey methodologies and different years in which available data was collected. Membership profile data are not available for faith-based addiction recovery support groups such as Celebrate Recovery.

Most of the critical research questions raised by Caetano in 1993 about ethnic group participation in AA and other recovery mutual aid groups remain unanswered nearly 20 years later, but some conclusions can be drawn. First, there is clear evidence of efforts by 12-step groups to reach out to people of color (e.g., specialized literature; Alcoholics Anonymous, 2001). Second, AA and NA now have an established presence within most urban ethnic communities in the U.S. Third, while these groups were birthed within a particular historical and cultural context, they have been nuanced for cultural fit as they spread across ethnic boundaries (Caetano, 1993; Hoffman, 1994; Womak, 1996).

Abstinence-Based Religious and Cultural Revitalization Movements within Communities of Color

Culturally indigenous recovery support resources (CIRSR) are recovery mutual aid efforts organized by and on behalf of members of particular ethnic cultures. CIRSR mobilize distinctive cultural features (e.g., history, language, values, symbols, rituals, art, music, humor) to buttress successful recovery from addiction. To illustrate the role of indigenous recovery-focused cultural and religious revitalization movements as a framework of long-term addiction recovery, we will briefly describe the evolution of such movements within Native American and African American communities.

Organized mutual support for addiction recovery first occurred within Native American tribes experiencing a rise in alcohol problems in tandem with efforts to revive their cultural traditions in the face of physical and cultural assaults on their communities. These blended religious/cultural revitalization and personal healing movements date to the Delaware Prophets of the 1730s and extend historically through the Handsome Lake Movement, the Shawnee Prophet Movement, the Kickapoo Prophet Movement, Indian Christian evangelism, Indian temperance societies, the Indian Shaker Church, Peyote Societies, the American Indian Church, the ghost dance movements and the more recent “Indianization of AA,” the Red Road, and the contemporary Wellbriety Movement (Coyhis & White, 2002; Womak, 1996). These movements

were birthed by charismatic "wounded healers" who escaped addiction through a transformational change experience that was sudden, unplanned, positive, and permanent—similar to that of AA co-founder Bill Wilson in late 1934 (White, 2004b).

Early milestones in the rise of indigenous addiction recovery movements among African Americans include the use of early mainstream temperance societies as a framework for recovery initiation (Signorney & Smith, 1833) and Frederick Douglass' 1845 personal commitment to sobriety and his call for sobriety as a preparatory step toward full citizenship (White et al., 2006). Douglass played a key leadership role in the "colored temperance movement" and the growth of local African American temperance societies (e.g., the Black Templars; Cheagle, 1969; Herd, 1985).

This tradition extended into the mid-20th century through creation of AA groups specifically for African Americans (beginning in Washington, DC in 1945), the subsequent racial integration of AA and NA, the growing use of the Black Church as a place of healing and recovery, Malcolm X's conversion to the Nation of Islam (NOI), and NOI outreach efforts to addicted African Americans (C., Glen, 2005; White, 1998; White et al., 2006). Addiction ministries of the 1950s and 1960s rose in response to rising heroin addiction among African Americans—with drugs framed as tools of genocide by the Black Panthers and other Black Nationalist organizations (Tabor, 1970). The past two decades have witnessed the rise of indigenous faith-based recovery movements within predominately African American communities and the birth of recovery advocacy and peer support organizations serving predominately African American communities (Whiters, Santibanez, Dennison, & Clark, 2010; Williams & Laird, 1992). Collectively, these religious and cultural revitalization movements have provided diverse Africentric pathways of addiction recovery initiation and maintenance. Clergy now constitute a major recovery support resource within African American communities (Bohnert et al., 2010; Sexton, Carlson, Siegal, Leukefeld, & Booth, 2006). Faith-based organizations may be particularly well-suited to provide non-clinical addiction recovery support services (DeKrall, Bulling, Shank, & Tomkins, 2011).

CIRSR exist alongside the growth of AA and NA within Native American and African American communities, with individuals picking which resources best met their needs, participating in both simultaneously, or using one program to initiate recovery (e.g., AA/NA) only to then migrate to another to maintain that recovery (the Black Church/Celebrate Recovery)—the latter reported among a population of African American women in recovery in the urban centers of Illinois (White, Woll, & Webber, 2003). Whether individuals within communities of color respond best to mainstream groups, culturally specific recovery mutual aid resources, or combinations of such resources may be linked to different degrees of cultural affiliation (Bell, 2002).

Distinctive Features of Culturally Indigenous Recovery Support Resources

Culturally indigenous addiction recovery support resources (CIRSR) share many features with the mainstream spiritual, religious, and secular recovery support groups described elsewhere in this special issue of *Journal of Groups in Addiction and Recovery*. Nearly all are founded and led by people in recovery. Most share an abstinence-based approach to problem resolution. All involve a reconstruction of personal identity, daily lifestyle, and interpersonal relationships, although to different degrees of intensity. All but Moderation Management contain the elements of problem admission, commitment to abstinence, service to others, and sober fellowship. That said, there are distinctive differences between mainstream recovery mutual aid groups and CIRSR.

Etiology of Addiction. CIRSR share a broader understanding of the etiological roots of addiction. Addiction is often viewed within communities of color as an outgrowth of historical/intergenerational trauma, the targeted promotion of drugs to communities of color (a tool of economic and political exploitation), and as a personal response to present social, economic, and political marginalization (Brave Heart, 2003). Sharing of cultural pain within

CIRSR as a dimension of personal recovery may include discussions of slavery, the loss of land, extermination campaigns, epidemic diseases, the purposeful break-up of families and tribes, the loss of families and culture via immigration or deportation, forced internment as prisoners of war, other forms of physical sequestration, immigration distress, acculturation pressure, racism, and discrimination. Within CIRSR, the sharing of such experiences is viewed as a valuable step in consciousness raising, identity reconstruction, and embracing recovery as an act of personal/cultural healing rather than as strategies of denial, diversion, or rationalization as they are sometimes cast in mainstream mutual aid and addiction treatment contexts (Green, 1995; White & Sanders, 2008).

Ecology of Recovery. Within CIRSR, personal recovery is nested in broader concerns for the survival and healing of families, neighborhoods, and communities—recovery as *a people*. Recovery is often framed as a political as well as a personal act—a means of cultural survival and revitalization. Recovery of the person, family, and community are viewed as inseparable, suggesting that one part of the recovery ecosystem cannot be treated or healed without treating and healing the whole. This is reflected in the Wellbriety Movement's concept of the *Healing Forest* (Coyhis, 1999) and the concept of *community recovery* that is gaining salience in predominately African American communities (White, Evans, & Lamb, 2010). This simultaneous focus on person, family, and community can be evidenced in Rev. Cecil Williams' personal recovery/community revitalization work in the Tenderloin district of San Francisco (Williams & Laird, 1992) and in the historic recovery and renewal of the Alkali Lake community following decades of pervasive alcoholism (Chelsea & Chelsea, 1985; Taylor, 1987).

Culture as an Agent of Healing. One of the underlying premises of many CIRSR is that AOD problems rose in tandem with the loss of cultural traditions and that the renewal of those traditions and their adaptation to contemporary needs can provide a framework for recovery of the person, family, and community (Bowser & Bilal, 2001; Sanders, 2002; for studies of the association of recovery with increased cultural identification, see Flores, 1985 and Westermeyer & Neider, 1984).

C*ontinuity of Support*. Within CIRSR, what is traditionally called "relapse" is not viewed as a moral failure deeming someone unworthy of further support. The individual who has resumed AOD after seeking recovery is viewed as a fallen warrior in the struggle for personal/cultural survival. The corollary to that belief is that no warrior should be left on the battlefield—that the community has a responsibility to care for its wounded warriors—a concept exemplified in White Bison's Warrior Down relapse prevention and intervention initiative for Native Americans (White Bison, 2012).

Multiplicity versus Singularity of Purpose. Where 12-step and many secular recovery mutual aid groups adhere to a singularity of purpose and avoid getting involved in what are perceived as "outside issues," CIRSR tend to see AOD problems nested in multiple contexts that deserve attention. Organizations promoting CIRSR have much more boundary fluidity—e.g., involvement in mutual aid, professional treatment, and policy advocacy as well as simultaneous involvement in such issues as addiction, mental illness, domestic violence, child neglect and abuse, homelessness, HIV/AIDS, health care disparities, cultural revitalization, and economic development.

Mutual Support and Political Advocacy. The greater link between recovery support and personal and political advocacy seen in CIRSR may stem from awareness that recovery of persons within communities of color involves finding ways to survive and thrive in the face of multiple sources of stigma and discrimination—first described by Bell and Evans (1981) as *double consciousness*.

Respect for Transformational Change Experiences. CIRSR share a deep respect for life-transforming conversions, epiphanies, defining moments, peak experiences, and the personal "calling" to service that often emanates from such experiences. Service to others in this context is less a task to be completed to support one's own recovery and more a manifestation of the newly reborn person. The affirmation of the transformational power of spiritual experience that

permeates CIRSR draws on deep traditions within communities of color and unapologetic respect for the multiple therapeutic functions served by culturally indigenous religious institutions (Thompson & McRae, 2001; Whitley, 2012; Wright, 2003).

Hope versus Pain. CIRSR rise from communities whose members have lived a literal and metaphorical "bottom." In this context, hope is a greater motivator for addiction recovery than new increments of physical or psychological pain. CIRSR serve communities, families, and individuals with unfathomable capacities for prolonged physical and psychological pain. Pain in this context is not viewed as a motivator for recovery in the absence of hope. Hope is viewed as the key catalytic ingredient in recovery initiation.

Catalytic Metaphors. Hope is conveyed within CIRSR through *catalytic metaphors* that are culturally vibrant ("hot"). Such metaphors encompass words, ideas, and stories that, by creating dramatic breakthroughs in perception of self and the world, spark and anchor processes of personal transformation. These catalytic metaphors are linked to recovery and integrated as prominent themes in an overarching culture of recovery. In a very real sense, culture and its stories and metaphors become the "treatment" (Spicer, 2001).

Witnessing. Within the CIRSR context, one is expected to give as well as receive hope. That is achieved by becoming a recovery carrier—one who makes recovery contagious through the act of personal witnessing in the community. Such assertive and public recovery evangelism, in contrast to the anonymity practiced by most mainstream recovery support groups, is a way of offering hope (living proof) of the transformative power of recovery and the fruits it can bear through community service and cultural awakening.

Indigenous Healers and Institutions. CIRSR within communities of color emanate from or subsequently engage culturally indigenous healers and institutions. Such healing roles include the medicine man/woman, cacique (Indian healer), curandero (Mexican folk healer), Espiritista (Puerto Rican spirit healer), minister, priest, shaman, monk, and herbalist (Abbott, 1998; Brave Heart & DeBruyn 1998; Jilek, 1974, 1978; Singer & Borrero, 1984; White & Sanders, 2008).

Community Credentialing. Credibility of recovery carriers inside communities of color is based on *experiential knowledge* (lived knowledge of the problem and its solution) and *experiential expertise* (the ability to translate personal knowledge into skills in helping others within the community—living proof of one's power as a healer; Borkman 1976). This vetting is guided by community elders and conveyed through community storytelling. It constitutes a credential that no university, professional association, or governmental body can bestow (White & Sanders, 2008).

The Philadelphia Story

Community recovery capital is the quantity and quality of extra-personal/familial assets available to individuals to initiate and maintain addiction recovery and enhance the quality of personal/family life in long-term recovery (White & Cloud, 2008). There have been recent calls to develop and mobilize community recovery resources beyond professionally directed addiction treatment and recovery mutual aid organizations (White, 2009b; White, Kelly, & Roth, this issue)—particularly within communities of color (Coyhis, 1999; White & Sanders, 2008). The goals of these efforts include increasing the ethnic diversity and level of representation within mainstream recovery mutual aid groups, increasing the presence and capacity of CIRSR within ethnic communities, and building bridges of collaboration between these natural resources and mainstream addiction treatment and allied health and human service organizations.

The authors have been involved for seven years in efforts to achieve these goals within a larger recovery-focused transformation of the City of Philadelphia's behavioral health care system facilitated by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBH/IDS; See Achara-Abrahams, Evans, & King, 2011; Evans, 2007). The importance of achieving these goals is indicated in part by Philadelphia's growing racial diversity:

43.4% Black; 41% White; 0.5% American Indian or Alaskan Native; 12.3% persons of Hispanic or Latino origin; 6.3% Asian persons; and 2.8% persons reporting two or more races (U.S. Census Bureau, 2010). Table 2 outlines those strategies consistently reported through service recipient and provider focus groups and town meetings as well as through internal DBH/IDS evaluations that have been identified as most important in increasing recovery capital within communities of color in the City of Philadelphia. The strategies are organized within six core functions: 1) mapping recovery resources, 2) celebrating recovery at a community level, 3) mobilizing culturally diverse peers, 4) assuring representation, 5) assertive community outreach, education, and collaboration, and 6) targeted funding.

Table 2: Strategies to Increase Community Recovery Capital for Diverse Ethnic Groups

Strategy	Reported Effects
Core Function: Mapping Recovery Resource	
Health disparities and recovery resource mapping: analysis of service utilization across ethnic communities; identification of all treatment providers, recovery support meetings, recovery homes, recovery ministries, etc. by zip code.	1) Increased ability to assure recovery resources as close as possible to areas with the highest density of AOD problems. 2) Increased choices and improved matching of individuals to treatment and recovery support resources. 3) Increase in targeted RFPs for recovery support in underserved areas. 4) Creation of "learning community" to generate lessons for whole service system.
Bi-annual recovery prevalence survey included within a larger public health survey.	Increased capacity to measure: 1) recovery prevalence by ethnic groups, 2) health status of people in recovery across ethnic groups, 3) perceptions of quality of addiction treatment by areas of the community and by ethnic groups, and 4) changes in recovery prevalence over time in areas of focused recovery support initiatives.
Focus groups and town meetings exploring issues related to accessing services and supports in communities of color.	1) Increased understanding of the barriers related to service access and retention. 2) Increased dialogue and collaboration between people in recovery, CIRSR, and treatment providers.
Core Function: Celebrating Recovery at a Community Level	
Support for public *recovery celebration events* and visible *celebration of multiple pathways of recovery* across diverse ethnic communities.	People from diverse and previously closed recovery groups beginning to see themselves as part of a larger entity: *People in Recovery*. Persons from diverse backgrounds seeking recovery see "people like me."
Core Function: Mobilizing Culturally Diverse Peers	

Strategy	Reported Effects
Work with treatment providers to develop *consumer councils/alumni associations* and *assertive linkage procedures* to mutual aid and other recovery support entities.	1) Transition from treatment culture to a recovery culture within provider agencies. 2) Recovery leadership development within all geographical areas of the City of Philadelphia.
Youth Leadership Initiative: Developed Philadelphia Youth Move (Motivating Others Through Voices of Experience). Focused on increasing peer supports for children and adolescents, promoting advocacy for and by youth of color, addressing stigma through education and sharing of personal recovery stories, and providing youth of color with leadership training.	1) Inclusion of child/adolescent/family recovery support needs within all strategic planning efforts. 2) Increase in adolescent peer recovery support groups.
Assertive outreach to recovering people of color to promote their participation in Storytelling Trainings.	1) Increased sharing of hope-based recovery stories by people of color. 2) Increased representation of recovering people of color during community events. 3) Development of informal peer-based recovery network in communities of color.
Peer-based community outreach through the Taking it to the Streets Initiative: Focus on peer outreach to underserved populations in the community at venues such as homeless shelters and safe havens.	1) Increased awareness of recovery support services among people of color. 2) Assertive linkages of persons in treatment to CIRSR.
Core Function: Assuring Representation	
Assuring ethnic diversity and recovery representation in DBH/IDS staff and all DBH/IDS policy and advisory councils.	Improved constituency representation in DBH/IDS leadership initiatives across ethnic communities and diverse pathways of recovery.
Expectation of cultural competence within practice guidelines governing treatment and recovery support services.	Increased recruitment, retention, and long-term recovery support for underserved populations. Concept of cultural competence now extended to encompass diverse communities of recovery.
Core Function: Assertive Community Outreach, Education, and Collaboration	
Cross-systems collaborations to bring increased recovery orientation to systems with high representation of persons of color, e.g., drug, mental health, and juvenile courts, recovery homes for prison	Increased access of historically underserved populations to addiction treatment and recovery support services.

Strategy	Reported Effects
re-entry, assertive linkage to communities of recovery within child welfare projects.	
Faith & Spiritual Affairs Initiative aimed at mobilizing recovery support within faith communities, including a special initiative aimed at enhancing service access and recovery support within the African American Muslim community.	1) Increased acceptance of and support for people of recovery within Philadelphia's religious institutions. 2) Religious leaders embracing role of their organizations as CIRSR. 3) Growth of 12-step support group adaptations for the Muslim community.
Use of Community Coalitions Initiative and Mini-grants to imbed recovery support services within non-traditional service providers and forge education, outreach, and recovery support coalitions of treatment providers, community service providers, recovery community organizations, and faith organizations.	1) Increased recovery orientation of treatment providers. 2) Enhanced community capacity for delivery of peer-based recovery support services. 3) Increased utilization of treatment and recovery support services via their integration into non-stigmatized service sites.
Creation of Culture-Specific Community Task Forces to identify and respond to education and recovery support needs within various communities of color.	1) Recovery-focused education and support embedded within indigenous culture-specific service organizations. 2) Mobilization of indigenous community leaders to serve as recovery advocates and promote the sustained development of community recovery capital. 3) Ensured that strategies and solutions were community-driven.
Committee-led efforts to *address stigma of medication-assisted recovery* and increasing the recovery orientation of medication-assisted treatment.	Increased advocacy related to stigma attached to medication-assisted treatment and recovery within ethnic communities.
Published and posted articles, interviews, and video clips that increase *visibility of CIRSR*.	Heightening the visibility resistance, resilience, and recovery within ethnic communities.
Core Function: Targeted Funding	
Financial and volunteer support for *recovery mural arts projects.*	Increased public visibility and celebration of recovery within ethnic neighborhoods.
Funding support for PRO-ACT (recovery advocacy organization) to operate *recovery community centers* accessible to people of color.	1) Heightened visibility of PRO-ACT as a recovery advocacy organization. 2) Recovery community centers serve as a central meeting place for diverse recovery support organizations and a peer-based service hub.

DBH/IDS used a mix of funding mechanisms to support the strategies outlined above. These included reinvesting savings from Community Behavioral Health, Philadelphia's own non-profit, managed behavioral health organization for Medicaid recipients, as well as assertive efforts to increase federal support for behavioral health services. In addition, consistent with the

larger recovery-focused transformation that is underway in Philadelphia, many DBH/IDS staff roles and responsibilities have been realigned to support the transformation effort. As a result, many of the strategies employed to expand CIRSR were cost neutral. For example, existing staff conducted focus groups to explore people's experiences with accessing services, led storytelling trainings, and identified and mobilized people in recovery who volunteered their time to conduct street outreach and provide community education. This realignment of staff roles has been critical to the sustainability of these efforts, as many of these efforts are now embedded in the culture of the organization.

The specific strategies outlined in Table 2 were developed in response to Philadelphia's local culture, needs, and resources. Most importantly, they were developed in partnership with diverse stakeholders in the community, including people receiving services, treatment providers, recovery advocacy organizations, and faith-based organizations. We have found that CIRSR can be strategically increased within a community through efforts by federal, state, and local planning and funding authorities. Although the specific strategies might change across communities, many of the outlined core functions of CIRSR can serve as a framework for developing and organizing efforts to promote more community recovery capital for diverse ethnic groups.

A warning caveat is pertinent for systems seeking to facilitate the development of CIRSR. There is a long tradition of harm in the name of help in the relationship between culturally dominant institutions and poor communities of color. For generations, politicians, philanthropists, researchers, educators, and armies of professional helpers and social control agents have tried to rally local ethnic communities with promises of outside help. All too often, these efforts were ill-informed, ill-timed, inadequately resourced, too narrowly focused, and too short in their vision and execution. In retrospect, most such projects drew more resources out of the community than they put into it.

What poor communities of color do not need is another outside organization or charismatic rescuer conveying the message, "You have the problem, I/we have the solution" (Humphreys & Hamilton, 1995). A long history of colonization in the name of empowerment (and the inevitable aftermath of the experience of betrayal and mistrust) dictate efforts to build recovery support structures that assure sustained continuity of commitment and contact and a sustained partnership with indigenous community leaders—both community elders and vetted recovery carriers within ethnic communities (White & Sanders, 2008). Strategies to promote CIRSR must be designed to ensure that solutions come from within and remain in the control of these communities and their CIRSR (Humphreys & Hamilton, 1995).

Summary

There has been a progressive increase in the participation of persons of color within 12-step mutual aid groups in the United States, and research to date suggests that affiliation, retention, and recovery rates of ethnic minority members within these groups is comparable to such rates for Whites. Rates of participation of persons of color within most secular recovery mutual aid societies remain quite low, while such rates of affiliation are currently unknown for explicitly religious recovery mutual aid societies. Significant progress is being made in understanding diverse secular, spiritual, and religious frameworks of recovery. The next frontier will be the greater understanding of how pathways and styles of addiction recovery differ across cultural contexts. There is some evidence that as minority representation increases within recovery mutual aid societies, culturally nuanced adaptations of core ideas and meeting rituals occur that enhance affiliation rates and benefits of participation.

There is an equally rich history of culturally indigenous recovery support resources (CIRSR) within communities of color, particularly within Native American and African American communities. CIRSR share many characteristics with culturally dominant recovery mutual aid organizations, but they differ in such areas as their conceptualization of the etiology of addiction,

a whole personal/family/community recovery perspective, an openness to transformational change as a primary medium of recovery initiation, and the inclusion of culturally salient catalytic metaphors and healing practices. Co-participation in CIRSR, mainstream recovery mutual aid groups, and professionally directed addiction treatment is common and warrants study to determine what particular service combinations and sequences create recovery outcomes for persons of color greater than experienced with any of these elements in isolation. CIRSR have historically risen spontaneously within communities of color, but CIRSR may also be increased strategically through carefully crafted social policies and programs. Such resources have increased within the City of Philadelphia as part of the city's recovery-focused transformation of its behavioral healthcare system. Several strategies were suggested for possible replication in other communities, but a caution was added on the critical importance of nesting these strategies within a long-term commitment to and partnership with local communities of color. Supporting the development and mobilization of culturally indigenous recovery support resources that are non-hierarchical, reciprocal, non-commercialized, and neighborhood- and family-based may be particularly important within communities whose historical experiences have engendered distrust of offers of help from culturally dominant social institutions.

References

Abbott, P. J. (1998). Traditional and western healing practices for alcoholism in American Indians and Alaska Natives. *Substance Use and Misuse, 33*, 2605-2646.

Achara-Abrahams, I., Evans, A. C., & King, J. K. (2011). Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 187-208). New York: Springer Science.

Alcoholics Anonymous. (2001). *Can AA help me too? Black/African Americans share their stories*. New York: Alcoholics Anonymous World Services, Inc.

Arndt, S., Velez, M. B., Segre, L., & Clayton, R. (2010). Remission from substance dependence in U.S. Whites, African Americans, and Latinos. *Journal of Ethnicity in Substance Abuse*, *9*, 237-248. doi:10.1080/15332640.2010.522889

Bell, P. (2002). *Chemical dependency and the African American*. Center City, MN: Hazelden.

Bell, P., & Evans, J. (1981). *Counseling the Black client. Alcohol use and abuse in Black America.* Minneapolis, MN: Hazelden.

Bohnert, A. S. B., Perron, B. E., Jarman, C. N., Vaughn, M. G., Chatters, L. M., & Taylor, R. J. (2010). Use of clergy services among individuals seeking treatment for alcohol use problems. *American Journal on Addictions*, *19*(4), 345-351. doi:10.1111/j.1521-0391.2010.00050.x

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review, 50*, 445-456.

Bowser, B. P., & Bilal, R. (2001). Drug treatment effectiveness: African American culture in recovery. *Journal of Psychoactive Drugs*, *33*(4), 391-402. doi:10.1080/02791072.2001.10399924

Brave Heart, M.Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7-13. doi:10.1080/02791072.2003.10399988

Brave Heart, M. Y., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research Journal, 8*(2), 60-82.

C., Glen. (2005). *Early Black A.A*. Retrieved April 11, 2005 from http://hindsfoot.org/m/black1.html

Caetano, R. (1993). Ethnic minority groups and Alcoholics Anonymous: A review. In B. McCrady, & W. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 209-231). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Caetano, R., Baruah, J., & Chartier, K. G. (2011). Ten-year trends (1992-2002) in sociodemographic predictors and indicators of alcohol abuse and dependence among Whites, Blacks, and Hispanics in the United States. *Alcoholism: Clinical and Experimental Research*, *35*(8), 1458-1466. doi:10.1111/j.1530-0277.2011.01482.x

Chartier, K. G., & Caetano, R. (2011). Trends in alcohol services utilization from 1991-1992 to 2001-2002: Ethnic group differences in the U.S. population. *Alcoholism: Clinical and Experimental Research*, *35*(8), 1485-1497. doi:10.1111/j.1530-0277.2011.01485.x

Cheagle, R. (1969). *The colored temperance movement* (Unpublished thesis). Washington, DC: Howard University.

Chelsea, P., & Chelsea, A. (1985). *Honour of all: The people of Alkali Lake* (Video). British Columbia, Canada: The Alkali Lake Tribal Council.

Coyhis, D. (1999). *The Wellbriety journey: Nine talks by Don Coyhis*. Colorado Springs, CO: White Bison, Inc.

Coyhis, D., & White, W. L. (2002). Alcohol problems in Native America: Changing paradigms and clinical practices. *Alcoholism Treatment Quarterly, 20*(3-4), 157-165. doi:10.1300/J020v20n03_10

Coyhis, D., & White, W. L. (2006). *Alcohol problems in Native America: The untold story of resistance, resilience and recovery*. Colorado Springs, CO: White Bison, Inc.

DeKrall, M. B., Bulling, D. J., Shank, N. C., & Tomkins, A. J. (2011). Faith-based organizations in a system of behavioral health care. *Journal of Psychology and Theology*, *39*(3), 255-267.

Evans, A. C. (2007). The recovery-focused transformation of an urban behavioral health care system: An interview with Arthur Evans, PhD. In W. White, *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Flores, P. J. (1985). Alcoholism treatment and the relationship of Native American cultural values to recovery. *International Journal of the Addictions, 20*(11-12), 1707-1726. doi:10.3109/10826088509047258

Goebert, D., & Nishimura, S. (2011). Comparison of substance abuse treatment utilization among Native Hawaiians, Asian Americans and Euro Americans. *Journal of Substance Use*, *16*(2), 161-170. doi:10.3109/14659891.2011.554594

Green, W. (1995). *Dysfunctional by design: The rebirth of cultural survivors*. Evanston, IL: Chicago Spectrum Press.

Helmer, J. (1975). *Drugs and minority oppression*. New York: Seabury Press.

Herd, D. (1985). We cannot stagger to freedom: A history of Blacks and alcohol in American politics. In L. Brill & C. Winick (Eds.), *The yearbook of substance use and abuse: Volume III* (pp. 1-82). New York: Human Sciences Press, Inc.

Hoffman, F. (1994). Cultural adaptations of Alcoholics Anonymous to serve Hispanic populations. *International Journal of the Addictions, 29*(4), 445-460.

Humphreys, K., & Hamilton, E. G. (1995). Alternating themes: Advocacy and self reliance. *Social Policy*, Winter, 24-32.

Humphreys, K., Mavis, B., & Stofflemayr, B. (1991). Factors predicting attendance at self-help groups after substance abuse treatment: Preliminary findings. *Journal of Consulting and Clinical Psychology, 59*(4), 591-593. doi:10.1037/0022-006X.59.4.591

Humphreys, K., Mavis, B. E., & Stöffelmayr, B. E. (1994). Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services*, *11*, 165-180.

James, W., & Johnson, S. (1996). *Doin' drugs: Patterns of African American addiction*. Texas: University of Texas Press.

Jilek, W. G. (1974). Indian healing power: Indigenous therapeutic practices in the Pacific Northwest. *Psychiatric Annals, 4*(11), 13-21.

Jilek, W. G. (1978). Native renaissance: The survival and revival of indigenous therapeutic ceremonials among North American Indians. *Transcultural Psychiatry, 15*, 117-147. doi:10.1177/136346157801500201

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*, 241-250. doi:10.1016/S0740-5472(03)00021-7

Leland, J. (1976). *Firewater myths: North American Indian drinking and alcohol addiction* (Monographs of the Rutgers Center of Alcohol Studies No. 11). New Brunswick, New Jersey: Rutgers Center of Alcohol Studies.

Mulia, N., Ye, Y., Greenfield, T. K., & Zemore, S. E. (2009). Disparities in alcohol-related problems among White, Black and Hispanic Americans. *Alcoholism: Clinical & Experimental Research*, *33*(4), 654-662. doi:10.1111/j.1530-0277.2008.00880.x

Musto, D. (1973). *The American disease: Origins of narcotic control*. New Haven: Yale University Press.

Neuspiel, D. R. (1996). Racism and perinatal addiction. *Ethnicity and Disease, 6*, 47-55.

Sanders, M. (2002). The response of African American communities to alcohol and other drug problems: An opportunity for treatment providers. *Alcoholism Treatment Quarterly*, *20*(3/4), 167-174. doi:10.1300/J020v20n03_11

Sexton, R. L., Carlson, R. G., Siegal, H. A., Luekefeld, C. G., & Booth, B. M. (2006). The role of African-American clergy in providing informal services to drug users in the rural south: Preliminary ethnographic findings. *Ethnicity in Substance Abuse*, *5*(1), 1-21. doi:10.1300/J233v05n01_01

Sigorney, L., & Smith, G. (1833). *The intemperate and the reformed*. Boston: Seth Bliss.

Singer, M., & Borrero, M. G. (1984). Indigenous treatment for alcoholism: The case of Puerto Rican spiritualism. *Medical Anthropology: Cross-Cultural Studies in Health and Illness, 8,* 246-273. doi:10.1080/01459740.1984.9965908

Spicer, P. (2001). Culture and the restoration of self among former American Indian drinkers. *Social Science & Medicine, 53*(2), 227-240. doi:10.1016/S0277-9536(00)00333-6

Tabor, M. (1970). *Capitalism plus dope equals genocide*. Black Panther Party, U.S.A.

Taylor, V. (1987). The triumph of the Alkali Lake Indian band. *Alcohol Health and Research World, 12*(1), 57.

Thompson, D. A., & McRae, M. B. (2001). The need to belong: A theory of the therapeutic function of the Black Church tradition. *Counseling and Values*, *46*, 40-53.

U.S. Census Bureau. (2010). *US Census Bureau Quick Facts: City of Philadelphia*. Retrieved January 5, 2012 from http://quickfacts.census.gov/qfd/states/42/4260000.html

Wallace, J. M. (1999). The social ecology of addiction: Race, risk and resilience. *Pediatrics, 103*(Suppl 2), 1122-1127.

Westermeyer, J., & Neider, J. (1984). Predicting treatment outcome after ten years among American Indian alcoholics. *Alcoholism: Clinical and Experimental Research, 8*(2), 179-184. doi:10.1111/j.1530-0277.1984.tb05833.x

White Bison. (2012). *Warrior down*. Retrieved January 5, 2012 from http://www.whitebison.org/prisons/Warrior%20Down.pdf

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

White, W. L. (2004a). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction, 99*, 532-538. doi:10.1111/j.1360-0443.2004.00684.x

White, W. L. (2004b). Transformational change: A historical review. *Journal of Clinical Psychology, 60*(5), 461-470. doi:10.1002/jclp.20001

White, W. L. (2009a). *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.

White, W. L. (2009b). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158. doi:10.1016/j.jsat.2008.10.006

White, W. L., & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22-27.

White, W. L., Evans, A. C., & Lamb, R. (2010). *Community recovery*. Retrieved January 5, 2012 from www.facesandvoicesofrecovery.com

White, W. L., Kelly, J. F., & Roth, J. D. (in press). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction and Recovery.*

White, W. L., & Sanders, M. (2002). Addiction and recovery among African Americans before 1900. *Counselor, 3*(6), 64-66.

White, W. L., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395. doi:10.1080/07347320802072198

White, W. L., Sanders, M., & Sanders, T. (2006). Addiction in the African American community: The recovery legacies of Frederick Douglass and Malcolm X. *Counselor, 7*(5), 53-58.

White, W. L., Woll, P., & Webber, R. (2003). *Project SAFE: Best practices resource manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

Whiters, D., Santibanez, S., Dennison, D., & Clark, H. W. (2010). A case study in collaborating with Atlanta-based African-American churches: A promising means for reaching inner-city substance users with rapid HIV testing. *Journal of Evidence-based Social Work*, *7*(1-2), 103-114. doi:10.1080/15433710903175981

Whitley, R. (2012). "Thanks you God": Religion and recovery from dual diagnosis among low-income African Americans. *Transcultural Psychiatry, 49*(1), 87-104. doi:10.1177/1363461511425099

Williams, C., & Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. New York: Harper San Francisco.

Womak, M. L. (1996). *The Indianization of Alcoholics Anonymous: An examination of Native American recovery movements.* Tucson, AZ: University of Arizona, Native American Research & Training Center.

Wright, E. M. (2003). Substance abuse in African American communities. In D. J. Gilbert & E. M. Wright (Eds.), *African American women and HIV/AIDS: Critical responses* (pp. 31-51). Westport, CT: Praeger.

White, W. & Chaney, R. (2012). Commentary--Resilience and recovery across the generations: A critical research agenda. *Counselor*, 13(2), 54-57.

Commentary

Resilience and Recovery across the Generations: A Critical Research Agenda

William L. White, M.A. and Rita A. Chaney, M.S.

The authors have spent decades observing individuals with severe alcohol and other drug (AOD) problems achieve stable recovery and enhanced quality of life. The ability of adults and families to enjoy the fruits of such recoveries is all too often interrupted by encounters with these same problems in the lives of their own adolescent children. This common dilemma within the life course of recovery is the subject of this short essay.

Clinical interventions with alcohol and other drug problems in America have been grounded historically in studies of the pathology of alcohol and drug problems (e.g., extensive studies of the history, epidemiology, psychopharmacology, and personal and social consequences of prolonged and excessive AOD use). We, as a country and as a professionalized addictions field, know a lot about psychoactive drugs, drug consumption trends, the multiple pathways through which people develop AOD problems, and the neurobiological adaptations that contribute to alcohol and other drug dependence. We have also learned a great deal from studies of various approaches to the diagnosis and treatment of substance use disorders. But what do we know from the standpoint of science as a culture and as a profession about the prevalence, neurobiology, pathways, styles and stages of long-term recovery from AOD problems? There are emerging calls to extend the field's pathology and intervention paradigms to a recovery paradigm (Erickson & White, submitted for publication; Laudet, 2008; White, 2005; White, 2007b). This shift would create a more substantive body of empirical evidence capable of answering questions that are critical to people attempting to initiate recovery, maintain recovery, and enhance the quality and meaningfulness of their lives in recovery.

A growing number of American addiction scientists and recovery advocates are calling upon the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to co-develop, co-fund, and co-disseminate the findings of a comprehensive recovery-focused research agenda (Laudet, 2008; Laudet & White, 2008; White, 2000). A

solutions-focused knowledge base is crucial for developing family and community environments that can support long-term recovery and prevent the continued development of AOD problems within our most vulnerable populations.

In this paper, we will focus on one issue—the mechanisms through which individuals with intergenerational histories of severe alcohol and other drug problems resist developing or recover from such problems. We will use this discussion to illustrate just how much we do not know about some of the most critical issues facing recovering people, their families and their children.

Unanswered Questions

Scientific studies confirm that alcohol and drug problems can be and often are transmitted across generations via complex biological, psychological, and social processes. We are beginning to learn more about the risk factors that contribute to this problem transmission across and within generations of family members, e.g., genetic vulnerability, prenatal alcohol/drug exposure, early age of onset of AOD use, parental/sibling modeling of excessive AOD use, drug culture socialization, defective parenting, physical/emotional deprivation/trauma/abandonment, exposure to domestic violence, and isolation from support outside the family (Capone & Wood,2008; Grant & Dawson, 1997; Merickangas, Stolar, Stevens, et al, 1998; Miles, Stallings, Young, et., al, 1998; Nature Neuroscience, 2005). But unanswered as of now are perhaps the most important two questions: 1) How do adolescents and transition-age youth with a family history of AOD problems and related risk factors resist the development of AOD problems over the course of their lives? 2) How do family histories of AOD problems and the outcomes of those problems affect individual recovery prospects and processes of other affected family members?

We know that AOD use of individuals within one's immediate living environment exerts an influence on treatment/recovery outcomes (Godley, Kahn, Dennis, Godley, & Funk, 2005; Laudet, Morgen, & White, 2006; McCrady, 2004). In situations where intimate partners are both addicted, the post-treatment recovery or re-addiction of one partner is predictive of the recovery or addiction of the other partner (Hser, 2007; McAweeney, Zucker, Fitzgerald, Puttler, & Wong, 2005). But the role of recovery status of one family member in influencing intergenerational and intragenerational

patterns of resistance and recovery for other family members remains a frontier of primarily unanswered questions.

Consider the more detailed questions below that are of concern to anyone imbedded within a family history of alcohol and other drug problems and to addiction professional working with such families. The terms *resist* and *resistance* as used here refer to the process through which individuals who are high risk for the development of AOD problems successfully avoid developing such problems. The term *recovery* refers to the process through which individuals with severe AOD problems resolve these problems, improve their global health and enhance their participation in and contributions to the life of their communities (White, 2007a).

1. How is the course of a substance use disorder (SUD) and the prospects of successful long-term recovery affected by the presence or absence of SUDs in one's family history? Does recovery of family members from earlier generations or one's own generation constitute a special form of family recovery capital that increases one's odds of successful recovery?[1] Is there any evidence of intragenerational or intergenerational learning or family adaptation to SUD risks? (The intent here is the development of a knowledge base that allows us to move beyond just treatment of individuals to strategies aimed at stemming the processes through which AOD problems are intergenerationally transmitted.)

2. What influence, if any, does an AOD-related adverse experience (e.g., hospitalization, job loss, divorce, arrest, incarceration) of one family member have on SUD resistance and recovery initiation or maintenance of other family members?

3. What influence, if any, does an AOD-related death of one family member have on the resistance, recovery initiation or recovery maintenance of other family members? Does the type of death (e.g., overdose, accident, medical complications, suicide, or victim of violence) mediate such influence? What effect does infliction of death upon another by an addicted family member (e.g., an act of

[1] Recovery capital is the quantity and quality of internal and external resources that can be mobilized to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999). There are different types of recovery capital, including personal recovery capital, family/social recovery capital and community/cultural recovery capital (White & Cloud, 2008).

violence, death of another resulting from drinking and driving) have on the resistance or recovery prospects of other family members?

4. Do identical twins born within family trees with histories of AOD problems share similar patterns of resistance and recovery? If not, what factors are related to differences in their resistance and recovery experiences?

5. If an adolescent son or daughter is at increased risk of developing a SUD because of a family history of such disorders, do the children have less risk of developing a SUD if the parent is in stable recovery? If one or more children were to develop an SUD, are their prospects of recovery better because of the parent's recovery?

6. Does the degree of density of recovery among family network members with SUDs influence the resistance and recovery odds of coming generations within this family? (Density could be measured by the number or percentage of all family and extended family members with SUDs who achieved stable recovery.) Is there a recovery "tipping point" within families when intergenerational transmission slows or ceases?

7. Are intergenerational resistance and recovery gender-linked, e.g., are sons of recovering fathers less likely to develop or more likely to recover from a SUD than daughters of recovering fathers? What other factors influence resistance and recovery, e.g., role of the family member in recovery (grandparent, aunt/uncle, cousin, parent, sibling); birth order of the person in recovery (e.g., older sibling versus younger sibling), family member status (blood, adopted, foster), parental status (blood versus step-parent), degree of physical contact (e.g., recovering person residing within or outside the home), and degree of emotional attachment with the family member in recovery?

8. How do the following factors influence the resistance and recovery odds of children whose parents are in recovery: AOD problem severity of the parent, primary drug choices of the parent and the child, developmental age of child at onset of parental recovery, degree of emotional attachment in the parent-child relationship, presence and degree/duration of adverse childhood experiences, and presence of surrogate parental figures?

9. What strategies of prevention and early intervention can specifically lower the SUD risks of children of recovering parents or stop the development of AOD problems at an early stage? Are different strategies more successful with different at-risk populations or at different developmental ages?

10. Does participation of a family member in specialty sector addiction treatment and/or recovery mutual aid groups affect the resistance and recovery prospects of other family members? If so, are there particular types of treatment (e.g., family therapy) that have a greater effect on resistance and recovery of other family members? How does child participation in parental or sibling treatment affect the child's future resistance and recovery prospects? Would that outcome be influenced by the post-treatment recovery status of the family member who was treated? How does participation in child-focused peer support groups (e.g., Alatot, Alateen) or a developmentally appropriate, educational support group for children and adolescents affect subsequent resistance or recovery?

11. How do preferred recovery pathways differ for individuals with and without family addiction/recovery histories? Is the preferred recovery pathway of the parent or other family members predictive of the best recovery pathway for the child in this family who develops a SUD?

12. In what would be an interesting reversal of intergenerational transmission, does the addiction and recovery of a child influence that child's parents' prospects of addiction, resistance or recovery? Are there effects on sibling resistance and recovery under such circumstances?

13: How are resistance and recovery of persons in AOD-enmeshed family trees influenced by community recovery capital (i.e., the quantity and accessibility of local resources that assist people in resisting and recovering from AOD-related problems)?

14. Within families with histories of AOD problems, do patterns of intergenerational and intragenerational resistance and recovery differ across ethnic, cultural and religious groups? If so, how?

15. What general resiliency factors[2] within families and extended family networks enhance the odds of resistance and recovery?

16. What manner of presenting one's recovery status/story has the greatest influence on the resistance and recovery of other family members? What effect does degree of exposure of family members to communities of recovery exert on resistance and recovery?

17. Are there specific family activities, events or developmental issues that pose significant challenges to resistance and recovery? If so, what works to support resistance and recovery?

18. What effect does degree of exposure of family members to communities of recovery have on resistance and recovery? Are there other community supports such as faith-based organizations or opportunities for community activities/advocacy that strengthen resistance and recovery?

19. What are the sources of resistance among individuals with family histories of AOD problems who do not go on to develop AOD problems?

20. For parents with extensive intergenerational histories of AOD problems, are there any indicators or early warning signs suggesting which of their children might be at highest risk for AOD problem development? Are there any research-grounded responses that could lower the vulnerability, increase the resistance or enhance the future recovery prospects of these children?

21. Does personal or family recovery ameliorate the effects of historical trauma?[3] Is there a tipping point of healing through which individual/family recovery breaks the cycle of passing on the effects of historical trauma to new generations, e.g., Are the resistance and

[2] Family protective, resiliency and recovery factors include rituals for family gathering, family communication skills, collective problem solving, personality compatibility, collective health and hardiness, mutual affection and support, shared values, connection to community resources, optimism and hope (McCubbin, McCubbin, Thompson, et la, 1997).

[3] Historical trauma is the collective distress emanating from immense losses and traumatic events experienced by a whole people and passed intergenerationally through parent-child interactions and interactions with extended family and community members (Coyhis, 2008).

recovery rates of children in Native American communities elevated within communities whose adults and elders have achieved high rates of recovery?

The Search for Answers

With addiction treatment consciously moving towards a "recovery-oriented system of care" that places emphasis on the role of the family and community in long-term recovery processes, the need to answer the above questions will become more urgent. These questions are intensely personal and important to millions of individuals in long-term recovery. Why, after decades of addiction research, do we not have answers to these questions? Why, after decades of addiction research, have we not even had studies that asked these questions? We will know a recovery research agenda is a reality when such questions are asked and answered within the country's leading research centers. We will know that achievement is real when the fruits of that knowledge are accessible to all individuals and families in recovery. That day is long overdue.

Acknowledgements: We would like to thank the following individuals for helpful comments and suggestions on an early draft of this article: Mike Flaherty, Steve Hornberger, Joan King, Alexandre Laudet, Bob Savage, Jason Schwartz, and Richard Simonelli.

About the Authors: William L. White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems. Rita A. Chaney is a Licensed Mental Health Counselor and freelance writer.

References

Erickson, C. & White, W. (2009) Commentary: The neurobiology of addiction recovery. *Alcoholism Treatment Quarterly*, 27(3), 338-341.

Capone, C. & Wood, M.D. (2008). Density of familial alcoholism and its effects on alcohol use and problems in college students. *Alcoholism: Clinical and Experimental Research*. 32(8), 1451-8.

Coyhis, D. (2008). What is historical trauma? (Presentation slides.) Colorado Springs, CO: White Bison, Inc.

Godley, M. D., Kahn, J. H., Dennis, M. L., Godley, S. H., & Funk, R. R. (2005). The stability and impact of environmental factors on

substance use and problems after adolescent outpatient treatment for cannabis use or dependence. *Psychology of Addictive Behavior*s, *19*(1), 62-70.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

Grant, B. F., & Dawson, D. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. *Journal of Substance Abuse, 9*, 103-110.

Hser, Y.I. (2007). Predicting long-term stable recovery from heroin addiction: findings from a 33-year follow-up study. *Journal of Addictive Diseases*, 26:51-60.

Laudet, A.B. (2008). Building the science of recovery. Presented at the Recovery Symposium, May 1-2, Philadelphia, PA: Sponsored by the Northeast Addiction Technology Transfer Center.

Laudet, A, Morgen, K., & White, W. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*, *24*(102), 33-73.

Laudet, A.B. & White, W.L. (2008) Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse*, 43(1), 27-54.

McAweeney, M. J., Zucker, R. A., Fitzgerald, H. E., Puttler, L. I., & Wong, M. M. (2005). Individual and partner predictors of recovery from alcohol use disorder over a nine-year interval: Findings from a community sample of married men. *Journal of Studies on Alcohol*, *66*(2), 220-228.

McCrady, B.S. (2004). To have but one true friend: Implications for practice of research on alcohol use disorders and social networks. *Addictive Behaviors*, *18*(2), 113-121.

McCubbin, H.I., McCubbin, M.A., Thompson, A.I., Han, S-Y. & Allen, C.T. (1997). Families under stress: What makes them resilient? American Association of Family and Consumer Sciences Commemorative Lecture delivered by Hamilton I. McCubbin on June 22, 1997, in Washington, D. C.

Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M.A., Fenton, B., Zhang, H., O'Malley, S.S., & Rounsaville, B.H. (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, 55, 973-979.

Miles, D.R., Stallings, M.C. Young, S.E. Hewitt, J.K., Crowley, T.J., & Fulker, D.W. (1998). A family history and direct interview study of familial aggregation of substance abuse: the adolescent substance abuse study. *Drug and Alcohol Dependence*, 49, 105-114.

Nature Neuroscience (multiple authors of special issue). (2005). Focus on neurobiology of addiction. *Nature Neuroscience*. 8(11). Accessed October 31, 2011 at: http://www.nature.com/neuro/focus/addiction/index.html

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, *23*(1), 3-15.

White, W. (2000, April). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Presented at Recovery Community Support Program (RCSP) Conference, Washington, D.C. Posted at www.williamwhitepapers.com

White, W. (2007a) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241.

White, W. (2007b). In search of the neurobiology of addiction recovery: A brief commentary on science and stigma. Posted at: www.wiiliamwhiteppaers.com

White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor.* , 9(5), 22-27.

White, W. & Chaney, R. (2012). Commentary--Resilience and recovery across the generations: A critical research agenda. *Counselor*, 13(2), 54-57.

Commentary

Resilience and Recovery across the Generations: A Critical Research Agenda

William L. White, M.A. and Rita A. Chaney, M.S.

The authors have spent decades observing individuals with severe alcohol and other drug (AOD) problems achieve stable recovery and enhanced quality of life. The ability of adults and families to enjoy the fruits of such recoveries is all too often interrupted by encounters with these same problems in the lives of their own adolescent children. This common dilemma within the life course of recovery is the subject of this short essay.

Clinical interventions with alcohol and other drug problems in America have been grounded historically in studies of the pathology of alcohol and drug problems (e.g., extensive studies of the history, epidemiology, psychopharmacology, and personal and social consequences of prolonged and excessive AOD use). We, as a country and as a professionalized addictions field, know a lot about psychoactive drugs, drug consumption trends, the multiple pathways through which people develop AOD problems, and the neurobiological adaptations that contribute to alcohol and other drug dependence. We have also learned a great deal from studies of various approaches to the diagnosis and treatment of substance use disorders. But what do we know from the standpoint of science as a culture and as a profession about the prevalence, neurobiology, pathways, styles and stages of long-term recovery from AOD problems? There are emerging calls to extend the field's pathology and intervention paradigms to a recovery paradigm (Erickson & White, submitted for publication; Laudet, 2008; White, 2005; White, 2007b). This shift would create a more substantive body of empirical evidence capable of answering questions that are critical to people attempting to initiate recovery, maintain recovery, and enhance the quality and meaningfulness of their lives in recovery.

A growing number of American addiction scientists and recovery advocates are calling upon the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to co-develop, co-fund, and co-disseminate the findings of a comprehensive recovery-focused research agenda (Laudet, 2008; Laudet & White, 2008; White, 2000). A

solutions-focused knowledge base is crucial for developing family and community environments that can support long-term recovery and prevent the continued development of AOD problems within our most vulnerable populations.

In this paper, we will focus on one issue—the mechanisms through which individuals with intergenerational histories of severe alcohol and other drug problems resist developing or recover from such problems. We will use this discussion to illustrate just how much we do not know about some of the most critical issues facing recovering people, their families and their children.

Unanswered Questions

Scientific studies confirm that alcohol and drug problems can be and often are transmitted across generations via complex biological, psychological, and social processes. We are beginning to learn more about the risk factors that contribute to this problem transmission across and within generations of family members, e.g., genetic vulnerability, prenatal alcohol/drug exposure, early age of onset of AOD use, parental/sibling modeling of excessive AOD use, drug culture socialization, defective parenting, physical/emotional deprivation/trauma/abandonment, exposure to domestic violence, and isolation from support outside the family (Capone & Wood,2008; Grant & Dawson, 1997; Merickangas, Stolar, Stevens, et al, 1998; Miles, Stallings, Young, et., al, 1998; Nature Neuroscience, 2005). But unanswered as of now are perhaps the most important two questions: 1) How do adolescents and transition-age youth with a family history of AOD problems and related risk factors resist the development of AOD problems over the course of their lives? 2) How do family histories of AOD problems and the outcomes of those problems affect individual recovery prospects and processes of other affected family members?

We know that AOD use of individuals within one's immediate living environment exerts an influence on treatment/recovery outcomes (Godley, Kahn, Dennis, Godley, & Funk, 2005; Laudet, Morgen, & White, 2006; McCrady, 2004). In situations where intimate partners are both addicted, the post-treatment recovery or re-addiction of one partner is predictive of the recovery or addiction of the other partner (Hser, 2007; McAweeney, Zucker, Fitzgerald, Puttler, & Wong, 2005). But the role of recovery status of one family member in influencing intergenerational and intragenerational

patterns of resistance and recovery for other family members remains a frontier of primarily unanswered questions.

Consider the more detailed questions below that are of concern to anyone imbedded within a family history of alcohol and other drug problems and to addiction professional working with such families. The terms *resist* and *resistance* as used here refer to the process through which individuals who are high risk for the development of AOD problems successfully avoid developing such problems. The term *recovery* refers to the process through which individuals with severe AOD problems resolve these problems, improve their global health and enhance their participation in and contributions to the life of their communities (White, 2007a).

1. How is the course of a substance use disorder (SUD) and the prospects of successful long-term recovery affected by the presence or absence of SUDs in one's family history? Does recovery of family members from earlier generations or one's own generation constitute a special form of family recovery capital that increases one's odds of successful recovery?[1] Is there any evidence of intragenerational or intergenerational learning or family adaptation to SUD risks? (The intent here is the development of a knowledge base that allows us to move beyond just treatment of individuals to strategies aimed at stemming the processes through which AOD problems are intergenerationally transmitted.)

2. What influence, if any, does an AOD-related adverse experience (e.g., hospitalization, job loss, divorce, arrest, incarceration) of one family member have on SUD resistance and recovery initiation or maintenance of other family members?

3. What influence, if any, does an AOD-related death of one family member have on the resistance, recovery initiation or recovery maintenance of other family members? Does the type of death (e.g., overdose, accident, medical complications, suicide, or victim of violence) mediate such influence? What effect does infliction of death upon another by an addicted family member (e.g., an act of

[1] Recovery capital is the quantity and quality of internal and external resources that can be mobilized to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999). There are different types of recovery capital, including personal recovery capital, family/social recovery capital and community/cultural recovery capital (White & Cloud, 2008).

violence, death of another resulting from drinking and driving) have on the resistance or recovery prospects of other family members?

4. Do identical twins born within family trees with histories of AOD problems share similar patterns of resistance and recovery? If not, what factors are related to differences in their resistance and recovery experiences?

5. If an adolescent son or daughter is at increased risk of developing a SUD because of a family history of such disorders, do the children have less risk of developing a SUD if the parent is in stable recovery? If one or more children were to develop an SUD, are their prospects of recovery better because of the parent's recovery?

6. Does the degree of density of recovery among family network members with SUDs influence the resistance and recovery odds of coming generations within this family? (Density could be measured by the number or percentage of all family and extended family members with SUDs who achieved stable recovery.) Is there a recovery "tipping point" within families when intergenerational transmission slows or ceases?

7. Are intergenerational resistance and recovery gender-linked, e.g., are sons of recovering fathers less likely to develop or more likely to recover from a SUD than daughters of recovering fathers? What other factors influence resistance and recovery, e.g., role of the family member in recovery (grandparent, aunt/uncle, cousin, parent, sibling); birth order of the person in recovery (e.g., older sibling versus younger sibling), family member status (blood, adopted, foster), parental status (blood versus step-parent), degree of physical contact (e.g., recovering person residing within or outside the home), and degree of emotional attachment with the family member in recovery?

8. How do the following factors influence the resistance and recovery odds of children whose parents are in recovery: AOD problem severity of the parent, primary drug choices of the parent and the child, developmental age of child at onset of parental recovery, degree of emotional attachment in the parent-child relationship, presence and degree/duration of adverse childhood experiences, and presence of surrogate parental figures?

9. What strategies of prevention and early intervention can specifically lower the SUD risks of children of recovering parents or stop the development of AOD problems at an early stage? Are different strategies more successful with different at-risk populations or at different developmental ages?

10. Does participation of a family member in specialty sector addiction treatment and/or recovery mutual aid groups affect the resistance and recovery prospects of other family members? If so, are there particular types of treatment (e.g., family therapy) that have a greater effect on resistance and recovery of other family members? How does child participation in parental or sibling treatment affect the child's future resistance and recovery prospects? Would that outcome be influenced by the post-treatment recovery status of the family member who was treated? How does participation in child-focused peer support groups (e.g., Alatot, Alateen) or a developmentally appropriate, educational support group for children and adolescents affect subsequent resistance or recovery?

11. How do preferred recovery pathways differ for individuals with and without family addiction/recovery histories? Is the preferred recovery pathway of the parent or other family members predictive of the best recovery pathway for the child in this family who develops a SUD?

12. In what would be an interesting reversal of intergenerational transmission, does the addiction and recovery of a child influence that child's parents' prospects of addiction, resistance or recovery? Are there effects on sibling resistance and recovery under such circumstances?

13: How are resistance and recovery of persons in AOD-enmeshed family trees influenced by community recovery capital (i.e., the quantity and accessibility of local resources that assist people in resisting and recovering from AOD-related problems)?

14. Within families with histories of AOD problems, do patterns of intergenerational and intragenerational resistance and recovery differ across ethnic, cultural and religious groups? If so, how?

15. What general resiliency factors[2] within families and extended family networks enhance the odds of resistance and recovery?

16. What manner of presenting one's recovery status/story has the greatest influence on the resistance and recovery of other family members? What effect does degree of exposure of family members to communities of recovery exert on resistance and recovery?

17. Are there specific family activities, events or developmental issues that pose significant challenges to resistance and recovery? If so, what works to support resistance and recovery?

18. What effect does degree of exposure of family members to communities of recovery have on resistance and recovery? Are there other community supports such as faith-based organizations or opportunities for community activities/advocacy that strengthen resistance and recovery?

19. What are the sources of resistance among individuals with family histories of AOD problems who do not go on to develop AOD problems?

20. For parents with extensive intergenerational histories of AOD problems, are there any indicators or early warning signs suggesting which of their children might be at highest risk for AOD problem development? Are there any research-grounded responses that could lower the vulnerability, increase the resistance or enhance the future recovery prospects of these children?

21. Does personal or family recovery ameliorate the effects of historical trauma?[3] Is there a tipping point of healing through which individual/family recovery breaks the cycle of passing on the effects of historical trauma to new generations, e.g., Are the resistance and

[2] Family protective, resiliency and recovery factors include rituals for family gathering, family communication skills, collective problem solving, personality compatibility, collective health and hardiness, mutual affection and support, shared values, connection to community resources, optimism and hope (McCubbin, McCubbin, Thompson, et la, 1997).

[3] Historical trauma is the collective distress emanating from immense losses and traumatic events experienced by a whole people and passed intergenerationally through parent-child interactions and interactions with extended family and community members (Coyhis, 2008).

recovery rates of children in Native American communities elevated within communities whose adults and elders have achieved high rates of recovery?

The Search for Answers

With addiction treatment consciously moving towards a "recovery-oriented system of care" that places emphasis on the role of the family and community in long-term recovery processes, the need to answer the above questions will become more urgent. These questions are intensely personal and important to millions of individuals in long-term recovery. Why, after decades of addiction research, do we not have answers to these questions? Why, after decades of addiction research, have we not even had studies that asked these questions? We will know a recovery research agenda is a reality when such questions are asked and answered within the country's leading research centers. We will know that achievement is real when the fruits of that knowledge are accessible to all individuals and families in recovery. That day is long overdue.

Acknowledgements: We would like to thank the following individuals for helpful comments and suggestions on an early draft of this article: Mike Flaherty, Steve Hornberger, Joan King, Alexandre Laudet, Bob Savage, Jason Schwartz, and Richard Simonelli.

About the Authors: William L. White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems. Rita A. Chaney is a Licensed Mental Health Counselor and freelance writer.

References

Erickson, C. & White, W. (2009) Commentary: The neurobiology of addiction recovery. *Alcoholism Treatment Quarterly*, 27(3), 338-341.

Capone, C. & Wood, M.D. (2008). Density of familial alcoholism and its effects on alcohol use and problems in college students. *Alcoholism: Clinical and Experimental Research*. 32(8), 1451-8.

Coyhis, D. (2008). What is historical trauma? (Presentation slides.) Colorado Springs, CO: White Bison, Inc.

Godley, M. D., Kahn, J. H., Dennis, M. L., Godley, S. H., & Funk, R. R. (2005). The stability and impact of environmental factors on

substance use and problems after adolescent outpatient treatment for cannabis use or dependence. *Psychology of Addictive Behavior*s, *19*(1), 62-70.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

Grant, B. F., & Dawson, D. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. *Journal of Substance Abuse, 9*, 103-110.

Hser, Y.I. (2007). Predicting long-term stable recovery from heroin addiction: findings from a 33-year follow-up study. *Journal of Addictive Diseases*, 26:51-60.

Laudet, A.B. (2008). Building the science of recovery. Presented at the Recovery Symposium, May 1-2, Philadelphia, PA: Sponsored by the Northeast Addiction Technology Transfer Center.

Laudet, A, Morgen, K., & White, W. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*, *24*(102), 33-73.

Laudet, A.B. & White, W.L. (2008) Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse*, 43(1), 27-54.

McAweeney, M. J., Zucker, R. A., Fitzgerald, H. E., Puttler, L. I., & Wong, M. M. (2005). Individual and partner predictors of recovery from alcohol use disorder over a nine-year interval: Findings from a community sample of married men. *Journal of Studies on Alcohol*, *66*(2), 220-228.

McCrady, B.S. (2004). To have but one true friend: Implications for practice of research on alcohol use disorders and social networks. *Addictive Behaviors*, *18*(2), 113-121.

McCubbin, H.I., McCubbin, M.A., Thompson, A.I., Han, S-Y. & Allen, C.T. (1997). Families under stress: What makes them resilient? American Association of Family and Consumer Sciences Commemorative Lecture delivered by Hamilton I. McCubbin on June 22, 1997, in Washington, D. C.

Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M.A., Fenton, B., Zhang, H., O'Malley, S.S., & Rounsaville, B.H. (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, 55, 973-979.

Miles, D.R., Stallings, M.C. Young, S.E. Hewitt, J.K., Crowley, T.J., & Fulker, D.W. (1998). A family history and direct interview study of familial aggregation of substance abuse: the adolescent substance abuse study. *Drug and Alcohol Dependence*, 49, 105-114.

Nature Neuroscience (multiple authors of special issue). (2005). Focus on neurobiology of addiction. *Nature Neuroscience*. 8(11). Accessed October 31, 2011 at: http://www.nature.com/neuro/focus/addiction/index.html

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, *23*(1), 3-15.

White, W. (2000, April). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Presented at Recovery Community Support Program (RCSP) Conference, Washington, D.C. Posted at www.williamwhitepapers.com

White, W. (2007a) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241.

White, W. (2007b). In search of the neurobiology of addiction recovery: A brief commentary on science and stigma. Posted at: www.wiiliamwhiteppaers.com

White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor.* , 9(5), 22-27.

White, W. & Chaney, R. (2012). Commentary--Resilience and recovery across the generations: A critical research agenda. *Counselor*, 13(2), 54-57.

Commentary

Resilience and Recovery across the Generations: A Critical Research Agenda

William L. White, M.A. and Rita A. Chaney, M.S.

The authors have spent decades observing individuals with severe alcohol and other drug (AOD) problems achieve stable recovery and enhanced quality of life. The ability of adults and families to enjoy the fruits of such recoveries is all too often interrupted by encounters with these same problems in the lives of their own adolescent children. This common dilemma within the life course of recovery is the subject of this short essay.

Clinical interventions with alcohol and other drug problems in America have been grounded historically in studies of the pathology of alcohol and drug problems (e.g., extensive studies of the history, epidemiology, psychopharmacology, and personal and social consequences of prolonged and excessive AOD use). We, as a country and as a professionalized addictions field, know a lot about psychoactive drugs, drug consumption trends, the multiple pathways through which people develop AOD problems, and the neurobiological adaptations that contribute to alcohol and other drug dependence. We have also learned a great deal from studies of various approaches to the diagnosis and treatment of substance use disorders. But what do we know from the standpoint of science as a culture and as a profession about the prevalence, neurobiology, pathways, styles and stages of long-term recovery from AOD problems? There are emerging calls to extend the field's pathology and intervention paradigms to a recovery paradigm (Erickson & White, submitted for publication; Laudet, 2008; White, 2005; White, 2007b). This shift would create a more substantive body of empirical evidence capable of answering questions that are critical to people attempting to initiate recovery, maintain recovery, and enhance the quality and meaningfulness of their lives in recovery.

A growing number of American addiction scientists and recovery advocates are calling upon the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to co-develop, co-fund, and co-disseminate the findings of a comprehensive recovery-focused research agenda (Laudet, 2008; Laudet & White, 2008; White, 2000). A

solutions-focused knowledge base is crucial for developing family and community environments that can support long-term recovery and prevent the continued development of AOD problems within our most vulnerable populations.

In this paper, we will focus on one issue—the mechanisms through which individuals with intergenerational histories of severe alcohol and other drug problems resist developing or recover from such problems. We will use this discussion to illustrate just how much we do not know about some of the most critical issues facing recovering people, their families and their children.

Unanswered Questions

Scientific studies confirm that alcohol and drug problems can be and often are transmitted across generations via complex biological, psychological, and social processes. We are beginning to learn more about the risk factors that contribute to this problem transmission across and within generations of family members, e.g., genetic vulnerability, prenatal alcohol/drug exposure, early age of onset of AOD use, parental/sibling modeling of excessive AOD use, drug culture socialization, defective parenting, physical/emotional deprivation/trauma/abandonment, exposure to domestic violence, and isolation from support outside the family (Capone & Wood,2008; Grant & Dawson, 1997; Merickangas, Stolar, Stevens, et al, 1998; Miles, Stallings, Young, et., al, 1998; Nature Neuroscience, 2005). But unanswered as of now are perhaps the most important two questions: 1) How do adolescents and transition-age youth with a family history of AOD problems and related risk factors resist the development of AOD problems over the course of their lives? 2) How do family histories of AOD problems and the outcomes of those problems affect individual recovery prospects and processes of other affected family members?

We know that AOD use of individuals within one's immediate living environment exerts an influence on treatment/recovery outcomes (Godley, Kahn, Dennis, Godley, & Funk, 2005; Laudet, Morgen, & White, 2006; McCrady, 2004). In situations where intimate partners are both addicted, the post-treatment recovery or re-addiction of one partner is predictive of the recovery or addiction of the other partner (Hser, 2007; McAweeney, Zucker, Fitzgerald, Puttler, & Wong, 2005). But the role of recovery status of one family member in influencing intergenerational and intragenerational

patterns of resistance and recovery for other family members remains a frontier of primarily unanswered questions.

Consider the more detailed questions below that are of concern to anyone imbedded within a family history of alcohol and other drug problems and to addiction professional working with such families. The terms *resist* and *resistance* as used here refer to the process through which individuals who are high risk for the development of AOD problems successfully avoid developing such problems. The term *recovery* refers to the process through which individuals with severe AOD problems resolve these problems, improve their global health and enhance their participation in and contributions to the life of their communities (White, 2007a).

1. How is the course of a substance use disorder (SUD) and the prospects of successful long-term recovery affected by the presence or absence of SUDs in one's family history? Does recovery of family members from earlier generations or one's own generation constitute a special form of family recovery capital that increases one's odds of successful recovery?[1] Is there any evidence of intragenerational or intergenerational learning or family adaptation to SUD risks? (The intent here is the development of a knowledge base that allows us to move beyond just treatment of individuals to strategies aimed at stemming the processes through which AOD problems are intergenerationally transmitted.)

2. What influence, if any, does an AOD-related adverse experience (e.g., hospitalization, job loss, divorce, arrest, incarceration) of one family member have on SUD resistance and recovery initiation or maintenance of other family members?

3. What influence, if any, does an AOD-related death of one family member have on the resistance, recovery initiation or recovery maintenance of other family members? Does the type of death (e.g., overdose, accident, medical complications, suicide, or victim of violence) mediate such influence? What effect does infliction of death upon another by an addicted family member (e.g., an act of

[1] Recovery capital is the quantity and quality of internal and external resources that can be mobilized to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999). There are different types of recovery capital, including personal recovery capital, family/social recovery capital and community/cultural recovery capital (White & Cloud, 2008).

violence, death of another resulting from drinking and driving) have on the resistance or recovery prospects of other family members?

4. Do identical twins born within family trees with histories of AOD problems share similar patterns of resistance and recovery? If not, what factors are related to differences in their resistance and recovery experiences?

5. If an adolescent son or daughter is at increased risk of developing a SUD because of a family history of such disorders, do the children have less risk of developing a SUD if the parent is in stable recovery? If one or more children were to develop an SUD, are their prospects of recovery better because of the parent's recovery?

6. Does the degree of density of recovery among family network members with SUDs influence the resistance and recovery odds of coming generations within this family? (Density could be measured by the number or percentage of all family and extended family members with SUDs who achieved stable recovery.) Is there a recovery "tipping point" within families when intergenerational transmission slows or ceases?

7. Are intergenerational resistance and recovery gender-linked, e.g., are sons of recovering fathers less likely to develop or more likely to recover from a SUD than daughters of recovering fathers? What other factors influence resistance and recovery, e.g., role of the family member in recovery (grandparent, aunt/uncle, cousin, parent, sibling); birth order of the person in recovery (e.g., older sibling versus younger sibling), family member status (blood, adopted, foster), parental status (blood versus step-parent), degree of physical contact (e.g., recovering person residing within or outside the home), and degree of emotional attachment with the family member in recovery?

8. How do the following factors influence the resistance and recovery odds of children whose parents are in recovery: AOD problem severity of the parent, primary drug choices of the parent and the child, developmental age of child at onset of parental recovery, degree of emotional attachment in the parent-child relationship, presence and degree/duration of adverse childhood experiences, and presence of surrogate parental figures?

9. What strategies of prevention and early intervention can specifically lower the SUD risks of children of recovering parents or stop the development of AOD problems at an early stage? Are different strategies more successful with different at-risk populations or at different developmental ages?

10. Does participation of a family member in specialty sector addiction treatment and/or recovery mutual aid groups affect the resistance and recovery prospects of other family members? If so, are there particular types of treatment (e.g., family therapy) that have a greater effect on resistance and recovery of other family members? How does child participation in parental or sibling treatment affect the child's future resistance and recovery prospects? Would that outcome be influenced by the post-treatment recovery status of the family member who was treated? How does participation in child-focused peer support groups (e.g., Alatot, Alateen) or a developmentally appropriate, educational support group for children and adolescents affect subsequent resistance or recovery?

11. How do preferred recovery pathways differ for individuals with and without family addiction/recovery histories? Is the preferred recovery pathway of the parent or other family members predictive of the best recovery pathway for the child in this family who develops a SUD?

12. In what would be an interesting reversal of intergenerational transmission, does the addiction and recovery of a child influence that child's parents' prospects of addiction, resistance or recovery? Are there effects on sibling resistance and recovery under such circumstances?

13: How are resistance and recovery of persons in AOD-enmeshed family trees influenced by community recovery capital (i.e., the quantity and accessibility of local resources that assist people in resisting and recovering from AOD-related problems)?

14. Within families with histories of AOD problems, do patterns of intergenerational and intragenerational resistance and recovery differ across ethnic, cultural and religious groups? If so, how?

15. What general resiliency factors[2] within families and extended family networks enhance the odds of resistance and recovery?

16. What manner of presenting one's recovery status/story has the greatest influence on the resistance and recovery of other family members? What effect does degree of exposure of family members to communities of recovery exert on resistance and recovery?

17. Are there specific family activities, events or developmental issues that pose significant challenges to resistance and recovery? If so, what works to support resistance and recovery?

18. What effect does degree of exposure of family members to communities of recovery have on resistance and recovery? Are there other community supports such as faith-based organizations or opportunities for community activities/advocacy that strengthen resistance and recovery?

19. What are the sources of resistance among individuals with family histories of AOD problems who do not go on to develop AOD problems?

20. For parents with extensive intergenerational histories of AOD problems, are there any indicators or early warning signs suggesting which of their children might be at highest risk for AOD problem development? Are there any research-grounded responses that could lower the vulnerability, increase the resistance or enhance the future recovery prospects of these children?

21. Does personal or family recovery ameliorate the effects of historical trauma?[3] Is there a tipping point of healing through which individual/family recovery breaks the cycle of passing on the effects of historical trauma to new generations, e.g., Are the resistance and

[2] Family protective, resiliency and recovery factors include rituals for family gathering, family communication skills, collective problem solving, personality compatibility, collective health and hardiness, mutual affection and support, shared values, connection to community resources, optimism and hope (McCubbin, McCubbin, Thompson, et la, 1997).

[3] Historical trauma is the collective distress emanating from immense losses and traumatic events experienced by a whole people and passed intergenerationally through parent-child interactions and interactions with extended family and community members (Coyhis, 2008).

recovery rates of children in Native American communities elevated within communities whose adults and elders have achieved high rates of recovery?

The Search for Answers

With addiction treatment consciously moving towards a "recovery-oriented system of care" that places emphasis on the role of the family and community in long-term recovery processes, the need to answer the above questions will become more urgent. These questions are intensely personal and important to millions of individuals in long-term recovery. Why, after decades of addiction research, do we not have answers to these questions? Why, after decades of addiction research, have we not even had studies that asked these questions? We will know a recovery research agenda is a reality when such questions are asked and answered within the country's leading research centers. We will know that achievement is real when the fruits of that knowledge are accessible to all individuals and families in recovery. That day is long overdue.

Acknowledgements: We would like to thank the following individuals for helpful comments and suggestions on an early draft of this article: Mike Flaherty, Steve Hornberger, Joan King, Alexandre Laudet, Bob Savage, Jason Schwartz, and Richard Simonelli.

About the Authors: William L. White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems. Rita A. Chaney is a Licensed Mental Health Counselor and freelance writer.

References

Erickson, C. & White, W. (2009) Commentary: The neurobiology of addiction recovery. *Alcoholism Treatment Quarterly*, 27(3), 338-341.

Capone, C. & Wood, M.D. (2008). Density of familial alcoholism and its effects on alcohol use and problems in college students. *Alcoholism: Clinical and Experimental Research*. 32(8), 1451-8.

Coyhis, D. (2008). What is historical trauma? (Presentation slides.) Colorado Springs, CO: White Bison, Inc.

Godley, M. D., Kahn, J. H., Dennis, M. L., Godley, S. H., & Funk, R. R. (2005). The stability and impact of environmental factors on

substance use and problems after adolescent outpatient treatment for cannabis use or dependence. *Psychology of Addictive Behavior*s, *19*(1), 62-70.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

Grant, B. F., & Dawson, D. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. *Journal of Substance Abuse, 9*, 103-110.

Hser, Y.I. (2007). Predicting long-term stable recovery from heroin addiction: findings from a 33-year follow-up study. *Journal of Addictive Diseases*, 26:51-60.

Laudet, A.B. (2008). Building the science of recovery. Presented at the Recovery Symposium, May 1-2, Philadelphia, PA: Sponsored by the Northeast Addiction Technology Transfer Center.

Laudet, A, Morgen, K., & White, W. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*, *24*(102), 33-73.

Laudet, A.B. & White, W.L. (2008) Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse*, 43(1), 27-54.

McAweeney, M. J., Zucker, R. A., Fitzgerald, H. E., Puttler, L. I., & Wong, M. M. (2005). Individual and partner predictors of recovery from alcohol use disorder over a nine-year interval: Findings from a community sample of married men. *Journal of Studies on Alcohol*, *66*(2), 220-228.

McCrady, B.S. (2004). To have but one true friend: Implications for practice of research on alcohol use disorders and social networks. *Addictive Behaviors*, *18*(2), 113-121.

McCubbin, H.I., McCubbin, M.A., Thompson, A.I., Han, S-Y. & Allen, C.T. (1997). Families under stress: What makes them resilient? American Association of Family and Consumer Sciences Commemorative Lecture delivered by Hamilton I. McCubbin on June 22, 1997, in Washington, D. C.

Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M.A., Fenton, B., Zhang, H., O'Malley, S.S., & Rounsaville, B.H. (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, 55, 973-979.

Miles, D.R., Stallings, M.C. Young, S.E. Hewitt, J.K., Crowley, T.J., & Fulker, D.W. (1998). A family history and direct interview study of familial aggregation of substance abuse: the adolescent substance abuse study. *Drug and Alcohol Dependence*, 49, 105-114.

Nature Neuroscience (multiple authors of special issue). (2005). Focus on neurobiology of addiction. *Nature Neuroscience*. 8(11). Accessed October 31, 2011 at: http://www.nature.com/neuro/focus/addiction/index.html

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, *23*(1), 3-15.

White, W. (2000, April). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Presented at Recovery Community Support Program (RCSP) Conference, Washington, D.C. Posted at www.williamwhitepapers.com

White, W. (2007a) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241.

White, W. (2007b). In search of the neurobiology of addiction recovery: A brief commentary on science and stigma. Posted at: www.wiiliamwhiteppaers.com

White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor.* , 9(5), 22-27.



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). Mel Schulstad (1918-2012): A personal tribute a pioneer of modern addiction counseling. *Alcoholism Treatment Quarterly*, 30(2), 256-258. Posted at **www.williamwhitepapers.com**

Mel Schulstad (1918-2012): A Personal Tribute to a Pioneer of Modern Addiction Counseling

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

On January 6, 2012, the addictions field lost one of its modern pioneers when Mel Schulstad died quietly in his sleep at the age of 93. Mel was born March 9, 1918, in Duluth, MN and was raised by his grandparents in Reynolds, ND before enlisting in the US Army Air Corps in 1939. He flew B-17 bombers over France and Germany from November 1942 to May 1945 and was twice awarded the Distinguished Flying Cross for valor in combat. He retired as a full colonel in 1965.

Mel's long career in the addictions counseling field began in the early 1970s following his own recovery from alcoholism. He helped found the alcoholism counselor association in Virginia, and he was the founding president of NAADAC: The Association for Addiction Professionals. Mel was one of the leading figures in the early movement to professionalize addiction counseling and was the personification of the transformative power of addiction recovery.

I have had the privilege of training and mentoring addiction counselors from all over the United States and in other countries for more than four decades. When asked who trained addiction counselors before there were addiction studies programs, addiction counselor certification systems, and training workshops galore, it is hard for me to not think of Mel Schulstad and the role he played in the lives of so many first-generation alcoholism/addiction counselors. No one exerted a greater influence on the emerging practice of addiction counseling than Mel. He was both catalyst and witness of our transition from "paraprofessionals" to addiction professionals. He was the consummate advocate, often working behind the scenes with government officials and legislators on issues affecting the lives of people suffering from addiction, as well as individuals and families in long-term recovery.

Mel's service to NAADAC continued throughout his career and long after his retirement. He helped establish the

NAADAC Archives at the Library of Virginia and co-chaired the fundraising effort to create a permanent headquarters for NAADAC. It is quite fitting that NAADAC's professional of the year award bears Mel's name. For decades, Mel was an indomitable presence at NAADAC conferences where he helped recognize the achievements of those working in the profession he had helped create. Mel made contributions to two influential books (the Foreword to *Under the Influence*, 1984, and co-author of *Beyond the Influence*, 2000).

Long after his official retirement, Mel remained concerned with a broad number of issues affecting the addiction counselor and the larger field of addiction treatment. He continued to push for advanced education and training of addiction counselors even as he worried about very skilled counselors being pushed out of the field because of their lack of academic credentials. In our final discussions and my interviews with him, he often spoke of two concerns.

The first involved language that persisted within the field that he had sought to change for more than 20 years:

> *…the worst thing is the nomenclature that we've chosen in this field. We've made "abusers" out of hundreds and thousands of people…that's a very, very detrimental term. We don't use that language with any other medical problem. We don't talk about people who abuse sugar or abuse food. We're the only health care arena in which we lambaste the victim with the title of abusing something. Then we wonder why we're held in such disregard or why Congress doesn't want to flood us with money like they do for other illnesses. Our very nomenclature invites disrespect and contempt* (From 2011 Mel Schustad Interview).

A second of Mel's recent concerns was the rush to integrate addiction and mental health treatment. He felt this posed significant risks to the integrity of specialty sector addiction treatment:

> *I see alcoholism and drug dependence being gradually sucked back under what is now being called behavioral health, which includes the mental health field which decades ago did not want us and from which we successfully escaped at least for a while. I think the field will suffer from this new wave of integration. The challenge is going to be to hang onto our historical focus on the care of the suffering alcoholic and addict and his or her family and what we have learned about how to do that. These are in danger of getting lost* (From 2011 Mel Schustad Interview).

Even into his nineties, Mel Schulstad continued to offer his wisdom and encouragement to those of us who regularly sought his counsel, whether professional colleagues or the desperate men and women he met through his volunteer service work. In spite of innumerable professional awards and recognitions, he rarely spoke of what he had achieved—only how much he had been blessed. His was a life of humility and service. The only things that surpassed the duration of his commitment to the field and those it served were the quality of his contributions and his personal integrity. He loved people seeking recovery and those in recovery. He loved addiction counselors. He loved the addictions field. If one were to put a face on the modern era of addiction counseling, it would be the image of Mel Schulstad.



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., Evans, A.C., Lamb, R. & Achara-Abrahams, I. (2013) Addiction recovery communities as indigenous cultures: Implications for professional and scientific collaboration. Alcoholism Treatment Quarterly, 31(2), 121-128. Posted at www.williamwhitepapers.com

Brief Field Report

Addiction Recovery Communities as Indigenous Cultures: Implications for Professional and Scientific Collaborations

William L. White, MA[1]
Chestnut Health Systems, Bloomington, Illinois USA

Arthur C. Evans, Jr., PhD, Roland Lamb, MA, and Ijeoma Achara-Abrahams, PsyD
Philadelphia Department of Behavioral Health and Intellectual disAbilities, Philadelphia, Pennsylvania USA

This commentary conceptualizes recovery mutual aid organizations and other grassroots, non-professional recovery support institutions as indigenous cultures, identifies ethical issues that can arise in professional and scientific collaboration with such cultures, and provides a checklist that can guide professional and scientific collaborations with grassroots recovery support organizations.

KEYWORDS Experiential knowledge, indigenous intelligence, recovery communities, recovery mutual aid

Introduction

Addiction treatment as a specialized system of care has grown significantly in the United States over the past half-century. One of the more important contextual changes now influencing that system of care involves the expansion and diversification of non-clinical recovery supports available as an adjunct or alternative to addiction treatment (Valentine, 2011; White, 2009, 2010). Secular, spiritual, and religious recovery mutual aid groups have grown in size, have become more geographically accessible, and now extend to Internet-based recovery communities (White & Kurtz, 2006). New grassroots recovery community organizations have formed and linked themselves into an increasingly vibrant new recovery advocacy movement—

[1]Address correspondence to William L. White, MA, Chestnut Health Systems, 3329 Sunset Key Circle, Unit #203, Punta Gorda, FL 33955, email: bwhite@chestnut.org

new in terms of its constituencies, core ideas, and strategies (White, 2007). New recovery support institutions have emerged through this process that fall outside the traditional categories of professional treatment and recovery mutual aid groups. These new recovery institutions include recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes, recovery-focused sporting activities, and recovery-themed activities in literature, art, music, film, and theatre (White, Kelly, & Roth, 2012).

Interest is growing in the effects these recovery support alternatives can exert on long-term recovery outcomes (White, Humphreys, et al., 2012). As a result, addiction treatment and addiction research organizations are increasingly reaching out to collaborate with these new recovery support organizations (Achara-Abrahams, Evans, & King, 2011), and such collaborations are likely to increase under the growing influence of the Affordable Care Act (Buck, 2011). In our work with such groups in Philadelphia, Pennsylvania and throughout the country, we have become acutely aware of some of the difficult ethical and professional practice issues that are arising within the context of these collaborations (White et al., 2007).

Based on this experience, we contend that:

1) local communities of recovery are best viewed as indigenous cultures (indigenous understood here to mean rooted within and naturally arising from the community; natural support as opposed to professionalized support within a formal health care institution),

2) many forms of inadvertent harm in the name of help can flow from these professional-indigenous collaborations,

3) the ethical issues and ethical guidelines noted in the professional literature on the relationships between addiction professionals/researchers and historically disempowered ethnic communities can be applied to relationships with communities of recovery, and

4) professionals can use a process of self-inventory to help heighten their effectiveness, ethical sensitivities and ethical decision-making abilities within these collaborative relationships.

The primary purpose of this article is to share the inventory checklist we have developed to guide our own collaborations in this area.

Inventory for Professional Collaborations with Indigenous Communities of Recovery

Table 1 illustrates the kinds of questions that can guide professional collaborations with indigenous communities of recovery. These are the kinds of questions that have arisen through our collaborations and through our consultations with other collaborative ventures—both in the service and research contexts. The table may be used as a self-assessment instrument, or questions can be used as a survey to be filled out by key persons representing particular collaborations.

Table 1: Inventory for Professional Collaborations with Indigenous Communities of Recovery

Rating Scale: 1=very weak; 2=weak; 3=adequate; 4=strong; 5=very strong; Circle the appropriate rating in response to each question.

Area of Collaboration	Key Questions	Rating
Conscientious Preparation	Did we adequately educate ourselves about indigenous recovery cultures in preparation for the collaborative project?	1 2 3 4 5

Mental & Emotional Stretching	Have we explored how the specific community with whom we are collaborating views the etiology of AOD problems within their community? Did we prepare ourselves for alternative ways to view the etiology of alcohol and other drug (AOD) problems and their solutions (e.g., historical trauma, colonization, cultural disintegration, economic marginalization; as an example, see Brave Heart, 2003; Brave Heart, Chase, Elkins, & Altschul, 2011; Brave Heart & DeBruyn, 1998; Coyhis & White, 2006)?	1 2 3 4 5 1 2 3 4 5
Credibility	Have we established our value to indigenous recovery communities through vetting of our authenticity within these communities as well as through our professional credentials or organizational authority? Have we articulated both our personal and professional commitment to the issues? Have we focused on establishing credibility through building rapport, personal relationships, and trust (Achara-Abrahams et al., 2012)? Have we consistently demonstrated respect for indigenous elders for their wisdom and leadership?	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
First Do No Harm	Have we discussed ways in which past collaborations between professionals/scientists and indigenous cultures have caused harm and injury and how the risk of such injuries can be minimized (See White, 2009)? Have we asked the community about their concerns related to the current partnership and fully addressed these concerns?	1 2 3 4 5 1 2 3 4 5
Representation & Inclusion	Have members/leaders of indigenous communities of recovery been fully involved in the design, implementation, and evaluation of the collaborative effort—to include formulation of findings and recommendations? Has attention been given to overcoming barriers to participation, particularly among those community members who may have been under-represented in past projects/research (Green et al., 2007)?	1 2 3 4 5 1 2 3 4 5
Focus	Is the project/based on mutual benefits and the perceived need for change across all partners? Have we explored whether the project or research issue is supported by or of concern to members of the recovery community? Did the impetus for the project/research come from the recovery community? If not, has the community had an opportunity to refine the focus to reflect their interests and needs (Green et al., 2007)?	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
Authenticity of Representation	Were recovery community members involved in the selection of who would represent them within the collaboration? (Were we able to avoid problems of “double agentry”—persons representing hidden personal or institutional interests?)	1 2 3 4 5 1 2 3 4 5

	Does the representation of people from the recovery community reflect the diversity of views and lived experiences that are inherent in the community?	
Humility & Respect	Have we consistently acknowledged in word and deed respect for experiential knowledge (concepts of indigenous science, indigenous intelligence, and indigenous healing rituals) of communities of recovery as a starting point rather than an adjunct to professional/scientific knowledge (See Borkman, 1976; Echo-Hawk, 2011; Lucero, 2011; Whareratä Group, 2010)?	1 2 3 4 5
Self-respect	Have we consistently refused to participate in any indigenous cultural practices that we felt posed harm to others or violated our own personal/professional beliefs?	1 2 3 4 5
Theory-building	Did we incorporate experiential knowledge of diverse recovery communities into our theory-building process? Are recovery community members actively involved with interpreting research data and verifying conclusions or lessons learned? Is there a mechanism in place to resolve in a transparent way any differences between the conclusions of the recovery community and those of the professionals? (Marshall & Batten, 2003).	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
Partnership	Has the authority and power of decision-making been equally shared within the collaborative relationship, e.g., a supportive versus directive relational style (see Echo-Hawk, 2011; Lamb, Evans, & White, 2009)? Are positions of leadership and authority shared with recovery community members?	1 2 3 4 5 1 2 3 4 5
Empowerment	Were opportunities for mentorship and leadership development included reciprocally within the collaborative process (See Achara-Abrahams et al., 2012)?	1 2 3 4 5
Understanding	Have we exhibited through word and deed our belief in the legitimacy of multiple pathways and styles of long-term recovery (See Sanders & Powell, 2012; White & Kurtz, 2006)?	1 2 3 4 5
Recovery Focus	Have we designed this project/study in a way that will help answer important questions that individuals, families, and communities have about recovery from addiction and related problems?	1 2 3 4 5
Stewardship	Did we establish an explicit agreement across the collaborative partnership that fairly allocated financial resources and other assets (professional and public recognition, co-authorship, etc.)? Is the indigenous community stronger today because of this collaboration?	1 2 3 4 5 1 2 3 4 5
Honesty & Fidelity	Have we been truthful in our collaborative communications (and did we avoid making promises or raising expectations that could not be met)?	1 2 3 4 5
Flexibility	Does the implementation process include a mechanism for collaboratively monitoring progress?	1 2 3 4 5 1 2 3 4 5

	Did we demonstrate flexibility in changing the methods and focus, as deemed necessary by the recovery community (Green et al., 2007)?	
Amends	When mistakes of omission or commission have occurred within the collaboration, have we admitted such mistakes and made amends where possible?	1 2 3 4 5
Loyalty	Have we maintained continuity of contact over time with those with whom we have collaborated (and avoided replicating patterns of exploitation and abandonment)?	1 2 3 4 5
Discretion	Have we respected the confidentiality and privacy of those with whom we are collaborating?	1 2 3 4 5
Consent	Have we engaged in ongoing communication and continued to ask for consent at every step of the project/research process to ensure that the community is still fully informed and engaged (Marshall & Batten, 2003)?	1 2 3 4 5
Hope	Have we conveyed information about this project/study in ways that will convey hope to individuals, families, and communities, e.g., emphasis on strengths, resiliencies, and solutions rather than focus on the intractability of problems (See White & Sanders, 2008)?	1 2 3 4 5
Advocacy	Have we taken what we have learned in this collaboration about recovery support needs and supported recovery community mobilization, promoted pro-recovery policies, and garnered resources to address these unmet needs?	1 2 3 4 5
Service via Transfer of Knowledge	Have we—both professional and indigenous partners—disseminated findings and lessons from this project in ways that will reach members of diverse communities of recovery and the larger pool of individuals concerned about the effects of alcohol and drugs on individuals, families, and communities?	1 2 3 4 5
Gratitude	Have we consistently expressed our gratitude for the collaborative relationship?	1 2 3 4 5
Self-interest	Have we protected ourselves and our organization from any harm that could result from this collaboration?	1 2 3 4 5
Measurement	Have we integrated culturally nuanced measures of change with professional/scientific approaches to evaluation? Have we measured changes in the family, neighborhood, and community environment as well as changes in individuals? Were data for this project collected in a culturally nuanced manner?	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5

Summary

Collaborations between the professional/scientific community and new recovery community institutions mark new territory laden with complex ethical and professional practice issues. This article presents an instrument that can be used for purposes of self-evaluation by organizations involved in such collaborations. Once such an inventory has been completed by

the key participants in the collaboration, discussions can begin on how to sustain or improve performance in these key areas.

Acknowledgement: Support for this work was provided by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

References

Achara-Abrahams, I., Evans, A. C., & King, J. K. (2011). Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 187–208). New York: Springer Science.

Achara-Abrahams, I., Evans, A. C., Ortiz, J., Villegas, D. L., O'Dell, J., Ali, O., & Hawkins, D. (2012). Recovery management and African Americans: A report from the field. *Alcoholism Treatment Quarterly*, *30*, 263-292. doi:10.1080/07347324.2012.691049

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review, 50*, 443–456.

Brave Heart, M. Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7-13. doi:10.1080/02791072.2003.10399988

Brave Heart, M. Y., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma among indigenous peoples of the Americas: Concepts, research and clinical considerations. *Journal of Psychoactive Drugs*, *43*(4), 282-290. doi:10.1080/02791072.2011.628913

Brave Heart, M. Y., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research Journal, 8*(2), 60-82.

Buck, J. A. (2011). The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Affairs*, *30*(8), 1402–1410. doi:10.1377/hlthaff.2011.0480

Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

Echo-Hawk, H. (2011). Indigenous communities and evidence building. *Journal of Psychoactive Drugs*, *43*(4), 269-275. doi:10.1080/02791072.2011.628920

Green, L., George, M. A., Daniel, M., Frankish, C. J., Herbert, C. J., Bowie, W. R., & O'Neil, M. (2007). Guidelines and categories for classifying participatory research projects in health. Royal Society of Canada, Ontario. Retrieved September 27, 2012 from http://lgreen.net/guidelines.html

Lamb, R., Evans, A. C., & White, W. (2009). The role of partnership in recovery-oriented systems of care: The Philadelphia experience. Accessed November 30, 2012 at www.facesandvoicesofrecovery.org

Lucero, E. (2011). From tradition to evidence: Decolonization of the evidence-based practice system. *Journal of Psychoactive Drugs*, *43*(4), 319-324. doi:10.1080/02791072.2011.628925

Marshall, A., & Batten, S. (2003). Ethical issues in cross-cultural research. In W. M. Roth (Ed.), *Connections* (pp. 139 – 151). Retrieved September 27, 2012 from http://education2.uvic.ca/Research/conferences/connections2003/10Marshall105.pdf

Sanders, M., & Powell, J. (2012). Multiple pathways of recovery for African American men. *Alcoholism Treatment Quarterly*, *30*, 315-325. doi:10.1080/07347324.2012.690697

Valentine, P. (2011). Peer-based recovery support services within a recovery community organization: The CCAR experience. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 259–279). New York: Springer Science.

Wharerätä Group. (2010). The Wharerätä Declaration. Retrieved September 14, 2012 from http://wmhconf2010.hhd.org/sites/wmhconf2010.hhd.org/files/the%20wharerata%20declaration.pdf

White, W., Humphreys, K., Bourgeois, M., Chiapella, P., Evans, A., Flaherty, M.,…Taylor, P., (2012). *The status and future of addiction recovery support services in the United States*. Manuscript submitted for publication.

White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1–2), 21–61.

White, W. L. (2007). The new recovery advocacy movement in America. *Addiction, 102,* 696–703. doi:10.1111/j.1360-0443.2007.01808.x

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.

White, W. L. (2010). Non-clinical addiction recovery support services: History, rationale, models, potentials and pitfalls. *Alcoholism Treatment Quarterly, 28*, 256–272. doi:10.1080/07347324.2010.488527

White, W. L., Kelly, J. F., & Roth, J. D. (2012). New addiction-recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery, 7*(2-4), 297-317. doi:10.1080/1556035X.2012.705719

White, W. L., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits, R. & Donohue, B. (2007). *Ethical guidelines for the delivery of peer-based recovery support services*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. L., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395. doi:10.1080/07347320802072198



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: Evans, A.C., Lamb, R. & White, W.L. (2014). Promoting Intergenerational Resilience and Recovery: Policy, Clinical, and Recovery Support Strategies to Alter the Intergenerational Transmission of Alcohol, Drug, and Related Problems. Philadelphia: Department of Behavioral Health and Intellectual disAbility Services. Posted at **www.williamwhitepapers.com**

Promoting Resilience and Recovery: Policy, Clinical, and Recovery Support Strategies to Inhibit the Intergenerational Transmission of Addiction and Related Problems

Arthur C. Evans, Jr., PhD, Roland Lamb, MA, and William L. White, MA

In 2005, the City of Philadelphia began transformation of its behavioral health system around the principles of resilience, recovery, and self-determination. The resulting processes and programs have drawn national and international attention in tandem with the emergence of recovery as a new organizing paradigm within the alcohol and drug (AOD) problems and larger behavioral health arenas.[1] Clinical responses to severe, complex, and chronic AOD problems have since begun to shift from models of acute biopsychosocial stabilization to models of sustained recovery management wrapped within larger recovery-oriented systems of care.[2] This shift entails the integration of person- and family-focused clinical interventions with larger environmental (population-based public health) approaches to enhancing the long-term health of whole communities.[3]

One of the critical questions emerging within this integration is how to break intergenerational cycles of AOD and related problem transmission at personal, family, and community levels.[4] This paper: 1) reviews the processes and mechanisms through which alcohol and other drug problems are transmitted within and across generations, 2) identifies protective

[1] Achara-Abrahams, I., Evans, A. C., & King, J. K. (2011). Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 187-208). New York: Springer Science. El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine, 6*(1), 1-9. Wardle, I. (2012). Five years of recovery: December 2005 to December 2010—From challenge to orthodoxy. *Drugs: Education, Prevention and Policy*, *19*(4), 294-298. White, W. L. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.

[2] Kelly, J. F., & White, W. L. (Eds., 2011). *Addiction recovery management: Theory, science and practice* (pp. 187-208). New York: Springer Science. White, W. L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

[3] Evans, A. C., Lamb. R., & White, W. L. (2013). The community as patient: Recovery-focused community mobilization in Philadelphia, 2005-2012. *Alcoholism Treatment Quarterly*, *31*(4), 450-465.

[4] White, W. L., & Chaney, R. A. (2008). Intergenerational patterns of resistance and recovery within families with histories of alcohol and other drug problems: What we need to know. Posted at www.facesandvoicesofrecovery.org

personal, family, and environmental factors that can neutralize or diminish such transmission, and 3) explores potential policies and community-level programming through which the City of Philadelphia can reduce the long-term prevalence of substance use disorders among its population through targeted services to high-risk children and families. The purpose of this paper is to provide a platform for discussion between the Philadelphia Department of Behavioral Health and Intellectual disAbility Services and its community partners toward the goal of formulating a long-term strategy to break intergenerational cycles of addiction and related problems within the City of Philadelphia.

Background

The addiction research literature is replete with references to *family density of alcoholism*, *familial loading for alcoholism*,[5] *familial aggregation of alcoholism*,[6] *family aggregation of substance abuse*,[7] *intergenerational continuity of substance use*,[8] *intergenerational transmission of substance abuse*,[9] and the *intergenerational cycle of substance abuse*.[10] In fact, concern about the intergenerational transmission of substance use disorders (SUDs) dates to the earliest days of the American Temperance Movement.[11]

Most research to date on the intergenerational transmission of substance use disorders (SUDs) has focused on the intergenerational effects of alcohol use disorders. One in four children under age 18 (28.6% of all children in the U.S.) are exposed to alcohol use disorder (AUD) in the family.[12] Children with parents with an AUD have an elevated risk of developing an SUD over the life course compared to children without this risk factor, although the degree of such risk varies across studies.[13] Risk may extend from dependence on a specific substance to

---

[5] Hill, S. Y., & Yuan, H. (1999). Familial density of alcoholism and onset of adolescent drinking. *Journal of Studies on Alcohol, 60*, 7-17.

[6] Grant, B. F. (2000). Estimates of US children exposed to alcohol abuse and dependence in the family. *American Journal of Public Health, 90*(1), 112-115.

[7] Miles, D. R., Stallings, M. C., Young, S. E., Hewitt, J. K., Crowley, T J., & Fulker, D. W. (1998). A family history and direct interview study of familial aggregation of substance abuse: the adolescent substance abuse study. *Drug and Alcohol Dependence*, *49*, 105-114.

[8] Bailey, J. A., Hill, K. G., Oesterle, S., & Hawkins, J. D. (2006). Linking substance use and problem behavior across three generations. *Journal of Abnormal Child Psychology*, *34*(3), 273-292. Fawzy, F. I., Coombs, R. H., & Gerber, B. (1983). Generational continuity in the use of substance: The impact of parental substance use on adolescent substance use. *Addictive Behaviors*, *8*, 109-114. Knight, K., Menard, S & Simmons, S. (2013). *Intergenerational continuity of substance use. Substance Use & Misuse*, Posted online on August 21, 2013. (doi:10.3109/10826084.2013.824478)

[9] Markwood, M., Dozier, C., Hooks, K., & Markwood, N. (2000). Culture and the intergenerational transmission of substance abuse, woman abuse, and child abuse: A diathesis-stress perspective. *Children and Youth Services Review*, *22*(3-4), 237-250.

[10] Sheridan, M. J. (1995). A proposed intergenerational model of substance abuse, family functioning, and abuse/neglect. *Child Abuse & Neglect, 19*(5), 519-530.

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

[12] Grant, B. F. (2000). Estimates of US children exposed to alcohol abuse and dependence in the family. *American Journal of Public Health*, *90*(1), 112-115.

[13] Chassin, L., Pitts, S. C., DeLucia, C., & Todd, M. (1999). A longitudinal study of children of alcoholics: Predicting young adult substance use disorders, anxiety, and depression. *Journal of Abnormal Psychology, 108*(1), 106-119. Hoffman, J. P., & Cerbone, F. G. (2002). Parental substance use disorder and the risk of adolescent drug abuse: An event history analysis. *Drug and Alcohol Dependence*, *66*, 255-264. Hussong, A. M., & Chassin, L. (1997). Substance use initiation among adolescent children of alcoholics: Testing protective factors. *Journal of Studies on Alcohol, 58*(3), 272-279. Jacob, T., & Windle, M. (2000). Young adult children of alcoholics, depressed, and non-distressed parents. *Journal of Studies on Alcohol, 61*, 836-844. Pandina, R. J., & Johnson, V. (1990). Serious alcohol and drug problems among adolescents with a family history of alcoholism. *Journal of Studies on Alcohol, 51*(3), 278-282. Bailey, J. A., Hill, K. G., Oesterle, S., & Hawkins, J. D. (2006). Linking substance use and problem behavior across three generations. *Journal of Abnormal Child Psychology*, *34*(3), 273-292.

increased risk for a broad spectrum of substance use patterns,[14] early onset of alcohol use,[15] increased frequency of binge drinking,[16] and a more rapid progression of problem development.[17]

Children of parents with SUDs are more than 5 times more likely to develop an AOD-related problem, including tobacco dependence, than children without parental alcoholism.[18] Children with family histories of drug use disorders other than AUD are as much as 8 times more likely to subsequently develop a drug use disorder than children without such family history.[19] There is a documented "generalization effect" through which children of alcohol dependent parents consume a far greater variety of substances than their addicted parents.[20] Early manifestations of this SUD risk factor include disinhibition, impulsivity, and sensation seeking.[21]

The risks faced by children of an SUD-affected parent extend beyond vulnerability to alcohol problems to include increased vulnerability for other drug problems, conduct disorder, delinquency, antisocial personality, anxiety, depression, suicide, eating disorders, school absenteeism, school failure, teen pregnancy, violence, and accidents).[22] These effects can extend into adult relationship difficulties, including the increased risk of selecting intimate partners with substance-related problems.[23]

---

[14] Grant, B. F. (2000). Estimates of US children exposed to alcohol abuse and dependence in the family. *American Journal of Public Health, 90*(1), 112-115. Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance use prevention. *Psychological Bulletin*, *112*, 64-105. Pandina, R. J., & Johnson, V. (1990). Serious alcohol and drug problems among adolescents with a family history of alcoholism. *Journal of Studies on Alcohol, 51*(3), 278-282.

[15] Hill, S. Y., & Yuan, H. (1999). Familial density of alcoholism and onset of adolescent drinking. *Journal of Studies on Alcohol*, *60*, 7-17.

[16] Bröning, S., Kumpfer, K., Kruse1, K., Sack, P., Schaunig-Busch, I., Ruths, S., Moesgen, D., Pflug, E. Klein, & Thomasius, R. (2012). Selective prevention programs for children from substance-affected families: a comprehensive systematic review. *Substance Abuse Treatment*, *Prevention*, *and Policy* 2012, 7:23 Accessed January 8, 2014 at http://www.substanceabusepolicy.com/content/7/1/23

[17] Chassin, L., Currran, P. J., Hussong, A. M., & Colder, C. R. (1996). The relation of parent alcoholism to adolescent substance use: A longitudinal follow-up study. *Journal of Abnormal Psychology*, *105*(1), 70-80.

[18] Chassin, L., Rogosch, F., & Barbera, M. (1991). Substance use and symptomatology among adolescent children of alcoholics. *Journal of Abnormal Psychology*, *100*(4), 449-463. Ford, E.S., Anda, R.F., Edwards, V.J., Perry, G.S., Zhao, G. Li, C. & Croft, J.B. (2011). Adverse childhood experience and smoking status in five states. *Preventive Medicine*, 53(3), 188-93.

[19] Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M.A., Fenton, B. Zhang, H., O'Malley, S., Rounsaville, B. (1998). Familial transmission of substance use disorders.. *JAMA Psychiatry*, 55(11), 973-979.

[20] Fawzy, F. I., Coombs, R. H., & Gerber, B. (1983). Generational continuity in the use of substance: The impact of parental substance use on adolescent substance use. *Addictive Behaviors, 8*, 109-114.

[21] Mylant, M. L., Ide, B., Cuevas, E., & Meehan, M. (2002). Adolescent children of alcoholics: Vulnerable or resilient? *Journal of the American Psychiatric Nurses Association*. *8*(2), 57-64.

[22] Miles, D. R., Stallings, M. C., Young, S. E., Hewitt, J. K., Crowley, T. J., & Fulker, D. W. (1998). A family history and direct interview study of familial aggregation of substance abuse: the adolescent substance abuse study. *Drug and Alcohol Dependence*, *49*, 105-114. Price, A. W., & Emshoff, J. G. (1977). Breaking the cycle of addiction: Prevention and intervention with children of alcoholics. *Alcohol Health and Research World, 21*(3), 241-245. Fuller-Thomson, E., Katz, B., Phan, T., Liddycoat, P.M. & Brennenstuhl, S. (2013). The long arm of parental addictions: The Association with adult children's depression in a population-based study. *Psychiatry Research*, 210(1), 95-101.

[23] Greenfield, S. F., Swartz, M. S., Landerman, L. R., & George, L. K. (1993). Long-term psychosocial effects of childhood exposure to parental problem drinking. *American Journal of Psychiatry*, *150*, 608-613.

Only a minority of children of alcoholics (COAs) develop an SUD[24]—between 33-40%,[25] with many leading highly successful lives,[26] and there are people without family risk factors who develop SUDs .[27] It is not possible to predict a child's future development solely based on parental addiction status,[28] but addiction risk is much greater within affected families than in the general population, and this risk may be intensified by increased density of SUD within one's familial history (e.g., grandparents, aunts/uncles, etc.).[29] The presence, intensity, and duration of childhood problems in the face of parental AOD-related problems are predicted not by parental SUD status alone but the interaction of multiple risk factors and the availability of key protective factors.[30] These multiple risk and protective factors appear to influence a broad spectrum of intergenerational problems, including addiction and other behavioral health challenges, poverty, education failure, unemployment, incarceration, trauma, child neglect, and abuse as well as other forms of trauma and violence.

We will next summarize research on eleven potential mechanisms involved in the intergenerational transmission of AOD-related problems.

Pathways, Mechanisms, and Trajectories of AOD Problem Transmission

SUDs are transmitted intergenerationally through a variety of genetic/biological and environmental (parent/sibling/family, peer, and community) mechanisms that vary across individuals and subgroups.[31] These pathways and mechanisms exert independent effects but may also operate simultaneously and interact to magnify the total risk profile.

Genetic/Neurobiological Influences. Early studies of twins separated at birth found twins with a biological alcoholic parent were 4 times more likely to develop adult alcoholism as children without this family risk.[32] Subsequent studies confirmed such risks and extend such risks to the

[24] Slutske, W. S., D'Onofrio, B. M., Turkheimer, E., Emery, R. E., Harden, K. P., Heath, A. C., & Martin, N. G. (2008). Searching for an environmental effect of parental alcoholism on offspring alcohol use disorder: A genetically informed study of children of alcoholics. *Journal of Abnormal Psychology, 117*, 534-551. Windle, M., & Tubman, J. G. (1999). Children of alcoholics. In W. K. Silverman & T. Ollendick (Eds.), *Developmental issues in the clinical treatment of children and adolescents* (pp. 393-414). Allyn & Bacon: Needhma Heights, MA.

[25] Bröning, S., Kumpfer, K., Kruse1, K., Sack, P., Schaunig-Busch, I., Ruths, S., Moesgen, D., Pflug, E. Klein, & Thomasius, R. (2012). Selective prevention programs for children from substance-affected families: a comprehensive systematic review. *Substance Abuse Treatment, Prevention, and Policy* 2012, 7:23 Accessed January 8, 2014 at http://www.substanceabusepolicy.com/content/7/1/23

[26] Mylant, M. L., Ide, B., Cuevas, E., & Meehan, M. (2002). Adolescent children of alcoholics: Vulnerable or resilient? *Journal of the American Psychiatric Nurses Association*. *8*(2), 57-64. Luthar, S. S., Cichetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*, 543-562.

[27] Schuckit, M. & Smith, T. (2001). The clinical course of alcohol dependence associated with a low level of response to alcohol. *Addiction*, 96, 903-910.

[28] Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies on Alcohol, 47*(1), 34-40.

[29] Harford, T. C., & Grant, B. F. (1990). Alcohol abuse among grandsons of alcoholics: Some preliminary findings. *Alcoholism: Clinical and Experimental Research, 14*(5), 739-740.

[30] Barnard, M., & McKegany, N. (2004). The impact of parental drug use on children: What is the problem and what can be done to help? *Addiction*, *99*, 552-559.

[31] Orford, J., & Velleman, R. (1991). Environmental intergenerational transmission of alcohol problems: A comparison of two hypotheses. *British Journal of Medical Psychology, 64*(2), 189-200. Whiteman, S. D., Jensen, A. C., & Maggs, J. L. (2013). Similarities in adolescent siblings' substance use: Testing competing pathways of influence. *Journal of Studies on Alcohol and Drugs*, *74*, 104-113.

[32] Goodwin, D. W., Schulsinger, F., Hermansen, L., Guze, S. B., & Winokur, G. (1973). Alcohol problems in adoptees raised apart from alcoholic biological parents. *Archives of General Psychiatry*, *28*, 238-243. Schuckit, M. A. (1972). Family history and half-sibling research in alcoholism. *Annals of the New York Academy of Science*, *197*, 121-125.

transmission of other SUDs[33] and sparked speculation of a common genetic risk for multiple substance dependencies.[34]

There is growing consensus that there are multiple genes and chromosomes involved in such transmission as opposed to a single mechanism of gene expression and that the genetic risks for SUDs can be magnified by environmental conditions.[35] The focus on genetic research has been on parental SUD, but SUD risk may also be influenced by greater density of SUD within the family and extended family.[36]

Research examining the precise source of genetic risk for SUD has focused on such factors as:

- impaired neuropsychological functioning (executive functioning of the brain) affecting decision-making and judgment,
- atypical tolerance (less subjective experience of intoxication from low levels of consumption) predicts 4-fold increase in risk for alcohol use disorder,[37]
- greater neurological reward (stronger euphoric effects) and greater stress-response dampening (e.g., enhanced sense of personal power, tension reduction, and social comfort and fluidity),[38] and
- less early negative feedback from AOD experiences.

Genetic risks may be magnified when combined with prenatal and postnatal neurological insult.

Fetal Alcohol Spectrum Disorders (FASDs) span a broad array of functional deficits resulting from prenatal alcohol exposure. Since the 1973 discovery of fetal alcohol syndrome (FAS) by Jones and Smith, research has established a much broader span of severity of effects of such exposure, including more subtle functional impairments that would not meet criteria for FAS. These effects include impairments in brain functioning (e.g., memory, impaired capacity for attention and sustained focusing, choice generation, choice analysis, impaired problem solving, and learning from past experience) among persons with normal intelligence and without the distinctive facial characteristics often associated with FAS.[39] In fact, those with milder forms of FASDs may be at greater risk for the development of substance use disorders than those with FAS.[40]

---

[33] Prescott, C., & Kendler, K. (1999). Genetic and environmental contributions to alcohol abuse and dependence in a population-based sample of male twins. *American Journal of Psychiatry*, *156*, 34-40. Tsuang, M. T., Lyons, M. J., Eisen, S. A., Goldberg, J., True, W., Lin, N.,…Eaves, L. (1996). Genetic influences on DSM-II-R drug abuse and dependence: A study of 3,372 twin pairs. *American Journal of Medical Genetics*, *67*, 473-477. Vassoler, F. M., & Sadri-Vakali, G. (2013). Mechanisms of transgenerational inheritance of addictive-like behaviors. *Neuroscience*. doi: 10.1016/j.neuroscience.2013.07.064

[34] Kendler, K. S., Jacobson, K. C., Prescott, C. A., & Neale, M. C. (2003). Specificity of genetic and environmental risk factors for use and abuse/dependence of cannabis, cocaine, hallucinogens, sedatives, stimulants, and opiates in male twins. *American Journal of Psychiatry*, *160*, 687-695.

[35] Douglas-Siegal, J. A., & Ryan, J. P. (2013). The effect of recovery coaches for substance-involved mothers in child welfare: Impact on juvenile delinquency. *Journal of Substance Abuse Treatment*, *45*, 381-387.

[36] Bailey, J. A., Hill, K. G., Oesterle, S., & Hawkins, J. D. (2006). Linking substance use and problem behavior across three generations. *Journal of Abnormal Child Psychology*, *34*(3), 273-292.

[37] Schuckit, M. & Smith, T. (2000). A comparison of correlates of DSM-IV alcohol abuse or dependence among more than 400 sons of alcoholics and controls. *Alcoholism: Clinical and Experimental Research*, 25(1), 1-8.

[38] Levenson, R. W., Oyama, O. N., & Meel, P. S. (1987). Greater reinforcement from alcohol for those at risk: Parental risk, personality risk, and sex. *Journal of Abnormal Psychology*, *96*, 242-253. Newlin, D. B. & Thomson, J. B. (1990). Alcohol challenge with sons of alcoholics: A critical review and analysis. *Psychological Bulletin*, *108*, 383-402.

[39] Grant, T.M., Browh, N.N., Dubovsky, D., Sparrow, J. & Ries, R. (2013). The impact of prenatal alcohol exposure on addiction treatment. *Journal of Addiction Medicine*, 7(2), 87-95.

[40] Streissguth, A., Barr, H., Kogan, J. et al, (1996). *Understanding the occurrence of secondary disabilities in clients with fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE)*. Final report to the Centers for Disease Control and Prevention. Seattle, WA: University of Washington, Fetal Alcohol and Drug Unit, Tech Report No. 96-06.

A recent research review of FASDs by Therese Grant and colleagues[41] reported several findings of import to the issue of intergenerational transmission of AOD-related problems, including:

- increased risk for early onset AOD use and related problems,
- increased risks for adult substance use disorders among persons who have experienced FASDs (e.g., with nearly half of adults with FASDs experiencing a substance use disorder)[42],
- increased risks for mood disorders which can in turn heighten risk for excessive AOD consumption and related problems,
- decreased social skills that could heighten risk for involvement in AOD-using social networks, and
- neurocognitive impairments of patients with FASDs undergoing addiction treatment may compromise treatment engagement, completion, and post-treatment recovery outcomes.

In spite of these findings, Grant and colleagues also discovered that addiction treatment programs did not routinely screen for FASDs nor provide specialized approaches to the treatment of patients with learning or behavioral problems resulting from FASDs.

In reviewing local experience in the Philadelphia areas with FASDs, local informants noted other factors through which FASDs could contribute to the intergenerational transmission of substance use disorders. These risk factors include defective parenting, increased risk for neglect and abuse (including multiple placements in the child welfare system), increased risk for physical/sexual trauma resulting from impaired parental supervision, risks of early pregnancy while using alcohol and other drugs, and subsequent recycling of risk factors in next generation.[43]

Assortative Mating. Genetic and neurobiological risks within families affected by SUDs may be enhanced by the propensity of children exposed to parental SUDS to later be attracted to and marry individuals who share this SUD family history. The children born of such unions may have elevated SUD risks due to the progressive concentration of genetic risk across generations resulting from this selection process.[44] Assortative mating offers one explanation for the progressive density of AOD-related problems across generations. This same process may also elevate other risk for children raised in this environment, e.g., increasing risk of prenatal AOD exposure.[45]

Co-occurring Conditions and Temperament. SUD risk of children exposed to parental SUD may also flow from a more indirect route. For example, some researchers have speculated that intergenerational SUDs could be spawned by exposure to parental conditions that generate risks for the development of externalizing disorders that can be expressed via excessive AOD use. Others have suggested that genetically influenced psychiatric illnesses in children and adolescents increase the risk for self-medication with alcohol and other drugs and the subsequent development of SUDs. Others have attributed the mechanism of risk transmission

---

[41] Grant, T.M., Browh, N.N., Dubovsky, D., Sparrow, J. & Ries, R. (2013). The impact of prenatal alcohol exposure on addiction treatment. *Journal of Addiction Medicine*, 7(2), 87-95.

[42] Streissguth, A., Barr, H., Kogan, J. et al, (1996). *Understanding the occurrence of secondary disabilities in clients with fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE)*. Final report to the Centers for Disease Control and Prevention. Seattle, WA: University of Washington, Fetal Alcohol and Drug Unit, Tech Report No. 96-06.

[43] Personal communications with Bev Haberle, PRO-ACT, March 2014.

[44] Orford, J., & Velleman, R. (1991). Environmental intergenerational transmission of alcohol problems: A comparison of two hypotheses. *British Journal of Medical Psychology, 64*(2), 189-200. Merikangas, K. & Brunetto, W. (1996). Assortative mating and psychiatric disorders. In G. Papasimitrou, & J. Medlewicz (Eds.), *Baillier's clinical psychiatry: International practice and research* (pp. 175-185). London, England: Baliiere Tindall.

[45] Bailey, J. A., Hill, K. G., Oesterle, S., & Hawkins, J. D. (2006). Linking substance use and problem behavior across three generations. *Journal of Abnormal Child Psychology*, *34*(3), 273-292.

to be via temperament (rebelliousness, unconventionality, impulsiveness, emotional hyper-reactivity, sensation-seeking, risk-taking, behavioral hyperactivity, low capacity for persistence, slow rate of stress decompression, emotionally disinhibited, and anxiety),[46] early conduct disorder,[47] and self-medication of deficits.[48]

Developmental/Historical Trauma. Adverse childhood experiences (addicted or mentally ill parent, parental discord/separation/divorce, or physical/sexual abuse) increase the likelihood of early age of onset of drinking and drinking to cope (versus for pleasure or social conformity) during early onset of alcohol use.[49] Exposure to parental alcoholism significantly increases the range and intensity of stressors experienced by children of these parents.[50] Also of note are the elevated rates of physical and sexual abuse among children of parents with SUDs.[51] While there are mixed findings on the association between childhood physical/sexual abuse and the development of adolescent/adult SUDs,[52] there is a general association between the former and the latter, particularly among women.[53] Substance use in such circumstances may serve as a mechanism to regulate negative affect related to PTSD, and the damaged self-esteem emanating from such trauma can lead to deviant peer associations, which in turn leads to increased AOD exposure.[54]

The links between developmental trauma and adult SUD risk may be magnified in the presence of particular traumagenic factors, including early age of onset of trauma, long duration of trauma, a larger cumulative volume of traumatic events, trauma inflicted by family members, multiple perpetrators of trauma, more physically invasive forms of trauma, physical violence or threat of such violence as a dimension of the trauma, and response to disclosure of trauma (disbelief or blame rather than protection).[55] Adverse childhood experiences increase the risks

---

[46] Chassin, L., Pillow, D. R., Curran, P. J., Molina, B. S. G., & Barrera, M. (1993). Relation of parental alcoholism to early adolescent substance use: A test of three mediating mechanisms. *Journal of Abnormal Psychology, 102*(1), 3-19.

[47] Merikangas, K. R., Dierker, L. C., & Szatmari, P. (1998). Psychopathology among offspring of parents with substance abuse and/or anxiety disorders: A high-risk study. *Journal of Child Psychology and Psychiatry*, *39*, 711-720.

[48] Kumpfer, K. L. & Bluth, B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to "substance abuse disorders". *Substance Use & Misuse*, *5*, 671-698.

[49] Rothman, E. F., Edwards, E. M., Hereen, E. N., & Hingson, R. W. (2008). Adverse childhood experiences predict earlier age of drinking onset: Results from a representative U.S. Sample of current and former drinkers. *Pediatrics*, *122*(2), 298-304.

[50] Sher, K. J., Gershuny, B. S., Peterson, L., & Raskin, G. (1997). The role of childhood stressors in the intergenerational transmission of alcohol use disorders. *Journal of Studies on Alcohol*, *58*(4), 414-427. Anda, R.F., Whitfield, C.L., Felitti, V.J., Chapman, D., Edwards, V.J., Dube, S.R. & Williamson, D.F. (2002). Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression, *Psychiatric Services*, 53(8), 1001-9. Dube, S.R., Anda, R.F., Felitti, V.J., Croft, J.B., Edwards, V.J & Giles, W.H. (2001). Growing up with parental alcohol abuse: Exposure to childhood abuse, neglect, and household dysfunction. *Child Abuse and Neglect*, 25(12), 1627-40.

[51] Langeland, W., & Hartgers, C. (1998). Child sexual and physical abuse and alcoholism: A review. *Journal of Studies on Alcohol, 59*, 336-348.

[52] Sher, K. J., Gershuny, B. S., Peterson, L., & Raskin, G. (1997). The role of childhood stressors in the intergenerational transmission of alcohol use disorders. *Journal of Studies on Alcohol*, *58*(4), 414-427. Elliott, J.C., Stohl, M., Wall, M.M., Keyes, K.M., Goodwin, R.D., Skodol, A.E., Krueger, R.F., Grant, B.F. & Hasin, D.S. (2014). The risk of persistent adult alcohol and nicotine dependence: the role of childhood maltreatment. Addiction, e-pub ahead of print, accessed March 25, 2014 At: http://www.ncbi.nlm.nih.gov/pubmed/24401044

[53] Langeland, W., & Hartgers, C. (1998). Child sexual and physical abuse and alcoholism: A review. *Journal of Studies on Alcohol, 59*, 336-348. Wilsnack, S. C., Vogeltanz, N. D., Klassen, A. D., & Harris, T. R. (1997). Childhood sexual abuse and women's substance abuse: National survey findings. *Journal of Studies on Alcohol*, *58*, 264-271. Mersky, J.P., Topitzes, J. & Reynolds, A.J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: A cohort study of an urban, minority sample in the U.S. *Child Abuse and Neglect*, 37(11), 917-25.

[54] Kaplan, H. B. (1980). *Deviant behavior in defense of self*. New York: Academic Press. Chassin, L., Pillow, D. R., Curran, P. J., Molina, B. S. G., & Barrera, M. (1993). Relation of parental alcoholism to early adolescent substance use: A test of three mediating mechanisms. *Journal of Abnormal Psychology, 102*(1), 3-19.

[55] White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best practices resource manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse. Xiao, Q., Dong, M.X., Yao, J;, Li. W.X. & Ye, D.Q. (2008).

of developing alcohol problems in later life as a response to stressful experiences[56] and contribute to substance use problem persistence in the face of substance-related illnesses.[57]

Historical trauma, such as that experienced by Native American tribes, has been linked to the intergenerational transmission of AOD and related problems through the mechanisms of negative affect, loss of institutions for acculturation and support, and the depletion of coping skills.[58]

Family Dynamics and Parenting. Studies of family dynamics surrounding parental addiction note unrealistic expectations of children, poor boundary management, low cohesion, weak communication, heightened conflict, role ambiguity and role reversals, lower levels of parental competence, and increased risk of neglect and maltreatment as well as increased risk of victimization by persons outside the immediate family.[59] Reports of ineffective parenting by substance-affected parents note weak engagement, transmission of negative affect, inadequate support, inadequate, inconsistent or harsh discipline, hostile communications and conflict, weak rule-setting, monitoring and supervision, hardship, increased access to dangerous substances, and paradoxical effects of mother/father problem disclosure—increasing rather than decreasing SUD risk among children.[60] These conditions can be further exacerbated by poverty, minority status, and single parenthood.[61] Weak monitoring has been linked to increased involvement with AOD-using peers, and strict alcohol-specific rule setting and monitoring in combination with warm parent-child communication have been shown to lower rates of early alcohol exposure and alcohol-related problems.[62] What have been characterized as "closed family systems" may result in AOD use as an expression of adolescent individuation and separation while simultaneously isolating the family from community resources to intervene early in the development of AOD problems.

Parental Modeling and Collusion. Much of the family literature on parental influences on intergenerational SUD transmission has focused on such specific mechanisms as parental modeling (child emulation/identification of parental AOD use) and its effects on positive AOD

Parental alcoholism, adverse childhood experiences, and later risk of personal alcohol abuse among Chinese medical students. *Biomedical and Environmental Sciences*, 21(5), 411-19.

[56] Keys, K.M., Shmulewitz, D., Greenstein, E., McLaughlin, K., Wall, M., Aharonovish, E., Weizman, A., Frish, A., Spivak, B., Grant. B.F. & Hasin, D. (2014). Exposure to the Lebanon War of 2006 and effects on alcohol use disorders: The moderating role of childhood maltreatment. *Drug and Alcohol Dependence*, 134, 296-303.

[57] Edwards, V.J., Anda, R.F., Gu, D., Dube, S.R. & Felitti, V.J. (2007). Adverse childhood experiences and smoking persistence in adults with smoking-related symptoms and illness. *The Permanente Journal*, 11(2), 5-13.

[58] Brave Heart, M. Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, *35*(1), 7-13. Brave Heart, M. Y., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research Journal*, *8*(2), 60-82.

[59] Sheridan, M. J. (1995). A proposed intergenerational model of substance abuse, family functioning, and abuse/neglect. *Child Abuse & Neglect, 19*(5), 519-530.

[60] Chassin, L., Pillow, D. R., Curran, P. J., Molina, B. S. G., & Barrera, M. (1993). Relation of parental alcoholism to early adolescent substance use: A test of three mediating mechanisms. *Journal of Abnormal Psychology, 102*(1), 3-19. Hawkins, J.D., Catalano, R.F. & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance use prevention. *Psychological Bulletin*, 112, 64-105. Jacob, T., & Johnson, S. (1997). Parenting influences on the development of alcohol abuse and dependence. *Alcohol Health and Research World, 21*(3), 204-209.

[61] Barnard, M. & McKegany, N. (2004). The impact of parental drug use on children: What is the problem and what can be done to help? *Addiction*, *99*, 552-559.

[62] Chassin, L., Pillow, D. R., Curran, P. J., Molina, B. S. G., & Barrera, M. (1993). Relation of parental alcoholism to early adolescent substance use: A test of three mediating mechanisms. *Journal of Abnormal Psychology*, *102*(1), 3-19. Konig, I.M., Van Den Eijnden, R, & Vollebergh, W.M. (2014). Alcohol-specific parenting, adolescents' self-control, and alcohol use: A moderated mediation model. *Journal of Studies on Alcohol and Drugs*, 75, 16-23. Li, K., Simons-Morton, B.G., Brooks-Russell, A. Ehsani, J. & Hingson, R. (2014). Drinking and parenting practices as predictors of impaired driving behaviors among U.S. adolescents. *Journal of Studies on Alcohol and Drugs*, 75, 5-15.

beliefs/expectancies[63]and parental collusion (coaching and permissiveness related to AOD use.[64] The magnification of risk may be greatest if parental AOD dependence overlaps the adolescent development of their children.[65] The literature also notes the potential for "aversive transmission"—AOD problems in a parent sparking aversion to AOD (abstinence or minimal AOD use) in a child.[66]

Older Sibling Influences. Several studies have suggested that sibling influence on AOD use could be greater than parental influence,[67] particularly when the AOD-involved sibling is older, close-in-age, same-sex, and shares a peer social network with the other siblings.[68] Siblings of older youth with AOD problems are at increased risk of developing such problems if they experiment with AOD use during adolescence and do so during pre-adolescence or early adolescence.[69] The mechanisms of such influence include modeling, introduction to drug-using peer network, and opportunities for substance procurement and use.[70]

Early Age of Onset of AOD Use. As noted, a number of confluent factors influence early onset of AOD use among children whose parents have an SUD compared to children without this parental risk factor.[71] Two things are significant related to this finding. First, early onset of AOD use is:

- predictive of adult SUD,[72]
- faster development of drug dependence,[73]
- greater problem severity,[74]

---

[63] Belles, S., Budde, A., Moesgen, D., & Klein, M. (2011). Parental problem drinking predicts implicit alcohol expectancy in adolescents and young adults. *Addictive Behaviors*, *36*, 1091-1094. Wiers, R. W., Gunning, W. B., & Sergeant, J. A. (1998). Do young children of alcoholics hold more positive or negative alcohol-related expectancies than controls? *Alcoholism, Clinical and Experimental Research*, *22*, 1855–1863. Ullman, A. D., & Orenstein, A. (1994). Why some children of alcoholics become alcoholics: Emulation of the drinker. *Adolescence, 29*(113), 1-11.

[64] Varvil-Weld, L., Mallett. K. A., Turrisi, R., & Abar, C. C. (2013). Using parental profiles to predict membership in a subset of college students experiencing excessive alcohol consequences: Findings from a longitudinal study. *Journal of Studies on Alcohol and Drugs*, *73*, 434-443.

[65] Biederman, J., Faraone, S. V., Monuteaux, M. C., & Feighner, J. A. (2000). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics, 106*(4), 792-797.

[66] Ullman, A. D., & Orenstein, A. (1994). Why some children of alcoholics become alcoholics: Emulation of the drinker. *Adolescence, 29*(113), 1-11.

[67] Windle, M. (2000). Parental, sibling, and peer influences on adolescent substance use and alcohol problems. *Applied Developmental Science*, *4*, 98-110. Luthar, S. S., Anton, S. F., Merikangas, K. R., & Rounsaville, B. J. (1992). Vulnerability to drug abuse among opioid addicts' siblings: Individual, familial, and peer influences. *Comprehensive Psychiatry, 33*(3), 190-196.

[68] Whiteman, S. D., Jensen, A. C., & Maggs, J. L. (2013). Similarities in adolescent siblings' substance use: Testing competing pathways of influence. *Journal of Studies on Alcohol and Drugs*, *74*, 104-113.

[69] Luthar, S. S., Anton, S. F., Merikangas, K. R., & Rounsaville, B. J. (1992). Vulnerability to drug abuse among opioid addicts' siblings: Individual, familial, and peer influences. *Comprehensive Psychiatry, 33*(3), 190-196.

[70] Windle, M. (2000). Parental, sibling, and peer influences on adolescent substance use and alcohol problems. *Applied Developmental Science*, *4*, 98-110.

[71] Hawkins, J. D., Graham, J. W., Maguin, E, Abbott, R. D, Hill, K. G, & Catalano, R.F. (1997). Exploring the effects of age of alcohol use initiation and psychosocial risk factors on subsequent alcohol misuse. *Journal of Studies on Alcohol*. *58*(3), 280–290.

[72] Grant, B. F., & Dawson, S. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse*, *9*, 103-110. 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.

[73] Kreichbaun, N., & Zering, G. (2000). Adolescent patients. In G. Zering (Ed.), *Handbook of alcoholism* (pp. 129-136). Boca Raton, LA: CRC Press.

[74] National Institute on Alcohol Abuse and Alcoholism. (2003). Underage drinking: A major public health challenge. Alcohol Alert, 59, 1-7. Arria, A. M., Dohey, M. A., Mezzich, A. C., Bukstein, O. G., & Van Thiel, D. H. (1995). Self-reported health problems and physical symptomatology in adolescent alcohol abusers. *Journal of Adolescent Health*, *16*(32), 226-231.

- greater problem complexity—the presence of comorbid physical and psychiatric disorders,
- less social support for subsequent recovery,[75]
- increased risk of accidents while under the influence of alcohol[76] and alcohol-related violence,[77] and
- poor intervention outcomes via less help-seeking and greater post-intervention relapse.[78]

Second, any strategy aimed at breaking intergenerational cycles of SUDs will require interventions aimed at preventing and at least postponing early AOD exposure, particularly among high-risk children and adolescents.

Disruption of Family Rituals. Several researchers have noted the role of disrupted family rituals in the intergenerational transmission of AOD problems.[79] Family rituals span religious and holiday observances, rituals of entering or exiting the home, dinner rituals, and weekend or vacation rituals. Rituals play a critical role in family health by clarifying roles, delineating boundaries within and without the family, and defining rules so that all members know that "this is the way our family is."[80] When family rituals are maintained in the presence of parental AUDs, children are less likely to subsequently develop alcohol or other drug problems.[81] Research by Wolin and colleagues[82] found that "transmitter families" abandon family rituals or allow rituals to be disrupted, accept intoxicated behavior without expressions of disapproval, ignore the behavior without talking about it, get pulled into collusion roles, or get needs met outside the family. "Non-transmitter families" maintained family rituals, expressed strong disapproval when drinking threatened to disrupt such rituals, and talked about behavior with each other in disapproving tones.[83]

Environmental factors. Intergenerational transmission of AOD problems can also be intensified by environmental factors, such as distress or disorganization within the neighborhood, key community institutions, and the community as a whole. Such factors increase the prevalence

---

[75] Sobell, M. B., Sobell, L. C., Cunningham, J. C., & Agrawal, S. (1998). Natural recovery over the lifespan. In E. L. Gomberg, A. M. Hegedus, & R. A. Zucker (Eds.), *Alcohol problems and aging* (NIAAA Research Monograph No. 33, pp. 397-405). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism. Wymbs, B.T., McCarty, C.A., Mason, W.A., King, K.M., Baer, J.S., Vander Stoep, A. & McCauley, E. (2014). Early adolescent substance use as a risk factor for developing conduct disorder and depression symptoms. *Journal of Studies on Alcohol and Drugs*, 75, 279-289.

[76] Hingston, R. W., Heeren, T., Jananka., A., & Howland, J. (2000). Age of drinking onset and unintentional injury involvement after drinking. *Journal of the American Medical Association*, *284*, 1527-1533.

[77] Hingston R. W., Heeren T., & Zakocs R. (2001). Age of drinking onset and involvement in physical fights after drinking. *Pediatrics*, *108*(4), 872-877.

[78] Keller, M., Lavori, P., Beardslee, W., Wunder, J., Drs., D., & Hasin, D. (1992). Clinical course and outcome of substance abuse disorders in adolescents. *Journal of Substance Abuse Treatment, 9*, 9-14. Kessler, R. C., Aguilar-Gaxiola, S., Berglund, P., Caraveo-Anduaga, J., DeWitt, D., Greenfield, S.,…Vega, W. (2001). Patterns and predictors of treatment seeking after onset of a substance use disorder. *Archives of General Psychiatry, 58*(11), 1065-1071. Chen, J., & Millar, W. (1998). Age of smoking initiation: Implications for quitting. *Health Reports, 9*(4), 39-46.

[79] Steinglass, P., Bennett, L. Wolin, S., & Reis, D. (1987). *The alcoholic family*. New York: Basic Books. Hawkins, C. A. (1997). Disruptions of family rituals as a mediator of the relationship between parental drinking and adult adjustment in offspring. *Addictive Behaviors, 22*(2), 219-231. Wolin, S. J., Bennett, L. A., & Noonan, D. L. (1979). Family rituals and the recurrence of alcoholism over generations. *American Journal of Psychiatry, 136*(4B), 589-593. Wolin, S. J., Bennett, L. A., Noonan, D. L., & Teitelbaum, M. A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol, 41*(3), 199-214.

[80] Wolin, S. J., Bennett, L. A., Noonan, D. L., & Teitelbaum, M. A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol, 41*(3), 199-214.

[81] Wolin, S. J., Bennett, L. A., Noonan, D. L., & Teitelbaum, M. A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol, 41*(3), 199-214.

[82] Wolin, S. J., Bennett, L. A., Noonan, D. L., & Teitelbaum, M. A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol, 41*(3), 199-214.

[83] Wolin, S. J., Bennett, L. A., Noonan, D. L., & Teitelbaum, M. A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol, 41*(3), 199-214.

of peer AOD use/peer modeling, AOD availability, and AOD promotion at local/cultural levels and can concentrate AOD-related problems within particular families and neighborhoods.

SUMMARY. High genetic risks, neonatal insult from maternal AOD use, developmental vulnerabilities, high-risk family and community environments, and inadequate personal, family, and community protective factors combine to elevate risk for development of severe and prolonged substance use disorders and continuing intergenerational cycles of addiction and related problems.[84] This section of our paper identified eleven potential mechanisms that can influence the intergenerational transmission of AOD problems. Each of these mechanisms have severity and density dimensions that can influence and potentially magnify risks and that interact with recovery and resiliency capital factors to shape one's ultimate risk for AOD problems. Multiple risk factors (diverse etiological pathways) may set the stage for development of SUDs among children from affected families, with SUDs then becoming functionally autonomous from these factors.[85] What we are seeking in this exercise is the identification of potential sequences/combinations of interventions that can reduce risk factors where possible and to amplify protective factors that can neutralize or diminish these risk factors.

Potential Protective Factors

Research on the risks faced by children of parents with SUDs has in recent decades been extended to the study of resilience among such children. The concept of resilience posits that resilience, by definition, exists only in the presence of adversity and risk.[86] It is based on the understanding that protective factors exist that minimize or neutralize the effects of adversity allowing children at high risk of developing AOD and related problems to effectively cope, and in many cases, thrive.[87] Werner's[88] classic study of resilience in children of alcoholics concluded that: "The risks associated with parental alcoholism can be buffered by constitutional characteristics of the child, and by qualities of the early caregiving environment" (p. 39). Protective characteristics in the Werner study included qualities of temperament that drew positive attention from parents and others, intelligence, communication skills, achievement orientation, caring attitude toward others, and positive self-concept. Mylant et al.[89] note five SUD protective factors: 1) personality characteristics that evoke positive social responses from others, 2) capitalizing on special abilities, e.g., academic or athletic success, 3) parenting that fosters competence and self-esteem, 4) relationships with other supportive adults, and 5) opportunities that arrived during critical life transitions.

---

[84] Kumpfer, K. L. & Bluth, B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to "substance abuse disorders". *Substance Use & Misuse*, *5*, 671-698.

[85] Chassin, L., Currran, P. J., Hussong, A. M., & Colder, C. R. (1996). The relation of parent alcoholism to adolescent substance use: A longitudinal follow-up study. *Journal of Abnormal Psychology, 105*(1), 70-80. Cadoret, R., Yates, W., Troughton, E., Eoodworth, G., & Stewart, M. (1995). Adoption study demonstrating two genetic pathways to drug abuse. *Archives of General Psychiatry*, *53*, 42-52. Hussong, A. M., Curran, P. J., & Chassin, L. (1998). Pathways of risk for accelerated heavy alcohol use among adolescent children of alcoholic parents. *Journal of Abnormal Child Psychology, 26*(6), 453-466.

[86] Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry, 57*, 316-331.

[87] Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance use prevention. *Psychological Bulletin*, *112*, 64-105. Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, *57*, 316-331.

[88] Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies on Alcohol, 47*(1), 34-40.

[89] Mylant, M. L., Ide, B., Cuevas, E., & Meehan, M. (2002). Adolescent children of alcoholics: Vulnerable or resilient? *Journal of the American Psychiatric Nurses Association*. *8*(2), 57-64.

Benard's research review in the late 1990s concluded, "50-70% of "high risk" children grow up to be successful, confident, competent, and caring individuals."[90] Subsequent reviews noted three elements of such resilience: 1) strengths of the child, 2) strengths of the family, and 3) strengths of the community. Personal strengths include happiness, hope, competence, confidence, purpose, determination, and social and coping skills; family strengths include parent-child bonding, parental supervision and discipline, family communication, maternal and paternal disapproval of AOD use, and availability of supports outside the family.[91] As noted earlier, maintenance of family rituals in the presence of parental SUD has also been found to be a protective factor for children in such families.[92] Resiliency studies have evolved from a focus on resiliency traits to resiliency as a relational process between child, family, and community.[93]

Protective factors include "turning points" (e.g., events, relationships, and opportunities) that fundamentally and positively alter the trajectory of a child's life for years to come,[94] developmental differentiation (de-identification) between younger siblings and older AOD-using siblings,[95] and parenting-related protective factors, including nurturance (warmth), socialization (clarity of family values and expectations), modeling, and control (supervision, monitoring, and discipline).[96] Supportive community networks have also been found to reduce and ameliorate the effects of adverse childhood experiences.[97]

Surprisingly, little research has been conducted on the effects of parental recovery status on the future risk of children developing an SUD. Moos and Billings[98] reported better emotional health and functioning of children of recovering alcoholics compared to children of alcoholics who had relapsed but did not find differences in the children's substance use behaviors. Studies of family structure show far greater impaired structure in alcoholic families than in families in

---

[90] Benard, B. (1997). Turning it around for all youth: From risk to resilience (ERIC/CUE Digest No. 126). New York: ERIC Clearinghouse on Urban Education. Also see: Kumpfer, K. L. & Bluth, B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to "substance abuse disorders". *Substance Use & Misuse*, *5*, 671-698.

[91] Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, *57*, 316-331. 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*(3), 305-313. Varvil-Weld, L., Mallett. K.A., Turrisi, R. & Abar, C.C. (2013). Using parental profiles to predict membership in a subset of college students experiencing excessive alcohol consequences: Findings from a longitudinal study. *Journal of Studies on Alcohol and Drugs*, *73*, 434-443. Kumpfer, K. L. & Bluth, B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to "substance abuse disorders". *Substance Use & Misuse*, *5*, 671-698.

[92] Wolin, S. J., Bennett, L. A., & Noonan, D. L. (1979). Family rituals and the recurrence of alcoholism over generations. *American Journal of Psychiatry, 136*(4B), 589-593. Wolin, S. J., Bennett, L. A., Noonan, D. L., & Teitelbaum, M. A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol, 41*(3), 199-214. Fies, B. H. (1993). Family rituals in alcohol and nonalcoholic households: Relation to adolescent health symptomatology and problem drinking. *Family Relations*, *42*, 187-192.

[93] Kumpfer, K. L. & Bluth, B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to "substance abuse disorders". *Substance Use & Misuse*, *5*, 671-698.

[94] Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, *57*, 316-331. Larkin, H., Beckos, B.A. & Shields, J.J. (2012). Mobilizing resilience and recovery in response to adverse childhood experiences (ACE)" A Restorative Integral Support (RIS) case study, *Journal of Prevention and Intervention in the Community*, 40(4), 335-46.

[95] Whiteman, S. D., Jensen, A. C., & Maggs, J. L. (2013). Similarities in adolescent siblings' substance use: Testing competing pathways of influence. *Journal of Studies on Alcohol and Drugs*, *74*, 104-113.

[96] Bröning, S., Kumpfer, K., Kruse1, K., Sack, P., Schaunig-Busch, I., Ruths, S., Moesgen, D., Pflug, E. Klein, & Thomasius, R. (2012). Selective prevention programs for children from substance-affected families: a comprehensive systematic review. *Substance Abuse Treatment, Prevention, and Policy* 2012, 7:23 Accessed January 8, 2014 at http://www.substanceabusepolicy.com/content/7/1/23

[97] Hall, J. Porter, L., Longhi, D., Becker-Green, J. & Dreyfus.S. (2012). Reducing adverse childhood experiences (ACE) by building community capacity: A summary of Washington Family Policy Council research findings. *Journal of Prevention and Intervention in the Community*, 40(4), 325-34.

[98] Moos, R. H., & Billings, A. G. (1982). Children of alcoholics during the recovery process: Alcoholic and matched control families. *Addictive Behaviors, 7*, 155-163.

recovery or community controls,[99] that the distressing effects of addiction on the family decline in recovery,[100] and that families in recovery function as well as families not affected by addiction (although less socially active).[101] Also of note is a study by Chassin and Barrera[102] finding that children of parents in recovery have lower AOD consumption than children whose parents continue to have AOD-related problems.[103] Parental recovery status may be offset by sibling influences: "…sibling drinking, affiliation with peers who drink, lowered socioeconomic status, and high levels of environmental stress may place adolescent children of alcoholics on a high-risk developmental trajectory regardless of whether parental alcoholism is active or remitted.[104]

Also of note is Knight and colleagues'[105] conclusion that "...intergenerational risk may be reduced if substance use can be curtailed in adolescence." This would suggest the potential role of student assistance programs and assertive treatment of high-risk adolescents as potential intervention points for breaking intergenerational cycles of addiction.

Research on the long-term resiliency of children at increased risk for development of SUDs suggests optimism for the development of future strategies to break intergenerational cycles of addiction. Given the complexity of both risk and resiliency factors, such strategies will require discovery of the most potent combinations and sequences of interventions and implementing these interventions at personal, family, community, and state and national social policy levels.

Evaluations of Intergenerational Interventions

Optimism also comes from studies evaluating interventions that exert influence across generations. The question plaguing family models of intervention is whether the highest risk families can be engaged for such interventions. Research to date suggests that high risk families can be engaged and retained in service interventions for an extended period of time[106] and that parental addiction recovery prospects are enhanced by elevating the functioning of the spouse and family[107] and through family involvement in treatment.[108] Interventions into parental SUDs seem quite promising. For example, the use of recovery coaches in child welfare settings has been shown to reduce risk of prenatal substance use exposure, increased access to addiction treatment and enhanced odds of family reunification.[109] Studies of addiction treatment outcomes

---

[99] Preli, R., & Protinsky, H. (1988). Aspects of family structures in alcoholic, recovered, and nonalcoholic families. *Journal of Marital and Family Therapy*, *14*(3), 311-314.

[100] Moos, R. H., Finney, J. W., & Gamble, W. (1982). The process of recovery from alcoholism. II. Comparing spouses of alcoholics patients and matched community controls. *Journal of Studies on Alcohol*, *43*, 888-909.

[101] Moos, R. H., Finney, J. W., & Chan, D. A. (1981). The process of recovery from alcoholism. I. Comparing alcoholic patients and matched community controls. *Journal of Studies on Alcohol*, *42*, 383-402.

[102] Chassin, L. & Barrera, M. (1993). Substance use escalation and substance use restraint among adolescent children of alcoholics. *Psychology of Addictive Behaviors*, *7*(1), 3-20.

[103] Chassin, L. & Barrera, M. (1993). Substance use escalation and substance use restraint among adolescent children of alcoholics. *Psychology of Addictive Behaviors*, *7*(1), 3-20.

[104] Ellis, D. A., Zucker, R. A., & Fitzgerald, H. E. (1997). Children of alcoholics: The role of family influences on development and risk. *Alcohol, Health & Research World*, *21*, 218-226. Chassin, L., Pitts, S. C., DeLucia, C., & Todd, M. (1999). A longitudinal study of children of alcoholics: Predicting young adult substance use disorders, anxiety, and depression. *Journal of Abnormal Psychology*, *108*(1), 106-119.

[105] Knight, K., Menard, S & Simmons, S. (2013). *Intergenerational continuity of substance use. Substance Use & Misuse*, Posted online on August 21, 2013. (doi:10.3109/10826084.2013.824478)

[106] Barnard, M., & McKegany, N. (2004). The impact of parental drug use on children: What is the problem and what can be done to help? *Addiction*, *99*, 552-559.

[107] Steinglass, P. (1981). The impact of alcoholism on the family: Relationship between degree of alcoholism and psychiatric symptomatology. *Journal of Studies on Alcohol*, *42*, 288-303.

[108] Orford, J., Oppenheimer, E., Egert, S., Hensman, C., & Guthrie, S. (1976). The cohesiveness of alcohol: Complicated marriages and its influence on treatment outcome. *British Journal of Psychiatry*, *128*, 318-399.

[109] Ryan, J. P., Choi, S., Huang, J., Hernandez, P., & Larrison, C. (2008). Recovery coaches and substance exposure at birth: An experiment in child welfare. *Child Abuse and Neglect*, *32*, 1072-1079. Ryan, J. P., Marsh, J., Testa, M. F., &

have also found that recovery enhances family functioning[110] and that families in recovery function on par with community controls.[111] Spouses of recovered alcoholics report less marital conflict than spouses of alcoholics not in recovery and spouses of community controls[112]—suggesting a lessening of this risk factor for intergenerational transmission.

Some optimism also comes from research on fetal alcohol spectrum disorders (FASDs) where studies have confirmed three important findings: 1) assertive case management (education, coaching, and monitoring) of pregnant women and women about to become pregnant dramatically increases the odds of a healthy pregnancy via elimination or severe reductions in drinking)[113], 2) a stable, nurturing home spanning most of one's childhood can serve as a protective factor for the development of AOD problems among children experiencing FASDs,[114] and 3) accommodations can be made to the delivery of addiction treatment that address impairments related to FASDs[115]

Research to date suggests multiple targets for parental intervention: 1) enhancing general parenting effectiveness, 2) enhancing AOD-specific parenting practices, and 3) outreach aimed at engaging the addicted parent and related family-focused interventions.[116] Child-focused interventions could include educating high-risk children (e.g., family history of AOD problems) about their risks related to problem drinking. At-risk children educated about such risks subsequently consume less alcohol than at-risk children not educated about such risks.[117]

Multi-component programs (targeting children and parents or child, parent and community) have greater effects than programs with a single target.[118] Also informing potential interventions is the discovery that past prevention programs have the potential for iatrogenic effects (harm in the name of help, e.g., increasing rather than decreasing drug use and its mediators rather than reducing them).[119] In a review of research on prevention programs, Werch

---

Louderman, R. (2006). Integrating substance abuse treatment and child welfare services: Findings from the Illinois AODA Waiver Demonstration. *Social Work Research*, *30,* 95-107. Marsh, J., Ryan, J. P., Choi, S., & Testa, M. (2006). Integrated services for families with multiple problems: Obstacles to family reunification. *Children and Youth Services Review*, *28,* 1074-1087.

[110] Orford, J., Oppenheimer, E., Egert, S., Hensman, C., & Guthrie, S. (1976). The cohesiveness of alcohol: Complicated marriages and its influence on treatment outcome. *British Journal of Psychiatry*, *128*, 318-399.

[111] Moos, R. H., & Moos, B. S. (1984). The process of recovery from alcoholism: III. Comparing function in families of alcoholics and matched control families. *Journal of Studies on Alcohol, 45*(2), 111-118.

[112] Moos, R. H., & Moos, B. S. (1984). The process of recovery from alcoholism: III. Comparing function in families of alcoholics and matched control families. *Journal of Studies on Alcohol, 45*(2), 111-118.

[113] Grant, T., Streissguth, A. & Ernst, C. (2002). Benefits and challenges of paraprofessional advocacy with mothers who abuse alcohol and drugs and their children. *Zero to Three*, 23, 14-20. May, P.A., Miller, J.H., Goodhart. K.A., Maestas, O.R., Buckley, D., Trujillo, P.M. & Gossage, J.P. (2008). Enhanced case management to prevent fetal alcohol spectrum disorders in northern plains communities. *Maternal and Child Health Journal*, 12, 749-759. May, P.A., Marais, A-S., Gossage, P., et al (2013). Case management reduces drinking during pregnancy among high-risk women. *International Journal of Alcohol and Drug Research*, 2(3), 61-70.

[114] Streissguth, A.P., Bookstein, F.L., Barr, H.M., et al (2004). Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects. *Journal of Development & Behavioral Pediatrics*, 25, 228-238.

[115] Sparrow, J., Grant, T.M., Connor, P. & Whitney, N. (2013). The value of the neuropsychological assessment for adults with fetal alcohol spectrum disorders: A case study. *International Journal of Alcohol and Drug Research,* 2, 79-86.

[116] Lam, W.K., Cance, J.D., Eke, A.N., Fishbeing, D.H. Hawkins, S.R. & Williams, C. (2007). Children of African-American mothers who uswe crack cocacine: Parenting influences on youth substance use. Journal of Pedatric Psychology, 32(8), 877-887.

[117] Kumpfer, K. (1989). Promising prevention strategies for high-risk children of substance abusers. *OSAP High Risk Youth Update*, *2*(1),1-3.

[118] Tobler, N., & Kumpfer, K. L. (2000). *Meta-analysis of effectiveness of family-focused substance abuse prevention programs*. Report submitted to the Center for Substance Abuse Prevention, Rockville, MD.

[119] Werch, C. E., & Owen, D. M. (2002). Iatrogenic effects of alcohol and drug prevention programs. *Journal of Studies on Alcohol*, *63*(5), 581-590. Brown, J. H., & Caston, M. D. (1995). On becoming "at risk" through drug education: How symbolic policies and their practices affect students. *Evaluation Review*, *19*, 451-492. Goodstadt, M. S. (1980). Drug education: A turn on or turn off? *Journal of Drug Education*, *10*, 89-99. Gorman, D. M. (1997). The failure of drug education. *Public Interest*, *129*, 49-60.

and Owen[120] found 17 alcohol and drug prevention studies reporting negative effects of the intervention, e.g., increased alcohol use. Great care must be taken in the design of such interventions as well as in the rigorous evaluation of piloted interventions before widespread application.

Clinical and Recovery Support Strategies

Based on this review, we believe the following practices could be implemented within addiction treatment programs and recovery community organizations to reduce intergenerational cycles of addiction. These recommendations are proposed as discussion points for the continued evolution of the behavioral healthcare system within the City of Philadelphia.

Recommendation 1: *Shift the "unit of service"* for addiction treatment programs from the individual to the family and extended family with concomitant changes in assessment; service planning and delivery; and long-term monitoring, support, and if and when needed, early re-intervention. In this shift, assessment and service planning would potentially encompass service plans for each individual family member and the family as a unit. Each person seeking recovery would be asked three core questions at the point of engagement: 1) How can we help you achieve and maintain stable recovery? 2) What does your partner need at this time to enhance his or her present and future physical/emotional health and security? 3) What do your children most need to enhance their present and future physical/emotional health and security? These same questions would be asked of family members, with cumulative responses shaping the resulting service plans.

Recommendation 2: *Conduct screenings for fetal alcohol spectrum disorders (FASDs) for all persons entering addiction treatment and integrate accommodations for the potential cognitive/behavioral deficits such individuals may exhibit that could compromise their long-term recovery outcomes*.[121]

Recommendation 3: *Communicate to all parents undergoing addiction treatment or participating in recovery support services* that their children are at increased risk to develop an AOD problem and that there are specific actions they can take (e.g., effective parenting, key AOD-specific parenting practices, maintenance of key family rituals, etc.) to lower that risk. The actions that parents could take could be modeled by staff and volunteers (e.g., effective listening) and by the program as a whole (e.g., modeling rituals of daily communication, exit and entry, mealtime rituals, holiday celebrations, etc.).

Recommendation 4: *Integrate services for couples, children, and families within all addiction treatment programs*, including educational (e.g., parenting effectiveness training, marital communication and conflict resolution, and effective boundary management), screening and early intervention, therapeutic and peer recovery support tracks that use engaging media (including internet resources, art, music and drama). Each family undergoing treatment should be aided in preparation of a family relapse prevention and management plan that includes identification of resources for rapid responses to any crises within the family.

Recommendation 5: *Establish child-focused goals* for families in addiction treatment and families with children affected by FASDs that include (adapted from Kumpfer & Bluth, 2004)[122]

- attachment of each child with at least one caring adult,

[120] Werch, C. E., & Owen, D. M. (2002). Iatrogenic effects of alcohol and drug prevention programs. *Journal of Studies on Alcohol, 63*(5), 581-590.

[121] Grant, T.M., Brown, N.N., Graham, J.C., Whitney, N., Dubovsky, D. & Nelson, L. (2013). Screening in treatment programs for fetal alcohol spectrum disorders that could affect therapeutic progress. *International Journal of Alcohol and Drug Research,* 2(3), 37-49.

[122] Kumpfer, K. L. & Bluth, B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to "substance abuse disorders". *Substance Use & Misuse, 5*, 671-698.

- availability of at least one positive, encouraging role model for each child,
- balance of emotional closeness and support with clear behavioral expectations,
- ensuring regular parent-child time,
- consistent family rituals,
- positive ethnic/cultural identification,
- availability of teaching/coaching life skills and competencies,
- clear expectations/consistent discipline (including AOD use rules),
- communication of high expectations,
- encouraging dreams and aspirations via identification of strengths and interests, and
- attachment to extended family and social network.

Recommendation 6: *Target the younger siblings* of adolescents and young adults admitted for addiction treatment for prevention and early intervention services, with services delivered by the treatment program or through assertive linkage to community resources (e.g., student assistance programs within the schools).

Recommendation 7: *Develop collaborative, multi-agency models of intense interventions* for families/children of those entering service with the highest levels of problem severity and lowest levels of recovery capital (prioritize resources for these families at highest risk for intergenerational transmission of multiple problems).

Recommendation 8: *Add evaluation of physical/emotional health, AOD status and school performance of children* as a recovery-focused, post-treatment benchmark within all addiction treatment follow-up data collection.

Policy Implications and Policy Level Strategies

The issues raised in this paper have profound implications for behavioral health policy, funding, and service system evaluation. In this final section of the paper, we will try to outline some potential directions that DBH/IDS and our local, state, and national counterparts might take to address the intergenerational transmission of addiction and related problems.

This review suggests a number of broad strategies, many of which are already being undertaken by communities across the country, including 1) programs to treat parental addiction, 2) prevention programs aimed at preventing adult addiction, 3) programs aimed at prevention of fetal alcohol syndrome and fetal alcohol effects, 4) school-based prevention programs for children, 5) programs targeting children (particularly sons) of alcohol dependent fathers, 6) mutual aid via Alateen, COA, and ACOA groups, and 7) Strengthening Families Programs (SFPs) aimed at both parents and children.[123] Broad intervention goals for high-risk children include decreasing their exposure to risk factors through treatment and recovery support strategies for parents and by enhancing protective factors within the child and within the child's environment, e.g., access to adults who can buffer reduced competencies of the addicted parent.[124] Breaking intergenerational cycles of addiction is inseparable from addressing broader adversities that affect the fate of at- risk children.

[123] Cuijpers, P. (2005). Prevention programs for children of problem drinkers: A review. *Drug Education Prevention and Policy, 12*(6), 465-475.

[124] Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies on Alcohol, 47*(1), 34-40.

Earlier work has sought to conceptualize what is needed in this area. Masten[125] suggested a four-part strategy: "1) reduce environmental risk and vulnerability, 2) reduce stressors and pileup, 3) increase available resources, and 4) mobilize protective processes."[126] Schuckit and Smith[127] suggested that a key step in addressing intergenerational transmission of AOD problems was to shrink the adult SUD population through effective prevention, early intervention, and treatment programs. Grant[128] offered a particularly bold vision.

> *What is urgently needed is a comprehensive strategy that integrates all systems oriented toward the provision of health, social, and treatment services, designed to improve the lives of children at risk from their exposure to alcohol abuse and dependence [and other drug problems] in the family. Such a strategy must include a broadening of an array of services targeted to the needs of these children at every developmental stage, coupled with aggressive interventions to enhance their lives and protect their safety.*

Based on the review conducted in this paper, we would offer the following concrete steps that policy leaders and systems administrators could take to forge a long-term plan to address the intergenerational transmission of AOD problems.

Recommendation 1: *Issue a Policy Statement* on Promoting Family Recovery and Intergenerational Health as a public health issue to signal this increased focus on needs of children and families affected by addiction and related problems.

Recommendation 2: *Create The Intergenerational Fund*—a multi-agency coalition committing staff and public financial resources toward joint policy initiatives that support innovative projects aimed at stemming the intergenerational transmission of AOD problems, mental health challenges, child neglect and abuse, school failure, criminality, and violence.

Recommendation 3: *Broaden and sustain early intervention resources* within each community to include student assistance programs in all middle and high schools and encouraging pediatricians to assess AOD family history and screening for AOD problems in pre-teens and adolescents. We believe successful models of physician screening, brief intervention, and referral to treatment for adults could be adapted for use with latency-age children and adolescents.

Recommendation 4: *Identify and intensify intensity and duration of services for individuals and families at greatest risk* of contributing to future AOD problems. A small percentage of AOD users and their families experience an inordinate proportion of the total negative consequences and costs of AOD use. This high risk population could be identified and targeted for specialized, multi-agency prevention, early intervention, treatment, and recovery support strategies.[129] Children of the most severely AOD dependent parents could be identified for intensified service interventions with particular focus on those exhibiting developmental antecedents of SUDs

---

[125] Masten, A. S. (1994). Resilience in individual development: Successful adaptation despite risk and adversity. In M. C. Wang & E. W. Gordon (Eds.), *Educational resilience in inner-city America: Challenges and prospects* (pp. 3-25). Hillsdale, NJ: Erlbaum.

[126] Kumpfer, K. L. & Bluth, B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to "substance abuse disorders". *Substance Use & Misuse, 5*, 671-698.

[127] Schuckit, M. & Smith, T. (2001). The clinical course of alcohol dependence associated with a low level of response to alcohol. *Addiction*, 96, 903-910.

[128] Grant, B. F. (2000). Estimates of US children exposed to alcohol abuse and dependence in the family. *American Journal of Public Health, 90*(1), 112-115.

[129] Varvil-Weld, L., Mallett. K. A., Turrisi, R., & Abar, C. C. (2013). Using parental profiles to predict membership in a subset of college students experiencing excessive alcohol consequences: Findings from a longitudinal study. *Journal of Studies on Alcohol and Drugs, 73*, 434-443.

and/or exhibiting early onset of AOD use. One of the goals of these interventions would be linkage of children and families to natural and sustainable supports that exist within the community. Also of value would be the expansion of family education, use of family advocates and The Recovering Families Parenting Program and the Guiding Good Choices Program through the Recovery Community Center.

Recommendation 5: *Develop clinical guidelines* (and monitoring benchmarks) for minimal levels of child/family-focused services to be provided by publicly funded addiction treatment programs.

Recommendation 6: *Provide support for at least one designated child/family service position* within every publicly funded addiction treatment program toward goals of:

- integrating family/child assessment into the intake and clinical assessment process,
- integrating parenting training/coaching into primary addiction treatment or continuing care,
- providing prevention and early intervention services to children whose older sibling has been admitted to addiction treatment, and
- facilitating peer-based recovery support services for children and adult family members.

Recommendation 7: *Integrate child/family services* into existing and new post-treatment monitoring, support, and early re-intervention efforts within both addiction treatment programs and within the recovery support menu of recovery community organizations, e.g., offering parenting in recovery training for local communities of recovery, encouraging development and utilization of child and family recovery support groups, etc. Recovery community organizations could be encouraged and supported to expand recovery support services for families and children and to include families and children in recovery celebration events.

Recommendation 8: *Support community-based programs* aimed at the prevention/postponement of AOD use and assertive early intervention into AOD problems among adolescent and young adults and programs aimed at the prevention of and early intervention with fetal alcohol spectrum disorders (FASDs).

Recommendation 9: *Support ethnic cultural revitalization movements* that address health and relationship challenges within the contexts of historical trauma and needed personal/cultural renewal.

Recommendation 10: *Support and conduct research* on the intergenerational transmission of AOD and related problems, including the isolation of active ingredients within programs that ameliorate this risk. Such research should include studies of resilient children and isolation of the factors that contribute to their resiliency. There is a paucity of well-designed studies to inform national and community-level policy development aimed at breaking intergenerational cycles of addiction.[130] Such studies are needed to marshal and target limited resources and to avoid potential iatrogenic effects of interventions into this incredibly complex issue.[131] Research efforts should include exploration of mechanisms to establish baseline and regularly updated rates of

[130] Woolfall, K., & Sumnall, H. (2010). Evaluating interventions for children of substance using parents: A review of outcome measures, *Addiction Research and Theory*, *18*(3), 326-343.

[131] Bröning, S., Kumpfer, K., Kruse1, K., Sack, P., Schaunig-Busch, I., Ruths, S., Moesgen, D., Pflug, E. Klein, & Thomasius, R. (2012). Selective prevention programs for children from substance-affected families: a comprehensive systematic review. *Substance Abuse Treatment, Prevention, and Policy* 2012, 7:23 Accessed January 8, 2014 at http://www.substanceabusepolicy.com/content/7/1/23

intergenerational SUD transmission. Such data to our knowledge has never been collected to guide systems planning and service evaluation.

Recommendation 11: *Assess the extent to which the issues outlined in these recommendations suggest changes in policies and procedures* for program licensure, funding, pay-for-performance benchmarks, program monitoring, quality assurance and worker training and credentialing.

Conclusions

It is our belief that America cannot, in the long-term, treat its way out of its most severe, complex, chronic and costly AOD problems without extending that treatment to address the broader needs of families and children. The central policy question is how local communities can muster the resources to serve more than a small fraction of at-risk children and families.[132] Meeting that challenge will require the strategic integration and selective focusing of existing resources and garnering additional resources dedicated to the specific goal of breaking intergenerational cycles of addiction and related problems. What is needed is leadership within a single community to demonstrate the viability and effects of a sustained community effort to achieve this goal. This paper is an invitation and challenge to the City of Philadelphia to become that pioneering community.

Acknowledgements: The authors would like to thank the following individuals for feedback and suggestions that have been incorporated into this paper: Rita Chaney, Beverly Haberle and Jeannine L. Lisitski.

[132] Barnard, M. & McKegany, N. (2004). The impact of parental drug use on children: What is the problem and what can be done to help? *Addiction*, *99*, 552-559.



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. (2014). In memoriam: A tribute to David Powell. *Journal of Groups in Addiction and Recovery*, 9, 188-190. Posted at www.williamwhitepapers.com

In Memoriam:
A Tribute to David Powell

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

David Powell, PhD, who had recently assumed the position of Assistant Clinical Professor within the Department of Psychiatry at Yale University School of Medicine, died from a fall at his home on November 1, 2013. His passing is a great loss to his family and to the addictions field that he so faithfully served for more than four decades.

David Powell was born March 22, 1945 in Queens, New York. The consummate student, David received degrees in counseling (Princeton Theological Seminary, 1970), psychology (New School for Social Research, 1972; Indiana Northern University, 1974), medical ethics (Harvard University, 2000; Yale University, 2002) and Islamic Studies (Hartford Seminary, 2003). He was a licensed alcohol and drug abuse counselor, a licensed marriage and family therapist and a diplomat in the International Academy of Behavioral Medicine.

For nearly three decades, David Powell served as the Chief Executive Officer of ETP, Inc., delivering employee assistance program services to major U.S. companies including IBM, US Tobacco, Berlin Steel, Trump, Aetna Insurance Company, Travelers Insurance Companies, and Rolls Royce. It was at ETP that David designed and administered the Clinical Preceptorship Program, a comprehensive clinical supervision system implemented worldwide by the U.S. Navy and Marine Corps. Before taking the position at Yale, he served as the President of the International Center for Health Concerns, Inc., and the Clinical Supervision Institute.

Over the course of his career, David Powell served on the editorial boards of numerous journals, served as co-editor of the *Journal of Chemical Dependency Treatment,* and published more than 150 articles, including regular contributions to the addiction trade journals. The latter reflected his sustained mission of elevating the quality of frontline addiction treatment. David authored ten books, including *Clinical Supervision in Alcohol and Drug Abuse Counseling,* which has served as the major

text on clinical supervision since its initial publication in 1979 (with evolving new editions since). He also chaired of the expert workgroup that developed the Center for Substance Abuse Treatment's *Treatment Improvement Protocol #52, Clinical Supervision and Professional Development of the Substance Abuse Counselor* (2009).

David was ever-present within the addictions field. His work addressed many frontier issues within the field, but he is unquestionably best known for his pioneering efforts to enhance the quality of clinical supervision in addiction treatment. He pushed this agenda through his numerous publications, frenetic presentation schedule and through consultations with leading addiction treatment organizations, including Betty Ford Center, Caron Foundation, Sierra Tucson, Hazelden and Phoenix House. Over the course of his career, David trained addiction professionals in all 50 states and in more than 80 countries. He was also instrumental in introducing recovery mutual aid groups to countries in which no such resources existed and in helping numerous countries develop addiction treatment and addiction counselor training programs. He served on the Board of Directors for the Asia Pacific Certification Board and the Middle East Certification Board. It was through his writings that many of us became acquainted with international addiction counselor training efforts.

David had numerous passions in his work with all of us. Beyond his work in clinical supervision, he was deeply involved in workforce development issues within the field, the integration of spirituality within addiction treatment and sorting the ambiguities within some of the field's most complex ethical issues. He was particularly passionate about the need for the field to develop future leaders. As he said in a recent interview, "Old-timers like me need to take folks under our wings and mentor them over the next five years. The key step is being able to be replaceable, to train somebody to do what you can do. Another concern is that we are losing our history. The people that got us to where we are, the shoulders on which we now stand, we not only don't know who they are, but we don't seem to care. That is unfortunate. A generation of leaders is ready to turn over the mantle of leadership. The question is who's going to accept that mantel."

For years, David and I communicated on issues of import to the field we both loved, but the pace of those communications had quickened in the months before his death. We both were acutely aware that we were in the twilight of our careers and spoke often about how the work we had begun could be best carried forward. That preoccupation with legacy and the future of the field led both of us to capture more of our work in writing and to invest more time in mentoring younger leaders within the field. David and I had just finished two small but, in retrospect, very important projects. The first was an interview with David—a career retrospective—and the second was assembling and editing several papers David had written on his international work. (Both are available for download at www.williamwhitepapers.com.)

Two days before he died, David and I exchanged a series of emails reflecting on the growth of luxurious addiction treatment for the "1%ers" (the very rich and famous) and what this meant for those being treated in such environments and what it meant for our field. We both knew at this point in our lives that time was a most precious and ephemeral gift, but we continued to share numerous plans of the work we still hoped to complete. And most calls ended with us reflecting on the good fortune bestowed upon us via the love of our respective wives and children and what full lives we had been blessed to live.

As I think about David's influence on the field and on me, my thoughts always come back to his unwavering focus on the person/family seeking or in recovery. As he said in a recent interview, "That's the issue [recovery]: it is not about any of us. It is to keep our eye on the prize, which is what

drove most of us into this field in the first place. And that prize is the person who's in recovery and seeing them grow." When I think of David, I am aware just how few people have so fully integrated such a piercing mind and a compassionate heart. His intellectual brilliance and unrelenting service activities masked a side of David few of us saw: his love of music and railroad models and his joy at playing the White Rabbit at the New York World's Fair.

David Powell offered us his brilliance and unquenchable energy, but also his humility and his friendship. The field misses his presence dearly, as do I. His passing provides an opportunity for personal and collective recommitment to the recovery vision that drove David's decades of service and innumerable contributions.



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. (2014). Ernest Kurtz: The historian as storyteller and healer. *Alcoholism Treatment Quarterly*, 32(4), 458-484. Posted at **www.williamwhitepapers.com**

Ernest Kurtz:
The Historian as Storyteller and Healer

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

History and imperfection are my specialties—not necessarily in that order.
--Ernest Kurtz, 1996

The lives of Fr. Edward Dowling, Sr. Mary Ignatia Gavin, Fr. John C. Ford, Fr. Ralph Pfau, Dr. Austin Ripley, Fr. Joseph Martin, Sr. Therese Golden, and the history of Guest House constitute critical chapters in the larger story of the rise of Alcoholics Anonymous (AA) and the role of spirituality in long-term recovery from alcoholism. It is thus quite fitting that *Recovery Through Catholic Eyes* is dedicated to Ernest Kurtz, the person most singularly responsible for uncovering and telling this larger story.

Ernest Kurtz published his seminal work, Not-God: A History of Alcoholics Anonymous, in 1979 and has continued his writing and teaching on the topics of AA, spirituality, shame, and storytelling. This final chapter of *Recovery Through Catholic Eyes* explores and honors his ideas, activities, and sustained influence. The chapter contains four sections: 1) a brief biography, 2) a sampling of the topical themes that permeate Kurtz's work, 3) a profile of Kurtz the man, and 4) an appendix containing a chronology of the Kurtz publications. The chapter is designed to let Kurtz, and those profoundly influenced by him, speak directly to the reader in their own words.

When I began writing a book in the early 1990s on the history of addiction treatment and recovery in America, several people directed me to Ernie Kurtz as the authoritative source. I had no way of knowing that what I expected to be a brief consultation on the history of AA would evolve into a prolonged mentorship, multiple professional collaborations, and an enduring friendship. Through these years, Ernie Kurtz communicated a number of crucial lessons to me about researching and writing history. He repeatedly challenged:

1) Tell the story chronologically (do not confuse your reader).

2) Tell the story in context (let your reader know what else is going on around the event you are profiling).

3) Present the historical evidence (sources)—all the evidence.

4) Separate statements of fact from conjecture and opinion.

5) Tell the story from multiple perspectives.

6) Localize and personalize the story.

7) Stay connected to your readers—keep them wanting to turn the page to find out what happens next (for an elaboration of these, see White, 2004).

I will try to be faithful to these guidelines in telling Ernie's own story.

Three sources form the foundation of this chapter: the complete publications of Ernie Kurtz (See appendix), taped and transcribed interviews conducted with Ernie Kurtz in 2008 and 2009, and comments solicited from those who have worked professionally with Ernie Kurtz over the past three decades.

A Prepared Life

Ernest Kurtz was born September 9, 1935 —the same year AA was founded—in Rochester, New York—a city whose financial and cultural history was dominated by the Eastman Kodak Company and later, also by the Xerox Corporation. Also like AA, Kurtz was born in the heart of the Great Depression—a time when America and many alcoholics were economically and spiritually hitting bottom. He was the oldest of two children born to Edward and Josephine Kurzejewski [Koo-zhay-yev'-ski]. Ernie relates:

Eight years of grammar school in a German parish shortened that name for practical use, and when I began graduate school bringing transcripts in two names, I was advised to choose one. Tired of too-lengthy phone interactions, I opted for the one that was easier to spell. But I do remain proud of my Polish heritage and advertise it whenever appropriate. (Kurtz, Personal Communication, August, 2009)

Josephine worked as a homemaker, and Edward, like most men in the depression era, worked in whatever job he could find to support his family. The Kurzejewski family lived in St. Boniface Parish—a close-knit German neighborhood where Ernie attended Catholic grammar school. One of his earliest childhood recollections reveals his love of learning and teaching and the extent of his young and still developing ego.

The first or second month after beginning first grade ("I remember, it still was hot"), I gathered the neighborhood kids in front of the porch of the house in which I lived, and gave a lecture on something I had just discovered. To know something was to want to teach it to others, to make it understandable. (Kurtz, 2009 Interview)

Following grammar school, Kurtz entered St. Bernard's Seminary and College in Rochester. Minor seminary—four years of high school (1949-1953) and two years of college (1953-1955)—was followed by major seminary and college graduation from St. Bernard's in 1957 with a Bachelor of Arts in philosophy. Ordained to the priesthood in 1961, he was assigned as a parish priest to Our Lady of Good Counsel in Rochester's soon-to-be racially mixed 19th ward. Kurtz found parish life "rewarding and fulfilling" and reveled in the varied activities, whether preparing a sermon, performing liturgy, or working with the youth club. While visiting sick parishioners, Kurtz befriended several Jewish Rabbis who were also visiting the sick. It was especially from two of them, in the lunchroom of the Strong Memorial Hospital, that Ernie really absorbed the power of story as a teaching device.

To be more effective as a pastoral counselor, Kurtz enrolled in psychology classes at the University of Rochester. There, he fell under the influence of Professor Marvin Becker and became enthralled with the history of ideas. As this interest increased, he was encouraged by his Bishop to pursue further education. After considering several schools, Kurtz entered Harvard University in the fall of 1966. He "ploughed a very wide and wandering path" in his 12 years at Harvard, completing an MA in history in 1968 and a PhD in the History of American Civilization in 1978. Kurtz was involved in many activities during his school years, including serving as a teaching fellow at the Harvard Divinity School, returning to serve as a parish priest in Rochester (1972-1973), doing "Sunday work" for a number of parishes in the Boston area, and for a time providing pastoral coverage at a rehabilitation hospital in exchange for room and board.

Several factors influenced Kurtz's choice of the history of Alcoholics Anonymous as a dissertation topic. First, slipping into his own alcoholism, he was admitted to Guest House's three-month treatment program for priests in 1975 after continuing to drink following detoxification at the Harvard Infirmary. Second, Kurtz found himself drawn to questions about the history of AA while researching his original dissertation topic on the history of the city of Cleveland, Ohio.

I was going to these AA meetings and was hearing things about the history of AA that I knew couldn't be true: "Oxford Movement" and all that. I also became very interested in the source of the ideas upon which AA was founded. I began to investigate AA history and the further I got into it, the more fascinated I became. I was spending more time on AA history than doing my doctoral research on Cleveland. On one of my visits back to Guest House, my former counselor suggested that I should discuss my interest in AA history with Dan Anderson at Hazelden. When I met with Dan, he expressed enthusiasm and informed me that AA was about to establish an archive that would include all of Bill Wilson's correspondence. Now that's a graduate student's dream—getting access to previously unviewed correspondence of some historically significant person. (Kurtz, 2008 Interview)

Getting approval to conduct a scholarly history on Alcoholics Anonymous required more than getting such a proposal by Kurtz's Harvard dissertation committee; it required obtaining approval for unprecedented access to AA's historical documents.

Dan Anderson put me in touch with Dr. Milton Maxwell, who was one of the AA Trustees at the time. Maxwell shared Dan's interest in my potential work on the history of AA. All this led me to request a switch in my dissertation topic. My Harvard mentors approved, as did the AA Trustee's Archives Committee (Milton Maxwell, Joe Jackson, and George Gordon). The approval from the Archives Committee was much tougher than my committee at Harvard. My work with these treasured documents was later supplemented by a review of taped interviews with AA oldtimers that were on these old reel-to-reel tapes. I had unlimited access to AA's primary documents in a way that had never existed before or since. It was a truly unique opportunity, to participate in the beginning of an archive. (Kurtz, 2008 Interview)

Kurtz's dissertation on AA was completed and approved in 1978. At the suggestion of his Harvard mentors and Dan Anderson, he spent the year following completion of his doctoral work

transforming his dissertation into a book. As the book neared completion, a troubling issue was raised by AA's trustees.

Milton Maxwell, who by that time, was the head of the trustees, called me, and said, "Ernie, you mention in the book Bill's experimentation with LSD." He went on: "The other trustees have asked me if you would cut that from the book." He added, "We had the agreement that with your dissertation there could be no censorship, but this is not the dissertation. You're going to publish a book."

Ouch! After a sleepless night I went to my academic mentors, Oscar Handlin and Bill Hutchinson, telling them, "This is what I've been asked. Out of respect for AA, I do not want to do something that would be injurious to AA, though I doubt that anything I might do will injure AA. But that does seem to me to be an important part of this story." Oscar and Bill agreed, saying, "This is part of AA's story as you tell how Wilson's thirst for alcohol became a thirst for helping alcoholics. This thirst took many varied expressions. That's an essential part of your story." So I gritted my teeth and prayed over it and decided to leave it in the book. (Kurtz, 2008 Interview)

Kurtz's *Not-God: A History of Alcoholics Anonymous* was published in 1979 by Hazelden Publishing.

When the book was published, AA Trustees were holding their breath, concerned about possible backlash for having given me such access to the archives. The first 300 calls they received were people saying how wonderful the book was and that it revealed Bill's humanity rather than presenting him as a tin god. When the membership responded that way, the Trustees were happy and then respected my decision. The book also added to AA's legitimacy since it was based on a dissertation approved at Harvard University by one of the leading historians of our time, Oscar Handlin. (Kurtz, 2008 Interview)

Not-God as a scholarly document consists of two parts: 1) the history of Alcoholics Anonymous and 2) an interpretation of the historical significance of AA in the larger context of American history and the history of religious ideas. The book meticulously details AA's birth and evolution from 1935 into the 1970s at a level not previously nor subsequently matched, and it delves deeply into the inner workings of AA's program of alcoholism recovery. It is remarkable, in light of AA's growth to a membership of more than 2,000,000 members in 150 countries, that Not-God remains the definitive history of Alcoholics Anonymous 30 years after its initial publication. As partial testimony to its influence, the book has remained in print for three decades through three editions and has sold more than 50,000 copies.

On the Heels of Not-God

In the years following its publication, the popularity of *Not-God* created new opportunities for Kurtz. Requests came to lecture at colleges and universities, alcoholism treatment programs, and professional alcoholism conferences. As a result of *Not-God* and Kurtz's popularity as a lecturer at summer schools on alcohol studies across the country, he became widely known in the alcoholism field and began offering additional presentations on such topics as shame as an obstacle to alcoholism recovery, the role of spirituality in alcoholism recovery, and the redemptive power of storytelling.

There were important turning points in the life of Ernie Kurtz during the early 1980s. Most significantly, he left the priesthood, accepted a teaching appointment at the University of Georgia,

and met and married social worker Linda Farris, who was completing her Doctor of Public Administration Degree at the university. Their shared interests in self-help movements provided numerous later opportunities for professional collaboration. In 1982, Ernie published his second book, *Shame and Guilt: Characteristics of the Dependency Cycle*. This work presented one of the earliest published treatises on the distinction between shame and guilt, the roles these experiences played in the development and progression of alcoholism, and their role in the alcoholism recovery process. It is important to note that the Kurtz treatise on shame and guilt predated the profit-motivated exploitation of these topics within pop psychology and pop therapy circles, a commodification that sorely twisted his ideas.

Following Kurtz's relocation to Chicago in 1984, he began teaching a history of religion class at Loyola University of Chicago. While there, he sought out various theologians to explore his growing interest in the spiritual dimensions of AA. In 1986, Kurtz accepted an offer to relocate and serve as the Director of Research and Education at Guest House in Lake Orion, Michigan. One of his primary responsibilities there was developing a training program for priests who had graduated from Guest House and who were requesting guidance on facilitating so-called "12-step retreats" in their home communities. It was in developing this training that he first developed the key ideas and outlines that would later evolve into the book, *The Spirituality of Imperfection*. The Guest House work ended when a new administrator wanted Kurtz to serve in a marketing role, to which he replied with his usual candor, "I'm horrible at such things: you can't be a big enough fool to ask me to do that." Ernie left his Guest House position in 1990 and relocated to Ann Arbor, Michigan with his wife, Linda, who had accepted a position in the Department of Social Work at Eastern Michigan University.

The Guest House years brought Ernie considerable national visibility. He was invited to serve on the editorial boards of *Alcoholism Treatment Quarterly* and *Dionysus* and deepened his involvement in teaching at on Rutgers University's Summer School of Alcohol Studies. The late 1980s were also a productive writing and speaking period. Between 1986 and 1990, Kurtz authored and co-authored articles on AA, published additional work on shame, published a book on AA history for the lay public (*AA: The Story*), and made presentations related to the history of AA at international conferences in Canada, England, Norway, Poland, and Russia. He was also invited in 1988 to provide "An Historical Perspective on Jews in AA Recovery" at the Third Annual JACS/Enoch V. Deutsch Memorial Lecture in New York City, which led to his journeying to Israel with a J.A.C.S. group and lecturing on Alcoholics Anonymous to an audience of academics and government personnel at Hebrew University in Jerusalem. Each of these experiences further whetted Kurtz's interest in the varieties of spiritual experience within AA. [J.A.C.S.: Jewish Alcoholics, Chemically Dependent Persons, and Significant Others: a group formed by Jewish alcoholics to help other Jews understand that AA is not "a Christian program."]

The Spirituality of Imperfection

During much of the 1990s, Ernie Kurtz worked as an Adjunct Research Scientist at the Center for Self-Help Research within the School of Social Work at the University of Michigan. He continued to lecture in venues of great prestige, but spent most of his time presenting at small seminaries, colleges and universities, community

hospitals, and local alcoholism treatment programs. He also continued his reading and research on AA and spirituality.

Significant cultural contexts set the stage for Ernie Kurtz's contributions during the 1990s. The 1980s birthed an American culture marked by rampant materialism, perhaps best personified in Gordon Gekko's "Greed is good" speech in the 1987 movie Wall Street. Even alcoholism treatment and recovery were commodified and aggressively marketed. Local alcoholism treatment programs initially conceived as service entities increasingly defined themselves as businesses guided by the mantra, "margin before mission." In time, some both within and outside its fellowship expressed concern about the "corruption" of Alcoholics Anonymous due to the growing encroachment of addiction treatment vocabulary into AA meetings. Even some AA members began to lament the loss of "real AA." By the early 1990s, the country, alcoholism treatment programs, and AA were trying to re-center themselves.

It was within this context that Kurtz produced some of his most influential work. The first of these contributions was a book drawing on a larger and longer spiritual wisdom. Kurtz describes how that project developed.

Kathy Ketcham had been Jim Milam's co-author of the book, Under the Influence, but she felt that book lacked an understanding of the role of spirituality in recovery. She approached Father James Royce, a Jesuit priest and one of the real pioneers of the alcoholism field, and invited him to do a book with her on that subject. He declined but recommended that she should talk with me. Kathy called and raised the possibility of collaboration with me serving as content expert and her serving as professional writer. I was taken with her skill and obvious enthusiasm for the project, so I arranged to present on this subject at the VA hospital in Walla Walla, Washington, close to where Kathy lived. Kathy sat in the back scribbling furiously all during the workshop, and then we spent three days after that hammering out an outline for this book. We sent drafts back and forth (these were the days before email) until we had the essence of what became The Spirituality of Imperfection. I can be difficult to work with and a few times decided that I had to send Kathy flowers as amends for my lapses from proper politeness. (Kurtz, 2008 Interview)

After an initial exploration of spirituality's assumptions, the book delineated six dimensions of AA spirituality (release, gratitude, humility, tolerance, forgiveness, and being-at-home) using the medium of just 100 stories. It was Kurtz's first attempt to interpret AA spirituality to a broader public audience. When asked to explain the phenomenal cultural response to the book, Kurtz replied:

Alcoholism is not contagious, but recovery is. Recovery of our humanity is what we're talking about here, not recovery from a particular disorder or disease. And this recovery comes about in touching bottom, that hole in the middle of oneself—recognizing oneself as finite, as limited, as one who makes mistakes and does things that are bad. And yet realizing that that's not all of me. Being in touch with that hole at the core of our being while embracing also that our being is larger than that hole—that's what Sister Ignatia had. That's why biographies of such people are so important. They illumine these things, especially in the lives of non-alcoholics . . . . I love Ernest Becker's concise image and description of this: "Man is a god who shits." We have this capacity for altruism, healing, profound spirituality, and yet even in those moments, we are periodically

reminded of our ties to the earth, of the reality that despite all our grand accomplishments, we too shall decay. (Kurtz, 2008 Interview)

Since its initial publication in 1994, *The Spirituality of Imperfection* has sold more than 200,000 copies.

Ernie Kurtz continued to participate in various research forums on AA and to publish scholarly pieces throughout the 1990s. Three are particularly noteworthy. In 1994, Ernie co-authored an article with William Miller in the *Journal of Studies on Alcohol* titled "Models of Alcoholism Used in Treatment: Contrasting AA With Other Perspectives With Which It Is Often Confused." Many in the alcoholism field were shocked to see the authors' names appearing together. William Miller explains:

When Ernie and I first published together, we both had the experience of our colleagues asking us, "What in the world are you doing working with HIM?" That was in the heat of a "behavior therapy versus disease model" polarization in the field, which to some extent was a reincarnation of the older "craft versus science" tension that still rears its head in the addiction field around flash-phrases like "evidence-based treatment" and "harm reduction." (William Miller, Personal communication, June 2009)

Many readers were also surprised by the article's clear, unequivocal, and well-documented demonstration that:

AA writings do not assert that: (1) there is only one form of alcoholism or alcohol problem; (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 actions. (Miller & Kurtz, 1994, p. 165)

The 1994 Miller-Kurtz article stands historically as the first crack in the ideological walls that dominated the polarized thinking about alcohol policy and alcoholism treatment in the second half of the twentieth century. The article was also the first to effectively confront the sweeping generalizations about Alcoholics Anonymous that had begun to appear in professional publications and presentations as well as the popular press. These misconceptions came, in this author's view, primarily from alcoholism treatment programs that had wrapped themselves in the AA mantle.

A second Kurtz article, "Spirituality and Recovery: The Historical Journey," was based on a 1996 presentation at the National Clergy Council on Alcoholism. That presentation touched on many recurrent themes in Ernie's work. After reviewing the early history of AA and the distinction between AA and professional alcoholism treatment, Kurtz made note of the crucial contributions non-alcoholics (Sister Ignatia, Father Dowling, Willard Richardson, Frank Amos, Dr. Silkworth, and others) had made within the history of AA.

They were not alcoholic, but they did all have something in common: each in his or her own way, had experienced tragedy in their lives. They all had known kenosis; they had stared into the abyss. They had lived through a dark night of the soul…..you do not have to be an alcoholic to understand one. But it seems that you have to have had this confrontation with tragedy in your own life….You have to have known utter hopelessness or utter helplessness.

You have to have screamed the first prayer, "God: help me." (Kurtz, 1996; reprinted in Kurtz, 1999, p. 120)

Kurtz then addressed the corruption of Alcoholics Anonymous that could occur when the distinction was lost between an AA meeting and a group therapy session. He argued not for the superiority of one over the other, but pointed out how each was injured when it lost its identity and drifted toward the other. Noting also the development of groups that called themselves "Twelve-Step" but lacked essential AA ingredients, Ernie (with some trepidation) attempted to define the "real AA" of history, suggesting these characteristics of "real AA":

1) The use of a language of spirituality that speaks of powerlessness, a Higher Power, character defects, inventory, amends, and service, rather than of the vocabulary of therapy with its references to co-dependency, inner children, and the use of diagnostic and clinical terms
2) Humor, with its appreciation of paradox and irony
3) A distinct story-style that shares "experience, strength, and hope" via stories that "describe in a general way what we used to be like, what happened, and what we are like now" rather than telling "what happened to me" and "how I feel about that"
4) Respect for the Twelve Traditions
5) The realization that one is present and participating not because one "wanted to" but because one had to, and the concomitant sense of identification and fitting in, of belonging in this setting and place, being at home in this community of recovery for the same reason.

In a third seminal article, Kurtz opened with the provocative question, "Whatever Happened to Twelve Step Programs?" The article described the history of the development of AA's Twelve Steps, and then raised concerns about the "commodification of the Twelve Steps." This discussion explored the professionalization and commercialization of alcoholism treatment and the presence of people and institutions who sought to economically exploit the larger recovery movement that had become something of a cultural phenomenon during the mid- to late-1980s. Kurtz particularly loathed the aggressive marketing of all manner of recovery paraphernalia—items he collectively castigated as "recovery porn." He expressed concern that the term "Twelve-Step" had become increasingly "laden with connotations of self-pity, narcissism, and greed" (Reprinted in Kurtz, 1999, p. 162). Kurtz's proposed antidote to such corruption was a re-emphasis on the genuine spirituality found within the authentic Twelve Steps of Alcoholics Anonymous and guarded by that fellowship's Twelve Traditions. He promised enthusiastic support of any business or other enterprise that implemented those same Twelve Traditions in its own practice.

Increased interest in Ernie's published articles led, through the encouragement of Charlie Bishop, Jr., to the publication of The Collected Ernie Kurtz in 1999. This book contains many Kurtz articles published in scholarly journals that had become difficult to obtain as well as some unpublished pieces (e.g., "Bill W. Takes LSD").

The Varieties of AA and Recovery Experience

Since 1998, Ernest Kurtz has served as an Adjunct Assistant Research Scientist within the Department of Psychiatry at the University of Michigan Medical School, where he provides consultation on research studies on topics ranging from alcoholism to life transitions. He also serves as a consultant to the Great Lakes

Addiction Technology Transfer Center of the Center for Substance Abuse Treatment, where he helps develop articles, monographs, and audiovisual products for addiction professionals and recovery support specialists. Collectively, these products use the latest scientific studies to chart diverse pathways and styles of long-term addition recovery and provide guidance on how to link clients in addiction treatment to communities of recovery in the United States. This latter interest led to Kurtz serving as a consultant to Faces and Voices of Recovery between 2001-2007. In this role, he led the effort to create and regularly update a guide to the broad spectrum of spiritual, secular, and explicitly religious recovery mutual aid groups in the United States. (See www.facesandvoicesofrecovery.org/resources/support_home.php).

Although health problems have restricted his travel and presentations in recent years, Ernie Kurtz continues to write (with a new book on spirituality currently in the works) and to serve in his favorite role as "armchair consultant" to many projects. He continues to inspire and support people interested in the history of AA and the role of spirituality in addiction recovery.

Permeating Themes

Numerous themes permeate the professional contributions of Ernie Kurtz. Some of the more prominent of these are highlighted and illustrated below with excerpts from Kurtz's writings and presentations.

The Role of Respect in Recovery Research: Ernie has been a key figure in conferences for researchers interested in conducting studies of AA. He welcomes such studies, but challenges researchers to set aside their pre-existing ideas about Alcoholics Anonymous. He consistently reminds research scientists interested in this area that respect for AA members and AA as an institution is an essential ingredient in the conduct of good science and ethical research practice.

Why is it that some who choose to research Alcoholics Anonymous seem to bring to that task attitudes toward 'the spiritual' that if held toward homosexuality would be termed homophobic? Why, to be more concrete, are pejorative terms such as religiosity and authoritarianism preferred to the as-descriptive-words spirituality and commitment? (Kurtz, 1992; reprinted in Kurtz, 1999, p. 8)

Immersion in the literature on AA indeed suggests that, as with the classic Rorschach inkblots, those who tell about AA may reveal more about themselves than about the fellowship and its program. This caveat of course applies also to us. We have sought to respond to its warning by staying as close as possible to AA's own literature. (Miller & Kurtz, 1994, p. 165)

Importance of Cultural Context: "You have to understand what was going on at that time" is a frequent admonition as Kurtz mentors those of us interested in the birth and evolution of Alcoholics Anonymous.

Alcoholics Anonymous came into being during the cultural trauma of the Great Depression, and A.A. could not have come out of any era other than the American 1930's…..Alcoholics Anonymous recaptured in very American terms the ancient tradition that recognized and accepted limitation. (Kurtz, 1996; reprinted in Kurtz, 1999, p.127)

History is in the Details: One of Kurtz's favorite historians is Barbara Tuchman, whom he often quotes and encourages his mentees to read. Like Tuchman, Kurtz prefers historical evidence over sweeping

and usually ill-founded generalizations. He is a stickler about the sources of data upon which any historical conclusions are based. The proffered theories of many students are consistently met with the question, "And what is your evidence for that?"

I would speculate and then Ernie would caution me not to let mere conjectures get too far away from what was actually available in the documentary record. (Ron Roizen, Personal Communication, July 2009)

The science of history is, at its best, about data and judging the quality of data upon which one's conclusions are based. When his mentees present interview data that conflicts with evidence from archival documents, Ernie initiates a discussion of memory as both a storage area and a construction, or reconstruction, site. He emphasizes the importance of reconciling conflicting accounts and listening for how memory could be distorted for ideological gain or personal prestige. In short, Ernie spends a good deal of his life teaching people how to, in his favorite phrase, "do history."

How AA Works: Ernie has sustained his fascination with the details of AA history, but he also returns repeatedly to the questions of how AA works as an organization and how it works in the lives of its members. It is in these latter explorations that we get the continual thread reflected in the titles of Ernie's most renowned books.

Sitting in that side parlor of the Seiberling gatehouse on the evening of 12 May 1935, Bill presented Dr. Bob four aspects of one core idea. Utterly hopeless, totally deflated, requiring conversion and needing others, the drinking alcoholic was quite obviously not perfect, not absolute, not God." (Kurtz, 1979, p. 55)

"Don't take the first drink" reminds that the alcoholic is not God. It signals the importance of accepting limitation. "Keep coming to meetings" speaks to the alcoholic as not-God. It alerts to the wholeness to be found in limitation. Since to be human is to be limited, wholeness as human is always unfinished process rather than an achieved condition. (Kurtz, 1979, p. 212)

Bill [Wilson] never lost what recent self-styled spiritual mentors apparently never gain: the sense of humor that warned him that he could be wrong. Bill Wilson never forgot that if he, as an alcoholic in recovery, had any spirituality, it was a spirituality of imperfection. (Kurtz, 1999, p. 49)

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 Blythwood 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)

Importance of AA Traditions: The endless opportunities for Kurtz to talk about the meaning of AA's Twelve Steps (perhaps most eloquently summarized in his essay "Whatever Happened to Twelve Step Programs?"), never fail to also elicit comment on the less acknowledged role of the Twelve Traditions of Alcoholics Anonymous.

The Traditions are to the fellowship of AA what the Steps are to the spirituality of the individual AA member. The spirituality of the fellowship is fostered and safeguarded by the Twelve Traditions. The traditions are why AA survived and thrived when so many of its predecessors did not. The"secret" of AA's success lies in the protective shield of its Traditions. (Kurtz Interview 2008)

AA's Historical Significance: Ernie returns to the question of AA's historical significance many times in his writings, presentations, and discussions. The first thing he does in response to this question is disavow contributions that have been mistakenly attributed to Alcoholics Anonymous, e.g., the disease concept of alcoholism.

On the basic question, the data are clear: Contrary to common opinion, Alcoholics Anonymous neither originated nor promulgated what has come to be called the disease concept of alcoholism…."What alcoholism is" has never been among the main concerns of later members of Alcoholics Anonymous. Consistently over time, members of Alcoholics Anonymous, especially as members of Alcoholics Anonymous, have been interested not in alcoholism but in alcoholics–in people rather than in things. (Kurtz, 2002, p. 6)

Ernie challenged the prevailing wisdom by arguing with considerable evidence that the disease conception of alcoholism is not part of AA's core philosophy—a courageous and, I believe, fundamentally correct historical argument. It is a model of scholarship worth emulating. (Ron Roizen, Personal Communication July 2009)

Kurtz frequently notes what Alcoholics Anonymous means to alcoholics and their families and what AA means within the history of addiction treatment, but he also extends this to a broader discussion of AA's contribution to the world beyond alcoholics.

A.A.'s revolutionary contribution was not medical diagnosis of the "disease" of alcoholism but its insistence that the most important reality in the life of the alcoholic, sobriety, could not be attained alone. (Kurtz, 1996; reprinted in Kurtz, 1999, p.168)

…AA built upon its concept of "alcoholic"—its insight into essential limitation—an effective modality of healing for the malaise of its age, shame…. A.A.'s intellectual significance, then, is itself appropriately limited. A.A. suggests, for those afflicted with existential shame over their failure to be perfect, both a philosophy and a therapy that enable that shame's transcendence…Perhaps in this lies its greatest significance, both intellectually and socially, for us all. (Kurtz, 1999, 218-219)

Power of Story: Kurtz views the acts of story reconstruction, storytelling, and story-listening as among the most important dimensions of recovery from alcoholism within the fellowship of AA. He returns to this subject again and again in his writings and presentations.

…from its beginnings and still today, the philosophy and spirituality—the healing—of Alcoholics Anonymous is transmitted primarily by the practice of storytelling, of telling a particular kind of story the very format of which inculcates a way of thinking that shapes a particular way of life. (Kurtz, 1986, reprinted in Kurtz, 1999, p. 26)

In this mutuality between telling and listening, between speaking and hearing, lies the deepest spiritual significance of mutual-aid groups….Those wrestling with spiritual dilemmas do not need answers but presence—permission to confront the dilemma and struggle with it aloud, in the presence of others who in some way "understand," in the sense that they awarely stand under the same dilemma. (Kurtz & Ketcham, 1992, p. 95, edited)

For in the settings of A.A. storytelling and storylistening, two paradoxical things happen. First, participants discover their shared story; and second, they come to

realize that each of their stories is unique. (Kurtz & Ketcham, 1992, p. 204)

Guilt, Shame, and Alcoholism Recovery: Kurtz's views on guilt and shame in his writings, presentations, and interviews begin with their nexus to addiction.

Addiction has a lot to do with guilt and shame, those oh-so-negative realities. Some oldtimers suggest that we are made with a God-shaped hole in the middle of our being, and we are not at rest until somehow that hole is filled. So we try to fill it with booze. We try to fill it with pot and other drugs. We try to fill it with sex. We try to fill it with gambling. We try to fill it with big cars and investment portfolios. We try to fill it with honors and publicity. But the hole remains. The need is not to have this hole filled with pat answers, but to experience connection with others who recognize and participate in these same efforts to find some kind of full-fill-ment. (Kurtz 2008 Interview)

Having established the guilt/shame/addiction connection, he then presents a quite nuanced distinction between shame and guilt and the processes through which each are addressed in the recovery process.

Guilt results from a fault of doing, whereas shame results from a fault of being. There are two ways in which human beings feel bad: feeling bad for what we do (guilt) or feeling bad for what we are (shame). I see the inventory and amends steps (Steps 4, 5, 8, 9, and 10) in Alcoholics Anonymous as an effective remedy for guilt, but shame is qualitatively different than guilt, and it is most effectively touched by Steps 6 and 7. Shame requires a new way of seeing—insight that changes one's very being through a kind of conversion. In guilt, we can be reformed; in shame, we must be transformed. You don't reform the alcoholic. Reformation does not work. The alcoholic needs to be transformed. Surmounting guilt can lead to feelings of righteousness, whereas transcending shame opens us to a new identity and a humanness free of self-righteousness. (Kurtz 2008 Interview)

Respect for Multiple Pathways and Styles of Long-Term Recovery: Respect for the varieties of recovery experience within and outside Alcoholics Anonymous permeates Kurtz's intellectual contributions.

If I were to write another book on A.A., its title would be Varieties of the Alcoholics Anonymous Experience. (Kurtz, 1996; reprinted in Kurtz, 1999, p. 116)

His fascination with and respect for other, non-AA, varieties of the recovery experience seem to have begun with Kurtz's interest in the "varieties of AA experience," observed first in the development of specialized meetings and Eleventh Step groups (e.g., Calix Society, J.A.C.S.). That study soon broadened to include secular and religious recovery support groups that rose as alternatives to AA. In this regard, Kurtz shares the view of AA co-founder Bill Wilson that "the roads to recovery are many" and that all are cause for celebration (Wilson, 1944).

Kurtz, the Man

In closing this chapter, we will try to move beyond Ernie Kurtz as an iconic scholar and describe something of the man. This effort is challenged by the many roles he has played and the many facets of his character.

Man Behind the Scholar: Kurtz has received high praise from the most

esteemed intellects within the addictions field.

Dr. William R. Miller is an Emeritus Distinguished Professor of Psychology and Psychiatry at the University of New Mexico and one of the most internationally respected scientists in the field of addictions research.

I have learned much from Ernie about the 12-Step program and fellowship, first from his lucid writings and then from the man himself. A solid historian who is also a consummate storyteller is a real find, and being a lover of good stories, I was drawn to Ernie from the moment we met. We also share a broader interest in the interface of spirituality and health, looking through the varied lenses of skeptic and believer, scholar and healer, story-teller and story-listener. His Spirituality of Imperfection is, to me, a masterwork. The word that comes to mind when I think of Ernie is mensch. I feel both an awed respect for his intellect and personal affection for the man. He is someone who does not speak often, and ponders before he does so. Thus, when Ernie Kurtz has something to say, I want to hear it. I treasure him as a colleague, a friend, and a rare gift. (William Miller, Personal Communication, July 2009)

Dr. Ron Roizen, a leading alcoholism sociologist, adds:

The world of alcohol history I have worked in would be greatly diminished without Ernie's example and his collegial friendship. The lasting influence Ernie has had on me may simply be his serious mind, serious work, and serious communication. My work in alcohol studies, humble as it is, would be sorely diminished without Ernie as a sounding board, a patient correspondent, a critic, a congratulator, a reader, a model, and a discriminating scholar. (Ron Roizen, Personal Communication, July 2009)

One of the things Kurtz has long done is contribute to the development of repositories of historical documents for use by present and future scholars. Dr. David Lewis describes Kurtz's influence on the founding and activities of the Chester B. Kirk Collection.

The origin of Brown University's collections of historical materials about the founding and activities of Alcoholics Anonymous began when Ernie Kurtz called me fifteen years ago with information that book dealer Charles Bishop was looking to sell the substantial portion of his collection (15,000 items!). With the generous support of Chester H. Kirk, Brown acquired this collection. Ernie Kurtz then helped establish the anonymity policy for use of that collection and assisted in the planning for two meetings of AA historians and authors, which took place subsequently at Brown. Over time, the archive at Brown has grown to include the collections of Dr. Bob, Clarence Snyder, Marty Mann, The Rutgers Anti Saloon League collection, and others. I've had the help of numerous individuals in locating donors of materials and money and giving me advice about how I should proceed, but Ernie was a prime player and the one who got the collections started. He played other roles as well. I saw Ernie the scholar in action sitting at my dining table in Providence with historian Bill White meticulously sorting through and cataloging Dan Anderson's archives before they went to Brown's John Hay Library. It was a pleasure to see Ernie's academic side and vast fund of knowledge and meticulous attention to detail with each of the letters and reports in that material. It is a pleasure to have worked with Ernie Kurtz for many years. It is my privilege to count him as a friend. (Lewis 2009, Personal Communication).

The Author: Most people know Ernie Kurtz through his written word. His popularity as an author has many sources. First, he is above all a storyteller and a quite good one. Second, he possesses two quite admirable additional traits in a writer: he can "turn a phrase" and "tell it like it is."

For the last decade, the surest way to make a buck has been to convince people of their shame and then to find a way of blaming someone for it. (Kurtz, 1987, reprinted in Kurtz 1999, p. 77)

Spirituality has to do with the reality of the here and now, with living humanly as one is, with the very real, very agonizing, 'passions of the soul.' Spirituality involves learning how to live with imperfection. (Kurtz and Ketcham, 1992, p. 18)

The admission of limitation, and, specifically, of insufficiency of self-control—this is the beginning of Twelve-Step spirituality. (Kurtz, 1996, Reprinted Kurtz, 1999, p. 147)

Addiction has been described as the belief that whenever there is 'something wrong with me,' it can be 'fixed' by something outside of me…It is no wonder, then, that 'locating divinity in drugs' becomes a kind of spiritual death. (Kurtz & Ketcham, 1992, p. 120)

The Collaborator: Ernie has been quite open to collaborative work over the course of his career, but as Ernie suggested earlier, some of these collaborations have had their rough moments, as Kathy Ketcham describes.

My correspondence with Ernie over the twenty years of our partnership fills many files, including ones labeled "acrimonious letters" and "loving exchanges." On July 12, 1989, months into our work on what would become The Spirituality of Imperfection, I asked Ernie in a letter to explain a story I'd read, the deeper meaning of which had escaped me. Ernie responded with a three-page letter that began, "Please don't do things like that to me! Our initial joy at finding each other in order to work together seemed to spring in part from a sense that we were intuitively attuned. Now you threaten to go linear on me!" "It is not that I 'resist' explaining stories," Ernie continued in a gentler tone. "Stories cannot be explained. Story is art-form. As with any other art-form, the only possible answer to 'what does it mean?' is 'If I could have put it into words, I would not have had to paint the painting, sculpt the statue, write the sonata, or tell the story.' Note the underlining and bold type. Ernie knew in those years he was dealing with a thick-headed neophyte, and he eschewed subtlety. The letter went on (and on), and I wondered if we would ever be able to breach the schism between us. But in the last paragraph, Ernie extended a hand. "This letter has been a far too lengthy, pompous, discursive, preachy 'explanation.' On the precise topic that you query: We are 'the story!' I doubt that I want to let that hang out in our book, but it may help us survive producing that book." We survived the book, of course, and twenty years later, we are now working (and playing) on a book about sin, shame, and spirituality. The message of our collaboration and our written work is the same: In all our imperfection, indeed precisely because of our limitations and shortcomings, we need each other, then, now, always. (Ketcham, 2009, personal communication)

The Teacher: Gail Milgram, Professor Emerita and long-time Director of the Rutgers School of Alcohol and Drug Studies, had the opportunity to work with Ernie Kurtz for almost 20 years.

Ernest Kurtz served on the faculty of the Rutgers School of Alcohol Studies from 1978 to 1997. His animated and exciting style and wonderful content made his lectures come alive; he told stories, instilling meaning and understanding. All the School's participants attended Ernie's lectures; his wisdom, experience, and renown filled every seat in the lecture hall. After Ernie was finished, he would always receive a standing ovation. His writings continue to exert a great influence on the School. He helps us understand the importance of fellowship, traditions, and spirituality and how they relate to recovery. Ernie Kurtz shaped the field as we know it today, and for that, we owe him our sincere gratitude and heartfelt thanks. (Milgram 2009, Personal Communication)

Kurtz has given considerable thought to the crafts of teaching and coaching and how he can best help those he mentors to also become good teachers. When recently asked the essence of great teachers, he reflected:

There has to be a fundamental honesty. The first honesty for any teacher, of course, is "I don't know." That is so difficult for some people, and people who cannot say those words should never go into teaching. Some people, including myself, go into teaching in the hopes that someday you will know everything. Someplace along the line, you have to embrace what you know and don't know. Teaching requires that basic honesty. (Kurtz, 2008 interview)

When his professional peers were asked to comment on Kurtz's contributions to their own work, people frequently comment on his generosity as a teacher.

When I ask for help regarding one or another historical question, he's as likely as not to send me considerably more than I asked for. I once emailed back to him in this regard, "I asked for a peanut, and you sent me Georgia." (Ron Roizen, Personal Communication, July 2009)

The Mentor: In mentoring, as in teaching, Ernie gives considerable thought to the process involved.

Discussions of mentoring often focus on what the mentor gives and the mentee receives, but these relationships have to be two-way. This is the nature of mentoring. It's impossible to teach effectively without learning. There are some people who don't know this who have a lot to teach but can't connect with their students because they have stopped learning through the teaching process. Another pitfall is possessing one's students and sheltering them from opposing ideas. Those who come to learn from us are a precious gift. We have to realize this and pass that gift on to others. I think an important mentorship role is this linking one's students to other people. I've also learned that nothing is more important in mentoring others than genuine enthusiasm. You cannot teach something you don't love. (Kurtz, 2008 Interview)

People regularly run ideas by Ernie and receive encouragement to pursue their sense of calling. In a casual conversation, Tom Garrett, who worked with Ernie at Guest House, described his interest in doing something to aid alcoholic priests serving in India. Ernie suggested an outreach program from Guest House and encouraged Tom to lead the effort, which he did over the coming years. Tom recently reflected, "Without Ernie's suggesting the program in the first place and supporting the program with the director and the board of directors, it wouldn't have happened" (Tom Garrett Interview, June 30, 2009).

It is difficult to find an AA-related book written in the past 25 years that does not include a thank-you for assistance and

support to Ernie Kurtz. The number of books, dissertations, theses, and sundry professional presentations Ernie has been consulted on is incalculable. Glenn Chestnut describes Ernie's permeating influence on AA scholarship.

Ernie's influence on AA history writing has been profound, and often carried out quietly in the background, in ways of which the general public was never fully aware. One of his special concerns over the years has been to locate and nurture other researchers who were just starting out, to make sure that a tradition of good AA history writing would continue into the next generation. The reason we have a number of our best published studies of AA is because Ernie encouraged these authors and helped them and guided them at crucial points during their own researches, and often worked to find publishers for their books. Likewise, when Nancy Olson started the AAHistoryLovers website (which soon became the principal international forum for the discussion of AA historical research), she turned to Ernie at least two or three times a week to give her guidance and support. Ernie has always been there for all of us. He has been one of the major supporting pillars for the overall enterprise of AA historical writing during the Twelve Step movement's second generation. (Glenn Chestnut, 2009, personal communication)

Reverend Sally Brown describes the mentoring she and her husband experienced from Kurtz.

Twenty years after first reading Not-God, my husband, David R. Brown, and I embarked on our own historical project, A Biography of Mrs. Marty Mann. One of our earliest contacts was Ernie, who strongly encouraged us to do a carefully documented account of Marty's life rather than a dramatic, quick, and easy "AA story." Ernie's clinching argument was that this was the first biography of a pivotal person in the alcoholism movement and that we should lay a reliable base for future researchers to follow. During our cross-country research, Dave and I visited and interviewed Ernie at his home in Ann Arbor. He was generous and gracious with his time and information then, and later via telephone. His steady support and encouragement and helpful links to others were invaluable. We know we are only two among legions Ernie has blessed with his knowledge, his teaching, and his writing. (Sally Brown, July 2009, Personal Communication)

Dr. John Crowley, Professor Emeritus at Syracuse University and Professor of English at the University of Alabama, describes a similar experience.

When I was writing my book on Bill W. and A.A., I imagined Ernie Kurtz, with whom I had never communicated, as my ideal reader. If I could halfway please him, I thought, I'd know the book wasn't half bad. So I sent it to him, and he had only encouraging things to say. I finally met Ernie at the Brown University alcoholism and addiction confab in 2002. I can't think of anyone now whose opinion in the field I value more. (John Crowley 2009, Personal Communication)

In my own extended mentorship with Ernie Kurtz, I have found the best of what one could want from a mentor: encyclopedic knowledge, high expectations, piercing questions, straightforward encouragement, unfiltered honesty, a sense of humor, connections to a network of other gifted and generous people, and patience with the pace of one's development. I vividly recall a book chapter I sent to Ernie for review in the early 1990s. His response was to suggest that if my work on this chapter was a prize fight, I would be

lying bloodied and battered on the canvas. What then followed was a detailed litany of the flaws of the chapter, with a closing admonition that I needed to get up off the canvas—that I could still win the fight because I was better than my opponent. Ernie was right on both counts: the chapter did initially beat me, and I did get up and eventually win the fight—but not without Ernie's guidance and encouragement. To continue the fight analogy, he is a good man to have in your corner.

The Bridgebuilder: Kurtz has spent a lifetime connecting ideas, people, and institutions. That process began early in his career.

It struck me early on that non-recovering professionals, especially academics, and AA members did not trust each other and often did not like each other very much. This bothered me because I knew good people and had friends in both camps. So I have tried throughout my own professional career to build bridges between these two groups. I have tried to connect these people, to forge links of understanding between the proven conclusions of science and the differently demonstrated experiences of spirituality. My goal when I walk into a room obviously split into recovery and professional camps is to have them talking with each other before I leave. I feel very strongly that these two caring communities need to discover their common ground and respect each other, learn from each other. (Kurtz 2008 Interview)

Because Kurtz's name is so associated with the history of AA, few understand his personal connection to numerous other recovery mutual aid societies. He played an important role in the early development of Moderation Management, has maintained connections with leaders of numerous secular and religious recovery support fellowships, and encouraged and brought attention to groups ranging from Methadone Anonymous to Moms on Meth to Millati Islami (A Muslim 12-step fellowship). In the last decade, Ernie Kurtz has had direct connections with more recovery mutual aid groups than any other person. He is quite literally a walking encyclopedia of addiction recovery in America. And importantly, he facilitates relationships between members of these groups. He has been a force to move American recovery mutual aid societies from a position of competition and conflict to a position of mutual respect and collaboration that has contributed to the embrace of a larger identity: "people in recovery." Pat Taylor, Director of Faces and Voices of Recovery, describes Kurtz's approach to creating the Guide to Recovery Support.

His willingness to share his knowledge, experiences, and understanding were boundless, and I feel extremely fortunate to have been exposed to his questioning and curious mind and wonderful spirit as he marshaled the resources of the internet and his vast web of colleagues to expand opportunities for individuals and professionals to find support to sustain recovery from addiction. (Taylor, 2009, Personal Communication)

Kurtz's role of bridge builder extends to his mentoring activities. He has long served as a central node of communication for people interested in recovery mutual aid and the role of spirituality in recovery. In that avocation, he spends much of his time connecting people with one another. What that bridge-building did for this author was move me from a local platform—in how I saw myself and was seen by others—to a national and international platform. Much of what I have been able to achieve and contribute came from Ernie first expanding my professional development and then

connecting me to key people and venues of influence.

The Statesperson and Activist: Ernie Kurtz earned a statesman status in the addictions and recovery arenas through sheer endurance, the quality of his writings and presentations, and his character. He would not define himself as a statesman or activist, but there are numerous examples that support those titles. Those roles are evident through his local involvements such as serving on the boards of the Washtenaw County Council on Alcoholism and Dawn Farm—a local addiction treatment facility in Ann Arbor. Jim Balmer, the Director of Dawn Farm, describes Ernie's contributions.

Ernie's tenure as a Trustee for the Dawn Farm Community of Programs helped steer this organization toward a greater commitment to our roots in the recovery movement. His understanding of the principles of Alcoholics Anonymous helped other Trustees see the importance of maintaining our respect and deference to community-based and non-professional recovery workers. The lessons we learned about the primacy of the recovery community stay with us to this day. (Balmer, 2009, personal communication)

Kurtz's activism is also evident at a national level. Here's one example. On January 20, 2000, Audrey Kishline, the founder of Moderation Management, announced that she would be attending AA, Women for Sobriety, and SMART Recovery meetings to achieve a newly set goal of abstinence. On March 25, 2000, Kishline, while legally intoxicated, was involved in a head-on crash that killed a father and his 12-year-old daughter. The event ignited a media frenzy and renewed an acrimonious, polarized debate about "controlled drinking." Published editorials and internet posts variably blamed MM or AA for the deaths that had resulted from Kishline's intoxication. At the height of this frenzied debate, Ernie Kurtz mobilized 34 prominent individuals from all spectrums of the addiction/recovery fields to formulate and publish a statement on this incident and the professional and public responses to it. The statement read in part:

That Ms. Kishline was intoxicated at the time of the crash has been claimed to indicate the failure of the approach of one or another of the mutual-aid groups Ms. Kishline attended. Such claims are not in accord with everyday experience in the field, in which relapse is common, whichever approach the drinker adopts. Recovery from serious alcohol problems is a difficult goal, and there are different paths to it. We believe that the approach represented by Alcoholics Anonymous and that represented by Moderation Management are both needed.
(Downloaded on August 5, 2009 from http://listserv.kent.edu/cgi-bin/wa.exe?A2=ind0007b&L=addict-l&F=P&P=24932)

This straightforward statement, signed by people no one would expect to appear together, quieted the frenzy and stands today as a historically important footnote in the American debate about moderation versus abstinence in the resolution of alcohol problems. Ernie Kurtz was the common relational link to those 34 people. It is doubtful that any other person could have brought those individuals together and mobilized them for a common cause. That such activism was selective made Ernie's voice and the voices of those he called upon to stand with him all the more powerful.

A Closing Reflection

Ernie Kurtz continues to challenge others to pursue work that will build on his

own. In recent years, he has been particularly adamant on the need for new studies on the history of AA.

Something's wrong when a single history of Alcoholics Anonymous—Not-God—has remained authoritative for 30 years. Part of it is that no one before or since had access to the AA Archives the way I did. But we need new historical studies of AA. So much new information has been discovered, particularly through the AA History Lover's listserv and through AA members who have delved into various questions related to the history of AA. Not God is a history of ideas. We do not know a lot about the economics of early Alcoholics Anonymous. We do not know much about the interpersonal actions or relationships among people in the fellowship's early days. It really is time for AA's story to be told from new and different perspectives. (Kurtz 2008 Interview)

Historian Barbara Tuchman (1981) once observed that the key to writing good history is a love of your subject. Ernie found such a love early in his life and has continued to spread that contagious passion to generations of individuals who share his interests in the history of AA, spirituality, and the power of storytelling. He continues today to pursue that love through his research and writing. When this book comes out, he will likely be sitting in his study in Ann Arbor pursuing that love, and he will, as the intensely private person that he is, be embarrassed by this fuss we have made over him.

References

Tuchman, B. (1981). *Practicing history*. New York: Alfred A. Knopf.

White, W. (2004). Teaching addiction/treatment/recovery history: Rationale, methods and resources. *Journal of Teaching in the Addictions*, 2(2), 33-43.

Wilson, B. (1944). Bill's comments on Wylie ideas, hunches. *A.A. Grapevine*, 1(4), 4.

Appendix

Chronology of Ernest Kurtz Publications

Books

Kurtz, E. (1979). *Not-God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden (2nd printing, 1980; 3rd, 1981; paperback, 1982; revised and expanded edition, 1991).

Kurtz, E. (1981). *Shame and guilt: Characteristics of the dependency cycle*. Center City, MN: Hazelden.

Anonymous. (1984). *90 Meetings ninety days: A journal of experience, strength, and hope in Twelve-Step recovery*. Minneapolis, MN: Johnson Institute.

Kurtz, E. (1988). *A.A.: The story*. New York: Harper & Row.

Kurtz, E., & Ketcham, K. (1992). *The spirituality of imperfection*. New York: Bantam Books.

Kurtz, E. (1999). *The collected Ernie Kurtz*. Wheeling, WV: Bishop of Books.

Kurtz, E. & Kethcam, K.(in press). *Experiencing spirituality*. New York: Tarcher Penguin.

Articles and Monographs

Kurtz, E. (1982). The tragedy of southern religion. *Georgia Historical Quarterly*, 66, 217-247.

Kurtz, E. (1984). The modernist controversy. In S.S. Hill (Ed.),

Encyclopedia of religion in the South (pp. 504-506). Macon, GA: Mercer University Press.

Kurtz, E. (1984). The Southern Sociological Congress. In S.S. Hill (Ed.), *Encyclopedia of religion in the South* (pp. 725-726). Macon, GA: Mercer University Press.

Kurtz, E., & Kurtz, L.F. (1985). The social thought of alcoholics. *Journal of Drug Issues*, 15, 119 134. Also in: T.D. Watts (Ed.) (1986), *Social thought on alcoholism: A comprehensive review* (pp.117 136). Malabar, FL: Krieger.

Kurtz, E. (1986). Origins of A.A. spirituality. *The N.C.C.A. Blue Book*, 38, 34-42.

Kurtz, E. (1987). Shame in the eighties. *Alcoholism Treatment Quarterly*, 4, 1 6.

Kurtz, E. (1987). Alcoholics Anonymous: A phenomenon in American religious history. In P. Freese (Ed.), *Religion and philosophy in the United States of America* (vol. 2, pp. 447 462). Essen: Verlag Die Blaue Eule.

Kurtz, E. (1987). An addiction syllabus: How to educate about the disease. *The N.C.C.A. Blue Book*, 39, 21 30.

Kurtz, E. (1992). Commentary on "lay treatment." In J.W. Lagenbucher, B.S. McCrady, W. Frankenstein, & P.E. Nathan (Eds.), *Annual review of addictions research and treatment* (pp. 397-400). New York: Pergamon.

Kurtz, E. (1993). Research on Alcoholics Anonymous: The historical context. In W.R. Miller, & B.S. McCrady (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp.13-26). New Brunswick, NJ: Rutgers Center of Alcohol Studies Press.

Miller, W.R., & Kurtz, E. (1994). Models of alcoholism used in treatment: Contrasting A.A. and other perspectives with which it is often confused. *Journal of Studies on Alcohol*, 55, 159 166.

Kurtz, E. (1996). Spirituality and recovery: The historical journey. *The N.C.C.A. Blue Book*, 47, 5 29.

Kurtz, E. (1996). Twelve step programs. In P.H. Van Ness (Ed.), *Spirituality and the secular quest* (vol. 22, pp. 277 302) of E. Cousins (General Ed.), World spirituality: An encyclopedic history of the religious quest. New York: Crossroad/Continuum.

Kurtz, E. (1997). On line self help groups. In T.A. Young, & S. Kollmeyer (Eds.), The Michigan self help group directory (2nd ed., pp. xvii xx). Lansing, MI: Michigan Protection and Advocacy Service, Inc.

Kurtz, E. (1999). The historical context. In W.R. Miller (Ed.), Integrating spirituality in treatment: Resources for Practitioners (pp. 19 46). Washington, DC: American Psychological Association.

Strobbe, S., & Kurtz, E. (2012). Narratives for recovery: Personal stories in the 'Big Book' of Alcoholics Anonymous. *Journal of Groups in Addiction and Recovery*, 7(1), 29Y52.

White, W., Kurtz. E., & Acker, C. (2001). The combined addiction disease chronologies of William White, Ernie Kurtz, and Caroline Acker. Posted at www.bhrm.org.

Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. *Alcoholism Treatment Quarterly*, 20(3/4), 5-40.

Robinson, E.A.R., Brower, K.J., & Kurtz, E. (2003). Life changing experiences,

spirituality and religiousness of persons entering alcohol treatment. *Alcoholism Treatment Quarterly*, 21(4), 3-16.

Kurtz, E., & White, W. (2003). Alcoholics Anonymous. In J. Blocker, & I. Tyrell, (Eds.), *Alcohol and temperance in modern history* (pp. 27-31). Santa Barbara, CA: ABC-CLIO.

White, W., Kurtz, E., & Sanders, M. (2006). *Recovery management*. (Monograph) Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W., & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61.

White, W., & Kurtz. E. (2008). Twelve defining moments in the history of Alcoholics Anonymous. In M. Galanter, & L. Kaskutas (Eds.), *Recent developments in alcoholism* (Vol. 18, pp. 37-57). New York: Plenum Publishing Corporation.

Video Products

Kurtz, E. (2009). *Ernie Kurtz on the history of A.A., spirituality, shame, and storytelling* [DVD of filmed interview]. Chicago, IL: Great Lakes Addiction Technology Transfer Center.



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: 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. Posted at **www.williamwhitepapers.com**

An Interpretive Phenomenological Analysis of Secular, Spiritual, and Religious Pathways of Long-term Addiction Recovery

ABSTRACT

The emergence of recovery as an organizing construct has sparked interest in mapping the varieties of addiction recovery experience. The present study uses Interpretive (qualitative) Phenomenological Analysis (IPA) to examine six-diverse pathways of long-term addiction recovery. Semi-structured interviews were conducted with six subjects representing natural recovery, Twelve-Step (AA/NA) recovery (2), secular recovery, faith-based recovery, and medication-assisted recovery. Common and distinct features of these pathways of addiction recovery are discussed with noted implications for the design of addiction treatment, recovery support services, and an understanding of recovery itself. Qualitative research can be a valuable tool in the elucidation of addiction recovery pathways.



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. (2015) From trauma to transformative recovery, *Advances in Addiction and Recovery*, 3(1), 28-30. Posted at **www.williamwhitepapers.com**

From Trauma to Transformative Recovery

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Between 1986 and 2003, I served as the evaluator of an innovative approach to the treatment of addicted women with histories of neglect or abuse of their children. Project SAFE eventually expanded from four pilot sites to more than 20 Illinois communities using a model that integrated addiction treatment, child welfare, mental health, and domestic violence services. This project garnered considerable professional and public attention, including being profiled within Bill Moyers' PBS documentary, *Moyers on Addiction: Close to Home*. My subsequent writings on recovery management and recovery-oriented systems of care were profoundly influenced by the more than 15 years I spent interviewing the women served by Project SAFE and the Project SAFE outreach workers, therapists, parenting trainers, and child protection case workers. This blog offers a few reflections on what was learned within this project about the role of trauma in addiction and addiction recovery.

Trauma, particularly physical/sexual abuse, was ever present in the lives of the women served by Project SAFE, but one must be cautious in over-interpreting trauma as the etiological agent in addiction and related problems. After all, multitudes of women have experienced childhood and adult trauma without developing the severity, complexity, and chronicity of problems commonly experienced by the women in Project SAFE. So an early challenge within Project SAFE was to understand what distinguished the trauma resilient from the trauma impaired. Our collective experience with thousands of women across diverse community and cultural contexts led to the conclusion that the resilient and the impaired differed in two fundamental ways. They differed in the nature of the trauma they had experienced, and they differed substantially in the recovery capital that influenced their capacities for resilience.

What separated community populations of women and our clinical population of women was not the presence of trauma but the characteristics of such trauma. A cluster of traumagenic factors distinguished the clinical group from the more resilient community group. Trauma in the former was more likely to:

1) begin at an earlier age (marking less developmental resources to cope with the trauma),

2) involve more physically and psychologically invasive forms of victimization,
3) take place over a longer period of time (e.g., multiple events over days, months, or years rather than a single point-in-time episode),
4) involve multiple perpetrators over time (confirming lack of safety, personal vulnerability, and suspicion that the cause lies within oneself),
5) involve perpetrators drawn from the family or social network (marking a greater violation of trust),
6) involve physical injury/disfigurement or threats of such if event(s) disclosed, and
7) generate environmental responses of disbelief or victim blaming when victimization disclosed.

Women with histories of perpetration of violence against their children, partners, or others also had experienced three additional factors: serial episodes of abandonment, desensitization to violence through prolonged horrification (witnessing violence against persons close to them in their developmental years), and violence coaching (transmission of a technology of violence and praise for violence from the family and social environment). Combinations of these potent traumagenic factors dramatically increased the risk of a broad cluster of problems in personal and interpersonal functioning.

The second conclusion we drew was that women experiencing one or more of these traumagenic factors in community and clinical populations differed widely in the their level of adult functioning, with some exhibiting profound impairments and others exhibiting extraordinary levels of resilience and positive personal and social functioning. While some of this difference could be accounted for by variations in the number and intensity of traumagenic factors, there was another quite influential force that often tipped the scales from pathology to resilience. Women exhibiting the greatest resilience had experienced trauma, but they also possessed high levels of *recovery capital*—internal and external assets that could be mobilized to initiate and sustain recovery from trauma and its potential progeny of related problems. Such resources fell into three categories: personal recovery capital, family recovery capital, and community recovery capital, with each arena constituting a potential focus of policy development and service programming.

In contrast to this resilience profile, women served by Project SAFE were collectively marked by the combination of multiple traumagenic factors and low recovery capital. That combination predictively produced distorted thinking about oneself and the world, emotional distress and volatility, migration from self-medication to addiction, assortative mating (recapitulation of developmental trauma in toxic adult intimate relationships), addiction to crisis, impaired parenting, and chronic self-defeating styles of interacting with professional helpers.

The first challenge in Project SAFE was for the outreach workers, therapists, case workers, parenting trainers, and others not to be personally paralyzed in response to the horror contained in the stories of the women they were serving. The second challenge was not to be professionally paralyzed by the number, severity, complexity and chronicity of the problems presented by the women entering Project SAFE and the resulting multitude of community agencies involved in their lives. Through training, skilled clinical supervision, and mutual professional support, those twin challenges were overcome, traditional models of clinical sense-making and intervention were cast aside, and <u>new understandings and approaches</u> were forged that have been described in a series of reports and training manuals.

So let me now share the rest of the story—the story of recovery. As a long-tenured addiction professional and the evaluator on this project, what most intrigued me was that so many women who were given little chance of success achieved levels of health and functioning that no one, most importantly the women themselves, could have predicted. Equally intriguing were

the processes involved in that achievement. Here are just a few of the lessons of Project SAFE that still have salience today.

Hope, not pain or consequence, is the critical ingredient to successful treatment and recovery of traumatized women. Women with multiple traumagenic factors and low recovery capital don't hit bottom, they live on the bottom. They have incomprehensible capacities for physical and psychological pain. What is catalytic is not pain, but the discovery of hope within relationships that are personally empowering—experienced sequentially within Project SAFE with outreach workers, SAFE clinical staff, a community of peers in recovery, and then within a larger community of recovering women. In project SAFE, this process most often began through a process of assertive outreach during what I have called a stage of precovery (See Precovery: "And then the Miracle Occurred"). The move from precovery to recovery initiation was marked by exposure to women in recovery with whom they could identify and who made recovery contagious by the examples of their own survival and transformed lives.

Life-limiting mottoes for living must be experientially disconfirmed for recovery to proceed. The mottoes that women brought to their involvement in Project SAFE included: I am unlovable; I am bad; there is no safety; everybody's on the make--no one can be trusted; if I get close to people, they will leave me or die; my body does not belong to me; and I am not worthy or capable of recovery. The triple challenges in providing effective addiction treatment to traumatized women are to: 1) avoid confirming these messages by recapitulating processes of victimization (e.g., problems rather than solutions focus, emotional battering via confrontation techniques, or emotional or sexual exploitation) and abandonment (e.g., acute care that provides brief stabilization without continued support or disciplinary discharge from treatment for regressive behavior), 2) experientially challenge these messages (e.g., providing enduring support within frequently tested relationships that unequivocally convey acceptance, regard, respect, safety, and security), and 3) forge new mottoes for living within the processes of story reconstruction and storytelling.

The most powerful catalyst for healing trauma is the experience of mutual identification and support within a community of recovering people. Such an experience within Project SAFE marked the transition from toxic dependencies on drugs, people, and enabling institutions to healthy interdependence and mutual accountability within a community of recovering women and children. This suggests that recovery outcomes in traumatized women may be as contingent on community recovery capital (welcoming recovery landscapes) as one's personal vulnerabilities and resources. Systematically increasing community recovery capital involves expanding beyond intrapersonal, clinically focused models of recovery support to encompass models for building strong cultures of recovery and models of recovery community building and recovery community mobilization.

Effective parenting is contingent upon experiencing the essence of such parenting. Parents cannot authentically give to their children what they have not personally experienced. In Project SAFE, the journey to effective parenting involved an emotional/relational component (active resistance, emotional regression / dependence, reparenting of mothers by Project SAFE staff and volunteers; and a subsequent focus on selfhood and mutual help) and a skill component (parental modeling, training, and coaching with SAFE clients and their children).

Effective parenting emerges in middle-to-late stage recovery. While abuse and neglect of children often remit upon initial recovery stabilization, effective parenting and the larger arena of improved family health must be preceded by heightened recovery stabilization and maintenance and the subsequent transition to an enhanced focus on the quality of personal and family life in long-term recovery. This suggests the need for structured supports for the developmental needs of children during early recovery (via indigenous peer and professional support)

and the need for scaffolding (See Stephanie Brown's discussion of scaffolding) for the whole family from these same supports during the early recovery process.

Project SAFE began with a focus on the psychopathology of the women it served but quickly shifted its emphasis to the creation of a healing community within which the potential and transformative power of recovery was nurtured and celebrated. I remain in awe of the stories of these women and what they were able to achieve.

Acknowledgement: Originally published as a blog at www.williamwhitepapers.com



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. (2015) From trauma to transformative recovery, *Advances in Addiction and Recovery*, 3(1), 28-30. Posted at **www.williamwhitepapers.com**

From Trauma to Transformative Recovery

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Between 1986 and 2003, I served as the evaluator of an innovative approach to the treatment of addicted women with histories of neglect or abuse of their children. Project SAFE eventually expanded from four pilot sites to more than 20 Illinois communities using a model that integrated addiction treatment, child welfare, mental health, and domestic violence services. This project garnered considerable professional and public attention, including being profiled within Bill Moyers' PBS documentary, *Moyers on Addiction: Close to Home*. My subsequent writings on recovery management and recovery-oriented systems of care were profoundly influenced by the more than 15 years I spent interviewing the women served by Project SAFE and the Project SAFE outreach workers, therapists, parenting trainers, and child protection case workers. This blog offers a few reflections on what was learned within this project about the role of trauma in addiction and addiction recovery.

Trauma, particularly physical/sexual abuse, was ever present in the lives of the women served by Project SAFE, but one must be cautious in over-interpreting trauma as the etiological agent in addiction and related problems. After all, multitudes of women have experienced childhood and adult trauma without developing the severity, complexity, and chronicity of problems commonly experienced by the women in Project SAFE. So an early challenge within Project SAFE was to understand what distinguished the trauma resilient from the trauma impaired. Our collective experience with thousands of women across diverse community and cultural contexts led to the conclusion that the resilient and the impaired differed in two fundamental ways. They differed in the nature of the trauma they had experienced, and they differed substantially in the recovery capital that influenced their capacities for resilience.

What separated community populations of women and our clinical population of women was not the presence of trauma but the characteristics of such trauma. A cluster of traumagenic factors distinguished the clinical group from the more resilient community group. Trauma in the former was more likely to:

1) begin at an earlier age (marking less developmental resources to cope with the trauma),

2) involve more physically and psychologically invasive forms of victimization,
3) take place over a longer period of time (e.g., multiple events over days, months, or years rather than a single point-in-time episode),
4) involve multiple perpetrators over time (confirming lack of safety, personal vulnerability, and suspicion that the cause lies within oneself),
5) involve perpetrators drawn from the family or social network (marking a greater violation of trust),
6) involve physical injury/disfigurement or threats of such if event(s) disclosed, and
7) generate environmental responses of disbelief or victim blaming when victimization disclosed.

Women with histories of perpetration of violence against their children, partners, or others also had experienced three additional factors: serial episodes of abandonment, desensitization to violence through prolonged horrification (witnessing violence against persons close to them in their developmental years), and violence coaching (transmission of a technology of violence and praise for violence from the family and social environment). Combinations of these potent traumagenic factors dramatically increased the risk of a broad cluster of problems in personal and interpersonal functioning.

The second conclusion we drew was that women experiencing one or more of these traumagenic factors in community and clinical populations differed widely in the their level of adult functioning, with some exhibiting profound impairments and others exhibiting extraordinary levels of resilience and positive personal and social functioning. While some of this difference could be accounted for by variations in the number and intensity of traumagenic factors, there was another quite influential force that often tipped the scales from pathology to resilience. Women exhibiting the greatest resilience had experienced trauma, but they also possessed high levels of *recovery capital*—internal and external assets that could be mobilized to initiate and sustain recovery from trauma and its potential progeny of related problems. Such resources fell into three categories: personal recovery capital, family recovery capital, and community recovery capital, with each arena constituting a potential focus of policy development and service programming.

In contrast to this resilience profile, women served by Project SAFE were collectively marked by the combination of multiple traumagenic factors and low recovery capital. That combination predictively produced distorted thinking about oneself and the world, emotional distress and volatility, migration from self-medication to addiction, assortative mating (recapitulation of developmental trauma in toxic adult intimate relationships), addiction to crisis, impaired parenting, and chronic self-defeating styles of interacting with professional helpers.

The first challenge in Project SAFE was for the outreach workers, therapists, case workers, parenting trainers, and others not to be personally paralyzed in response to the horror contained in the stories of the women they were serving. The second challenge was not to be professionally paralyzed by the number, severity, complexity and chronicity of the problems presented by the women entering Project SAFE and the resulting multitude of community agencies involved in their lives. Through training, skilled clinical supervision, and mutual professional support, those twin challenges were overcome, traditional models of clinical sense-making and intervention were cast aside, and <u>new understandings and approaches</u> were forged that have been described in a series of reports and training manuals.

So let me now share the rest of the story—the story of recovery. As a long-tenured addiction professional and the evaluator on this project, what most intrigued me was that so many women who were given little chance of success achieved levels of health and functioning that no one, most importantly the women themselves, could have predicted. Equally intriguing were

the processes involved in that achievement. Here are just a few of the lessons of Project SAFE that still have salience today.

Hope, not pain or consequence, is the critical ingredient to successful treatment and recovery of traumatized women. Women with multiple traumagenic factors and low recovery capital don't hit bottom, they live on the bottom. They have incomprehensible capacities for physical and psychological pain. What is catalytic is not pain, but the discovery of hope within relationships that are personally empowering—experienced sequentially within Project SAFE with outreach workers, SAFE clinical staff, a community of peers in recovery, and then within a larger community of recovering women. In project SAFE, this process most often began through a process of assertive outreach during what I have called a stage of precovery (See Precovery: "And then the Miracle Occurred"). The move from precovery to recovery initiation was marked by exposure to women in recovery with whom they could identify and who made recovery contagious by the examples of their own survival and transformed lives.

Life-limiting mottoes for living must be experientially disconfirmed for recovery to proceed. The mottoes that women brought to their involvement in Project SAFE included: I am unlovable; I am bad; there is no safety; everybody's on the make--no one can be trusted; if I get close to people, they will leave me or die; my body does not belong to me; and I am not worthy or capable of recovery. The triple challenges in providing effective addiction treatment to traumatized women are to: 1) avoid confirming these messages by recapitulating processes of victimization (e.g., problems rather than solutions focus, emotional battering via confrontation techniques, or emotional or sexual exploitation) and abandonment (e.g., acute care that provides brief stabilization without continued support or disciplinary discharge from treatment for regressive behavior), 2) experientially challenge these messages (e.g., providing enduring support within frequently tested relationships that unequivocally convey acceptance, regard, respect, safety, and security), and 3) forge new mottoes for living within the processes of story reconstruction and storytelling.

The most powerful catalyst for healing trauma is the experience of mutual identification and support within a community of recovering people. Such an experience within Project SAFE marked the transition from toxic dependencies on drugs, people, and enabling institutions to healthy interdependence and mutual accountability within a community of recovering women and children. This suggests that recovery outcomes in traumatized women may be as contingent on community recovery capital (welcoming recovery landscapes) as one's personal vulnerabilities and resources. Systematically increasing community recovery capital involves expanding beyond intrapersonal, clinically focused models of recovery support to encompass models for building strong cultures of recovery and models of recovery community building and recovery community mobilization.

Effective parenting is contingent upon experiencing the essence of such parenting. Parents cannot authentically give to their children what they have not personally experienced. In Project SAFE, the journey to effective parenting involved an emotional/relational component (active resistance, emotional regression / dependence, reparenting of mothers by Project SAFE staff and volunteers; and a subsequent focus on selfhood and mutual help) and a skill component (parental modeling, training, and coaching with SAFE clients and their children).

Effective parenting emerges in middle-to-late stage recovery. While abuse and neglect of children often remit upon initial recovery stabilization, effective parenting and the larger arena of improved family health must be preceded by heightened recovery stabilization and maintenance and the subsequent transition to an enhanced focus on the quality of personal and family life in long-term recovery. This suggests the need for structured supports for the developmental needs of children during early recovery (via indigenous peer and professional support)

and the need for scaffolding (See Stephanie Brown's discussion of scaffolding) for the whole family from these same supports during the early recovery process.

Project SAFE began with a focus on the psychopathology of the women it served but quickly shifted its emphasis to the creation of a healing community within which the potential and transformative power of recovery was nurtured and celebrated. I remain in awe of the stories of these women and what they were able to achieve.

Acknowledgement: Originally published as a blog at www.williamwhitepapers.com

Religions **2015**, *6*, 58–81; doi:10.3390/rel6010058

OPEN ACCESS

religions

ISSN 2077-1444

www.mdpi.com/journal/religions

Article

Recovery Spirituality

Ernest Kurtz [1,†,*] and William L. White [2,†]

[1] Adjunct Assistant Research Scientist, Department of Psychiatry, University of Michigan Medical School, 1235 Bardstown Trail, Ann Arbor, MI 48105, USA

[2] Emeritus Senior Research Consultant, Chestnut Health Systems, 3329 Sunset Key Circle, Unit 203, Punta Gorda, FL 33955, USA; E-Mail: bwhite@chestnut.org

† These authors contributed equally to this work.

* Author to whom correspondence should be addressed; E-Mail: kurtzern@med.umich.edu; Tel.: +1-734-769-2544; Fax: +1-734-665-6354.

Academic Editors: Chris Cook and Wendy Dossett

Received: 19 December 2014 / Accepted: 15 January 2015 / Published: 27 January 2015

Abstract: There is growing interest in Alcoholics Anonymous (A.A.) and other secular, spiritual, and religious frameworks of long-term addiction recovery. The present paper explores the varieties of spiritual experience within A.A., with particular reference to the growth of a wing of recovery spirituality promoted within A.A. It is suggested that the essence of secular spirituality is reflected in the experience of *beyond* (horizontal and vertical transcendence) and *between* (connection and mutuality) and in six facets of spirituality (Release, Gratitude, Humility, Tolerance, Forgiveness, and a Sense of Being-at-home) shared across religious, spiritual, and secular pathways of addiction recovery. The growing varieties of A.A. spirituality (spanning the "Christianizers" and "Seculizers") reflect A.A.'s adaptation to the larger diversification of religious experience and the growing secularization of spirituality across the cultural contexts within which A.A. is nested.

Keywords: Alcoholics Anonymous; spirituality; recovery spirituality; secular spirituality; facets of spirituality; transcendence

---

1. Prologue

Sometimes, at an Alcoholics Anonymous (A.A.) meeting, a speaker will describe the "what happened" part of her or his story of "what we used to be like, what happened, and what we are like now" by saying, "I got sick and tired of being sick and tired."

As long-tenured scholars of the very varied literature on A.A., we find ourselves sick and tired of hearing too often, over too many years, observers (they can hardly be called "students") of Alcoholics Anonymous decrying its lack of scientifically demonstrated value and its apparent reliance on some nebulous entity called "spirituality". Some claim that the A.A. fellowship and program lack "proven results", not realizing how that assertion evidences their own lamentable lack of familiarity with the available scholarly literature on A.A. [1–4]. Often these critics especially excoriate the claim made by many students and members of Alcoholics Anonymous that "spirituality" has something to do with how A.A. "works". "Show us the proof", comes the demand. "Where is the hard data, the substantiated, irrefutable evidence that demonstrates how, and why, Alcoholics Anonymous achieves such a claim? What is this 'spirituality'?" [5,6].

This critical instinct is correct in a very important way: it is precisely in the realm of spirituality that any approach to understanding Alcoholics Anonymous must take place. This poses a problem for those who deny the existence of such a reality as spirituality. To them, the only possible reply is that traditionally given by the disciples of any wisdom figure: "Come and see." ([7], p. 90–91; [8], p. 4). And so, if anyone genuinely wishes to come to some valid understanding of Alcoholics Anonymous, let her or him follow the advice given newcomers to A.A. "Attend ninety meetings—insofar as possible, ninety *different* meetings"—if not in ninety days, then in not more than one hundred and twenty days. Surely any doctoral-level researcher has spent far longer and more onerous efforts in pursuit of some other piece of publishable research. (And those efforts almost certainly did not include free cups of coffee).

At those meetings, you will hear stories—stories that "disclose in a general way what we used to be like, what happened, and what we are like now" ([9], p. 58). Alas, there will be no opportunity to pass out questionnaires or other "instruments". A funny thing about "instruments" or other paraphernalia—things—intended to measure: they do not work well at capturing the non-physical, and if there is one sure truth about *spirituality*, clear from its very word/name, it is not a physical entity. And so to try to measure, weigh, or calibrate spirituality makes as much sense as attempting to understand interpersonal love by calculating genital tumescence [10]. Comprehending "the spiritual" requires different "tools".

So a bit more about those meetings and what you will do there. The requirements we suggest are two, though really one: Listen—with a genuinely open mind, trying to absorb rather than critique, and Identify—strive to put yourself in the frame of mind you might have in reading a good novel. Do not, then, listen for or pass judgment on *facts*; unless you happen to be an alcoholic, you will likely find incredible many of the details you hear. The facts in any story are of relatively minor import. Listen, rather, for the thoughts and feelings described: that is where the action is in any good story, and they convey depths of truth that transcend the detailing of events [11].

For this is the kind of research on which this article is based. Your co-authors have, between them, been researching 12-Step meetings and other addiction-related professional and peer support

modalities for a combined total of 83 years, in many cities beyond the eight in which we have resided, as we both for many years traveled the United States and beyond to offer presentations at addictions conferences and to teach in addictions studies programs at Rutgers University, the University of North Carolina, and the University of Chicago. What follows here is based on those years of careful listening at a wide variety of A.A. meetings, the regular reading of member-stories in the *A.A. Grapevine* and elsewhere [12,13], and, of course, sustained familiarity with the published research on A.A. and other addiction recovery mutual aid groups. Also, since some explicitly challenge how adequately non-specialists can investigate spirituality [14], Ernest Kurtz has studied theology for four years in a Catholic seminary and two years at Harvard Divinity School and taught for two years in the theology department of Loyola University of Chicago.

2. Introduction

Although addiction recovery mutual aid dates from the mid-eighteenth century, Alcoholics Anonymous (A.A.) is the benchmark by which past and present mutual-aid groups are measured [15]. A.A. has earned that distinction by its membership size and international dispersion, its organizational longevity, its influence on professionally directed addiction treatment, the breadth and depth of A.A.-related historical and scientific research, and A.A.'s wide adaptation to other problems of living [16].

The early history of Alcoholics Anonymous is well-documented within A.A.'s own literature [17–19], through independent historical scholarship [20,21], and through the recent proliferation of biographies of key figures in A.A.'s story [22–30]. Jeff Sandoz's article in this issue [31] summarizes the well-known "spiritual rather than religious"[1] framework of alcoholism recovery detailed in A.A.'s two basic texts [9,33]. Intriguingly, this "simple program" had by even two decades ago generated thousands of interpretive books, articles, and commentaries, usually revealing more about the authors than about A.A. [34].

One large reason lies behind this plethora of publications by A.A. attackers, defenders, and interested bystanders all struggling to define what Alcoholics Anonymous is and is not: the reality that A.A. is so decentralized that in a very real sense, there really is no such single entity as "Alcoholics Anonymous"—only A.A. members and local A.A. groups that reflect a broad and ever increasing variety of A.A. experience. To suggest that Alcoholics Anonymous represents a "one size fits all approach" to alcoholism recovery, as some critics are prone to do, ignores the actual rich diversity of A.A. experience in local A.A. groups and the diverse cultural, religious, and political contexts in which A.A. is flourishing internationally [35–37].

That difficulty is compounded because most who comment on Alcoholics Anonymous attend too much to its Twelve Steps, ignoring its organizationally more significant Twelve Traditions. A.A.'s Twelve Traditions underlie and make not only possible but inevitable the vast varieties among A.A. groups. Anyone wishing to comment seriously on Alcoholics Anonymous must think carefully about how the reality of that deeply internalized organizational blueprint may influence what they observe.

---

[1] In the minds of some, at least, there seems to be a subtle but real distinction between "spiritual rather than religious" and "spiritual but not religious"; see, relatedly, Zinnbauer *et al*. [32].

The sociologist Robin Room, who has done so, has suggested that its Traditions may be A.A.'s greatest contribution to society, offering as they do a tested pattern for living a chastened individualism [38].

Newcomers to Alcoholics Anonymous are advised, "Try to attend ninety meetings in ninety days". On a superficial but valid level, this encourages immersion in the A.A. program. But more significantly, this gentle mandate pushes the newcomer to try out many different meetings, hopefully to find some that fit his style, meetings at which she discovers a real sense of being "at home".

There are two broad patterns of diversification within the history of A.A. The first occurs through organizational schism, when one or more members experience incongruity between their personal beliefs and A.A. practices, prompting them to abandon Alcoholics Anonymous and start an organization that offers an alternative to the A.A. approach. This process is reflected in the genealogy of A.A. adaptations and alternatives. These span (1) religious alternatives (e.g., Alcoholics Victorious, 1948; Alcoholics for Christ, 1977: Millati Islami, 1989; Celebrate Recovery, 1991; Buddhist Recovery Network, 2008); (2) alternatives for other drug dependencies (e.g., Addicts Anonymous, 1947; Narcotics Anonymous, 1950/1953; Synanon, 1958; Cocaine Anonymous, 1982); (3) gender-specific alternatives (Women for Sobriety, 1975) [39]; (4) secular alternatives (e.g., Secular Organizations for Sobriety [40], 1985; Rational Recovery, 1986 [41]; SMART Recovery, 1994); and (5) moderation-based mutual support (Moderation Management, 1994) [42].

The second pattern of diversification occurs when individuals or subgroups seek and promote different styles of recovery within A.A. itself. This latter trend includes organizational adjuncts for A.A. members who pursue spiritual growth through a particular religious orientation—"11th Step Groups" (e.g., Calix Society, 1947; Jewish Alcoholics, Chemically Dependent People and Significant Others [J.A.C.S.], 1979)—and adaptations that seek either to secularize or to Christianize A.A. history and practice. The former include explicitly secular groups within A.A. (Alcoholics Anonymous for Atheists and Agnostics, 1975, and other groups [43]); the latter involve groups that promote a more spiritual/religious focus within meetings (the "Primary Purpose" and "Back to Basics" movements). These divergent wings of belief within A.A. and the proliferation of spiritual, religious, and secular alternatives to A.A. are unfolding within a larger recognition of the legitimacy of multiple pathways and styles of long-term addiction recovery [44].

The authors have been involved in sustained investigations into the "varieties of recovery experience" and have published articles on a wide spectrum of addiction recovery mutual aid organizations [15,45,46]. We have conducted historical investigations of spiritual, religious, and secular recovery mutual aid groups, published interviews with key recovery mutual aid leaders [47], and helped develop a key Mutual Aid Guide [48]. Through perspectives drawn from these experiences, we will focus in this article on the growing varieties of A.A. experience, with particular emphasis on the emergence of an atheist/agnostic wing within A.A. and what this development potentially means for the future of secularization or religious revivalism within Alcoholics Anonymous.

3. The Historical Context

Alcoholics Anonymous began in the 1930s within the Oxford Group, an attempt to recapture "First Century Christianity" [20]. Although A.A. early departed those roots, first in New York City, by 1940 also in its Akron, Ohio, birthplace, a strong religious tinge perdured, most evident in its "Big Book"

chapter "We Agnostics", which blandly assumed that all who approached the fellowship would find God. But there were early dissenters; one—atheist Jimmy B.—had a profound effect summarized in the addition of the phrase "as we understand Him" after the word "God" in the 3rd and 11th of A.A.'s 12 Steps.

There were others. Robert Thomsen's 1975 biography, *Bill W.*, based primarily on extensive interviews with Wilson, offered a description of the late 1930s Tuesday evening meetings at the Wilson's Clinton Street Brooklyn home:

> There were agnostics in the Tuesday night group, and several hardcore atheists who objected to any mention of God. On many evenings Bill had to remember his first meeting with Ebby. He'd been told to ask for help from anything he believed in. These men, he could see, believed in each other and in the strength of the group. At some time each of them had been totally unable to stop drinking on his own, yet when two of them had worked at it together, somehow they had become more powerful and they had finally been able to stop. This, then—whatever it was that occurred between them—was what they could accept as a power greater than themselves" ([49], p. 230).

But such individuals were exceptional during A.A.'s early years and even beyond. During World War II and the decade of the 1950s, sociologists noted the religiosity of an American public conscious of being confronted by "godless atheistic communism". The period is aptly summed up in social philosopher Will Herberg's best-selling description of American reality in *Protestant, Catholic, Jew* [50], by President-elect Dwight David Eisenhower's often mocked declaration, "Our government makes no sense unless it is founded on a deeply-felt religious faith—and I don't care what it is", and by Stephen J. Whitfield's post-Cold War summary of the era [51]. The counter-cultural 1960s, not least because of the assassinations and war that blotted that decade, witnessed a fraying of that faith. Over that decade and the next, especially in the mid-1970s, those who complained of the "religiosity" of Alcoholics Anonymous were told that its program and fellowship were "spiritual but not religious"—a formulation that would wildfire through the larger culture in the 1990s [52–55].

In the 1980s, meanwhile, some members of Alcoholics Anonymous who felt oppressed by its religiosity and who, more importantly from the perspective of A.A. itself, saw evidence that the fellowship's religiosity was alienating new members and keeping still others away from even trying its program, departed A.A. to found two secular counterparts: Secular Organizations for Sobriety [40] and Rational Recovery [41]. Even before that decade, in 1975, a group of Chicago A.A. members formed "Alcoholics Anonymous for Atheists and Agnostics", more familiarly known as "Quad-A". Other similarly motivated diversely named groups formed in various places over the years, but the next significant development took place in Toronto, Ontario, Canada, in 2009 and 2010, when the groups "Beyond Belief" and "We Agnostics", recognizing the need to make their availability more widely known, formed the website, AA Agnostica. A more complete and detailed history of atheists and agnostics in Alcoholics Anonymous may be found at that website: http://AAagnostica.org/a-history-of-agnostic-groups-in-A.A./ –http://bit.ly/1vN7rqo [56].[2]

---

[2] This article will use the URL address-shortener bit.ly. A listing of worldwide agnostic meetings may be found at http://www.agnosticAAnyc.org/worldwide.html, http://v.gd/jShmlk, http://bit.ly/1A6dtqp [43].

4. Leading Up To the Present: Lines Are Drawn

The story told there begins not in 1975 but decades later, in 2011, when the Greater Toronto Area Alcoholics Anonymous Intergroup "passed a motion at its regular monthly meeting that the two groups ["Beyond Belief" and "We Agnostics"] be removed from the meeting books directory, the GTA A.A. website, and the list of meetings given over the phone by Intergroup to newcomers". For despite a long history of tolerance within Alcoholics Anonymous, and the reality that the General Service Office of Alcoholics Anonymous recognizes atheist and agnostic groups, the era that began on 11 September 2001 (and was reinforced on 11 March 2004 and 7 July 2005)—labeled by Jürgen Habermas the "post-secular" epoch [57–60]—brought to a head the long-simmering disagreement within A.A. between its "Big Book Fundamentalists" and its "Modernizing Secularizers".[3]

The "Big Book Fundamentalists" draw their inspiration and practice from their understanding of how Alcoholics Anonymous functioned at its birthplace in Akron, Ohio, during the mid-1930s, when the alcoholics met as "the alcoholic squadron" of the Oxford Group, and in the early-1940s Cleveland "Beginners' Meetings" offspring of that approach. Although this style infuses many groups to varying extents, it finds its most explicit expression in the "Primary Purpose" and "Back to Basics" movements founded within A.A. in 1988 and 1995, respectively [71]. Followers of these movements continue to give lip-service to the "spiritual rather than religious" shibboleth, but members and groups formed in this Akronite tradition insist on a brand of "spirituality" that harbors no room for disagreement about a very explicitly Christian content. Such explicitness spans efforts to Christianize early A.A. history, elevate Christian literature on par with A.A.'s own literature, and assert Christian conversion as a central mechanism of A.A.'s effectiveness.

The "Secularizers", meanwhile, interpret the "post-secular" era's reality in a way more congruent with the Habermas understanding. Their "Awareness of What is Missing" [59] focuses on the steadily increasing number of "nones" responding to surveys of religious affiliation. These "nones" tend to be younger, and in surveys that asked their thoughts on the subject, most replied that they were "spiritual but not religious" [52–55]. Some of these had problems with alcohol and drugs, and some of those who tried Alcoholics Anonymous found it "too religious" for their comfort. The members of atheist/agnostic A.A. groups generally direct their 12th Step efforts at this population, seeking to "make A.A. safe for atheists" [72–74].

5. Recovery Spirituality

A true "Recovery Spirituality" will embrace both the quasi-religious spirituality of the "Big Book Fundamentalists" and a more secular spirituality in which atheists and agnostics who have "the only requirement for A.A. membership…a desire to stop drinking" ([9], p. 562) can also find a helpful home [75].

Although "secular spirituality" is not the same as "atheist [or agnostic] spirituality", it is important to examine the approach of these groups in some detail, for the vast majority of A.A.

---

[3] On "post-secular", see first Stark [61]; then, since we are treating of "Secular Spirituality", see also Gourgouris [62], Robbins [63], Harrington [64], Bullivant and Lee [65], and Singh [66]. For a sense of the full context of what is going on here, see Taylor [67], Watson [68], McGrath [69], and Heelas [70].

members—including most who belong to atheist or agnostic groups—view spirituality as the key to what makes A.A. work [76,77]. Some secularizers, especially a few who are less atheist than anti-theist [78], reject the term *spirituality*, but several recent books argue for its retention. As early as 2002, University of Texas philosopher Robert C. Solomon published *Spirituality for the Skeptic* [79], describing spirituality as *thoughtfulness*, and suggesting that "spirituality, like philosophy, involves those questions that have no ultimate answers" and must be understood, ultimately, "in terms of the *transformation* of the self" ([79], pp. 5–6). Within the next decade and just beyond, other writers developed that insight, at times explicitly exploring an "atheist spirituality." André Comte-Sponville's *The Little Book of Atheist Spirituality* [80], Ronald Dworkin's *Religion Without God* [81], and Sam Harris's *Waking Up: A Guide to Spirituality Without Religion* [82] detailed in varying degrees the content of such an approach.[4]

Meanwhile, specifically in the addictions field, Marya Hornbacher's Waiting: A Non-Believer's Higher Power [83], Vince Hawkins's An Atheists [sic] Unofficial Guide to A.A. [84], Roger C.'s The Little Book: A Collection of Alternative 12 Steps [85], Archer Voxx's The Five Keys: 12 Step Recovery Without A God [86], John Lauritsen's A Freethinker in Alcoholics Anonymous [87], and Adam N.'s Common Sense Recovery: An Atheist's Guide to Alcoholics Anonymous [88] all offered concrete suggestions on how those who resisted the "God-talk" in Alcoholics Anonymous might nevertheless live that program and its spirituality within that fellowship. Also, true to larger A.A. practice, the year 2013 brought the secularizers' own meditation book, Beyond Belief: Agnostic Musings for 12 Step Life: finally, a daily reflection book for nonbelievers, freethinkers and everyone, reflecting the experience of someone who enjoyed 38 years of continuous sobriety [89].

The varied vocabulary in the above suggests an important point. Even recalling the diverse names by which atheists and agnostics refer to themselves—"unbeliever", "non-believer", "freethinker", "unconventional believer", "humanist", and surely there are others—alcoholic atheists and agnostics are not the only ones seeking and practicing a secular spirituality [90–101]. *Spirituality*, secular or otherwise, escapes clear definition: there are simply too many definitions. Although we deem the best available discussion of spirituality to be that offered by Sandra Marie Schneiders [102], for the purposes of this article, we adopt the brief, broad definition set forth by Celia Kourie ([103], pp. 19, 22): "Spirituality refers to the raison-d'être of one's existence, the meaning and values to which one ascribes. Thus everyone embodies a spirituality. It should be seen in a wider context to refer to the deepest dimension of the human person. It refers therefore to the 'ultimate values' that give meaning to our lives." "Secular spirituality", as we use the term, embraces that understanding [104–107].

Spirituality of any kind, as a non-material entity, is impossible to measure directly [108–110]. There exists a wealth of indirect measurements, with attention paid to such qualities as "self-acceptance" or "purpose in life". But as Harold Koenig has effectively criticized, measuring "spirituality" with

---

[4] In choosing to use the term "spirituality" even in reference to atheist and agnostic groups, we follow the example of, among others, Sam Harris, who "address[es] the animosity that many readers feel toward the term spiritual" in his book, *Waking Up* [82]. Noting that "many nonbelievers now consider all things 'spiritual' to be contaminated by medieval superstition", Harris argues that "there is no other term with which to discuss the efforts people make to fully bring their minds into the present or to induce non-ordinary states of consciousness. And no other word links this spectrum of experience to our ethical lives" ([82], pp. 6–7).

"indicators of good mental health"—which seems the practice of most such research—is "meaningless and tautological" ([111], p. 349; [112]). The same seems true of equating spirituality with "positive emotions" [113]. But what, then, can be said of "atheist spirituality" or—more precisely for our purposes—"secular spirituality", and what light does that phenomenon shed on the spirituality found in A.A. groups and meetings?

6. A Secular Spirituality

The advantage of studying secular spirituality in some detail is that thus reducing the phenomenon of spirituality to a bare minimum allows seeing more clearly its essence. Admittedly, the meetings we attended from which we derive our analysis were populated mainly by Christians and Jews, with a substantial minority of these identifying themselves as "spiritual rather than religious", with fewer agnostics and atheists, even fewer who professed a Westernized Buddhism, very few Muslims, and none who identified as Hindus. We have tried to supplement that insofar as possible with our reading [114–116].

In barest summary, pondering what we heard across the meetings we have attended over the years as well as the stories that we have read in different sources, the spirituality that we witnessed can be summed up in two words—the prepositions *beyond* and *between.* These form the schema of any secular spirituality, the skeleton of A.A. spirituality. There is more to that spirituality, of course: that skeleton is enfleshed and clothed, and below, we will examine six such qualities similarly derived from our listening and reading. But we must begin with those prepositions, two words that, we think, aptly and adequately summarize 12-Step spirituality, whether religious or secular, whether of the relative newcomer or the veteran old-timer.

"Beyond": *Beyond* derives from the Old English *begeondan*, a root not found in other Germanic languages, a preposition meaning literally "on the farther side". It thus implies some kind of barrier, but a barrier that does not obstruct seeing—and perhaps even going—beyond, farther. The barrier, then, is in some way permeable: it invites—indeed teases—transgression. *Beyond* pulls forwards; it is not content with stasis. *Beyond* hints "more", but of *different*, not of the same. That which is beyond, then, in some way *beyonds* us, in the striking verb pioneered by literary scholar Kenneth Burke ([117], pp. 44–45).

Beyond awakens and pulls to *transcendence* [118,119]. For many ages—for most humans for most of human history—*beyond* pulled towards the horizon. It implied horizontal movement, an invitation to explore. But just about always for some, and in the age of flight and space travel for just about all, *beyond* points also vertically, pulling upwards, to new heights. Even before flight, of course, many religious traditions located "heaven" in the heavens. *Beyond*, then, suggests a dual transcendence: *out* from the narrow confines of the self-centered self; and *up* toward some reality greater than, larger than, the self-involved self. "Selfishness—self-centeredness! That, we think, is the root of our troubles", A.A.'s basic text suggests ([9], p. 62), capturing a truism that applies not only to alcoholics.

"Beyond's" vertical transcendence implies a going *out and up*, a movement *toward* some reality. This need not entail "higher" in the sense of some kind of heaven or sky-god; it rather connotes a getting-out-of-self to that which is "higher" or greater in the sense of some ideal or of some reality larger than the bare, narrow self. That reality might be one of the classic "transcendentals"—beauty,

goodness, truth—or one of the "A.A. transcendentals" such as gratitude or sobriety itself. It might also point to the power of the A.A. group or of the fellowship or program itself; there is no need for that "power" to be capitalized, though some may choose to do so. But in whatever way, any spirituality—including any secular spirituality—*beyonds* its adherents, pulling them to a transcendence to reality larger/greater than the bare self.

This beyonding, this transcending escape from the bondage of self, opens to a capacity for the wonder and awe that grounds all spirituality. Whether in the wondrous perfection of a newborn infant or the sublime grandeur of a glimpsed universe, the recognition and acceptance that there *is* reality that transcends self opens to a genuinely new perception and appreciation of *all* reality. This recognition is not easily granted: the bogey of self does not readily surrender its centrality. But when it does, the resulting new vision is greater even than the "new pair of glasses" promised by one of A.A.'s earliest members [120].

And as a post-secular literature makes clear, transcendence can be horizontal as well as vertical [67,121–124]. Spirituality's second preposition, *between*, offers a specification of "beyond's" horizontal transcendence: it *connects* with others. "Between" is more apt than "beside" because it connotes actual connection rather than mere next-ness: there is a "something" *between*, something linking, as the Oxford English Dictionary puts it: "in reference to any objective relation *uniting* two parties, and *holding them in a certain connection* (italics added)". Spirituality, then, in "pulling beyond" also *pulls to, connects.* And what is there, horizontally beyond? At first, most obvious level, beyond the "self" are *others*, and *between* captures the nature of that relationship, the between-ness of *equal connection,* a connection of equals. "Between" thus orients to the fundamental first reality that the author of the Book of Genesis put in the mouth of the Creator God: "It is not good for man to be alone." Nor is this an exclusively "religious" observation: given the development of sexual reproduction, some being in the mist of evolutionary pre-history made—and implemented—the same observation, reaching out in some way to an-other [125]. Fundamental to all living existence is the need for others, in one form or another.

This spiritually based human need-for-others, however, has some unique qualities, and one of the most important is the reality of its *mutuality*. Mutual relationships involve not the giving *or* getting of competition, nor even the "giving *and* getting" of cooperation, but a very real and genuine giving *by* getting, getting *by* giving [126,127]. This, then, is a very special and even unique kind of *between-ness*. Mutual bonds are more than alternately reciprocal. And to appreciate the centrality of this to the 12-Step program, we need to recall the basic first two happenings in the story of Alcoholics Anonymous, the first 12-Step program.

A.A. co-founder Bill Wilson, whose "spiritual experience" in New York City's Towns Hospital in December 1934 had propelled into sobriety, was in Akron, Ohio, in May of 1935. The proxy-fight he was there to pursue was failing, and Bill dejectedly paced the lonely hotel lobby, catching the sounds of pleasant chatter and the tinkle of ice cubes in the adjacent bar, when an old familiar thought rose: "I need a drink". Recalling how trying to help other alcoholics had freed him of that craving over the preceding months, even though none he had approached had stayed dry, Wilson walked to the lobby telephone booth and began the series of calls that led him the next day to a meeting with Dr. Robert Holbrook Smith, a local surgeon with a known "drink problem".

Before his journey to Akron, Wilson's physician, Dr. William Duncan Silkworth, had urged him to "stop preaching at the drunks—give them the medical stuff, the hopelessness, *etc.*". But how could Wilson teach medicine to a physician? So the next day when they met, Bill simply told Dr. Bob his story, and the surgeon identified and expressed willingness to try what Wilson had done. Bill described this meeting twenty years later, at A.A.'s "Coming of Age" convention:

> You see, our talk was a completely *mutual* thing. I knew that I needed this alcoholic as much as he needed me. *This was it*. And this mutual give-and-take is at the very heart of all of A.A.'s Twelfth Step work today ([17], p.70, italics in the original).

Bob went on one last "toot" at a medical convention a month later, and it was only after his final alcoholic drink on 17 June 1935, that A.A.'s core spiritual insight was nailed down. Not long after, Bill and Bob visited the hospitalized drunk who would become "A.A. #3", Bill D. They told Bill D. their stories and then asked him to let them know as soon as possible whether or not he was interested in what they had to offer, for if he was not, they had to seek out others, because it was only by carrying their message to other alcoholics that they themselves could remain sober. Bill D. later recorded his thought on hearing that:

> All the other people that had talked to me wanted to help *me*, and my pride prevented me from listening to them, and caused only resentment on my part, but I felt as if I would be a real stinker if I did not listen to a couple of fellows for a short time, if that would cure *them* ([9], p. 185, italics in the original).

The Twelfth Step of Alcoholics Anonymous is often misunderstood by those outside the fellowship: "Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics…"

> "But," somebody asks, "what if that drunk you seek out doesn't want to stop drinking? What do you do about a 'failed' 12th Step call?"
>
> "Well, a 'failed 12th Step call' is one on which you drink. It's your 12th Step call, you are 'carrying the message', and so if you stay sober, the call is a success."

We may reach up; we *must* reach out. The topic here is spirituality, remember—that essentially ineffable reality that is at the core of our human *be*-ing. The wisdom of the human race—our art, music, literature—all attest to our bonds with each other. Indeed, they *bond*—bind—us with each other. To look *beyond* is to look and to seek outside of self—up *and* around. To look *between* is to look "around" and to discover that we are bonded to/with each other. Transcendence *must* be horizontal as well as vertical: to look only "up", to reach only "up", is to feel one's aloneness, and standing alone can be dizzying. To realize our full humanity we must also reach out, and when we do look around, between, we discover our connections—the between-nesses that link us with others [128–130].

Genuine spirituality reminds us of our between-nesses as well as our beyond-ing.

No, it does more than "remind" us: spirituality *consists in* that reach, those links. We are *beyonding* and *betweening* beings. That is why we are here. One is tempted to say that "Alone, we are nothing." But only tempted, and even that only at very unusual moments. For in the most real sense, it is impossible to be "alone"—*a lone*. Connection is always present. The question is, do we recognize it,

live it, honor it? We may say, with John Donne, that "No one is an island"; but how well are we living our prepositions [131]?

A.A.'s 12-Step spirituality does not end here. *Beyond* and *between* are the foundation, the skeleton: the actual living and experiencing of spirituality comprises certain phenomena, experiences. In our years of listening to and reading 12-Step stories, six different experiences have emerged with some consistency [132–134]. This does not mean that all of them are heard in every story. It does mean that just about every story delineates and describes at least one, and usually two or three of these experiences. To name them: Release, Gratitude, Humility, Tolerance, Forgiveness, and Being-at-home.[5]

7. The Contents of Recovery Spirituality

Release: especially in early recovery, but also at later critical junctures of the recovering life, the individual experiences a profound sense of being *freed*: for one who has been addicted, there is no better term to describe the removal of that obsession-compulsion. This is sometimes described as the feeling that a great weight has been lifted, or as if chains in which one has been bound have fallen away. In each case, the sense is not of freeing oneself but of *discovering* that one has been unbound, liberated, *set* free. This sense of "being released", interestingly, seems to come only to those who *have* released, who have let go—most obviously in this setting of alcohol or some other drug of choice: it seems, then, that one becomes able to experience release only after one has oneself performed an act of releasing, of letting go.

Gratitude: the experience of thankfulness, the recognition that one has been gift-ed, has received gifts [79,135–137]. Sometimes expressed as a corollary of Release, the recovering person describes an appreciation for what is recognized as a freely bestowed gift. Within Alcoholics Anonymous, this is often posited as gratitude for "the gift of sobriety", for most recovered alcoholics remember how they had been unable to attain recovery on their own, despite their most genuine and valiant efforts. But beyond this, immersion in and internalization of the 12-Step program begets a special kind of vision that enables recognizing new realities, realities previously ignored or taken for granted or simply not seen, realities that one now *can* recognize. Gratitude anchors sobriety. Members who express difficulty with living some aspect of the 12-Step program are often encouraged to "write out a 'gratitude list'—the things you have to be grateful for". Trite and even cruel as such an admonition may sound to some outsider, experience attests that those who have been through it know that "it works" [138].

Humility: the recognition and acceptance that one is neither *all* nor *nothing*. In an era that worships celebrity, humility does not enjoy a good press. Some might wish to be thought humble, but no one wants the real thing or what is commonly mistaken to be the real thing, a sycophantic creepiness. But real humility is simply the acceptance that one is of some value, but not of infinite value: one is "not God". To be human is to be middling. More vividly, in the memorable phrasing of anthropologist Ernest Becker: "Man is a god who shits" ([139], p. 58). On the one hand, we are capable of love and altruism and generosity and many wonderful things, but it is also true that periodically, we have to squat down and be reminded that we are also made of decay and will one day return to stinking decay. Humility is simply what keeps *both* of those realities in appropriately close awareness [140].

---

[5] These experiences are discussed in greater detail in *The Spirituality of Imperfection* [7].

Tolerance, of course, flows from "all of the above". It is difficult to be self-righteously judgmental when one is aware of one's middling status as a receiver of the gift of a fundamental freeing. Having "hit bottom", one learns to look up and around rather than down. Recognizing, really *experiencing* the realities laid bare by humility, aware of the gifts one has received, it does not necessarily become easier to put up with the inanities of others, but if we see those in the context of what we are learning about ourselves we may become able to smile a bit at our own upset. There are many wisdom stories in which the self-righteous person asks the god for what she/he "deserves"; and then is crushed by the discovery of what that will in fact entail. The recovering alcoholic knows better. Aware of that wisdom, one hesitates to judge. In fact, one is likely to be terrified at the very possibility.

Forgiveness: "Resentment is the number one offender", the A.A. "Big Book" cautions, going on to declare that "It destroys more alcoholics than anything else. From it stem all forms of spiritual disease." ([9], p. 64). Dostoyevsky and Nietzsche were the great explorers of *ressentiment*, but active alcoholics may be its pre-eminent practitioners [141–145]. The opposite of resentment is forgiveness, and research on forgiveness verifies its spiritual nature in that it is one of those realities that cannot be "willed" [146,147]. Forgiveness in fact becomes more impossible the harder one tries to will it. As is true of all spiritual realities, forgiveness becomes possible only when *will* is replaced by *willingness*: it results not from effort but from openness. Research also suggests how that openness comes about: what makes forgiveness possible is the experience of being forgiven. How one attains that is one role of A.A.'s Ninth Step, making direct amends to those one has injured. Apologies are not amends. Some effort to re-even the scales of justice is required, and sometimes—certainly not always—the individual who has been wronged expresses forgiveness. Experiencing this is to discover that being forgiven is a genuinely spiritual experience, one that one wants to pass on to others [148–151].

Being-at-Home: Everyone needs a sense of "community"—the deep experience of being in some way *at one* with some others. Unlike other communities that one may join, "home" is a place where we *belong* because it is where our very weaknesses and flaws *fit in* and are in fact the *way* we "fit in". Once upon a time, in infancy and early childhood, many if not most people experienced that. It was called "family". Our need for it does not cease as we age. And so we seek such places. Also once upon a time, this was the function of churches, which began as the place where those conscious of being sinners gathered together. Interestingly, this is to some extent replicated for some new to Alcoholics Anonymous, who park their cars blocks away from the meeting-place lest someone see them attending. But even after one becomes willing to park close-in, the key thing about such places is that one fits into them not because of strong points, competencies, but through mutually acknowledged flaws, weaknesses, *in*abilities...something one *can't* do: "drink alcohol like 'normal' people". To find and dwell in such a place, the whole history of spirituality attests, is an essential facet of spirituality.

Secular Spirituality and the Future of A.A.

In the United States, the percentage of religious "nones"—the non-affiliated—had risen to close to 20% in 2012, and 46% of the overall population "seldom or never attend religious services" [152–157]. Across the pond, the 2009 British Attitudes Survey for the first time recorded more "No Religion" (50.9%) than "Christian" (43.1%) respondents; and according to a 2011 YouGov poll, only 34% of UK citizens claimed they believed in a God or gods. A February 2012 YouGov survey found 43% of

respondents claiming to belong to a religion and 76% claiming they were not very religious or not religious at all [158–161]. Matters seem not much different in the rest of Europe [162–166].

Still, it seems, few "nones" in any nation label themselves atheist or agnostic. Most are younger, and listening to them and to their music, the term "secular spirituality" may be a good fit: surely their *beyonding* and *betweening* are evident and real, although so is a focus on "self". What might those changes and this reality portend for the Alcoholics Anonymous that presents itself as "a spiritual program"? In our view, the two opposite responses noted earlier within A.A. will probably continue to be operative into the foreseeable future. Remember, however, that these are "opposites" and so deal with extremes. The great majority of A.A. members will more than likely continue to settle somewhere comfortably in-between, generally tolerating the extremes but probably more often than not seeking out groups that better fit their middling inclinations.

Still, especially if—or as—the animus of "post-secularity" spreads and is internalized by a population increasingly aware of Islamic reality, the "Big Book Fundamentalists" may grow stronger and more numerous. It is unclear whether they will abandon their misconstrual of a 1990 General Service Office report on membership, claiming that it portrays A.A.'s "success rate" as 5% or less, which they allege demonstrates the necessity of their own more stringent approach. Carefully rigorous studies refute that 5% claim [167,168], but those with this mindset do not demonstrate much openness to the findings of research.

Although the variety among A.A. groups has long embraced a spectrum from more "conservative" to more "liberal" approaches to living the Twelve Steps, the end of the twentieth century found Alcoholics Anonymous unsurprisingly enmeshed in the post-modern rebirth of fundamentalisms [169]. Standing at one far end of that spectrum, both the "Primary Purpose" (1988) and "Back to Basics" (1995) movements seek to bring about within A.A. a return to a largely imagined pristine purity. Two observations may be made about these programs: (1) they have helped some, especially among the more religiously inclined, who had been unable to "get the program" in more ordinary A.A.; and (2) they have estranged at least an equal number who are alienated by their heavy emphasis on a very explicit "old time religion". Although this site is less than fully accepting of these groups, a useful and generally balanced perspective on both groups, and on A.A. "Big Book Fundamentalists" in general, is available [170].

On the opposite side stand the "Modernizing Secularizers" in Alcoholics Anonymous, some of whom not only reject the heavy religious emphasis of the "Back to Basics" enthusiasts but also are antagonized by even the bare mentions of "God" in the Twelve Steps. Although far from all "Modernizing Secularizers" identify as atheists or agnostics, such are the most avid objectors to the sometimes-practice of closing A.A. meetings with the Lord's Prayer and favor finding substitutes for the "God" noun and pronouns in the Steps themselves. And although atheist and agnostic A.A. groups are recognized by the Fellowship's General Service Office, some religiously inclined A.A. members refuse to acknowledge them.

The developing significance of the "Modernizing Secularizers" was underlined in November 2014, when WAAFT—We Agnostics, Atheists, and Free Thinkers—held its first national gathering in Santa Monica, California. The convention was attended by some 300, including visitors from Australia, Turkey, France, and Spain, and was addressed by the current manager of the Alcoholics Anonymous General Service Office and by a former non-alcoholic (and Episcopal minister) Head Trustee of the

fellowship, both of whom warmly praised the group for what they offer the A.A. fellowship as a whole. The "Modernizing Secularizer" perspective is best set forth in the books referenced earlier [83–89] and at the AA Agnostica website [171], the archives of which contain descriptions of the WAAFT convention.

The secular approach and the growing reality of atheist and agnostic meetings of Alcoholics Anonymous may become of increasing importance especially in the United States of America. In at least two of that nation's nine judicial districts, A.A. has been deemed sufficiently "religious" that prisoners and parolees cannot be required to attend its meetings as a condition of their rehabilitation. In its 1996 Griffin v. Coughlin decision, the 2nd Circuit's appellate court ruled that "Adherence to the A.A. fellowship entails engagement in religious activity and religious proselytization" [172]. Just over a decade later, the Ninth United States Circuit Court of Appeals ruled that the constitutional dividing line between church and state is so clear that a parole officer can be sued for damages for ordering a parolee to go through rehabilitation at Alcoholics Anonymous or an affiliated program for drug addicts [173]. Two useful summaries, each with links to specific legal sources, may be found at [174,175].

Faithful to the A.A. Tradition of avoiding public controversy and having no opinion on outside issues, the New York General Service Office of Alcoholics Anonymous declines to comment on those decisions or on the sometimes distorted reporting of them that has appeared in the public press or in private commentaries. Some members and students of A.A. have however suggested that the existence and current increase of atheist and agnostic A.A. groups rebut such claims, demonstrating their falsity. It will probably require another appellate court decision to test that claim. Until such time, it is *not* true that "American courts have found that Alcoholics Anonymous is a religion"; but it is accurate to observe that those who supervise United States penology practices need to keep in mind the nation's constitutional separation of church and state.

8. Conclusions

Within the "Recovery Spirituality" that no one doubts can embrace a religiously oriented spirituality, there also exists room for a "secular spirituality" that can include even "an atheist spirituality". Its core content is summarized in the two prepositions, *beyond* and *between*. How those prepositions are specified varies among A.A. groups, the main difference in the United States being geographic. In the American South, lower mid-West, and southwest, many meeting participants tend to offer an explicitly Christian witness, often mentioning "Jesus Christ" as well as some relationship with "God". On the coasts, in the northeast, and upper mid-West, such effusions are rare, and it is more common for the Serenity Prayer instead of the Lord's Prayer to close meetings that sometimes began with a reading from the also Conference-approved *Living Sober* [176] rather than the God-heavy "How It Works". Some may mention their "Higher Power" or "God", but rarely as central to their stories.

But even within those parameters, in the vast majority of A.A. groups, the topic of "spirituality" is rarely raised.[6] Most speakers talk about, and most discussions revolve around, more quotidian areas where members are endeavoring to live the 12-Step program: a lack of patience with one's spouse, inappropriate concern over one's children's activities, anxiety over a coming medical diagnosis, worry about an employment situation, and the list goes on. When a newcomer is present, members usually

[6] A standard bit of experience-based A.A. humor runs that someone stopped attending a "We Agnostics" group "because there was too much talk about God".

tell how they first came to A.A. What comes out in those talks and "shares" usually are hints and reminders of the six "spirituality facets" noted above: Release, Gratitude, Humility, Tolerance, Forgiveness, and a sense of Being-at-home. There are no labels, denominational or otherwise, for this spirituality. It simply is. And on the basis of available evidence, it will continue to be.

Author Contributions

Ernest Kurtz and William White each contributed to the research upon which the paper is based. Kurtz prepared the original draft, and both authors revised, read, and approved the final manuscript.

Conflict of Interest

The authors declare no conflict of interest.

References

1. John F. Kelly, and Claire M. Greene. "Toward an Enhanced Understanding of the Psychological Mechanisms by which Spirituality Aids Recovery in Alcoholics Anonymous." *Alcoholism Treatment Quarterly* 32 (2014): 299–318.
2. Keith Humphreys, Janet C. Blodgett, and Todd H. Wagner. "Estimating the Efficacy of Alcoholics Anonymous without Self-Selection Bias: An Instrumental Variables Re-Analysis of Randomized Clinical Trials." *Alcoholism: Clinical and Experimental Research* 38 (2014): 2688–94.
3. Lee Ann Kaskutas. "Alcoholics Anonymous Effectiveness: Faith Meets Science." *Journal of Addictive Diseases* 28 (2009): 145–57.
4. Shulamith Lala Ashenberg Straussner, and Helga Byrne. "Alcoholics Anonymous: Key Research Findings from 2002–2007." *Alcoholism Treatment Quarterly* 27 (2009): 349–67.
5. Agent Orange [*pseud.*]. "The Orange Papers: One Man's Analysis of Alcoholics Anonymous and Substance Misuse Recovery Programs, and Real Recovery. An Online Book." 24 November 2014. Available online: http://www.orange-papers.org/ (accessed on 7 January 2015).
6. Agent Green [*pseud*]. "The Effectiveness of Alcoholics Anonymous." 5 December 2013. Available online: http://www.green-papers.org/ (accessed on 7 January 2015).
7. Ernest Kurtz, and Katherine Ketcham. *The Spirituality of Imperfection*. New York: Bantam, 1992.
8. Ernest Kurtz, and Katherine Ketcham. *Experiencing Spirituality: Finding Meaning through Storytelling*. New York: Tarcher/Penguin, 2014.
9. Alcoholics Anonymous. *Alcoholics Anonymous*, 4th ed. New York: A.A. World Services, 2001.
10. Leslie Farber. "I'm Sorry, Dear." In *Lying, Despair, Jealousy, Envy, Sex, Suicide, Drugs and the Good Life*. New York: Basic Books, 1976, pp. 123–45.
11. Peg O'Connor. "Who Gets to Be an Expert on Their Own Experiences?" *Psychology Today*, 10 September 2014. Available online: http://www.psychologytoday.com/blog/philosophy-stirred-not-shaken/201409/who-gets-be-expert-their-own-experiences (accessed on 7 January 2015).
12. Maria Gabrielle Swora. "Narrating Community: The Creation of Social Structure in Alcoholics Anonymous Through the Performance of Autobiography." *Narrative Inquiry* 11 (2001): 363–84.

13. Judith Grant. "Rural Women's Stories of Recovery from Addiction." *Addiction Research and Theory* 15 (2007): 521–41.
14. Robert Walker, Theodore M. Godlaski, and Michele Staton-Tindall. "Spirituality, Drugs, and Alcohol: A Philosophical Analysis." *Substance Use & Misuse* 48 (2013): 1233–45.
15. William L. White. "Addiction Recovery Mutual Aid Groups: An Enduring International Phenomenon." *Addiction* 99 (2004): 532–38.
16. Ernest Kurtz, and William L. White. "Alcoholics Anonymous." In *Alcohol and Temperance in Modern History: An International Encyclopedia*. Edited by Jack S. Blocker, David M. Fahey and Ian R. Tyrell. Santa Barbara: ABC-CLIO, 2003, pp. 27–31.
17. Alcoholics Anonymous. *Alcoholics Anonymous Comes of Age.* New York: Alcoholics Anonymous World Services, Inc., 1957.
18. Alcoholics Anonymous. *Dr. Bob and the Good Oldtimers: A Biography, with Recollections of Early A.A. in the Midwest.* New York: Alcoholics Anonymous World Services, Inc., 1980.
19. Alcoholics Anonymous. "*Pass It On*": *The Story of Bill Wilson and How the A.A. Message Reached the World*. New York: Alcoholics Anonymous World Services, Inc., 1984.
20. Ernest Kurtz. *Not. God: A History of Alcoholics Anonymous*. Center City: Hazelden, 1979.
21. William L. White, and Ernest Kurtz. "Twelve Defining Moments in the History of Alcoholics Anonymous." In *Recent Developments in Alcoholism*. Edited by Marc Galanter and Lee Ann Kaskutas. New York: Plenum Publishing Corporation, 2008, vol. 18, pp. 37–57.
22. William G. Borchert. *The Lois Wilson Story: When Love Is Not Enough.* Center City: Hazelden, 2005.
23. Sally Brown, and David R. Brown. *Mrs. Marty Mann: The First Lady of Alcoholics Anonymous*. Center City: Hazelden, 2001.
24. Susan Cheever. *My Name Is Bill: Bill Wilson—His Life and the Creation of Alcoholics Anonymous*. New York: Washington Square Press, 2005.
25. Mary Darrah. *Sister Ignatia: Angel of Alcoholics Anonymous*. Center City: Hazelden, 2001.
26. Francis Hartigan. *Bill W.: A Biography of Alcoholics Anonymous Cofounder Bill Wilson*. New York: St. Martin's Griffin, 2001.
27. Mitchell K. *How It Worked: The Story of Clarence H. Snyde*r. Washingtonville: Self-Published, 1997.
28. Dale Mitchel [*pseud*.]. *Silkworth: The Little Doctor Who Loved Drunks, the Biography of William Duncan Silkworth*, *M.D*. Center City: Hazelden, 2002.
29. Matthew J. Raphael [*pseud.*]. *Bill W. and Mr. Wilson: The Legend and Life of A.A.'s Cofounder*. Amherst: University of Massachusetts Press, 2000.
30. Bill Wilson. *Bill W.: My First 40 Years*. Center City: Hazelden, 2000.
31. Jeff Sandoz. "Finding God through the Spirituality of 12 Steps of Alcoholics Anonymous." *Religions* 5 (2014): 948–60.
32. Brian J. Zinnbauer, Kenneth I. Pargament, Brenda Cole, Mark S. Rye, Eric M. Butter, Timothy G. Belavich, Kathleen M. Hipp, Allie B. Scott, and Jill L. Kadar. "Religion and Spirituality: Unfuzzying the Fuzzy." *Journal for the Scientific Study of Religion* 36 (1997): 549–64.

33. Alcoholics Anonymous. *Twelve Steps and Twelve Traditions*. New York: Alcoholics Anonymous World Services, Inc., 1989.
34. Charlie Bishop, and Bill Pittman. *To Be Continued...The Alcoholics Anonymous World Bibliography, 1935–1994*. Wheeling: The Bishop of Books, 1994.
35. Monica J. Horstmann, and Scott J. Tonigan. "Faith Development in Alcoholics Anonymous (AA)." *Alcoholism Treatment Quarterly* 18 (2000): 75–84.
36. Henry A. Montgomery, William R. Miller, and Scott J. Tonigan. "Differences among AA Groups: Implications for Research." *Journal of Studies on Alcohol* 54 (1993): 502–04.
37. Scott J. Tonigan, Francesca Ashcroft, and William R. Miller. "AA Group Dynamics and 12-Step activity." *Journal of Studies on Alcohol* 56 (1995): 616–21.
38. Robin Room. "Alcoholics Anonymous as a Social Movement." In *Research on Alcoholics Anonymous: Opportunities and Alternatives*. Edited by Barbara S. McCrady and William R. Miller. New Brunswick: Rutgers Center of Alcohol Studies, 1993, pp. 167–87.
39. Jean Kirkpatrick. *Goodbye Hangovers, Hello Life*. New York: Ballantine Books, 1986.
40. Jim Christopher. *Unhooked: Staying Sober and Drug Free*. Buffalo: Prometheus Books, 1989.
41. Jack Trimpey. *The Small Book*. New York: Delacorte Press, 1989.
42. Audrey Kishline. *Moderate Drinking*. Tucson: See Sharp Press, 1994.
43. AA Agnostica. "Worldwide Agnostic A.A. Meetings." Available online: http://www.agnosticaanyc.org/worldwide.html (accessed 3 December 2014).
44. William White, and Ernest Kurtz. "The Varieties of Recovery Experience." *International Journal of Self Help and Self Care* 3 (2006): 21–61.
45. Michael T. Flaherty, Ernest Kurtz, William L. White, and Ariel Larson. "An Interpretive Phenomenological Analysis of Secular, Spiritual, and Religious Pathways of Long-term Addiction Recovery." *Alcoholism Treatment Quarterly* 32 (2014): 337–56.
46. William L. White. *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, 2nd ed. Bloomington: Chestnut Health Systems, 2014.
47. William L. White. "Pioneer Interviews." November 2014. Available online: http://www.williamwhitepapers.com/papers/topics/pioneer_interviews/ (accessed on 7 January 2015).
48. Faces and Voices of Recovery. "Guide to Mutual Aid Resources." November 2014. Available online: http://www.facesandvoicesofrecovery.org/guide/support/ (accessed on 7 January 2015).
49. Robert Thomsen. *Bill W.* New York: Harper & Row, 1975.
50. Will Herberg. *Protestant, Catholic, Jew*. New York: Doubleday Anchor, 1959.
51. Stephen J. Whitfield. *The Culture of the Cold War*, 2nd ed. Baltimore: Johns Hopkins, 1996.
52. Linda A. Mercadante. *Belief without Borders: Inside the Minds of the Spiritual but Not. Religious*. New York: Oxford University Press, 2014.
53. Robert C. Fuller. *Spiritual, But Not. Religious: Understanding Unchurched America*. New York: Oxford, 2001.
54. Nancy T. Ammerman. "Spiritual but not Religious? Beyond Binary Choices in the Study of Religion." *Journal for the Scientific Study of Religion* 52 (2013): 258–78.
55. Barbara Newman. "On Being Spiritual But Not (yet? ever?) Religious." *Spiritus: A Journal of Christian Spirituality* 10 (2010): 282–87.

56. Roger C. "A History of Agnostic Groups in AA." 20 August 2012. Available online: http://aaagnostica.org/a-history-of-agnostic-groups-in-aa/ (accessed on 7 January 2015).
57. Jürgen Habermas. "Religion in the Public Sphere." *European Journal of Philosophy* 14 (2006): 1–25.
58. Jürgen Habermas. "Notes on Post-Secular Society." *New Perspectives Quarterly* 25 (2008): 17–29.
59. Jürgen Habermas, ed. *An Awareness of What is Missing: Faith and Reason in a Post-Secular Age*. Cambridge: Polity Press, 2010 [2008 German].
60. Jürgen Habermas. "A Postsecular World Society? On the Philosophical Significance of Postsecular Consciousness and the Multicultural World Society: An interview with Jürgen Habermas by Eduardo Mendieta." 2012. Available online: http://blogs.ssrc.org/tif/wp-content/uploads/2010/02/A-Postsecular-World-Society-TIF.pdf (accessed on 7 January 2015).
61. Rodney Stark. "Secularization, R.I.P." *Sociology of Religion* 60 (1999): 249–73.
62. Stathis Gourgouris. "Why I Am Not a Postsecularist." *Boundary 2* 40 (2013): 41–54.
63. Bruce Robbins. "Why I Am Not a Postsecularist." *Boundary 2* 40 (2013): 55–76.
64. Austin Harrington. "Habermas and the 'Post-Secular Society'." *European Journal of Social Theory* 10 (2007): 543–60.
65. Stephen Bullivant, and Lois Lee. "Interdisciplinary Studies of Non-Religion and Secularity: The State of the Union." *Journal of Contemporary Religion* 27 (2012): 19–27.
66. Aakash Singh. "Is *Who* Postsecular? A Post-Postcolonial Response." *Telos* 167 (2014): 27–48.
67. Charles Taylor. *A Secular Age*. Cambridge: Harvard-Belknap, 2007.
68. Peter Watson. *The Age of Atheists: How We Have Sought to Live Since the Death of God*. New York: Simon & Schuster, 2014.
69. Alister McGrath. *The Twilight of Atheism: The Rise and Fall of Disbelief in the Modern World*. New York: Doubleday, 2004.
70. Paul Heelas. "Challenging Secularization Theory: The Growth of 'New Age' Spiritualities of Life." *Hedgehog Review* 8 (2006): 46–58.
71. Wally P. *Back To Basics—The Alcoholics Anonymous Beginners Meetings*, rev. ed. Tucson: Faith with Works Publishing Co., 2003.
72. Ernest Kurtz, and William L. White. "AAAgnostica and the Varieties of AA Experience." 1 August 2014. Available online: http://www.williamwhitepapers.com/blog/2014/08/aaagnostica-and-the-varieties-of-aa-experience-ernie-kurtz-and-william-white.html (accessed on 7 January 2015).
73. R.L. Wild. "Only with God's Help?" *The New Humanist*, January 1975. Available online: http://paganpressbooks.com/jpl/WILD.HTM (accessed on 21 January 2015).
74. J. Scott Tonigan, William R. Miller, and Carol Schermer. "Atheists, Agnostics and Alcoholics Anonymous." *Journal of Studies on Alcohol* 63 (2002): 534–41.
75. Daniel Steinmetz-Jenkins. "Faith as an Option." *The Immanent Frame*, 6 November 2014. Available online: http://blogs.ssrc.org/tif/2014/11/06/faith-as-an-option/ (accessed on 7 January 2015).

76. Scott J. Tonigan, Kristina N. Rynes, and Barbara S. McCrady. "Spirituality as a Change Mechanism in 12-step Programs: A Replication, Extension, and Refinement." *Substance Use & Misuse* 48 (2013): 1161–73.
77. Alison D. Spalding, and Gary J. Metz. "Spirituality and Quality of Life in Alcoholics Anonymous." *Alcoholism Treatment Quarterly* 15 (1997): 1–14.
78. Reza Aslan. "Sam Harris and 'New Atheists' aren't new, aren't even atheists." *Salon*, 21 November 2014. Available online: http://www.salon.com/2014/11/21/reza_aslan_sam_harris_and_new_atheists_arent_new_arent_even_atheists/ (accessed on 7 January 2015).
79. Robert C. Solomon. *Spirituality for the Skeptic: The Thoughtful Love of Life*. New York: Oxford University Press, 2002.
80. André Comte-Sponville. *The Little Book of Atheist Spirituality*. New York: Viking-Penguin, 2007.
81. Ronald Dworkin. *Religion without God*. Cambridge: Harvard, 2013.
82. Sam Harris. *Waking Up: A Guide to Spirituality Without Religion.* New York: Simon & Schuster, 2014.
83. Marya Hornbacher. *Waiting: A Non-Believer's Higher Power*. Center City: Hazelden, 2011.
84. Vince Hawkins. *An. Atheists [sic] Unofficial Guide to Alcoholics Anonymous*, rev. ed. CreateSpace Independent Publishing, 2013.
85. Roger C. *The Little Book: A Collection of Alternative 12 Steps.* Toronto: AAAgnostica, 2013.
86. Archer Voxx. *The Five Keys: 12 Step Recovery without a God*. Colorado Springs: Maze Publishing, 2013. Kindle edition.
87. John Lauritsen. *A Freethinker in Alcoholics Anonymous*. Dorchester: Pagan Press, 2014.
88. Adam N. *Common Sense Recovery: An. Atheist's Guide to Alcoholics Anonymous.* Toronto: AAAgnostica, 2014.
89. Joe C. *Beyond Belief: Agnostic Musings for 12 Step Life: finally, a Daily Reflection Book for Nonbelievers, Freethinkers and Everyone.* Toronto: Rebellion Dogs Publishing, 2013.
90. Tatjana Schnell, and William J.F. Keenan. "Meaning-Making in an Atheist World." *Archive for the Psychology of Religion* 33 (2011): 55–78.
91. Heinz Streib, and Constantin Klein. "Atheists, Agnostics, and Apostates." In *Handbook of Psychology, Religion and Spirituality*. Edited by Kenneth I. Pargament. New York: APA, forthcoming.
92. Veit Bader. "Religion and the Myths of Secularization and Separation." *RELIGARE Working Paper* 8 (2011): 1–34.
93. Anesa Miller-Pogacar. "Varieties of Post-Atheist Spirituality in Mikhail Epstein's Approach to Culturology." *Slavic and East. European Journal* 39 (1995): 344–56.
94. Jerome A. Stone. "Spirituality for Naturalists." *Zygon.* 47 (2012): 481–500.
95. Jeffrey K. Hadden. "Toward Desacralizing Secularization Theory." *Social Forces* 65 (1987): 587–611.
96. Saba Mahmood. "Secular Imperatives?" *Public Culture* 20 (2008): 461–65.
97. Christopher F. Silver. "A Word by Any Other Name: The Emergent Field of Non-religion and the Implications for Social Meaning." 8 October 2012. Available online: http://www.religiousstudiesproject.com/2012/10/10/a-word-by-any-other-name-the-emergent-field-of-non-

religion-and-the-implications-for-social-meaning-by-christopher-f-silver/ (accessed on 7 January 2015).

98. Harald Walach. "Secular, Non-dogmatic Spirituality." In *Secular Spirituality: The Next Step Towards Enlightenment.* Switzerland: Springer International Publishing, 2015. (Original German Drachen Verlag, 2011, pp. 93–172.)
99. Harald Walach. "Getting on with Enlightenment: The Necessity of a Secular Non-dogmatic Spirituality." In *Secular Spirituality: The Next Step Towards Enlightenment.* Switzerland: Springer International Publishing, 2015. (Original German Drachen Verlag, 2011, pp. 187–207.)
100. Graham Ward. "The Myth of Secularism." *Telos* 167 (2014): 162–79.
101. Yuri Contreras-Vejar. "The Still Born God: Religion, Politics and the Modern West. By Mark Lilla." *International Journal of Politics, Culture, and Society* 21 (2008): 81–85.
102. Sandra Marie Schneiders. "Religion *vs.* Spirituality: A Contemporary Conundrum." *Spiritus: A Journal of Christian Spirituality* 3 (2003): 163–85.
103. Celia Kourie. "'The Turn' to Spirituality." *Acta Theologica Supplementum* 8 (2006): 19–38.
104. Cornel W. du Toit. "Secular Spirituality Versus Secular Dualism: Towards Postsecular Holism as Model for a Natural Theology." *HTS Teologiese Studies/Theological Studies* 62 (2006): 1251–68.
105. Jessica MacLaren. "A Kaleidoscope of Understandings: Spiritual Nursing in a Multi-faith Society." *Journal of Advanced Nursing* 45 (2004): 457–64.
106. Edward Bailey. "Implicit Religion." *Religion* 40 (2010): 271–78.
107. Teemu Taira. "Atheist Spirituality: A Follow on from New Atheism?" In *Media Portrayals of Religion and the Secular Sacred: Representation and Change*. Edited by Kim Knott, Elizabeth Poole and Teemu Taira. Farnam: Ashgate, 2013, pp. 388–404.
108. Allaman Allamani, Stan-Shlomo Einstein, and Theodore M. Godlaski. "A Review of the Many Meanings of an Unseizable Concept." *Substance Use & Misuse* 48 (2013): 1081–84.
109. David N. Elkins, James L. Hedstrom, Lori L. Hughes, Andrew J. Leaf, and Cheryl Saunders. "Toward a Humanistic-Phenomenological Spirituality: Definition, Description, and Measurement." *Journal of Humanistic Psychology* 28 (1988): 5–18.
110. Christopher C.H. Cook. "Addiction and spirituality." *Addiction* 99 (2004): 539–51.
111. Harold G. Koenig. "Concerns about Measuring 'Spirituality' in Research." *Journal of Nervous and Mental Diseases* 196 (2008): 349–55.
112. Simon Dein, Christopher C.H. Cook, and Harold Koenig. "Religion, Spirituality, and Mental Health: Current Controversies and Future Directions." *Journal of Nervous and Mental Disease* 200 (2012): 852–55.
113. George Vaillant. *Spiritual Evolution*. New York: Broadway, 2008.
114. Roger C. *Don't Tell: Stories and Essays by Agnostics and Atheists in A.A*. Toronto: AA Agnostica, 2014.
115. Anonymous. *Selected Stories and Letters from the AA Grapevine Written by Agnostics, Atheists, Freethinkers and Believers with an Open Mind*. Unpublished manuscript, 2014; compiled by the AA Agnostica site for private use because of copyright restrictions; a list of these stories may be obtained from AA Agnostica, which will allow locating them on the AAGV online site (requires subscription).

116. Lesley L. Green, Mindy Thompson Fullilove, and Robert E. Fullilove. "Stories of Spiritual Awakening: The Nature of Spirituality in Recovery." *Journal of Substance Abuse Treatment* 15 (1998): 325–31.
117. Richard M. Coe. "Defining Rhetoric—and Us." *Journal of Advanced Composition* 10 (1990): 39–52.
118. Christopher C.H. Cook. "Transcendence, Immanence and Mental Health." In *Spirituality, Theology and Mental Health: Interdisciplinary Perspectives*. Edited by Christopher Cook. London: SCM Press, 2013, pp. 141–59.
119. Richard Bernstein. "The Uneasy Tensions of Immanence and Transcendence." *International Journal of Politics, Culture, and Society* 21 (2008): 11–16.
120. Chuck, C. *A New Pair of Glasses*. Newport Beach: New Look Publishing, 2008.
121. Thomas J. Coleman III, Christopher F. Silver, and Jenny Holcombe. "Focusing on Horizontal Transcendence: Much More than a 'Non-Belief'." *Essays in the Philosophy of Humanism* 21 (2013): 1–18.
122. Cornel W. duToit. "Towards a New Natural Theology Based on Horizontal Transcendence." *HTS Teologiese Studies/Theological Studies* 65 (2009): article 186. doi:10.4102/hts.v65i1.186.
123. Michael Daniels. "On Transcendence in Transpersonal Psychology." *Transpersonal Psychology Review* 5 (2001): 3–11.
124. Ursula Goodenough. "Vertical and Horizontal Transcendence." *Zygon* 36 (2001): 21–31.
125. Rabbi Jonathan Sacks. "The Love that Brings New Life into the World." 17 October 2014. Available online: http://www.rabbisacks.org/love-brings-new-life-world-rabbi-sacks-institution-marriage/ (Accessed on 7 January 2015).
126. Frank Riessman. "The 'Helper' Therapy Principle." *Social Work* 10 (1965): 27–32.
127. Randolph G. Atkins, Jr., and James E. Hawdon. "Religiosity and Participation in Mutual-aid Support Groups for Addiction." *Journal of Substance Abuse Treatment* 33 (2007): 321–31.
128. Paul DiLorenzo, Raymond Johnson, and Marian Bussey. "The Role of Spirituality in the Recovery Process." *Child. Welfare* 80 (2001): 257–73.
129. Stephen G. Post. "The Ontological Generality: Recovery in Triadic Community with a Higher Power, Neighbor, and Self." *Alcoholism Treatment Quarterly* 32 (2014): 120–40.
130. Charles A. Walker. "Spirituality, Connectedness & Ultimate Concern." *The Journal of Theory Construction & Testing* 10 (2006): 41. Available online: http://connection.ebscohost.com/c/articles/23465577/spirituality-connectedness-ultimate-concern (accessed on 23 January 2015).
131. Arthur A. Callaham. "It's Not Easy Being Purple: Franz Bibfeldt and the Quest for a Religious Middle." *The Criterion—Publication of the University of Chicago Divinity School* 44 (2005): 24–29.
132. Elizabeth A.R. Robinson, Kirk J. Brower, and Ernest Kurtz. "Life-Changing Experiences, Spirituality and Religiousness of Persons Entering Treatment for Alcohol Problems." *Alcoholism Treatment Quarterly* 21 (2003): 3–16.
133. Elizabeth A.R. Robinson, James A. Cranford, Jon R. Webb, and Kirk J. Brower. "Six-Month Changes in Spirituality, Religiousness, and Heavy Drinking in a Treatment-Seeking Sample." *Journal of Studies on Alcohol and Drugs* 68 (2007): 282–90.

134. Elizabeth A.R. Robinson, Amy R. Krentzman, Jon R. Webb, and Kirk J. Brower. "Six-Month Changes in Spirituality and Religiousness in Alcoholics Predict Drinking Outcomes at Nine Months." *Journal of Studies on Alcohol and Drugs* 72 (2011): 660–68.
135. Robert A. Emmons, and Cheryl A. Crumpler. "Gratitude as a human strength: Appraising the evidence." *Journal of Social and Clinical Psychology* 19 (2000): 56–69.
136. Robert A. Emmons, and Michael E. McCullough. "Counting Blessings *Versus* Burdens: An Experimental Investigation of Gratitude and Subjective Well-Being in Daily Life." *Journal of Personality and Social Psychology* 84 (2003): 377–89.
137. Michael E. McCullough, Robert A. Emmons, and Jo-Ann Tsang. "The Grateful Disposition: A Conceptual and Empirical Topography." *Journal of Personality and Social Psychology* 82 (2002): 112–27.
138. John Bishop. "Secular Spirituality and the Logic of Giving Thanks." *Sophia* 49 (2012): 523–34.
139. Ernest Becker. *The Denial of Death*. New York: Macmillan, 1975.
140. June Price Tangney. "Humility: Theoretical Perspectives, Empirical Findings and Directions for Future Research." *Journal of Social and Clinical Psychology*, 19 (2000): 70–82.
141. Alina Wyman. "The Specter of Freedom: 'Ressentiment' and Dostoevski's 'Notes from Underground'." *Studies in East. European Thought* 59 (2007): 119–40.
142. Joshua Hren. "The Genealogy of resentment and the Achilles' Heel of Humanitarianism: Thinking with Dostoevsky, Scheler, and Manent on 'Love of Mankind'." *Logos: A Journal of Catholic Thought and Culture* 17 (2014): 17–43.
143. Bernard N. Meltzer, and Gil Richard Musolf. "Resentment and Ressentiment." *Sociological Inquiry* 72 (2002): 240–55.
144. Robert C. Solomon. *Living with Nietzsche: What the Great "Immoralist" Has to Teach Us*. New York: Oxford, 2003.
145. Jay R. Wallace. "Ressentiment, Value, and Self-Vindication: Making Sense of Nietzsche's Slave Revolt." In *Nietzsche and Morality*. Edited by Brian Leiter and Neil Sinhababu. Oxford: Clarendon, 2007, pp. 110–37.
146. Lin Bauer, Jack Duffy, Elizabeth Fountain, Steen Halling, Maria Holzer, Elaine Jones, Michael Leifer, and Jan O. Rowe. "Exploring Self-Forgiveness." *Journal of Religion and Health* 31 (1992): 149–60.
147. Steen Halling. "Embracing Human Fallibility: On Forgiving Oneself and Forgiving Others." *Journal of Religion and Health* 33 (1994): 107–13.
148. Richard S. Downie. "Forgiveness." *The Philosophical Quarterly* 15 (1965): 128–34.
149. Dorothea M. Dolling. "This Word Forgiveness." *Parabola* 12 (1987): 6–9.
150. Jon R. Webb, and Richard P. Trautman. "Forgiveness and Alcohol Use: Applying a Specific Spiritual Principle to Substance Abuse Problems." *Addictive Disorders & Their Treatment* 9 (2010): 8–17.
151. Michael E. McCullough. "Forgiveness as human strength: Theory, measurement, and links to well-being." *Journal of Social and Clinical Psychology* 19 (2000): 43–55.
152. Robert D. Putnam, and David E. Campbell. *American Grace: How Religion Divides and Unites Us*. New York: Simon & Schuster, 2012.

153. Paul Taylor, and Pew Research Center. *The Next America: Boomers, Millennials, and the Looming Generational Showdown*. New York: Public Affairs (Perseus), 2014.
154. Penny Long Marler, and C. Kirk Hadaway. "'Being Religious' or 'Being Spiritual' in America: A Zero-Sum Proposition?" *Journal for the Scientific Study of Religion* 41 (2002): 289–300.
155. Michael Hout, and Claude S. Fischer. "Explaining Why More Americans Have No Religious Preference: Political Backlash and Generational Succession, 1987–2012." *Sociological Science* 1 (2014): 423–47.
156. Greg Melleuish. "Living in an Age of Comfort: Understanding Religion in the Twenty-first Century." *Telos* 166 (2014): 9–24.
157. Robert Wuthnow. *After the Baby Boomers: How Twenty- and Thirty.-Somethings. Are Shaping the Future of American Religion*. Princeton: Princeton University Press, 2010.
158. Grace Davie. "Believing without Belonging: Is This the Future of Religion in Britain?" *Social Compass* 37 (1990): 455–69.
159. David Voas, and Alasdair Crockett. "Religion in Britain: Neither Believing nor Belonging." *Sociology* 39 (2005): 11–28.
160. Wikipedia. "Religion in the United Kingdom." 23 November 2014. Available online: https://en.wikipedia.org/wiki/Religion_in_the_United_Kingdom (accessed on 7 January 2015).
161. Tony Glendinning, and Steve Bruce. "New Ways of Believing or Belonging: Is Religion Giving Way to Spirituality?" *The British Journal of Sociology* 57 (2006): 399–414.
162. Dick Houtman, and Stef Aupers. "The Spiritual Turn and the Decline of Tradition: The Spread of Post-Christian Spirituality in 14 Western Countries, 1981–2000." *Journal for the Scientific Study of Religion* 46 (2007): 305–20.
163. Kocku von Stuckrad. "Secular Religion: A Discourse–Historical Approach to Religion in Contemporary Western Europe." *Journal of Contemporary Religion* 28 (2013): 1–14.
164. Joantine Berghuijs, Jos Pieper, and Cok Bakker. "Being 'Spiritual' and Being 'Religious' in Europe: Diverging Life Orientations." *Journal of Contemporary Religion* 28 (2013): 15–32.
165. Paul Heelas. "The Spiritual Revolution of Northern Europe: Personal Beliefs." *Nordic Journal of Religion and Society* 19 (2007): 1–28.
166. Heinz Streib, and Ralph W. Hood. "Modeling the Religious Field: Religion, Spirituality, Mysticism, and Related World Views." *Implicit Religion* 16 (2013): 137–55.
167. Arthur S., Tom E., and Glenn C. "Alcoholics Anonymous (AA) Recovery Outcome Rates: Contemporary Myth and Misinterpretation." 1 January 2008. Available online: http://hindsfoot.org/archives.html (accessed on 7 January 2015).
168. Don McIntire. "How Well Does A.A. Work?" *Alcoholism Treatment Quarterly* 18 (2000): 1–18.
169. Karen Armstrong. *The Battle for God: A History of Fundamentalism*. New York: Random House, 2011.
170. Back to Basics. "An Enquiry into Primary Purpose and Back to Basics AA Groups." Available online: https://drive.google.com/a/umich.edu/file/d/0B0cW38yqky8uOW1BTnZaRjEtNnc/view (accessed on 7 January 2015).
171. AA Agnostica. "AA Agnostica." Available online: http://AAagnostica.org/ (accessed on 7 January 2015).

172. James Barron. "Saying A.A. is Religious, Court Lets Inmate Skip It." *The New York Times*, 12 June 1996. Available online: http://www.nytimes.com/1996/06/12/nyregion/saying-aa-is-religious-court-lets-inmate-skip-it.html (accessed on 21 January 2015).
173. Inouye v. Kemna, 504 F.3d 705 (9th Cir. 2007). Available online: http://caselaw.findlaw.com/us-9th-circuit/1008140.html (accessed on 7 January 2015).
174. Thomas A. Horvath. "Court Ordered 12-Step Attendance is Illegal." Available online: http://www.practicalrecovery.com/non-12-step/court-ordered-12-step-attendance-is-illegal/ (accessed on 7 January 2015).
175. National Drug Court Resource Center. "Constitutional and Other Legal Issues in Drug Court: A Webliography." Available online: http://www.ndcrc.org/content/constitutional-and-other-legal-issues-drug-court (accessed on 21 January 2015).
176. Alcoholics Anonymous. *Living Sober*. New York: Alcoholics Anonymous World Services, 1975.

© 2015 by the authors; licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution license (http://creativecommons.org/licenses/by/4.0/).



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. (2015). A personal tribute: Ernie Kurtz, 1935-2015. Posted at **www.williamwhitepapers.com**

A Personal Tribute to Ernie Kurtz, 1935-2015

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Ernest Kurtz, who made landmark contributions to the study of addiction recovery, died January 19, 2015 of pancreatic cancer. Following publication of *Not-God: A History of Alcoholics Anonymous* in 1979, Kurtz focused his studies on the growing varieties of recovery experience, the healing of shame and guilt, and the role of spirituality in addiction recovery.

Ernest Kurtz was born in Rochester, New York, September 9, 1935--only two months after the meeting of two desperate alcoholics in Akron, Ohio marked the birth of Alcoholics Anonymous. Kurtz attended St. Bernard's Seminary and College and was then ordained as a Catholic Priest in 1961. Following five years of parish work, he began his graduate studies at Harvard University where he completed an M.A. in philosophy and a Ph.D. in the history of American civilization. His Ph.D dissertation on the history of A.A. marked a turning point in the scholarly study of A.A. and the larger arenas of addiction recovery and recovery mutual aid societies, both legitimizing such studies and setting a benchmark by which future studies would be evaluated.

Kurtz subsequently taught at the university level (University of Georgia, Loyola University of Chicago), served as Director of Research at Guest House—an addiction treatment program for Catholic clergy, and served as a research associate at the University of Michigan Center for Self-help Research. He trained generations of modern addiction professionals through his perpetual presence at Rutgers Summer School of Alcohol and Drug Studies and other prominent training venues. He leaves a series of seminal publications and books that followed on the heels of *Not-God*, including *The Spirituality of Imperfection* (with Katherine Ketcham), *Shame and Guilt*, *The Collected Ernie Kurtz,* and the recently released *Experiencing Spirituality* (with Katherine Ketcham).

In the early 1990s, I contacted Ernie, as did legions of people before and after me, requesting help with a project. I

was writing a book on the history of addiction treatment and recovery in the United States and sought Ernie's review and comment on the chapters on A.A. I was quite intimidated by approaching him and did not know at that time that Ernie loved up-and-coming historians of both academic and amateur standing. He welcomed me as he did so many others. I had no inkling at the time that this initial consultation would morph into a sustained mentorship and friendship that would endure for more than twenty-five years and produce the most significant collaborations of my professional career.

Before critiquing my A.A. chapters, Ernie insisted that I had to master the basics of researching and writing history. He created a stack of "must read" history books, including the works of Barbara Tuchman, who he suggested I emulate. As that initial consultation expanded into a broader mentorship of all my historical research and writings, I began to make note of the guidelines within Ernie's repeated admonitions. He challenged me to:

1) Tell the story chronologically (do not confuse your reader but give them hints on what is coming),
2) Tell the story in context (let your reader know what else is going on around the event you are profiling),
3) Present and document the historical evidence—ALL of the evidence,
4) Separate statements of fact from conjecture and opinion,
5) Tell the story from multiple perspectives,
6) Localize and personalize the story, and
7) Stay connected to my readers—keep them wanting to turn the page to find out what happens next.

Ernie also talked a good deal about the ethics of historical research and disclosed his own past dilemmas as a teaching tool, e.g., his response to a request by an A.A. General Service Board trustee not to include the account of Bill Wilson's LSD use in *Not-God*.

I recently published an in-depth profile of Ernie's life and work in Alcoholism Treatment Quarterly, which I would commend to the readers. What I would offer here for readers is a personal glimpse into Ernie's mentorship and why so many aspiring and accomplished historians have held him in such high regard and why so many now mourn his passing.

In his mentorship of others, Ernie, like A.A. itself, expressed far more interested in alcoholics than the disorder of alcoholism. He found within the recovery experience of the alcoholic something of great universal value—the acceptance of human limitation—one's not-Godness, what he often characterized as the spirituality of imperfection. He felt such acceptance was a powerful and essential antidote to many of the ills plaguing individuals, families, communities, and countries. Causes and consequences of alcoholism captured far less of his attention than the paradoxes that existed within the experience of alcoholism recovery. He found something relevant to all that hidden gifts could be found within the curse of illness, that strength could rise from the acknowledgement of weakness, that wholeness could rise from brokenness, that authentic connection

and community could rise from the most severe forms of estrangement and isolation, that envy and resentment could give way to forgiveness and gratitude, that grandiosity and self- hatred could both give way to self-acceptance and humility, and that injury to others could give way to service to others. These poignant lessons he found within his observations of men and women recovering from alcoholism. In his mentorship of others, Ernie was far more interested in calling our attention to the possibilities that could flow from recovery from alcoholism—and what those possibilities revealed about the human condition and human potential--than in the pathologies that alcoholism continued to wreak in the absence of recovery.

Ernie knew stuff, and he knew people. What he did for me and so many others, including legions of M.A. and Ph.D. students, was connect us to information and sources that escaped the usual search methods. He was a walking encyclopedia of the subjects he held most dear and freely shared those resources. So many people's research had crossed Ernie's path that he served as a crossroads continually connecting people with shared interests. Ernie loved connecting people and he played a key role in forging a community of A.A. historians in collaborations with Brown University, A.A. Archivists, A.A. History Lovers, and other such groups. Many of the stories I was able to share through my writings were made possible by Ernie opening doors to people whose names would never have been revealed in a search of the published literature.

Mentoring under Ernie's guidance was not for the faint of heart. I ended many a session with a piece of work bruised or battered, but always believing I could and would do better. Faint praise was not Ernie's style. Those seeking a warm and fuzzy father figure and blind adoration of their capabilities were quickly dismissed of any such expectations. He had very high expectations, and he didn't brook fools. His feedback was extremely pointed, lacking any attempt at sugar coating, but, when he saw potential, his challenges to elevate the quality of one's research, thinking, and writing were quite inspiring.

My mentorship by Ernie evolved into later collaborations on numerous formal studies, monographs, and articles. That experience also taught me a style of collaboration that I found effective and professionally fulfilling. When Ernie and I found a topic we wanted to mutually explore, we would divide and share the research; brainstorm the central ideas and our potential approach; determine which of us would take the lead writing responsibility; create, discuss, and repeatedly revise a detailed outline; prepare a first draft; and repeatedly revise it—sometimes with input from external reviewers before taking it through a formal peer review process. When working on papers using this process, I often learned as much from what we did not include in the papers as from what was included. The frontier issues, often lacking sufficient evidence to then include, were left on the editing floor to be later gathered for further investigation and discussion.

Ernie was a lover of stories and had a profound belief in the healing power of personal story reconstruction and storytelling. With so much to explore

within the history of A.A., he repeatedly came back to the personal narratives forged in A.A. and what happened when these stories were exchanged among A.A. members. In that same vein, he believed that history was a form of collective storytelling and that wisdom and healing could flow from this form of sensemaking. He believed that the study of history could make a difference in present and future decision-making. And Ernie loved the ideas that flowed from his study of history. Few things energized him more over the years I knew him than his intellectual exchanges with the likes of Robin Room, Ron Roizen, Bill Miller, Alan Marlatt, and innumerable others.

Ernie often said that if he were to do another book on A.A., it would be titled *Varieties of A.A. Experience*. He was particularly interested in the growth of secular spirituality within A.A., as represented by such groups as Atheists and Agnostics in A.A. (Quad A) and A.A. Agnostica, and he had a deep interest in the growth of secular and religious alternatives to A.A. He led the effort by Faces and Voices of Recovery to create a Guide to Recovery Mutual Aid Resources that catalogued secular, spiritual, and religious mutual aid groups in the United States. Ernie was one of the few people who commanded wide relationships and respect across these boundaries. When Ernie reflected on these diverse pathways of recovery, he saw more similarities than differences. He saw recovery across these pathways as an escape from self-entrapment—an achievement of *beyond* and *between* (connection with resources and relationships beyond the self)--manifested in six core experiences: release, gratitude, humility, tolerance, forgiveness, and being-at-home (Kurtz and White, in press, *Religions*).

These past months, Ernie and I were acutely aware his days were limited. Two things struck me about our final months of working together. First, he was primarily concerned with the burdens his illness and death would impose on his wife (Ernie had left the priesthood and later married Linda Farris); he spoke rarely of any other concern about the process of dying. Second, he was concerned that the final fruits of his work be completed, not as a tribute to himself, but as a resource for future historians he hoped would carry his work forward. Toward that end, we spent the closing weeks of his life creating a Kurtz section of my website that contains his collected papers, interviews, and links to his books, and we completed the final revisions of our last co-authored paper four days before his death—a paper he thought of as a final testimony of his work and thought.

The fact that people representing diverse and sometimes warring constituencies today mourn the passing of Ernie Kurtz is itself a remarkable tribute to the man and his contributions. My heart weighs heavy in the face of Ernie's absence, but I draw great comfort from the memories of our work together and the many gifts he left us all.



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: Sanders, M. & White, W. (2016). African Americans who made (and are making) a difference in promoting resistance to and recovery from alcohol and other drug problems. Posted at **www.williamwhitepapers.com**

African Americans Who Have Made (and are Making) a Difference in Promoting Resistance to and Recovery from Alcohol and Other Drug Problems

Mark Sanders and William L. White

African American communities have often been portrayed as passive victims to alcohol and other drug problems (AOD) within their communities. Such portrayals fail to capture the long history of indigenous resistance to and recovery from such problems among African Americans and their community institutions. As part of a larger effort to reconstruct the history of addiction treatment and recovery within African American communities in the United States, the authors would like to briefly profile a few of the African Americans who addressed, and are addressing, AOD problems in the United States.

This list is by no means complete and we invite readers to share with us others who should be included (at Onthemark25@aol.com). Admittedly, the very brief summaries also do not do full justice to the depth and duration of contributions of many of those profiled. That said, we hope readers will conclude this brief review with a new appreciation of the forces of resistance and recovery that have long existed within African American communities as well as the larger contributions African Americans have made within the history of addiction treatment and recovery in the United States. That we will likely grieve those we forget to include and be deluged with reports of others who should be included in this list offer additional evidence of such contributions.

Ijeoma Achara-Abraham, Ph.D., currently provides training and consultation services to assist in the recovery-focused transformation of large behavioral health systems. She formerly served as the Director of Strategic Planning for the Philadelphia Department of Behavioral Health and Intellectual disAbilities Services, and, while on the faculty of Yale University, aided the systems transformation effort of the Connecticut's Department of Mental Health and Addiction Services.

Lonnetta Albright is the Executive Director of the Great Lakes Addiction Technology Transfer Center (GLATTC), Center for Substance Abuse Treatment. Under her leadership, GLATTC is helping affiliate states shift from an acute care model of addictions treatment towards recovery management (RM) and recovery oriented systems of care (ROSC). GLATTC has promoted evidence-based addiction

treatment and has co-published a series of monographs on RM and ROSC.

Michelle Alexander, J.D., author of *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*, is a civil rights lawyer who has served as the Director of the Racial Justice Project for the ACLU of Northern California and taught at Stanford University and at the Kirwan Institute for the Study of Race and Ethnicity and the Moritz College of Law at The Ohio State University. Her research and writings have focused on the racial bias within the nation's drug policies, law enforcement practices, and the larger criminal justice system.

Chaney Allen is author of one of the first (1978) autobiographies (*I'm Black and I'm Sober*) of an African American in recovery. She founded the California Black Commission on Alcoholism and the California Women's Commission on Alcoholism. Through the Alcoholism and Counseling Education Center, she trained counselors in techniques for working with minority members with alcohol problems.

Paul Austin is the author of *Return of the Lost One: My Bout with Alcoholism* (2000), an autobiography of alcoholism recovery by an African American man.

Marion Barry (1936-2014), civil rights activists and Mayor of Washington, D.C. between 1979-1991, was arrested by the FBI in 1990 after being videotaped smoking crack cocaine. He rebounded from this adversity and was re-elected as Mayor of Washington, D.C. from 1995-1999. At the time of his death, he was in long-term recovery.

Andrea Barthwell, M.D., FASAM, is founder and CEO of Two Dreams addiction treatment program. She is a former president of the American Society of Addiction Medicine and served as Director of Demand Reduction at the office of the National Drug control Policy under President George W. Bush.

Louis E. Baxter, Sr., M.D., FASAM, has served as the President of the American Society of Addiction Medicine, Executive Medical Director of the Professional Assistance Program of New Jersey, Inc., and Medical Director of the Division of Addiction Services for the New Jersey Department of Health and Senior Services.

Lula A. Beatty, Ph.D., is director of the Special Populations Office, Office of the Director, at the National Institute on Drug Abuse (NIDA), where she has helped develop racial/ethnic minority research and health disparities programs. She has led efforts at NIDA to increase participation of underrepresented scholars in drug abuse and addiction research, and monitoring NIDA's support of racial/ethnic minority and health disparities research. She has also served as Director of Research at the Institute for Urban Affairs and Research at Howard University and as President of the American Psychological Association's Section on the Psychology of Black Women.

Barbara Bedford distinguished herself as a -ad clinician within the Illinois Drug Abuse Program and went on to direct a regional training center for the National Institute on Drug Abuse. Through her leadership, innumerable people in recovery and allied professionals were trained and certified as addiction counselors throughout the Midwest in the 1970s and 1980s.

Carl Bell, M.D., is an international researcher and author of more than 450 book chapters and articles addressing violence prevention, HIV prevention, mental health, addiction/co-occurring disorders, and fetal alcohol syndrome prevention in the African American community.

Peter Bell, an early advocate for addressing the special needs of African Americans within addiction treatment in the Unites States, cofounded and, for fifteen years, served as executive director of the Institute on Black Chemical Abuse. He is the author

of *Chemical Dependency and the African American*, *The Black Alcoholic: Growing Up Black and Proud* (A Substance Abuse Prevention Curriculum for African Americans) and *Cultural Pain and African Americans*.

Jeheil C. Berman (1791-1858) was a Black minister who in 1833 organized the Home Temperance Society (HTS) in Middleton, Connecticut. HTS became part of the expanding network of African American Temperance societies organized in the years before the Civil War.

Theodora Binion, the long-serving Director of the Illinois Division of Alcoholism and Substance Abuse, has led efforts to increase the use of evidence-based practices and to increase the recovery orientation of addiction treatment. She was an early pioneer in advocating cultural competence training for addiction counselors.

Anita Bertrand Bradley is founder and Executive Director of the Northern Ohio Recovery Association and a member of the Advisory Council of the Center for Substance Abuse Treatment. She earlier served as the Executive Director of Compass House, Inc., in Lorain, Ohio.

Len Bias (1963-1986) was a first team All American college basketball player at the University of Maryland who, after being drafted number one by the NBA Boston Celtics, died two days later from a cocaine induced heart attack. His death heightened awareness of the harmful effects of cocaine but also contributed to public alarm and the subsequent increase in drug penalties that fueled the growth of the U.S. prison population from 400,000 inmates to 2.4 million inmates, inmates who were disproportionately African American men.

Mary J. Blige, the nine-time Grammy award winning singer known as the "Queen of Hip-Hop Soul," increased recovery awareness by openly disclosing her long-term recovery from alcohol and cocaine dependence.

Delbert Boone used his own past incarceration and recovery from addiction as a foundation to explore the relationship between addiction and criminal conduct. He has consulted with numerous correctional and treatment systems and has produced a series of educational videos on addiction recovery.

Frances Brisbane, Ph.D., is Dean and Professor of the School of Social Welfare, State University of New York at Stony Brook and the Dean of the Black Alcoholism and Addictions Institute. The Institute is co-sponsored by the National Black Alcoholism and Addictions Council in Washington, D.C. (founded in 1979) and The Morehouse Research Institute of Morehouse College. In 1985, she co-authored (with Maxine Womble) the book *Treatment of the Black Alcoholic*. She is a widely recognized leader in the movement to enhance the culture competence of social workers and addiction professionals practicing in the United States.

Claude Brown (1937-2002) is the award-winning novelist best known for his books *Manchild in the Promised Land* (1965) and *The Children of Ham* (1976). More than any previous works, these twin novels graphically portrayed the effects of the mid-twentieth century heroin epidemic upon African American urban communities.

Jan Brown, a certified professional recovery coach and the founder and Executive Director of SpiritWorks Foundation, is a leader in the development and delivery of peer-based recovery support services. She served as a subject matter expert in the development of the International Credentialing and Reciprocity Consortium's (IC&RC) peer recovery credential.

William J. Brown (1814-1885), an African-American shoemaker in Providence, Rhode Island, helped organize temperance societies among African American communities of the Northeast during the early- to mid-nineteenth century. African

Americans were excluded from participation in most mainstream temperance organizations during this era.

Henry McNeil "Mandrake" Brown (1935-1996), a Chicago-based activist who protested the marketing of alcohol and tobacco products to the African American community, was most noted for being arrested for whitewashing billboards promoting these products and for using zoning laws to removed 700 illegal billboards in Chicago's African American communities. He co-founded the Citywide Coalition Against Tobacco and Alcohol Billboards and the National Association of African Americans for Positive Imagery.

William Wells Brown (1814-1884) was an escaped slave, abolitionist and temperance activist. He is the author of the first African American novel, *Clotel, or the President's Daughter: A Narrative of Slave Life in the United States*, which was published in 1853.

"Brother" Earl Cannamore used years of charismatic presentations and a series of educational videos (e.g., "Street Talk," "Cocaine Monkey" and "Goodbye Cocaine,") to spread the message of recovery to the African American community and beyond.

Ray Charles (1930-2004), legally blind from the age of seven and ranked by *Rolling Stone Magazine* as the 10th greatest artists of all time, was addicted to heroin for 16 years. His musical career and his addiction and long-term recovery were portrayed in the movie *Ray*, which won actor Jamie Foxx an Academy Award for the lead role.

Rosylyn V. Cheagle submitted her Master's thesis at Howard University in 1969 on the subject of *The Colored Temperance Movement, 1830-1860*. Her historical research is important in documenting the rise of alcohol problems in African American communities and in affirming the existence of strong indigenous efforts to resist and recover from such problems.

Kenneth Christmon, D.S.W., (1953-1994) served as Assistant Professor at the School of Social Work, Rutgers University, where he made important contributions to the study of the historical evolution of alcohol problems in the African American community. His contributions are profiled in the 1995 book, *The life and work of Prof. Kenneth Christmon.*

H. Westley Clark, M.D., J.D., FASAM, served as the Director of the Center for Substance Abuse Treatment (CSAT) for 16 years. He has been an extremely positive force in the modern evolution of addiction treatment as an effective advocate of evidence-based treatment practices and the development of recovery-oriented systems of care.

Father George Clements responded to the cocaine crisis that plagued African American communities in the 1980's and 1990's by founding such programs as One Church-One Child, One Church-One Addict, and One Church-One Inmate. It was his belief that the church could play a major role in helping to support individual and family recovery within the African American community.

William A. Cloud, Ph.D., Professor at the Graduate School of Social Work, University of Denver, has conducted studies with Dr. Robert Granfield on natural recovery from substance use disorders. Among the many contributions of this work was the introduction of the concept of *recovery capital* and its role in recovery initiation and successful long-term recovery maintenance.

Natalie Cole (1950-2015) is the Grammy award winning singer and daughter of the famed singer Nat King Cole. In her 2000 autobiography, *Angel on My Shoulder*, she chronicled her addiction to heroin and cocaine and the initiation of her recovery at Hazelden in 1983.

Clarence L. Cooper Jr. (1934-1978), used his personal experience of addiction to

author several award-winning books on addiction within the African American community, including *The Farm* and *The Scene.* The Farm is one of the few naturalistic accounts of mid-twentieth century addiction treatment at the Federal Narcotics Farm in Lexington, Kentucky.

Dorothy Dandridge (1922-1965) was the first African American actress to be nominated for an Academy Award for Best Actress for her lead role in the 1954 film, *Carmen Jones* (and the first African American woman to appear on the cover of *Life Magazine*. Drinking heavily as a result of relationship failures and the lack of availability or substantive roles for African American actresses, Dandridge died of an overdose of antidepressant medication. Her career inspired African American actresses Cicely Tyson, Jada Pinkett-Smith, Whitney Houston, and Halle Berry.

Danny K. Davis, U.S. congressman from Chicago, Illinois, authored a bill in the U.S. Congress to expunge the records of non-violent offenders, many of whom were incarcerated for drug related offenses. He leads an annual recovery rally in Chicago.

Fred T. Davis, Jr., in his role with the National Council of Alcoholism in the 1970s, was an early champion of culturally-specific approaches to alcoholism treatment for African Americans.

Angela Cornelius Dawson, Executive Director of the Ohio Commission on Minority Health, formerly served as Director of the Ohio Department of Alcohol and Drug Addiction Services. She played a leading role in helping increase the recovery orientation of addiction treatment within the state of Ohio.

Dr. Louis E. Deere, D.O., M.D., a Dallas-based psychiatrist in long-term recovery, has contributed to the field through his specialization in addiction treatment, his work as an educator at the University of Texas Southwestern Medical School, and through his decades of public education on addiction, addiction treatment, and addiction recovery.

Frederick Douglass (1818-1895), who played a pivotal role in the abolition of slavery in the United States, was also a leading temperance advocate. Douglass viewed ritualized drunkenness (drinking contests for slaves hosted by slave masters) as part of the machinery of slavery and viewed sobriety as a key strategy in the emancipation and full citizenship of African-Americans.

W.E.B. Du Bois, Ph.D., (1868-1963), the noted author (*The Souls of Black Folks, Black Reconstruction in America*) and civil rights activist, also was an early supporter temperance. He viewed temperance as a strategy of self-development within African-American communities, but cooled his support of the larger temperance movement when restriction of Black drinking became a White strategy of social oppression and control. Dr. DuBois was the first African American to complete a PhD at Harvard.

Sarah Jane Woodson Early, (1825-1907) served as Superintendent of the Department of Colored People in the South within the Woman's Christian Temperance Union during the 1880s. She was a graduate of Oberlin College and was the first African American woman employed as a college teacher (Wilberforce University, 1858).

Arthur C. Evans, Jr., Ph.D., Commissioner of the Philadelphia Department of Behavioral Health and Intellectual disAbilities Services, led a recovery-focused transformation of Philadelphia's behavioral health care system that included a focus on overcoming minority community disparities in health care access and quality. Under his leadership, Philadelphia has become a model of efforts to develop recovery-oriented systems of care.

Reverend Dr. Leon Finney Jr. has devoted his professional life to the revitalization of

urban communities. The Woodlawn Organization, which he founded in 1961, opened one of the first detox facilities on the south side of Chicago.

Marc Fomby, CEO of FTC Prevention Services, is a national trainer who specializes in substance use and gang prevention strategies.

Patrice Gaines is a former Washington Post Reporter and prison reform advocate whose inspiring book *Laughing the Dark: From Colored Girl to Woman of Color—from Prison to Power* recounts her life during and following her addiction and incarceration as a young woman.

Donald Goines (1936-1974) is the author of such novels as *Dope Fiend*, *Inner City Hoodlum,* and *Crime Partners*. Goines joined the Air Force at age 15 and subsequently developed an addiction to heroin. He supported his addiction through criminal activity and through income from his writing. His novels, like those of Iceberg Slim, vividly portrayed the effects of drug addiction on urban African American communities.

Whoopi Goldberg, nominated for an Academy Award for best actress in the movie *Color Purple* and recipient of an Academy Award for best supporting actress in the movie *Ghost,* is in long-term recovery and overcame homelessness and addiction to become a successful comedienne, actress, talk show host, and activist.

Dwight Eugene "Doc" Gooden, a highly successful and popular major league baseball pitcher, recounted his recovery from drug and alcohol addiction in his 2013 memoir, *Doc*.

Lou Gossett, Jr., the Emmy (*Roots*) and Oscar (*An Officer and a Gentleman*) award winning actor, has been vocal about his own status as a person in long-term recovery. His life story is told in the book, *An Actor and a Gentleman* (2010).

William "Bill" Green has worked in the addictions field for more than 30 years as a counselor, supervisor, trainer and author of the book, *Dysfunctional by Design: The Rebirth of Cultural Survivors* (1995), a memoir of his own recovery journey.

Clara McBride-Hale (1905-1992), known as Mother Hale, founded Hale House in New York City, a home for children who were born prenatally exposed to drugs due to their parents' addiction.

Troy Harden, Ed.D., faculty member at Northeastern Illinois University School of Social Work, is a pioneer in the Rights of Passages Recovery Movement for African Americans initiating and sustaining addiction recovery. He has carried this work to urban areas throughout the United States, to maximum security prisons, and to South Africa.

Frances Harper (1825-1911) served as Superintendent of the Department of Colored People in the North within the Woman's Christian Temperance Union during the 1880s.

Frederick D. Harper, Ph.D., Professor Emeritus of Counseling at Howard University, made significant contributions to the historical study of alcohol problems among African Americans. His 1976 edited text, *Alcohol Abuse & Black America*, exerted considerable influence on the treatment of African Americans during the rise of modern alcoholism treatment.

Carl Hart, Ph.D., Professor of Psychology and Psychiatry at Columbia University, is a neuroscientist known for his research of drug addiction. He received the Pen/E.O.Wilson Literary Science writing award for his book, *High Price: A Neuroscientist's Journey of Self-discovery That Challenges Everything You Know about Drugs and Society* (2023).

Jimmy Hendrix, (1942-1970), one of the most celebrated guitarists, died of a

barbiturate overdose at the age of 27. The highly publicized, drug-related death of such an iconic figure heightened public awareness of the risks of drug experimentation.

Denise Herd, Ph.D., Professor of Public Health at the University of California Berkeley, has conducted a series of seminal studies on the history of alcohol use and related problems among African Americans, including the landmark paper *"We Cannot Stagger to Freedom": A History of Blacks and Alcohol in American Politics*.

Renata Henry, currently the Project Director for the Region 3 Central East Addiction Technology Center, has had a distinguished career in the addictions field, having previously served as the Deputy Secretary for Behavioral Health and Disabilities with the Maryland Department of Health and Mental Hygiene and the Director of Division of Substance Abuse and Mental Health of the Delaware Health and Social Services

Warren W. Hewitt, Jr. D.P.H, currently the HIV/AIDS Coordinator at the Center for Substance Abuse Treatment, has also served as the Senior Adviser to the Deputy Director for Demand Reduction in the White House Office of National Drug Control Policy and as the Associate Director of the Office of Minority Health of the Department of Health and Human Services.

Billie Holiday, (1915-1959) transcended a turbulent childhood to become one of the most popular and influential jazz and pop singers of the 1950s. Her life and music career were plagued be abusive relationships, addiction to heroin and alcohol, drug-related arrests, continual harassment by the Bureau of Narcotics, and repeated efforts at treatment. Her life was vividly portrayed in the 1972 film *Lady Sings the Blues* starring Diana Ross.

Deborah Hollis is the Director of Recovery Oriented Systems of Care, Behavioral Health and Developmental Disabilities Administration, of the Michigan Department of Community Health. She has led Michigan efforts to extend exclusively acute care models of addiction treatment toward models of sustained recovery management wrapped within larger systems of recovery support within local communities.

Cherie Hunter is an international speaker and consultant in the addictions field. After serving 20 years in the Illinois Air National Guard where she co-developed and directed youth drug and alcohol after school programs, she served as Director of External Training and the Center for Criminal Justice at Treatment Alternatives for Safe Communities (TASC) in Chicago. Her work has focused on recovery management in the criminal justice system, the community re-entry process, and the special needs of women.

Samuel L. Jackson, famed actor and film producer, developed an addiction to alcohol and cocaine for which he sought treatment in the early 1990's and immediately afterwards played an addict in his breakout role in Spike Lee's *Jungle Fever*. He has been in recovery for more than two decades.

Jesse Jackson, Sr. civil rights activist and former presidential candidate, has long highlighted the destructive influences of addiction on African American families and communities. He is known for such inspirational quotes: "Down with dope, up with hope, register and vote" and has been a vocal advocate challenging the disparity in sentencing between crack and powder cocaine and its effects on the incarceration of African Americans.

Andre Johnson, President/CEO of the Detroit Recovery Project, Inc.—a prominent recovery advocacy organization, has been a leader in development of recovery support services within African American communities and has also been instrumental in the development of such services in East Africa.

Michael Johnson, is a national trainer specializing in addictions treatment in the criminal justice system. He is the author of numerous workbooks on relapse prevention and recovery.

Solomon Jones used his addiction recovery experience as a foundation for becoming a successful journalist (*Philadelphia Daily News*) and author (*Pipe Dreams* and eight other novels). He has also taught creative writing at Temple University.

Roland Lamb, Director of the Office of Addiction Services, Philadelphia Department of Behavioral Health and Intellectual disAbility Services, has worked in the addictions field for more than 40 years, championing recovery-oriented models of service delivery and addressing health disparities within communities of color.

Allen "Skip" Land, (1942-2013), long-time Director of Clinical Services at Chicago's A Safe Haven, was an effective leader in the development of extended care and recovery residence programs in the U.S.

Daniel Lanier Jr., D.S.W., while serving as manager of the Employee Assistance Program for General Motors Corporation, called upon the employee assistance field to address the special needs of African American employees with alcohol and other drug problems.

John R. Larkins, D.S.W. (1913-1980), author of *Alcohol and the Negro: Explosive Issues* (1965), served as Coordinator for Civil Rights for the North Carolina Department of Welfare and in other NC state administrative positions. His book was one of the first to examine the history of alcohol use and related problems within the African American community.

Benneth Lee is an International speaker and consultant specializing in working with gang affiliated African American clients with substance use disorders and those in the criminal justice system. He is the founder of The National Alliance for the Empowerment of the Formerly Incarcerated.

John W. Lewis (1810-1861) served as president of the New England Colored Temperance Society (founded in 1836)—one of the most influential of the early nineteenth century African American Temperance Societies.

Rev. Stephen Lloyd Johnson is the author of *Getting Off Crack* (1994) and the co-author (with William James) of *Doing Drugs: African American Patterns of Addiction* (1996).

John Lucas Jr., former NBA basketball player and former coach of the San Antonio Spurs, has been quite public about his long-term recovery from cocaine dependence. He has spent the past 30+ years providing peer-based recovery support for NBA basketball players who have been suspended for violating the NBA's substance use policy. He is the author of *Winning a Day at a Time* (1994).

William L. Mallory, Sr. (1931-2013) served in the Ohio Legislature for 28 years and was the first African American Floor Leader. He spearheaded a statewide initiative to develop The Urban Minority Alcoholism Outreach Programs (UMAOP), later renamed The Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOP) that served the Ohio communities of Cincinnati, Cleveland, Columbus, Dayton, Toledo, Youngstown, Mansfield, Lorain, and Akron.

Denise Matthews, a long-tenured addictions counselor, was a leader in challenging the confrontation tactics used within early therapeutic communities, positing that such tactics were disrespectful, non-therapeutic, and traumatizing to clients.

Clifton D. Mitchell has served multiple roles within SAMHSA/CSAT, including Chief of the Treatment and Systems Improvement

Branch and Coordinator of SAMHSA's Faith-Based and Community Partners Initiative.

Lonnie Mitchell, Ph.D., (1927-1997) led the efforts of the then newly created National Institute on Drug Abuse to recruit and prepare the nation's addiction treatment workforce. He and his state and local partners forged a system of education, training, and credentialing of what was at the time a primarily "paraprofessional ex-addict" workforce while at the same time recruiting and training physicians, nurses, psychologists, and social workers to collaborate with the "new profession" of addiction counseling.

Malcolm X, (Malcolm Little, el-Hajj Malik el-Shabazz, 1925-1965), the noted human rights activist, recovered from addiction through his conversion to Islam, viewed addiction as an failed escape from oppression, and championed assertive outreach (a practice he referred to as "fishing for the dead") to rescue African American men and women addicted to alcohol and other drugs.

Annie Moody co-founded one of the largest faith-based addiction ministries at Trinity United Methodist Church in Chicago in 1986—typifying the growing involvement of the church in addressing addiction problems within African American communities.

Philander Moore is the Unit Manager for the Substance Abuse Program Services Unit within the Mental Health Substance Abuse Division at Texas Department of State Health Services, where he and his staff are leading Texas' recovery-focused systems transformation effort. Prior to his work with the state, Philander served in the United States Air Force for 9 years as a Certified Chemical Dependency counselor.

Stacia Murphy has been a tireless leader within the new recovery advocacy movement, having served as the President of the National Council on Alcoholism and Drug Dependence (NCADD, 1999-2006) and the Executive Director of the Alcoholism Council/Fellowship Center, the New York Affiliate of the NCADD (1984-1999).

Gloria Mouzon, M.D., served as the Medical Director of the Women's Treatment Center in Chicago, Illinois for more than 25 years.

Don Newcomb, best known as the highly successful baseball player (Brooklyn/Los Angeles Dodgers, Cincinnati Reds, and Cleveland Indians), used his own addiction recovery to help innumerable others. His public statements on his recovery heightened awareness of alcoholism in the African American community and the potential for full recovery.

Huey P. Newton, Ph.D., (1942-1989), co-founder of the Black Panther Party for Self-Defense (1966), later experienced drug problems and died of street violence. His death brought attention to growing drug problems and drug-related violence within African American communities.

Jewell Oates, Ph.D., served as the Executive Director of the Women's Treatment Center in Chicago for nearly 30 years. She was a tireless advocate for addressing the special needs of women within addiction treatment.

Charlie "Yardbird/Bird" Parker (1920-1955) was the famed jazz musician whose productivity and life were cut short by his addiction to heroin and alcohol. His life became a cautionary tale about addiction and the lost potential of genius.

James W.C. Pennington (born Jim Pembroke, 1807-1870) escaped slavery at age 19 and went on to a distinguished career as a minister, abolitionist, and temperance advocate. His 1841 book, *The Origin and History of the Colored People,* is considered by many to be the first history of the African American experience. His autobiography, *The Fugitive Blacksmith*, was published in 1849.

Alfred "Coach" Powell, a nationally known consultant on prevention programs within the African American community, is the author of *Message in the Bottle: The 40 oz. Scandal*, and *Hip Hop Hypocrisy: When Lies Sound Like the Truth*.

Joe Powell, is the Executive Director of the Association of Persons Affected by Addiction (APAA) in Dallas Texas and a long-tenured leader within the new recovery advocacy movement in the United States.

Beny Primm, M.D., (1928-2015) was the founder and long-tenured Executive Director of the Addiction Treatment and Research Corporation (Manhattan and Baltimore). He was a forceful public health advocate during the early days of the AIDS epidemic, a highly respected proponent of medication-assisted treatment of opioid addiction, and a longtime leader within the American Association for the Treatment of Opioid Dependence. He also served as Director of the Center for Substance Abuse Treatment under President George Bush.

Emma Redmond is a key figure in the development of early alcoholism/addiction counselor training programs in the Midwest during the closing decades of the twentieth century.

Don Rogers (1962–1986), a renowned college (UCLA) and NFL (Cleveland Browns) football player, died of a cocaine-induced heart attack on June 27, 1986, eight days after the cocaine-related death of Len Bias. Both deaths heightened social panic regarding increased cocaine use and the relationship between drugs and sports.

Diana Ross, famed singer and actress, announced in 2002 that she was seeking treatment for addiction to alcohol and pain medication. Her public disclosure of her recovery from addiction inspired other women to seek help.

Jim S., M.D., organized the Washington Colored Group in April, 1945—the first African American group of Alcoholics Anonymous in the U.S. It later changed its name to the Cosmopolitan Group to signal that is was a group for "all people."

Onaje Salim, Ed.D, is Acting Deputy Director, Center for Behavioral Health Statistics and Quality for SAMHSA/Center for Substance Abuse Treatment. He as the former director, Georgia Office of Addictive Disease Services, Division of Mental Health, Developmental Disabilities and Addictive Diseases.

Mark Sanders, a long-term educator in the addictions field, is author of *Treating the African American Male Substance Abuser* and *Counseling Chemically Dependent African American Women*. In 2013, he edited a book entitle, *Substance Use Disorders in African American Communities* which included chapters on addiction treatment and recovery written by 13 African American authors.

Afena Shakur, a former Black Panther in long-term recovery from cocaine dependence, directs the Tupak Shakur Foundation in Stone Mountain, Georgia. Her 2005 biography is entitled, *Afena Shakur: Evolution of a Revolutionary*, was authored by actress Jasmine Guy.

Darryl Strawberry, the famed American League baseball player, recovered from addiction and cancer and went on to become an ordained Christian minister and founder of the Darryl Strawberry Recovery Center, an addiction treatment program in St. Cloud, Florida.

Michael "Cetewayo" Tabor is the author of a 1970 Black Panther pamphlet entitled *Capitalism Plus Dope Equals Genocide*. His contention that "capitalist exploitation and racial oppression are the main contributing factors to drug addiction in regard to Black people" marked a new era of radical theories on the etiology of addiction and political liberation and cultural renewal strategies for the amelioration of such problems.

Lucy Thurman (1849-1918) served as the National Superintendent of the Department of Colored Work within the Woman's Christian Temperance Union in the 1890s.

Wilma Townsend, a pioneer in the recovery movement, is a Public Health Analyst at the Center for Substance Abuse Treatment's Office of Consumer Affairs. She has championed the development of recovery-oriented behavioral health care and the expansion of peer-based recovery support services.

Calvin R. Trent, Ph.D., retired General Manager. Division of Special Population Health Services for the Detroit Department of Health and Wellness Promotion, is a leading advocate for recovery-focused transformation of addiction treatment in the United States. Under his leadership, innovative addiction treatment and recovery support services were dramatically expanded within the City of Detroit.

Sojourner Truth (1797-1883) the famed abolitionist and advocate of women suffrage was also a temperance advocate, but challenged that movement to go beyond pledges of abstinence: "There is one trouble about this temperance work. You get a man to sign the pledge and that is all there is of it, when you ought to get him to work, and carry food and clothing to his poor starving wife and children. Treat them as human beings should be treated and fewer temperance converts would backslide."

Dawn Tyus, is Director of the Center for Substance Abuse Treatment's Southeast Addiction Technology Transfer Center located at the Morehouse School of Medicine's National Center for Primary Care.

Vanity (Denise Matthews) is the singer and actress best known for her performances with Rock and Roll Hall of Fame singer, Prince. In 1994, Vanity overdosed on Crack Cocaine and suffered renal failure. She stated that Jesus spoke to her at that time and promised to save her if she gave up the Vanity persona. Now in long-term recovery, she is a religious evangelist who regularly leads large revivals in churches with recovery ministries.

Hattie Wash, Psy.D., has over 30 years' experience providing Afro-centric direct services for African Americans with substance use disorders. She was the first president of the Illinois Chapter of The Black Alcoholism Council and is the author of *Cultural Specific: A Model for the Treatment of African American Alcoholics*.

Booker T. Washington, (1856-1915), educator, author, and African American civil rights leader, championed temperance and alcohol prohibition as essential for "intellectual awakening and moral revolution." He saw temperance as an essential strategy for the cultural and economic uplift of African Americans in the years following the Civil War.

Ida B. Wells (1862-1931) rose from her status as a former slave to become a journalist, newspaper editor, and civil rights activist. Through her writings she exposed the increase in lynching in the 1890s and challenged Frances Willard, leader of the Woman's Christian Temperance Union for her failure to publicly oppose the practice of lynching and for comments by Willard that provided justification for such atrocities.

Jacob C. White, Jr. (1837-1902) a Philadelphia abolitionist and temperance advocate, urged Blacks in 1854 to avoid alcohol and focus their energies on education and the elevation of the race.

David Njabulo Whiters, Ph.D., is the founder of Recovery Consultants of Atlanta. He consults nationally and internationally (including in Africa) on the development of recovery-oriented systems of care and peer-based addiction recovery support services.

Cecil Williams is Pastor Emeritus of Glide Memorial United Methodist Church in San

Francisco. He championed community activism of the church and launched a recovery ministry described in his book *No Hiding Place: Empowerment and Recovery for Troubled Communities* (1992).

Roland F. Williams, co-authored (with Terry Gorski) *Relapse Prevention Counseling for African Americans: A Culturally Specific Model* (2007). He has trained nationally and internationally on culturally-nuanced approaches to relapse prevention.

Maxine Womble, M.A., was a prominent leader in the National Black Alcoholism Council (NBAC) and co-author of the book *Treatment of the Black Alcoholic* (with Dr. Frances Brisbane).

Lewis Woodson (1806-1978), a mid-nineteenth century champion of Black nationalism, championed temperance on the grounds that excessive alcohol use was threating the very future of African American communities by draining its limited resources.

Ednita M. Wright, Ph.D., an Associate Professor of Human Services and Teacher Education at Onondaga Community College and faculty member in the School of Social Work at Syracuse University, has focused much of her work on HIV/AIDS, substance use policy, and substance use treatment issues. Her published contributions include a seminal 2003 book chapter entitled "Substance Abuse in African American Communities."

Acknowledgement: Support for this interview series is provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.

About the Authors: Mark Sanders, a former faculty member of the Addictions Studies Program at Governors State University, is an international speaker in the addictions field and author of four books, including *Counseling Chemically Dependent African American Women*. William White is Emeritus Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Their prior co-authored publications include the following:

White, W. and Sanders, M. (2002) Addiction and recovery among African Americans before 1900. *Counselor* 3(6):64-66.

White, W., Sanders, M. & Sanders, T. (2006). Addiction in the African American Community: The Recovery Legacies of Frederick Douglass and Malcolm X. *Counselor*, 7(5), 53-58.

Sanders, T., Sanders, M. & White, W. (2006). "When I Get Low, I Get High": The portrayal of addiction and recovery in African American music, *Counselor*, 7(6), 30-35.

White, W. & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, 26(3), 365-395.

Galanter, M., White, W. L., Khalsa, J. & Hansen, H. (2023). A scoping review of spirituality in relation to substance use disorders: Psychological, biological, and cultural issues. *Journal of Addictive Diseases*, Published Online February 11, 2023.

ABSTRACT

Background: Spirituality is a construct encompassing a diversity of strongly held beliefs and pursuits related to life's meaning and purpose. Empirical studies in key domains of spirituality related to substance use disorder (SUD) can be valuable in guiding research, and potentially clinical care.

Objectives: To conduct a scoping review of research on the psychological, biological, and cultural dimensions of spirituality and their role in relation to SUD. To identify limitations in empirical findings within these domains and identify promising areas for related research.

Data Sources: Study Appraisal, and Synthesis Methods: Illustrative studies available in the empirical literature are reviewed in order to characterize these three key domains.

Results: Certain areas of importance stand out: On Psychology, attribution of SUD to a spiritual outlook; spiritual awakening; the relation of spirituality to drug craving; and spirituality in the context of psychedelic-assisted psychotherapy. On Biology, heritability of traits related to shared spiritual experience; neurophysiologic correlates of spiritually related experiences; and correlates in brain imaging; On Culture, spiritual aspects of SUD in different cultural settings; distinctions between spiritual and religious phenomena; roles that international organizations play; and context of acquiring recovery capital. The need for further research in each area is defined.

Conclusions: There is utility in examining the diversity of findings in the roles of psychology, biology, and culture in the SUD field. Further research, particularly applying randomization and clinical controls, would be useful in improving the effective application of the construct of spirituality in clinical care.